



**Community Managed Mental Health Sector  
National Disability Insurance Scheme Workforce  
Development Scoping Paper Project**

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**FINAL REPORT**

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**October 2015**

## **Report preparation**

This report has been prepared by Human Capital Alliance (International) Pty Ltd (HCA) for the Mental Health Coordinating Council NSW (MHCC) in October 2015.

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## **Disclaimer**

HCA prepares its reports with diligence and care and has made every effort to ensure that evidence on which this report has relied was obtained from proper sources and was accurately and faithfully assembled. It cannot, however, be held responsible for errors and omissions or for its inappropriate use.

## **Acknowledgements**

We acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia. Australia is the only place in the world where Aboriginal and Torres Strait Islander Australians belong. There is no place in Australia where this is not true.

HCA wish to acknowledge and thank Tina Smith, Senior Policy Officer with MHCC, members of the project Advisory Group and all stakeholders from the community managed mental health sector who participated in surveys and interviews for this scoping project. Your insights, experience and aspirations were invaluable to this project.

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## **Abbreviations**

ACT	Australian Capital Territory
AQF	Australian Qualifications Framework
CMHA	Community Mental Health Australia
CMO	Community managed organisations
COAG	Council of Australian Governments
DSS	Department of Social Services
GP	General Practitioners
HCA	Human Capital Alliance
HWA	Health Workforce Australia
ILC	Information, Linkages and Capacity
MHA	Mental Health Australia
MHCC	Mental Health Coordinating Council
NDIA	National Disability Insurance Scheme
NDIS	National Disability Insurance Scheme
NDS	National Disability Service
NGO	Non-government organisations
NSW	New South Wales
NT	Northern Territory
OTJ	On-the-job
PIR	Partners in Recovery
PHaMS	Personal Helpers and Mentors
QLD	Queensland
RAS	Recovery Assessment Scale
SA	South Australia
SACS	Social and Community Services
TAS	Tasmania

UNCRPD	United National Convention on the Rights of People with Disabilities
VET	Vocational education and training
VIC	Victoria
WIN	Workforce Innovation Networks

## **Terminology**

### **Community managed organisations (CMOs) /non-government organisations (NGOs)**

CMOs are not-for-profit organisations managed by a board of elected community members. NGOs are private organisations which may be not-for-profit, or for profit. In this guide, the acronym CMO has been used to describe both unless otherwise stated, e.g. when referencing publications where other terminology is used by the author.

### **Consumer / client /carer / service user**

In this report the term ‘consumer’ has been used to refer to people who access and are supported by CMOs, although the terms ‘client’ and ‘service user’ are preferred by many in the sector. These differences are based on sector history, the policy environment, traditional service models and the emergence of new approaches to language. This change includes a shift from the use of medical and clinical language, towards recovery oriented language - a language that reflects hope and optimism. The adoption of recovery oriented language has not been even across the sector.

In this report, the term ‘carer’ has been used to describe the people who care for and support people who experience mental health conditions. A carer may be a family member, friend or other chosen person.

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## Executive summary

### Project aim and background

As part of Mental Health Australia's (MHA) *National Disability Insurance Scheme Capacity Building Project*, MHA funded the NSW Mental Health Coordinating Council (MHCC) to undertake this project to develop a *Community Managed Mental Health Sector National Disability Insurance Scheme (NDIS) Workforce Development Scoping Paper*. The project was undertaken by MHCC on behalf of, and in partnership with, Community Mental Health Australia (CMHA). Human Capital Alliance (International) Pty Ltd (HCA), a workforce development consultancy firm, was contracted to assist with the project.

The overall outcome of the Mental Health NDIS Workforce Scoping Paper Project was to:

*“Scope the Australian community managed mental health sector’s workforce development needs in relation to the delivery of services for psychosocial disability support and to make recommendations about next steps and priorities to address these needs in the context of the national implementation of the NDIS.”*

As part of this outcome, the project also aimed to identify good practice workforce development practices and strategies employed by CMOs to prepare workers to deliver services under the NDIS. This information was used to provide guidance and recommendations to the sector as it moves in to the new era of service delivery under the NDIS.

An Advisory Group was established to guide the project and included representatives from community mental health peak bodies in most states and territories<sup>1</sup>, industry representatives, consumer representatives, the National Disability Service (NDS), the Commonwealth Department of Social Services (DSS) and MHA.

This scoping study was a preliminary attempt to understand the community managed mental health sector’s workforce development needs nationally in relation to the delivery of services for psychosocial disability support within the NDIS context and make recommendations about next steps and priorities to address these needs. By its nature this project has only been able to scope and explore workforce related issues that are emerging under, or in preparation for, the NDIS; further investigations will need to be undertaken to clarify and resolve many of the issues and tensions highlighted by this project.

### Methodology

The methodology consisted of three separate but linked research activities, namely:

- stakeholder interviews with:
  - key informants able to provide insight from specific NDIS operational experience or an overview from policy or research perspectives of the likely NDIS impact on workforce;

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<sup>1</sup> Due to capacity issues, community managed mental health sector peak bodies from Queensland and the Northern Territory were unable to provide representation for this project.

- selected individuals at six state and territory community managed mental health sector peak bodies and selected industry representatives to identify current workforce development responses;
- a small number of nominated mental health consumers and carers to attain an essential perspective on workforce development needs;
- a review of international and locally collected literature and policy with relevance to person-centred approaches to the support of persons with a disability and more directly to the NDIS; and
- a survey of CMOs to develop an understanding of ‘good practice’ workforce development responses to the introduction of NDIS philosophy and service payment approach.

## **Findings and recommendations**

It is important to acknowledge an overall perspective from the study that many service providers consider the NDIS to be a ‘tough’ environment, with pricing constraints and perceived rigidity in the catalogue of supports (NDIA Price Guide) seemingly making it difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner. Some of the perceived difficulties in this regard were summarised by one of the study’s Project Officers as follows:

- having to back away from minimum workforce qualification standard since services cannot afford to pay the salaries required to attract and retain that level of worker
- having a 95% direct service provision model with little margin for non direct service work
- a pricing structure that makes very little allowance for induction, training, development, collaboration, and innovation, and routine administration
- no detail on how the Information, Linkages and Capacity Building (ILC) is going to be implemented so no ability to plan for it or estimate income (for services) from it
- losing very experienced, qualified and dedicated staff in the near to medium term future
- many roles becoming more administrative and less recovery/support/ case management focussed – exacerbating the loss of valuable staff; and
- workforce instability due to the need to employ people on a casual basis.

A summary of key findings, based on the data gathered with all its limitations, and recommendations that flow from the findings are set out below.

### **NDIS has affected the nature of work being performed**

Organisations that have participated in the NDIS pilot sites have identified a change in the nature of work being undertaken with mental health consumers which has mostly resulted in the need to increase skills in the workforce delivering NDIS services. Most CMOs with NDIS experience believe the amount and type of work required to be performed has increased, and for most this has been added on to existing work requirements. The increased work, and its more diverse nature, has required a re-think on the types of skills required to provide many if not most of the NDIS funded services. ‘Good practice’ CMOs have identified the singular importance of relationship skills, and the strategic and competitive advantage a workforce with high quality relationship capabilities provides.

Consumers and some other stakeholders also emphasised that workers that had attitudes and values that acknowledged the rights of consumers to choose, and skills that supported consumer decision-making, gave consumers and their carers service choice and control.

In addition to the increase in the total amount and type of work, and the types of skills required, a pattern of division of labour, at least for work performed under NDIS funding, appears to have rapidly emerged. At least two ‘divisions’ seem to have been formed around two potentially distinct areas of work.

*The first area* of work largely relates to support for individual consumers that provides basic — some services and stakeholders have called it ‘maintenance’ — assistance in self-care in the home and the community (NDIA “Core Support Items”).

*The second area* of work appears to be more in keeping with the principles of the Recovery Oriented Framework, and provides support to consumers individually or in groups, which is more developmental in nature (NDIA “Capacity Building Support Items”).

The evidence for this emerging division of labour in the mental health CMO sector is still limited, although there is stronger evidence of this having already occurred in similar person-centred service environments overseas and in the initial NDS studies here in Australia. In truth, this scoping study has produced only enough evidence to reveal the issue but insufficient to offer a definitive perspective. Further research is warranted to better understand the work actually being performed, and that which consumers actually value.

The *Design of Individual Supports for People with Psychosocial Disability Project* (Individual Supports Project) currently being carried out by MHA aims to describe in detail the range of disability supports that may be sourced by individuals with psychosocial disability through an NDIS individually funded package. It will make recommendations to the NDIA where new support items may be needed. The project should be progressed further to better understanding the actual support work being performed (and desired by consumers) for mental health NDIS participants, and mapping mental health sector roles, skills and qualification requirements and determining the corresponding appropriate pricing. The research should ideally make consumers and their carers a central focus.

**Five key areas for skill development essential for NDIS psychosocial support**

- ▶ **Understanding NDIS processes**
- ▶ **Customer service**
- ▶ **Individualised funding management**
- ▶ **Business planning/ organisational planning**
- ▶ **Care coordination**

**Recommendation 1.** Conduct further research into the support services consumers most need and identify the worker role/s consistent with these service requirements. This could most easily be facilitated by extending MHA's 'Design of individual supports' project with funds from the Sector Development Fund promoted in the MSW Strategy. The project scope would extend to fulfilling the following research elements:

- Mental health sector role mapping
- Mental health sector skills and qualification requirements mapping
- Identification of appropriate supports pricing based on the outcomes of the above two projects

The last project should also consider how the costs for different types of essential work can be accounted for e.g. essential on-the-job training, newer staff shadowing more senior workers, ensuring two workers can work with a consumer at once when necessary, appropriate professional supervision etc. The findings of this research should inform other significant decision making areas including training investment, recruitment strategies and remuneration considerations.

The above recommendation makes explicit a focus on allowing within the price of labour for skills formation and practice supervision provision, in the absence of which stakeholders have warned of high consumer and worker risks.

### **A change in work has influenced a change in skills requirements**

This project identified an emerging tension between minimum qualifications and/or the skills required to carry out NDIS psychosocial disability services that will need to be explored and resolved in future work. The findings of this research indicated that nearly all organisations were committed to employ staff with Certificate IV in Mental Health or Mental Health Peer Work, reflecting the sector's determination at the ground and macro level to lift the workforce's skill level. In practice though, many service providers were often recruiting staff without qualifications. One could argue that this was a contingency measure forced by insufficient availability in the labour market of Certificate IV qualified workers. Some qualitative data from the survey suggested alternatively that many of these recruitment decisions were simply driven more by trying to find the right fit for the skills required for the perceived support role, at the least cost.

Whatever the cause, a number of CMOs identified that they are recruiting with a focus on specific individual attributes or competencies, particularly those classified as 'soft skills' including appropriate attitudes, values, beliefs and interests, appropriate communication style, capacity to relate and empathise. This at least partially reflects the thoughts of consumers.

Regardless of the merits of emerging recruitment practice, the outcome is likely to be that individuals are being employed whose skills may be adequate for most of the time undertaking 'core' support work, but found lacking when consumers need their mental health issue to be properly understood.

Accordingly the final chapter of this report suggests short term workforce development strategies encapsulated in recommendations 2 and 3.

**Recommendation 2.** NDIS implementation funds are allocated to support a sufficient number of scholarships for Certificate IV Mental Health and Peer Support Work courses, on top of State Government subsidies, to meet the demands of NDIS growth.

The scholarship numbers can be determined through workforce planning based on the research findings of Recommendation 1.

**Recommendation 3.** Current workers, or those employed in the future without Certificate IV in Mental Health or Mental Health Peer Work qualifications, should be supported to develop sufficient skills to work with NDIS consumers that require psychosocial recovery support 'on-the-job'. This would be done by subsidising employers to allow study time and appropriate reflection (possibly with a mentor or supervisor) on their workplace experiences.

### **Employment and deployment of workers**

The findings of the scoping study indicated that just over half of organisations surveyed had been increasingly employing workers in a casual role, even those that had previously employed on an almost 100% permanent basis. It was observed mostly though that the increased casualisation of the current and possibly future NDIS workforce is clearly a reaction to the indeterminate demand for labour. Despite the degree of uncertainty in the employment environment, a number of service providers are still aiming for more permanent employment structures, the benefits of which are extolled in the human resources literature.

The key to making effective decisions in this environment is time: with time some of the uncertainties around revenue streams (including ILC funding), price relativities, and the way consumers demand services might dissolve or at least become more manageable. Over time, it is hoped that a sufficiently strong pattern of workforce demand could thus emerge to enable proper workforce planning and management of labour required. With greater understanding of the pattern of demand for workforce, employers can then choose to continue to use a predominantly casual workforce, look to an appropriate mix of casual and permanent employees, or attempt to employ predominantly on a permanent basis but retain some flexibility by applying innovative work practices.

Once the levels of uncertainty have receded CMOs will no doubt need help in building their understanding of the workforce demand and the various ways they can appropriately respond.

**Recommendation 4.** Provide organisations with support in forming innovative workforce employment and deployment decisions by developing and providing guides and tools to assist in identifying service patterns and developing strategies to adopt workforce solutions that match emerging service patterns.

**Recommendation 5.** Conduct research into management tools and mechanisms used by ‘good practice’ CMOs to deploy workers according to their skill mix and skill level to match with consumers based on their levels of need. The findings can be incorporated into the guides proposed in Recommendation 4 or within a separate advisory process.

**Recommendation 6.** NDIS implementation funds are allocated to peak bodies to organise and conduct workshops that juxtapose experienced and inexperienced CMOs to share learnings and information. The ideal will be to include in the mix CMOs that are early adopters of workforce development innovation and likely ‘opinion leaders’. Incentives to opinion leader CMOs (in the form of research grants tied to a commitment to share findings) may need to be considered to ensure their appropriate participation in workshops.

### Attempting to understand future impact of NDIS on the workforce

NDIS have developed information packs, workshops and workbooks for organisations and clients that will be involved in delivering and receiving NDIS support services. One specific example is the *“Imagining and planning for the future under a NDIS: Workbook”* (NDIS, 2013). Existing resources tend to focus almost exclusively on the mechanics of the NDIS, and where they do not they are more general in nature (broad strategy documents) than advisory or prescriptive. There is a need for resources that specifically help organisations think through management and workforce issues.

**Recommendation 7.** Based on consultation with a representative sample of CMOs, identify a list of ‘frequently asked questions’ and then fund development of an information pack with questions and answers around how to structure a workforce in the short and long term that can deal with fluctuations in demand. This recommendation would be consistent with the suggestions of the MSW Strategy and could be funded from the Sector Development Fund.

### Quality assurance / continuous improvement processes

The issue of quality is currently the subject of significant policy activity at the Commonwealth and State / Territory levels and many from the mental health sector have made submissions to this policy development process. The environment though, like other parts of the NDIS service domain, remains for the moment uncertain.

Many survey respondents expressed a fear that quality is being compromised by insufficiently skilled workers being asked to perform work that requires greater competence yet there has been reduced initial and ongoing training investment and practice supervision in a more dispersed workforce context that has yet to be properly mastered. This latter issue seems to be the most challenging, and even overseas where greater experience in a person-centred service environment has been built, the ‘remote’ supervision issue remains a concern. Greater use of consumer feedback and direction, along with improved use of communication technology, would seem to hold promise of better quality assurance and continuous improvement processes.

**Recommendation 8.** The Government develops quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework, including continuous improvement processes.

The NDIS Sector Development Fund supports training for CMOs in the quality assurance and continuous improvement processes similar to recommendations.

## **Workforce size**

The MSW Strategy, echoing initial observations of the Productivity Commission, notes that the workforce will need to double in size by the time the NDIS reaches its full implementation state. No data for this study was explicitly collected on how to expand the workforce other than thoughts gathered through the literature review.

Irrespective of the early trial site experiences, as the NDIS rolls out, increasing recruitment difficulties are to be expected. Traditionally workforce growth is driven by an increased training rate, and earlier recommendations, particularly Recommendation 4, acknowledge this pathway. For very rapid growth of a workforce, more non-conventional means of sustaining growth need to be considered that rely on reduced barriers to workforce entry. While this study has underscored the tensions and anxieties in relation to employing less qualified (but still appropriately skilled) labour, it could potentially be an effective strategy for rapidly increasing available supply of workers — but only if the studies suggested in Recommendation 1 indicate such workers are suitable for the work required to be performed.

**Recommendation 9.** That more interventions, such as the WIN project, in existing pilot sites or areas targeted for further roll-out be funded to explore different and innovative approaches to workforce recruitment and development and the extent to which service collaboration can be effective in increasing the workforce pool. A deliberate attempt be made to include a higher proportion of mental health CMOs in the WIN projects.

**Recommendation 10.** Pending the outcomes of research discussed in Recommendation 1, undertake a national workforce planning project to gain a more precise understanding of the requirements for different types of workforce at different levels of training and qualification. Relative investment in different training models could then be re-calibrated.

In some quarters the use of persons with lived experience has been seen as a possible population from which to rapidly increase recruitment. MHCC depicts this approach as a possible win-win, where service provider workforce challenges are at least partly ameliorated and employment pathways for people with disadvantages are created (MHCC, 2015b).

## **What does good practice workforce development look like?**

It would be exciting to be able to identify a prototype service provider model that could be paraded as an example of good practice workforce development, but in truth, at this early stage of the NDIS roll-out and with still so much uncertainty, 'good practice' is still difficult to discern. While some

innovative workforce development practice can be identified in isolation, this has not translated yet to a broader approach.

What seems possible though is to offer an opinion on the characteristics of organisations that seem best placed to ultimately respond to NDIS workforce challenges quickest and most effectively. These are:

- a proactive and contributing approach that aligns with the maturing of the NDIS and underpins a determination to enable such an important social reform to succeed
- a resolve to remain flexible in workforce development and deployment decision-making until the emergence of clear patterns of workforce demand and supply. The old [HR] management maxim applies in this circumstance, that it is not that decisions are perfect but that the adjustment to poor decisions is rapid. Thus, short-term workforce decisions are not seen as binding on a long term workforce development approach
- adoption of a marketing approach. With this approach the ‘customer is always right’ and the business driver is not a focus on costs but rather on increasing revenue through increased market share, even to the extent of progressing into non traditional (non welfare) markets
- in the same vein, placing consumers at the heart of workforce development decision-making. In this regard, some advice from Gianfrancesco (2014) is salutatory:

*“Listen carefully to what customers tell you before deciding what a ‘qualified workforce’ is.”*

# Chapter 1 - Introduction

## Preamble

As part of Mental Health Australia's (MHA) *National Disability Insurance Scheme Capacity Building Project*, MHA funded the NSW Mental Health Coordinating Council (MHCC) to undertake this project to develop a *Community Managed Mental Health Sector National Disability Insurance Scheme (NDIS) Workforce Development Scoping Paper*. The project was undertaken by MHCC on behalf of, and in partnership with, Community Mental Health Australia (CMHA). Human Capital Alliance (International) Pty Ltd (HCA), a workforce development consultancy firm, were contracted to assist with the project.

This research project was part of a number of other NDIS related research and consultation efforts being undertaken by MHA in partnership with CMHA. The most relevant of these other projects to this Mental Health NDIS Workforce Scoping Paper Project is the *Design of Individual Supports for People with Psychosocial Disability Project ( Individual Supports Project)*.

The Individual Supports Project, due to conclude in late 2015, will articulate a model for delivery of disability supports for people impaired by a mental health condition and also the skills and/or qualification required to deliver these services. The findings and recommendations of the Mental Health NDIS Workforce Scoping Paper Project was limited by the absence of an agreed model for the delivery of NDIS funded services and supports for people with psychosocial disability.

For a greater understanding of disability attributable to a mental health condition (i.e., psychosocial disability) please refer to the following document:

*National Mental Health Consumer Carer Forum (2011). Further Unravelling Psychosocial Disability.*

To obtain a comprehensive understanding of the workforce development needs of the community managed mental health sector in the context of the NDIS, this project should be viewed as a prelude to further investigations necessary prior to and following the full roll-out of the NDIS in 2016. This project was able to shed light on many of the emerging workforce changes and challenges with the implementation of the NDIS; resolving these issues will require further and more extensive exploration.

## Background

In July 2013, the federal government, in agreement with the state and territory governments, began a trial of the NDIS. The core philosophy of the scheme is to ensure that people with disabilities have access to individualised support that is ongoing, flexible and tailored to their needs. The NDIS was trialled at seven pilot sites across Australia before full roll-out commences from July 2016.

To support the roll-out of the NDIS, the Council of Australian Governments (COAG) outlined a set of principles to determine the funding responsibilities under the NDIS and the responsibilities of other existing 'mainstream' support systems (COAG, 2013). As defined by COAG the responsibility of mental health under the NDIS would be as follows:

*The NDIS will be responsible for supports related to a person's ongoing functional impairment and that enable the person to undertake activities of daily living, including "maintenance"*

*supports delivered or supervised by clinically trained or qualified health practitioners where this is directly related to a functional impairment and integrally linked to the care and support a person requires to live in the community and participate in education and employment.*

The extent and specific detail of how and what support will be provided, particularly in relation to the provision of psychosocial support, is still unclear and yet to be fully determined. As the NDIS unfolds it continues to evolve and will continue to do so for several years to come.

Understanding how the NDIS will, initially, function and the impact it will have on delivering support is currently a central concern of the community managed mental health sector across Australia. Prior to the announcement of the NDIS, a considerable amount of workforce development activities and initiatives have been undertaken by the community managed mental health sector broadly to develop and enhance service delivery. Now, with a new structure and system of service delivery fast-approaching, it will be vital for the sector to understand how it can continue to provide quality support to people affected by mental health conditions.

Many community managed organisations (CMOs) Australia-wide have already begun to prepare their workforce either in response to participating in an NDIS trial site or in preparation for the full roll-out of the scheme in 2016. Identifying and describing effective approaches in workforce development implemented so far by CMOs, in the context of the NDIS while still providing recovery oriented services, will be invaluable for the sector and to inform and guide the Australian Government as the NDIS continues to unfold and evolve.

## **Key Project Outcomes**

The overall outcome of the Mental Health NDIS Workforce Scoping Paper Project was to:

*“Scope the Australian community managed mental health sector’s workforce development needs in relation to the delivery of services for psychosocial disability support and to make recommendations about next steps and priorities to address these needs in the context of the national implementation of the NDIS.”*

As part of this outcome, the project also aimed to identify good practice workforce development practices and strategies employed by CMOs to prepare workers to deliver services under the NDIS. This information was used to provide guidance and recommendations to the sector as it moves in to the new era of service delivery under the NDIS.

