FINAL REPORT

Mental Health Training

NEEDS ASSESSMENT

for the NGO Sector in NSW

for

Mental Health Coordinating Council

Prepared by

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December 2006

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- CONTENTS -

1. INTRODUCTION 1
2. BACKGROUND 1
2.1 About the MHCC 1
2.2 About the NGO Development Strategy 1
2.3 About the Training Needs Assessment 2
3. CONTEXT FOR NGO WORKFORCE DEVELOPMENT 5
4. FINDINGS 6
4.1 Profile of Survey Respondents 6
4.2 Current Workforce Experience, Skills and Qualifications 8
4.3 Recent Training Undertaken 9
4.4 Barriers to Training 10
4.5 Future Workforce Skills and Knowledge 14
4.6 Minimum Standards 20
4.7 Mental Health Traineeships 22
4.8 Pathways and Partnership Issues 23
4.9 Training Needs of Non-Specialist NGO workers 25
4.10 Role of the MHCC 28
4.11 Additional Comments 31
5. CONCLUSIONS 32
GLOSSARY 35
ATTACHMENTS 36
ATTACHMENT 1- MHCC WORKFORCE DEVELOPMENT REFERENCE GROUP 36
ATTACHMENT 2 - MHCC BOARD MEMBERS 2005 37
ATTACHMENT 3- MHCC MEMBERS WORKFORCE DEVELOPMENT SURVEY 38
ATTACHMENT 4- MHCC WORKFORCE DEVELOPMENT SURVEY RESULTS 49
ATTACHMENT 5- MHCC MENTAL HEALTH CONSUMER CONSULTATIONS 72
ATTACHMENT 6- MHCC FONGA CONSULTATIONS 77
ATTACHMENT 7- LIST OF INTERVIEWEES 81
ATTACHMENT 8- SAMPLE STRUCTURED INTERVIEW QUESTIONS 82

TABLES

Table 1: NGO mental health organisation feedback on factors that pose barriers to staff undertaking further training 11
Table 2: NGO mental health organisation feedback on preferred mental health training topics and levels 15

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1. INTRODUCTION

This report was commissioned by the Mental Health Coordinating Council as part of its Non-Government Organisations (NGOs) Development Strategy. Prepared by independent consultants (Anni Gethin and Edwina Deakin), it provides a preliminary assessment of the workforce training needs of mental health workers employed by non-government service providers in NSW.

While the needs of workers employed in mental health NGOs (so called specialist organisations) are the primary focus, the report also incorporates feedback on the mental health training needs of non-specialist workers employed in other NGOs, as well as the views of some mental health consumers and carer representatives.

The assessment incorporates both quantitative and qualitative feedback from the NGO sector. It has been written to provide an evidence base to the scoping of options and strategies to enhance mental health NGO training and workforce development.

2. BACKGROUND

2.1 About the MHCC

The Mental Health Coordinating Council (MHCC) is the peak body for non-government organisations (NGOs) working for mental health throughout NSW.

MHCC's membership includes NGO service providers, both specialist and mainstream, consumer and carer groups, and other bodies interested in mental health. The MHCC has a total of 156[1] members.

The MHCC has an ongoing leadership, policy advice and advocacy role in NGO mental health issues. It facilitates linkages between government, non-government and private sector providers acting as a liaison body for the views of its membership.

The MHCC informs its membership of issues and opportunities relevant to the NGO mental health sector through a regular newsletter and with other communication. It also undertakes numerous special projects and initiatives.

The MHCC is managed by the MHCC Board made up of elected representatives from its membership.

2.2 About the NGO Development Strategy

The NGO Development Strategy is a major initiative of the MHCC. The Strategy aims to build the capacity of NGOs which provide services for people with mental illness.

The Strategy, funded by the Centre for Mental Health within NSW Health, commenced in August 2004. It is due to conclude at the end of 2007.

The Strategy has three stated aims:

1) To increase the capacity of the NGO sector to provide mental health services in the community, specifically through improved workforce development practices, quality planning, and effective service delivery approaches;

2) To encourage improved collaboration and partnerships in service planning and delivery both between NGOs, as well as between NGOs, funding bodies and relevant training or research organisations; and

3) To promote the importance and value of NGOs in assisting people affected by mental illness or a disability related to mental illness.

To address these aims, the Strategy has been divided into 3 program areas:

[1] As at 13th November 2006

i) **Workforce Development** (which will identify and promote the establishment of good practice workforce development and training across the NGO sector);

ii) **Quality and Outcomes** (which will identify and promote quality and evidence-based practice, including the use of outcome measurement and consumer evaluation of services); and

iii) **Partnerships** (which will identify and promote good practice planning and operational models between funding bodies and the NGO sector).

2.3 About the Training Needs Assessment

The MHCC established a Workforce Development Reference Group in order to assist the development of the Workforce Development program area of the NGO Development Strategy. (See Attachment 1 for a list of Reference Group members).

One key initiative agreed to by the Group was the need to conduct a training needs assessment of the NGO mental health sector.

2.3.1 Aims

The stated aim of the training needs assessment was to determine the training needs for NGO workers who:

- Directly provide mental health services;
- Manage or support those who provide these services;
- Provide other services to people, some of whom have a mental illness.

Some key questions to be investigated were:

- Are there gaps in the training currently available?
- Should the MHCC develop its own training program?
- If so, what should the content, structure, or other aspects of the training program be like?

2.3.2 Stakeholder groups

The prime stakeholder group assessed was ‘NGO non-clinical mental health workers based in NSW’. Their views and needs were principally accessed through consulting with MHCC member organisations and with the membership of the MHCC’s Workforce Development Reference Group.

A number of individuals representing specific stakeholders were also consulted by way of interviews and workshops:

1) Carers who support clients, friends or relatives with mental health needs;

2) Mental health consumers, particularly those who are in peer support or self-help roles; and

3) Peak non-government organisations or non-specialist NGO representatives (namely stakeholders who do not have an exclusive or even majority focus on mental health clients, but nonetheless may require some training in this area).

2.3.3 Consultancy

In March 2006 the MHCC undertook a selective tender process to identify suitably qualified consultants to assist it to undertake the Training Needs Assessment.

Anni Gethin, of AGA Consulting and Edwina Deakin, of EJD Consulting and Associates, submitted a joint tender and were selected to design and conduct the needs assessment.

The consultancy commenced in April and concluded in December 2006 with the submission of a revised final report.

2.3.4 Methodology

The consultants designed and implemented the following methodology as part of the training needs assessment:

a) Background research[2]

The consultants reviewed existing MHCC resources regarding workforce development issues and training needs. This included:

- Past research conducted by Heidi Freeman, the MHCC NGO Development Project Officer, including the August 2005 *Training and Workforce Development for the Mental Health NGO Sector* Options Paper;
- Past minutes from the MHCC's Workforce Development Reference Group;
- Other models of training needs assessment, including the Vicserv 2002-2003 Training Needs Survey from Victoria.

b) Consultations and workshops

MHCC staff and the consultants conducted a number of face-to-face consultations and workshops with representatives from a range of stakeholder groups. These included:

- Meetings and discussions with Jenna Bateman, MHCC Executive Officer and Heidi Freeman, MHCC NGO Workforce Development Officer, and Tina Smith, MHCC Special Project Officer;
- 17 May workshop with MHCC's Workforce Development Reference Group;
- 16 June workshop with the MHCC's Board.(Membership list included at Attachment 2)
- 29 September workshop with mental health consumers attended by 6 consumers with an additional two consumers providing input via email; and
- 6 October workshop with representatives on the Forum of Non- Government Agencies (FONGA) convened by NCOSS. Approximately 20 individuals participated primarily representing the views of non-specialist NGO service providers.

A total of 47 individuals were consulted through these processes.

Included as Attachment 5 is the MHCC write-up of the outcomes of the consumer consultations.

Included as Attachment 6 is the MHCC write-up of the outcomes of the FONGA consultations.

c) Membership survey

As agreed with the MHCC, the key data gathering instrument for feedback on NGO mental health workers' training needs was a written survey sent to all MHCC member organisations (a copy of which is included at Attachment 3).

The survey was initially sent out to members in electronic form with a cover email note from the MHCC Executive Officer. A total of 149 copies were distributed to all MHCC members, though some larger member organisations were invited to copy and forward the survey to sub-units within their organisations.

While a number of responses were received via return email, the consultants and the MHCC resolved that a printed version of the survey would also be distributed to improve response rates. This occurred on 9 June 2006.

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[2] Note: As the MHCC had already conducted considerable amounts of background research on workforce development issues, the consultant's were not required to conduct a conventional literature review. As such the data contained in this report needs to be reviewed within the context of these other research and development exercises.

Both MHCC staff and the consultants also undertook follow-up phone calls to either remind members to complete the surveys or to complete the surveys over the phone.

A total of 53 survey responses were received.

Excluding member organisations who did not employ staff in the target group, namely those without 'NGO mental health workers' (for example consumer and carer organisations), the response rate was calculated at 42%[3].

See Attachment 4 for a full breakdown of the type and number of responses received.

It should be noted that the consultants had intended to undertake a number of cross-tabulations based on the respondents' size, geographical location and service type. However, given the relatively small numbers of organisations that fell into these discrete categories of service (for example provided only one type of service, or who were exclusively in regional, rural and remote parts of NSW [7]) the consultants concluded that data generated from these types of cross-tabs were not statistically valid.

As such most of the survey data is presented as a consolidated block of membership feedback[4].

d) Interviews

Following analysis of the survey data, the consultants also conducted a number of phone interviews with selected NGO stakeholders.

In the case of MHCC members, the purpose of the interviews was to further investigate issues arising from the surveys.

Included as Attachment 8 is a sample copy of the structured questions that were used as the basis of the interviews[5].

Interviewees were selected that cover the full breadth of service types and geographical areas.

Phone-interviews were also conducted with a number of consumers, as well as with carer and other non-specialist NGO organisations regarding their perspectives on NGO worker training, as well as their own sector’s mental health training needs. These interviews included a number of peak NGOs and other individuals with knowledge of the needs of family workers, youth workers, aboriginal workers, drug and alcohol workers, as well as bi-lingual workers or workers engaged with CALD communities.

A total of 20 interviews were conducted.

Included as Attachment 7 is a list of all interviewees. Note: all input was provided on the basis of anonymity.

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[3] This rate was calculated with n=126. This was based on excluding a total of 24 member organisations most of whom did not employ mental health staff. It also takes into account the fact that one organisation provided responses on behalf of all three of its offices (members), plus the fact that three non-members (though eligible for membership) also participated in the survey.

The figure however should be considered indicative only as at least 2 larger members submitted more than one response (based on the views of unit managers within their organisations). Note: All surveys were submitted anonymously.

[4] Note: Section 5 recommends that some further consultations and research on specific NGO sub-groups training be undertaken in due course.

[5] Note: Some modifications were made to the structured interview questions depending on the particular interests and expertise of the respondent (for example modifications were made in the case of the consumer and carer respondents).

2.3.5 Reports

The consultants submitted a draft report for comments to the MHCC on 13 July 2006 with revised reports incorporating a range of feedback on 31 July, 9 August and 31 October 2006.

The final MHCC Training Needs Assessment report was submitted to the MHCC on 14 December 2006.

3. CONTEXT FOR NGO WORKFORCE DEVELOPMENT

Over the last decade the NGO mental health sector across Australia has grown significantly. This growth has not only been seen in the number of NGO workers employed in the sector, but also in the number of organisations and service types.

Over the same period of time Australia has also witnessed an increase emphasis on capacity building and workforce development issues. These emphases have been reflected in numerous Commonwealth and State reports, including in particular in the National Standards for the Mental Health Workforce (2002), and other subsequent documentation including the National Mental Health Report (2004), the National Mental Health Plan 2003- 2008, and National Mental Health Strategy (2003 – 2008).

Parallelling the growth in the NGO sector has been an increase in the breadth of services and service types available to mental health consumers. These range from supported accommodation and employment providers, to centre-based or drop-in services, through to referral, advocacy, education and information services, as well as growing numbers of carer, consumer and peer-support organisations.

The growth in the NGO sector has also been accompanied by increasing levels of quality, professionalism and sophistication in the services and support available to consumers. Nonetheless this growth has also created a range of opportunities and challenges in terms of workforce development.

Some key opportunities and strengths include:

- A diverse workforce containing a broad range of professions, skills, experience and capacities;
- A broad network of service providers and service types, that are accessible to mental health consumers in most parts of NSW;
- The availability of a range of community-based, support, counselling, rehabilitation and recovery approaches that complement and/or provide alternative approaches to mainstream clinical mental health services;
- Strong partnerships and linkages between the public and community health sectors that operate at both state, regional and local service levels;
- Increased government funding being invested in mental health services, including in new community based models of care involving NGOs;
- Increased opportunities for partnerships and collaborations between clinical and non-clinical service providers, as well as between different types of NGOs; plus
- A highly committed workforce and a sector that values and supports capacity building and workforce development initiatives.

Some key challenges facing the NGO mental health sector include:

- Diversity in the size, resources and capacities of mental health NGOs throughout NSW;
- Differential access to resources, specifically in terms of staffing and funding levels;
- Differential access to training and other professional development opportunities. This is particularly true for staff based outside the metropolitan areas;
- In some cases, a mobile and changing workforce means some workers have less than optimal career development and salary enhancement opportunities;

- Compared to other jurisdictions, some perceptual differences associated with the roles and responsibilities of 'clinical' health services, and so called 'non-clinical' disability support services, the later predominately associated with the NGO sector; plus
- Incomplete public and government understandings of the potential and actual roles and capacities of NGO mental health providers and the outcomes and benefits the sector can deliver.
- Potential difficulties in sourcing an appropriately trained and experienced workforce to meet the demand of a rapidly growing sector.

These types of opportunities, strengths and challenges, plus the sheer diversity of the NSW NGO mental health sector, provide the context for much of the feedback contained in this Training Needs Assessment.

4. FINDINGS

The following findings describe the outputs and outcomes of the various instruments used in the Training Needs Assessment (see Methodology Section 2.3.4).

Note: Within the context of these findings:

1) All survey respondents and quantitative survey data reflect the views of NGO mental health organisations in NSW who are members of the MHCC.
2) Specialist NGOs refers to NGOs with a specific expertise in and focus on mental health consumers (eg. members of the MHCC).
3) Non-Specialist NGOs refers to NGOs that do not have a specific expertise in or focus on mental health consumers.
4) All *italicised words* are direct quotes of respondents to this assessment.

It should also be noted that all of the survey data and much of the qualitative feedback represents the memberships' views as reported in May and June 2006. As such some members' views may have changed in recent months.

4.1 Profile of Survey Respondents

The 53 survey respondents were representatives of MHCC member organisations[6]. They were either coordinators or chief executive officers (CEOs) of their organisations, or managers of units within larger organisations.

4.1.1 Location

The respondents' organisations fell into the following categories:

- 34 were based in the metropolitan areas of Sydney, Wollongong and/or Newcastle;
- 7 were based in rural, regional or remote parts of NSW (i.e. non-metropolitan areas);
- 10 were based in both metropolitan and non- metropolitan areas
- 2 were described solely as other (e.g. NSW wide).

[6] 3 non-members also completed and returned the survey. As all were NGOs with a role in mental health issues (and therefore eligible for MHCC membership), their feedback was also included in the survey results.

Of these:

- 74% of organisations were partly or solely located in Sydney;
- 28% were from Newcastle or Wollongong;
- 30% were based in another regional centre;
- 21% were based in a rural town, and
- 8% were based in an area described as remote.

4.1.2 Staff size and composition

The respondents were responsible for staff ranging in size from 1 to 160 staff, with an average of 25 full-time equivalent (FTE) staff members.

- 54% employed 10 or less FTE staff;
- 28% employed between 11 and 25 FTE staff;
- 8% employed between 26 and 100 FTE staff; and
- 10% had over 100 FTE staff.

Of these employees, respondents reported that the following were employed in mental health programs:

- 26% had no staff employed in mental health programs;
- 47% employed between 1 and 11 staff in mental health programs;
- 12% employed between 11 and 25 staff in mental health programs;
- 8% employed between 26 and 100 staff in mental health programs; and
- 6% employed over 100 staff in mental health programs.

Based on the survey data, and noting its limitations in terms of response rates, averaging and its self-selecting sampling, the consultants estimated that the number of FTE staff employed by MHCC member organisations was between 2,500 and 3,000.

The estimated number of FTE mental health staff employed by MHCC member organisations was between 1,500 and 2,000[7]. It should be noted that this number is increasing rapidly as the size of the sector grows.

4.1.3 Volunteers

Survey respondents reported that they had the following numbers of volunteers contributing to their agency (though not necessarily in the mental health field):

- 56% had no volunteers;
- 24% had between 1 and 11 volunteers;
- 12% had between 11 and 25 volunteers;
- 4% had between 26 and 100 volunteers; and
- 4% had over 100 volunteers.

Note: The 2006 MHCC Annual Member Survey found that the ratio of paid to volunteer staff was 1:1.3.

