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Mental Health Workforce Profile

Community Managed Organisations Mental Health Workforce Report 2021

NEW SOUTH WALES

mhcc
mental health coordinating council

Report preparation

Mental Health Workforce Profile: Community Managed Organisations Report 2021, was prepared by Human Capital Alliance (International) Pty Ltd (HCA) for the Mental Health Coordinating Council, New South Wales to report on the findings from the Community Managed Organisations Mental Health Workforce Survey 2021.

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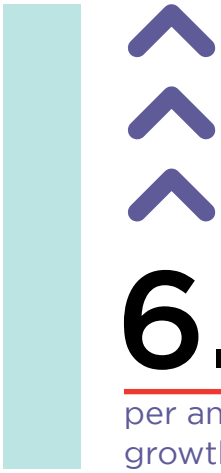
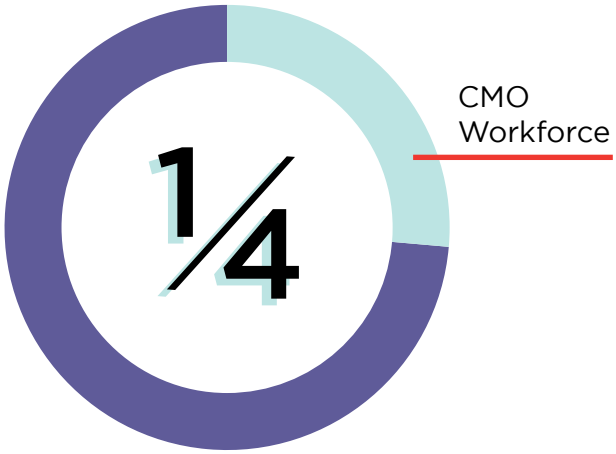
Snapshot:

the community managed mental health workforce in 2021



6.5%

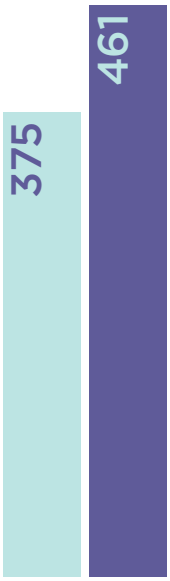
per annum workforce growth



of the entire mental health workforce in NSW works at a CMO

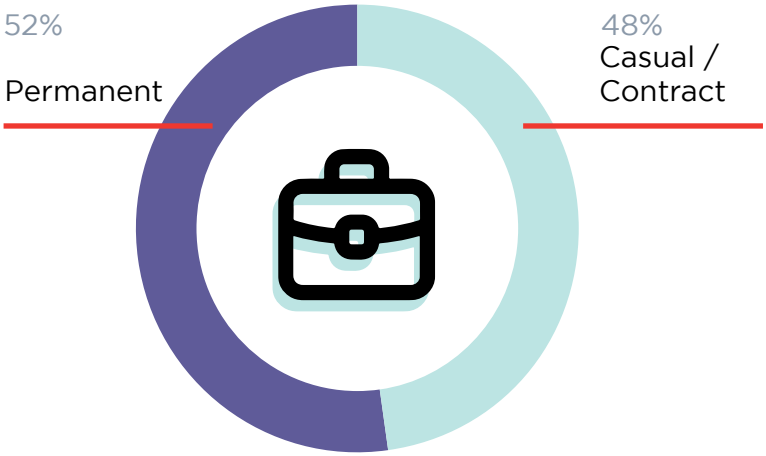
14%

of all workers in the CMO sector are Peer Workers, up nearly 3% in 2 years.



72%

of workers are female



48% of all CMO workers are employed on a temporary contract or casual (hourly rate of pay) basis.

64%

of CMO workers are under 45 years of age

Findings highlights

Workforce 2021

The community managed sector mental health workforce accounts for just over one-quarter, 26.7%, of the total mental health workforce in New South Wales. The size of the community managed mental health workforce is estimated to be 5,838 paid workers, including direct care, managers and administrators, and 2,429 volunteers. In terms of full-time equivalents, the paid workforce is 3,911.3, representing just over one-quarter of the total mental health workforce in NSW, including public sector and private sector employed workers[1]. For all workers, paid and unpaid, the workforce size is 4,111 full time equivalents.

A growing workforce

The 2021 Workforce Survey estimates the full-time equivalent of the paid workforce is 3,911.3, compared with 3,463.9 in 2019, meaning that the workforce has potentially grown by 12.9% over the two years or 6.5% per annum. This is a high workforce growth rate. In 2019, the Workforce Survey estimated the size of the community managed sector mental health workforce to be 4,745 paid workers, compared to 5,838 two years later. Most of the organisations surveyed believe a further increase in workforce numbers, with higher skill levels, will be demanded in the future.