## **Advisory Group**

An Advisory Group was established to guide the project and included representatives from community mental health peak bodies in most states and territories<sup>2</sup>, industry representatives, consumer representatives, the National Disability Service (NDS), the Commonwealth Department of Social Services (DSS) and MHA. The members of the Advisory Group are listed in Attachment 1. Convened by MHCC, the Advisory Group met throughout the project via teleconference to discuss and plan the project methodology, project findings and recommendations. The role of the Advisory Group was to:

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<sup>2</sup> Due to capacity issues, community managed mental health sector peak bodies from Queensland and the Northern Territory were unable to provide representation for this project.

- provide guidance to the project team throughout the project in respect of the current community managed mental health sector and NDIS;
- inform the project team about workforce development activities of peak organisations in each jurisdiction;
- monitor literature collected throughout the review process and provide any documentation that appears to be missing (especially 'grey' literature that might have limited access);
- work with the project team to provide input to the survey instrument;
- work with the project team to finalise project recommendations; and,
- review and comment on project deliverables.

Efforts to recruit a families and carers representative to the Advisory Group were not successful.

## **Project Officers**

In addition to the Advisory Group, six Project Officers were recruited from each of the state and territory CMO peak bodies . The role of the Project Officers was to work closely with the consultants by assisting with:

- knowledge about state and territory, and national, community managed mental health sector workforce development activities and directions;
- identifying potential CMO survey respondents;
- conducting survey data collection;
- identifying relevant literature for the project; and
- providing guidance on the findings and recommendations of the project.

A list of each of the Project Officers is provided in Attachment 2.

## **Project methodology**

The methodology consisted of three separate but linked research activities, namely:

- stakeholder interviews with:
  - key informants able to provide insight from specific NDIS operational experience or an overview from policy or research perspectives of the likely NDIS impact on workforce;
  - selected individuals at six state and territory community managed mental health sector peak bodies and selected industry representatives to identify current workforce development responses;
  - a small number of nominated consumers and carers to attain an essential perspective on workforce development needs;
- a review of international and locally collected literature and policy with relevance to person-centred approaches to the support of persons with a disability and more directly to the NDIS; and
- a survey of CMOs to develop an understanding of 'good practice' workforce development responses to the introduction of NDIS philosophy and service payment approach.

The activity associated with each of these research actions is detailed below.

## **Stakeholder interviews**

To obtain a broad understanding of the implications of the NDIS on service delivery of psychosocial support, a range of perspectives were sought from individuals intersecting at different points with the NDIS.

### ***NDIS operational key informants***

Interviews were conducted with key informants from the Commonwealth DSS with the purpose of obtaining a deeper understanding of the operational and policy frameworks of the NDIS, specifically in regard to workforce development. In addition, interviews with key informants from the disability sector with operational and research experience with the NDIS were also conducted as a comparative exercise and to examine the likely impacts on the CMO sector.

### ***Peak body and industry representatives***

Information about the future of the sector in the context of the NDIS was obtained through interviews with selected individuals (mostly the nominated Project Officers) from the peak bodies in six states and one territory. These interviews were utilised to scope how the peak bodies were supporting their membership to prepare for the NDIS, what issues were being confronted by CMOs and how they were responding to develop and prepare their workforce. In addition, preliminary interviews were also conducted with industry representatives, including from the public/'mainstream' mental health services, to obtain a more 'first-hand' account of how CMOs are responding to the NDIS.

### ***Consumers and carers***

While not originally in scope for the project methodology, during discussions with the Advisory Group it was acknowledged that consultations with consumers and carers would provide additional valuable insight into relevant workforce development issues related to the NDIS. Advisory Group members were asked to invite consumers and carers from their networks and it was desirable if consumers and carers had either direct experience or a good understanding of accessing support under the NDIS (see Appendix 3 for a copy of the Participant Information Sheet for consumers).

Due to the relative infancy of the NDIS and the limited number of consumers who have received a support package under the NDIS, or with experience in NDIS trial sites, there were difficulties in recruiting consumer and carer participants. Therefore it is important to note that this scoping project has been informed by only six interviews with consumers and carers.

Informal interviews were conducted by the consultants either by phone or face-to-face to explore:

- whether a successful or unsuccessful application through the NDIS had been made;
- the process involved and where they obtained information;
- the type of support they were currently receiving;
- the type of support they required or hoped to receive under the NDIS;
- the advantages and disadvantages of receiving a support package;
- the skills and attitudes required and expected of workers providing support; and
- CMO workforce issues relevant to receiving support.

## Literature and policy review

At the commencement of the project Advisory Group members were invited to search for and provide grey and peer reviewed literature and documents that may be relevant and useful for the project; this was also an expected component of the role of Project Officers.

A central online file sharing system was created using 'Dropbox' accessible by all Advisory Group members and Project Officers where documents were placed for review.

In addition, a review of international peer reviewed literature in relation to person-centred models of support and the impact on workforce was undertaken in the databases PsychInfo and Medline. The key search terms included:

<b>Person-centred services OR</b>	<b>Workforce AND</b>	<b>Skills OR</b>
client-centred services	needs	changes
personalisation	implications	requirements
individualised funding	development	
self-directed services	activities	

The literature search resulted in a large amount of literature available on the implementation of person-centred services and recovery services in mental health but few documents expressly concentrated on the effects and needs of the workforce to deliver those services.

All of the literature assembled was reviewed and analysed for relevance against the proposed outcome of this scoping study. All relevant documents have been included where appropriate throughout this report.

A total of fifty articles were referenced in this report from these search processes and documents provided to the project team by the Advisory Group and Project Officers.

## CMO 'good practice' survey

A list of relevant CMOs to be surveyed, ones that might be fashioning a response to the new NDIS environment, was constructed from suggestions provided by each of the Project Officers in Tasmania (TAS), New South Wales (NSW), Australian Capital Territory (ACT), West and South Australia (WA, SA) and Victoria (VIC). Suggestions from the Queensland (QLD) peak body and a Northern Territory (NT) provider were used to further build the survey population. In the end a total of 34 CMOs were included in the survey population<sup>3</sup>, which provided an indicative but not necessarily representative sample population. There is also no way of knowing the extent to which the sample population represents 'good practice' service providers.

The survey instrument was developed as a draft by HCA but then modified through a series of consultations with the Project Officers and select members of the Advisory Group, before being pilot tested (and further modified) with two CMOs. A final draft was approved by the Advisory Group (see Attachment 4 for a copy of the survey tool).

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<sup>3</sup> For confidentiality reasons the CMOs interviewed are not identified.

The survey was mostly administered through interviews between CEOs or other senior executives and human resources managers in each CMO and their respective state or territory Project Officers, except in QLD and the NT where HCA consultants collected the data. CMO interview subjects were provided the survey tool in advance (providing the chance to begin completing the instrument) and then their responses were elicited during the interview.

Responses from each interview were then entered by the interviewer into a SurveyMonkey online database.

The thirty-four interviews conducted in total were distributed across the states and territories as shown in Table 1.

**Table 1: Distribution of survey respondents by State & Territory**

State / Territory	Number of interviews	Proportion of total interviewed (%)
ACT	5	14.7
NSW	8	23.5
NT	1	2.9
QLD	4	11.8
SA	2	5.9
TAS	6	17.6
VIC	4	11.8
WA	4	11.8
<b>Total</b>	<b>34</b>	<b>100</b>

Most of the organisations surveyed (59%) were providing mental health services in addition to other programs (including other areas of disability). The distribution of the surveyed CMOs by type of organisation is shown in Figure 1. Most of the CMOs interviewed (53%) had direct experience with NDIS consumers having at least a part of their total organisation operating in an NDIS trial site while 41% had no direct experience of the NDIS.

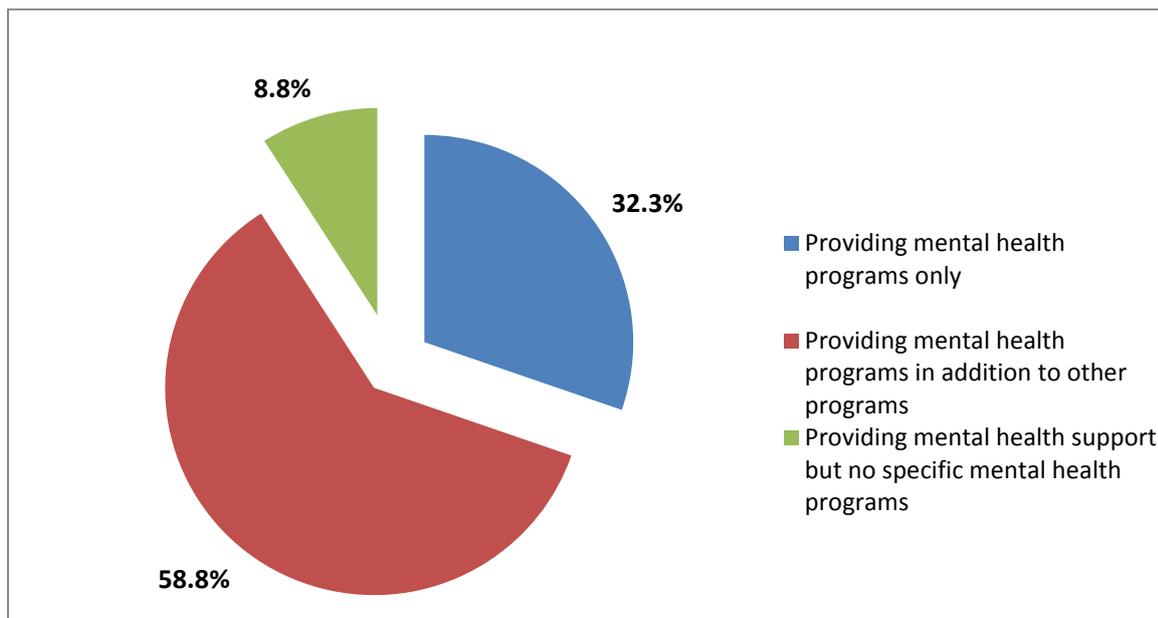


Figure 1: Distribution of surveyed CMOs by type of organisation (n=34)

The thirty-four surveyed organisations were employing approximately<sup>4</sup> 1800 direct care workers, of which 74% were employed on a permanent basis. The level of permanent employment ranged between services from a high of 100% (13 CMOs) to a low of 3%. Just under 70% of the workers employed were ‘Community mental health/support workers’, but only 6.1% were designated ‘peer support workers’. Just under a third of the total workers employed by the surveyed CMOs are working in NDIS pilot sites.

As noted above, 18 or 53% of the surveyed CMOs had experience with NDIS consumers. The degree of experience is detailed in Figure 2 below, ranging from 6 months to two years.

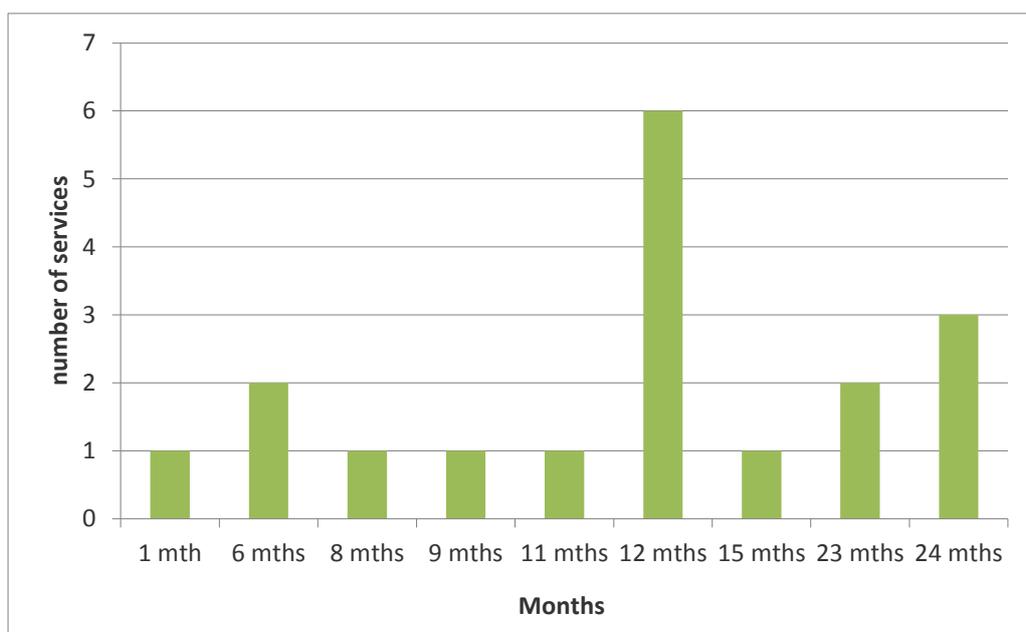


Figure 2: Distribution of CMOs by months of direct experience with the NDIS (n=18, missing values)

<sup>4</sup> One service provider did not finish any employment details.

# Chapter 2: Policy and literature scan of mental health and disability workforce directions under the NDIS

## Introduction

Currently Australia's mental health services are provided through a combination of Commonwealth and State government grant funding mechanisms that overlap and produce gaps in service delivery requirements. A large proportion of Commonwealth mental health funding is provided for Medicare payments to general practitioners (GPs), psychiatrists and psychologists as well as a broad range of community mental health and suicide prevention programs delivered by a range of CMOs. State and Territory governments provide much needed acute and community mental health services and to a lesser extent fund CMOs.

The challenges for consumers with existing or potentially serious mental illnesses to access specialist mental health services can include high intake criteria and excessive waiting periods, which in combination provide an impediment to timely intervention. Individuals with early stage and manageable mental health conditions (e.g. depression and anxiety, substance abuse) often do not meet the criteria for acceptance into mental health services and remain undiagnosed and unsupported within the community. Consumers are often therefore dissatisfied with the existing service structure which does not match their needs. Australian Bureau of Statistics (ABS, 2008) estimates that one-fifth of the adult population (or 3.2 million Australians) will experience a mental health condition within any one year however, only a small proportion will be able to access services.

A number of recent commentaries on mental health services, noting the significant current estimated unmet service needs of persons experiencing mental health conditions, have highlighted the limitations of current workforce capacity and the longer term difficulty of overcoming workforce shortages. For instance the *National Mental Health Workforce Strategy* (MHWAC, 2011) notes:

*“Workforce shortages are a significant long-term problem, and despite efforts and resources being applied to recruitment and retention, and an increased number of training places, these interventions will not, of themselves, be sufficient to meet ongoing workforce requirements.”*

A stronger statement of the entrenched and enormous scope of the workforce limitations has been articulated by the Inspire Foundation (Hosie et al, 2014):

*“... even a relatively modest increase in the proportion of people seeking help for mental health difficulties, combined with projected Australian population growth, would produce a cumulative increase in the use of mental health services ranging from 135% to 160% for select mental health professions, over 15 years. ... It is highly likely that existing services will not meet this demand.”*

Due to the complexity and challenges of mental health service delivery (including access for consumers and workforce concerns) in early 2014 the Commonwealth Government requested the National Mental Health Commission (the Commission) to undertake a review of existing mental health services and programs across the government, private and non-government sectors.

Mental Health Council of Australia (MHCA) in its submission to the Commission (2014) confirms a commonly reported observation of the mental health system:

*“Services available to consumers and carers are currently provided through a maze of fragmented and often ad hoc programs and service streams, with little national coordination or clear lines of accountability for outcomes.”*

It provides a number of recommendations including clear roles and responsibilities for state and territory governments to ensure mental health service planning meets the needs of the community and a focus on outcomes rather than activity.

The Commission in its recent *Report of the National Review of Mental Health Programmes and Services (2014)* confirms its finding for a need for mental health reform when it states:

*“Instead of a “mental health system” – which implies a planned, unitary whole – we have a collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.” (p 38)*

The Commission’s review (2014) found Australia’s mental health services, programs and systems *“are not maximising the best outcomes for either a social or economic perspective”* (p 11) and provides twenty-five recommendations to reform the sector.

The Commission proposes that to achieve fundamental system change to improve its sustainability one (of three) major components that should be enacted will be to follow person-centred design principles, that is to design services around the specific needs of individuals rather than delivering services broadly to the population from service priorities. Similar to the disability sector, the consumer voice has been extremely strong in promoting person-centred care, based on individual needs, for people with mental health conditions. This feature has found its way to the top of the eight principles of the (latest) *Fourth National Mental Health Plan, 2009* (Gallagher, 2009) viz.:

- respect for the rights and needs of consumers, carers and families;
- services delivered with a commitment to a recovery approach;
- social inclusion;
- recognition of social, cultural and geographic diversity and experience;
- recognition that the focus of care may be different across the life span;
- services delivered to support continuity and coordination of care;
- service equity across areas, communities and age groups; and
- consideration of the spectrum of mental health, mental health conditions and mental illness.

Consumer rights are also at the heart of the Commission’s philosophy with its concept of ‘a contributing life’:

*“... a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or*

*volunteering. It means having a home and being free from financial stress and uncertainty.”*  
(NMHC Report Cards 1 and 2)

This philosophy puts people with lived experience and their families and supporters at the centre of policy and service thinking and fosters a shared objective across all entities that promote mental health and prevent mental illness and suicide – not just government and not just health but education, housing, employment, human services and social support.

## **Mental health services and the NDIS**

The 2011 Productivity Commission’s inquiry into Disability Care and Support proposed the NDIS be developed to address major problems in the disability support sector. This scheme proposes to provide services to approved recipients for psychosocial disability, obviously integrating with the existing mental health system. However, NDIS services are intended only for individuals with psychosocial disability support needs due to severe mental illness and estimates of potential recipients are varied.

A number of challenges around implementing the NDIS for recipients with severe mental illness are highlighted in MHCA’s *Mental Health and the National Disability Insurance Scheme Position Paper* (2013). The challenges and solutions posed centre around eligibility criteria and the issue of ‘permanent disability’, uncertainty around numbers of individuals who would be eligible for the NDIS, assessment practices, implications of existing mental health programs coming under NDIS and the need to define early intervention services.

Frank Quinlan (CEO of MHA) stated to the Joint Parliamentary Committee on the NDIS in November 2014 *“The NDIS will not replace the mental health system”* highlighting the small number of mental health service recipients that may be serviced by the NDIS and the need for a strong mental health system.

Concerns about redirection of existing mental health programs such as Personal Helpers and Mentors (PHAMs) and Partners in Recovery (PIR) as they come into scope of the NDIS are also raised by the Commission (2014) suggesting fears of lack of continuity of service and eligibility for consumers. At the same time the Commission recognises the potential of the NDIS to enable people to access to *“educational, recreational and social opportunities which they otherwise may not have.”* (p62)

Clearly there is a complex intercept between NDIS psychosocial disability services and the mental health system which will need to unravel as implementation of the NDIS rolls out. However similarity in principles of both systems is evident.

The NDIS focuses on providing client-centred services for recipients of the scheme similar to mental health services which have aimed to be directed by the individual needs of consumers and their carers (prior to the Commission’s review).

*“To ensure that mental health outcomes are as appropriate, effective and long-lasting as possible, policy makers and service providers need to adopt a person-centred, recovery oriented approach. This approach allows people flexibility, choice and control over their recovery pathway, and responds to each individual’s unique needs, circumstances, life-stage choices and preferences.”*  
(COAG, 2012)

An essential theme for future mental health services has been taken up as mentioned above, that is to support a ‘recovery’ focus at all stages of service delivery. A recovery focus takes on the belief that all individuals with a mental health condition can ‘recover’ from an episode of mental ill health and with the appropriate support can lead a ‘contributing life’ (the Commission 2012/3). The *Fourth National Mental Health Plan* (Gallagher, 2009) describes a recovery philosophy:

*“A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved—the individual consumer, their family and carers, and service providers.”*

A comparison of the NDIS and recovery oriented mental health practice is shown in Table 2 below. There is a strong correlation between the two service philosophies and therefore they should be consistent, although with seemingly different processes, to meet the needs of consumers.

**Table 2: Comparison of NDIS & Recovery Oriented Practice principles**

National Disability Insurance Scheme Principles	Principles of recovery oriented mental health practice
1. People with disability have the same right as other members of Australian society to realise their potential for physical, social, emotional and intellectual development.	1. Uniqueness of the individual Recovery oriented mental health practice: <ul style="list-style-type: none"> <li>▪ recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community</li> <li>▪ accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life</li> <li>▪ empowers individuals so they recognise that they are at the centre of the care they receive.</li> </ul>
2. People with disability should be supported to participate in and contribute to social and economic life to the extent of their ability.	
3. People with disability and their families and carers should have certainty that people with disability will receive the care and support they need over their lifetime.	
4. People with disability should be supported to exercise choice, including in relation to taking reasonable risks, in the pursuit of their goals and the planning and delivery of their supports.	2. Real choices Recovery oriented mental health practice: <ul style="list-style-type: none"> <li>▪ supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively</li> </ul>

National Disability Insurance Scheme Principles	Principles of recovery oriented mental health practice
	<p>explored</p> <ul style="list-style-type: none"> <li>▪ supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time</li> <li>▪ ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.</li> </ul>
<p>5. People with disability should be supported to receive reasonable and necessary supports, including early intervention supports.</p>	
<p>6. People with disability have the same right as other members of Australian society to respect for their worth and dignity and to live free from abuse, neglect and exploitation.</p>	<p>3. Attitudes and rights</p> <p>Recovery oriented mental health practice:</p> <ul style="list-style-type: none"> <li>▪ involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual</li> <li>▪ promotes and protects individual’s legal, citizenship and human rights</li> <li>▪ supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual</li> <li>▪ instils hope in an individual’s future and ability to live a meaningful life.</li> </ul>
<p>7. People with disability have the same right as other members of Australian society to pursue any grievance.</p>	
<p>8. People with disability have the same right as other members of Australian society to be able to determine their own best interests, including the right to exercise choice and control, and to engage as equal partners in decisions that will affect their lives, to the full extent of their capacity.</p>	<p>5. Partnership and communication</p> <p>Recovery oriented mental health practice:</p> <ul style="list-style-type: none"> <li>▪ acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them</li> <li>▪ values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement</li> <li>▪ involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.</li> </ul>
<p>9. People with disability should be supported in all their dealings and communications with the</p>	

National Disability Insurance Scheme Principles	Principles of recovery oriented mental health practice
Agency so that their capacity to exercise choice and control is maximised in a way that is appropriate to their circumstances and cultural needs.	
10. People with disability should have their privacy and dignity respected.	<p>4. Dignity and respect</p> <p>Recovery oriented mental health practice:</p> <ul style="list-style-type: none"> <li>▪ consists of being courteous, respectful and honest in all interactions</li> <li>▪ involves sensitivity and respect for each individual, particularly for their values, beliefs and culture</li> <li>▪ challenges discrimination and stigma wherever it exists within our own services or the broader community</li> </ul>
<p>11. Reasonable and necessary supports for people with disability should:</p> <p>(a) support people with disability to pursue their goals and maximise their independence; and</p> <p>(b) support people with disability to live independently and to be included in the community as fully participating citizens; and</p> <p>(c) develop and support the capacity of people with disability to undertake activities that enable them to participate in the mainstream community and in employment.</p>	
12. The role of families, carers and other significant persons in the lives of people with disability is to be acknowledged and respected.	
13. The role of advocacy in representing the interests of people with disability is to be acknowledged and respected	
	<p>6. Evaluating recovery</p> <p>Recovery oriented mental health practice:</p> <ul style="list-style-type: none"> <li>▪ ensures and enables continuous evaluation of recovery based practice at several levels</li> <li>▪ individuals and their carers can track their own progress</li> <li>▪ services demonstrate that they use the individual's experiences of care to inform quality improvement activities</li> <li>▪ the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment,</li> </ul>

National Disability Insurance Scheme Principles	Principles of recovery oriented mental health practice
	education and social and family relationships as well as health and well being measures.
Source: National Disability Insurance Scheme Act 2013 <a href="http://www.disabilitycareaustralia.gov.au/document/151">http://www.disabilitycareaustralia.gov.au/document/151</a>	Source: Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK. Also in Australian documents Framework for recovery based mental health in MH06

## Potential workforce implications of person-centred care/NDIS

NDS, quoting a report from Price Waterhouse Coopers, has suggested the disability workforce will need to double by 2018 in order to deliver the services envisaged under full implementation of the NDIS (Windsor and NDS, unpublished). The recently released *Integrated Market, Sector and Workforce Strategy* (MSW Strategy) (Senior Officials Working Group for the Disability Reform Council, 2015) similarly assess the workforce requirements of the disability sector will need to double when the scheme is fully rolled out in 2019-20. The strategy also notes that the aged care and child care sectors are competitive markets for the required workforce and are also experiencing shortages.