[7] These figures are crude estimates of the potential workforce only. For example, they do not take into account the high number of part time positions in NGO agencies which are likely to swell the number of individuals who may require training. As noted in the conclusion, more work remains to be done to accurately quantify the size and nature of the NGO mental health workforce in NSW.

4.1.4 Services

Survey respondents came from organisations providing the full range of NGO services to mental health consumers:

- 51% provided supported accommodation/ outreach;
- 49% provided leisure and recreation services;
- 47% provided advocacy, education and information;
- 47% offered consumer support or networks;
- 37% provided employment services;
- 35% offered centre-based programs;
- 31% provided carer support;
- 20% provided respite services; and
- 14% provided other services, such as counselling, systemic advocacy, living skills and/ or referral.

Note: Many organisations provided more than one service.

4.1.5 Funding source

Survey respondents came from organisations with the following funding sources:

- 54% were funded by NSW Health (or an Area Health Service);
- 30% were funded by the Department of Ageing, Disability and Home Care;
- 22% were funded by Commonwealth Department of Families, Community Services and Indigenous Affairs (FaCSIA);
- 22% received funding from private sources including corporate donations, own fund raising and client fees;
- 14% were funded by the NSW Department of Community Services;
- 8% were funded by Department of Employment and Workplace Relations (DEWR); and
- 6% were funded by Defence Housing Authority (DHA).

Naturally many organisations received funding from a number of funding sources.

4.2 Current Workforce Experience, Skills and Qualifications

4.2.1 Coordinators and managers qualifications

Survey respondents (namely Coordinators, CEOs or Managers within mental health NGOs) for the most part indicated they were very experienced in working with clients with a mental illness or in a related area, with an average of 14 years experience. The range of experience reported spanned from 2 years to 30 years experience.

The respondents also indicated they were well qualified:

- 41% reported having a post graduate qualification;
- 54% a bachelor's degree;
- 42% a diploma or graduate certificate;
- 21% a Certificate IV; with
- Only 4% reporting they had no qualification.

4.2.2 Staff qualifications

Survey respondents reported that the majority of mental health staff in their organisations had tertiary qualifications:[8]

- 70% had some tertiary qualification;
- 52% had a health qualification;
- 32% had a mental health qualification; and
- 5% had a Certificate IV (non clinical mental health).

4.3 Recent Training Undertaken

Survey respondents indicated that the mental health related training being undertaken by staff and volunteers in their organisations was both extensive (in quantity) and diverse (in subject range).

Over half (60%) of the respondents had themselves undertaken training in the last 12 months. This training largely involved participation in a range of short courses (e.g. mental health first aid, dual diagnosis, working with challenging behaviours), and conferences (e.g. Vicserv and CAPA Conferences).

4.3.1 Courses over last 12 months

The majority of survey respondents (88%) reported that mental health staff in their organisations had undertaken training in the last 12 months. Approximately half the respondents indicated they had trained 50% or more of their staff over the last 12 months.

Of those organisations with staff who had undertaken training in the last 12 months, the most commonly undertaken courses were short courses specifically in:

- Mental Health First Aid (37%);
- Managing aggressive/challenging behaviour (22%); and
- Understanding mental illness (15%).

In addition to these courses, staff training had been undertaken in diverse topics including:

- Borderline personality disorder;
- Dual diagnosis;
- Self harm in young people;
- Small group work;
- Infant mental health;
- Post natal depression; and
- Domestic violence.

4.3.2 Training providers used over last 12 months

Survey respondents indicated that the training undertaken in their organisations over the last 12 months had been provided through a diverse range of providers. These included the use of in-house training, private providers, non-profit providers, government departments, universities and professional bodies.

Most of the training over the last 12 months had been provided through the following five organisations:

- In-house (43%);
- Centre for Community Welfare Training (CCWT) (37%);
- Health [NSW Health or Area Health Service] (34%);

[8] These figures are estimates based on the information provided by respondents.

- MHCC (22%); and
- TAFE (20%).

Survey and interview feedback appeared to indicate that there was a difference in the staff training opportunities available through the larger, well resourced NGOs, and smaller NGOs with access to very limited resources. This contrast was evident in some respondents' comments, for example:

From large NGOs:

- *Staff undertake quite a lot of training in various aspects of service delivery. All staff are required to have Certificate IV Disability Studies as a baseline qualification. If they don't have it when employed, the organisation assists them to achieve the qualification through traineeships.*
- *We provide a comprehensive in house, accredited induction and orientation training program that covers key competencies of workers, with modules that need to be completed after 1, 3, 6 and 12 months of being employed. We also provide NSW wide training in key identified areas (for example working with people with a borderline personality disorder) a couple of times a year.*

  An allocation of 1% of staff's annual wage is also available for staff to use in areas of their own particular interest/need. We also have generous study leave provisions for staff undertaking further courses of study.

From small NGOs:

- *Our organisation lacks the finances to undertake all this training. Cost can really be quite prohibitive.*
- *We have a very limited budget [for training].*
- *Sadly, when it comes to either providing direct services to clients or sending them [staff] away to be trained, work pressures often mean we can't do the training. It would be nice to have some extra resources so we didn't have to always 'rob Peter to pay Paul'.*

4.4 Barriers to Training

Respondents from both specialist and non-specialist NGOs indicated there were a number of barriers to staff undertaking training.

4.4.1 General barriers

Through the surveys, specialist NGOs were asked to select which factors created a barrier to staff training in their organisation. Not unexpectedly, the main barriers to emerge were issues of:

- Cost and access to funding (not just in terms of training or course fees, but also travel and accommodation expenses);
- Cost and time associated with backfilling positions (when staff were absent on training);
- Managing staff absences in terms of service provision or finding time for staff to be away from the office;

  Plus, to a lesser extent
- Identified training topics not being available or accessible.

What follows is a table indicating the major identified barriers to staff training in descending order of significance as reported by the survey respondents:

Table 1: NGO mental health organisation feedback on factors that pose barriers to staff undertaking further training
(n= 53)

Barrier Factors	% Agree
Cost of backfilling position or time away from office	70%
Cost of training fees or course registration	63%
Travel and accommodation costs	55%
Course times not compatible with rostering or shift work	39%
No training budget and/or funding insufficient to cover costs associated with staff training	37%
Identified training topics not available	35%
Staff resistance to participate in training	18%
Insufficient access to technology (for on-line training options)	14%
Board or senior management not supportive of external staff training	2%

Source: Anni Gethin and Edwina Deakin, Training Need Assessment Survey, 2006

Other general comments received in relation to barriers to training from specialist NGO staff included:

- *Remuneration of the NGO workforce in general has to be the biggest barrier to training. It's hard enough getting people to apply to work in the sector generally given the relatively low salaries. Then to add training on top, without providing any financial incentive or even career opportunities, can be a bit rich.*
- *People won't exert themselves through study to achieve minimum remuneration when completed. There has to be across the board improvements in pay levels to attract people into the roles.*
- *Staff are interested in further training however work commitments make attending TAFE difficult for a small organisation.*
- *Cost is a continual issue with the cost of courses difficult to cover when the worker has other responsibilities to be aware of – many single parent or parents with mortgages are unable to afford the cost of courses they could do.*

4.4.2 Longer course barriers

In terms of longer courses, barriers nominated by survey respondents were primarily those of:

- Time (54%);
- Cost (i.e. lack of funding to pay for training) (50%); and
- Problems associated with backfilling positions related core services (19%).

Respondents also identified barriers such as motivation, family and other commitments, and the lack of financial rewards for undertaking further training.

4.4.3 Shorter course barriers

The main barriers nominated by survey respondents to undertaking short courses were the same as those to longer courses, though with different weightings:

- Cost (52%);
- Problems associating with backfilling (34%); and
- Time (21%).

Funding for training was cited as a particularly important issue, with one respondent commenting that all the other barriers to training:

> '*…couldn't even be considered if there was no money to pay for any courses*.'

Problems associated with backfilling were also raised by numerous respondents. Respondents indicated that this problem occurred because they could not afford:

a) to pay staff to fill-in for absent staff;

b) to pay staff overtime or additional days works to attend training; and/or

c) the impact on client services if no suitably qualified individual was available to backfill the position.

4.4.4 Barriers to rural NGOs

Organisations in rural and regional areas reported additional barriers to accessing staff training, namely a lack of appropriate local courses, in addition to the cost and time associated with travelling out- of-area.

Comments provided by rural and regional respondents included:

- *[There is] limited training in mental health [available] in rural communities.*
- *Living in a rural or regional area is also difficult because any courses have to be sufficiently relevant to justify the cost, travel time as well as the course.*
- *[We] need to have Non-clinical Mental Health Cert IV available in rural TAFEs.*
- *Travel is a big issue especially for the Broken Hill and Lightening Ridge sites.*

Other respondents with rural staff also commented that family commitments were often much harder to manage when the additional travel time and overnight stays had to be factored in, even for short courses out-of-area.

(Also see comments in 4.4.7 and Attachment 6 regarding priority for rural staff in any potential training scholarships).

4.4.5 Barriers to non-specialist worker training

As noted elsewhere, workers and managers in non-specialist NGOs also expressed a strong desire to receive further training in mental health issues. Like their specialist mental health colleagues, they also noted that significant barriers were costs of attending training, time away from the office and costs of backfilling staff positions when staff were absent.

Rural non-specialist NGOs also reported similar barriers to accessing training as their specialist colleagues including time away from the office, lack of options for backfilling positions, and cost of travel and accommodation.

One respondent commented that low English literacy skills or cultural barriers had also proven to be a barrier to some non-specialist staff participating in training. For example, some community workers (specifically those who work with specific CALD communities, or who may not have previously participated in formal training processes [particularly within an English language context]) were reported to find written based or concept based training very challenging.

In order that these often highly skilled individuals are not excluded from future training opportunities care needs to be taken to *focus on practice-based (rather than theory or written-based) training*. Ideally, it was

noted this training should be conducted in the workplace, to minimise any stigmas or fears associated with unfamiliar or formal educational venues.

It was also noted that CALD staff or those with low literacy skills often did not volunteer when training opportunities are made available. As such, managers needed to be aware of this pattern, and encourage staff in what ever way possible to attend training considered vital to their service quality.

One final barrier to mental health training noted by two non-specialist respondents was the issue of course titles. As one respondent noted:

- *I think the term mental health first aid can be a bit confusing especially to new staff. I know the term is well established but I think some re-badging or improved promotions that better spell out actually what you'll come up knowing and who it's suitable for would be great.*

4.4.6 Barriers to consumer training

Mental health consumers consulted in the interviews and workshops identified other barriers to their participating in mental health training (for example, to become a consumer advocate or to work in the NGO mental health sector).

Key consumer barriers identified included:

a) Insufficient traineeships or subsidies to enable consumers to afford training fees; and

b) Potential lack of information on what training opportunities exist and how to access them.

Consumers consulted also identified a number of training design issues that had posed participation barriers in the past. These included:

- Early course start times (for example before 10:00 or 11:00 am) were not suitable to some consumers as their medication or mental illness made early morning starts difficult;
- All day courses and/or long blocks of training (for example, sessions of more than one or two hour's duration) did not suit some consumers with shorter concentration spans or who required frequent breaks to manage their condition.

Other comments received in relation to consumer barriers to training include:

- *Most [of our] members are consumers and would like to work in the sector but find it difficult to find a way even if they have good qualifications.*
- *The infrequency of the NSW Institute of Psychiatry Courses is a real barrier. As far as I know the demand always exceeds supply and yet there is little scope for additional courses becoming available, particularly outside of Western Sydney.*

4.4.7 Scholarships

In order to address the cost barriers to attending training, a number of respondents were asked their views on whether the introduction of a scholarship scheme would be of assistance.

All those consulted strongly supported the suggestion. They also urged the MHCC to pursue options for establishing such a scheme with at least two respondents recommending this be done via corporate sponsorship.

In terms of whether any specific groups should have priority access to a training scholarship program, a range of options emerged. These options were largely reflective of the specific group or representative being consulted. However, one priority group that was strongly supported by the majority of specialist and non-specialist respondents were staff located in rural and remote areas.

Other options recommended by respondents were specific scholarships for the following groups:

- Mental health consumers;
- Bi-lingual workers or those from culturally and linguistically diverse backgrounds;
- HIV/ AIDS counsellors; and
- Aboriginal and Torres Strait islander workers.

While all the respondents consulted on the scholarship option strongly supported the idea, a number wanted to ensure that this option was not pursued in isolation and that other ways of keeping training costs down or improving access were also being pursued.

As one respondent commented:

- *I think the MHCC and other [NGO] peaks need to get really smart about how to deliver training to their sectors… Subsidies and scholarships are really good ideas but we need to also look at more train-the-trainer schemes and other options especially for non-city-based staff.*
  For example one scheme we're looking at is to subsidise one staff member from each regional area to come to Sydney and be trained, and then they will take responsibility for training back in their regions.

4.5 Future Workforce Skills and Knowledge

The vast majority of NGO stakeholders consulted (specialist and non-specialist alike) identified some type of mental health training as part of their future workforce development needs.

For example, 81% of survey respondents (representing the NGO mental health organisations) thought there was a need for their staff to undertake more training than they were currently doing. In addition, every peak non-specialist NGO respondent (including those representing family workers, youth workers, drug and alcohol workers, housing officers, Aboriginal workers and HIV/ AID counsellors) all indicated that mental health training had been identified by their sector as a priority training topic for the coming years.

What follows is an analysis of the issues that respondents recommended should be covered in future mental health training. The analysis is broken into four areas:

1) Mental Health Topics (4.5.1);
2) Professional Practice Issues (4.5.2);
3) Communication and Interpersonal Issues (4.5.3); and
4) Local Networks and Referral Issues (4.5.4).

Respondents also provided feedback on the levels of courses required (4.5.1 and 4.5.5), the type of training (4.5.4), plus a range of other comments related to future training needs (4.5.6).

4.5.1 Mental health topics

Mental health NGO survey respondents were asked to indicate, from a list, what topics, skills and or knowledge areas their staff could require training in during the next 12 months. They were also asked to identify what level of training would be required: introductory, intermediate or advanced.

All the topics listed rated at 60% or above with 'Understanding mental illness' being selected by 83% of all respondents.

Table 2: NGO mental health organisation feedback on preferred mental health training topics and levels
(n= 53)

Topic	Total (selecting topic)	Of those who selected the topic		
		Introd.	Intermed	Advanced
Understanding mental illness	83%	30%	55%	57%
Supporting client participation in the organization	75%	33%	45%	55%
Impacts of substance misuse	75%	38%	48%	55%
Mental health services and support	74%	33%	41%	56%
Behaviour risk management	74%	18%	46%	67%
Mental health interventions	72%	29%	47%	55%
Assessing/responding to individuals at risk of self harm or suicide	74%	28%	44%	59%
Interviewing techniques, counselling and communication skills	72%	24%	45%	55%
Dual Diagnosis*	72%*	36%	39%	68%
Mental health first aid	72%	47%	50%	55%
Processing and maintaining workplace records and information	72%	34%	42%	58%
Occupational Health and Safety	68%	28%	36%	69%
Outcome measurement	68%	36%	50%	67%
Management and governance issues	66%	29%	63%	49%
Working with culturally diverse clients	62%	42%	36%	45%

Source: Anni Gethin and Edwina Deakin, Training Need Assessment Survey, 2006

For specialist NGOs there was an identifiable preference for more training at an intermediate or advanced level, rather than an introductory level.

Table 2 (above) lists the preferred training topics of survey respondents in descending order. Respondents also identified a range of additional topics in which their mental health staff or non-specialist staff might also require training in. These included:

- Dealing with anger/aggression;
- Intellectual disability and mental illness;
- Men's health;
- Mental health in young people, and especially suicide and self-harm related issues;
- Dementia;
- Torture and trauma (specifically in relation to refugee communities);
- Mental health issues in older people (including those that related to earlier trauma for example in refugee communities);
- Grief and loss (including in relation to Aboriginal communities);
- Post-natal depression; and
- Infant and children's mental health.

Most non-specialist NGOs who were consulted, commented that the mental health first aid courses run by the MHCC and others appeared to cover the basic issues required by their staff. Other short course topics identified as needed were:

a) How to identify a mental health problem in a client;

b) What type of support or assistance can be provided by generalist staff;

c) When and who to contact when additional support or specialist assistance is required (this included knowledge of what local providers were available); plus

d) How to work collaboratively with specialist providers while continuing to support the client with the other needs.

For the most part non-specialist respondents indicated that introductory level courses on these issues were sufficient, although more advanced courses for supervisors or more senior staff were viewed as beneficial.

