DECEMBER 2019

FINAL REPORT

The NSW CMO Mental Health Workforce

Findings from the 2019 MHCC Workforce Survey

mhcc
mental health coordinating council

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Report preparation

This Final Report was prepared by Human Capital Alliance (International) Pty Ltd (HCA) for the NSW Mental Health Coordinating Council (MHCC) to report the findings from the MHCC Workforce Survey.

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

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Acronyms & Abbreviations

ACCHS	Aboriginal Community Controlled Health Services
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CMO	Community managed organisation
FTE	Full time equivalent
HR	Human resources
HRIS	Human resources information systems
HCA	Human Capital Alliance
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied
LHD	Local Health District
MH NGOE NBEDS	Mental health Non-Government Organisation Establishments National Best Endeavours Data Set
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NHWPRC	National Health Workforce Planning and Research Collaboration
NSW	New South Wales
PHN	Primary Health Networks
VET	Vocational Education and Training

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Preamble

The MHCC is the peak body representing NGOs / CMOs responding to the needs of people affected by mental health conditions in NSW. MHCC's purpose is to support a strong and sustainable community managed mental health sector that supplies effective health, psychosocial and wellbeing programs.

This report presents the findings of a 2019 NSW mental health workforce survey undertaken by MHCC in collaboration with Human Capital Alliance. MHCC is committed to improving data about the community mental health sector. This important project provides an understanding of the size, nature and context of the NSW community mental health workforce, who work alongside other specialist mental health and primary health care service providers in delivering treatment, rehabilitation and support services. It will enable MHCC to better identify workforce opportunities and challenges and pursue capacity-building strategies in the current mental health reform and NDIS implementation environments.

MHCC approached the workforce survey with a sense of excitement and urgency - the current environment shows great promise; it is also uncertain and evolving with change management and learning occurring 'on the run'. Psychosocial rehabilitation supports have historically been delivered by a skilled and qualified workforce with specialist capability to practice in ways that promote recovery, prevent psychiatric crises and suicide risk. The type of providers, workforce and nature of supports provided to people living with a mental health condition is evolving under the NDIS and mental health reforms being initiated by PHNs in partnership with LHDs (e.g., the commissioning of the National Psychosocial Support Measure). We must embrace these changes and ensure providers continue to be able to respond effectively, safely and viably to the unique needs of people living with mental health conditions. This means a commitment to investing in the community sector mental health workforce inclusive of, but not limited to, the peer workforce.

The 2019 workforce survey focused on current workforce supply. MHCC anticipates growth in future workforce demand. Funding and policy settings that ensure a skilled and experienced community-based mental health sector and its workforce are essential. Good workforce planning needs investment in both forward demand estimates and related skill/capability development. This must include five-year funding contracts for CMOs that allow for strategic workforce planning and development. Short-term contracts can result in unstable employment for workers and reduce the quality of services.

MHCC thanks everyone who has contributed to the 2019 workforce study. Workers are at the core of supporting people living with mental health conditions to live fulfilling lives in the communities of their choice. We hope that the findings presented in this report will help us continue discussion about investment in the workforce as a key community mental health sector development strategy.

Carmel Tebutt, CEO,
Mental Health Coordinating Council

Executive Summary

Background

Information about the size and composition of the community managed organisation (CMO) mental health workforce in New South Wales (NSW) is currently limited especially compared to information available on the workforce providing public sector mental health services. A routine data collection, the Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set (MH NGOE NBEDS) is currently being implemented to improve data collection, and hence understanding, about the mental health-related non-government organisations. It has been initiated in Western Australia and Queensland but not yet in NSW.

In order to obtain data upon which to make decisions about the workforce MHCC has initiated an employer survey of CMO sector organisations delivering mental health services in NSW. This report details the findings from the survey.

Method

A single survey was developed comprising a total of 27 questions of fixed and open response style (see Appendix p.30). A simple survey was designed to maximise the response rate and focus on collecting information about the workforce size, composition and competence, and the factors driving current and future workforce demand.

The survey was administered to 117 CMOs, 76 of who were MHCC members. This sample population was considered to be representative of the majority, if not all, CMOs delivering mental health services in NSW. A range of initiatives were implemented to optimise the response, which largely worked well with MHCC members but not other parts of the survey sample population. The response was underpinned by a high response rate of 62% for MHCC member CMOs but the non-member response was poorer.

For some of the 27 questions, especially those that explored more detailed elements of a CMO's staffing, only estimates (or non-responses) were provided by some CMOs due to simple human resource information systems or limited methods for collecting human resources (HR) information.

Findings highlights

The high response rate, along with a review of the respondent population by sector experts, indicated that the findings from the survey were highly credible. The highlights of the findings were:

- the size of the mental health workforce is about 4,745 paid workers (this is both direct care and managers/administrators) and 4,160 volunteers. In terms of full-time equivalents (FTE), the paid workforce was 3,464 representing close to one-quarter of the total mental health workforce in NSW in 2016-2017 of 14,182 FTE (this includes public and private sector employed workers and based on

the AIHW National Mental Health Establishments Database and Private Health Establishments Collection)

- the workforce was female dominated (70%) and nearly two-thirds of the workforce were under 45 years of age.
- the workforce was primarily made up of Mental Health Support Workers (63%) and there were also significant numbers of allied health workers including nurses (12%) and Peer Workers (11.3%).
- almost half the workforce (49%) was employed on a temporary contract or on a casual (hourly rate of pay) basis, and there was a high level of part time employment
- qualifications of the main workforce categories were a mixture of levels ranging from no qualification to an undergraduate degree. The emerging Peer Worker workforce appeared to generally have a lower level of nationally recognised qualification compared to the Mental Health Support Worker workforce.

Perceptions of the future

Most of the surveyed CMOs believe that an increase in workforce numbers, with higher skill levels, will be demanded in the future. This, from their perspective, will be driven primarily by the broad mental health reforms occurring in NSW (see for instance the NSW reforms outlined in Living Well, NSW MHC [2014]) and Australia more broadly, and by prevailing tendering and commissioning processes.

Conclusion

MHCC and the CMO mental health sector have begun through the survey reported upon in this study the important task of understanding the size, nature and context of its workforce. Despite the method limitations of an employer survey for workforce research, the study has delivered credible information to guide appropriate workforce development strategies and interventions for building CMO capacity to collect and use data on their own workforce.

This initial study, though, should be viewed as the beginning of ongoing and routine workforce data collection that will allow examination of workforce trends (in workforce size and composition) over time. Future data collection, however, should also be extended to gaining a better insight into service, and therefore workforce, demand, in addition to estimating supply. It is only by looking at supply and demand of the workforce, that judgements about the adequacy of the current workforce, in terms of both quantity (numbers) and quality (competence and qualifications), be possible.

Introduction

In NSW, and nationally, the CMO mental health workforce is recognised as a significant component of the mental health workforce. Yet, information about the size and composition of the CMO workforce is currently limited especially compared to information available about the workforce providing public sector mental health services. Variability in the way that the sector is defined and classified, the different methods that have been employed to collect information about the sector, along with only sporadic prioritisation of this information at a State or Territory level, have been significant contributors to the current paucity of information.

The most recent assessment of the CMO mental health workforce in Australia was a national survey of the mental health non-government organisation (NGO) workforce conducted in 2009-2010 (National Health Workforce Planning and Research Collaboration [NHWPRC], 2011). Just over one-third of the CMO[1] mental health sector (based on a population estimate of 798 organisations) was able to be surveyed. Based on this data, the size of the national CMO mental health workforce was conservatively estimated to range from 14,739 to 26,494 paid employees. The survey data also indicated that the CMO mental health workforce was predominantly characterised by 'non-clinical' roles, such as support workers, consumer workers, management/administration and social workers, with some organisations also employing workers for clinical roles such as psychologists, counsellors, registered nurses and occupational therapists.