Female dominated and young

The workforce is female dominated, with 72% of all workers female, and nearly two-thirds of the workforce, 64%, under 45 years of age.

Workforce composition changing

Compared to the 2019 Workforce Survey the workforce in 2021 is still primarily made up of Mental Health Support Workers (55%). However, they are not as prominent as they were two years ago when they comprised 63% of the workforce. In 2021 there are significant numbers of Support Coordinators (12%) and Peer Workers (14%).

[1] 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

Peer Worker numbers

The Peer Worker category has increased in both number and proportion since the 2019 Workforce Survey. Peer Workers now make up 14% of the workforce compared to 11.3% in 2019.

Conditions of employment

Almost half the workforce, 48%, is employed on a temporary contract or casual (hourly rate of pay) basis. There is a high level of part time employment, with just over half the workforce (54%) employed on a part-time basis. This places the mental health community managed organisations sector workforce high in the rankings of part-time employment compared with the total Australian workforce (32%).

Better educated

Overall, the mental health community managed sector workforce is better qualified than the general Australian workforce. Qualifications across all categories in the community managed workforce are a mixture of levels ranging from no qualification to an undergraduate degree. The predominant qualification is a relevant Certificate III or Certificate IV.

Places to fill: employment vacancy

There are a number of 'Difficult to fill' vacancies identified by the surveyed community managed organisations. The estimated overall vacancy rate (6%) appears to have grown in size since the 2019 Workforce Survey. Some specific workforce categories are of concern, with quite high vacancy rates among Peer Workers (15%), Psychiatrist/other Medical Practitioners (16%) and Allied Health type workers (27%).

Volunteers, a precious resource

By headcount, volunteers account for an estimated 42% of the community mental health sector workforce, but by full time equivalent that proportion reduces to just 8%. This figure does not include carers or people with lived experience 'working' in self-help groups.

Conclusions from the Survey

The Mental Health Workforce Profile 2021 has revealed notable trends in the Community Managed Organisations (CMO) mental health workforce. It is too early to be definitive, but there is emerging evidence of the continued overall growth of the community managed mental health sector and an increasing demand for a peer workforce.

The forces of change operating on how services in the sector are delivered and workforce decisions influenced appear to be pushing an increased demand for a more skilled workforce. There is a potential recruitment difficulty emerging, especially for specific workforce categories that is over and above the normal disadvantage the CMO sector experiences in competition for labour with public sector services.

Future data collection should be extended to gain a better insight into service, and therefore workforce demand, in addition to estimating supply.

Through the 2019 Mental Health Workforce Survey, Mental Health Coordinating Council and the CMO mental health sector began 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 2019 Workforce Study delivered credible information to guide appropriate workforce development strategies and interventions for building CMO capacity to collect and use data on their own workforce. Findings from the *Mental Health Workforce Profile 2021* largely validate the earlier study results in all aspects.

Perceptions of the future

Most of the surveyed CMOs identified that an increase in workforce numbers, with higher skill levels, will be demanded in the future.

From their perspective, this will be driven primarily by funding levels to recruit appropriate staff, the commissioning of mental health services by Primary Health Networks and contestable tendering and funding environments.

Currently, CMOs believe the demand for workforce is being driven mostly by the National Disability Insurance Scheme (NDIS) environment. This is a factor which will remain an influence in the future but will diminish as the NDIS becomes more established.

The mental health reforms occurring in New South Wales and Australia more broadly, are also likely to influence workforce demand.

Contents

Introduction

Past information on CMO sector mental health workforce

In New South Wales, and nationally, the community managed mental health sector is recognised as a significant component of the mental health workforce. Yet, information about the size and composition of the CMO workforce remains incomplete in terms of both State and Territory and organisational coverage.

Data on the sector is especially limited when 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 national assessment of the CMO mental health workforce was a survey of the mental health non-government organisation workforce conducted in 2009-2010 by National Health Workforce Planning and Research Collaboration (NHWPRC). Just over one-third of the CMO[2] 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, Peer Workers, management roles, administration and Social Workers. Some organisations also employed workers for clinical roles such as Psychologists, Counsellors, Registered Nurses and Occupational Therapists.

In the past, information specifically about the size and composition of the NSW CMO mental health workforce could only be extrapolated from the NHWPRC data. Using the NHWPRC (2011) survey the size of the workforce in NSW was estimated at anywhere between 2,900 and 5,300 workers.

MHCC initiatives

Given this context, in 2019 Mental Health Coordinating Council (MHCC) initiated an employer workforce survey of CMO sector organisations delivering mental health services in NSW to better understand and support decisions about the workforce.