Specific to mental health, HCA in its workforce review for the Commission suggested that in order to meet the demands of existing mental health services, and the ability to respond to new services and approaches would require investment in the workforces of primary health care, self-help strategies and community mental health and acute services. This highlights an already stretched workforce in need of investment and it is therefore reasonable to suggest increases would be required across the full mental health sector including CMOs delivering mental health and psychosocial support under the NDIS (Ridoutt, Pilbeam, & Perkins, 2014).

Accordingly, CMOs need to increase their workforces by implementing innovative strategies to recruit and develop the capacity of their workforces to meet the future needs of consumers under the NDIS. The necessary strategies and relevant guidance for these efforts has been slow to reach community mental health services as the NDIS has been piloted and this project was required to assist in scoping the workforce needs for the mental health sector. However, an unpublished report used for development of the MSW Strategy (Windsor and NDS, unpublished) suggests that to deliver services under full implementation of the NDIS action will be required around four priority areas:

1. *Building a sufficient and diverse workforce:* expanding the workforce and diversifying it from primarily ageing Anglo-Australian women. Clients request workers that have similar interests and enthusiasms and providers are encouraged to consider this in their recruitment practices.
2. *Encouraging innovative and efficient use of the workforce:* finding solutions to stabilise the workforce with strong supervision, management practices and training relevant to the new support roles.

3. *Ensuring workers have the knowledge, skills and values to support NDIS implementation: quality formal and informal training for the new environment requires investment to develop new and advanced support skills.*
4. *Establishing the infrastructure and knowledge base to support implementation. Includes collecting and analysing workforce data, research into practice, sector governance.*

The recently released MSW Strategy aligns to the priority areas in the NDS document mentioned above:

1. *Assisting the sector to build a sustainable and diverse workforce*
2. *Encouraging innovative and efficient use of the workforce*
3. *Development of a skilled workforce to support the NDIS. (Senior Officials Working Group for the Disability Reform Council, 2015)*

While both these documents provide strong suggestions of the issues for the disability workforce, throughout the interviews undertaken as part of this scoping study it is apparent that there is a perceived distinction between the roles of mental health support work and general disability support work. The role differentiations will need to be acknowledged and further work undertaken to explore these differences to enable future planning efforts. This understanding is confirmed in the NDS reports and NDIS Strategy. For instance, the NDS report (Windsor and NDS, unpublished) identifies:

*“Under the NDIS, workers who support people with mental illness and cognitive impairment provide a combination of assistance with daily living and more specialised support that draws on evidence-based recovery frameworks.*

*The role of mental health support under the NDIS needs to be further analysed. This is supported by objective 2.1 of the National Mental Health Workforce Strategy, which identifies the need to define work roles in the areas of clinical, community and peer support. As with approaches to unpacking other support roles, this work needs to reflect and embed evidence-based approaches to providing effective support”. (p80).*

Specifically in regard to mental health the MSW Strategy identifies the need to:

*“... define mental health support roles, related job design and training requirements and establish how these roles differ from and overlap with other disability support roles.”*  
(Senior Officials Working Group for the Disability Reform Council, 2015, p. 21)

It is suggested in the MSW Strategy that the ‘Sector Development Fund’ or the possible establishment of the ‘Transforming the Workforce Program’ with the National Disability Insurance Agency (NDIA) could:

*“... seed-fund innovative workforce and service projects to redesign and test new work roles and related models of supervision, deploy workforce, give more flexibility and improve outcomes through the use of technology.”*  
(Senior Officials Working Group for the Disability Reform Council, 2015, p. 21)

Other sections of this report discuss what actions are being taken by CMOs within trial sites and preparations for organisations waiting to commence. It also investigates international examples where person-centred services for people with mental health conditions have been in place for a

longer period than Australia's NDIS pilots to learn about their associated workforce development activities.

## **International service delivery models**

Williams (2012) received a Churchill Fellowship to visit England, Ireland, Scotland, Belgium and the Netherlands to investigate policy and practice of self-directed support for people with mental illness. While the research focused on broad policy and practice, a number of workforce development activities were identified including recruitment, training, management and deployment.

### **Recruitment of mental health support workers**

An interesting and potentially applicable example of workforce innovation overseas was consumer involvement in recruiting appropriate staff.

Williams (2012) described an English organisation who were involving consumers in the selection of support workers, *Look Ahead Housing and Care*:

*"Another key innovation has been the involvement of customers in all stages of the recruitment process, from identifying the skills and qualities they want in people supporting them, to incorporating this into job descriptions and participating as a member of selection panels to choose staff."* (p 14)

Similarly in Ireland one adolescent service, *Jigsaw* involved its youth clients in interviewing staff who would be "a youth friendly professional" and non-judgemental.

A persuasive example of the development of a 'safe but less qualified support workforce' developed in the UK is provided by Peter Gianfrancesco (2014). He explains that the UK support workforce was developed by listening carefully to customers as to what they thought was required as a 'qualified workforce'. The results observed from adopting this strategy include:

- staff are much more productive
- staff are more flexible and multi-skilled
- staff have become innovators and promoters
- the workforce is more diverse and more casualised
- staff are satisfied
- workforce had to increase productivity by 20%
- a new paradigm of staff deployment
  - move away from traditional structural model (teams)
  - multi-skilled staff covering full range of client needs are more efficient
- workforce has become more casual and/or self-employed and generally operating at a lower level of qualification but with new sought after attributes.

In the Netherlands, the structure of personal health budgets allows the payment of family members and friends or acquaintances for support needs suggesting an alternative way to recruit people into the workforce.

*"The PGB [personal health budgets] has expanded the social care workforce as it taps into a broader group of people such as neighbours and students, many of whom would not normally consider working in this sector".* (Williams, 2012)

## **Management and deployment of support workers**

In Scotland Williams (2012) noticed that providing self-directed support for mental health service recipients had required an increase in the numbers, development and management of its workforce. Increased staff costs were also experienced in delivering more personalised and flexible care.

An innovative example of the use of personal budgets by care recipients may be seen in the Buurtzorg (“Care in the Neighbourhood”) program in the Netherlands. This program was developed in 2006 as a system of home care by staff dissatisfied with existing home care services for consumers. The organisational model of Buurtzorg aims to reduce contact time with care recipients by using their own resources and facilitating contact and integrating with local carers and informal caregivers. The model has six sequential components delivered as a coherent package. The deployment of the staff resources is particularly interesting as they are working in self-managing teams which has developed a better use of each team member’s competence and encourages taking responsibility for a greater diversity of care tasks (Huijbers, 2015).

## **Training of support workers**

When establishing new services or delivery structures, ensuring that all workers are informed and have the skills to deliver services in the new environment is essential. Within England, the level of investment in training workers on the introduction of personalisation of support services in budget pilot sites was evaluated by Manthorpe et al., (2010). They found that the training implications of implementing personalisation were “profound” especially for personal assistants, service users, the third sector and provider organisations. The training activities, which included using e-learning facilities, embedding ‘training’ into communication strategies and delivering face-to-face sessions, were “incorporated as part of staff development, focused on skills acquisition and were a means of supporting staff”. A major risk to the implementation of training was budgetary pressures. This risk, as will be shown later, was also identified by CMOs interviewed as part of this project who were concerned that there is no funding structure to allow them to train their staff in the current NDIS model.

## **Building the required workforce**

### **Recruitment and seeking minimum level qualifications**

In order to build a safe, reliable and engaged workforce to suit the needs of not only NDIS but all mental health service recipients, the community mental health sector has advocated for a minimum qualification. The sector’s peak bodies including CMHA and MHCC have argued that for psychosocial disability and recovery support work, the minimum qualifications are a Certificate IV in Mental Health or a Certificate IV in Mental Health Peer Support work or equivalent (MHCC, 2015a).

An example of a suggested entry pathway for recovery support work (other than general administration and university qualified entrants) is proposed by the Mental Health Community Coalition of the ACT (MHCC ACT) (2012) in its document: *A Real Career: Workforce Development Strategy*. The strategy offers two pathways for people who do not follow an administration or ‘clinical’ (university qualified) path. The first is for ‘recovery practitioners’ enter as trainees (mandatory completion of the Certificate IV in Mental Health) or appropriately qualified graduates. The second path is for ‘Peer support practitioners’; an identical career progression to the aforementioned but positions are held by peer workers (presumably completing the Cert IV Peer

Support Work). In general minimum workforce entry requirements like those outlined above tend to restrict workforce growth, which may explain why in the UK rapid workforce growth was fuelled by a decrease in the number and level of qualifications in the workforce (Gianfrancesco, 2014).

Regardless of the type of worker, it is likely that the scope of growth required as a consequence of the introduction of the NDIS means a range of strategies to enable a rapid expansion and development of the workforce will be required,. Suggestions from the literature are provided below.

Specifically in rural and remote areas, workforce recruitment (and retention) issues are particularly challenging to manage to ensure services are delivered. Blignault & Rosen (2012) suggest that in remote NSW, social brokerage models of service delivery work well. They also suggest management responses to meet the needs of these communities:

*“... such as building service hubs as practical and close to the remote communities, and training programs linked to employment opportunities for local residents of serviced communities.”*

An example of a UK strategy to implement apprenticeships in the social care sector delivering personalised services in Barking and Dagenham Councils is provided by West-Whyllie (2011). The provision of apprenticeships in these regions has ‘stimulated’ the workforce market for personal assistants to support clients’ independence and choice. The results suggest that *“apprenticeships offer an ‘ideal vehicle for developing the workforce of the future”*.

### Higher level support roles

Through an understanding of the role of mental health support roles and in reflections from the NDIS trials, a ‘higher’ level support role has been identified in order to deliver appropriate person-centred services to participants in the NDIS with mental health or psychosocial support needs. Windsor and Associates and NDS (unpublished) have identified emerging more complex support roles to foster recovery in mental health. Emerging and recommended roles relevant to mental health include:

- practice coach role
- lead support worker
- peer support worker
- mental health support worker
- family support workers (for extremely disadvantaged families).

In order to develop the workforce to deliver higher order mental health support work,

*“The role of support workers needs to be specifically addressed in developing best practice models of support and responding to participant preferences. Delivering improved outcomes for participants and locating support in homes and local communities demands new approaches to supervising, developing and motivating workers to deliver high quality services. The practice coach and lead support roles begin to address this from a workforce perspective.”*  
(Windsor and Associates and NDS, unpublished)

In response to the need for higher level support skills, MHC SA Workforce Development and Training Unit working with MHCC suggest appropriate higher level qualifications are required by members of the workforce. They are:

- Diploma of Community Services (Alcohol and Other Drugs and Mental Health) CHC50408
- Advanced Diploma in Community Sector Management (Leadership in Action) CHC60308

They also advocate for a focus on developing ‘soft skills’ in management and leadership that are best developed ‘on-the-job’. (Mental Health Coalition of South Australia, 2012)

### **Role of peer support workers**

Peer support or peer workers (also known as consumer and carer consultants or providers) are individuals who have a lived experience of a mental health condition either as a person who has lived with a mental health condition or as a carer of someone who has experienced a mental health condition. They are employed across the public, non-government and to a lesser extent private mental health service sectors. Peer support workers are a key component of recovery oriented mental health services as they illustrate to individuals receiving mental health services that others who have lived with a mental health condition can recover to participate in social and employment activities and provide them with support for their own recovery.

The mental health community sector has advocated strongly for the inclusion and development of the peer support workforce through all mental health services. In its submission to the NDIS, MHCC clearly stated a value of the inclusion of peer support workers in the workforce delivering NDIS services:

*“MHCC support focused development of the peer workforce as a key strategy for ensuring quality and safety for people with psychosocial disability in an environment that is unlikely to be fully regulated.”* (MHCC, 2015a)

The literature provides mixed evidence of the effects of peer support (Nicholas, Reifels, King, & Pollock, 2014) (as well as personal support services (Siskind, Harris, Pirkis, & Whiteford, 2012)). However, strong support for peer work as a way to implement recovery services across mental health exists. The evidence base for the peer support workforce is developing and certainly requires further investigation in relation to effectiveness as the role is recognised and implemented within organisational workforce development strategies.

The workforce characteristics of peer support work were explored by Griffith University for Queensland Alliance for Mental Health (Walsh, Stewart, Crozier, Roennfeldt, & Wheeler, 2015). The report identifies a lived experience of recovery (rather than a lived experience of mental illness) as the basis for peer relationships to develop throughout peer support work. The requisite knowledge, skills and personal characteristics required of peer support workers to perform their role are identified in Table 3.

**Table 3: Requisite skills, knowledge and personal characteristics of peer support workers – Griffith University**

<b>Knowledge</b>	<ul style="list-style-type: none"> <li>▪ theory of recovery</li> <li>▪ mental health system</li> <li>▪ how to use lived experience of recovery with peers</li> </ul>
<b>Skills</b>	<ul style="list-style-type: none"> <li>▪ good communication</li> <li>▪ good listener</li> <li>▪ non-judgemental</li> <li>▪ self-care / self reflection</li> <li>▪ use of disclosure</li> <li>▪ boundary setting</li> </ul>
<b>Personal characteristics</b>	<ul style="list-style-type: none"> <li>▪ sense of humour</li> <li>▪ courage</li> <li>▪ openness</li> <li>▪ sense of concern</li> <li>▪ empathy and understanding</li> </ul>

A lack of clarity and workplace supports for the peer support workforce has been identified (MHCC, 2015b) and a number of studies have been undertaken and workforce strategies and frameworks are being developed in response. For example, the MHCC ACT's 'A Workforce Development Strategy for the Community Mental Health Sector of the ACT' specific objective in relation to peer workers was to:

*"Build a framework for developing a well trained and supported peer workforce that recognises the unique skills of peer workers and give them an equal opportunity to build a meaningful career". (MHCC ACT, 2012, p 13)*

The benefits of including peer workers have been acknowledged by MHCC as a result of observations of the trial of NDIS in the Hunter region:

*"The opportunities for development of peer work roles have broader applicability across the community services and health sector in Australia (i.e., peer work roles in disability, homelessness, substance misuse work, etc.). While these roles are critical to more effective service delivery they also provide employment pathways for people with disadvantages and will help to address projected workforce shortages."* (MHCC, 2015b)

From the observations of the Hunter trial site MHCC identified seven priority actions in relation to providing psychosocial support under the NDIS in NSW. Priority Action 6, which relates specifically to workforce development, including the peer workforce, is detailed in Box 1.

**BOX 1:**

**Workforce recommendation from *Further Unravelling Psychosocial Disability* (MHCC, 2015b)**

**Priority Action 5: Development of strategic directions for NDIS psychosocial disability and recovery support workforce**

- Pursue directions to establish the peer workforce within both government and non-government organisations involved in the provision of services under the NDIS.
- Undertake activities to promote the complexity of skills required in psychosocial disability and recovery support work, including the skills required for complex care coordination.
- Strengthen mechanisms for sharing the learning from the Hunter NDIS trial site both across NSW and nationally.

## Workforce development responses to NDIS trials

### WA experience

In a presentation from Ian Moore from UnitingCare WA (2015) on learnings from the WA Disability Sector's journey towards individualised services he suggests a range of questions that are essential for organisations to consider in order to develop strategies to build the capacity of their workforce to deliver mental health services under the NDIS:

- *Who are we trying to recruit? What is the best way of targeting these people?*
- *What makes us an employer of choice? What is our value add?*
- *How do we celebrate and support diversity in the workforce?*
- *What is our Peer workforce development strategy?*
- *What is our staff competency profile? What gaps are there? And what are our strategies to address this?*
- *What is our current culture? What are staff attitudes towards the sector changes?*
- *What is our current retention rate? What do we know makes our staff happy/unhappy?*
- *What do flexible contracts mean for our organisation and the consumers of our services?*
- *How do we ensure that staff have a work life balance?"*

These questions highlight the extent to which the mental health support workforce will need to adapt to deliver services under the NDIS. It raises key themes that are highlighted in other sources such as:

- recruitment of a new, diverse and competent workforce (including peer workforce) to suit the needs of customers
- ensuring the employer meets the challenges of the new environment with a strong culture, leadership and management practices
- enabling flexibility for workers while maintaining satisfactory employment conditions to meet the needs of consumers in the provision of services.

### VIC experience

#### BOX 2:

#### Workforce recommendation from *Learn and Build in Barwon* (VICSERV, 2015)

##### Address workforce issues

- A workforce strategy should be developed to provide both the mental health workforce and the primary health workers, especially GPs, to prepare for the National Disability Insurance Scheme (NDIS) in relation to mental health and their roles.
- The workforce strategy should provide particular assistance to the consumer and carer peer workforce (both paid and volunteer) to prepare for the National Disability Insurance Scheme (NDIS). This should build the capacity of this workforce to assist consumers and carers to access the scheme productively.

VICSERV (2015) conducted a project to “tell the story” of the Barwon pilot site implementation of the NDIS and the effect it had on the provision of mental health services through the perspectives of consumers, their families and carers and service providers. Primarily in relation to workforce, the agreement by providers to extend block funding twice throughout the pilot period enabled service providers to retain their workforce under current contracts and without creating new roles. Service leaders reported however that “*they are concerned about the potential loss of their skilled, knowledgeable and experienced workforce.*” This concern is centred on the future pricing levels for NDIS services as it is envisaged that the prices will be too low to retain their existing workforce. This

will also be impacted by “*how the Victorian Government will articulate its role in the provision of rehabilitation and recovery services*”. Accordingly, seven recommendations were outlined by VICSERV, including one specific to workforce (see Box 2).

To understand the impact of the NDIS in the Barwon (VIC) pilot site on the provision of mental health services, VICSERV (2015) conducted a project to “*tell the story*” of the Barwon pilot site exploring the perspectives of consumers, their families and carers and service providers. The report of the findings echoes the view that the NDIS is not a replacement for psychosocial rehabilitation services or the mental health system and while many service providers were able to retain much of their workforce, there was overwhelming concern at the potential loss of the skilled workforce in anticipation of the NDIS pricing review and how the Victorian Government will determine its role in service provision.

Specific examples of service providers in the Barwon district and the workforce implications of implementing the NDIS are included from VICSERV’s journal on psychosocial rehabilitation *newParadigm*.

Workforce needs from a consumer and carer perspective were investigated by Mental Illness Fellowship Victoria (MI Fellowship) who conducted interviews with consumers and carers from the Barwon (VIC) trial. They identified relevant workforce issues relating to implementation of the NDIS:

- staff skills and knowledge of the scheme to provide support through the application process. Currently this is unfunded but provides a substantial difference to the outcomes and experiences for consumers and carers.
- NDIS services should not be used as a substitute for state funded community mental health services as this is a separate service.
- the rates of payment under the NDIS for support work are too little to allow organisations to employ staff at Certificate IV, diploma or degree levels which they have done previously and fear that the workforce will be deskilled and set at a Certificate II or III level. Strong concerns were noted that employing workers under the Certificate IV level will substantially reduce the skilled services available and the quality of mental health care leading to increased need of clinical and other social services. (Daya, 2015).

A project team headed up by Mind Australia in Victoria sought to understand the choices that people with psychosocial disability would make when offered individualised funding packages. The participants in this project recommended that support workers employed in the sector have the following characteristics, skills and knowledge

- *“being respectful and compassionate*
- *having a good knowledge of the mental health system*
- *understanding the impact of mental ill health and psychosocial disability*
- *being able to take up multiple roles*
- *having good communication skills.”* (Brophy et al., 2015)

In order to capture the perspectives of community sector support workers engaged in providing services in the Barwon NDIS trial site, Pathways Rehabilitation and Support Services Ltd interviewed seven workers to provide a lived account of their roles under the new service structure. The major issues that arose from these discussions included

- role conflict and ambiguity as providing services in the NDIS practice environment often conflicts with recovery focused practice
- work stress due to loss of control, practice constraints, ethical and moral challenges
- lack of process, consistency and collaborative practice with NDIA lead to worker challenges and practice demands
- management and workforce issues arose out of pressures of role changes, time limitations, fears of losing previous roles in social work, psychology or peer work to undertake roles as personal care assistants
- positive outcomes and practices were seen in teamwork and staff becoming united using humour and a belief that they made a difference to their clients' lives.