Consumer feedback emphasised the need for mental health workers to receive good training in the effects of medications used in mental health treatment. They also strongly recommended training in human rights principles and the need for consumers to be continuously involved in the options and decisions about their lives. For example, a number of consumers repeated the importance of workers being trained in understanding, and demonstrating in their *words and actions,* the consumer adage:

- *Nothing about us, without us.*

(Also see comments below regarding Communication and Interpersonal issues- Section 4.5.3)

4.5.2 Professional practice issues

In addition to the mental health topics covered above, many specialist respondents identified a particular need for all mental health training to include a professional practice and ethics component. The most common issues recommended in this area included:

- Legislative requirements and duty of care issues;
- Professional boundaries with consumers;
  (This including how to set boundaries with clients in a residential or more intense treatment setting [which was seen as different to client relationships in non-residential contexts]).
- Ethics;(This included ethical decision making).
- Managing staff-client relationships;
- Skills in collaborating with other staff and with other organisations.
  (This included issues of client confidentiality and disclosure.).

Other professional practice issues raised included the issues of *staff burnout* and ways to assist staff manage the stresses and demands that are sometimes associated with working with clients with mental illness. This issue was raised by both specialist and non-specialist NGO respondents. As one interviewee commented:

> *I know staff burnout issues are hard to talk about in training, but we really do need to help staff learn ways to cope better with working with difficult clients or those in crisis We also need to help good staff to stay working in the sector and not leave because it's all got too hard.*

4.5.3 Communication and interpersonal skills

In addition to the above topic and professional practice areas, many respondents indicated a strong need for mental health training (for both specialist and non-specialist NGO staff) to cover a range of communication and interpersonal skills.

As elaborated upon in interviews and workshops (particularly, though not exclusively, by consumers) this training was seen as necessary to ensure communication with clients was conducted in a *consistent*, *non-judgemental* and *supportive* manner.

Participants in the consumer workshop, for example, indicated that workers needed an *awareness* of and *sensitivity* to what it was like to have a mental illness. This included an understanding of the impacts of specific medications (as previously noted), as well as an understanding of the associated disability or financial hardship. In short, consumers expressed a need for staff to be provided with a greater understanding of the lifestyle impacts of living with a mental illness. In the words of two different consumers:

- *We need to ensure that there is no sense of blame or 'you-brought-this-on-yourself' attitudes- both of which I've actually experienced… What we most need is understanding [when we're talking to staff].*
- *It took a long time for the staff I spoke to, to actually believe I had a problem. While they didn't say it in so many words they nonetheless told me 'Get a grip- get over it'… Frankly it put me back months - even years- in terms of my recovery as I wasn't taken seriously.*

Good interpersonal communication skills were identified as particularly important to workers, and specifically, good listening skills. Feedback indicated that good interpersonal communication required training in *how to suspend judgement* or communicate in a manner that removed any actual or perceived *stigmas about people with mental illness.*

Consumers also indicated a need for workers to *concentrate on the positives rather than the negatives.* This again was linked to workers receiving training that increased their a*wareness, sensitivity and friendliness* in their interactions with consumers.

Other respondent feedback nominated the following communication-based issues for inclusion in future mental health training:

- Skills and techniques to gain the consumer's trust and building rapport;
- Skills and techniques for getting the client to speak, and to engage in the options and issues discussed;
- How to ask the right questions of the client; plus
- How to communicate effectively and use appropriate language, not just with consumers, but also with clinicians, family members and support people, and other workers (so called 'style switching').

As one specialist respondent also commented:

- *Forming relationships and engaging clients to own their own case management is a real skill that is not recognised in the formal training. It would be great if this could change.*

In addition, feedback suggested there was a need for mental health workers to also receive training in cultural diversity and in sensitivity to the cultural or social impacts of mental illness in specific language or cultural communities, including in particular, Aboriginal and Torres Strait Islander communities.

A final communication and practice based issue identified by a number of respondents was the need for training that emphasised *a strengths-based approach* or a *mental wellness perspective* (as opposed to a mental illness perspective). To some this was seen as critical given *prevailing deficit models of mental health,* and because:

- *focusing on the positives, and how to build on the clients' strengths, can be one of the most powerful tools available to a worker.*

4.5.4 Local service network and referrals

Another issue raised by a number of respondents was ways to compliment competency based training with information on local services and procedures. This was seen as very important in supporting workers to make appropriate referrals, as well as assisting them to support clients and carers within a particular area or region. While this issue was raised by many NGO specialist respondents, it was also one of the most common comments provided by non-specialist interviewees.

In order to meet this need, it was observed that all training would need to include local content. It might also require the input from local experts specifically regarding referral protocols and procedures.

As one non-specialist respondent put it:

- *A balance between universal learning and that really practical knowledge of what to do and who to call is really important for our sector. We all work as part of a broader service system and knowing how that operates in your specific area is vital to our effectiveness (and I guess to our credibility as well).*

A related and common response from non- specialist respondents was the practicalities of how, when and to whom exactly to make a referral. This issue was raised in feedback regarding youth services, drug and alcohol services, family services, as well as by staff working with consumers with HIV/ AIDS.

(Also see comments under Pathways and Partnerships at Section 4.8).

4.5.5 Types of training courses

While the research in this needs assessment shows strong support by specialist NGOs for effective Certificate IV courses in mental health, many also acknowledged the utility and value of specific short courses(of one or two days duration).

In general, the feedback indicated that it would be ideal if all mental health courses were accredited, and potentially count towards higher qualifications. However, numerous respondents also added that workers often valued the *quality and relevance of a course* more highly than whether or not it *was formally accredited.*

When further probed, respondents offered a number of criteria for what was most sought in mental health training. These commonly included the following criteria:

a) Sound, up-to-date content;

b) A relevant and practice-focused approach;

c) A professional and interesting delivery style;

d) Application of quality standards; plus

e) Adequate notification period.

As one respondent summed up:

- *We all know there are accredited courses out there that are absolute 'crap'. From both the workers' and the manager's perspective, it is far more important that the course is good, and is recognised and promoted as good, rather than whether it meets some paper-based standard.*

Within this context, numerous respondents stated that the MHCC Mental Health First Aid Course was a good model for short courses. They commented that its duration was, for the most part, manageable from a time-off-work perspective. For non-specialist staff in particular, it provided the necessary basics in terms of what was required, namely capacity to identify problems, basic intervention and communication skills, plus knowledge of appropriate referral procedures.

A number of respondents noted the importance of having access to courses that optimised choice and flexibility. For example, while some trainees (such as carers who also worked) preferred evening courses, others (such as consumers or workers with family commitments) reported this option to be not as popular.

Furthermore, while some respondents indicated short blocks of intense training were often beneficial from a work management perspective, others, including consumers, noted that more paced training, involving shorter blocks of time (eg. 4 hours or less), was more conducive to concentration and learning.

The related issues of:

- Access to transport (costs and availability, for example via public transport);
- Training related childcare; and
- Provision of respite care (for carers in particular),

also arose as issues that needed to be considered when planning training for some parts of the NGO sector.

4.5.6 Advanced courses

There is a clear need for more advanced level courses. For example, those who had previously attended a Mental Health First Aid course, or those who already had good basic mental health knowledge, reported a desire to attend a similar short course but pitched at an advanced level or to more experienced staff.

One suggested feature of such an advanced course would be a demonstration of a successful model assessment tool that could be used (for example by senior staff or counsellors in non-specialist organisations) to assess the needs of clients with mental health issues.

4.5.7 Other future training issues

The following additional comments were provided regarding what mental health training may be required in the future:

- *It would be great to know what other resources or model assessment tools are out there.*
- *In employment a good basic understanding of mental health issues and consequences are the main training required. Unfortunately mental health first aid did not necessarily provide this.*
- *Our client base appears to have more serious mental health problems than in the past, requiring greater expertise.*
- *Staff need to know more about the cognitive aspects of mental illness and treatments or interventions. Specifically, how cognitive impairment (intellectual disability) impacts on mental health and vice versa. Staff have difficulty in managing clients with dual diagnosis.*
- *There should be a course, workshop or stimulus that teaches people to think 'outside-the-box'. We need to have fresh ideas, strategic thinking in management and service delivery.*

It was also noted that non specialist NGOs may have specific training requirements. For example:

- *Training in how to work with and manage staff and volunteers with a mental illness is needed by our organisation and I suspect many other community organisations who do not specialise in providing mental health services.*

4.6 Minimum Standards

Survey respondents were asked about the desirability of a minimum standard for non clinical mental health workers[9].

The minimum standard option was favoured by 65% of all respondents. [10]

Options were then given as to what skills and knowledge a minimum standard should contain, with the majority of respondents (61%) selecting all of the options listed, namely:

- Develop a case management plan;
- Design mental health interventions;
- Interviewing techniques and communication skills;
- Impacts of substance misuse;
- Working with culturally diverse clients;
- Behaviour risk management; and

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[9] It should be noted the question deliberately did not specify if the standard would be mandatory or voluntary as each of these issues were felt at this stage to raise different sectoral challenges. As noted in the recommendations consultants believe further investigation of this issue, including cost-benefits of both options would be necessary.

[10] At a recent consultation – Wednesday 25th October, concerning the Review of the Community Services Training Package, representatives from the NGO mental health sector all provided feedback that strongly supported the introduction of a minimum standard of training for workers in the sector.

- Assessing and responding to individuals at risk of self harm or suicide.

A range of additional options were also suggested by respondents including:

- Ethics and boundaries;
- Dealing with challenging behaviours; and
- Dual diagnosis.

The majority of survey respondents (57%) foresaw potential challenges and issues with introducing a minimum standard, including many of those who agreed that such a standard was necessary. Some common queries raised included:

1) Who will determine what goes into the minimum standard?
2) Will it be an essential or desirable criterion for NGO mental health jobs?
3) How will its introduction be supported? Will there be more on-the-job training available for incumbent staff?
4) Will there also be minimum standards for sub-specialities of mental health work? (For example, mental health services to young people, in aged care, for complex cases such as dual diagnosis, or those with intellectual disability and mental illness)
5) Who is going to pay for the introduction of minimum standards in NSW?

Other respondent comments in support of minimum standards included:

- *It's important that minimum standards are approached from a competency based perspective.*
- *I like minimum standards but we also can't lose sight of people's attitudes, their communication or interpersonal skills, their ability to 'use their heads' in difficult situations. These things are critical to our sector and sometimes the discussion on standards loses sight of the 'human-factor' I think.*
- *Very, very essential and very beneficial in ensuring that personnel have that minimum standard.*
- *Ensuring that existing staff working in the NGO sector have access to and complete the training to obtain the minimum standards qualification. It will be important to ensure all NGO staff old and new have the qualification and provide support and care to a consistent level.*
- *I believe there needs to be a minimum level of competency; however, I don't think that everyone having a Cert IV in mental health is the answer. I often employ staff with far higher qualifications than that. That is why [we] have gone down the track of providing accredited competency based training.*
- *I'm a big fan of minimum standards for the sector BUT we have to be careful it doesn't become a 'tick-the-box' approach. We need to be sure any staff training is continually reinforced and applied in the workplace… It has to be about promoting a culture of education and learning and not just academic content.*
- *I believe that the absence of minimum standards in NSW is holding the sector back. For example I'm interested in consumer-operated or peer delivered services like the ones in the U.S. Until there is appropriate [minimum] training and Area Health Service recognition of the training, then it won't be possible to get these types of services up and running here.*

Some challenges identified by respondents regarding minimum standards included:

- *If NSW were to introduce minimum standards the way they did in Victoria- with significant investments in providing training and supporting NGO to raise their staff qualifications across the board- then I would be delighted.*

  A terrible outcome for NSW would be if minimum standards become mandatory but no additional resources or processes got put in place to allow us [specialist NGOs] to get from where we are

now to where we want to be. Clearly any debate on minimum standards can't stop with content alone.

- *I would not like to see people knocked back because they do not have the right qualifications. So it would be best if staff were supported in getting the appropriate training. Need to have time during work hours to do training.*
- *[A Minimum Standard] is very desirable, but in the disability sector, it's hard enough to get staff at all. To place a further filter would reduce the pool even more – many of our best staff are trained in-house.*
- *[I] question how applicable a single minimum qualification standard will be across various roles.*
- *[Minimum standards] might stop older experienced workers from gaining employment, especially in rural areas. It is very hard to find anyone to fill a position in a rural area, especially when such specific skills are needed.*
- *Challenges include competent trained staff working for the small SACS award wages.*
- *I would be concerned that [minimum standards] might exclude consumer or carer experience.*

4.7 Mental Health Traineeships

Respondents were asked about the prospect of establishing non-clinical mental health traineeships.

A minority of organisations (22%) employed trainees of any description. Nonetheless the majority of respondents (67%) expressed an interest in the possibility of employing mental health trainees sometime in the future.

Respondent comments included:

- *[We] would love to have a trainee in non clinical mental health.*
- *[We] have psychology interns [but] no actual traineeships.*
- *It would be particularly useful if undertaken by members of migrant and refugee communities, especially those communities experiencing severe distress. These could be a great way to help build capacity within these communities. However, affordability is a key concern – unless we received additional funding we could not afford to employ a new worker, even if their wages are partially subsidised.*
- *Only if a very generous subsidy [was attached to mental health traineeships]. We currently gets help through a social worker (not paid by us) to supervise work placements through programs such as Work for the Dole and people on community service orders. Sometimes the projects are especially for participants with a mental illness who are customers, volunteers and staff – someone with skills in this area who would be available to work in the organisation would be a huge help.*
- *Yes [to traineeships] - but only for a short while, so they could get a variety of experience. i.e. If a trainee could be moved between various services it would be good for them. There is not enough variety in [our organisation] to give a trainee well rounded training.*

Consumer and carer representatives consulted also strongly supported the traineeship option. They indicated that it could provide a structured method by which they could enter the paid workforce and, at the same time, be given appropriate training and support.

As one consumer respondent noted:

- *I think it [traineeships] is a great option for consumers. In fact, I think it should be linked to the Government's Welfare to Work agenda. Clearly these changes are going to impact heavily of some mental health clients and finding some way to use it to their advantage, in an area they are familiar with, would be great.*

The consultants, however, did receive one alternative view on traineeships from a non-specialist organisation representative who had experience in running a similar scheme. In the respondent's view the scheme was *painful to manage.* Further, while it did provide organisations with a modest income, it

tended to only apply to entry level (and young) workers and did not serve the needs of incumbent or experienced workers who may also require assistance to participate in training and/or to attain formal qualifications.

One constructive suggestion to overcome these limitations on traineeships was for the MHCC, or other peaks, to investigate the establishment of experienced worker traineeships as part of a future workforce development strategy. This was seen as particularly relevant in the light of recent Commonwealth Government announcements regarding worker retraining.

One final comment received from a number of respondents was the need to have a broad based approach to increasing staff access to training. While the vast majority of respondents supported the traineeship option, there were also a number who cautioned about it being, either

- *The only source of income in relation to training;*
  or
- *The only mechanism used to encourage training participation.*

Within this context respondents recommended a number of other incentive options also be pursued including:

a) Mechanisms to keep training costs low;

b) The establishment of training scholarships, and

c) Addressing current barriers to training including the accessibility and location of available training.

4.8 Pathways and Partnership Issues

While the consultants did not specifically question respondents on the issue of career pathways or workplace changes, a number of respondents commented on the importance of looking at workforce development and training in this holistic way. For the most part, these comments were raised in the context of questions on minimum standards, mental health traineeships or future training needs in general.

4.8.1 Clinical and non-clinical pathways

One common response given by a number of stakeholders consulted was the need for there to be a more *seamless* or *smooth transfer* of staff working in different parts of the mental health service sector. It was noted by a number of respondents that currently there were:

- *Too few NGO staff with clinical mental health experience and too few mental health staff who understood or who had worked in the NGO sector.*

To remedy this situation, and to improve the collaboration that many sought, it was recommended that more joint training be established involving *both clinical and non-clinical mental health staff.*

To quote other respondents who held this view:

- *Currently there is too much artificial division between clinical positions and non-clinical positions. What we need is a professional development system that enables there to be greater cross over from health to support positions and visa versa.*
- *There currently is far too much division and suspicion between various types of support for [mental health] clients. There's consumer support, NGOs and then clinical health people. It would be great if these different roles were better understood and one way to do this would be to encourage common training courses and approaches. These could include consumers and carers participants which could help as well.*

4.8.2 Consumer pathways

Consumer representatives consulted were strongly interested career pathways; many had experienced difficulties in moving into paid NGO mental health worker positions.

Respondent comments included:

- *At the moment the main course specifically for consumers is the Mental Health Advocacy Course run by the NSW Institute of Psychiatry. This course is fine for its purposes, but it does not lead into or on to any other courses to allow consumers to move into paid positions.*
- *I'd really like to see the MHCC offering courses for consumers as a first step into peer support work and paid employment. If they did this, lots more people might go onto other [mainstream] training which currently is a bit too daunting.*
- *Sometimes consumer advocates get stigmatised as "that's all they can do". If there was some way they could step into more formal training, without having to disclose their status, that would be a good thing.*
- *What I'd like to see is a more module-based approach where anyone who passes a specific [accredited] module can start to move on to higher and higher training and accreditation. This would be great news for consumers.*

4.8.3 Specialist/non- specialist worker issues

A number of non-specialist respondents also commented on the need to consider NGO career pathways within the context of mental health training. This view was based on recognition that parts of the NGO workforce are highly mobile, and that some staff *can be expected to move from one NGO job to another*. As such, it was noted as *useful* if specific mental health training modules could be offered that could count towards other accredited training (for example, in youth work or community housing training), and similarly, if other appropriate community work modules could be accredited towards the Certificate IV in mental health or another mental health qualification.