MHCC is the peak association representing not-for-profit mental health organisations 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.

A report on that Survey was published by MHCC (Ridoutt and Cowles, 2019). The 2019 Workforce Survey estimated the total number of people working to deliver mental health services in the NSW CMO sector as 4,745 paid workers and 4,160 volunteer workers. In terms of the paid workforce, this translates into a full time equivalent (FTE) of 3,463 workers.

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

MHCC has again undertaken the employer workforce survey in 2021 to develop trend data about the community managed mental health workforce and provide input into the development of workforce strategies. This new Mental Health Workforce Profile details the findings from the follow up survey.

Improving data about the community managed mental health sector is critical to inform policy development and advocacy. The results of the 2019 and 2021 workforce surveys make a significant contribution to this endeavour. It is also important that the Mental health non-government organisation establishments National Best Endeavours Data Set (MH NGOE NBEDS) which has been implemented in Western Australia and Queensland progress to national implementation.

Method overview of 2021 Survey

The Survey was administered mainly to MHCC membership but also to other non-affiliated CMOs and services working in the Aboriginal Community Controlled Health sector. The Survey tool was modified only slightly from that used in the 2019 Survey, in order to optimise consistency of data collection between Surveys.

A total of 47 organisations responded to the 2021 CMO Workforce Survey. Of the responses a total of 39 were 'viable' (that is all the workforce survey questions were answered). Most viable responses (n = 37) are from MHCC members. Based on MHCC members only, this represents a survey response rate of 52.5% (n=78). The response rate was slightly lower than the 2019 Survey.

For more details on the response rate and how the Survey was run see Appendix 1.

Survey findings

In the following sections results from the Survey data analysis are provided. For a concise description of the surveyed population, including the types of services that CMOs are providing, see Appendix 2.

Workforce size

The total number of workers (head count) employed by the responding organisations for delivery of direct care mental health services was 3025. This represents an average of 79.6 workers (n = 38) specifically delivering mental health services in each responding organisation. However, this average affords limited insight as nine large CMOs (just under one in four) accounted for 2487 or 82% of the total workforce[3]. The strong relationship between organisation size and worker numbers is shown in the table below:

Size of Organisation (*)	Average Numer of staff (head count)
Very Large (>$10 million)	274.8
Large ($2 million to $10 million)	42.3
Medium ($500,000 to $2 million)	20.3
Small ($100,000 to $500,000)	11.8
Very small (<$100,000)	8.0

** Size is based on annual revenue which is captured through MHCC membership*

Three large organisations that responded to the 2019 Workforce Survey did not respond to the 2021 Survey. Conversations with those organisations to elicit a survey response, while not successful, confirmed they are all still significant employers of mental health staff. Combined, they employed 1,282 workers in 2019.

A more accurate estimate of the CMO sector workforce headcount is therefore likely to not be 3,025 but rather 3,025 + 1,282, which is 4,307. This 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 and the estimate from the 2019 Survey of 3,495.

A review of MHCC organisations who did not respond to the 2021 Workforce Survey, other than the three large employers noted above, indicates that a further eight non-respondent organisations were all ‘Large’ or ‘Very large’ organisations. In theory these eight organisations could add approximately a further 1,200 workers to the total. 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%. This estimates the workforce size at approximately 4,740 direct support workers, based on the “more accurate” estimate that includes data from 2019 for the three large non-respondent organisations.

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

The raw head count estimate translates into 2033.9 FTE staffing. This provides an average FTE conversion factor of 0.67 (derived from the calculation FTE [2033.9]/ Head count [3,025]).[4] This is lower than the FTE conversion factor in 2019 (0.73). 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.[5] Given the nature of the work in the CMO sector a higher proportion of the workforce working part-time is anticipated. Using the above conversion factor of 0.67 and applying that to the headcount estimate of 4,740, the estimated direct support workforce FTE is 3,175.8.

In addition to the paid workforce, 26 organisations (62.2%, n = 37) have volunteer staff. In total there were 2208 volunteers (head count) contributing to delivery of mental health services. This translated into an estimated 181.5 FTE. By headcount, volunteers account for an estimated 42% of the CMO workforce, but by FTE that proportion reduces to just 8%. This figure does not include carers or people with lived experience 'working' in self-help groups.

As well as direct support staff, the respondent CMOs identified that 717 workers were working in non-direct support roles. If the same rule adopted above to the direct support workforce is applied, and the workforce numbers for three large organisations that responded in 2019 but not 2021 are included, then the total estimated workforce is as outlined in Table 1.