Information specifically about the size and composition of the NSW CMO mental health workforce is not readily available and can only be estimated from the NHWPRC data. Using the NHWPRC (2011) survey the size of the workforce in NSW is estimated at anywhere between 2,900 and 5,300 workers. A mapping survey conducted by MHCC in 2010 found that the NSW CMO mental health workforce was largely comprised of part-time and casual staff, and CMOs that were solely focussed on providing mental health services tended to have more full time staff and volunteers with mental health skills compared to other CMO types[2].

The Mental health non-government organisation establishments National Best Endeavours Data Set (MH NGOE NBEDS), is currently being implemented to improve data collection, and hence understanding, about the mental health-related non-government organisations. The dataset is still being established and data collection has only commenced in Western Australia and Queensland, and therefore there is still some way to go before comprehensive and standardised data about the CMO mental health workforce in NSW is available.

[1] Note that in the NHWPRC report the term NGO is used instead of CMO.

[2] MHCC typology is as follows (MHCC, 2010): 'Providing mental health programs/services only', 'Providing mental health programs in addition to other programs/services', 'Providing support but no specific mental health programs/services'.

In the interim, MHCC initiated an employer survey of CMO sector organisations delivering mental health services in NSW to better understand and support decisions about the workforce. This report details the findings from the survey regarding workforce size and composition, as well as the needs of the CMO mental health workforce to meet the workforce requirements of the changing landscape of mental health service delivery.

The insights the survey findings provide are critical as the sector undergoes significant changes in response to the NDIS and the various Commonwealth and state government mental health reform initiatives.

Aim & Objectives of the Survey

The aim of the Workforce Development Survey (the survey) was to gather information from MHCC member organisations that employed people with mental health skills on all programs that delivered mental health services.

The survey was primarily focussed on understanding the current supply of the CMO mental health workforce.

Specifically, the survey was used to determine:

- the current size of the workforce employed and workforce composition by gender, age, hours of work, years of experience and highest qualification
- perspectives on future workforce requirements, based on potential growth or reduction in service demand.

Method

Survey design

A single survey was developed comprising a total of 27 questions of fixed and open response style.

The survey was intended to be completed by Service Managers, HR Managers, or CEOs of MHCC member organisations (the person best placed within the organisation to provide workforce information).

The initial survey draft was informed by findings from the literature review (see Ridoutt and Cowles, 2019) and it was then modified in collaboration with the Advisory Group to ensure it could be optimally completed by CMOs.

A draft version of the survey was piloted online using SurveyMonkey with three organisations (members of the Advisory Group). The focus of pilot testing was to assess language and terminology, relevance of the questions and structure and flow of the survey. The survey was then further revised and finalised based on pilot testing and feedback from MHCC and Advisory Group members. The final version of the survey administered is provided as Appendix 1.

The sample population

The scope for the survey was initially limited to the mental health workforce population employed in NSW by MHCC members. To obtain a broader understanding of the mental health workforce in NSW, the scope was expanded to include workers in non-member community mental health sector organisations identified by MHCC as providing mental health services in NSW, and likely to be employing relevant workers. This included the opportunity for NSW Ministry of Health (the Ministry) funded mental health services (other than those members of MHCC), Ministry funded Aboriginal Community Controlled Health Services (ACCHSs) and Commonwealth funded Primary Health Networks (PHNs) to participate[3]. Table 1 provides an overview of the total survey sample population framework by type of community organisation.

[3] Three out of ten NSW PHNs are current members of MHCC.

Table 1: Survey sample size and stakeholder type

Stakeholder category	Number of Organisations/ services
MHCC Members	76
Ministry funded mental health services that are not MHCC members	27[4]
Ministry funded ACCHS	14
Total	**117**

Promotion and administration of the survey

The survey was promoted and administered in four stages:

1. Initial promotion: The survey was promoted in August to MHCC members using MHCC's weekly e-newsletter FYI e-News – News from the Peak
2. Pre-registration: Two weeks prior to the launch of the survey MHCC members were invited to pre-register the key respondent within the organisation to complete the survey. An email was also distributed by MHCC to member organisations
3. Administration: a link to the survey was disseminated in four ways:
    a. a link to the survey was included in the FYI e-News - News from the Peak
    b. a targeted email was sent by MHCC to respondents who had pre-registered for the survey (n=26)
    c. a separate email was sent by MHCC to all other members (n=50)
    d. Non MHCC members were invited by email by MHCC (n=41)
4. Follow-up: Survey reminders were conducted by phone and email by HCA and MHCC. Weekly reminders notices were also included in the FYI e-News – News from the Peak. CMOs known to be large employers were specifically targeted for follow-up.

The survey was open from 9 September 2019 to 27 September 2019, and then extended to 11 October 2019.

[4] This includes 15 affiliates of one organisation.

Data analysis

Fixed survey responses were quantitatively analysed using simple frequency distributions and where appropriate cross tabulations, to provide a total workforce size, workforce composition, insights into areas of shortage, identification of any gaps in skills and subsequent identification of future sector workforce requirements.

Open response questions were analysed through thematic analysis to identify common themes, and differences and similarities across the responding the organisations.

Survey findings

Response rate

A total of 48 viable responses were obtained for the survey. Viable responses were determined by completed responses to question five of the survey (see Appendix p.30) which asked respondents to provide a headcount and FTE of all staff working in direct support roles.

Most responses (n=48) were from MHCC members (see Table 2). Therefore, based on MHCC members only, this represents a survey response rate of 61.8% (n=76).

PHNs in contact with HCA and MHCC confirmed that they commissioned mental health services and funded other service providers to deliver services, but they did not employ staff in direct support roles other than for assessment and referral roles and functions.

Only one response was received from a non MHCC members. In contrast to MHCC members, this group of organisations were not followed up with the same intensity.

Table 2: Response rate by survey stakeholder category

Stakeholder category	Number of Organisations/ services	Number of respondents (viable response)	Response rate (%)
MHCC Members[5]	76	47	61.8%
Non-member organisations	15	0	0%
Ministry funded mental health services that are not MHCC Members	12	1	8%
Ministry funded ACCHS	14	0	0%

[5] Includes currently unpaid MHCC memberships

Based on current knowledge of the sector, most large CMOs that are direct care providers of psychosocial rehabilitation and recovery support services were captured through the survey and therefore the findings presented in this report are largely representative of the sector.

However, there are some limitations to the data. Several CMOs known to be delivering only mental health prevention, promotion and early intervention or undertaking research did not respond to the survey.

There are also limitations to the data collected due to the high level of variability between CMOs in relation to their human resources information systems (HRISs) or human resource data. Some survey respondents advised that some information requested through the survey was difficult to acquire from their existing records, or, in some cases, was not collected systematically (or at all) by the CMO. In such cases, respondents were asked to provide an estimate.

It is likely that estimates from smaller CMOs were fairly accurate, but less accurate for larger CMOs. Unless indicated by the respondent, it was not possible to determine if the data provided was an estimate or if it had been obtained from a HRIS.