NDS prepared a report on the experience of disability organisations after the first 12 months of NDIS implementation in the Hunter trial site. Few of the organisations interviewed were primarily community mental health organisations however, the majority of workforce findings are interesting and relevant to this project. While this trial site was considered fortunate as having been the recipients of a large number of transitional initiatives to NDIS, the findings indicated that workforce implications were still significant. Primarily they were centred around the following themes:

- recruitment of support workers to provide a broader service offering, also early indications of need for increased corporate level staff to support service changes
- different worker attributes were required – younger people whose interests matched those of NDIS recipients were mentioned
- a minority of the (older) existing workforce would not be able to transition to the new services
- need for new skills in their staff including advocacy skills and the promotion of self advocacy by participants, financial literacy (how to look at a plan and know what it means), marketing / business skills, language, literacy and numeracy. (NDS, 2014).

The Hunter region in NSW is an adult trial site for NDIS and has PIR. PIR is a Commonwealth funded program that has an (estimated) 70% 'in scope' or service similarity to NDIS. The implementation of PIR commenced not long after the NDIS trial and provides useful comparisons on many service issues, but particularly for workforce. Hunter PIR support facilitators are

*"appropriately skilled and experienced professionals who possess a comprehensive knowledge and understanding of the local service system (including health and welfare sectors) and both clinical and non-clinical support services. They also possess extensive experience working with the target group and a strong capacity to work with challenging issues, both at the level of the consumer and at the service delivery level. Support Facilitators have a dual role of not only coordinating the range of care and supports required by consumers but also developing and supporting the system-level reform required for better service integration across multiple service sectors". (Hunter PIR, 2015)*

This description of the experience, skills and roles of PIR support facilitators compares markedly with that of other 'support worker' or 'personal care assistant' roles under the NDIS. Accepting that the work being done by PIR is largely similar to psychosocial disability services under the NDIS, it assumes the need for workers with higher order support skills in mental health as mentioned above.

## Ensuring service quality

One of the main arguments to maintain a minimum qualification of a Certificate IV in Mental Health (or equivalent) for workers providing psychosocial disability or mental health support work is the need to ensure the quality of the service and safety of both service recipients and providers. Again using PIR as an indicator of how similar services are delivered, consideration of the quality of the services and the mechanisms in place to protect quality are important.

*“Hunter PIR operates under a clinical governance framework with a high level of accountability. There are established quality assurance processes, and staff participate in ongoing training and development specific to the needs of the target population. Established governance mechanisms regularly bring together all partners and stakeholders in the Hunter PIR network to ensure collective responsibility, collaboration strategic oversight and effective implementation of Hunter PIR in the region. In addition, Hunter PIR has an interface with the Hunter New England Local Health District which is highly significant. Hunter PIR ensures there are smooth transitions between primary care, hospital/acute care and community based care.”*  
(Hunter PIR, 2015)

MHCC have identified quality and safety as a key requirement to be established for the provision of psychosocial and mental health services.

*“The establishment of a national quality and safeguards framework is critical to the success of both the National Disability Strategy, the NDIS and parallel reforms that are occurring for the mental health sector. While this requires nine separate pieces of Commonwealth and State/territory disability-related legislation to be harmonised this is an important piece of foundational work towards Australia meeting its obligations under the United National Convention on the Rights of People with Disabilities (UNCRPD). The UNCRPD also speaks to the rights of people who may be subject to involuntary mental health treatment and for this reason mental health related legislation also needs to be considered in developing a national quality and safeguards framework.”* (MHCC, 2015a)

## **Chapter 3 – Current CMO workforce considerations**

### **Size of the CMO workforce**

The mental health CMO sector is not as well served by comprehensive workforce data collections as has been noted by Health Workforce Australia (HWA) in their inventory of workforce planning data (HWA, 2013).

A recent survey of NGO<sup>5</sup> mental health services by the National Health Workforce Planning and Research Collaboration (the Collaboration) (2011) estimated the workforce size (persons employed in the NGO services sector) as between 14,739 to 26,494 employees for the entire mental health NGO workforce. This estimate was extrapolated from the findings of a survey of NGO employers to which 268 responded, which was estimated to be 34% of the total number of NGOs providing mental health services. The sector itself conservatively estimates the size of the direct care workforce to be approximately 12,000 full time equivalent (FTE) (about 14,000 headcount)(CMHA, 2012).

To considerably increase the size of the available workforce as advocated by the NDIS, the training rate of vocational education and training (VET), particularly the Certificate IV in Mental Health, would have to grow rapidly. Over approximately the last decade the number of persons graduating with a Certificate IV qualification has grown rapidly (see Table 4 below); at the time of writing it was not possible to obtain data on mental health specific qualifications<sup>6</sup>. One can only assume mental health graduations are different to other community services and health occupations.

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<sup>5</sup> The terms CMO and NGO have been used variably in this report. The term CMO has been adopted for this report however the HWA report uses NGO. NGOs can be both not-for-profit and for-profit organisations. The term CMO refers specifically to not-for-profit organisations operating within the community sector.

<sup>6</sup> Community Services & Health Industry Skills Council, *EScan 2015 - Data Insight Tool*

**Table 4: Growth in graduations from health & community services Certificate IV courses, 2002 to 2012**

Year	Training package		Total
	CHC - Community Services	HLT - Health	
2002	3,208	55	3,263
2003	3,636	337	3,973
2004	4,170	495	4,665
2005	4,790	829	5,619
2006	5,765	886	6,651
2007	6,267	900	7,167
2008	7,024	1,471	8,495
2009	9,484	4,013	13,497
2010	11,094	3,858	14,952
2011	13,793	4,012	17,805
2012	15,369	3,918	19,287

For every individual that completes a Certificate IV course, two others have enrolled but not completed — a high wastage rate.

## Formal mental health qualifications

Mental health training and education has been a key focus of recent mental health reforms, for instance the Certificate IV in Mental Health was upgraded and restructured in 2008 and recently in 2015. The level of training and education, that is the proportion of front line workers with relevant qualifications, was proposed by the Fourth National Mental Health Plan (2009) to be a key indicator of performance and quality, although HWA has noted that no existing data sources are available to monitor this indicator and that new ways of quantifying exposure to education and training in different service sectors would need to be explored.

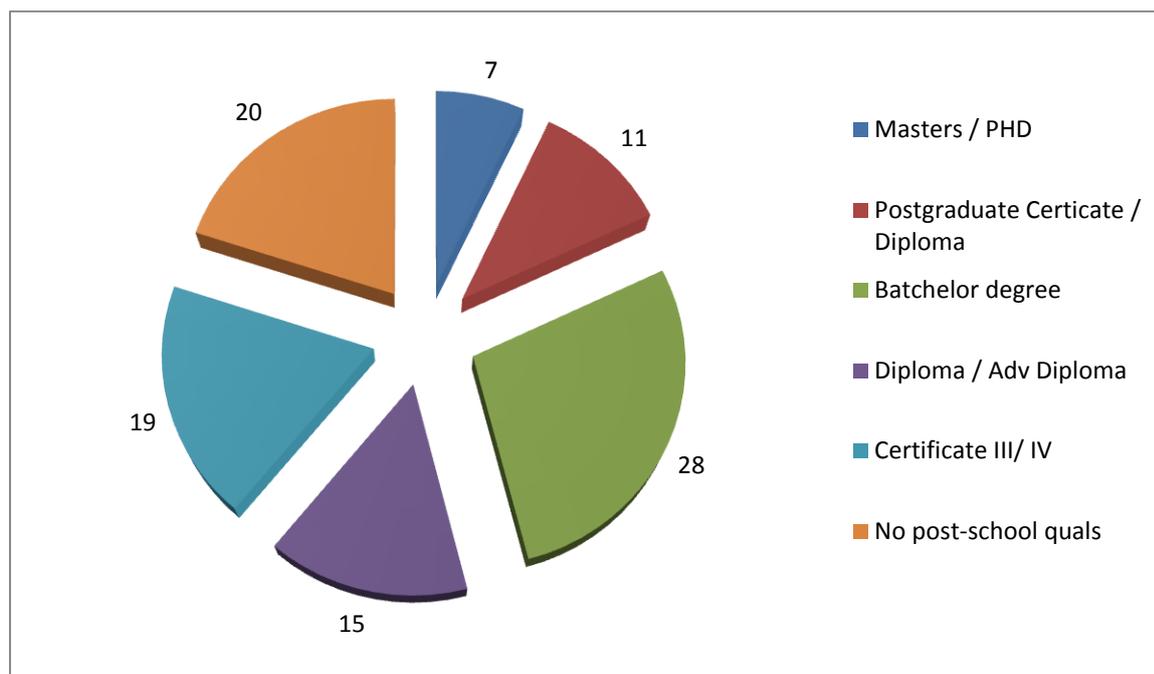
The majority (60%) of employer respondents to the Collaboration survey (2011) indicated that they employ some clinical/health professionals on the basis of their health qualifications. They employ other types of workers on the basis of their broader professional backgrounds. Clinical/health professionals employed in mental health NGOs included psychologists (21% of employer organisations), occupational therapists (8%), social workers (24%) and registered nurses (13%).

In a survey of the Victorian NGO workforce (VICSERV 2008), the level of education of the direct care workforce was found to be surprisingly high, with only 17% of the workforce unqualified and over half (56%) with a degree or higher qualification as shown in Table 5.

**Table 5: Distribution of Victorian NGO mental health workforce by highest level of education qualification (VICSERV, 2008)**

Qualification	% of workforce
Certificate III	0.4%
Certificate IV	7.4%
Diploma	15.5%
Advanced diploma	1.8%
Associate degree	1.8%
Bachelor's degree	36.0%
Graduate certificate	0.9%
Graduate diploma	9.9%
Master's degree	8.6%
PhD	0.7%
None	16.9%

The Collaboration survey (2011) of 719 individuals working in NGO mental health services similarly found 18.9% of respondents indicated that they have no post school qualifications. On the other hand, 43.4% had a bachelor degree or higher tertiary qualification (i.e. postgraduate certificate or diploma, Masters degree or PhD) as their highest educational qualification (see Figure 3). Similar to the Victorian study, 17.9% have a vocational graduate certificate or diploma or other advanced diploma/ diploma, but unlike the Victorian study many more (19.9%) have a Certificate III or IV as their highest qualification.



**Figure 3: Distribution of Australian NGO mental health workforce by highest qualification achieved (The Collaboration, 2011)**

Further analysis of the highest educational qualifications indicates that only 32.8% of respondents hold a mental health specific qualification, and 22.0% hold a health qualification. A survey of Victorian mental health NGOs (VICSERV, 2008) found similarly around 40% of the workforce has a mental health specific qualification, for example, Bachelor of Psychology, Bachelor of Mental Health Nursing or Certificate IV in Mental Health Studies. For these workers, 40% of these qualifications are at the Certificate IV level and the rest at bachelor and diploma level.

Current best estimates are therefore that less than half of the NGO mental health workforce holds a relevant mental health qualification, and less than one in five workers have a relevant Certificate IV qualification. There is clearly an already existing gap between the advocated ideal (all mental health workers have at least a Certificate IV in Mental Health or Mental Health Peer Work) and the current reality.

## Staff recruitment, training and development

The Collaboration survey (2011) of NGO mental health employers found 78% of the respondents had staff training and recruitment plans and/or workforce development plans. The same survey found that 52% of organisations were spending nothing from their annual budget on training and development or less than 2% of their budget (See Figure 4). On the other hand, the rest were allocating more than 3% (above the limit previously set under the Australian Training Act) of their budget with some allocating greater than 20%.

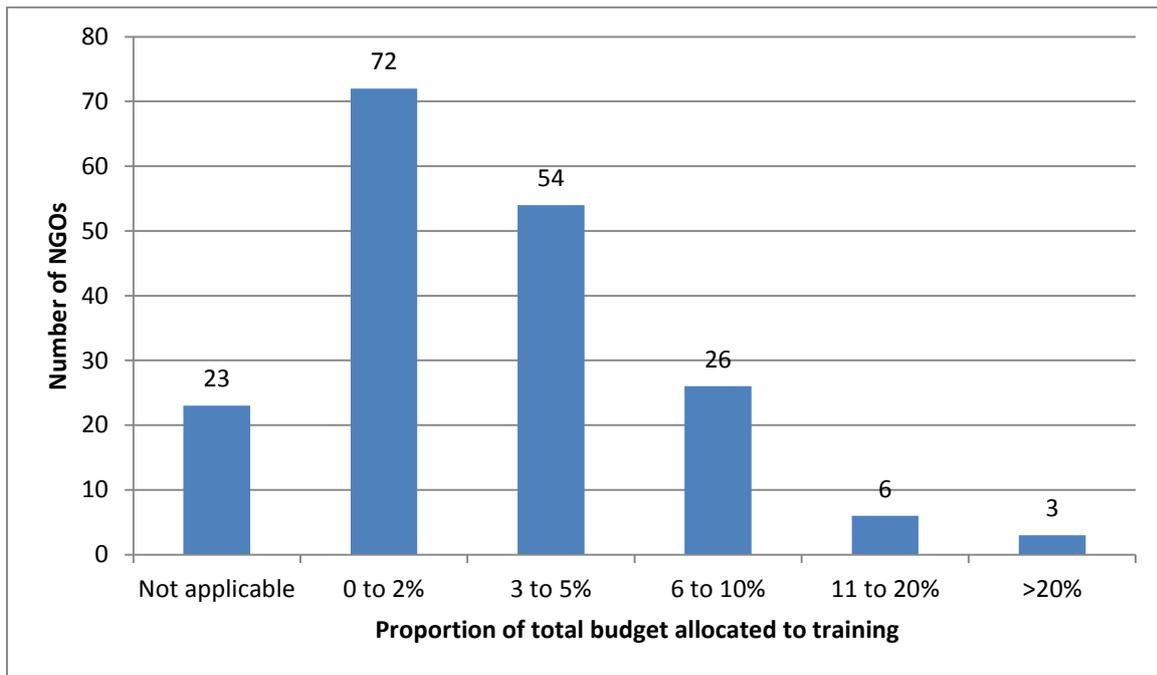
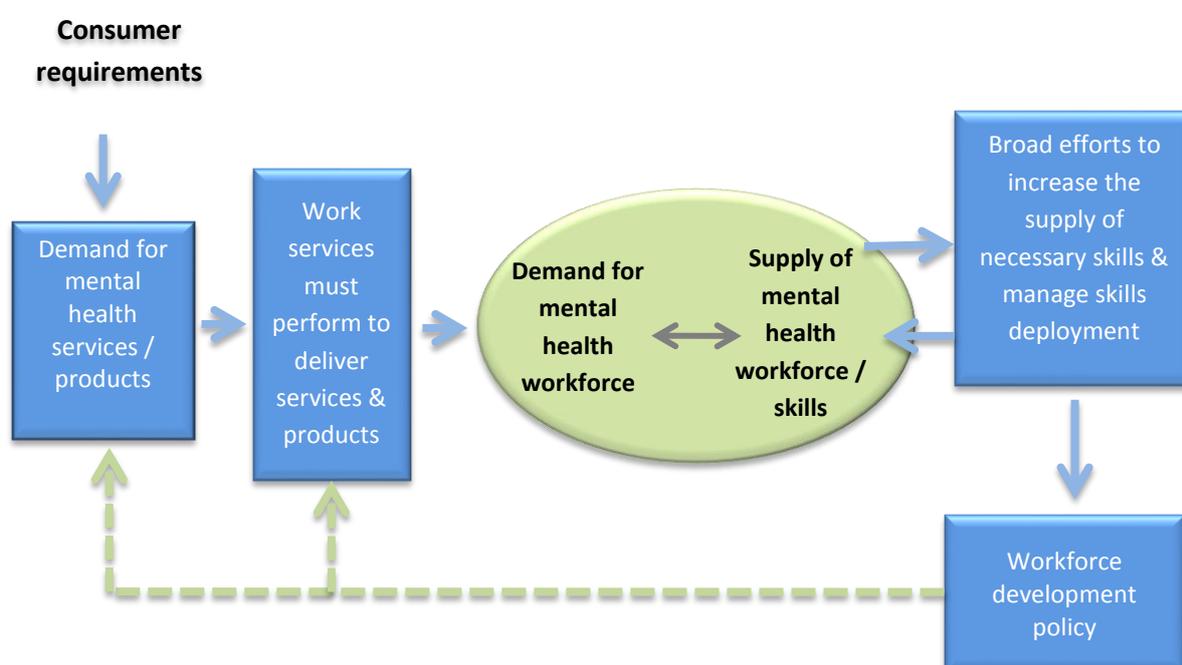


Figure 4: Distribution of NGO mental health organisations by proportion of budget allocated to training and development (The Collaboration, 2011)

## Chapter 4: Workforce development needs in Australia

### Introduction

Workforce development needs, whether expressed as requirements for recruitment, training and development, means of employment and deployment, work allocation and supervision, are all dictated by the way services are constructed and delivered. Services themselves should be planned and designed to respond to and satisfy the needs of consumers. The relationship between consumers, service providers and workforce requirements (and development) is summarised in Figure 5.



**Figure 5: Overview of workforce development needs in the context of consumer requirements**

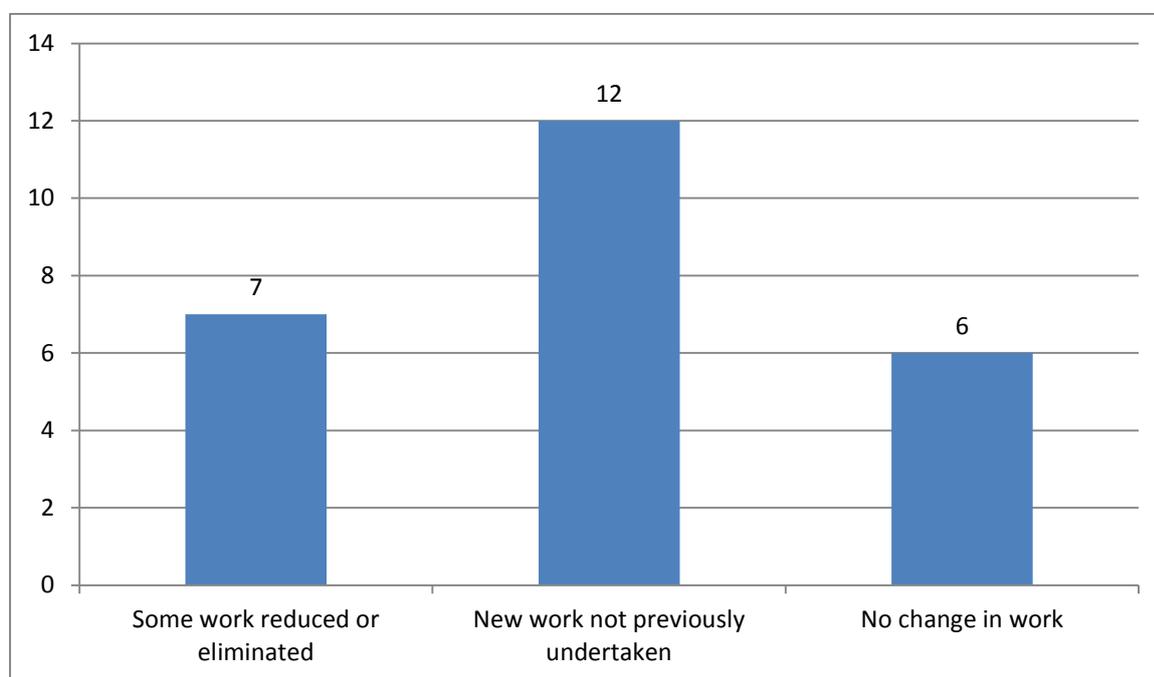
While this theoretical relationship holds [or should hold] for all health services, but not always applied in practice, with the evolution of the NDIS and the funds being placed directly in the hands of consumers, the relationship above will be actualised.

Significant changes in the demand for workforce will be felt, driven by the decisions of many individual consumers and their carers, in what Australian Governments eventually hope will become a “robust market”. In the subsequent sections of this chapter, an attempt will be made to predict what the implications of the NDIS will be on the demand for services by consumers, and how this might translate into workforce development needs.

## Changes in work & employment practice wrought by the NDIS

For most of the surveyed CMOs who have NDIS experience (65%), some form of change in the type of work has been experienced. The most likely type of change (65% of respondents) has been for some work not previously undertaken to be now required (See Figure 6). One CMO offered that there had been an increase in home-based service rather than centre-based, and another that the referral base had changed to more referrals from PIR & PHaMs. Not all the change was welcome:

*“The NDIS requires a completely different way of working. Normally clients come by referral and it’s that process plus the assessment process where details about the person are gathered. Now there is no understanding of the client before they come and that means no opportunity to assess, plan and risk mitigate. Also to build relationships of trust. With clients just asking for one or two services it’s very difficult to work with a recovery focus ...”*



**Figure 6: Number of surveyed CMOs with NDIS experience by type of change in work (n=18)**

For nearly half the CMOs who indicated they were doing work not previously undertaken (and 33% of the total with NDIS experience), the advent of new forms of work has been accompanied by some work previously undertaken having been reduced or eliminated. A typical CMO response:

*“Have eliminated some things and taken on others. As funding has decreased some groups have had to cease – started from about the last quarter of 2014. Lots of time assisting with planning for NDIS and coordination of support. The new things we have picked up include domestic assistance and counselling.”*

The implications for carers, as identified from the carer interviews were similar where potential decreases could mean a decrease in workforce numbers and therefore a reduction in programs and services for carers.