Within this context a number of peak bodies consulted indicated a strong desire to form partnerships with the MHCC in terms of training provision. These partnerships would potentially enable the MHCC (as an RTO) to deliver specific training modules that count towards another Certificate qualification and visa versa. As two respondents commented:

- *Such reciprocal recognition would not only build training numbers, but also assist both our sectors recruit staff with appropriate qualifications;* and
- *I think greater recognition of the fluidity of the NGO workforce is important. In lots of cases having staff move from one sector to another, and from one specialist area to another, can be a good thing. It cross-fertilises the sectors as it were.*

Another respondent observed that given that partnerships across sectors are increasingly common and required (for example in dual diagnosis or in initiatives such as HASI dealing with providing housing and accommodation support), there was *an imperative for there to be more cross-over training*. That is, there needed to be opportunities for staff in one sector (eg. mental health) to learn about the skills and challenges of another sector (eg. tenancy management).

As one respondent indicated:

> *Providing accredited training modules to staff from different service backgrounds can also have benefits once the training has concluded. In the case of HASI for example, accommodation support staff might better understand the tensions and issues being dealt with by community housing providers [by attending modules in the community housing certificate] and similarly housing staff might understand more about how to interact with the mental health sector [by attending modules in mental health].*

As another respondent commented:

> *[NGO] training for NGO [staff] needs to also focus on building the individual's capacity and confidence to work collaboratively with other staff and other providers…*
> *Partnerships are clearly where we're all expected to go and unless we have workers with skills to trust staff outside their own organisation and skills to know how to work together with them (including with clinical staff), then we're not going to be effective as a sector.*

Another non-specialist peak representative also indicated that they would like to be able to utilise the skills and knowledge of a professional mental health trainer for their sector's and organisation's basic training. According to the respondent, while the basic level worker training provided did include components of mental health at the low end of the spectrum (for example self-esteem, managing stress etc), these modules would benefit from having a *mental health expert's opinion* that could *introduce some higher end problem identification, intervention, referral information, as well as information on available resources.*

As the respondent commented:

> *It would be great to partner with the MHCC and see how they could assist in either delivering or advising on the delivery of these mental health training components [to our sector].*

4.9 Training Needs of Non-Specialist NGO workers

While this report has primarily focused on the training needs of workers employed in mental health NGOs, some consultation was also undertaken with representatives of so called non-specialist NGOs and other peak organisations whose sectors also deals with clients with a mental illness.

While some of this feedback is incorporated in other parts of the report, what follows is a summary of the major themes and issues raised by these non-specialist respondents.

Feedback received (within the context of the FONGA Workshop and various stakeholder interviews-see Section 2.3 and Attachment 6) indicated that there was a high need for workers in non-specialist NGOs to have access to training in mental health. Respondents saw this as particularly important because:

a) There was a measurable increase in NGO clients who were affected by mental illness; and

b) Non-specialist NGOs, such as neighbourhood centres and other community support services, were often *the first-port-of call*' particularly for those clients who may not have been previously diagnosed with mental illness, and/or who continue to require services only available through non-specialist providers.

4.9.1 Non-specialist sector needs

When non-specialist NGO respondents were consulted on their workers' mental health training needs a common list of topics were identified:

- The main kinds of mental illnesses;
- How to recognise a mental health problem;
- How to respond to or engage with a client with a mental illness;
- How to manage disruptive or challenging behaviours; plus
- The specialist mental health services that are available and how to refer clients.

(Also see comments under Barriers - Section 4.4.5- regarding literacy related issues).

A number of respondents noted that these types of issues were, in general, already covered in the mental health first aid courses.

A number of other administrative and procedural issues were also identified by managers. These could constitute the basis of more targeted workforce development initiatives and associated training. These issues included:

1) Occupational health and safety issues associated with engaging with mental health clients, including in regard to volunteers.
For example:

- What sorts of policies and procedures do organisations need to have in place concerning mental health?
- What are the potential impacts on home visiting or other types of client engagement practices?
- How appropriate is it to use volunteers with clients with mental health issues?
- What training should volunteers receive as a minimum regarding mental health?

2) Knowledge of the local mental health system.
For example:
- What mental health service providers exist in the area?
- How do NGOs refer clients or engage with those services?
- What joint case management options, or collaborative models, are available to assist clients who access both specialist and non-specialist NGOs?

4.9.2 Targeted training

Feedback from non-specialist NGO staff also indicated that there was an identified need for some targeted mental health training that specifically catered to the needs of sub-groups of community workers. Examples provided included:

- Youth worker training regarding mental health in young people;
- Drug and alcohol workers who are increasingly dealing with dual diagnosis issues;
- Mental health training for (pro-bono) lawyers and support staff engaged in the criminal justice system;
- Child care worker training, specifically to assist recognition of mental health problems in young children, as well as in their parents and carers;
- Identification and communication training for rural workers who are increasingly encountering clients with (undiagnosed) depression and other stress related disorders due to the drought, financial hardship and family breakdowns; and
- Training for employment services staff involved in Welfare to Work activities, specifically in how to identify and support clients with mental health problems who may be failing to meet Government expectations.

In addition to these targeted groups, a number of respondents commented that all services needed to be more culturally appropriate, specifically in relation to the mental health needs of Aboriginal clients and clients from culturally and linguistically diverse backgrounds (see comments below).

<u>Aboriginal Related Training</u>

A number of respondents raised specific issues in relation to mental health training for Aboriginal service providers and other services with high numbers of Aboriginal consumers (such as court liaison staff).

While specialist mental health courses for Aboriginal workers are being developed by the Aboriginal Health and Medical Research Centre, consideration needs to be given to training all workers dealing with high numbers of Aboriginal clients in topics such as:

- Mental illness and substance abuse
- Youth suicide;
- Grief and loss; and
- Family impacts of parental or carer mental health, including impacts on young children (especially if early mental health issues are emerging in the children as well).

On this latter point it was noted that Aboriginal mental health (much like some CALD mental health- see below) needed to be approached in *a family and community focused way (i.e. not just from the client's perspective*).

It was observed that Aboriginal people appeared to have much higher rates of undiagnosed mental health problems, particularly in rural and regional parts of NSW, yet often lack access to appropriate clinical services. As access to designated mental health workers were rare in these circumstances, different approaches to training needed to be considered. For example, community based and community empowerment strategies could be used as a *first step to getting local communities, and specifically the local elders, to acknowledge mental health as an issue*.

As one respondent noted:

- *Without community and elder support, local Aboriginal people are very unlikely to go to workers that are offering mental health support…In this sense [mental health] training needs to be approached from a 'big picture' perspective.*

There was also an identified need to raise the mental health awareness in local services and support networks used by Aboriginal people. Often these were the people best placed to identify mental health disorders, such as psychotic behaviour, at an early stage.

How to work with local mental health teams, and other key service providers (including, for example, court liaison staff) to deliver culturally appropriate support and interventions was also reported as a critical issue to the delivery of mental health training related to Aboriginal consumers.

As one respondent summed up:

- *You can't look at training staff in mental health for Aboriginal people in a linear or off-the-shelf manner. Without working closely with the local community and building their trust, even the best trained worker, and those with best intensions, will not be able to access clients in need. What is really needed is a grass-roots, bottom-up approach not a normal top down approach to mental health training for this sector. …Training needs to focus on the whole community, just like treatment options do as well.*

(Also see comments in Section 4.5.1in relation training in grief and loss issues which were common to many Aboriginal consumers and were reported to play a major role in the later development of mental health disorders and illness).

One final issue raised in relation to training relevant to Aboriginal consumers and their families, was for *workers to understand that some Aboriginal workers and families have a very different attitude to mental health* than do some other sections of the community.

As one worker commented:

- *Because there are so many people with mental health issues in the [Aboriginal] community, some workers sometimes find families, or even Aboriginal workers, uncaring or blasé about the condition. It's just that sometimes they have so many friends and relatives dealing with the same issues all the time, they just have different ways of coping with it.*

As such, some training in how to better understand these different family and community responses to mental illness was recommended for inclusion in mental health training targeted to workers engaged with Aboriginal consumers.

CALD related training

The feedback in relation to working with CALD consumers and delivering training on CALD related mental health issues echoed some of the feedback received in relation to Aboriginal communities. For example, respondents noted that effective engagement with CALD clients was not just about language issues, making services accessible, or employing bi-lingual staff- all of which was noted as important- but it was also about developing understandings and approaches that recognised *different world views on mental illness*.

As one respondent commented:

- *One of the biggest challenges for workers engaging with some CALD communities is a lack of appreciation of the different world view they come from. For example, if the client believes their symptoms aren't related to an illness, but rather are the product of bad luck or punishment or a*

past life, then the client and their family aren't going to accept conventional western approach to treat the symptoms of the individual patient as it were.

Even before communications skills and family and community engagement techniques can be discussed, what is really needed in terms of training is some basic education on specific CALD beliefs and attitudes to illness.

Similarly, a number of respondents also commented on the importance of using *a family-focused approach*, rather than individual focused approach, with certain types of CALD consumers. How to deploy this type of approach and engage with the family was identified as vital to mental health training for this sector.

(Also see comments in Section 4.5.1 regarding training in torture and trauma issues, and mental health issues in older people both of which were indicated as common in some older CALD communities especially those with refugee histories).

4.10 Role of the MHCC

Respondents were asked to indicate what roles they would like to see the MHCC play in terms of NGO workforce development in general and training in particular.

In terms of the NGO mental health sector, the vast majority of survey respondents were supportive of the MHCC taking an active role in workforce development. Only 2% thought the MHCC should have no role in workforce development.

4.10.1 General workforce development activities

As per the survey data, support was particularly strong (exceeding 85%) for the MHCC to have a role in the following workforce development activities:

- Information distribution to members;
- Providing advice to members on available training options;
- Being an advocate for workforce development and representing the NGO mental health sector in policy and planning debates related to training; and
- Providing subsidies to members to attend specific training courses (subject to funding availability).

There was also strong support (80%) for the MHCC to also pursue the following options:

- Researching members unmet needs, then informing providers of training demands;
- Brokering specific training; and
- Designing and delivering short courses.

A majority of the survey respondents (73%) also supported:

- Partnering with other agencies to develop and deliver training.

Although it should be noted that around a quarter of respondents were either opposed to (13%) or uncertain about (13%) this option.

As noted previously, non-specialist respondents would like specialist NGOs to provide support for partnering with other agencies. Most of those consulted, for example, explicitly identified opportunities whereby the mental health expertise of MHCC could be used to advise on training for their own sectors, with some offers of reciprocal arrangements, for example, in the case of community housing.

In the various interviews and workshops, one role that was frequently described for the MHCC was to provide leadership in ensuring more quality mental health training opportunities were made available across NSW.

As one respondent summed up:

There's a lot happening at the moment in terms of capacity building and improved mental health training. It would be great if the MHCC could provide a leadership and advocacy role to ensure that all the reforms reflect what the sector actually needs and that there is an overall level of quality [in the training available] out there.

Other related comments on the roles of the MHCC included:

- *The role most needed by the MHCC is a leadership role, and not just on process issues… That is someone to work with other parts of the NGO sector and other parts of industry and government to forge partnerships and establish mechanisms by which folk can work together … I guess its leadership in providing the opportunities and support to bring people and sectors together.*
- *Lobby government for a staged and funded workforce development program in NSW, including [for] rural areas, not just Newcastle, Sydney, and Wollongong.*
- *[What we need] is recurrent [workforce development] funding (no pilot programs).*
- *The MHCC should be able to provide support and offer specific training if needed. A standard should be set on the required education to function within the role, but the MHCC should not dictate terms to individual agencies as to what they should be hoping to achieve.*

4.10.2 RTO option[11]

Included on the list of possible roles in terms of workforce development was the option of the MHCC becoming a registered training organisation or RTO (for example offering Certificate IV courses in mental health).

While all but one of the previous workforce development options for the MHCC received an 80% or above positive response, (and 11% or less negative response), the survey respondents' feedback on the RTO option was as follows:

- 47% responded positively;
- 24% responded negatively; and
- 29% were unsure

When this issue was further explored in the open-ended survey responses, in interviews and in workshops, a range of perceived benefits and risks associated with the RTO option emerged. (It should be noted however that the roughly half of survey respondents who supported the RTO option did not offer as many comments as the other half who were either opposed or unsure).

Benefits identified by respondents included:

- *To have one entity coordinating the whole thing would be awesome.*
- *It would be a really progressive step.*
- *This option will help the MHCC become well known and offer better access to information.*
- *If the MHCC was to provide courses, maybe they would be closer to what the sector wants.*
- *There would be benefits in becoming well known and in ensuring that all have access to information.*
- *While in the past TAFEs could be really responsive to proposed changes to courses, I'm not sure with their current resources they are best placed to change Certificate IV content. Maybe MHCC could be more flexible in that regard.*

---

[11] Note: The survey questions in relation to the RTO option predated the MHCC Board's final decision to progress the MHCC moving towards becoming a Registered Training Organisation. As such some of the respondent feedback may have alternated over recent months following the broad sector consultations that the MHCC has initiated following the RTO decision.

- *It is essential that the MHCC, as the peak body, develop the skill base and expectations of staff in this industry.*
- *I think it's an excellent concept. MHCC could really involve employers in the process and provide something really useful at the other end.*

Potential risks identified by respondents included:

- *I'm worried the MHCC could be distracted from its first role of being an advocacy organisation for the sector.*
- *There could be conflicts of interest in being advocacy group and being a direct service provider. I haven't thought this through but I think there are some concerns or clashes in roles here.*
- *Becoming an RTO is both time consuming and costly. I'm concerned that it may be a long time before the MHCC could make any income from this option.*
- *I hold some concerns regarding the potential conflict of interest for the MHCC if it seeks to not only work with other training providers to advise, broker etc and to advocate for the sector generally in relation to training needs and workforce development, but to also establish itself as a trainer, either providing short courses or formal registered courses. I am not opposed outright, but I would be interested to have this explored further if it hasn't been already.*
- *I wouldn't want the MHCC to start to compete with some other training providers out there who are also trying to the right thing by the sector. I'm really not convinced this is the best use of scarce resources at this stage.*
- *- While I think its fine for the MHCC to become an RTO I think they need to be sure they don't loose sight of their peak body role. That is being an RTO will open up a degree of competitiveness with other RTOs- including other NGO providers. The MHCC will have to be careful that this competitiveness doesn't undermine the capacity to build partnerships and work together with others.*

Other related comments on the role of the MHCC included:

- *I know the MHCC looked at partnering with other providers in terms of training. Maybe this needs to be further considered again.*
- *I like the TAFE system as its everywhere, it neutral- a normalised environment (if you know what I mean). Do you think some people might be turned off by not everyone knowing who the MHCC is or even by it being a specific mental health thing? Heaps of people go to TAFE. Maybe it's better to keep it part of that bigger system.*
- *The MHCC could take an important role in getting information out about the benefits of this kind of work. Could examine how to get more people interested in the area.*
-
- *Maybe if the MHCC ran the courses they could also assist graduates with linking with potential employers…. Like they do at universities when employees come and talk about careers in this or that workplace. It could be great PR for working in the NGO sector too.*
- *I think whatever the MHCC does, it needs to start communicating it with the sector. As far as I know there has been no public statement and that has lead to lots of talk and speculation. Everyone in the industry needs to know officially what's happening, including any [RTO] competitors.*
- *Even if the MHCC becomes an RTO they also have a role to ensure other mental training is up to scratch… Not everyone will be able to access the MHCC courses, so, from the sector's perspective, it will be important for the MHCC to continue to pressure or assist other providers - including TAFE- to deliver quality and relevant training to workers. I'm assuming there is no conflict of interest in doing that.*

- *[I'd like to see the MHCC] set up a social club for mental health staff. [This could] help with networking and debriefing.*

4.11 Additional Comments

All respondents were invited to make any other comments in relation to training or workforce development at the conclusion of the feedback process. While most either did not respond or reiterated feedback already provided, some respondents used the invitation to provide some 'big picture' or broad sector views. Some of the most interesting of these are listed below:

- *I think the NGO sector (like the clinical staff) are way too focused on mental 'illness' and not enough focused on mental 'health' or mental 'wellness'. I would really like to see a lot more emphasis placed on promoting discussions and approaches that have a strengths- based approach where 'wellness' is the key underpinning.*
- *I would like more focus on early intervention and prevention. This isn't just an issue for young people but also those in the workplace- on farms- everywhere. It would be great if somehow training could also be linked to public awareness issues on early identification of mental health issues.*
- *One of the things I would like to see NGOs do more of is break down the 'silo' approach. We often criticise government for being too rigid and thinking in silos but half the time we too are only looking at our patch or the needs of our sector, and we know people don't fit into those categories. I'd really like to see more leadership from us in terms of partnerships and genuine collaboration. Maybe delivery of joint training [involving different parts of the NGO sector] is a good place to start.*
- *I'm sure half the time that all the different [NGO] sectors and groups are often worrying about the same sorts of [training] issues and yet we don't spend enough time learning from each other.*
- *I know training NGO staff is a big issue, but wouldn't it be great if we could also pioneer some corporate based mental health training. Corporations could sponsor it and short courses could be run for managers to recognise staff who may be having mental health issues. The course could also have early warning, coping and stress management strategies and education about referral and support services available.*

  I think it could be a big winner financially and be a great community awareness raiser as well as a fabulous early intervention and prevention strategy.
- *We need a lot more sector links and partnerships established. Mental health is everyone's business and we need more links- with schools, with youth organisations, with aged care providers- to build their knowledge and capacity. Clearly there aren't enough mental health trained staff to go round and some more capacity in other sectors would be good- really good.*

* * * *

5. CONCLUSIONS

This Mental Health Training Needs Assessment of Non Government Organisations in NSW provides valuable data on a range of issues related to current and future training needs of the sector.