Table 1: Estimated total number of workers employed in direct and non-direct support roles (n=37)

Direct support role	**Number of estimated workers (headcount)**
Direct support workforce	4,307
Non-Direct support roles	**Number of estimated workers (headcount)**
Management[6]	346
Administrative support staff	570
Technical support staff (e.g. IT)	84
Total non-direct workforce	**1000**

The total number of persons estimated to be working to deliver mental health services in the NSW CMO sector is therefore 5,838 paid workers (applying the 10% extrapolation) and 2,429 volunteer workers (applying the 10% factor). In terms of the paid workforce, this translates into an FTE of 3,911.3 workers and for all workers (paid and unpaid) 4,111 FTE.

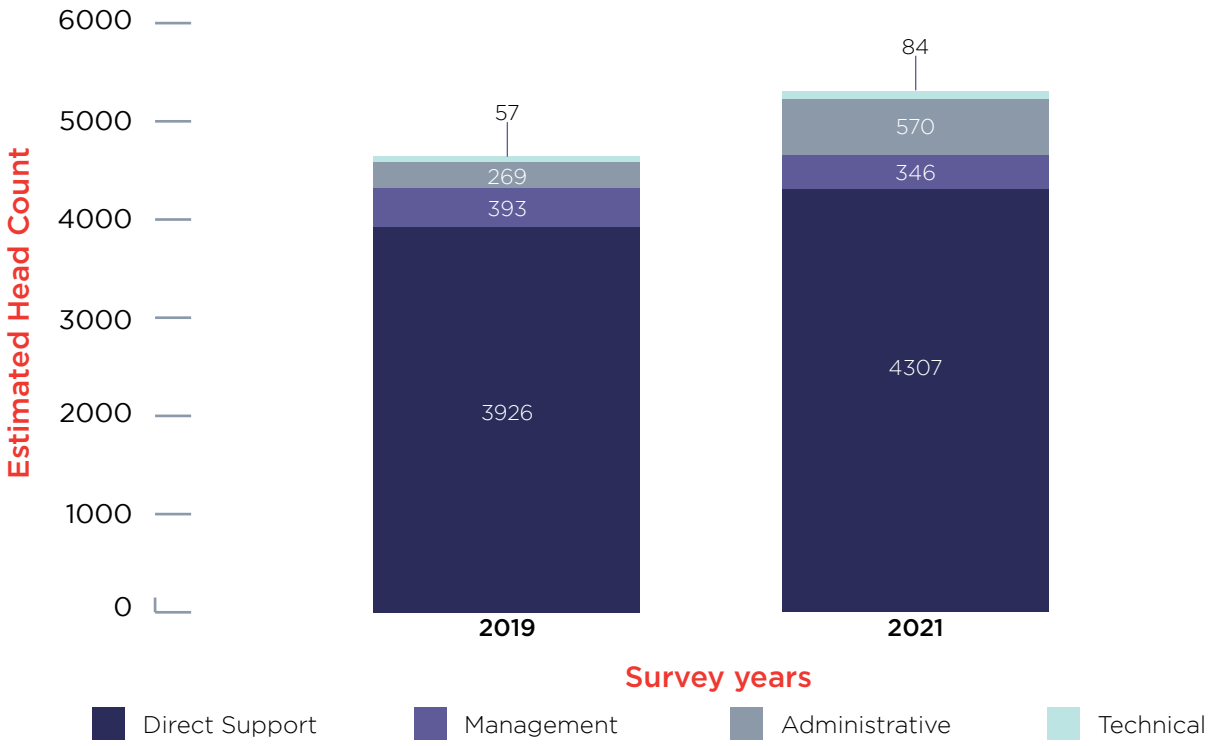
[4] A conversion factor closer to 1.0 indicates a higher proportion of the workforce working fulltime.
[5] Data obtained from AIHW (2017): https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce
[6] This does not include workers who have both management and direct support roles. For example, survey respondents identified 'team leaders', 'coordinators', etc. who had dual roles

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[7] of the mental health workforce not working in the CMO sector (including public and private hospitals, residential care services and public community mental health services). Thus, based on these figures, the CMO sector mental health workforce accounts for just over one-quarter (26.7%) of the total mental health workforce in NSW.

Workforce growth

Comparing the above data with the same estimates from the 2019 survey, Figure 1 shows that there has been considerable growth in the CMO mental health sector workforce. By headcount estimate the paid workforce has grown between 2019 and 2021 by 23 % (from 4,745 to 5,838). By FTE, the growth has been an estimated 12.9% (from 3,463.9 to 3,911.3), less than the head count growth (because of quite different FTE conversion factors) but still considerable annual growth of over 6%.