In some CMO cases some types of work were only reduced or eliminated. For a small number of CMOs the work had not changed as a consequence of the NDIS experience. Noted one such service:

*“The services delivered to the NDIS consumer is no different to those services required by other consumers. Work on the ground has not changed, [however] the back end infrastructure has required to be changed.”*

Along with changes in the nature of the work of CMOs, for many there has also been a consequent change in the way they employ their workforce. Ten of the 18 CMOs (56%) have felt the need to modify their workforce in favour of a more casualised or part time workforce (see Figure 8). CMOs justified this approach on the basis of the need for more flexibility. Typical of this argument is the following statement:

*“We anticipated that this is what would happen - already started with a permanent employee leaving and being replaced with a casual. As time progresses, more permanents will be replaced with casuals and fixed term contracts. Have to 'follow the funding' therefore have to change.”*

*“Change in the roles of the workforce, and especially the increase in personal assistance work, is driving this – usually employed as casuals. But we have not yet seen a reduction in existing roles. Expect a lot more change in future.”*

A good proportion of CMOs (6 or 33%), despite their service model changing, have not changed their means of employment. They argue that the workforce just needs to act more flexibly, like the following CMO:

*“Service continues to be around the needs of the person and the use of all types of staffing assist with providing an experienced and flexible workforce.”*

Indeed some CMOs are disdainful of the need to restructure the conditions of employment:

*“The staffing model has not changed - it is hard to find the evidence of the casualisation of the workforce... casualisation is a furphy.”*

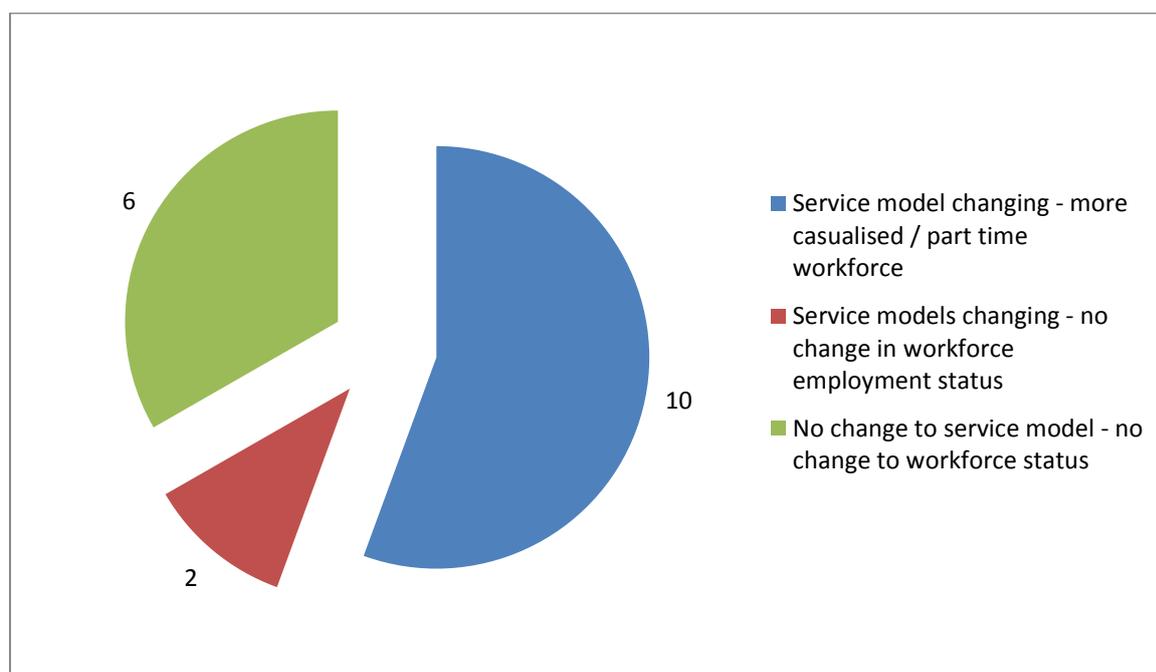


Figure 7: Distribution of CMO respondents by effect on workforce employment status of NDIS experience (n=18)

## Changes in recruitment & retention in response to NDIS

The majority of surveyed CMOs with direct NDIS experience (83%) either currently have, or plan to have, minimum qualification requirements of staff in relation to work in the NDIS (which is in line with current voluntary, and in some states, mandatory, minimum qualifications). By and large, minimum requirement translates into a relevant Certificate IV qualification, which might be in mental health, disability, community services, welfare work, counselling or drugs and alcohol. For some respondents, lived experience and recovery oriented practice were also identified as important, but this is not specified usually in conjunction with an academic qualification (for instance a Certificate IV in Mental Health Peer Work).

Of those CMOs who had recruited for NDIS work (61% of the organisations), the minimum employment requirements had not necessarily been adopted (see Figure 8) when actual recruitment occurred. Eight out of 20 persons recruited had an existing relevant Certificate IV qualification, and a further three recruited had committed to having their workers gain such a qualification within an appropriate timeframe. But just under half of the persons recruited had no relevant formal qualification, and instead particular skills or experiences were seemingly more valued.

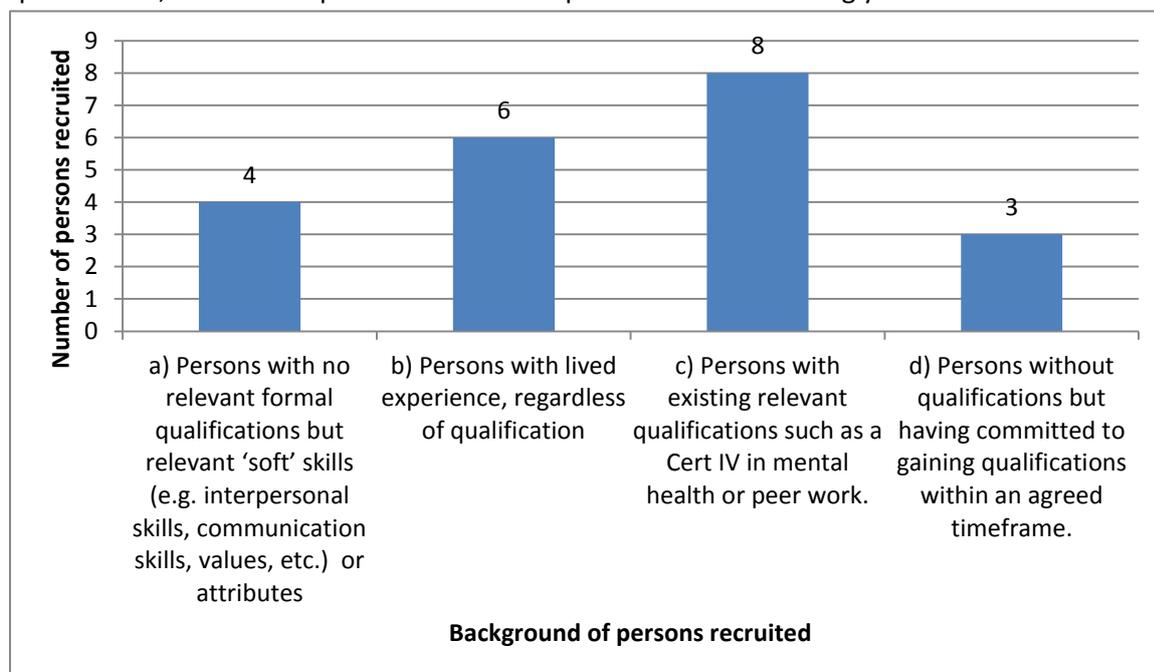


Figure 8: Types of persons recruited by CMOs to NDIS work

CMOs working in the NDIS environment were asked if it had affected their workforce turnover, either positively or negatively. Most (89%) responded that there had been no change, although several respondents noted that it was still too early to tell and that some leading indicators (e.g. levels of stress) might be predicting higher turnover, and other respondents identified future and emerging employment conditions (e.g. increased casualisation, heightened uncertainty, eroding wages compared to workload levels, etc.) as likely causes of increased turnover. For instance one CMO who indicated no change yet in turnover noted:

*“ We have a very loyal and dedicated staff who are sticking around despite uncertainty. More highly qualified staff though are expected to leave in the face of eroding work conditions and wages.”*

The small number of CMOs who indicated staff turnover had been impacted by the NDIS cited reasons of increased workload and scrutiny (not necessarily they argued a bad thing) and job insecurity, particularly the threat (or eventuality) of being made casual. One CMO noted:

*“Three staff left the organisation early in the transition in direct response to the process and what they considered was the likely result of a bad outcome for participants - also likely a factor was increased case load and scrutiny of work - so not necessarily a bad thing.”*

Those that are also directly impacted by such changes and challenges around recruitment and retention are of course consumers and carers. The experience is both positive and negative. For one consumer interviewed, who was an NDIS recipient, there was frustration in relation to the CMO’s inability to supply workers to meet increasing demand.

*“The service I have been accessing are good but they are not well-planned for dealing with the NDIS; rostering is highly changeable...because the service is under-staffed it means that the service is making a value judgement on what I need and then consumers like me go without. The last time this happened to me I’d had a bad week and was feeling comforted that the worker would be arriving; when they didn’t it greatly affected me and I was very upset.”*

For another consumer, also an NDIS recipient, the experience has been entirely positive but also profound and unexpected with increased access to supports and services.

*“Initially I thought that a package would only provide minimal support but it is not as rigid as expected, and has given me support I had never dreamed possible...the coordinator of supports has been invaluable, she has more power and skills to speak to different agencies and negotiate on my behalf.”*

## **Induction process change in response to NDIS**

As identified from the survey, most current induction processes for new workers consist of between three and four days of training, one part of which involves initial introduction to the organisation, policies, procedures and workplace health and safety (WHS), and another part which focuses on program specific issues such as the concept of individualised planning and person-centred service delivery. These processes according to most CMOs are either under threat of being diminished in quality, dramatically for casual workers and less so for contracted employees. The following quotes from survey respondents are typical:

*“The induction process for new employees has not changed with the introduction of the NDIS [yet]. There is an organisation induction and then a program level induction. We try to buddy/coach the new employee in their first few weeks of employment, however this is becoming harder as the pricing for NDIS does not allow for these opportunities.”*

*“Currently a very in depth process with a very high risk mitigation framework. Involves in depth one-on-one conversation with the program manager, shadowing on shifts, small and increasing case load, and a set of core external training that needs to be provided over a certain period of time.*

*In the future NDIS-world they are considering a much less rigorous and less time consuming process relying on in-house expertise only and giving only the absolute basics. It will be very difficult to assure standards and mitigate for risk. In case of incidents and emergencies staff*

*will be required to call publicly funded emergency services and mental health crises teams – i.e. it will be a cost shift from solid preventative practice to publicly funded post incident services.”*

Some services are trying to adjust by providing more efficient induction processes, for instance by delivering induction training online or by smart use of on-the-job measures. Others are trying to mitigate risk by improving practice supervision capabilities.

The most concern surrounds casual workers:

*“With casualised workforce it’s a nightmare – comes down to money. How to train before a new employee has started working and bringing in income – who will pay for this?”*

Some service providers have responded to this situation by attempting to change their recruitment practice, by employing more ‘ready made’ workers with the requisite skills and capacity to work fairly autonomously:

*“Unfortunately, we no longer spend as much time on induction, new staff have to “hit the ground running”. This has also changed the way we recruit for new staff, we are less likely to employ someone who hasn’t had some experience working in the NDIS.”*

Of course this puts enormous pressure on the labour market and the capacity of workforce supply to deliver a ‘ready made’ product. Accordingly some service providers have called for “mass staff training” funded not by the service providers but by a third party.

## **Workforce development priority concerns**

Survey respondents, both the 18 with NDIS experience and the other 16 with no experience, were asked to nominate and rank three workforce development issues that they could see as most important in their organisation. In some ways the response to this question highlighted and summarised many of the concerns that have been canvassed in previous sections of this chapter.

While many issues were raised, only a comparatively small number of issues were identified consistently by a majority of respondents. These are detailed in Table 6.

**Table 6: Main workforce issues in the NDIS environment identified by survey respondents (all respondents answered this question)**

<b>Workforce issue</b>	<b>Elements of the issue</b>
Recruitment of skilled staff – attracting and retaining staff	<ul style="list-style-type: none"> <li>▪ attracting people with the right skills set – direct care support, mental health, compassion, commitment, customer-focused, professional and ethical standards</li> <li>▪ attracting people who are suitably qualified and willing to work at a lower pay rate</li> <li>▪ whether supply will meet demand</li> <li>▪ developing the peer workforce</li> <li>▪ the need to consider a diverse and flexible workforce that includes volunteers.</li> </ul>
Low rates of pay	<ul style="list-style-type: none"> <li>▪ stress it causes for staff</li> <li>▪ limits ability to attract suitably skilled and qualified staff</li> <li>▪ does not cover running costs such as transport for staff.</li> </ul>
Casualisation of the workforce	<ul style="list-style-type: none"> <li>▪ consistency and continuity of support for consumers, but also consistency and stability for workers</li> </ul>

Workforce issue	Elements of the issue
	<ul style="list-style-type: none"> <li>▪ difficult for services to plan and recruit which has an impact on infrastructure of the CMO, uncertainty around contractual obligations</li> <li>▪ quality assurance and accountability processes will be critical, yet supervision will be more difficult</li> <li>▪ peer support and collegiality between workers will be more difficult to foster and maintain.</li> </ul>
Staff training and professional development	<ul style="list-style-type: none"> <li>▪ the need to upskill staff around attitudes and culture, individualised funding, administration of the NDIS</li> <li>▪ should be a focus on customer service, relationship building, support practices for different needs of consumers</li> <li>▪ lack of funding available under the NDIS for professional development which many claim puts significant constraints on what is possible.</li> </ul>
Workforce quality control and governance	<ul style="list-style-type: none"> <li>▪ uncertainty around whether to commence accreditation processes</li> <li>▪ concerns around monitoring/supervision, accountability and reporting with a more mobile and casual workforce</li> <li>▪ funding under NDIS does not seem to be available for ensuring processes in quality and accountability.</li> </ul>
Tools and infrastructure – supporting and implementing a new workforce model will require changes	<ul style="list-style-type: none"> <li>▪ financial systems</li> <li>▪ business model – customer service approach</li> <li>▪ infrastructure that may or may not need to be acquired – cars, IT, policies, procedures, etc.</li> </ul>

One of the most canvassed issues from the above table, discussed in previous sections, is the casualisation of the workforce. Nearly all CMOs emphasise that flexibility of their workforce is required because workers will need to be more mobile and dispersed. Many CMOs see flexibility as synonymous with a higher proportion of casual staff, an almost inexorable outcome of the rapid growth in workforce demand, the need to match labour costs with (fee for service) revenue streams, and the limited ‘profit’ margins from service payments from which to support permanent staffing arrangements (with fixed overheads). Few CMOs see this outcome as positive, but some are more sanguine. A response from one survey respondent highlights the complexities:

*“ It is unclear how much competition there will be, but the cost of the current service delivery compared to the projected NDIS line item payments is a substantial difference. There will be a need to investigate a more casual workforce with a core permanent staff group with the skills required... The tasks of scheduling visits and recording outcomes may become more of an administrative than [support] worker task. They could become a less specialised workforce with the ability to deliver comprehensive dollar dictated service hours.... the ability to deliver evidence-based interventions and outcomes will be governed by the timelines of the plan. With the need to take on more diverse commercial activities staff will be delivering services in related but sometimes different areas.”*

The other major issue is low rates of pay, which is linked to some extent with casual employment, but much more so to recruitment and retention and workforce quality. Many stakeholders at

different levels of interest expressed discomfort with an emerging division of labour, considering it to be an inevitable outcome of a low price of labour. They point to the price of the more commonly used NDIS items ‘assistance in self-care – individual’ and ‘assistance in community – individual’ which uses the hourly rate of Social and Community Services (SACS) award at level 2 to underpin the pricing estimate. This hourly rate classification level, if accepted, requires less skill than a Certificate IV qualified worker, the specified preferred minimum skill level by most mental health service providers, as demonstrated in Table 7 below. This table compares SACS Level 2 requirements with those of a Certificate IV as defined in the Australian Qualifications Framework (AQF).

**Table 7: Comparison of SACS Level 2 and AQF Level IV**

SACS Level 2 worker	AQF IV qualified worker
<p>A person employed as a SACS employee level 2 will work under general guidance within clearly defined guidelines and undertake a range of activities requiring the application of acquired skills and knowledge... performing functions which are defined by established routines, methods, standards and procedures with limited scope to exercise initiative in applying work practices and procedures.</p>	<p>Graduates at this level will have theoretical and practical knowledge and skills for specialised and/or skilled work and/or further learning. [They] ... will have broad factual, technical and some theoretical knowledge of a specific area or a broad field of work and learning. [They will] ... apply a range of methods, tools, materials and information to:</p> <ul style="list-style-type: none"> <li>▪ complete routine and non-routine activities</li> <li>▪ provide and transmit solutions to a variety of predictable and sometimes unpredictable problems.</li> </ul>

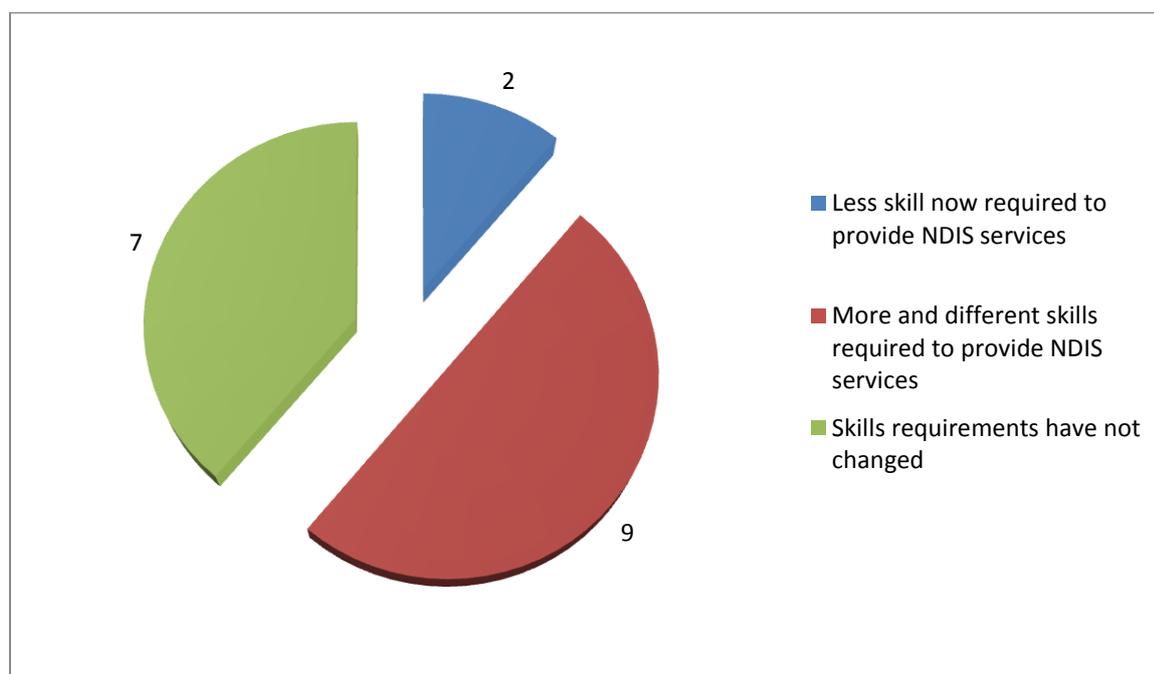
These two levels, the SACS 2 worker and the AQF IV graduate, appear more aligned with ‘core’ support work and capacity building work respectively.

This debate represents a major tension between the CMO mental health sector and the NDIS. The concept of a workforce not minimally qualified at the Certificate IV level, even if a lower level ‘core support’ role were demonstrated to exist and be prevalent, contradicts many years of sector advocacy for higher levels of skill and professionalism. Even if some stakeholders might allow that some NDIS work does not require Certificate IV level skills, they might still argue that each consumer encounter could turn from a core support to some other more complex support requirement, and that in any case all encounters are potentially opportunities for recovery and therefore capacity building support. A similar argument is used against the employment of less skilled workers in many other health and community sectors and industries including residential and community aged care, child care, medical science even engineering.

## Chapter 5: Workforce development strategies considered in Australia

### Changes in training & education approaches post-NDIS experience

As well as changes in the nature of the work and the way workers are employed, most of the CMOs with NDIS experience (11 or 61%) found a change in the skills needed by their workforce (see Figure 9). For the significant majority, their workforce skill needs had grown, with workers requiring more and different skills to perform their job adequately.



**Figure 9: NDIS effect on the workforce skills required by workers to perform mental health work (n=18)**

CMO perceptions of changing skill requirements and approaches to training and education by CMOs with NDIS experience and therefore in turn responses in [within those organisations with NDIS experience] seem to vary in line with a broader response to the changing environment from a welfare context to a contestable market. This variation will be pushed further as the achievement of a “robust and mature” market remains the focus of NDIA and DSS (NDIS, 2015). Several discernible CMOs approaches are evolving:

- a point of differentiation approach – where the CMO determines to compete in the market on the basis of mental health competence and experience, in particular an understanding of recovery principles
- a quality approach – where the CMO determines the best way to gather market share is to compete by providing higher skilled workers
- a cost driven approach – where CMOs tailor services specifically to the parameters they understand are inherent in the service prices.

These different approaches naturally promote a different valuing of training investment as identified across many industries by Ridoutt, et al.(2001), with CMOs focusing in cost unlikely to want to invest significantly in training.