While the consultants regard the data as representative of the views of the NGO sector, and believe it allows some useful conclusions to be drawn, they also recommend (as discussed below) that further targeted research and consultations be undertaken as part of the MHCC's ongoing dialogue with the sector.

Based on the data documented in Section 4, and solely using the feedback provided through the finite methodology described in Section 2.2, the consultants drew the following conclusions:

The mental health NGO workforce in NSW is generally well qualified, with most workers having a tertiary qualification. Currently, most qualifications are not specifically related to mental health.

While a significant majority of agencies have undertaken staff training in the last 12 months, there was considerable diversity in the type and duration of courses undertaken. The most common training undertaken was at an introductory level and involved short courses such as mental health first aid, managing challenging behaviours and mental health awareness.

Some, usually larger, agencies indicated they were able to provide extensive workforce development for their staff. Many, often smaller, agencies reported facing significant barriers to staff training specifically related to insufficient resources.

NGO mental health respondents indicated that, over the next 12 months, their staff could require training in a wide range of mental health topics at introductory, intermediate and advanced levels.

Most agencies would like to provide more staff training but reported being constrained by factors such as time, modest or nil training budgets, and the costs and impacts of backfilling for staff, particularly those in key service provision roles.

Very few agencies currently employ trainees of any description, but most would be interested in employing a mental health trainee if that option were available.

There was general support for the overall content of the current Certificate IV in mental health (non-clinical) course, though a number of respondents expressed a need for all mental health training to include:

a) More emphasis on ethics and professional boundaries issues;

b) An increase in the communication and interpersonal skills involved in engaging with consumers;

c) Information related to local service networks or referral procedures;

d) Opportunities for training pathways to enable new staff, as well as consumers and carers, to build skills and qualifications over time; and

e) Opportunities for higher level training for skilled staff, particularly in complex areas such as dual diagnosis, and for specialist groups such as those working with CALD communities, older people with dementia, or infants, children and young people with mental health problems.

A number of respondents also emphasised the need for mental health training to be closely linked to the adoption of quality, professional development cultures in NGOs. This would ensure the benefits of external training can be maximised within a work-based context.

Most respondents would like to see a minimum qualification standard for the sector. Some of the benefits of a minimum standard included enhancing the credibility of the sector and ensuring minimum competency levels. A number of challenges were also noted, including discouraging people from entering the sector, and the lack of remunerative reward. The issue of resourcing the introduction of minimum standards, specifically for incumbent staff, was seen as a significant challenge especially in the current NSW funding environment.

Respondents were highly supportive of the MHCC taking an active role in workforce development. Roles strongly favoured by the sector included providing leadership in ensuring quality and affordable training is available, providing information and research, brokering training, and delivering short courses.

While nearly half of the MHCC members surveyed in mid 2006 favoured the option of the MHCC becoming an RTO, roughly a quarter were opposed to this option, and the remaining quarter were unsure. Within this context respondents identified a number of perceived risks and benefits of the RTO option, all of which provide valuable input for future workforce development planning.

A number of non-specialist respondents strongly encouraged the MHCC to pursue their workforce development agenda in collaboration with other peak NGOs. There was also a preference for the MHCC to investigate opportunities to partner with other RTOs and other peaks, either to deliver specific mental health training components to other groups of workers (for example youth workers or community housing providers), and/or to develop reciprocal arrangements where specific, accredited training modules count towards other qualifications.

Many respondents expressed an interest in identifying ways to ensure staff training, and the related issue of staff remuneration, are properly resourced in the future. They also expressed a desire for there to be a more holistic approach to how training and skills development was approached. This included an expressed need to move away from what was termed a 'tick-a-box' approach to attending training, and a move towards building quality 'learning cultures' within NGO organisations.

Numerous respondents directly linked their feedback on training to the major challenges facing the NGO mental health sector, namely shortages in staffing, shortfalls in funding levels, challenges in accessing appropriate training opportunities (especial in non-metropolitan areas), plus challenges associated with the identity of the NGO sector, and differing perceptions of the roles of NGOs (and the staff skills and capacities that exist therein).

The consultants concluded that, while the response rates to the core survey instrument (at 42%) was credible, and the feedback provided valuable, the findings in the report should not be used as the sole means to determine future workforce development roles and actions undertaken on behalf of the MHCC or any other stakeholder group.

While the consultants note the high quality of the feedback gathered through interviews and workshops in this assessment, the outcomes of past MHCC consultations on this topic, plus the MHCC's ongoing dialogue with key stakeholders, the consultants nonetheless recommend that additional workshops be undertaken with specific stakeholder groups following a review of the findings contained in this report.

The purpose of these workshops would be to determine what similarities and differences exist in terms of training needs and how these could be developed into an integrated workforce development and training strategy that caters for all groups within the NGO sector. Key stakeholder groups that warrant further investigation include:

a) Specific types of non-specialist NGOs who assist consumers with mental illness;

b) Carers and consumers; and

c) Volunteers.

In addition, given that the training needs survey data did not allow meaningful disaggregation of the findings for specific segments of mental health NGOs - for example based on size, location (eg. non-metropolitan) or service type (eg. accommodation support providers) - the consultants believe some further segment consultations may also be warranted.

This type of follow-up research would benefit from an updated MHCC membership database that can support communications with specific membership segments, and relevant personnel within these

segments. It would also benefit from an ongoing process for establishing actual numbers and types of staff (and volunteers) employed in specialist and non-specialist NGOs across NSW.

Finally, the consultants concluded that the issue of developing minimum standards for NGO mental health staff warranted further research and analysis, including, for example, the input and feedback of key external stakeholders such as funding bodies, public health staff and clinicians, and other training providers such as TAFE.

In sum, the consultants believe that the report provides the MHCC with a valuable base on which to develop and refine a number of evidence-based workforce development options. Informed by further research and consultations, these options should be of great value and relevance, not only to NGO mental health workers and their organisations, but also to the thousands of mental health consumers who utilise these and other NGO services across NSW.

* * * *

GLOSSARY

CEO	Chief Executive Officer
Member	Refers to the MHCC membership consisting primarily of NGO service providers with a role in providing services to people with mental illness
Non-specialist	In the context of this report, non-specialist refers to NGOs without a specific expertise in mental health clients or mental health services (see specialist definition below) Non-specialist NGOs tend to not be members of the MHCC but are associated with other peak bodies such as the NSW Council on Social Services or NSW Family Services Inc.
FONGA	Forum of Non- Government Agencies (convened by the NSW Council of Social Services)
FTE	Full time Equivalent (as in a staff member)
MH	Mental health
MHCC	Mental Health Coordinating Council
NGO	Non-Government Organisation
Respondent	Representatives of MHCC member organisations who completed the surveys or participated in interviews or workshops.
RTO	Registered Training Organisation
Specialist	In the context of this report, specialist refers to NGOs who have specific expertise in mental health clients and mental health services (see non-specialist definition above) Most specialist NGOs are members of the MHCC.

* * * *

ATTACHMENTS

ATTACHMENT 1- MHCC WORKFORCE DEVELOPMENT REFERENCE GROUP

(Membership at 17 May 2006 - time of principal consultation with this group)

Melinda Bell	Aboriginal Health and Medical Research Centre
Tony Baldry	Aftercare
Pedro Diaz	Aftercare
Melissa Wartman	CARE Employment
Mary Jelen	Charmian Clift Collages
Narell Hosking	Charmian Clift Cottages
Charlie Pollicina	CO AS IT
Sue Cripps	Homelessness NSW
Lawrie Hallinan	KIAYU
Sue Maddrell	Migrant Network Services
Anne Chamberlain	Mission Australia
Moira Maraun	Moira Maraun and Associates
Vanessa Long	NADA
Sean Woods	Neami
Nhu Nguyen	New Horizons
Judy Mathews	New Horizons
Leigh Connell	Newtown Boarding House Project
Doug Holmes	NSW Consumer Action Group
Bill Gye	Pioneer Clubhouse
Janet Meagher	PRA
Kris Sargeant	Richmond Fellowship
Heidi Freeman and other Project Staff	MHCC

* * * *

ATTACHMENT 2 - MHCC BOARD MEMBERS 2005

Organisation
On Track Community Programs
Psychiatric Rehabilitation Association
NSW CAG
New Horizons
Kaiyu
Triple Care Farm-Mission Australia
Neami
Schizophrenia Fellowship
Club Speranza

ATTACHMENT 3- MHCC MEMBERS WORKFORCE DEVELOPMENT SURVEY

Mental Health Coordinating Council
Workforce Development Survey

For Managers and Coordinators

The Mental Health Coordinating Council (MHCC) would like to better understand the training and development needs of its members. This survey is for managers and coordinators of non-government services to provide information in relation to **mental health workers** within their organisations. While the MHCC recognises that members employ both clinical and non clinical workers, this survey is focused on non clinical mental health workforce development needs.

The survey should take 15 to 20 minutes to complete. Responses will be collated so that individual organisations are not identifiable. If your organisation has a number of unit or project managers please forward the survey onto them as they are more likely to have knowledge of their own staff's needs and training history. All these managers are invited to forward the survey directly to the MHCC (i.e. there is no need to consolidate the data and more than one survey is welcome from larger organisations).

If you require any assistance with the survey or further information please contact: Anni Gethin (independent research consultant to the MHCC) on 4734 8632 or 0422 415 469.

Please complete the survey in pen, then fax to **9810 8145**

New CLOSING DATE: 16 JUNE 2006

PLEASE NOTE: An electronic version of this survey was forwarded to your organisation by email on 29 MAY 2006.

If you have already responded electronically, please ignore this hard copy version. (However if you had trouble completing the survey due to technical difficulties, we would appreciate you completing the attached again. Your previous incomplete version will be ignored if indicated:

☐ Yes I have already responded by email though wish the attached responses to replace those previously sent.

ORGANISATION DETAILS	
1A	**Mental health related services your organisation provides** *(Please cross as many boxes as needed – leave other boxes blank).* ☐ Supported accommodation/ outreach ☐ Respite ☐ Centre based program ☐ Advocacy, education and information ☐ Employment ☐ Consumer support/networks ☐ Carer support ☐ Leisure and recreation ☐ Other *(please describe or attach list)*: ________________________________
1B	**Your Position** ☐ Coordinator or CEO (of your organisation) ☐ Director (of program or unit within your organisation) ☐ Manager (of program or service within your organisation) ☐ Other (please describe): ____
2	**Staff** *(you are responsible for)* Total number of staff (full-time equivalent): ____________________ Number of staff employed in mental health programs: ____________________ Number of volunteers employed in mental health programs: _______________
3	**Geographic location** *(where your organisation [or your part of your organisation] is based in NSW)* ☐ Sydney Metro ☐ Other metropolitan area (Newcastle or Wollongong) ☐ Regional Centre ☐ Rural Town ☐ Remote ☐ Other *(please describe)*: ____
4	**Main funding agencies** *(Please list top 3 funding agencies)* Funding agency (1): ____ Funding agency (2): ____ Funding agency (3): ____

RECENT STAFF TRAINING	
5	**Your own training** What mental health related training have you undertaken in the last 12 months? *(Please list name of courses)*
6	**Training last year** Over the past 12 months how many (approx) of the staff you are responsible for (see Q.2) attended external mental health related training? ______________
7	**Training providers** Over the last 12 months which training providers has your staff (or you) used for mental health related training (include 'own organisation' if running internal training)? *(Please list name of providers)*
8	**Training details** Over the last 12 months what have been the 3 main mental health topics, skills or knowledge areas in which your staff have been trained? *(Please list)*

WORKFORCE SKILLS AND KNOWLEDGE NEEDS

9

Skills and knowledge needs

From the following list please indicate what topics, skills and/or knowledge areas your staff could require training in the next 12 months.

For each topic you can select as many levels as needed – for example if some of your staff need introductory skills in dual diagnosis and others need more advanced skills – you can cross both introductory and advanced boxes.

Topic	Introductory	Intermediate	Advanced
Mental Health First Aid	☐	☐	☐
Understanding mental illness	☐	☐	☐
Mental health services and support	☐	☐	☐
Interviewing techniques, counselling and communication skills	☐	☐	☐
Mental health interventions	☐	☐	☐
Working with culturally diverse clients	☐	☐	☐
Behaviour risk management	☐	☐	☐
Assessing/responding to individuals at risk of self harm or suicide	☐	☐	☐
Supporting client participation in the organization	☐	☐	☐
Impacts of substance misuse	☐	☐	☐
Dual Diagnosis	☐	☐	☐
Occupational Health and Safety	☐	☐	☐
Processing and maintaining workplace records and information	☐	☐	☐
Outcome measurement	☐	☐	☐
Management and governance issues	☐	☐	☐

10

Other skills and knowledge

Are there any other topics that you think your mental health staff need? (*Please list*)

Topic	Level (Intro, Intermed, Adv)

11

Other staff training comments:

Are there any further comments you would like to make about your staff's skills and knowledge needs?*(Also see comments section at end)*

BARRIERS TO TRAINING

12

Training levels
Is there a need for your staff to attend more training than they do currently? (*Circle one*)

Yes/ No /Unsure

Comment: ______________________________

13

Longer courses
What are the 2 main barriers to your staff undertaking longer courses of study? (e.g. a Diploma or Certificate IV). *(Please list)*

14

Short courses
What are the 2 main barriers to your staff attending short training courses (e.g. 1 or 2 day non accredited courses)? *(Please list)*

15

Other barriers
Are the following factors barriers to your staff undertaking further training and development in general? (*Circle 'Yes', 'No' or 'Unsure' for each*)

Factor	Response
Cost of training fees or course registration	Yes / No / Unsure
Cost of backfilling position or time away from office	Yes / No / Unsure
Travel and accommodation costs	Yes / No / Unsure
Course times not compatible with rostering or shift work	Yes / No / Unsure
No training budget and/or funding insufficient to cover costs associated with staff training	Yes / No / Unsure
Funding cycle incompatible with longer term staff training and development	Yes / No / Unsure
Board or senior management not supportive of external staff training	Yes / No / Unsure
Identified training topics not available	Yes / No / Unsure
Staff resistance to participant in training	Yes / No / Unsure
Insufficient access to technology (for on-line training options)	Yes / No / Unsure
Other barriers (*details*):	

MINIMUM STANDARD QUALIFICATION FOR MENTAL HEALTH WORKFORCE	
16	**Desirability of minimum standard** What is your view on the following statement? There should be a minimum qualification standard for non clinical mental health workers. (*Circle one*) **Agree / Disagree / Unsure / Neither agree nor disagree**
17	**Minimum standard contents** If there were a minimum standard qualification, what skills and knowledge would you want staff to possess after its completion? (*Please cross as many boxes as needed*) ☐ Develop a case management plan ☐ Design mental health interventions ☐ Interviewing techniques and communication skills ☐ Impacts of substance misuse ☐ Working with culturally diverse clients ☐ Behaviour risk management ☐ Assessing and responding to individuals at risk of self harm or suicide Additional skills and knowledge you would like staff with a minimum qualification to have. *(Please list)*
18	**Challenges and issues** Do you see any challenges or issues with developing a minimum qualification standard for mental health workers working within the non government sector? (*Circle one*) **Yes/ No / Unsure** (If yes, please list what you see as the challenges or issues?)