Provider description

MHCC (2010) identifies three types of CMOs providing mental health services and support:

Type 1: solely involved in the provision of mental health services

Type 2: provide other types of services as well as mental health services (e.g. dual diagnosis, alcohol and other drug services)

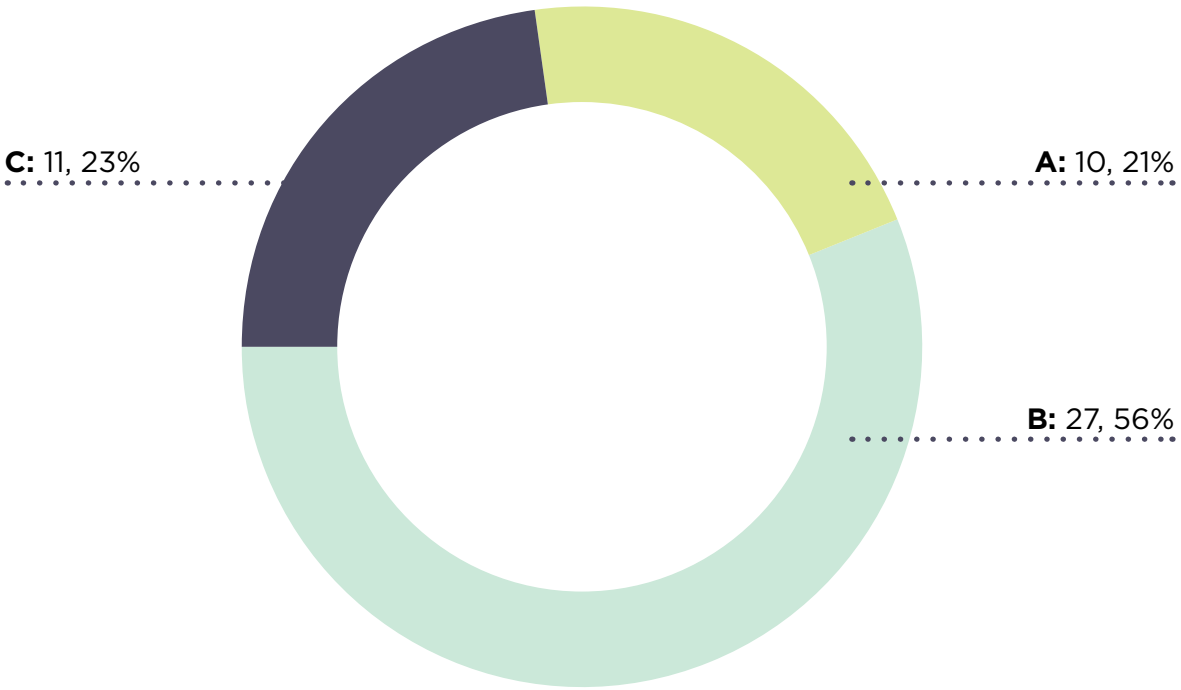
Type 3: do not provide services specific to addressing mental health but provide other support services which persons with a mental health problem are most likely to require (e.g. probation and parole, social housing, employment).

Most survey respondents (58%, n=48) indicated that they were categorised as Type 2, that is 'Providing mental health programs in addition to other programs/services' (see Figure 1) while just over one-fifth of the responding CMOs identified as Type 1. This finding is comparable with the 2010 MHCC survey undertaken of the CMO population which found, from a total of 247 CMO responses, that (MHCC, 2010):

- 14.2% of CMOs were providing mental health programs only (Type 1 services)
- 41.3% of were providing mental health programs in addition to other programs (Type 2 services)
- 44.5% were Type 3 mental health support providers.

The more focused nature of the survey sample population selection in the case of this study might help explain the large composition differences.

Figure 1: Number of respondents by CMO type (n=48)



Key to Figure 1:

A = Providing mental health programs/services only

B = Providing mental health programs in addition to other programs/services

C = Providing support but no specific mental health programs/services

The types of psychosocial services provided by CMOs was broad in range and has been perceived as even broader because of inconsistency in definition. For this survey an increasingly accepted and standardised taxonomy of service types was adopted - the MH NGOE NBEDS[6]. While establishment of the dataset is still under way and data collection is yet to commence in NSW, it was agreed this set of service definitions was most appropriate for the survey.

The MHNGOE NBEDS identifies 18 service type options. The survey results indicated that respondents were providing a broad range of mental health services. The most prevalent type of service offered by CMOs was an 'Intake /assessment / triage service', and the least prevalent service was 'Service integration infrastructure' (Table 3).

[6] https://meteor.aihw.gov.au/content/index.phtml/itemId/494729

Table 3: Types of mental health services delivered by respondent CMOs (n=48)

Mental health services provided by CMOs	Number of CMOs	Proportion of total CMOs
Counselling-face-to-face	22	44.9
Counselling[7], support, information and referral-telephone	20	40.8
Counselling, support, information and referral-online	9	18.4
Intake/Assessment/Triage for referral to other service	27	55.1
Self-help-online	6	12.2
Group support activities	26	55.3
Mutual support and self-help	14	29.8
Staffed residential services	14	29.8
Personalised support-linked to housing	17	36.2
Personalised support-other	21	44.7
Family and carer support	25	53.2
Individual advocacy	21	44.7
Care coordination	21	44.7
Service intergration infrastructure	6	12.2
Education, employment and training	21	44.7
Sector development and representation	15	31.9
Mental health promotion	26	55.3
Mental illness prevention	20	40.8

Previous attempts to understand the nature of CMO sector service mix, albeit using a different list of service types, have found a different emphasis. For instance, in NSW MHCC (2010) identified 'self-help group support', 'accommodation' and 'counselling' as the main areas program activity. A Department of Health (2014) review estimated in Victoria that the most common service sub-sectors or program types (by proportion of organisations and share of the workforce) were 'Home-based outreach support' and 'Psychosocial rehabilitation day programs'. Nationally the service area types found to be most prominent were 'recovery planning', 'education and training' and 'peer support' (NHWPRC, 2011). Based on these comparisons it seems that there has been a slight shift in emphasis towards more 'clinical' support, but given the different way this data was sought in different surveys it is not possible to be precise.

[7]55.3% of respondents offered at least one form counselling service.

Nine survey respondents nominated other mental health services being delivered, not from the 18 listed above, as follows:

- suicide prevention
- systemic advocacy
- telephone support and other types of services, but only for AOD clients not for persons with mental health issues
- homeless support service
- commissioning mental health services.

Workforce size

The total number of workers (head count) employed by the responding organisations for delivery of direct care mental health services was 3,495. This represents an average of 73 workers specifically delivering mental health services in each responding organisation. However, this average affords limited insight as only nine (just under one in five or 18.8%, n=48) CMOs accounted for 2,903 or 83% of the total workforce[8]. The workforce head count size estimate compares with previous estimates of the NSW CMO mental health workforce by NHWPRC (2011) of between 2,900 and 5,300. An expert review of the survey respondent population estimates that the significant bulk of CMO services with mental health staff have been included in the respondent population, and that the total number (to extrapolate to the entire CMO services population) could be increased by 10%.

The head count translates into 2,535.6 FTE staffing. This provides an average FTE conversion factor of 0.73 (derived from the calculation FTE/Head count).[9] As a comparison, the registered working psychologist population has a FTE conversion factor of 0.85, the total mental health nurse workforce has a FTE conversion factor of 0.95, and the working psychiatrist workforce has a FTE conversion factor of 0.97.[10]

In addition to the paid workforce, 26 organisations (60.5%, n=43)[11] had volunteer staff. In total there were 3,782 volunteers (head count) contributing to delivery of mental health services, which was almost 9% more than the paid workforce size. This figure does not include carers.

It was difficult to translate the volunteer headcount into an FTE estimate and any assumption of equivalence with the paid workforce would be inappropriate. However, as a guide one survey respondent noted:

> ***"[Our] organisation has two volunteer staff doing the job of about eight people. Both peer workers, and one is also an Occupational Therapist, Advocate and Researcher."***

As well as direct support staff, the respondent CMOs identified that 819 workers were working in non-direct support roles as outlined in Table 4.