Figure 1: Comparison of 2019 and 2021 estimates of CMO Mental Health sector paid workforce numbers by head count



By way of comparison, the Australian Institute of Health and Welfare, based on registration authority collected data, estimates the total psychiatrist workforce (all sectors) increased by 1.9% per annum between 2013 and 2016, and the total mental health nursing workforce increased by an estimated 1.5% per annum between 2012 and 2016[8].

[7] Missing workforce elements are mental health practitioners working in private community practice and in services commissioned by the PHNs.
[8] https://www.aihw.gov.au/getmedia/6975aa54-246d-426e-9e33-fec8ec7ce105/Mental-health-workforce-2019.pdf.aspx

Workforce composition

Most of the respondent organisations (63%, n = 38) indicated that their human resources information systems (HRISs) are limited in the level of detail and sophistication to extract accurate data; therefore, they were unable 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 good estimates.

The Workforce Survey findings indicated that female workers represent 72% of the CMO direct support mental health workforce (see Figure 2) and males 27%. Several organisations indicated that they did not hold accurate records for gender identity of their workforce.

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 3.

Figure 2: Gender identity of respondent workforce (n=37)

Table 2: Number of workers by age group (n = 37)

Age groups	Number of workers	Proportion (%) of total workforce
18-25	257	9.9
26-35	880	33.8
36-45	660	25.3
46-55	454	17.4
56-65	286	10.9
66+	69	2.6
Total	**2606**	**99.9**

Respondents indicate that almost half of the workforce in direct support roles are working as a Mental Health Support Worker (49%; Table 3). The other sizeable number of roles were identified as Consumer Peer Workers (14%) and Support Coordinators (8%).

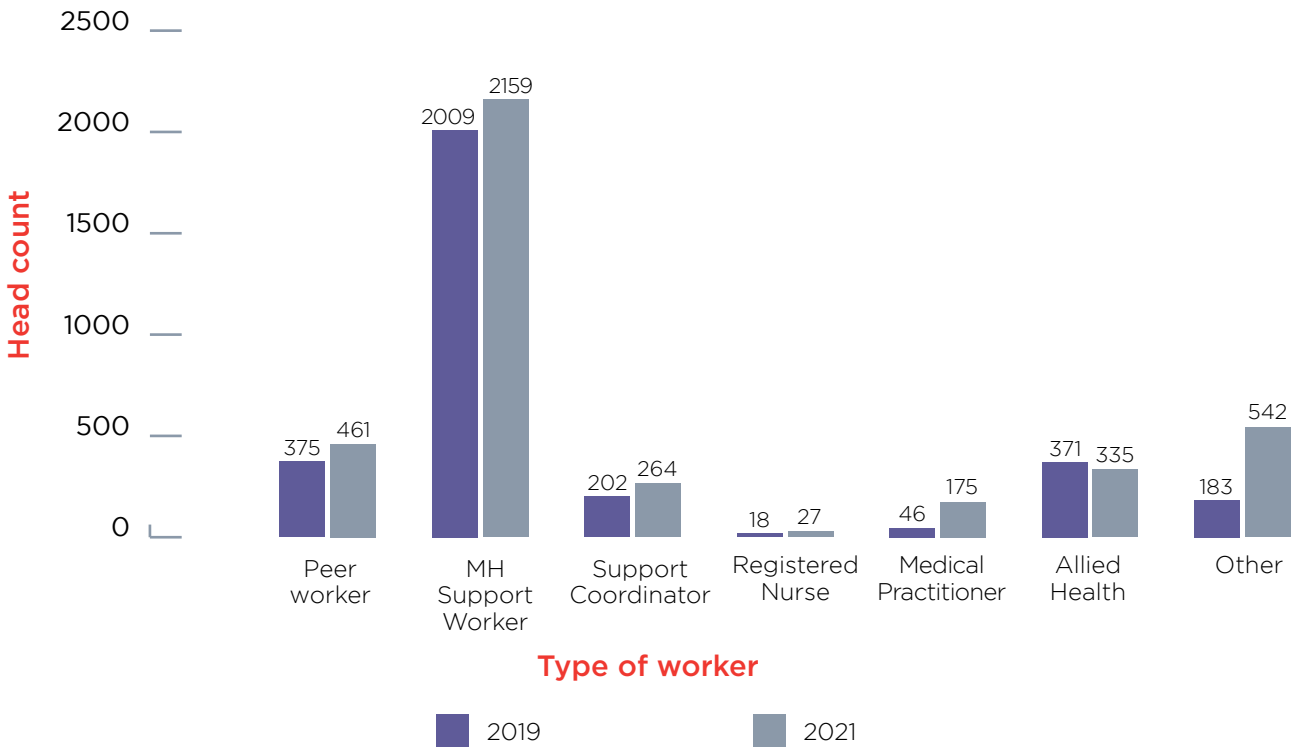
The FTE conversion factor varies considerably between types of workers, with some occupational categories being employed more frequently on a part-time basis than others. For example, Mental Health Support Workers are more commonly employed on a part-time basis compared to Nurses, Allied Health Workers and Support Coordinators.