CMO responses have also seemingly been conditioned by their understanding of the way service price interacts with and affects the work requirements. Some CMOs only see the prices driving the work in such a way that less skill is required:

*“The things that are funded generally require less skills than the work currently undertaken. There will be a change from a recovery focus to a maintenance focus under the NDIS. Again what to do when a client is in crisis? Subtle change in the relationship with clients – i.e. the change in meaning around keeping clients happy and having a service delivery focus. Again the focus has been taken away from recovery and a whole client focus, to one of maintenance.”*

Others can also observe this phenomenon but are identifying two possible pathways:

*“Again this is because of the separation of direct basic support work and therapeutic/recovery work leading to increased demand for less skilled workers [but] a requirement for different skills ...”*

*“Need for broader and more diverse set of skills, and for using existing skills differently. In some cases this means more highly skilled workers and in others less skilled. For example, the need for someone in attendance whilst a client takes a shower versus the need for coordination of support which is a highly complex process ... NDIS has removed the role of relationship building in supporting people with mental illness - this is very important particularly in terms of engagement and in times of crisis.”*

Still others are beginning to adjust:

*“According to the NDIA, staff don’t need a certain skill level to support people with mental illness. But we are trying to educate them on this matter. When the first NDIS plans were developed we had a lot more hours of support at the lower price because “you just take him out for a cup of tea”. However most plans are now being funded at a higher level ... or at least part of them are.”*

Irrespective of whether the skills needs had changed or not, all of the 18 responding CMOs with NDIS experience indicated they had to develop the skills and attitudes of their current workforce to better understand work in the NDIS environment. For some this effort was perceived as minor, and largely an extension of work already being undertaken in PIR for instance. For others, the emphasis was on changing attitudes, for instance one CMO noting the need to place:

*“... more emphasis on "work with" rather than "to and for" relationship with clients.”*

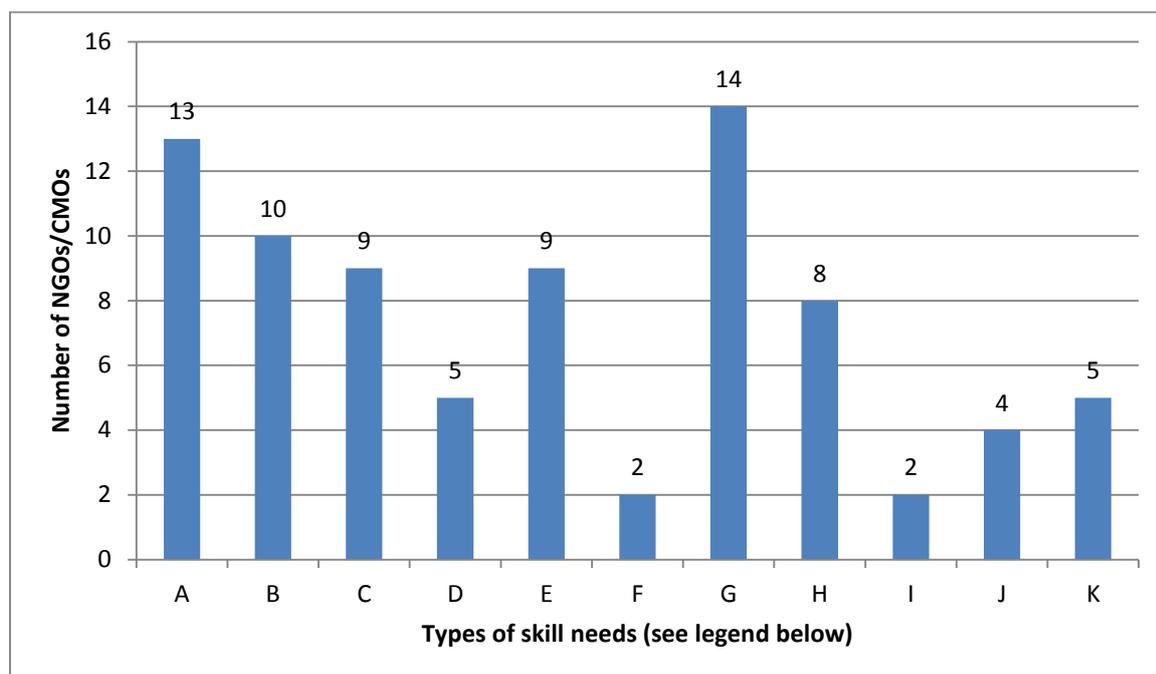
For some others, the effort was seen as major

*“This is a HUGE and ongoing process. We have invested lots into this and still not sure that all staff have really got their heads around it. This is made more difficult by the lack of clarity around many aspects of the NDIS.”*

In terms of specific areas of skills development, one of the CMOs identified many of the key issues that other CMOs also considered important, identifying a need to:

*“... change skills and attitude towards customer service, and retention of clients. Develop a business approach to grow and nurture market demands ...”*

Figure 10 highlights the five areas most identified by CMOs as areas of skills development. Most CMOs emphasise NDIS processes (14 or 78%) and customer service (13 or 72%) for skills development. These are the two areas of concern that also emerged from the stakeholder and consumer and carer interviews, although workplace safety issues were also prominently canvassed. Correlated skill development needs, to do with ‘business’ skills such as individualised funding management (10 or 56%), business planning and care coordination (9 or 50%), were also seen by a majority of CMOs as priority development areas.



**Figure 10: Skills needs identified by CMOs with NDIS experience (n=18)**

**Key:**

- |   |   |
|---|---|
| A = Customer service                          | F = Workplace Health and Safety knowledge |
| B = Individualised funding management         | G = NDIS processes                        |
| C = Business planning / organisation planning | H = Record keeping                        |
| D = Supported decision making                 | I = Privacy / confidentiality             |
| E = Care coordination                         | J = Advocacy                              |
|   | K = Outreach / engagement                 |

The focus on the identified skills for development is neatly summarised by one of the CMOs as follows:

*“... workers need to understand that it is the consumer/participant/client who pays the wages. If you do not have good customer service skills then you are unlikely to get a call back. Take for example the Uber taxi service where the taxi driver is so customer focused because they are reliant on the continued relationship with the customer for referrals or further bookings and to earn a salary.”*

A focus on consumer or a customer-focused service means that a clearer picture of what consumers need and expect from workers, will be crucial to informing appropriate skill development of workers. For the consumers interviewed for this project, it was the 'soft' skills of workers they valued most.

These skills range from the ability to be resourceful and creative:

*"Workers need skills that enable and facilitate the consumer to voice what they really need and want; they need to be highly skilled to hold conversations in a humane and respectful way... [they] should have a skills set that includes innovation, understanding of complexity, patience to spend time to get honest and clear views of the consumer. Developing goals with consumers is more sophisticated than just asking 'what do you want to do?'" (Consumer, NDIS recipient)*

*"...the worker is a good listener and good at problem-solving, she has a range of resources in her head that she taps into and tries to work out what might be suitable." (Consumer, NDIS recipient)*

Other skills were about just being there and gently prompting people in their personal development and/or everyday activities:

*"I really just need someone to come along once a week to help me with things like making doctors appointments for health checks I need and coordinating my self-care ... someone who can come to my apartment and help me with my housekeeping – but in a gentle way."(Consumer, non-recipient of NDIS)*

Additionally, a worker, as identified from the interviews, should also:

- have an understanding of working beside and with a consumer
- be even-tempered with a good sense of self to provide and enable stability
- have the strength to support and maintain consumers' sense of self and confidence
- have the ability to gently correct things like social skills
- have a good understanding of mental health conditions.

And for some consumers, their needs and wants from a worker or service are simple.

*"I'm looking for ongoing and consistent support... really need an agency that knows my case; I'm not always unwell but my depression isn't going anywhere and I would feel more secure knowing that I would be getting consistent and ongoing support."*

## **Preparation for the NDIS**

Of the CMOs included in the survey, 26 (76%) had prepared in one way or another for the advent of the NDIS. This included 10 of the 16 service providers with no direct experience with the NDIS. Many different ways of understanding the likely impact of the NDIS and therefore preparing the workforce were adopted by service providers (see Figure 11) but the most common were having internal discussions and obtaining information from peak bodies. Discussions with the NDIA and talking to experienced organisations were also common.

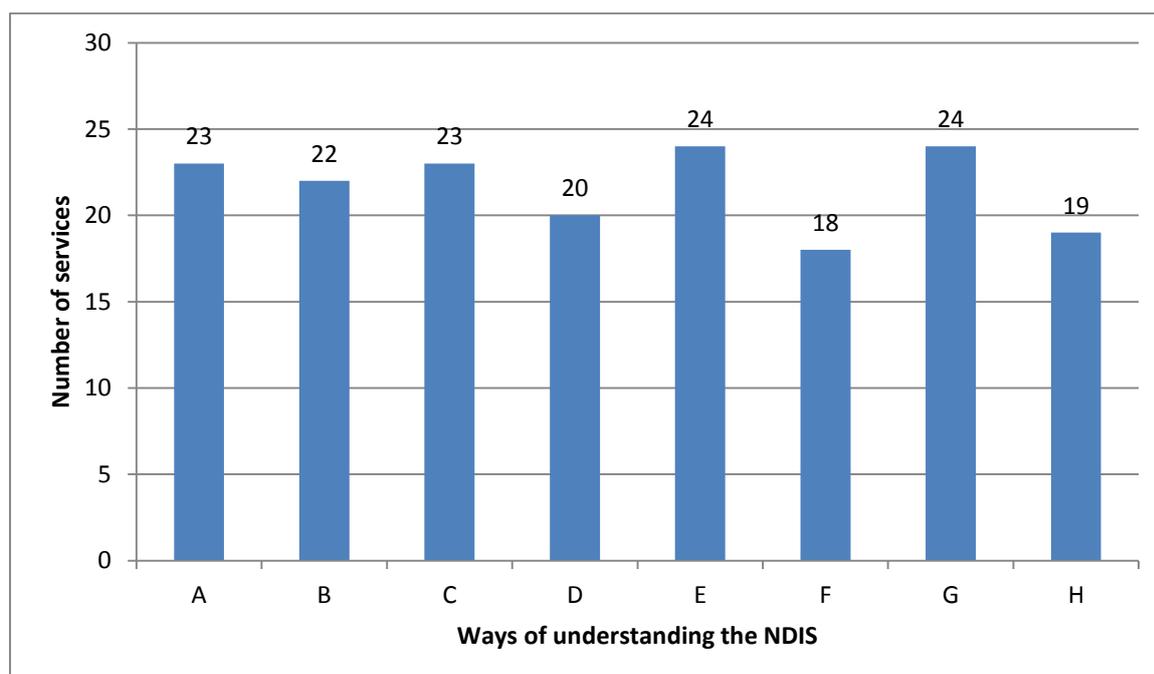


Figure 11: Ways service providers attempt to inform themselves about the NDIS (n = 26)

Key to 'Ways of understanding the NDIS':

A = Discussions with NDIA

B= Attending forums / workshops to hear from organisations in the pilot areas

C = Attending forums/workshops by NDIA etc. or with an NDIS theme

D = Talking to experienced organisations

E = Having internal discussions

F = Researching overseas experience - England

G = Obtaining information from peak bodies

H = Obtaining information from industry associations

In regard to talking with the NDIA service providers had varied experiences. For instance one service provider had formed a close alliance with the NDIA and received funding to run information sessions, while another provider noted:

*"[It is] ... difficult to get the facts and answers from the NDIA - do they even have the answers? There is a lack of understanding in NDIA on mental health / PSD generally and specifically - much confusion caused by lack of clarity around the "PHaMS in-kind" payment arrangements."*

The paucity of information available and lack of understanding about mental health and the difficulty in navigating the application processes was a concern echoed by carers and consumers interviewed. Carers were struggling to understand what might be available to them as were consumers. And both, to a large extent were basing their information on hearsay, that is, what they learned about other people's experiences and the possibilities of the services and support they may be able to consider. For some consumers it was not until they went through the NDIS application process, a stressful process in itself, that they were able to uncover information about some services.

Several CMOs, as well as seeking advice from industry associations (such as the ACT Chamber of Commerce and Business) presumably to explore issues of working in a market, had also or instead consulted with employee representative organisations to capture an understanding of the industrial relations perspective. Two organisations went even further to develop appropriate insights by “... talking with local politicians to understand the political state that is related to the NDIS” and through “... the executive team meeting with Disability Services Commission WA.”

## **Learning & development strategies adopted**

For a number of organisations, as noted previously, the constraints inherent in the mode and level of services payment makes organising and delivering formal learning and development experiences challenging’ in some cases to the point of “all too hard”. For instance one service noted:

*“Workers won't have sufficient funds to be trained, in a regional area there is already a finite pool of workers and this will be put under more pressure because who would want to work in the sector for so little money? Individualised doesn't necessarily mean it is holistic. Consumers will be reliant on people with less skills but not being funded to undertake training.”*

Another simply identified that their past preferred mode of training, mentoring and buddying with a more experienced worker, was now not feasible. Echoing this sentiment, another indicated additional external funding would be needed:

*“... funding means less [training] but the changes in the nature of the work means probably we should be offering more .... But no money! There is a need for ongoing subsidised training otherwise how can it be sustainable. Upskilling of new staff simply not possible – they need to come with what is needed for the job.”*

Despite a level of pessimism in the case of many service providers, most are still working towards innovative ways of maximising workers’ learning opportunities. For the most part the key strategies are to focus on on-the-job (OTJ) learning experiences, and to make the training highly targeted to specific areas of content and specific relevance to job requirements. Some service providers are trying to approach the problem methodically through reflection on practice:

*“Our strategy has been to hold monthly staff meetings where we look at and work through case studies and scenarios, e.g. what do consumers need, training around what is an NDIS plan. We have been directing people to the NDIS website where appropriate and developing through practice supervision.”*

Several other service providers picked up on the value of good supervision to worker development, and notwithstanding the challenges of quality supervision of dispersed (and casual) workers, seeking to improve in this area was considered a priority. To support supervision efforts some services were looking to innovative use of information and communications technology. In the same way several services identified online and other forms of remote and self-directed learning as a way to achieve worker development within financial constraints. In some ways this puts some of the responsibility for learning on to workers, possibly using unpaid time, a point made explicit by at least one service provider:

*“The cost of training may need to become the responsibility of the worker in some instances.”*

The key areas of content that service providers wanted to develop were customer service, sales and time management. Most CMOs were very unambitious with the learning and development objectives of their workers, and somewhat pessimistic about career progression opportunities, and therefore the capacity to motivate learning efforts. This was balanced in part by other service providers, who were looking for more strategic solutions based on collaboration with other service providers and NDIS resources, such as:

*“We will to strengthen our current workforce development policies. Will look to e-learning, partnering and collaboration on training, and support peer worker learning opportunities.”*

## **Approaches to maintaining workforce quality standards**

Quality assurance and control was not central to this scoping project, but it is of course intrinsically linked to workforce development. The question of how the quality of the workforce, and thus the quality of service delivery, would be managed and maintained under the new structure of the NDIS, where the workforce and service delivery would be more geographically distributed rather than centralised, was a shared concern from survey and interview respondents.

The survey indicated that many CMOs already adhere to and are quality assured against the National Standards for Mental Health Services (NSMHS) (health.gov.au), but some were not assured that, with the current structure of the NDIS, they would be able to continue to do so. On their own, the logistics of trying to manage a de-centralised workforce was, in general, expected to be challenging, and this was largely related to managing supervision and accountability of staff, and how to maintain skill development and continuous improvement of the service.

But the challenges around maintaining quality standards were also related to cost or funding, where CMOs were anticipating that funding would not be available or at least sufficient for them under the current cost structure of the NDIS, and therefore it would be challenging maintain existing quality processes and/ or employ new roles.

Three of the respondents, however, who were large CMOs and CMOs whose current service models and workforce were already highly mobile and geographically distributed, were expecting a less challenging transition to the NDIS; quality assurance costs could be absorbed and they had appropriate systems in place such as utilising mobile technology, case management systems and online learning tools for staff.

For others, the potential implications of inadequate or limited funding were that staff would be expected to be flexible, work more autonomously and commit to work at a high standard with more responsibility. But there would be less supervision by managers and services would need to just ‘trust’ that staff are providing quality services under limited supervision.

For consumers, the quality of the service provided by CMOs and workers was important, but complaints handling processes and procedures when quality was not adequate, were also crucial for a sense of security, choice and control.

*“After the last time I made a complaint to the service, things have improved somewhat, but even that process was fraught with problems. The service did not have any formal complaints or quality review process. The implications of this is that nobody is checking on the support being provided by workers, consumers are being left without support, there is instability and people are left feeling upset and isolated.” (Consumer, NDIS recipient)*

*“I feel comfortable and safe to approach them ... workers are all very approachable and I [feel] very confident to speak with them about any issues and to negotiate.” (Consumer, NDIS recipient)*

With the development of the *NDIS Quality and Safeguarding Framework* (NDIS QSF) (DSS, n.d.), DSS and the NDIA have also acknowledged five elements where challenges in regard to quality will arise:

1. NDIA provider registration
2. systems for handling complaints
3. ensuring staff are safe to work with participants
4. safeguards for participants who manage their own plans
5. reducing and eliminating restrictive practices in NDIS funded supports

Challenges aside, the survey and stakeholder interviews revealed that many CMOs were already thinking innovatively about new processes, new work roles and new ways to assess and maintain quality.

Just under half of the survey respondents (12) indicated that they were planning to maintain their current systems, standards and processes. As noted, the NSMHS was the most common standard used by CMOs; under the NDIS CMOs will also be expected to work within the NDIS QSF and adhere to the National Standards for Disability Services (NSDS) (DSS, n.d.). Yet some CMOs are looking to go further than this. In anticipation of providing new and different services, at least three CMOs stated that they were looking at new quality assurance programs, one being the Rainbow Tick Standards ([qip.com.au](http://qip.com.au)).

New processes, approaches and tools were also being considered or already implemented by a number of CMOs, and many of these were related to, and reliant upon, the consumer experience or ‘customer’ satisfaction with service as described by one respondent.

*“...accountability and reporting mechanisms where we can be sure the customer is receiving the service they want – that they are matched to the correct worker and that the worker is delivering the person-centred service they need.”*

Some of the processes and approaches described included:

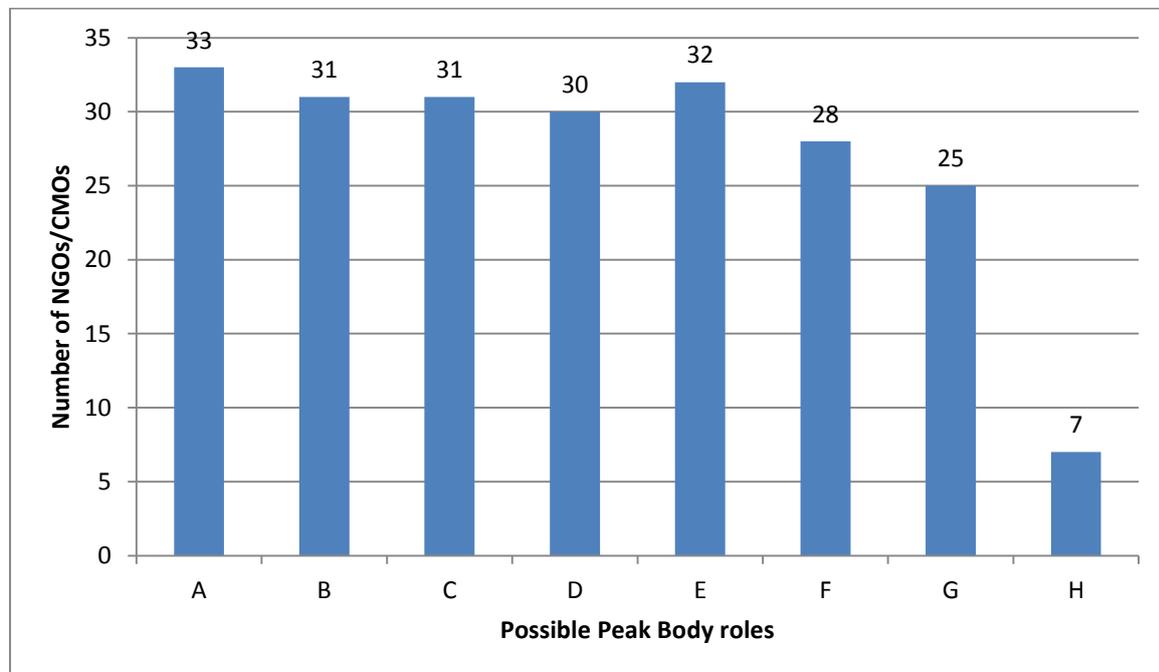
- data collection systems around quality (consumer/customer feedback), efficient use of time and face-to-face time
- re-designed supervision programs, such as permanent staff undertaking supervision of casual staff
- spot-audits of documentation or ‘pop-in’ checks of service provision
- increasing IT access for staff (laptops, tablets, etc.)
- online learning, particularly for professional development
- induction processes and information packs for staff
- feedback meetings with staff
- using volunteer/unpaid workforce to assist with tracking individual outcomes.

New tools (or enhancement of existing tools) described by survey respondents were largely associated with assessing individual outcomes or recovery outcomes such as employment, housing and social connection. These included the Recovery Assessment Scale (RAS) (Campbell-Orde *et al.*,

2005) and the Outcomes Star (Triangle Consulting Social Enterprise, 2014). One organisation was also exploring the use of the *WHO QualityRights Tool* (World Health Organization, 2015).

## Role of peak bodies

All of the service providers surveyed found at least one way for their peak bodies to provide support. In most cases they identified nearly all the roles offered as being valued (Figure 12).



**Figure 12: Preference of service providers for peak body roles in support of NDIS adjustment (n=33, missing values)**

Key to Peak Body roles:

- A. Ongoing advocacy and active involvement in the development of the NDIS to ensure it meets its stated objectives and that service provider organisations are sustainable
- B. Advocacy for changes in the service pricing arrangements to allow for more practice supervision and on-the-job training
- C. Clear articulation and promotion of the different requirements of people with psycho social disability (compared to physical and intellectual disabilities)
- D. Forums/meetings/etc. around the practical implementation of the NDIS and associated workforce experiences
- E. Research and dissemination of issues around the NDIS, including case studies of various organisations' approaches here and overseas, including ways they have restructured and/or reoriented themselves
- F. Development and delivery of courses based on appropriate skills clusters
- G. Support of on-the-job training efforts
- H. Other

The main suggested other role for peak bodies was to facilitate linking between providers and foster collaborative efforts across the sector.

## Chapter 6: Conclusion & recommendations

### Prelude

This scoping study was a preliminary attempt to understand the community managed mental health sector's workforce development needs nationally in relation to the delivery of services for psychosocial disability support within the NDIS context and make recommendations about next steps and priorities to address these needs. By its nature this project has only been able to scope and explore workforce related issues that are emerging under, or in preparation for, the NDIS; further investigations will need to be undertaken to clarify and resolve many of the issues and tensions highlighted by this project, particularly around minimum qualifications and/or skills required and the related pricing structure.

What follows in this chapter is a summary of key findings, based on the data gathered with all its limitations, and some recommendations that flow from the findings. In some cases, especially where the findings are tinged with uncertainty because of the data limitations, the recommendations are for further research and other forms of exploration — that is part of the role of a 'scoping' study.

Prior to discussing detailed findings, it is important to acknowledge an overall perspective from the study that many service providers consider the NDIS to be a 'tough' environment, with pricing constraints and perceived rigidity in the catalogue of supports (NDIA Price Guide) seemingly making it difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner. Some of the perceived difficulties in this regard were summarised by one of the study's Project Officers as follows:

- having to back away from minimum workforce qualification standard since services cannot afford to pay the salaries required to attract and retain that level of worker
- having a 95% direct service provision model with little margin for non-direct service work
- a pricing structure that makes very little allowance for induction, training, development, collaboration, and innovation, and routine administration
- no detail on how the Information, Linkages and Capacity Building (ILC) is going to be implemented so no ability to plan for it or estimate income (for services) from it
- losing very experienced, qualified and dedicated staff in the near to medium term future
- many roles becoming more administrative and less recovery/support/ case management focused – exacerbating the loss of valuable staff; and
- workforce instability due to the need to employ people on a casual basis.