[8] A total of 11 (24.4%, n=45) responding organisations indicated they employed no paid workers.

[9] A conversion factor closer to 1.0 indicates a higher proportion of the workforce working fulltime.

[10] Data obtained from AIHW (2017): https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce

[11] Responses to the survey dropped off from question five onwards.

Table 4: Number of workers employed in non-direct support roles (n=43)

Type of non-direct support role	Number of workers (headcount)
Management[12]	**393**
Administrative support staff	**269**
Technical support staff (e.g. IT)	**57**
Total	**819**

This number accounts for approximately 19% of the total workforce delivering or supporting CMO mental health services delivery in NSW.

The total number of persons estimated to be working to deliver mental health services in the NSW CMO sector therefore is 4,745 paid workers (applying the 10% extrapolation) and 4,160 volunteer workers. In terms of the paid workforce, this translates into an FTE of 3,463.9 workers.

To place this into perspective, the FTE number of workers employed in the specialised mental health workforce (as defined by the Australian Institute of Health and Welfare (AIHW) in the National Mental Health Establishments Database and Private Health Establishments Collection) in NSW in 2016-2017 was 10,728.4 FTE. This figure effectively includes nearly all of the mental health workforce not working in the CMO sector (including public and private hospitals, residential care services and community mental health care services). Thus, based on these figures, the CMO sector mental health workforce accounts for just under one-quarter (24.4%) of the total mental health workforce in NSW.

Workforce composition

Several organisations indicated that their HRISs were limited in the level of detail and sophistication to extract accurate data. Therefore, they were not able to provide precise numbers on the composition of their workforces. In such cases, they were advised by the research team to provide a 'best guess'. Accordingly, the numbers for workforce composition breakdown do not always align with total workforce size estimates, however, the proportional values are considered to be good estimates.

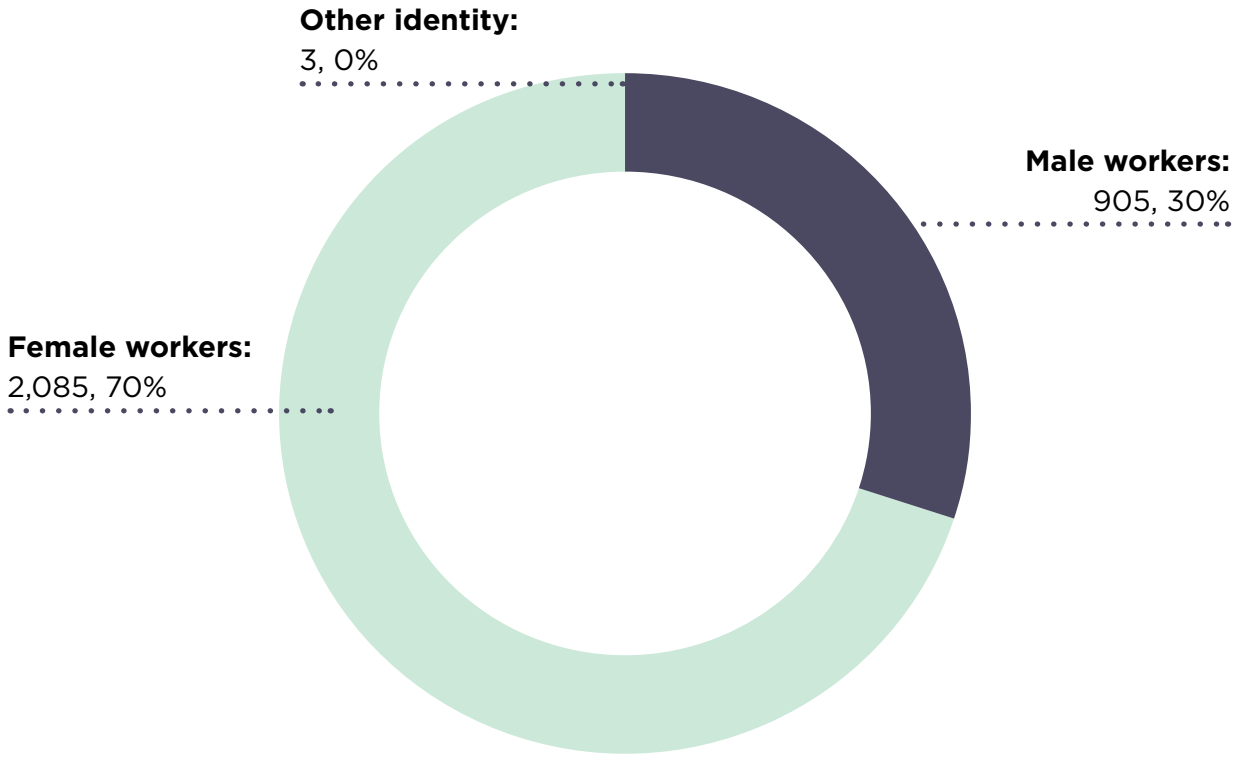
The survey findings indicated that women represented 70% of the CMO direct care mental health workforce (see Figure 2). Two organisations indicated that a total of

[12]This does not include workers who have both management and direct care roles. For example, survey respondents identified 'team leaders', 'coordinators', etc. who had dual roles.

[13]Missing workforce elements are mental health practitioners working in private community practice and in services commissioned by the PHNs.

three workers did not identify as either male or female, representing only 0.001% of the workforce. Several organisations indicated that they did not hold accurate records for gender identity of their workforce.

Figure 2: Gender identity of respondent workforce (n=46)



The age distribution of the CMO workforce was skewed towards a younger age profile. Nearly two-thirds of the workforce (64%, n=46) was under 45 years old as outlined in Table 5.

Table 5: Number of workers by age group (n=46)

Age groups	Number of workers	Proportion (%) of total workforce
18-25	347	13.6
26-35	724	28.4
36-45	562	22
46-55	526	20.6
56-65	333	13
66+	61	2.4
Total	**2553**	**100**

Respondents indicated that almost two-thirds of the workforce in direct support roles were working as a 'mental health support worker' (63%; Table 6). The other sizeable roles were allied health (11.6%), although there are many 'other' classified workers who might fit this category including counsellors) and 'peer workers' (11.3%).

The FTE conversion factor varies considerably between types of worker, with some occupational categories being employed much more on a part-time basis than others. For example, 'mental health support workers' were more commonly employed on a part-time basis compared to nurses, allied health workers and support coordinators.

Table 6: Number of workers by type of direct support roles (n=44)

Type of worker/occupation	Headcount	Proportion of total workforce (%)	FTE	FTE Conversion Factor
Identified Consumer Peer Worker	363	11.3	262.2	0.72
Identified Carer Peer Worker	8	0.2	7.5	0.94
Mental Health Support	2009	62.8	1477.7	0.74
Support Coordinator	202	6.3	162.7	0.81
Enrolled Nurse	1	0.03	1	1
Registered Nurse	18	0.6	16.5	0.92
Psychiatrist/other medical practitioner	46	1.4	33.4	0.73
Allied Health	371	11.6	341.1	0.92
Other	183	5.7	131.9	0.72
Total	**3201**	**100**	**2434**	**0.76**

A total of 20 respondents identified a range of 'other' roles as follows:

- Carer Advocate
- Carer educator
- Case Worker
- Client service officers
- Communication staff
- Community Development Officer
- Community Mentoring Program
- Counsellors
- Crisis Support workers (specifically trained in suicide intervention and crisis support)
- Designer
- Employment Consultants
- Facilitators
- Health promotion
- Homelessness Project Workers
- Information officers
- Parenting Support Worker
- Plan Facilitator
- Residential Care Workers
- Suicide Prevention Community Development Worker
- Transition workers
- Vocational Trainer of Hospitality Service
- Volunteer Coordinator
- Wellbeing Education Consultants

It is possible that some of the roles listed above may be unique to particular CMOs and the type of services they provide (e.g. National Disability Insurance Scheme [NDIS]) and the way the services are organised. Some CMOs also identified management, coordination and administration roles, noting that sometimes these roles had a direct care component.