<table>
<tr><th colspan="2">NON CLINICAL MENTAL HEALTH TRAINEESHIPS</th></tr>
<tr><td rowspan="2">19</td><td>Background
There is a possibility that mental health worker traineeships could be developed. Traineeships require the worker to enroll in a course of study and their employer is provided with a subsidy (for example $4000) for the wages of the trainee.</td></tr>
<tr><td>Current traineeships
Does your organisation currently employ any trainees? (Circle one)

Yes/ No / Unsure

If yes- what type of traineeships are they?
(Please list)
<table><tr><td></td></tr><tr><td></td></tr><tr><td></td></tr></table></td></tr>
<tr><td>20</td><td>Employing mental health trainees
Might your organisation be interested in employing a mental health trainee in the future? (Circle one)

Yes/ No / Unsure</td></tr>
</table>

ROLE OF MHCC IN WORKFORCE DEVELOPMENT

21

Roles for the MHCC
Please indicate which of the following roles would you like to see the Mental Health Coordinating Council (MHCC) undertake in terms of NGO workforce development in the future?

(*Circle 'Yes', 'No' or 'Unsure' for each*)

Role	Response
Information distribution to membership (e.g. training calendar)	Yes / No / Unsure
Providing advice to members on training options available	Yes / No / Unsure
Researching members unmet needs, then informing providers of training demands.	Yes / No / Unsure
Brokering specific training (e.g. Assisting with designing and/or funding training providers to run courses for which there is member demand) (*Subject to funding availability)*	Yes / No / Unsure
Providing subsidies to members to attend specific training courses *(Subject to funding availability)*	Yes / No / Unsure
Being an advocate for workforce development and representing the NGO mental health sector in policy and planning debates related to training	Yes / No / Unsure
Designing and delivering short courses (e.g. mental health first aid)	Yes / No / Unsure
Partnering with other agencies to develop and deliver training (e.g. Certificate IV)	Yes / No / Unsure
Becoming a registered training provider (e.g. offering Certificate IV)	Yes / No / Unsure
MHCC should have no role in workforce development issues	Yes / No / Unsure

Are there any other roles you would like to see the MHCC undertake in relation to workforce development (*Please specify*):

WORKFORCE DEVELOPMENT ISSUES	
22	**The importance of workforce development** How important is workforce development to your organisation? (*Circle one*) **Very Important** **Important** **Neutral** **Not Important** **Unsure**
23	**Future Directions** Is your organisation interested in being further consulted on workforce development issues in the future? (*Circle one*) **Yes / No** If yes, please indicate contact name, organisation and contact details: Name: ____________________ Position: ____________________ Organisation: ____________________ Tel: ____________________ Email: ____________________ *Please Note: All your other survey responses will be processed anonymously.*

QUALIFICATIONS

24	**Your experience** How many years experience do you have in working with clients with mental illness or in a related area? ____________________
25	**Your qualifications** What formal qualifications do you have? *(Please provide details in what topic or area)*
26	**Staff tertiary qualifications** How many (approx) of your mental health staff (see Q 2) have a tertiary qualification of any type (e.g. TAFE, University)? __________
27	**Health qualifications** How many (approx) of your mental health staff (see Q 2) have a health related qualification? __________
28	**Mental health qualifications** How many (approx) of your mental health staff (see Q 2) have a mental health related qualification? __________
29	**Certificate IV qualifications** How many (approx) of your mental health staff (see Q.2) have a Certificate IV (mental health non-clinical) qualification (or are in the process of getting one)? __________

Question 25 details:

Qualification	Details
Post graduate degree in…	
Bachelor's degree in…	
Diploma or Graduate Certificate in…	
Certificate IV	
Certificate III	

Other: ____________________________________

FURTHER COMMENTS

30	**Please add any further comments you wish to make:**

Thank you for filling in this survey.

Your time and answers are greatly appreciated.

Please fax to MHCC 9810 8145
(no cover page necessary)

Note: All survey responses are being processed independently and anonymously

If you have any other comments or queries regarding this survey please feel free to contact
Anni Gethin (independent research consultant assisting MHCC) on
Tel: 4734 8632or 0422 415 469 email: anni@annigethin.com

* * * *

ATTACHMENT 4- MHCC WORKFORCE DEVELOPMENT SURVEY RESULTS

Total Number of MHCC Members	149
Number of MHCC Members in Target Group (i.e. with NGO mental health staff)	126
Number of Surveys Received	53
Response Rate	42%

Note - All percentages have been rounded.

1A	**Mental health related services the organisation provides**	
Service		%
Supported accommodation/ outreach		51%
Respite		20%
Centre based program		35%
Advocacy, education and information		47%
Employment		37%
Consumer support/networks		47%
Carer support		31%
Leisure and recreation		49%
Other		14%

1B	**Position of respondent**	
Position		%
Coordinator or CEO		40%
Director (of program or unit within organisation)		12%
Manager (of program or service within organisation)		36%
Other		12%

2	**Staffing**	
In organisation or section		%
10 or under		54%
11 to 25		28%
26 to 100		8%
Over 100		10%

2	**Staffing** (continued)
Employed in mental health programs	
Nil	26%
10 or under	47%
11 to 25	12%
26 to 100	8%
Over 100	6%
Volunteers	
Nil	58%
10 or under	24%
11 to 25	10%
26 to 100	4%
Over 100	4%

3	**Geography**
Location or locations	**%**
Sydney Metro	74%
Other metropolitan area (Newcastle or Wollongong)	28%
Regional Centre	30%
Rural Town	21%
Remote	8%
Other (e.g. state-wide)	6%

4	**Organisation funding agencies**
Agency	**%**
NSW Health (AHS)	54%
NSW Department of Aging Disability and Home Care	30%
Department of Family Community Services and Indigenous Affairs	22%
NSW Department of Community Services	14%
Department of Employment and Work Relations	8%
Defence Housing Authority	6%
Also: HNEMH, private fund raising, corporate, community fundraising, private trust foundation, client fees, CDSE, gambling funds, NIDS, local council.	

5	Training by respondent
Training	**%**
Nil	40%
Some training	60%
MHFA	14%
Accreditation	
aggression management	
AHS Performance agreements	
APS courses	
CAN Assessment tool	
CAPA Conference	
CCWT self harm with young people	
Challenging people	
CMSA conference	
Conference	
Confidentiality	
Conflict resolution	
counselling program	
Cultural sensitivity	
Dealing with difficult people	
Diversional therapy	
Dual diagnosis	
Forums	
GROW residential training	
GROW staff in-service	
Guided incident response training	
Informal	
Inhouse	
Masters	
Mental health awareness and understanding	
Mental health going beyond crisis	
NMIT training for NEAMI staff	
Non clinical mental health modules	
OH&S	

5	**Training by respondent** (continued)
Outcome measurement training	
PND	
Psychosocial rehabilitation and recovery	
Referral and assessment	
RGF courses	
Risk management	
Safety improvement	
Self help	
TAFE	
THEMHS conference 2005	
Treatment of anxiety and panic disorders	
Understanding mental illness	
Vicserv conference	
Working with challenging behaviours	

6 **Staff Training last year**	
Training	**%**
Nil	12%
Some training	88%
Quantity not stated	12%
Between 0 and 25% of staff	16%
26% and 50%	22%
51% and 75%	11%
Over 75%	28%

7 **Training Providers**	
Training providers	%
Percentage stating provider(s)	87%
Of these:	
In-house	43%
CCWT	37%
Health (NSW Health or AHS)	34%
MHCC	22%
TAFE	20%
Institute of Psychiatry	7%
ACAP	

7	**Training Providers** (continued)
ACHS	
Albion St Centre	
Anglican Counselling Service	
APS	
Ausmed	
Beyond Blue	
CAPA	
Carers NSW	
CDDS	
Centre for mental health	
Community Welfare	
Compeer	
Cumberland College	
Delphi Centre	
DOCS NGO training unit	
ECAV	
Essentra	
Greg Pilah (consultant)	
HACC	
Illawarra Institute of mental health	
Institute of Psychiatry	
Interrelate	
Jansen Newman Institute	
Karitane	
Keepwell	
Lifeline	
Lifeline Western Sydney	
MAI-Wel?	
Mental Health Advocacy Service	
Mission Australia	
NADA	
NMIT	
Parramatta Mission	
Private Consultants	
Psychology solutions	
Psychoz	

7	**Training Providers** (continued)
RGF	
Safety and fire education	
SAL Consulting	
SFNSW	
Sydney University	
THEMHS conference	
Transcultural MH Centre	
Tressilian	
Universities / academics	
University of Newcastle	
Various	
Vicserv	
Wesley Suicide Awareness	

8 **Training details**	
Course	**%**
MHFA	37%
Managing challenging/aggressive behaviour	22%
Understanding mental illness	15%
Mental health (non clinical)	10%
Suicide and depression	9%
Borderline personality disorder	7%
OH&S	7%
Others:	
Accident counselling	
Adult survivors of CSA	
Advanced CBT	
Anxiety and panic	
AOD	
Carers	
Cert IV disability (MH)	
Cert IV non clinical mental health	
Child and family issues	
Client assessments	
Clinical assessment and diagnostic categories	
Clinical practice improvement	

8	**Training details** (continued)
Cognitive behavioural approaches	
Communication	
Counselling	
Crisis management	
Cultural sensitivity	
D&A	
Dealing with crises	
Dealing with the fear around mental illness	
Depression	
Diversional therapy	
Domestic violence related	
Dual diagnosis	
Essential features of GROW	
Gambling	
Grievance procedures	
Group therapy	
Hearing voices	
ISP development and implementing	
Loss and grief	
Managing medication	
Mental health and young people	
Mental health literacy	
Mentoring	
Motivational training	
OH&S	
Pharmacotherapy	
Principles of psychosocial rehabilitation	
Psychological approaches	
Psychosocial rehabilitation and recovery	
PTSD	
Quality issues	
Rehabilitation	
Risk management	
Safe home visiting	
Safety improvement	

8	**Training details** (continued)
Self harming behaviour in young people	
Small group work	
Sociology	
The mind and its potential	
Working with voices	

9 Skills and knowledge needs

Topic	Total (selecting topic)	Of those who selected the topic		
		Introd.	Intermed	Advanced
Mental Health First Aid	72%	47%	50%	55%
Understanding mental illness	83%	30%	55%	57%
Mental health services and support	74%	33%	41%	56%
Interviewing techniques, counselling and communication skills	72%	24%	45%	55%
Mental health interventions	72%	29%	47%	55%
Working with culturally diverse clients	62%	42%	36%	45%
Behaviour risk management	74%	18%	46%	67%
Assessing/responding to individuals at risk of self harm or suicide	74%	28%	44%	59%
Supporting client participation in the organization	75%	33%	45%	55%
Impacts of substance misuse	75%	38%	48%	55%
Dual Diagnosis*	72%*	36%	39%	68%
Occupational Health and Safety	68%	28%	36%	69%
Processing and maintaining workplace records and information	72%	34%	42%	58%
Outcome measurement	68%	36%	50%	67%
Management and governance issues	66%	29%	63%	49%

*Average from completed questions as dual diagnosis option faulty on some surveys

10	**Other skills and knowledge**
Affective disorders	
Anger management	
Client records	
Collaborative recovery model	
Creative therapy	
Dealing with aggression	

10	**Other skills and knowledge** (continued)
Dementia	
Depression	
Developmental disability and mental illness	
Dialectical behaviour therapy	
Disability standards	
Driver training	
Duty of care	
Engaging with clients	
Ethics and boundaries	
Grant applications	
How to promote recovery	
Infant mental health	
Intellectual disability and mental illness	
Intro to care conditions	
Media training	
Medication effects and side effects x 2	
Medications in mental health	
Men's health	
Models of recovery	
Motivational interviewing	
Personality disorders	
Prevention	
Psychosocial rehabilitation	
Relationship counselling	
Safe home visiting	
Specific mental health disorders	
Trauma neurological aspects	
Working with a psychosocial rehabilitation framework	
Working with Aboriginal communities	
Working with disclosures of sexual abuse	
Working with people with substance abuse	

11) Other staff training comments
(Organisation)is strongly committed to ongoing staff training
Need to have non clinical mental health Cert IV available in rural TAFEs.
No, well skilled staff, long term retention – so there is not the issue of needing to train new staff. Staff have been there from between 4 to 11 years.
Staff are interested in further training however work commitments make attending TAFE difficult for a small organisation.
A lot of the topics neami provides internally
Diverse depending upon area of expertise.
Forming relationships and engaging clients to own their own case management is a real skill that is not recognised in the formal training.
Staff need to know more about the cognitive aspects of mental illness and treatments or interventions. Specifically, how cognitive impairment (intellectual disability) impacts on mental health and vice versa. Staff have difficulty in managing clients with dual diagnosis.
Staff are well trained and supervised in training. Ongoing with counselling / psychotherapy / trauma and brief psychodynamic psychotherapy.
Team maintenance
We are a small organisation and our main role is to refer people to other organisations.
Training is important and all staff should be brought up to a professional level within the context of their employment.
We need money to pay for training.
Need to incorporate mental health as a module for Certificate IV Disability Studies.

12 Need for staff to attend more training than currently	
Need more training?	**%**
Yes	81%
No	15%
Unsure	4%

12) Training level Comments
Staff get a lot of training in this organisation. However staff could always benefit from more such as tertiary qualifications.
Mission provides all its organisations with a generous training budget. All employees that to do training as part of the performance management process and as part of the continuous quality improvement process.
Client base appears to have more serious mental health problems than in the past requiring greater expertise.
It is very difficult to find appropriate training. We do not provide intervention or counselling type services, but we do have a need for training on how to manage and work with staff and volunteers who have mental illnesses, i.e. those on PSP, WFD type programs. Also the consumer base of RG has a high level of mental illness. Occasionally there have been some serious problems resulting from possibly inappropriate interactions with those who have a mental illness, including physical violence. We are very keen to find out how we can work better with those who have a mental illness.
We provide a comprehensive in house, accredited induction and orientation training program that covers key competencies of workers, with modules that need to be completed in the 1, 3, 6 and 12 months of being employed. We also provide NSW wide training in key identified areas, e.g. working with people with a borderline personality disorder, a couple of times a year. An allocation of 1% of staff annual wage is also available for staff to use in area of their own particular interest/need. We also have generous study leave provision for staff undertaking further courses of study.
Always need more info.
Funding limits training opportunities.
All training is worthwhile if the quality is obvious and the material relevant (such as with Colin Rosson trauma)
Limited by costs of training, costs of backfilling staff and relevant training issues.
All (organisation) staff are interested in attending MH training.
There are continually further needs in many different areas but need more flexible options in regard to delivery.
Staff currently have opportunity for 5 days pro-rata per year – most take this – others doing own professional development as students. Some could do more.
No, they have plenty of opportunities and take them.
Availability in country areas
A good program of training is beneficial in the long run for clients.
Staff are currently preparing their work plans and these will include provision for training. However, shortage of funds is the main barrier to staff attending training.
New staff and original staff updating info

13	Barriers to attending longer courses
Barrier	**%**
Time	54%
Cost	50%
Backfill	19%
Lack of financial / career incentive	12%
Motivation / interest	12%
Access to local courses / distance	10%
Family and personal commitments	8%
Flexibility	
Lack of appropriate courses	
Literacy issues	
Other training needs	
Question the need for further training	
Relevance	
Rosters	
Staff already highly skilled	
Staff employed on a contract basis	
Workload	

13) Longer courses barriers comments
Most members are consumers and would like to work in the sector but find it difficult to find a way in – even if they have good qualifications.
Barriers are time, outside life may mean you have no time – person may be a carer or may need to travel a long time to get to work.
Most members are consumers and would like to work in the sector but find it difficult to find a way even if they have good qualifications

14	Barriers to attending short courses
Barrier	**%**
Cost	52%
Backfill	34%
Time	21%
Distance / access to local courses	12%
Appropriate courses	10%
Availability	8%
Part-time employees	8%
Equity – ensuring everyone has their fair share	
Low staffing levels - high needs of clients	
Needs to be accredited	
Other training needs	
Prior notice for planning	
Rostering / shift patterns	
Staff interest	
Transport	
Travel cost	

15	Other Barriers
Barrier	**%**
Cost of training fees or course registration	63%
Cost of backfilling position or time away from office	70%
Travel and accommodation costs	55%
Course times not compatible with rostering or shift work	39%
No training budget and/or funding insufficient to cover costs associated with staff training	37%
Funding cycle incompatible with longer term staff training and development	16%
Board or senior management not supportive of external staff training	2%
Identified training topics not available	35%
Staff resistance to participant in training	18%
Insufficient access to technology (for on-line training options)	14%

15) Other Barrier comments
Staff not training
High staff turnover may discourage some employers.
Limited training for mental health in rural communities
The organisation works on a term basis and sometimes courses are on when the tutors are on holidays – i.e. Between terms.
Some would like more training and others wouldn't – depends on their role in the organisation and the relevance of the training. For example truck drivers don't like attending training, even when very relevant to their jobs, while the customer service, education, policy and management do like to attend training.
Cost is a continual issue with the cost of courses difficult to cover when the worker has other responsibilities to be aware of – many single parent or parents with mortgages are unable to afford the cost of courses they could do – if family issues are also there.
Insufficient time to do online training.
Perceived value of training – e.g. keen to have a first aid certificate but less keen about safe working practices etc.
The above barriers are a 'sometimes' dependent on cost etc
Travel is a big issue especially for the Broken Hill and Lightening Ridge sites.
No courses in area
Not organised enough and training not prioritised highly enough in the organisation. Also we have a big workload.
Pressures of external life.