Table 3: Number of workers by type of direct support roles (n = 34, numbers unadjusted for large missing CMOs)

Type of worker/occupation	Headcount	Proportion of total workforce (%)	FTE	Proportion of FTE workforce (%)
Identified Consumer Peer Worker	394	14.0	237.4	14.3
Identified Carer Peer Worker	4	0.1	0.5	0.03
Recovery Coach	23	0.8	15.3	0.9
Mental Health Support Worker	1372	48.9	911.2	54.9
Support Coordinator	228	8.1	191.3	11.5
Enrolled Nurse	2	0.07	2	0.1
Registered Nurse	17	0.6	12.5	0.7
Psychiatrist/other medical practitioner	141	5.0	66.4	4.0
Allied Health	139	4.9	100.9	6.1
Other	485	17.3	359.8	21.7
Total	**2806**	**99.8**	**1659.4**	

Compared to the 2019 Survey all workforce categories have increased in numbers except for the ‘Allied Health’ workforce category. The proportion of ‘Other’ roles has increased (5.7% to 17.3%).

Figure 3: Comparison between 2019 and 2021 in types of worker employed (Head count[9])



A total of 21 respondents identified a range of 'Other' roles as follows:

- Carer Advocate
- Case Worker
- Client Service Officers[10]
- Child Wellbeing Workers
- Community Development / Health Promotion Officer
- Community Engagement Co-ordinator
- Counsellors[11]
- Crisis Support Workers (specifically trained in suicide intervention and crisis support)
- Employment Consultants
- Parenting Support Worker
- Suicide Prevention Community Development Worker
- Wellbeing Education Consultants
- Youth Engagement Workers CBT

It is possible that some of the roles listed above may be unique to a particular CMO and the type of services they provide (e.g. NDIS) and the way the services are organised. Some CMOs also identified management, coordination and administration roles, noting that sometimes these roles have a direct support component.

Just over one in ten (10.5%) of the direct support workforce are in 'Professional' roles (i.e., Allied Health, Registered Nurses, Medical Practitioners).

[9] Numbers in 2021 adjusted to account for non-responding three large CMOs.
[10] These roles were indicated to often be occupied by Social Worker students
[11] Some respondents may have included these in the allied health count.

Conditions of employment

Just over half (52%) of the workforce is employed on a permanent basis, with the remainder of the workforce being employed on a temporary basis. This includes 13% (down from 18% in the 2019 Survey) who are employed on a casual, hourly basis of remuneration (Table 5).

As noted previously, the workforce has a comparatively low FTE conversion factor which implied that a high number of workers are working part time. The Workforce Survey findings indicate that over half the workforce (54%, n=37) is employed on a part time basis. By way of comparison, the part-time 'Share of Employment' in the total Australian workforce in August 2019 is 32% and the proportion of persons working part-time in the 'Health care and social assistance' industry is 44.3%[12]. This places the CMO sector mental health workforce high in the rankings of part-time employment.

Table 4: Number of workers by employment status (n = 37)

Employment Status	Number of workers	Proportion (%) of total workforce
Permanent full time	810	27.6
Permanent part time	718	24.4
Contract full time	528	18.0
Contract part time	501	17.1
Casual (hourly remunerated)	376	12.8
Total	**2933**	**99.9**

Workplace diversity

Some organisations (21%, n = 38) indicate that they keep accurate data about the diversity of their workforce such as cultural background, gender identity, and lived experience. A further 32% has some data but indicated that it was not well-maintained, and 47% do not keep data on these worker characteristics. This is an improvement on the 2019 Workforce Survey data and is reflected in several comments, for example:

> " Newly introduced and collected in our annual engagement survey. "

> " Very recent changes to our annual staff survey have been implemented to include demographic information about staff and information about staff lived experience. At this stage, I will not respond because I can't estimate these details. "

[12] ABS Labour Market Information Portal, Available: http://lmip.gov.au/default.aspx?LMIP/GainInsights/IndustryInformation

A number of organisations collect worker background details on a voluntary basis:

" Information is provided on a voluntary nature unless specified for job role. Whilst many staff have difficult mental health experiences most choose not to formally identify this. "

A total of 23 respondents (60.5%, n=38 viable responses) used their available data to provide an estimate of the numbers in the different diversity and lived experience categories. These respondents indicate that 518 workers (approximately 17% of all workers in the sector) have lived experience of a mental illness, 50 workers (1.6%) had lived experience as a carer, 94 (3%) are of Aboriginal and/or Torres Strait Islander background, 225 (7.4%) are identified as culturally and linguistically diverse, and 86 (2.8%) were identified as LGBTQIA+. Organisations are unsure of the status of almost 15% of the workforce.