It is notable that 12% of the direct care workforce are allied health professional (i.e., Allied Health plus Registered Nurse).

Conditions of employment

Just over half (50.3%) of the workforce was employed on a permanent basis, with the remainder of the workforce being employed on a temporary basis. This included nearly one-fifth (18%) of the workforce who were employed on a casual, hourly basis of remuneration (Table 7).

Table 7: Number of workers by employment status (n=44)

Employment Status	Number of workers	Proportion (%) of total workforce
Permanent full time	982	28.8
Permanent part time	730	21.5
Contract full time	583	17.2
Contract part time	492	14.5
Casual (hourly remunerated)	611	18
Total	**3,398**	**100**

[14]These roles were indicated to often be occupied by Social Worker students

[15]Some respondents may have included these in the allied health count.

As noted previously the workforce has a comparatively low FTE conversion factor which implied that a high number of workers were working part time. The survey findings indicated that over half the workforce (54%, n=43) were employed on a part time basis. By way of comparison, the part-time 'Share of Employment' in the total Australian workforce in August 2019 was 32% and the proportion of persons working part-time in the 'Health care and social assistance' industry was 44.3%[16]. This places the CMO sector mental health workforce high in the rankings of part-time employment.

Some organisations (20.5%, n=44) indicated that they kept accurate data about the diversity of their workforce such as cultural background, gender identity, and lived experience. A further 25% (n=44) had some data but indicated that it was not well-maintained, and 54.5% did not keep data on these worker characteristics.

"If the employee has disclosed this, it will be on their employee details form."

"We might be aware of these things informally, but we do not have a process to identify formally."

A total of 28 respondents (64%, n=44) used their available data to provide an estimate of the numbers in the different diversity and lived experience categories. These respondents indicated that 691 workers (28.3%) had lived experience of a mental illness, 89 workers (3.6%) had lived experience as a carer, 179 (7.3%) were of Aboriginal and/or Torres Strait Islander background, 203 (8.3%) were identified as culturally and linguistically diverse, and 120 (4.9%) were identified as LGBTQIA+.

Some respondents indicated that, while they did not have specific 'numerical' diversity targets, there was an intention to connect with and employ a diverse workforce. Some CMOs also indicated that formal strategies or action plans had been developed, such as Reconciliation action plans to employ Aboriginal and Torres Strait Islanders, to increase the diversity of their workforce:

"Our organisation is very small for such targets, but we are working on projects developing more connection with culturally and linguistically diverse [communities]and First Nations communities and are prioritising applications received from people from these backgrounds and many of the other diversities."

Educational background of the workforce

Level of qualification data for selected non-professional workforce categories was provided by only a small number of respondents (17 of 48), therefore there are limitations on the applicability of the data, although these 17 respondents together account for 75.6% of the total survey respondent workforce. Table 8 illustrates that peer workers, mental health support workers, and support coordinators tended to have higher levels of education, with those holding a relevant degree qualification within these worker categories being 17%, 36% and 46% respectively of the 17 respondents. The most common form of worker in the workforce, the mental health support worker, were most likely to hold a Certificate level qualification (46% of all workers in this category, n=17), but were also reasonably likely to possess a degree (36%).

[16] ABS Labour Market Information Portal;
See http://lmip.gov.au/default.aspx?LMIP/GainInsights/IndustryInformation

The data in Table 8 can be compared with the distribution of qualifications for the entire Australian workforce, as follows (ABS, 2019):

- Bachelor degree or higher (32%)
- Cert III or higher Vocational Education and Training (VET) qualification (31%)
- No post-school qualification (32%)

All three workforces in Table 8 had a lower proportion of non-qualified workers than the total Australian workforce, a higher proportion of VET qualified workers, and, apart from the consumer peer workforce, a higher proportion of degree qualified workers. The distribution of qualifications within the public sector mental health services workforce is much more skewed to the possession of degree or higher qualifications with a much higher proportion in the workforce of professional workforce categories.[17]

Table 8: Proportion of workers by level of qualification (n=17)[18]

Types of Workers	Level of Qualification					
	No formal relevant qualifications	Certificate III	Certificate IV	Diploma	Advanced Diploma	Degree or higher
Consumer Peer Workers	23.6	10	33.6	15.7	0	17.1
Mental Health Support Workers	4.3	12.9	32.9	9.3	0.7	36.4
Support Coordina-tor	10	0	23.8	5	15	45.6

Perspectives on current workforce adequacy

Only eight respondent organisations (16.3%, n=44) indicated that they had vacant funded positions. Of these, seven respondents indicated that the positions had been vacant for more than three months. The total number of vacancies greater than three months duration was 71, which provides a medium-term vacancy rate estimate of 2% (based on the estimated workforce size). While this finding does not suggest there is a current under-supply of workforce in the CMO mental health sector, CMOs have long reported difficulties with recruiting staff in some parts of Sydney and in regional, rural and remote NSW.

Vacancy data, and the vacancy rate, does not provide any insights about staff turnover. Turnover is a calculation based on the proportion of the workforce that leaves an organisation during the year (number of workers who have left employment/number of

[17]National Mental Health Establishments Dataset 2015-16, provided by System Information and Analytics, NSW Ministry of Health

[18]Data for Carer Peer Worker was insufficient for analysis and therefore not included in the table.

workers employed). Vacancy rates measure levels of recruitment difficulty, while staff turnover measures retention difficulty. It is possible to have low vacancy rates but high turnover, especially in labour markets where wages are low (prompting high turnover) but employer recruitment behaviour is not too discriminating or demanding of labour qualifications (prompting relatively quick recruitment). Staff turnover was not measured by the survey, but anecdotally some larger CMO organisations reported quite high levels of staff turnover.