Interestingly though, based on analysis of qualitative responses to the survey, services yet to actually experience the NDIS environment were overwhelmingly more apprehensive (eight out of 16 with being uncertain) than those who had been involved in NDIS trial sites (five out of 18 negative, six with being still uncertain and nine being generally optimistic). This may highlight only a difference between anticipation, anxiety and a pragmatic response to reality; unfortunately these feelings were not explored in the study.

Certainly, as was canvassed early in this report, there is no fundamental inconsistency between the principles of the NDIS and a recovery based orientation and other similar models of care (strengths-based, person-centred approach). Some CMOs, and overseas experience especially in the UK, indicate that adaptation to the environment through a genuine focus on customer service and a willingness to adopt innovative workforce approaches is critical to ensuring synchronisation of the NDIS and the recovery approach in implementation.

## **NDIS has affected the nature of work being performed**

Organisations that have participated in the NDIS pilot sites have identified a change in the nature of work being undertaken with consumers which has mostly resulted in the need to increase skills in the workforce delivering NDIS services. The primary nature of the newly required skill sets identified by one of the consumer's stem from appropriate values and attitudes for individual service delivery that is, working with the consumer as opposed to working for or to the consumer. Survey respondents, while arguing that this ideal already exists in a recovery oriented approach, recognise too the need for still further cultural and attitudinal change in service delivery within the NDIS context, and the translation of this change into practical behaviour (applied skills).

Most CMOs with NDIS experience believe the amount and type of work required to be performed has increased, and for most this has been added on to existing work requirements. Again, for most CMOs this has not necessarily translated into a “de-skilling” of the workforce but rather an increase in the total skills required to provide NDIS services. As one CMO noted, they found that it has diversified and broadened the scope of the skill sets needed, from “less qualified” home help through to more “highly qualified” recovery focused supports.

The increased work, and its more diverse nature, has required a re-think on the types of skills required to provide many if not most of the NDIS funded services. ‘Good practice’ CMOs have identified the singular importance of relationship skills, and the strategic and competitive advantage a workforce with high quality relationship capabilities provides. This perspective is being led by CMOs that have taken a strong ‘customer service’ focus, which goes beyond being person-centred and adopts more marketing thinking about the place of a customer in the purchase of services. In the UK, Gianfrancesco (2014) has noted how such an approach reveals that customers can demand different things to those that organisations believe are important and often hold dear. In relation to workforce he states customers tend to desire “less qualified but experienced in life”<sup>7</sup> (not necessarily ‘lived experience’), flexible and responsive, and relationally competent. The small number of consumers interviewed for this study, largely supported this stance with some reservations. CMOs surveyed in this study identified the five skills as essential for NDIS psychosocial support work.

### **Five key areas for skill development essential for NDIS psychosocial support**

- ▶ **Understanding NDIS processes**
- ▶ **Customer service**
- ▶ **Individualised funding management**
- ▶ **Business planning/ organisational planning**
- ▶ **Care coordination**

<sup>7</sup> This does not necessarily translate into less skills.

Consumers and some other stakeholders also emphasised that workers that had attitudes and values that acknowledged the rights of consumers to choose, and skills that supported consumer decision-making, gave consumers and their carers service choice and control.

Despite the above picture of the NDIS generally affecting the work to increase the total amount and type of work, and the types of skills required, there appears to have been also an acceleration of processes of division of labour at least for work performed under NDIS funding. In this situation at least two 'divisions' seem to have been formed around two potentially distinct areas of work.

*The first area* of work largely relates to support for individual consumers that provides basic — some services and stakeholders have called it 'maintenance' — assistance in self-care in the home and the community. These are the two most demanded supports currently in the NDIS. In NDIA parlance, these supports are "Core Support Items" that enables a participant to complete activities of daily living and enables them to work towards their goals and aspirations.

*The second area* of work appears to be more in keeping with the principles of the Recovery Oriented Framework, and provides support to consumers individually or in groups, which is more developmental in nature. The NDIA label this type of work as within "Capacity Building Support Items", and note these are investment supports that enable a consumer to build their independence and skills so as to progress towards their goals.

The evidence for this emerging division of labour in the mental health CMO sector is still limited, although there is stronger evidence of this having already occurred in similar person-centred service environments overseas and in the initial NDS studies here in Australia. As noted earlier in this report, the possible emergence of a division of labour (or even consideration of it), is a major source of tension in the mental health sector and strikes at long held aims to increase the level of formal skills recognition. While some CMO respondents to the survey and in interviews have considered the possibility of a lower skilled level of worker, others are not in favour arguing that the possibility is being countenanced only because the NDIS service pricing, and consequent labour price, precludes employment of 'properly skilled and qualified' workers.

In truth, this scoping study has produced only enough evidence to reveal the issue but insufficient to offer a definitive perspective. Further research is warranted to better understand the work actually being performed, and that which consumers actually value. As one consumer noted:

*"I see the problem as at least partly due to the fact that we still haven't really defined what mental health support workers actually do and how [they are] therefore, to be valued. I am not necessarily saying that a Cert IV is the be all and end all. Far from it but I worry that ... we still haven't 'caught the space between consumers and mental health workers.'"*

The Individual Supports Project currently being carried out by MHA aims to describe in detail the range of disability supports that may be sourced by individuals with psychosocial disability through an NDIS individually funded package. It will make recommendations to the NDIA where new support items may be needed. It would make sense for this project to progress further to better understanding the actual support work being performed (and desired by consumers) for mental health NDIS participants, and mapping mental health sector roles, skills and qualification requirements and determining the corresponding appropriate pricing. The research should ideally make consumers and their carers a central focus.

**Recommendation 1.** Conduct further research into the support services consumers most need and want and identify the worker role/s consistent with these service requirements. This could most easily be facilitated by extending MHA's 'Design of individual supports' project with funds from the Sector Development Fund promoted in the MSW Strategy. The project scope would extend to fulfilling the following research elements:

- Mental health sector role mapping
- Mental health sector skills and qualification requirements mapping
- Identification of appropriate supports pricing based on the outcomes of the above two projects

The last project should also consider how the costs for different types of essential work can be accounted for e.g. essential on-the-job training, newer staff shadowing more senior workers, ensuring two workers can work with a consumer at once when necessary, appropriate professional supervision etc. The findings of this research should inform other significant decision making areas including training investment, recruitment strategies and remuneration considerations.

The above Recommendation makes explicit a focus on allowing within the price of labour for skills formation and practice supervision provision, in the absence of which stakeholders have warned of high consumer and worker risks.

## **A change of work has influenced a change in skill requirements**

This project identified an emerging tension between minimum qualifications and/or the skills required to carry out NDIS psychosocial disability services that will need to be explored and resolved in future work. The findings indicated that nearly all organisations were committed to employ staff with Certificate IV in Mental Health or Mental Health Peer Work, reflecting the sector's determination at the ground and macro level to lift the workforce's skill level. In practice though, many service providers were often recruiting staff without qualifications. One could argue that this was a contingency measure forced by insufficient availability in the labour market of Certificate IV qualified workers. Some qualitative data from the survey suggested alternatively that many of these recruitment decisions were simply driven more by trying to find the right fit for the skills required for the perceived support role, at the least cost.

Whatever the cause, a number of CMOs identified that they are recruiting with a focus on specific individual attributes or competencies, particularly those classified as 'soft skills' including appropriate attitudes, values, beliefs and interests, appropriate communication style, capacity to relate and empathise. This at least partially reflects the thoughts of consumers who detail a demand for workers with:

- a capacity to work beside and with a consumer be it for a range of things like developing personal skills, recreation activities, domestic duties etc.
- an even temper with a good sense of self to enable stability so that a consumer can develop their own sense of self
- the strength to support and maintain consumers' sense of self and confidence

- the ability to gently correct things like social skills where the consumer might say or do something which is not socially acceptable and they might not have an awareness
- a good understanding of mental health – understanding things like how a person might behave if they are hearing voices, or if they are sitting quietly
- an understanding and knowledge of who to contact if there is a problem or a consumer needs assistance with something that is beyond their capacity and skills.

Regardless of the merits of emerging recruitment practice, the outcome is likely to be that individuals are being employed whose skills may be adequate for most of the time undertaking ‘core’ support work, but found lacking when consumers need their mental health condition to be properly understood. There is a need for a minimum skills requirement to perform this work, the specifications of which may be guided by the findings of the research processes outlined in Recommendation 1.

In the short-term, pending the findings of the above recommended research, a pool of workers with appropriate personal attributes and mental health employability skills could be increasingly developed through regionally developed and delivered pre-vocational public domain training courses and/or in the workplace induction courses of larger organisations where the content goes beyond administrative and WHS introductions and develops base technical skills. The template for the pre-vocational training might be the newly released 2015 Community Services Training Package CHCSS00088 Induction Skill Set. The four units of competency included in this skill set are:

- CHCCOM005 Communicate and work in health or community services;
- CHCDIV001 Work with diverse people;
- HLTWHS002 Follow safe work practices for direct client care; and,
- HLTWHS006 Manage personal stressors in the work environment.

A specialist mental health unit could be added to this cluster such as ‘*CHCMHS002 Establish self-directed recovery relationships.*’

Such training strategies would need to be as local as possible, so that workers could be developed *in situ*, close to where they would be recruited. Such a training strategy by government is envisaged in the MSW Strategy through financial support of the “development of induction training” and analysis of training needs. The public domain courses especially could be prioritised in those areas scheduled for proximate NDIS roll-out. Parts of the courses could be designed and delivered in an online format to promote more consistency across course content and delivery.

Ideally the courses canvassed would deliver skills that were widely recognised such as through a Statement of Attainment conferred for the completion of a relevant unit of competence or skills cluster. There may be merit also in individuals who complete the pre-employment training or the induction training being issued a ‘Skills Passport’ (with minimal administrative burden on employers) that recognises actual skills attained. Such a ‘worker held’ record could capture other skills subsequently attained through workplace learning, practice supervision, on-the-job training or formal courses, thus contributing to that person’s employment mobility — both to move seamlessly between employers and geographic regions, and coming and going from the mental health workforce. How such a skills passport might prove more beneficial to worker mobility than normal CVs and formal qualifications as well as references and good selection processes, is open to debate,

but it is possible that for some workers it would prove to be a better record with some inbuilt employer validation of experiences.

The change in work noted has not just influenced a reduced demand for skill but also emphasised the need to deploy skills that underpin the delivery of Capacity Building Support Items. At first glance this is likely to require a worker with skills at least at the level of Certificate IV in Mental Health with perhaps also support from allied health professionals. The processes envisaged in Recommendation 1 should define more precisely whether this is in fact the case — it should not be taken for granted that evolving roles will be satisfied with the level of skill inherent in a Certificate IV qualification.

Assuming though that the Certificate IV is an appropriate level of skill attainment, the key elements of that qualification for the conduct of capacity building support work, on the basis of service provider responses to the survey, would appear to be those developing skills consistent with the recovery oriented approach. Within the Certificate IV the key competencies are:

- CHCMHS002 Establish self-directed recovery relationships
- CHCMHS003 Provide recovery oriented mental health services
- CHCMHS004 Work collaboratively with the care network and other services
- CHCMHS005 Provide services to people with co-existing mental health and alcohol and other drugs issues
- CHCMHS007 Work effectively in trauma informed care
- CHCMHS008 Promote and facilitate self advocacy
- CHCMHS011 Assess and promote social, emotional and physical wellbeing

Unfortunately investment in the training of the Certificate IV level workforce seems to have stagnated. Indeed in SA, the state government has recently decreased the financial subsidy for training and there were a reported only eighty subsidised places available in SA in the Certificate IV in Mental Health (and none for the peer work qualification). Clearly there is a need for more investment in formal, pre-vocational Certificate IV in Mental Health (and Mental Health Peer Work) training courses.

**Recommendation 2.** NDIS implementation funds are allocated to support a sufficient number of scholarships for Certificate IV Mental Health and Peer Support Work courses, on top of State Government subsidies, to meet the demands of NDIS growth.

The scholarship numbers can be determined through workforce planning based on the research findings of Recommendation 1.

From an efficiency perspective, and from a workforce planning perspective, it is in theory much easier and faster to build workforce numbers by upskilling people who already have some experience and relevant skills to the Certificate IV level — all while still being productive in the workforce. The workers targeted for upskilling to Certificate IV could be members of the existing NDIS mental health workforce. An exploration of the stages of upskilling is illustrated in Figure 13.

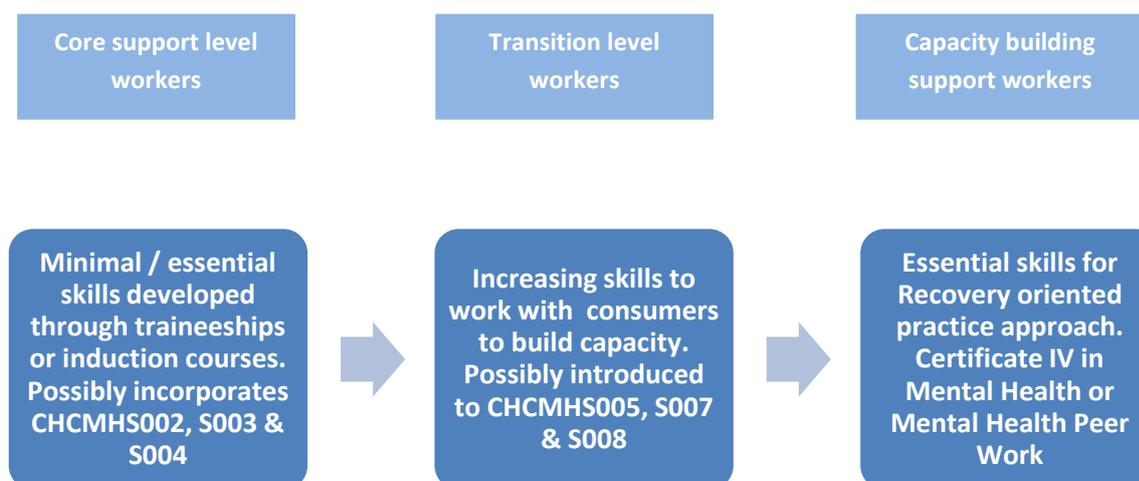


Figure 13: Workforce development pathway for workers delivering psychosocial support services under the NDIS

**Recommendation 3.** Current workers, or those employed in the future without Certificate IV in Mental Health or Mental Health Peer Work qualifications, should be supported to develop sufficient skills to work with NDIS consumers that require psychosocial recovery support ‘on-the-job’. This would be done by subsidising employers to allow study time and appropriate reflection (possibly with a mentor or supervisor) on their workplace experiences.

## Employment and deployment of workers

The findings of the scoping study indicated that just over half of organisations surveyed had been increasingly employing workers in a casual role, even those that had previously employed on an almost 100% permanent basis. This could easily become a permanent feature of the NDIS environment since overseas, based on much longer experience, the workforce has become more casual and/or self-employed. The strong sense from the survey’s qualitative data is that service providers feel pressured to employ in this way due to:

- incomplete information about the total NDIS system, especially the tier 2 or ILC component.
- the NDIS is in transition, leading for most service providers to much uncertainty about consumer numbers and total funding.
- The NDIS pricing structure provides for a generally lower hourly rate and its calculation is based on a high rate of consumer face time, with very little allowance for ‘downtime’ (for instance late consumer cancelled appointments) and corporate overheads. The obvious (and reasonable) response from managers is to try to synchronise revenue (‘billable hours’) with costs of production (worker hours), best achieved in theory through employing workers on a casual, if possible hourly basis.

It was observed mostly though that the increased casualisation of the current and possibly future NDIS workforce is clearly a reaction to the indeterminate demand for labour. As the NDS Discussion Paper noted:

*“Services are conscious of the more fragmented and uncertain nature of their income streams and the challenge of filling short shifts, especially late at night and on weekends.”*

Despite the degree of uncertainty in the employment environment, a number of service providers are still aiming for more permanent employment structures the benefits of which are extolled in the human resources (HR) literature as:

- greater security to the worker, leading to increased engagement and commitment by the worker to the employer
- employers have a greater incentive to invest in training workers because they are more likely to reap the benefits, thus increasing the capabilities of its workforce
- consumers will obtain continuity of care/support through ongoing availability of workers resulting, arguably, into provision of a better service.

Perhaps though there is no ‘correct’ path to follow. As some service providers and the overseas literature points out there are some benefits to having part of the workforce casual, including increased flexibility in deployment.

The key to making effective decisions in this environment is time: with time some of the uncertainties around revenue streams (including ILC funding), price relativities, and the way consumers demand services might dissolve or at least become more manageable. Over time, it is hoped that a sufficiently strong pattern of workforce demand could thus emerge to enable proper workforce planning and management of labour required. With greater understanding of the pattern of demand for workforce, employers can then choose to continue to use a predominantly casual workforce, look to an appropriate mix of casual and permanent employees, or attempt to employ predominantly on a permanent basis but retain some flexibility by applying innovative work practices.

Service providers will no doubt need help in building their understanding of the workforce demand, once the levels of uncertainty have receded, and the various ways they can appropriately respond. The MSW Strategy makes clear that providing such support is a priority. The MSW Strategy notes the need to establish:

*“... a Transforming the Workforce programme to demonstrate learning models of service delivery that enable suppliers to make better use of the talent and skills of the workforce and to stimulate innovation. This programme could seed-fund innovative workforce and service projects to redesign and test new work roles and related models of supervision, deploy workforce, give more flexibility and improve outcomes through the use of technology.”*

**Recommendation 4.** Provide CMOs with support in forming innovative workforce employment and deployment decisions by developing and providing guides and tools to assist in identifying service patterns and developing strategies to adopt workforce solutions that match emerging service patterns.

One stakeholder, the MHA, has argued that service providers should be given the opportunity to 'buy time' and survive while recommendations like the above can be acted upon through a funding guarantee for three years following the commencement of the NDIS in their local area. This too would not seem inconsistent with the MSW Strategy intentions for a mature market to evolve.

Overseas literature based on NDIS like experience has advocated a new paradigm of staff deployment which is a move away from traditional structural model (teams) towards individual multi-skilled staff covering the full range of consumer needs. At a micro worker deployment level, ideally CMOs need to ensure that workers therefore are matched in their skills and capabilities to the particular nature and level of needs of consumers. This requires effective management of the workforce, a genuine understanding of the needs of consumers and current and updated information about the skills, attitudes and qualifications of workers. This would avoid the situation presented in the NDS Discussion Paper where:

*"... some services are implementing policies such as recruiting a new worker in an area once they have three clients living there. A service coordinator spoke of how he was using clever rostering to 'fill the dance cards' of his existing staff."*

**Recommendation 5.** Conduct research into management tools and mechanisms used by 'good practice' CMOs to deploy workers according to their skill mix and skill level to match with consumers based on their levels of need. The findings can be incorporated into the guides proposed in Recommendation 4 or within a separate advisory process.

Diffusion of innovation theory (Rogers, 1962) offers a framework for how any innovations in the NDIS, including in the area of workforce development, can be more widely adopted across the CMO population. The theory tells us that new adopters are most influenced by and learn from organisations that have already adopted, particularly those that are considered to be 'early adopters'<sup>8</sup>.

In order to support workforce development activities of CMOs who will be providing services under the NDIS peak bodies can sponsor and organise workshops and forums that promote collaboration and problem-solving where experienced CMOs (possibly opinion leaders) that were involved in early trials of NDIS can provide information, share stories and answer questions of organisations that are preparing for the NDIS. Some stakeholders have questioned such a strategy in a competitive funding (and maturing market) environment, where all information and practices can be regarded as 'commercial in confidence'. They ask, "Why would a CMO share strategic information to its potential competitors?" and equate this to the supermarket company Woolworths sharing with its competitor Coles.

In answer to this, other stakeholders have promoted the idea of grants for CMOs who have successfully transitioned to the new NDIS arrangements and maintained service quality and employment standards. The grants would be to provide advice to government on how this was achieved, which government officers could then share with the broader mental health sector. This

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<sup>8</sup> These individuals / organisations have the highest degree of opinion leadership among the adopter categories. Early adopters are more discreet in adoption choices than innovators, who tend to be the first movers on innovations.

might be more likely to work in a competitive market than expecting CMOs to share their secrets of success directly with competing CMOs.

**Recommendation 6.** NDIS implementation funds are allocated to peak bodies to organise and conduct workshops that juxtapose experienced and inexperienced CMOs to share learnings and information. The ideal will be to include in the mix CMOs that are early adopters of workforce development innovation and likely ‘opinion leaders’. Incentives to opinion leader CMOs (in the form of research grants tied to a commitment to share findings) may need to be considered to ensure their appropriate participation in workshops.

## Attempting to understand future impact of NDIS on the workforce

NDIS have developed information packs, workshops and workbooks for organisations and clients that will be involved in delivering and receiving NDIS support services. One specific example is the *“Imagining and planning for the future under a NDIS: Workbook”* (NDIS, 2013). Existing resources tend to focus almost exclusively on the mechanics of the NDIS, and where they do not they are more general in nature (broad strategy documents) than advisory or prescriptive. There is a need for resources that specifically help organisations think through management and workforce issues.

**Recommendation 7.** Based on consultation with a representative sample of CMOs, identify a list of ‘frequently asked questions’ and then fund development of an information pack with questions and answers around how to structure a workforce in the short and long term that can deal with fluctuations in demand. This recommendation would be consistent with the suggestions of the MSW Strategy and could be funded from the Sector Development Fund.

## Quality assurance / continuous improvement processes

The issue of quality is currently the subject of significant policy activity at the Commonwealth and State / Territory levels and many from the mental health sector have made submissions to this policy development process. The environment though, like other parts of the NDIS service domain, remains for the moment uncertain.

Many survey respondents expressed a fear that quality is being compromised by insufficiently skilled workers being asked to perform work that requires greater competence yet, reduced initial and ongoing training investment and practice supervision in a more dispersed workforce context that has yet to be properly mastered. This latter issue seems to be the most challenging, and even overseas where greater experience in a person-centred service environment has been built, the ‘remote’ supervision issue remains a concern. Greater use of consumer feedback and direction, along with improved use of communication technology, would seem to hold promise of better quality assurance and continuous improvement processes.

**Recommendation 8.** The Government develops quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework, including continuous improvement processes.

The Sector Development Fund supports training for CMOs in the quality assurance and continuous improvement processes similar to earlier recommendations.