16 Desirability of a minimum standard	
Desirable?	**%**
Agree	65%
Disagree	22%
Unsure	8%
Neither agree nor disagree	6%

16) Desirability of a minimum standard comments
A minimum standard can create barriers to access work in the sector. It is a good idea provided there is money and accessibility.
I believe there needs to be a minimum level of competency; however I don't think that everyone having a Cert IV in MH is the answer. I often employ staff with far higher qualifications than that. That is why Neami has gone down the track of providing accredited competency based training.
Currently uncertain regarding definition of non clinical mental health workers. Very different roles played by people who work with clients/individuals versus those performing systemic advocacy work etc. As our organisation does (both?) so question how applicable a single minimum qualification standard will be across various roles.
Some of the best staff have no qualifications though are prepared to do once employed.
It is very desirable but in disability sector it's hard enough to get staff at all. To place a further filter would reduce the pool even more – many of our best staff are trained in-house.
Sometimes experience is better than a qualification.
Need to specify roles of 'non clinical workers' too general a statement.
Not for our service – gets sorted out in interview. Don't want to see that you need a qual just to get the interview.

17 Minimum standard contents	
Selecting any options	77%
Selecting all options	61%
Develop a case management plan	83%
Design mental health interventions	83%
Interviewing techniques and communication skills	90%
Impacts of substance misuse	78%
Working with culturally diverse clients	78%
Behaviour risk management	90%
Assessing and responding to individuals at risk of self harm or suicide	90%

17) Minimum standard contents comments
Shared language between services – especially useful for referrals. Often because services operate from a different philosophical base, or educational background, it can be hard to understand what they are talking about, as one word / term might mean one thing in one service and another in a different service.
For the RG the main issue is managing and relating to people with a mental illness, in terms of staff, volunteers and customers.
Experience as care / consumer is extremely valuable.
Training in work with CALD clients should include training in working with interpreter services. This is particularly important in mental health. Using family members to translate is highly inappropriate in mental health service provision.
Developing partnerships between mental health NGOS and community orgs who work with migrant and refugee communities.

18	Challenges and issues with minimum standard
Challenges and Issues	**%**
Yes	57%
No	15%
Unsure	13%
No answer	15%
Adapting knowledge to the field	
Agreed standards	
All the skills mentioned might not be necessary for all workers in the sector	
Competing interests	
Cost of training	
Costs prohibitive to attend on roster	
Difficulty in accessing training in rural NSW	
Excludes carers/consumers	
Facilitating current workforce into up-skilling	
Fear of change	
Financial benefits are so low	
Funding	
Identifying a starting point	
It ignores experience	
It is hard to get staff	
Lack of funding	
Less advanced than peoples current qualifications	
Limit participation at entry level especially for consumers	
Many of best staff are in-house trained	
MH not a priority	
Might stop older experienced workers form gaining employment. Especially in rural areas	
Need to be accredited	
Needs to be promoted as a career choice and a worthwhile job	
Offered as flexible units	
Older more experienced workers	
Overseas applicants	
Proper mentoring process in place	
Qualifying current employees	
Quality of staff	
Recruitment	

18	Challenges and issues with minimum standard (continued)
Relatively low existing skill base	
Relatively low pay	
Remuneration	
Shared language	
Some people may not be able to get the qualification due to the barriers. Don't want the situation where you need the qualification just to get the interview.	
Staff willingness / motivation	
Standard must be easily attainable or it is meaningless	
Such a diverse area that needs multiple skills and pays minimal wages	
Suitability	
That all staff old and new have the qualification	
That existing staff have access to and complete the training	
The diversity of jobs in our sector is the main challenge	
Time	
Understanding the mental health system	
Won't lead to more respect	

18) Other Challenges and issues comments
Needs to be accredited, offered as flexible units.
Difficulty in accessing training in rural NSW. Costs prohibitive to attend and roster.
Individuals don't not want to pay for training/degrees when the financial benefits are so low in their potential longer term career.
Limit participation at entry level, especially for consumers.
Who is responsible for what – should the person being employed have skills prior to or after they are employed and should training expire after a certain time and staff be retrained after x years. Needs assessment and competency.
Yes, might stop older experienced workers form gaining employment. Especially in rural areas. It is very hard to find anyone to fill a position in a rural area especially when such specific skills are needed.
There seems to be a view that having a minimum qualification standard will give the sector more respect with clinical services. I don't think that is the case. Given that many of the staff that we attract have tertiary qualifications. Making people complete a certificate that may be less advanced than their current skills and qualifications seems a bit tokenistic.
Excludes consumer / carer experience
Some current staff who are unqualified are exceptional workers though they feel they are too old to be bothered doing academic studies

18) Other Challenges and issues comments (continued)
People won't exert themselves through study to achieve minimum remuneration when completed. There has to be across the board improvements in pay levels to attract people into the roles.
Recruitment, suitability, adapting knowledge to the field.
Qualifying current employees
Challenges include competent trained staff working for the small SACS award wages.
Lack of funding
All of our workers are qualified – we have a domestic violence support worker who would refer on to our clinical staff as does the front line worker who acts as a reception person.
Ensuring that existing staff working in the NGO sector have access to and complete the training to obtain the minimum standards qualification. It will be important to ensure all NGO staff old and new have the qualification and provide support and care to a consistent level.
Not if assessment at interview identifies good potential, and a proper mentoring process is in place to coach and assist.
The diversity of jobs available in our sector is the main challenge.
Some people might not be able to get the qualification done – due to barriers listed above, and the sector may then lose these people. Don't want to be in the situation where you need to have a qualification just to get an interview.
I would not like to see people knocked back because they do not have the right qualification. So it would be best if staff were supported in getting the appropriate training.
Not wanting to over credentialise the workforce – as the skills mentioned might not be necessary for all workers in the sector. Level of qualifications should be tailored to the roles of workers. Also because many organisations are wholly reliant on funding, the organisation may not be able to afford the cost of training.
Needs to be promoted as a career choice and a worthwhile job.

19	**Current traineeships**
Traineeships	**%**
Yes	22%
No	71%
Unsure	7%

19) Current traineeships comments
Would love to in non clinical mental health.
Although this is not a traineeship, there is a sort of training program that Mission is developing specializing in mental health and it is intended to give employees the opportunity to go to university and gain qualifications allowing them to specialize in this area. However I am not sure about this, it is just something I heard in passing.
This was not accepted in the past by one of the directors of the organisation.
Placement for someone who has completed a tertiary counselling course.
It ignores experience.

20	Interested in employing a mental health trainee
Yes	67%
No	16%
Unsure	18%

20) Employing mental health trainees comments
Due to funding constraints.
Yes, only for a short while – so they could get a variety of experience, i.e. if a trainee could be moved between various services it would be good for them. There is not enough variety in clubhouse work to give a trainee well rounded training.
Only if a very generous subsidy. RG currently gets help through a social worker (not paid by RG) to supervise work placements through programs such as Work for the Dole and people on community service orders. Sometimes the projects are especially for participants with a mental illness who are customers, volunteers and staff – someone with skills in this area who would be available to work in the organisation would be a huge help.
No, lack of funding.
Yes if affordable. It would be particularly useful if undertaken by members of migrant and refugee communities, especially those communities experiencing severe distress. These could be a great way to help build the capacity within these communities. However, affordability is a key concern – unless we received additional funding we could not afford to employ a new worker, even if their wages are partially subsidized.

21 Roles of MHCC in Workforce development			
Roles	**Yes**	**No**	**Unsure**
Information distribution to membership	93%	0%	7%
Providing advice to members on training options available	93%	0%	7%
Researching members unmet needs, then informing providers of training demands.	80%	0%	20%
Brokering specific training	80%	11%	9%
Providing subsidies to members to attend specific training courses	87%	2%	11%
Being an advocate for workforce development and representing the NGO mental health sector in policy and planning debates related to training	93%	0%	7%
Designing and delivering short courses	80%	7%	13%
Partnering with other agencies to develop and deliver training	73%	13%	13%
Becoming a registered training provider	47%	24%	29%
MHCC should have no role in workforce development issues	2%	84%	13%

21) Roles for the MHCC comments
It is essential that MHCC as the peak body develop the skill base and expectations of staff in this industry.
Lobby government for a staged and funded workforce development program in NSW, including rural areas, not just Newcastle, Sydney, and Wollongong. That is recurrent funding (no pilot programs)
Fund holders – i.e. auspicing body for small organisations who apply for funds to do training and other related activities.
Training in how to work with and manage staff and volunteers with a mental illness is needed by our organisation and I suspect many other community organisations who do not specialize in providing mental health services.
Developing generic assessment tools and work practices.
The MHCC should be able to provide support and offer specific training if needed. A standard should be set on the required education to function within the role, but the MHCC should not dictate terms to individual agencies as to what they should be hoping to achieve.
It is too difficult to answer on behalf of mental health services.
Set up a social club for MH staff – help with networking and debriefing.
Training and resourcing MH NGOs and community based migrant orgs to work better together.
To raise awareness in non specialist mental health services of how to respond to mental health issues which arise with their clients.
Advocating for intellectual and mental illness as part of the National Mental Health Agenda.

22	Importance of workforce development
Ranking workforce development very important or important	100%

23 – Contact details - to be processed separately

24	Respondent experience
Average years	14
Range	2 to 30

25	Respondent qualifications
Qualification	**%**
Post graduate qualification	41%
Bachelor's degree;	54%
Diploma or graduate certificate;	42%
Certificate IV	21%
No qualification	4%

26	Mental health staff with qualifications
Approximate number of staff with tertiary qualifications	70%

27	Health qualifications
Approximate number of staff with health qualifications	52%

28	Mental health qualifications
Approximate number of staff with mental health qualifications	32%

29	Certificate IV (mental health non clinical)
Approximate number of staff with mental health qualifications	5%

29) Certificate IV qualification comments
All staff in accommodation and Day Programs either have the Certificate IV Disability Studies or are in the process of attaining it.

30) Any further comments
BM Food service, hall service for seniors, frail elderly and people with disabilities. Targets people affected by mental illness. Employs mental health access worker, vocational trainer (provides food based training). Not specialist mental health service.
It would be good to see the outcomes form this survey as well as from the 3 previous consultations on workforce development contracted by the MHCC.
I am concerned that there is such an emphasis on MHFA, it seems to be of a very basic standard and I would expect that my staff would have a much greater understanding of the MHFA topics before they start working with us or soon after. It seems to be designed for the lay person, no MH staff. I am also concerned about the push for minimum qualification, the majority of my staff have much higher qualifications than that including many staff with post graduate qualifications. Though at the same time I do believe in having a high standard of skill and competency.
Bring it on – you guys are doing a wonderful job.
Glad you are interested in helping community organisations which don't focus on mental health manage the mental health issues they face with staff and clients.
I am somewhat unsure as to how you have defined "mental health staff" in this survey. Our organisation does not provide services directly to individuals, but works on systemic advocacy and mental health research/projects. I have included a consideration of all staff in my responses (e.g. admin staff also).
In employment a good basic understanding of mental health issues and consequences are the main training required. Unfortunately mental health first aid did not necessarily provide this. Living in a rural or regional area is also difficult because any courses have to be sufficiently relevant to justify the cost, travel time as well as the course
Thank you for taking your time to arrange this survey.
All staff have counselling qualifications – form universities mainly – at masters, bachelor and diploma levels.
This was a painful survey to complete.
There appears to be no acknowledgement of a place for the status of consumer workers in organisations nor for the related skill base of persons employed for non clinical psychosocial professional or support roles. This questionnaire reflects a pure medical model framework and is a sad reflection of where the NSW NGO sector has become a de facto health department instead of a cutting edge group of organisations interested in raising the bar of partnerships and consumer focused recovery oriented services, rather than agencies of government.
Our organisation has excellent workforce development practices and a large training budget
Training essential for all staff and part of their performance review and CQI process; Staff keen to do training; Staff well educated; Staff attend high level of training each year and can choose what is most beneficial for them; Staff retention good.
Most of our clients have intellectual disabilities as well as mental health issues and we have been unable to sure (provide training?) to support staff.
There should be a course, workshop or other stimulus, that teaches people to think outside the box. Need to have fresh ideas, strategic thinking in management and service delivery.

30) Any further comments (continued)
Really encourage and support this initiative on behalf of MHCC. Looking forward to seeing a result. Especially want to stress the need to pay attention to ways of increasing access to culturally appropriate mental health services for migrants and refugees. Really good to be consulted.

* * * *

ATTACHMENT 5- MHCC MENTAL HEALTH CONSUMER CONSULTATIONS

MHCC consultation with mental health consumers regarding training for the NGO mental health sector

Friday 29th September 2006, 2:30 – 4:30pm

Rozelle Hospital Conference Centre

Attendance:

Amanda Marshall – Club Speranza

Kathryn Couttoupes (for Jane Fisher) – TAFE AOD Unit

Jan Heslep – Transcultural Mental Health Centre

Kimbo Bernhardt

Ian Hoffman – Consumer Rep, Uniting Care

Sam – Consumer Rep

Apologies:

Desley Casey

James Condren

Doug Holmes

An invitation was sent out to consumers through the FYI, MHCC's broad email list and also added on to invitations sent out for the consumer consultation regarding consumer outcome measurement. The attendance at the consultation was small. However, this allowed for a detailed discussion.

Questions were sent out with the invitation to attend. People were also invited to provide their response by phone, fax or email. A written response was received from Ian Hoffman (who also attended).Quotes from Ian's written response have been included in these notes (indented, italicised).

In the consultation the issues raised were as follows:

Areas to include in training:

Stigma:

There is more stigma around mental illness from workers in mental health NGOs than from any other part of the community. This needs to be addressed in training for workers in mental health NGOs. Workers need to understand that people do not choose to have a mental illness and that they should not be blamed for having one.

Communication:

Communication in mental health specific NGOs often promotes stigma around mental illness. Communication skills should be taught to mental health workers, with a premise of "do no harm". We need to train workers to listen!! Could there be a performance measurement tool to encourage this? Could it measure whether staff are friendly?

Awareness and Sensitivity:

The most important thing that any training we provide to mental health workers should focus on is **awareness and sensitivity**. Workers need to be aware of what it is like:

- to have a mental illness,
- to have a disability
- to be taking drugs for a mental illness and any related conditions, and
- what it is like to live in the extreme financial hardship that often comes along with serious mental illness, for example, living on $50 for a fortnight.

Awareness of these issues by mental health workers is very, very important. It influences all the work that they do. Mental health workers will be far more effective in their work if they are appropriately aware of these issues when they plan and deliver services. Part of the awareness that workers should have is of the abilities and the potential that people with a mental illness have. Concentrating on positives rather than negatives will produce good outcomes. Helping people with a mental illness to achieve their potential is what is really needed. Workers need to concentrate on awareness of what it is like to live with a disability. Workers need to have sensitivity. A person does not have a mental illness from 9 til 5. Workers should be aware of this. Service delivery should reflect this. Workers, especially those who plan services should be trained to be aware of this. Workers need to be aware, sensitive and friendly.

Human Rights:

Mental health workers should have a well developed understanding of human rights. Human rights should underpin all mental health service provision. This should be reflected in training.

> *"Consumers are real people with real problems.*
>
> *Basics… Universal Bill of Rights. Rights and Responsibilities of Consumers of Mental Health Services."*

Understanding Medication:

Workers need to have a very good understanding of the effects of psych medications. This is very important. Sometimes consumers are blamed for behaviour that results from medications – i.e. poor concentration, tiredness, inability to attend early morning activities, issues concerned with weight gain, etc. The effects of medications are far reaching and need to be considered in service delivery.

Cultural Sensitivity:

Mental health services need to be more sensitive to cultural diversity. This is important in service delivery for all mental health services as well as for mental health services that provide services to particular cultural and linguistic groups. There is a need for bi-lingual mental health service providers, for all language groups, especially for refugee and Indigenous communities. There is a need for CALD and ATSI service providers to have mental health training. There is a need for mental health service providers to have an understanding of what mental health and mental illness means in different cultures. There is a need for creativity and innovation in service delivery here because of the high level of need and shortage of appropriate services. Mental health NGOs are not responding adequately to these needs at present. MHCC needs to assist the sector to address these needs. Training is a very important vehicle for this. Targeted sponsorship for training could also assist here. We need to train workers from CALD and ATSI communities so as to assist them in development and delivery of services for their communities.

Planning Considerations

Partnerships with the Corporate Sector:

It was also noted that people with a mental illness may want to develop careers completely outside of the mental health sector, and if this is the case they should be encouraged to do so. Maybe we should be training workers to assist consumers to develop careers outside of mental health, such as in the private sector.