Some respondents indicate that, while they do not have specific 'numerical' diversity targets, there is an intention to connect with and employ a diverse workforce. Some CMOs also indicate that formal strategies or action plans have been developed, such as Reconciliation Action Plans to employ Aboriginal and Torres Strait Islander people, to increase the diversity of their workforce. In the 2019 Survey, the following comment was made by one CMO:

" 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 proportion of respondents (18 of 37 viable responses), therefore, there are limitations on the applicability of this data. Although these 18 respondents together account for two thirds of the total Survey respondent workforce.

Table 5 illustrates that Recovery Coaches and Support Coordinators tend to have higher levels of education, with those holding a relevant degree qualification within these worker categories being 53% and 57% respectively of the 18 respondents. The most common form of worker in the workforce, the Mental Health Support Worker, are most likely to hold a VET level qualification (59% of all workers in this category, n=18), but are also reasonably likely to also possess a degree (29%). Peer Workers are the least likely to hold any formally recognised qualification (14%) or to possess a degree qualification (8%).

The data in Table 5 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 four workforces in Table 5 have a lower proportion of non-qualified workers than the total Australian workforce, a higher proportion of VET qualified workers, and Recovery Coaches and Support Coordinators have a higher proportion of degree qualified workers.

Table 5: Proportion of workers by level of qualification (n=17)[13]

Types of Workers	Level of Qualification					
	No formal relevant qualifications	Certificate III	Certificate IV	Diploma	Advanced Diploma	Degree or higher
Consumer Peer Workers	14.4	12.2	39.4	12.8	11.7	8.3
Recovery Coaches	0	0	13.3	16.6	16.6	53.3
Mental Health Support Workers	8.2	7.3	30.9	20.9	3.6	29.0
Support Coordinators	1	2	6	23	11	57

The approach to qualifications for volunteers is seemingly less demanding than for the paid workforce. Of the organisations who responded to the question about minimum qualifications sought for volunteers to work in the mental health area (n = 28, or 75% of viable responses), most organisations (78.6%) do not require any qualification to work as a volunteer, while 17.8% required at least a Certificate level minimum and 3.6% required a degree as a minimum.

The approach to qualifications is partly explained by the type of work they are required to perform. As one organisation noted:

> **" This [the qualification requirement] depends on the work they are volunteering to do. If they are counselling, they need to have relevant formal qualifications. "**

It can also be explained by the companion approach to training of volunteers, demonstrated in the following quote:

> **" We always train our volunteers. Working with us is helping them work towards fulltime paid employment with other organisations. Our past volunteers include the CEO and one of our psychologists. "**

Volunteers are used for a wide variety of tasks within organisations. Indeed, there is significant variation between organisations in their approach to volunteer usage. Some illustration of the different approaches taken by organisations is provided in the sample list of ways volunteers are deployed, as seen in the Survey responses listed below:

- Cleaning, talking to clients and engaging with them, support to run the service
- Volunteers are student placements. They learn about the model of practice, participate in supervision, peer reflection, and do up to two shifts, or group work with paid workers where appropriate

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

- Administration and IT support
- Counselling and group meeting, phone and online support
- Advice, outreach patrols, serve tea at groups, admin duties
- Social inclusion supports
- Volunteers provide services that fit within their skillset such as cooking, gardening, cleaning, spending time with residents, IT services etc. These are supplementary to paid workforce staff
- Support the paid workforce
- Facilitate our support groups. Some administrative tasks
- Text volunteers providing crisis support through our text service
- Undertaking counselling work that would otherwise be done by paid workforce, filling roles also in the community visitor's scheme - visiting socially isolated LGBTQ+ elders
- Volunteers work within our organisation as board of governance, media, client grief support, reception and support paid employees. The tasks performed could otherwise be done by paid staff. Our organisation was built and shaped through 100% volunteer service
- Volunteers do not perform paid worker duties. They provide meaningful connections, fundraise, manage events, help build community awareness and provide assistance at times of vulnerability e.g., pop in visits to provide shopping or food, look after pets
- Tutoring and driving instruction primarily
- Our volunteers work on our telephone crisis support line, text and online service and face-to-face counselling
- Provide supervision support and are trained in conducting our psychoeducation 'chat group' sessions which they also run.