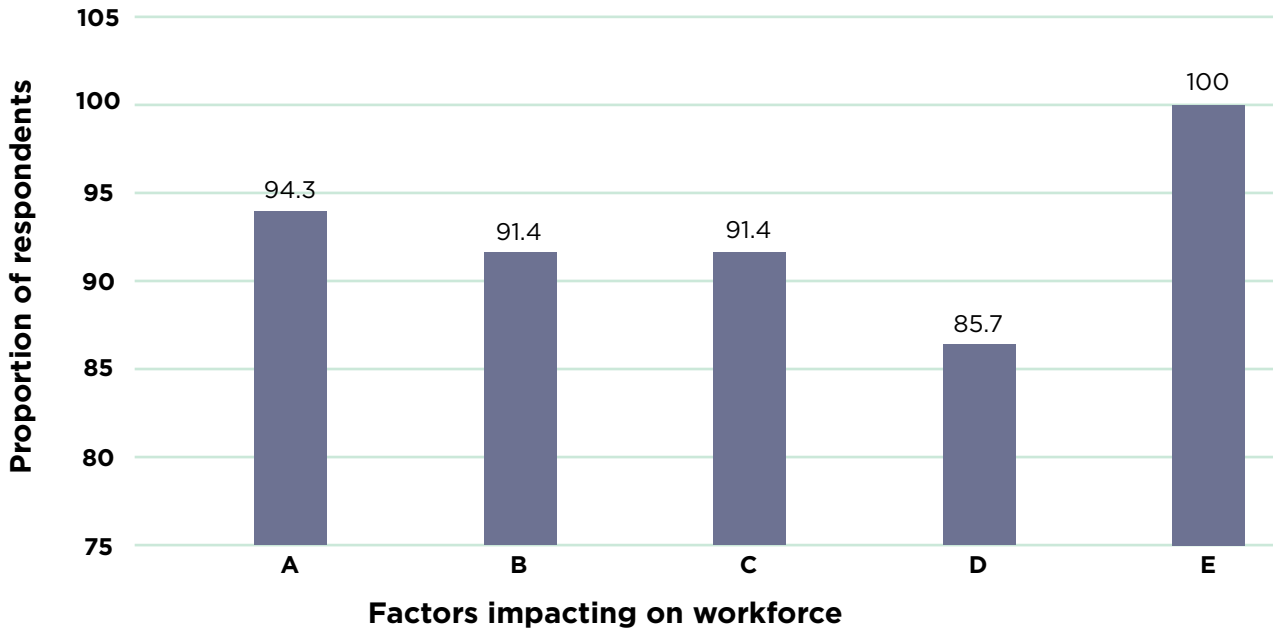
Almost three-quarters of total vacancies were accounted for by a single organisation which was in the process of expanding its number of designated peer worker positions. Most of the identified vacancies (65%, n=7), therefore, were for identified consumer peer workers. Other meaningful vacancy numbers were for mental health support workers (16%) and allied health workers (13%).

Most of the current vacancies (77%) were in metropolitan areas or regional cities. The most common reasons for vacancies were 'Insufficient number of workers with relevant qualifications' and 'Difficult to attract workers to service location of the position'.

Future workforce needs

Only 35 of the 48 respondents completed Section 4: Future workforce needs of the survey. Between 86% and 100% of the respondents to this section indicated that all the factors posed were having, or were likely to have, an impact on workforce demand either now or in the future (see Figure 3).

Figure 3: Proportion (%) of respondents selecting factor as having an impact on workforce demand (n=35)



Key to Factors:

A = Mental health reform environment

B = Service delivery in NDIS environment

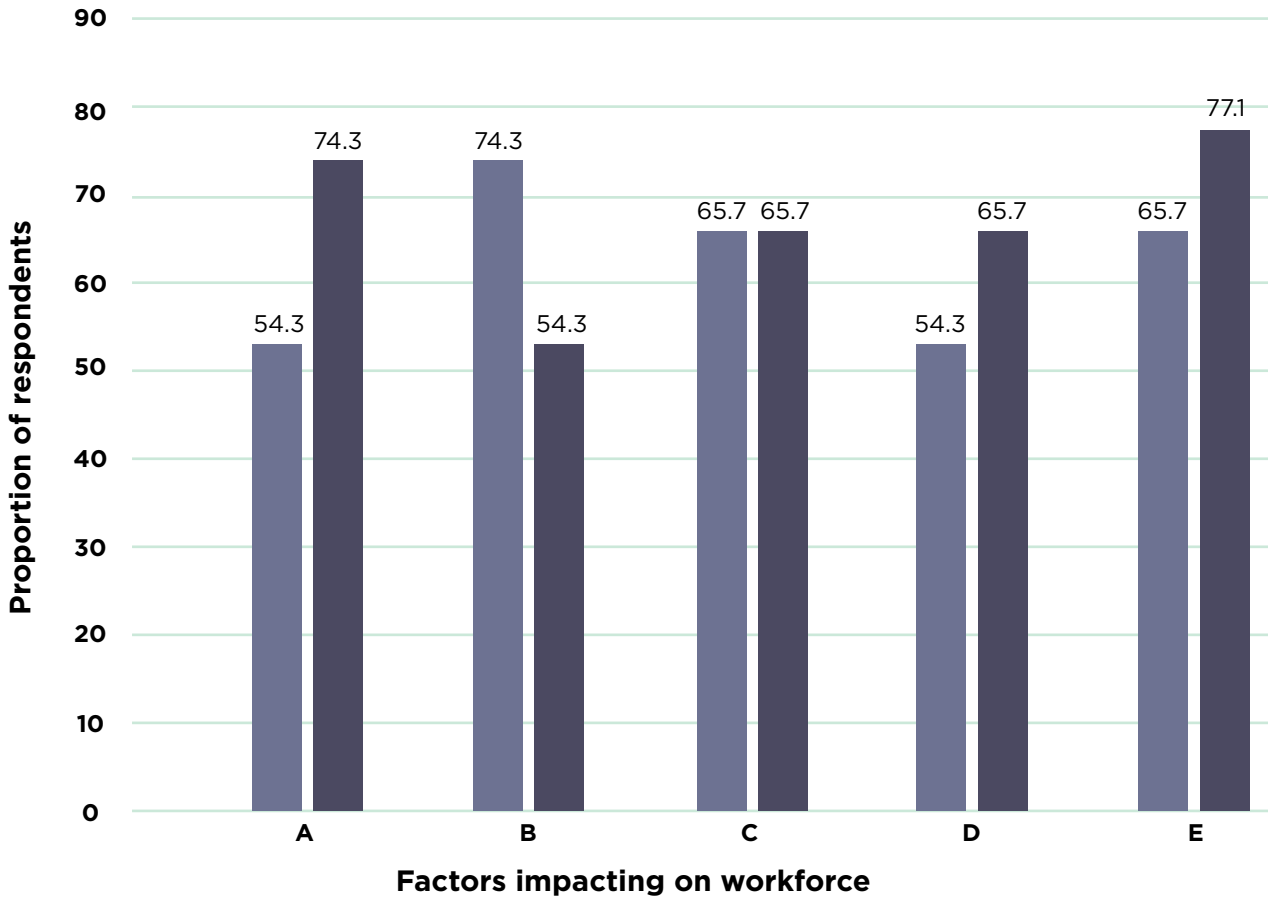
C = Contestable tendering and funding environment

D = PHN commissioning of mental health services

E = Funding level to recruit appropriate staff demand

Most of the responding organisations indicated that the factors would have the impact of increasing workforce demand (Table 9). Between 50% and 70% of respondents perceived that the factors would impact on increasing the demand for skilled workforce. A smaller, but still considerable proportion of responding CMOs (between 18% and 31%) also indicated that the factors would have an impact of increasing the demand for unskilled workforce. Few CMOs (less than 13%) perceived the identified factors would impact to reduce demand for either the skilled or unskilled workforce.

Figure 4: Distribution (%) of survey respondent population by perception of when factors will impact the workforce demand – now and / or in the future (n=35)



Key to Factors:

A = Mental health reform environment

B = Service delivery in NDIS environment

C = Contestable tendering and funding environment

D = PHN commissioning of mental health services

E = Funding level to recruit appropriate staff demand

Most of the factors were thought to be having an impact on workforce demand both now and in the future (see Figure 4) but some were viewed as more influential in the present. For instance, the NDIS service delivery environment was viewed as having a greater impact now (74% of respondents, n=35) than in the future (54%, n=35). In contrast, most respondents indicated that the Mental Health reform environment (74%, n=35) and the funding levels to recruit appropriate staff according to demand (77%, n=35) would have a greater impact in the future.