MHCC should work to develop partnerships with the corporate sector to help consumers find employment there. Training mental health service providers in how to relate to the corporate sector could assist here. However, this is an area that MHCC should also spend more time on. There should be a promotional scheme in this area. There is a great deal of benefit to consumers that would result. Perhaps we could work with the corporate sector to create scholarships for mental health consumers to provide them with the training they need to enter the corporate sector, i.e. a company might work with MHCC to design training to prepare consumers to work for them. It could be specialised training directly for the job roles they are being prepared for.

Burnout:

Many workers suffer from burnout. This is because the sector is not adequately resourced. Workers need to debrief after providing services. Service planning needs to accommodate this. Training for service providers, especially those who plan services, should address this. This could be very important for mental health workers who are also, or have been, consumers. It is important that the culture within NGOs is positive, so as to reduce the occurrence of burnout and the resulting loss to the sector of experienced workers. MHCC's workforce development strategies need to go beyond training and need to assist in the development of inclusive, innovative, enjoyable, training friendly cultures in which there are appropriate opportunities for debriefing. MHCC should consider what creates a positive organisational culture and how we can help NGOs develop and maintain such an organisational culture.

Priorities:

Too much money is spent in administration rather than service provision. We should not spend too much money providing training if there are other organisations already providing relevant training. We need to consider how many resources to put into training because the resources may be better spent in service delivery. In areas where appropriate training already exists it would be better if the MHCC concentrated on partnerships with the training providers to make sure that the training they provide is appropriate. For example, the Institute of Psychiatry provides training for consumer advocates, so we do not need to do so too. However, it was also suggested that it would be good if we could facilitate consumer advocacy training that is run by consumers.

Length of Employment:

Workers don't usually stay employed in the one organisation long enough for training they receive to benefit the organisation. They may move onto other positions in the mental health sector, or they may move outside of the sector. People move to new jobs for a variety of reasons. Sometimes it is because they are in short term funded positions. Sometimes it is because of burnout and negative organisational cultures. Management training may help address this.

We need to be aware of the short time some staff stay in positions when planning our training. While staff are staying in positions for a short time we have to consider whether it is a good use of resources to train them. Would the money be better spent in service provision? If we are putting resources into staff training, we also need to focus on organisational development. How do we get staff to stay in the one NGO for longer. We need to consider all aspects of workforce development – longer funding contracts, positive work cultures, support for workers, career paths, appropriate and competitive remuneration, respect for work undertaken, flexibility in working conditions.

Assisting Mental Health Consumers to Access Training:

Sponsored training places:

Mental health consumers should be a priority in the provision of sponsorship of training places in any training we provide. This is important both because many mental health consumers are facing severe financial hardship and also because consumers have so much to offer in mental health service provisions. They are the only ones who really know what it is like to live with a mental illness.

Flexible and appropriate training delivery:

We should be aware that mental health consumers are very capable intellectually. However, we also need to be aware that mental health consumers may have needs resulting from their mental illness and / or the medications they are taking as a result of that or other conditions. Training we provide should consider these needs. For example, training delivery should be flexible, maybe a whole day of training is not a good idea. If a consumer is taking medication it may affect their ability to concentrate, or to arrive at a very early time in the morning to attend training. Medication can make people tired, or make it hard to concentrate for long periods of time. They can also effect memory, eyesight, and other abilities. A comprehensive listing of side effects of medications can be obtained from clinicians. Mental health consumer representatives could (and should) be paid to provide more detailed understanding and ideas about how to deliver training appropriate for people with a mental illness.

Consumers as Mental Health Workers:

Benefits and disadvantages of mental health consumers as mental health service providers:

Mental health consumers may want to enter the NGO mental health workforce. They can be extremely good service providers because of the understanding that their experience of mental illness brings them. However, it is important that they are chosen because of the quality of the services they are able to provide. Mental health consumers would not benefit if a worker's ability to provide a quality service were compromised by their mental illness, for example, a worker working through their own mental health issues through the process of service provision, may provide poor quality services to consumers. There was some mixed opinion on the benefits and disadvantages of mental health consumers as mental health service providers, but all agreed that we need to always concentrate on what will provide the best services and outcomes for consumers, and that a mental health consumer's awareness of what life is like with a mental illness is invaluable in service provision.

Potential harm to mental health consumers of work in the mental health sector:

There was a concern that sometimes mental health service providers encourage mental health consumers to engage in some way in mental health service delivery or mental health advocacy. Before this is done, it is very, very important to consider the long term interests of the consumer. They may not wish to have their status as a mental health consumer publicly known. While there maybe short term benefit by engaging in activities such as addressing a public gathering to provide insight into mental illness, in the long term it may disadvantage the consumer. This sort of activity may benefit the organisation or the worker more than it benefits the consumer. We should consider this in the planning of training. If we are training people to be consumer advocates, we should include a consideration of long term goals in their training. We should also make workers aware of the potential damage to reputation that can come from these disclosures. Remember, not all consumers are ready, willing or able to work in the NGO sector or to be consumer advocates.

Respecting and renumerating mental health consumers for their participation in the mental health workforce.

Mental health consumers need to be paid for their contributions to the NGO mental health sector. Too often this does not happen. They are used as volunteers in all sorts of positions. This is sometimes seen as part of their recovery process. However, it is much more than that, it is valuable labour and needs to be respected and paid for. Pay rates should be at a level that respects the very valuable input that consumers provide. As well as being paid, consumers need to be paid at appropriate levels, not at the lowest level of pay within an NGO.

Consumer input into consultations

It was noted that mental health consumers provide input to consultations that no-one else could provide, yet are not valued adequately for this. They should be paid. If a psychiatrist was consulted they would probably charge a lot of money. The understanding and ideas provided by mental health consumers are at least as valuable, if not more so, and should be recognised as such

Mental Health Consumers as Trainers, Assessors and Course Writers:

Mental health consumers should be encouraged to apply for work within MHCC's training division, in the capacity of trainers, assessors, course writers and advisors. If their input is used in developing training it should not be unpaid. Consumers should be paid at the same rate as the course writer if they are being consulted by the course writer. We should be writing most if not all of our courses in paid consultation with consumers.

Mental Health Consumers as Volunteers:

Volunteers are less respected than workers. It is important to provide training to volunteers as well as workers. The work of volunteers, especially those who are consumers, needs to be respected. Accessible, relevant training can assist in providing volunteers in mental health NGOs who are also consumers with the respect that their valuable input deserves.

Mental health consumers who volunteer in mental health NGOs in lower skilled areas are not well integrated into the organisation. There is much more respect and integration provided to mental health consumers who volunteer in non-specialist community organisations like neighbourhood centres, than there is for consumers who volunteer in mental health specialist NGOs. Training for workers and managers of mental health specialist NGOs should address this.

We need training that nurtures volunteers. We need to help volunteers and those who work with volunteers.

> *"I think the best thing for consumers who want to be volunteers in an NGO, is to treat them with respect (just like any one else) and make sure they understand the support that is available."*

Providing Consumers with Information About Mental Health Services:

We should consider things such as having an information day to let people know about what mental health services are available in the NGO sector. Both mental health consumers and workers in NGOs and health services would benefit from this. This would be a good thing to do in Mental Health Week.

Don't Reinvent the Wheel:

We should look at previous consultations around training needs of mental health workers. In particular we should refer to the Deakin Report. We should also keep a look out for any new work/consultations in this area by others, and be aware of relevant government reports that may influence training development.

ATTACHMENT 6- MHCC FONGA CONSULTATIONS

MHCC consultation with FONGA members regarding training for the NGO mental health sector

Friday 6th October 2006, 11:15 – 11:40

NCOSS Meeting Room

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As we only had a short time to consult, we agreed that members would take the questions and notes provided and email back responses in addition to matters discussed at the FONGA meeting. Questions and issues to consider were distributed.

Main points raised were:

High Need for Mental Health Training:

There was general agreement that there was a high need for community workers across all sectors to access training in mental health, in recognition that mental health is becoming an increasingly important issue for community organisations.

Training in Mental Health Generally:

There were a variety of issues concerning general mental health training for staff in the community sector. Issues raised were:

Staff in community organisations need to know:

- about the main kinds of mental illnesses,
- how to recognise a mental health problem,
- how to respond to clients with mental illnesses,
- how to manage disruptive, dangerous or other types of difficult behaviour arising from clients who have mental health problems.
- OH&S type training in this area is important. Managers as well as frontline workers need training in this area.
- What are the legal, ethical and other responsibilities of community organisations when providing services to clients with mental health problems?
- How do these issues impact on working with volunteers?
  - What training do volunteers need?
  - What requirements are there for community organisations to provide volunteers with appropriate training for working with clients with a mental illness?
- What are the legal issues that workers and managers need to know concerning home visits?
- What sort of policy and procedures do organisations need to consider concerning mental health?
- How to negotiate the mental health system
- How to provide services for, consult and engage with mental health consumers.
- Is there funding available to assist organisations provide services to clients with a mental health problem?

Those at the FONGA meeting said they were aware of Mental Health First Aid training and recognised that it was very beneficial, but had not all had the opportunity to attend or send their staff to it.

Significant Level of Illiteracy Amongst Frontline Staff

There is a level of illiteracy amongst front line community workers. Many of these people have been working in the sector for a long time and hide their literacy difficulties. One of the ways they do this is by never volunteering for training. We need to reach this group. We need to provide training, even if it is not accredited, on a very practical level, ideally within the workplace, in a way that is going to attract this group. To do this we could approach managers and ask them to publicise the training and in doing so to state that it is hands on rather than written. It was stressed that this was not the majority of frontline workers, but still a significant number of them.

Accredited vs. Non Accredited Training:

Accredited training was preferred, but accessing the training was the most important thing. It was recognised that one of the important issues for workers was the desire to gain recognised qualifications which will assist in developing a rewarding career path. For this reason accredited training was important.

RPL and Articulation into Higher Education.

It was also very important that training articulated into higher learning opportunities i.e. accumulating Statements of Attainment → Certificates and Diplomas → Bachelors → Graduate Certificates and Diplomas → Masters. RPL was very important, as many workers had skills but no qualifications. Need to be aware that workers will move from different sectors within the NGO sector and training should assist in this process, rather than requiring workers to continually retrain.

Further Consultation:

Attendees at the FONGA meeting felt that we should undertake further consultation with workers in their sectors. They felt that they were unable to really provide sufficient information about the day to day needs for mental health training for workers in their sectors.

A representative from Western Sydney Community Forum noted that they have just commenced an online survey about the training needs of community workers in Western Sydney. She will forward the results of that survey.

Barriers to Training:

The main barriers to community sector staff attending training are costs and backfill. Backfill is an especially important issue for small community organisations where there is only one worker. It is also a very important issue for organisations in remote locations.

IT Issues:

Catholic Community Services have found success in providing on line training, and will pass on info about this to MHCC. However, online training does not suit everyone. Many workers do not have access to a computer to enable this and / or may not have adequate computer skills. Many services do not have adequate IT systems to reliably handle online training. For example, organisations may not have:

- video links,
- fast enough computers
- fast enough internet connection
- reliable enough internet connection
- sufficient storage space on computers
- enough computers for staff to spend time on a computer training. The computer may be needed for other work.

These issues need to also be considered for those attending face to face training that need to access information from the internet for their assessments. This is particularly important for rural and remote workers who usually experience very poor internet access. Unfortunately these are often the workers who are expected to get their training and resourcing on line.

Specific Areas / Workers Requiring Training:

Partnerships and access to mental health service providers:

One of the key issues for all those attending the FONGA meeting was how non mental health specific NGOs could work better with all mental health providers (NGO, NSW Health and private). They are not aware of all the services that are available, and when they do find out, don't know the protocols about how to access them. There was interest in how to provide services in partnership i.e. case management, appropriate community development interventions.

Who does what?

Another important issue was understanding what different mental health professionals and service providers did. For example, what is the difference between services provided by a psychologist and a psychiatrist? What can and can't mental health teams in community health centres do? Who is eligible for what type of service? Where can this information be found?

Pro bono lawyers:

Pro bono lawyers are a group that experience considerable difficulty working with mentally ill clients and have difficulty accessing training or information to assist them in this area. Community legal centres provide some training to pro bono lawyers in clusters – i.e. all those from inner west on one day and all those from Western Sydney on another. We could see if we could somehow link into this training offered by community legal centres, especially Redfern Legal Centre. One of the problems legal centre reps spoke of regarding pro bono lawyers is that they often did not believe what a client said regarding their behaviour, etc if the client had a mental illness. However, the legal centre staff felt that usually what the client said was actually correct.

Forensic Mental Health:

There was a lot of interest in forensic mental health. Many of the clients of community organisations had some involvement in the forensic system. Are there mental health services especially for people within the criminal justice system? How does the criminal justice system work? Are there particular things community development service providers should know about forensic mental health? Carol Berry from PIAC is co-ordinating a working group on mental health and the Criminal Justice System. Maybe information from the working group should be distributed to FONGA and wider community sector.

Young People's Mental Health Needs:

Charlie Khourey (sp?) from Marrickville Youth Interagency / Marrickville Council is doing work on young people's mental health. We may want to follow up with him on this area. Young people's mental health is an important issue for community organisations across the board.

Needs of Rural and Remote Workers:

Rural and remote workers **need** access to training. This is one of the most important things we could do. Workers in metropolitan areas can usually access training, but this is not so for remote workers. If we are going to offer scholarships or targeted sponsorship, then this is the group that is the most in need. A great diversity of workers in rural and remote areas are responding to mental health needs. There are high mental health needs due to the stresses of drought, financial hardship, community breakdown, etc.

Financial counsellors would be very likely to benefit from mental health training. Rural and remote workers are the workers with the greatest unmet need of mental health training!!!! All seemed to agree that this was an area of very high need.

Mental Health Training For Child Care Workers:

Childcare workers have a particular need for training in mental health. They need to know how to recognise mental health related problems in children and also in the families of children, especially, but not only their parents.

Mental Health Training for Neighbourhood Centre Staff:

Staff of neighbourhood centres need training in mental health as they are the ones that are likely to come across people with problems. These problems may not have been identified and the person not linked in to other required services.

Mental Health Training for Employment Service Providers:

Staff providing employment services need training in mental health. This is very important. Often people who fail to comply with employment service requirements do so because of mental health problems. Staff need to be able to recognise mental illnesses and be able to respond appropriately. It is particularly important for staff in a variety of community organisations whose clients are receiving benefits to be able to identify a mental health problem and assist clients in working with Centrelink and related service providers.

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ATTACHMENT 7- LIST OF INTERVIEWEES

Name	Organisation
Melinda Bell	Workforce Development Officer Aboriginal Health and Medical Research Centre
Larry Billington	Consumer Representative Board member Mental Health Association
Karen Burns	Parramatta Mission
Laurna Downes	Carers NSW
Laurel Draffen	Manager, Good Practice Unit NSW Federation of Housing Associations
Linda Duffell	UPFRONT Australia
Michael Duffy	Lecturer, Mental Health University of Technology, Sydney (formerly with Court Liaison Service, Dubbo)
John Ferguson	Policy and Training Officer Youth Action and Policy Alliance (YAPA)
Jan Heslep	Consumer Coordinator, Transcultural Mental Health Centre
Rhoda Immerman	Association of Relatives and Friends of the Mentally Ill (AFARMI) NSW
Vanessa Long	Manager Workforce Development Network of Alcohol and Drug Agencies (NADA)
Kerry Saloner	Senior Counsellor, AIDS Council of NSW (ACON)
Rhondda Shaw	Capacity Building Consultant, NSW Family Services Inc.
Barbel Winter	Executive Officer Multicultural Disability Advocacy Association
Cathie*	Consumer
Director	Billabong Clubhouse, Tamworth
Ian*	Consumer (comments in writing)
Manager	Mental Health Accommodation Rehabilitation Services, Lismore
Manager	Human Resources, Richmond Fellowship, NSW
Manager	Clarence Valley Community programs, Grafton

* Full names not included.

ATTACHMENT 8- SAMPLE STRUCTURED INTERVIEW QUESTIONS

- Have you identified mental health training as a need of staff in of your organisation?
  If yes, what specific issues or challenges are staff having to deal with regarding clients with mental illness?

- What topics or issues would you like to see staff in your organisation receive training in?
  Do courses exist that cover these issues?

- What type of mental health training would most suits the needs of staff in your organisation?
  Short courses (1 or 2 days), longer training (Cert IV, Accredited etc)?

- Are there any barriers to staff receiving appropriate MH training?
  Is there anything that would assist your organisation to overcome those barriers?

- Do you have any views about the establishment of mental health worker traineeships?

- What do you think about establishing scholarships for staff to attend MH training?
  What staff (or group of staff) should be given priority?

- What roles would you like to see the MHCC take in terms of MH training?

- If you could change one thing to improve staff access to appropriate MH training what would it be?

Some interviews conducted in mid 2006 also included the following:

- How useful do you think establishing a minimum standard for mental health workers would be?
  a) What would be the benefits?
  b) What would be the downsides?

- What roles would you like to see the MHCC take in terms of workforce development?
  a) What do you see as the benefits of it becoming a RTO?
  b) Are there any weaknesses or concerns about this option?

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