## Workforce size

The MSW Strategy, echoing initial observations of the Productivity Commission, notes that the workforce will need to double in size by the time the NDIS reaches its full implementation state.

No data for this study was explicitly collected on how to expand the workforce other than thoughts gathered through the literature review. The NDS (2014) review of early NDIS trial site recruitment found no great difficulties experienced by providers, but wondered if this might be because the sites were all high unemployment regions. Recruitment behaviour of respondents to the survey of this study showed a propensity to employ persons without qualifications, but it was impossible to determine with any conviction as to whether this was a reaction to labour market challenges or a policy born of economic necessity.

Irrespective of the early trial site experiences, as the NDIS rolls out, increasing recruitment difficulties are to be expected. Traditionally workforce growth is driven by an increased training rate, and earlier recommendations, particularly Recommendation 4, acknowledge this pathway. For very rapid growth of a workforce, more non-conventional means of sustaining growth need to be considered that rely on reduced barriers to workforce entry. While this study has underscored the tensions and anxieties in relation to employing less qualified (but still appropriately skilled) labour, it could potentially be an effective strategy for rapidly increasing available supply of workers — but only if the studies suggested in Recommendation 1 indicate such workers are suitable for the work required to be performed.

Other areas of the community services and health sector have already begun to face and deal with the need for rapid workforce growth, notably the aged care sector in the face of a burgeoning ageing population, and they have already established some first mover advantage over the disability sector. The Community Services and Health Industry Skills Council (CS&HISC) 2015 Environmental Scan reports on the Aged Care Workforce Innovation Networks (WIN) noting 148 individual providers received \$2.57 million in grant funding and contributed \$3.38 million to deliver a range of workforce development projects. Regional approaches to workforce development have been a feature of the WIN approach which has fostered collaborative solutions to regional workforce needs. In some regions this has helped successfully transition unemployed workers from declining industries (like manufacturing) into community services and attract workers from non-traditional sources (such as school graduates and tertiary education students). NDS runs a disability sector Workforce Innovation Network project and this study was advised that these collaborations are engaging mental health service providers. These initiatives are being supported by a targeted 6 month training program to build workforce planning skills in services<sup>9</sup>. There may be room to increase the participation of

<sup>9</sup> [http://www.nds.org.au/news/article/3323?cm\\_mid=4232680&cm\\_cruid=08a117cf-976a-e211-bb93-005056920608&cm\\_medium=email](http://www.nds.org.au/news/article/3323?cm_mid=4232680&cm_cruid=08a117cf-976a-e211-bb93-005056920608&cm_medium=email)

mental health service providers in the NDS projects or to consider creating a mental health focused WIN.

**Recommendation 9.** That more interventions, such as the WIN project, in existing pilot sites or areas targeted for further roll-out be funded to explore different and innovative approaches to workforce recruitment and development and the extent to which service collaboration can be effective in increasing the workforce pool. A deliberate attempt could be made to include a higher proportion of mental health CMOs in the WIN projects.

In relation to workforce planning, the NDS have taken the approach of supporting services to manage workforce risks and take up workforce opportunities, rather than attempt to develop a national workforce plan. This would be consistent with the 'market' approach of the MSW Strategy. They argue in any case the data does not exist for feasible workforce planning (a situation lamented in regard to the mental health workforce also, (HWA, 2013) and therefore believe it is more appropriate in a complex environment to use an adaptive systems approach rather than attempt to follow a linear plan or pathway.

No doubt the NDS approach makes imminent sense, and it is certainly true that even were the data sources to support CMO mental health workforce significantly improve, workforce planning would be still inexact and incapable of precise projections. But there does seem to be a need to improve on the crude order of magnitude measures currently prevailing about needed workforce growth. Moreover, the findings of research to come from enactment of Recommendation 1 could significantly change thinking, and a means of exploring policy options through workforce planning sensitivity analysis could be quite helpful.

**Recommendation 10.** Pending the outcomes of research discussed in Recommendation 1, undertake a national workforce planning project to gain a more precise understanding of the requirements for different types of workforce at different levels of training and qualification. Relative investment in different training models could then be re-calibrated.

In some quarters the use of persons with lived experience has been seen as a possible population from which to rapidly increase recruitment. MHCC depicts this approach as a possible win-win, where service provider workforce challenges are at least partly ameliorated and employment pathways for people with disadvantages are created (MHCC, 2015b). However, they also advise caution noting that a lack of clarity and workplace supports for the peer support workforce has been identified (MHCC, 2015b). Consumers interviewed for this study also advised care in this regard, noting that in support roles peer support workers may need more supervision than other workers.

## **What does good practice workforce development look like?**

It would be exciting to be able to identify a prototype service provider model that could be paraded as an example of good practice workforce development, but in truth, at this early stage of the NDIS

roll-out and with still so much uncertainty, 'good practice' is still difficult to discern. While some innovative workforce development practice can be identified in isolation, this has not translated yet to a broader approach.

What seems possible though is to offer an opinion on the characteristics of organisations that seem best placed to ultimately respond to NDIS workforce challenges quickest and most effectively. These are:

- a proactive and contributing approach that aligns with the maturing of the NDIS and underpins a determination to enable such an important social reform to succeed
- a resolve to remain flexible in workforce development and deployment decision-making until the emergence of clear patterns of workforce demand and supply. The old [HR] management maxim applies in this circumstance, that it is not that decisions are perfect but that the adjustment to poor decisions is rapid. Thus, short-term workforce decisions are not seen as binding on a long term workforce development approach
- adoption of a marketing approach. With this approach 'customer is always right' and the business driver is not a focus on costs but rather on increasing revenue through increased market share, even to the extent of progressing into non-traditional (non-welfare) markets
- in the same vein, placing consumers at the heart of workforce development decision-making. In this regard, some advice from Gianfrancesco (2014) is salutatory:

*"Listen carefully to what customers tell you before deciding what a 'qualified workforce' is."*

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## Attachment 1: Advisory Group Members

MEMBER	ORGANISATION	JURISDICTION
Tina Smith Senior Policy Officer	MHCC	NSW
Coralie Flatters Manager, Sector Development	WA Association for Mental Health (WAMH)	WA
Sonyalle Brackley RTO and training coordination	Mental Health Coalition South Australia (MHCSA)	SA
John Katsourakis Manager Education and Training	Psychiatric Disability Services of Victoria (VICSERV)	VIC
Russell Stevens Workforce Development Officer	Mental Health Council of Tasmania (MHCT)	TAS
Leith Felton-Taylor Policy and Sector Development Manager	Mental Health Community Coalition of the ACT (MHCC ACT)	ACT
Caroline Alcorso National Manager, Workforce Development	National Disability Service	National
Liz Ruck Senior Policy Officer	MHA	National
Phillip Dunn Acting CEO	Pathways	VIC
Melody Edwardson Acting CEO	Queensland Alliance for Mental Health (QAMH)	QLD
Debbie Hamilton	Consumer Representative	NSW
Carolyn Williams Regional Manager	New Horizons	NSW
Damien McGrath Director of Market, Sector and Workforce	Commonwealth DSS	National
Ian Moore Executive Manager, Business Development and Strategy	UnitingCareWest	WA
Keith Mahar Outreach Worker	Woden Community Service Inc. (Keith also contributed as a consumer representative)	ACT

## Attachment 2: Project Officers

Project Officer	Peak body	State or territory
Tina Smith, Senior Policy Officer (and Mark Clarkson, Business Development Manager)	MHCC	NSW
Coralie Flatters Manager, Sector Development	WAMH	WA
Sonyalle Brackley RTO and training coordination	MHCSA	SA
John Katsourakis Manager Education and Training	VICSERV	VIC
Russell Stevens Workforce Development Officer	MHCT	TAS
Leith Felton-Taylor Policy and Sector Development Manager	MHCC ACT	ACT

# Appendix 3: Consumer participant information sheet



**Mental Health  
Australia**



## **CONSUMER PARTICIPANT INFORMATION SHEET** **Community Managed Mental Health Sector NDIS** **Workforce Development Scoping Paper Project - 2015**

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### **1. About the project**

You have been invited to participate in a project to scope and investigate the workforce development needs of non-government community managed organisations (NGOs/CMOs) who provide services for people with high levels of psychosocial disability related to a mental health condition in the context of implementation of the National Disability Insurance Scheme (NDIS). The main outcome from the project is to identify best practice workforce development strategies and develop a paper and set of recommendations to enhance community managed mental health sector workforce readiness to deliver services under the NDIS.

### **2. Who is carrying out the project?**

The project is being conducted by the Mental Health Coordinating Council (MHCC) on behalf of Community Mental Health Australia (CMHA). MHCC has engaged consultancy firm Human Capital Alliance (HCA) who have considerable experience in the area of health/mental health workforce development to undertake aspects of the project.

### **3. Project funding**

The project has been funded by Mental Health Australia (MHA) as part of MHA's broader NDIS Capacity Building Project.

### **4. Who is being interviewed?**

A sample of consumers who are currently receiving support under the NDIS will be interviewed for the project.

Community sector organisations across Australia that provide services to people with mental health conditions will also be interviewed for the project; this includes, but is not limited to, organisations in NDIS trial sites. These interviews will be conducted by Project Officers identified from state and territory community mental health peak bodies.

### **5. What does the project involve?**

#### **Project Advisory Group**

An Advisory Group has been established to guide the project which includes representation from community mental health peak bodies in most states and territories, industry representatives, consumer representatives, the National Disability Service, the Commonwealth DSS and MHA.

### Data collection

Consultants from HCA will conduct interviews with consumers. The consultants are Lee Ridoutt, Victoria Pilbeam and Carla Cowles.

Project Officers from the following state and territory peak bodies have also been identified to conduct organisational interviews:

- Mark Clarkson - Mental Health Coordinating Council, NSW (MHCC)
- Coralie Flatters - WA Association for Mental Health
- Sonyalle Brackley – Mental Health Coalition South Australia (MHCSA)
- John Katsourakis – Psychiatric Disability Services of Victoria (VICSERV)
- Russell Stephens – Mental Health Council of Tasmania (MHCT)
- Leith Felton-Taylor – Mental Health Community Coalition ACT (MHCC ACT)

Interviews in other jurisdictions may be undertaken by HCA.

Information collected from the interviews will be analysed to identify:

- good practice and effective approaches to workforce development in relation to the NDIS
- ongoing workforce development needs to provide services under the NDIS
- recommendations for workforce development in relation to the NDIS.

### Literature and policy scan

A literature and policy scan is being conducted by HCA to examine the impact of the NDIS and to understand mental health and disability workforce directions relevant to the full roll-out of the NDIS from July 2016.

### Scoping paper and report

A final scoping paper that includes findings and recommendations will be developed by September 2015.

## 6. Where will the interviews take place and how long will they take?

Interviews will be conducted via phone by an HCA consultant and will take about 45-60 minutes. The questions will be provided to you before the interview for your review and consideration.

## 7. Can I withdraw from the project?

Participating in this project is completely **voluntary**. You are not under any obligation to participate. If you do participate, *you can still withdraw at any time*.

## 8. Will anyone else know the results?

Only consultants from HCA who interviewed you will have access to the information you give at the interview. All information provided by you will remain confidential and de-identified for discussion by the project Advisory Group and for the final report.

### For more information:

If you would like more information about this project or you have any concerns about participating in the survey please contact:

Carla Cowles - Staff Consultant Human Capital Alliance Ph: 02 9880 8003 E: <a href="mailto:carla.cowles@humancapitalalliance.com.au">carla.cowles@humancapitalalliance.com.au</a> W: <a href="http://www.humancapitalalliance.com.au">www.humancapitalalliance.com.au</a>	Mark Clarkson Mental Health Coordinating Council Ph: 02 9555 8388 E: <a href="mailto:mark@mhcc.org.au">mark@mhcc.org.au</a>
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## Attachment 4: Workforce development survey

About the respondent	
Contact name	
Position title	
Name of service/program	<i>This is the service that the survey will be based upon</i>
Organisation	<i>* If the service has a parent or umbrella organisation, please enter the name of that organisation.</i>
Which of the following types best describes your organisation? <i>Choose one type only</i>	<ul style="list-style-type: none"> <li>a) Providing mental health programs only</li> <li>b) Providing mental health programs in addition to other programs</li> <li>c) Providing mental health support but no specific mental health programs</li> </ul>
Location	
Date of survey completion	

<b>About the organisation</b>	
1.	<p>How many <b>direct support workers</b><sup>10</sup> does your service currently employ (Do not include agency workers, sub-contractors or self-employed persons):</p> <p><i>Inform the respondent that the next question explores more detail about the casual, permanent status etc.</i></p> <ul style="list-style-type: none"> <li>a) <b>Full time</b> (this means working normal hours, as defined in the award or agreement for your workplace)               <ul style="list-style-type: none"> <li>i. How many hours per week are considered full time?</li> </ul> </li> <li>b) <b>Part time</b> (this means working less than normal hours)</li> <li>c) <b>Full time equivalent</b> (FTE) (use the total hours worked by all staff to calculate the FTE staffing of the service)</li> </ul>
2.	<p>How many of these staff are employed in your service as ...</p> <p><i>Explain to the respondent that definitions may vary between organisations but we need them to answer as best they can within these definitions.</i></p> <ul style="list-style-type: none"> <li>a) <b>Permanent</b> employees (entitled to holiday and sick leave and have an expectation of ongoing employment with the service)?</li> <li>b) <b>Short-term contract</b> employees (may be entitled to some holiday or sick leave but are not paid any kind of casual loading; no expectation of ongoing employment with the service and have a definite termination date in their contracts)?</li> <li>c) <b>Casual</b> employees (not entitled to either holiday or sick leave, paid on an hourly or weekly basis and a casual loading in lieu of holiday pay, no expectation of ongoing employment with service)?</li> </ul>
3.	<p>Of these staff how many are:</p> <ul style="list-style-type: none"> <li>a) Community mental health/support workers?</li> <li>b) Of this total, how many are <b>identified</b> peer support workers?</li> <li>c) How many mental health/support workers (FTE) are employed in programs that are in scope for NDIS?</li> </ul>

<sup>10</sup> Direct support workers are all workers who directly provide support to clients. It excludes professionals (such as physiotherapists) and also excludes managers, supervisors, administrative staff, maintenance or cleaning staff

Experience in the NDIS	
4.	<p>Has your service had any direct experience in the NDIS through participation in one or more pilot sites?</p> <p>a) Yes</p> <p>b) No → <b>go to Question 18 in ‘Workforce Issues’</b></p>
5.	<p>If yes, how long has your service had direct experience in the NDIS? _____ months</p> <p>What fraction of your total work/client load does the NDIS experience represent (in the pilot site services)? _____ %</p> <p><i>Probe: Discuss how this might change in the future.</i></p>
Changes in the work	
6.	<p>In providing services to consumers through the NDIS, has the type of work changed? Please tick one or more of the responses below.</p> <p>a) Some work previously undertaken has been reduced or eliminated</p> <p>b) Some work not previously undertaken is now required</p> <p>c) Work has not changed, doing work previously undertaken</p>
7.	<p>If you chose either or both of the first two responses, please provide further explanation.</p>
8.	<p>Since the introduction of the NDIS, has this resulted in ...</p> <p>a) service models changing and the workforce mix changing (more casualised / more part time)?</p> <p>b) service models changing but no change in workforce mix (permanent / casual; fulltime / part time)?</p> <p>c) no change to service models and no change in workforce mix of permanent, casual,</p>

	<p>part time and full time workforce?</p> <p><i>Probe: Please explain your choice.</i></p>
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### Recruitment & Retention

9.	Do you currently have, or plan to have, minimum qualification requirements of staff in relation to the NDIS? a) Yes b) No <b>→ Go to question 11</b>
10.	If yes, what are those requirements and how easy is it to find workers that meet the requirements?

11.	<p>Have you recruited additional workers for the NDIS work?</p> <ul style="list-style-type: none"><li>a) Yes</li><li>b) No</li></ul> <p>If yes, what type/s of employees did you actually recruit? <i>Please choose one or more.</i></p> <ul style="list-style-type: none"><li>a) Persons with no relevant formal qualifications but relevant ‘soft’ skills (e.g. interpersonal skills, communication skills, values, etc.) or attributes</li><li>b) Persons with lived experience, regardless of qualification</li><li>c) Persons with existing relevant qualifications such as a Cert IV in mental health or peer work.</li><li>d) Persons without qualifications but having committed to gaining qualifications within an agreed timeframe.</li></ul> <p><i>Probe: Please explain your answer.</i></p>
12.	<p>Has the delivery of services in the NDIS environment affected your workforce turnover, either positively or negatively (less people leaving / more people leaving)?</p> <ul style="list-style-type: none"><li>a) Yes</li><li>b) No</li></ul> <p><i>Please explain your choice (probe how they know).</i></p>

**Training & Education**

13.	<p>Have changes in the work required to be performed in the NDIS environment affected the skills of particular roles needed to perform mental health work?</p> <ul style="list-style-type: none"><li>a) Yes, less skill is now required to access &amp; provide NDIS funded support services.</li><li>b) Yes, more and different skills are now required to access &amp; provide NDIS funded support services.</li><li>c) No, skill requirements have not changed from what has always been required to access &amp; provide NDIS funded support services.</li></ul> <p><i>Please explain your answer</i></p>
14.	<p>Have you needed to develop the skills and attitudes of your <b>current</b> workforce in order to better understand and work in the NDIS environment?</p> <ul style="list-style-type: none"><li>a) Yes</li><li>b) No</li></ul>

15.	<p>If yes, in which of the following areas have you placed a skill development priority? <i>More than one answer can be provided.</i></p> <ul style="list-style-type: none"><li>a) Customer service</li><li>b) Individualised funding management</li><li>c) Business planning / organisation planning</li><li>d) Supported decision-making</li><li>e) Care coordination</li><li>f) Workplace Health and Safety knowledge</li><li>g) NDIS processes</li><li>h) Record keeping</li><li>i) Privacy / confidentiality</li><li>j) Advocacy</li><li>k) Outreach / engagement</li><li>l) Other (please specify)</li></ul> <p><i>Probe: What types of skills development have been pursued? How is it being funded? Probe answer to this question also in relation to Question 14.</i></p>
16.	<p>If you answered no, please explain your answer?</p>

17.	Could you please explain how you induct and train new employees (including permanent, casual and short-term contract), and/or how you are planning to induct and train new employees under the NDIS?
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**Respondents who answered ‘no’ to question 4 come back in here**

Workforce Issues																	
18.	<p>Can you identify the <b>top three (3)</b> workforce issues you <i>have acted upon</i> or would <i>like to act upon</i> in response to the implementation of the NDIS in Australia?</p> <p>Please list those issues and rate each issue on a scale of 1 to 10, with 1 being of low impact or influence on your response and 10 being very significant impact or influence.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%;">Issues</th> <th style="width: 10%;">Least</th> <th style="width: 10%;">Somewhat</th> <th style="width: 10%;">Most</th> </tr> </thead> <tbody> <tr> <td>A.</td> <td>1 2 3 4 5 6 7 8 9 10</td> <td></td> <td></td> </tr> <tr> <td>B.</td> <td>1 2 3 4 5 6 7 8 9 10</td> <td></td> <td></td> </tr> <tr> <td>C.</td> <td>1 2 3 4 5 6 7 8 9 10</td> <td></td> <td></td> </tr> </tbody> </table>	Issues	Least	Somewhat	Most	A.	1 2 3 4 5 6 7 8 9 10			B.	1 2 3 4 5 6 7 8 9 10			C.	1 2 3 4 5 6 7 8 9 10		
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A.	1 2 3 4 5 6 7 8 9 10																
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C.	1 2 3 4 5 6 7 8 9 10																
19.	<p>Have you begun preparing for your workforce needs as the NDIS progressively rolls out?</p> <p>a) Yes</p> <p>b) No, not yet → <b>go to question 21.</b></p> <p>c) No, there is no need to. <i>Probe: Why is this so?</i></p>																

20.	<p>In what ways have you been attempting to understand the future impact the NDIS will have on your organisation's workforce? <i>More than one answer can be provided.</i></p> <ul style="list-style-type: none"> <li>a) Discussions with NDIA</li> <li>b) Attending forums / workshops to hear from organisations in the pilot areas</li> <li>c) Attending forums/workshops by NDIA etc. or with an NDIS theme</li> <li>d) Talking to experienced organisations</li> <li>e) Having internal discussions</li> <li>f) Researching overseas experience</li> <li>g) Obtaining information from peak bodies</li> <li>h) Obtaining information from industry associations</li> <li>i) Other - <i>Please provide an explanation of other strategies adopted</i></li> </ul>
21.	<p>In what ways do you think the workforce will need to change for the NDIS?</p> <p><i>Probe:</i></p> <p><i>What affect will this have on the current workforce? Will these changes to the workforce also change what tasks can be effectively delivered by this workforce? If so, what changes do you anticipate? Please include any evidence you might have to support your views.</i></p>
22.	<p>In what ways will your staff learning and development effort change to respond to the NDIS environment?</p> <p><i>Probe: Content? Method (for instance more on the job training)? Occurrence?</i></p>

23.	<p>If you anticipate an environment of more individualised and geographically distributed service delivery, how will you ensure service quality standards are maintained?</p> <p><b>Probe</b></p> <ul style="list-style-type: none"> <li>▪ <i>Will there be new roles or processes (i.e. practice governance) for service quality assurance in response to the changed workforce?</i></li> <li>▪ <i>How will quality of service provision be assessed?</i></li> <li>▪ <i>Are there specific tools the service will use to measure quality?</i></li> </ul>
24.	<p>What role should peak bodies take in representing the interests of service provider specifically in regard to workforce development and the NDIS?</p> <p>Rank the items below from 1 (highest needed support) to how ever many you believe appropriate.</p> <ul style="list-style-type: none"> <li>I. Ongoing advocacy and active involvement in the development of the NDIS to ensure it meets its stated objectives and that service provider organisations are sustainable</li> <li>J. Advocacy for changes in the service pricing arrangements to allow for more practice supervision and on the job training</li> <li>K. Clear articulation and promotion of the different requirements of people with psycho social disability (compared to physical and intellectual disabilities).</li> <li>L. Forums/meetings/etc. around the practical implementation of the NDIS and associated workforce experiences</li> <li>M. Research and dissemination of issues around the NDIS, including case studies of various organisations’ approaches here and overseas, including ways they have restructured and/or reoriented themselves</li> <li>N. Development and delivery of courses based on appropriate skills clusters</li> <li>O. Support of on the job training efforts</li> <li>P. Other – please provide an explanation</li> </ul>

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