Figure 3: Proportion (%) of respondents selecting factor as having an impact on workforce demand (n=35)

Factors potentially impacting on workforce	Number of CMOs nominating factor	Perception of increased demand		Perception of reduced demand	
		For skilled workers	For less skilled workers	For skilled workers	For less skilled workers
MH reform environment	33	22 (67%)	6 (18.2%)	1 (3%)	2 (6.1%)
Service delivery in NDIS environment	32	16 (50%)	10 (31.3%)	4 (12.5%)	0
Contestable tendering and funding environment	32	22	6 (18.8%)	1 (3.1%)	2 (6.3%)
PHN commissioning of mental health services	30	21 (70%)	5 (16.7%)	0	3 (10%)
Funding levels to recruit appropriate staff demand	35[19]	17 (48.6%)	7 (20%)	4 (11.4%)	4 (11.4%)

Some other comments were made by respondents to the issue of factors impacting on workforce demand that highlight other, related, issues:

" ... future workforce demand is increasing as populations increase and more funding is made available to the sector."

"We have zero funding and have two volunteers doing the work of eight staff. There is a critical and unmet need leading to thousands of Australians in crisis and we can't keep up with the demand as people slip through system gaps ... "

[19]Eight respondents did not provide an opinion on the likely direction of the impact of this factor.

Discussion

Employer surveys are a common, but imperfect means of undertaking workforce research (HCA, 2013). Yet, they are often used where no other option is available (e.g. when a workforce is not registered). The primary concern with a survey method relates to estimating the variable workforce size, since the estimate is highly sensitive to population sampling (have all possible employers been included in the survey administration?) and survey response rate (did all surveyed employers respond?) which can result in under-counting.

In the case of the CMO sector mental health workforce, in the absence of a comprehensive and routinely collected data set like the MH NGOE NBEDS, an employer survey represented the most viable option. Every attempt was made to optimise the high response rate achieved for this project (62% of MHCC membership). Nevertheless, several employers were still not included in the survey respondents.

There is no way of objectively quantifying the impact of this on the final workforce count, but there is considerable confidence, based on the knowledge and advice of MHCC and the Advisory Group for this project, that the respondent population covered most of the relevant employers and that no large employers of mental health workers had been excluded. Hence, the final workforce size estimate of 4,745 paid workers (3,463.9 FTE) which includes a 10% adjustment for employers not surveyed, is considered highly credible. This places the CMO sector, who are primarily delivering psychosocial support services, as a key part of meeting the total demand for NSW mental health workforce and services accounting for approximately one-quarter of supply.

Growth in NSW of the workforce in specialised mental health facilities (public and private hospitals and public community mental health services) between 2013 and 2017 was 2% per annum (AIHW, 2019). A rudimentary estimate of workforce growth in the CMO sector can be made by taking as the baseline the midpoint of the NHWPRC (2011) range estimate for workforce size (4,100, the midpoint between 2,900 and 5,300) and the estimate from this survey as the end point (4,745), which provides a workforce growth estimate of 1.97% per annum. While this growth estimate needs to be considered with caution, it mirrors closely the growth rate for the public sector mental health workforce.

Despite this apparent growth, a more significant increase could have been expected, at least since the 2011 NHWPRC survey findings. Yet, various factors (e.g. NDIS, mental health reforms, PHN commissioning) have influenced a growth in the workforce on the one hand, but other factors (e.g. concentration of service delivery in a smaller number of providers through mergers, defunding of traditional organisation-based service models) may also have potentially reduced growth in workforce. It will be important to collect data on a regular basis so the CMO workforce size can be tracked and the impact of mental health reform and the full rollout of the NDIS better understood.

Most of the surveyed CMOs felt that an increase in workforce numbers, with higher skill levels, will be demanded in the future. And this will, from their perspective, be driven primarily by the broad mental health reforms occurring in NSW (see for instance the NSW reforms outlined in Living Well, NSW MHC [2014]), and Australia more broadly, and by tendering and commissioning processes.

Should CMO employer perceptions be prescient, and a larger (and more skilled) workforce be required in the future, then recruitment ambitions might be undermined by the unstable or temporary nature of employment (contract and casual) of almost half the CMO sector workforce and the currently considerable proportion of the workforce with no qualifications or lower order VET qualifications.

Through this survey, MHCC, and the CMO mental health sector, have begun the important task of understanding the size, nature and context of its workforce. This provides important insight into immediately appropriate workforce development strategies and interventions for building CMO capacity to collect and use data on their own workforce. This initial study, though, should be viewed as the commencement of ongoing, and routine, workforce data collection, that will allow better understanding of workforce trends (in workforce size and composition). Future data collection, however, should also be extended to gaining a better insight into service, and therefore workforce, demand, in addition to estimating supply. It is only by looking at supply and demand of the workforce, will judgements about the adequacy of the current workforce, in terms of both quantity (numbers) and quality (competence and qualifications), be possible.

References

Australian Bureau of Statistics (2019), *Labour Force (trend and annual averages of original data)*; ABS, Education and Work; Department of Jobs and Small Business, Employment Projections.

Australian Institute of Health and Welfare (2019), *Mental health services in Australia.* https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities Last updated 9 October, 2019

Human Capital Alliance (2013), *Pharmacy Workforce Planning Study.* Pharmacy Guild of Australia, Canberra

National Health Workforce Planning and Research Collaboration (2011), *Mental Health Non-Government Organisation Workforce Project Final Report.* Health Workforce Australia: Adelaide.

NSW Mental Health Commission (2014), *Living Well: A Strategic Plan for Mental Health in NSW*. NSW MHC, Sydney

Appendix: Survey Tool

Thank you for taking the time to complete this CMO Workforce Survey.

* 1. Please complete the following contact details.

Your information will only be used for the purpose of following up with you if further information about your survey responses is required.

Name	
Position	
Organisation	
Post Code (NSW head office)	
Email address	
Phone number	

SECTION 1: Details about your organisation

The questions in this section will collect information about the type of services your organisation provides.

* 2. According to MHCC typology, which of the following definitions most closely describes your organisation's **operations in NSW**?

Please choose only one organisation type that you think fits best.

- ○ Providing mental health programs/services only
- ○ Providing mental health programs in addition to other programs/services
- ○ Providing support but no specific mental health programs/services

3. Please provide an estimate of the proportion of your total workforce resources working in mental health services in NSW (who may also be working across different services/programs).

This includes administrative support staff, management, enabler supports (e.g. finance) and all direct support staff.

- ○ 10%
- ○ 20%
- ○ 30%
- ○ 40%
- ○ 50%
- ○ 60%
- ○ 70%
- ○ 80%
- ○ 90%

* 4. What types of mental health services does your organisation offer in NSW. Please choose as many service types as appropriate to your organisation. You may choose more than one service type.

(This list is derived from the AIHW MH NGO-E MDS. Definitions can be found here)

- ☐ Counselling-face-to-face
- ☐ Counselling, support, information and referral-telephone
- ☐ Counselling, support, information and referral-online
- ☐ Intake / assessment / triage for referral to other services
- ☐ Self-help-online
- ☐ Group support activities
- ☐ Mutual support and self-help
- ☐ Staffed residential services
- ☐ Personalised support-linked to housing
- ☐ Other (please specify)
- ☐ Personalised support-other
- ☐ Family and carer support
- ☐ Individual advocacy
- ☐ Care coordination
- ☐ Service integration infrastructure
- ☐ Education, employment and training
- ☐ Sector development and representation
- ☐ Mental health promotion
- ☐ Mental illness prevention

SECTION 2: Details of current staffing

In this section we would like to understand the profile of the current workforce working in mental health services/programs in your organisation in NSW.

* 5. What is the total number (head count) and Full Time Equivalent (FTE) of **all direct support staff** (full time, part-time or casual) **employed by your organisation who are working in NSW in mental health specific services** (in the services you previously selected)?

**FTE can be calculated by dividing all hours worked by 38. FTE should not be greater than the head count.

If you are unsure or unable to provide the FTE information from your HR data, please provide an estimate of FTE.

Number of staff (head count)	
FTE of staff	

* 6. Please indicate the total **NUMBER (headcount)** of staff for each of the following **direct support** roles **currently employed by your organisation** (full time, part time or casual) **who are working in NSW in mental health specific services.**

Please enter '0' if there are no employees for category. The total number of staff should be the same as the number you provided in the previous question.

Identified Peer Workers	
Identified Carer Peer Workers	
Mental Health Support Worker	
Support Coordinator	
Enrolled Nurse	
Registered Nurse	
Psychiatrist/other medical practitioner	
Other allied health professionals	
Other (please specify the number)	

7. If you provided a number for 'Other' roles, please specify what these roles are.

8. Please indicate the total **FTE of staff** for each of the following **direct support** roles currently employed by your organisation (full time, part time or casual) **who are working in NSW in mental health specific services**.

Please enter '0' if there are no employees for category.

If you are unsure or unable to provide this information, please provide an estimate of FTE.

Identified Peer Worker	
Identified Carer Peer Worker	
Mental Health Support Worker	
Support Coordinator	
Enrolled Nurse	
Registered Nurse	
Psychiatrist/other medical practitioner	
Other allied health professional	
Other (please specify the number)	

* 9. Please indicate the number of **direct support staff** (full time, part time or casual) **working in mental health services in NSW** for each of the following EMPLOYMENT STATUS categories.

Please enter '0' if there are no employees for a category. The total number of staff should be the same as the number you provided in the first question of this section.

Permanent Full Time	
Permanent Part Time	
Fixed contract Full Time	
Fixed contract Part Time	
Casual / Hourly remunerated	

* 10. Please indicate the number of **direct support staff** (full time, part time or casual) **working in mental health services in NSW** by each of the following GENDER categories.

The total number of staff should be the same as the number you provided in the first question of this section.

Male	
Female	
Other identity	

* 11. Please indicate the number of **direct support staff** (full time, part time or casual) **working in mental health service delivery in NSW** for each of the following AGE categories.

Please enter '0' if there are no employees for a category. The total number of staff should be the same as the number you provided in the first question of this section.

18-25 years	
26-35 years	
36-45 years	
46-55 years	
56-65 years	
66+ years	

* 12. Does your organisation keep data on the cultural background, gender identity and/or lived experience of workers?

- ○ Yes good data is maintained
- ○ Yes, but the data is not well maintained
- ○ No

Would you like to comment on your response?

13. Please indicate the number of **direct support staff** (full time, part time or casual) **working in mental health services in NSW** who identify with the following CULTURAL BACKGROUND/LIVED EXPERIENCE categories.

If you indicated previously that your data on this aspect of your workers may be non existent or poor, you can provide an estimate or not respond to the question.

Persons with lived experience of mental illness (not just in identified positions)	
Persons with lived experience as a carer (not just in identified positions)	
Aboriginal and Torres Strait Islander	
Culturally and linguistically diverse	
LGBTQIA+	
Unsure or our organisation does not collect this information	

* 14. Please indicate the number (headcount) of staff for each of the following types of non-direct support roles employed by your organisation **working in NSW**.

Management	
Administrative support staff (e.g. receptionist, executive assistant, finance/accounts, marketing)	
Technical support staff (e.g. IT)	

15. Does your organisation have diversity employment targets for any of the categories above?

Please provide information about the targets and/or comments about your organisation's experiences or constraints.

* 16. In this question we would like to understand the qualifications of the Peer Workers, Carer Peer Workers, Mental Health Support Workers and Support Coordinators employed by your organisation.

Please provide an estimate of the % of these staff whose **highest relevant qualification** is one of the following ?

	No formal relevant qualification	% with Certificate III	% with Certificate IV	% with Diploma	% with Advanced Diploma	% with Degree or higher
Peer Workers						
Carer Peer Workers						
Mental Health Support Workers						
Support Coordinator						

Comments

17. Does your organisation collect information about professional registration of staff, such as registration with AHPRA or other professional bodies?

- Yes
- No

Please provide a comment.

* 18. Does your organisation utilise VOLUNTEERS (that is workers delivering support services but not being paid (includes *pro bono* arrangements)?

- Yes
- No

* 19. Please indicate the approximate NUMBER (headcount) of volunteers in your organisation?

SECTION 3: Perspectives on current workforce adequacy

In this section we would like to understand the current vacancy rates in your organisation for mental health specific services/programs for direct care and non-direct care roles (that are related specifically to mental health services).

* 20. Are there currently any funded direct support and non-direct support positions (that is, positions that have a defined and available budget) **to work in mental health services in NSW**that have been vacant for **more than three months**?

- ○ Yes
- ○ No

* 21. How many positions have been vacant for **more than three months**?

Please provide a whole number.

* 22. Of the vacancy number you specified in previous question, please indicate the number of those vacancies for each of the following ROLE/OCCUPATIONAL categories?

Please enter '0' if there are no vacancies. The total number should be the same as the number you provided in the previous question.

Administrative support	
Technical support (e.g. IT)	
Management	
Peer Worker	
Carer Peer Worker	
Mental Health Support Worker	
Support Coordinator	
Psychiatrist/other medical practitioner	
Enrolled Nurse	
Registered Nurse	
Other allied health professionals	

* 23. Of the vacancies you specified above, please indicate the number of vacancies by each of the following LOCATION types?

These locations are based on the Modified Monash Model (MMM) Categories.

Use the search tool to identify the correct MMM location classification.

Please enter '0' if there are no vacancies for a category. The total number should be the same as the number you provided in the previous question.

Metropolitan areas	
Regional centres	
Large rural towns	
Medium rural towns	
Small rural towns	
Remote communities	
Very remote communities	

* 24. For all of these vacancies, please indicate the main reasons you believe have contributed to the vacancies being unfilled for so long? You can choose one or more reasons or add more reasons.

- ☐ Insufficient number of workers with relevant qualifications
- ☐ Insufficient number of workers with appropriate professional association membership
- ☐ Difficult to attract workers to the mental health sector
- ☐ Difficult to attract workers to the service location of the position
- ☐ None of the above - please provide more information
- ☐ Can only offer short term contracts
- ☐ Unable to offer competitive salary
- ☐ Delayed recruitment processes

SECTION 4: Future workforce needs

In this section, we would like to understand what you believe will be the future workforce needs of the community managed mental health sector in NSW.

* 25. From the following list of factors, please choose any you think of**those factors** that are having an influence NOW and/or will have an influence in the FUTURE (over the next five years) on current workforce considerations in your organisation.

Please also indicate if you think the factors are impacting or will impact on an increase and/or decrease in skilled and/or unskilled workforce.

	Now	Future	Increased demand for skilled workers	Increased demand for less skilled workers	Reduced demand for skilled workers	Reduced demand for less skilled workers
MH reform environment at national and State/Territory levels (i.e. 5th plan, NSW MH plan/s)	☐	☐	☐	☐	☐	☐
Service delivery in NDIS environment	☐	☐	☐	☐	☐	☐
Contestable tendering and funding environment	☐	☐	☐	☐	☐	☐
PHN commissioning of mental health services	☐	☐	☐	☐	☐	☐
Funding levels to recruit appropriate staff to meet service demand	☐	☐	☐	☐	☐	☐
None of the above	☐	☐	☐	☐	☐	☐

26. Are there any other factors, not listed above, that you think are influencing the future workforce? Please specify the factors and how they are likely to influence the workforce.

27. Do you have any other comments you would like to make about the future needs of the community managed mental health sector?

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mental health coordinating council

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