Perspectives on current workforce adequacy

Just over 60% of respondent organisations (23, n = 38) indicate that they had vacant funded positions in the last six months. Of these, 19 respondent organisations (50% of total viable respondents) indicate that at least some of their vacant positions have been 'difficult to fill'[14]. The total number of 'difficult to fill' vacancies was 207, which provides a medium-term vacancy rate estimate of 6.8% (based on the estimated workforce size[15]). This finding is similar to the 2019 Workforce Survey result but does not suggest there is a significant current recruitment difficulty for workforce in the CMO mental health sector[16].

In the 2019 Survey findings, 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. In this Survey the 'difficult to fill' vacancies are more evenly distributed although one organisation still accounts for just over 44% of all such vacancies.

[14] Difficult to fill positions might be those vacant for more than is normal through human resource processes, positions that had to be filled with a less experienced or less qualified person than desired, or some other reason.
[15] A vacancy rate of 5% or lower is considered normal.
[16] The 'vacancy rate' in 2021 is higher than for 2019, suggesting the possibility of an emerging issue. However, the basis of the 'vacancy rate' calculation was different in the two years so direct comparison is

Many of the identified 'Difficult to fill' vacancies (30%, n=207) are still for identified Consumer Peer Workers (see Table 6). Other meaningful vacancy numbers are for Mental Health Support Workers (32%) and Allied Health Workers (18%). Perhaps more interesting than the absolute numbers, is the relative vacancy rates which show that some workforce categories have quite high vacancy rates including Peer Workers (15%), Psychiatrist/other Medical Practitioners (16%) and Allied Health type workers (27%).

Table 6: Distribution of 'Difficult to fill' vacancies by workforce categories employed

Type of worker/occupation	Workforce Headcount (taken from table 4)	'Difficult to fill' vacancy count	Vacancies as a proportion of workforce category (%)
Identified Consumer Peer Worker	394	62	15.4
Identified Carer Peer Worker	4	0	0
Recovery Coach	23	3	13.0
Mental Health Support Worker	1372	67	4.9
Support Coordinator	228	22	9.6
Enrolled Nurse	2	1	50.0
Registered Nurse	17	1	5.9
Psychiatrist/other medical practitioner	141	23	16.3
Allied Health	139	37	26.6

Most of the 'Difficult to fill' vacancies (85%) are in metropolitan areas or regional cities, while most of the rest (23%) are in large rural towns. The most common reasons for vacancies are 'Insufficient number of workers with relevant qualifications' (52% of organisations experiencing difficulties, n = 23) and 'Difficult to attract workers to service location of the position' (43%). A smaller proportion of organisations (22%) indicate the difficulty arose because they are 'Unable to offer competitive salary'. Some other reasons offered that made positions 'Difficult to fill' included:

- Only offer fixed term contracts
- New NDIS Worker Screening and other probity checks are causing delays with recruitment.
- Have had some workers leave to do independent NDIS work as they stated they were attracted to the higher remuneration and flexibility. This may add to some difficulties with attracting suitable and qualified candidates.
- As a faith-based organisation there are additional hiring hurdles.
- Not enough Psychologists in regional areas.

Drivers of current and future workforce demand

Only 32 of the 39 viable respondents completed Section 4: Future workforce needs of the Survey. Between 62% and 94% of the respondents to this section indicated that all the factors posed are currently having an impact on workforce demand (see Figure 4). 'Funding levels to recruit appropriate staff to meet service demand' is identified as the most influential factor on current workforce demand (97% of CMOS, n = 32) followed by the NDIS environment and Primary Health Network commissioning (both 84%).

The findings are similar to those in the 2019 Survey, except that the relative influence of the mental health reforms on current workforce demand is considered less by many CMOs.

Figure 4: Proportion (%) of respondents selecting factor as having an impact on current workforce demand (n= 32)

Key to factors:

A = Mental Health reform environment

B = Service delivery NDIS environment

C = Contestable tendering and funding environment

D = PHN commissioning of mental health services

E = Funding level to recruit appropriate staff to meet demand

Irrespective of the type of factor impacting current workforce demand, the overwhelming outcome of any of those factors appears to be an increased demand for skilled workers. Between 59% and 69% of organisations identified increased demand for skilled workers as the immediate outcome from specific influencing factors (see Table 7). 'Service delivery in the NDIS environment' went some of the other way with 31% of organisations identifying an increased demand for less skilled workers as an outcome of that influence factor. A small proportion of organisations identified some factors having potentially contrary outcomes. for instance, 'Contestable tendering and funding' is perceived to both increase demand for skilled workers (56%) and increase demand for less skilled workers (16%).

Table 7: factors currently influencing workforce demand in the CMO sector (n = 32)

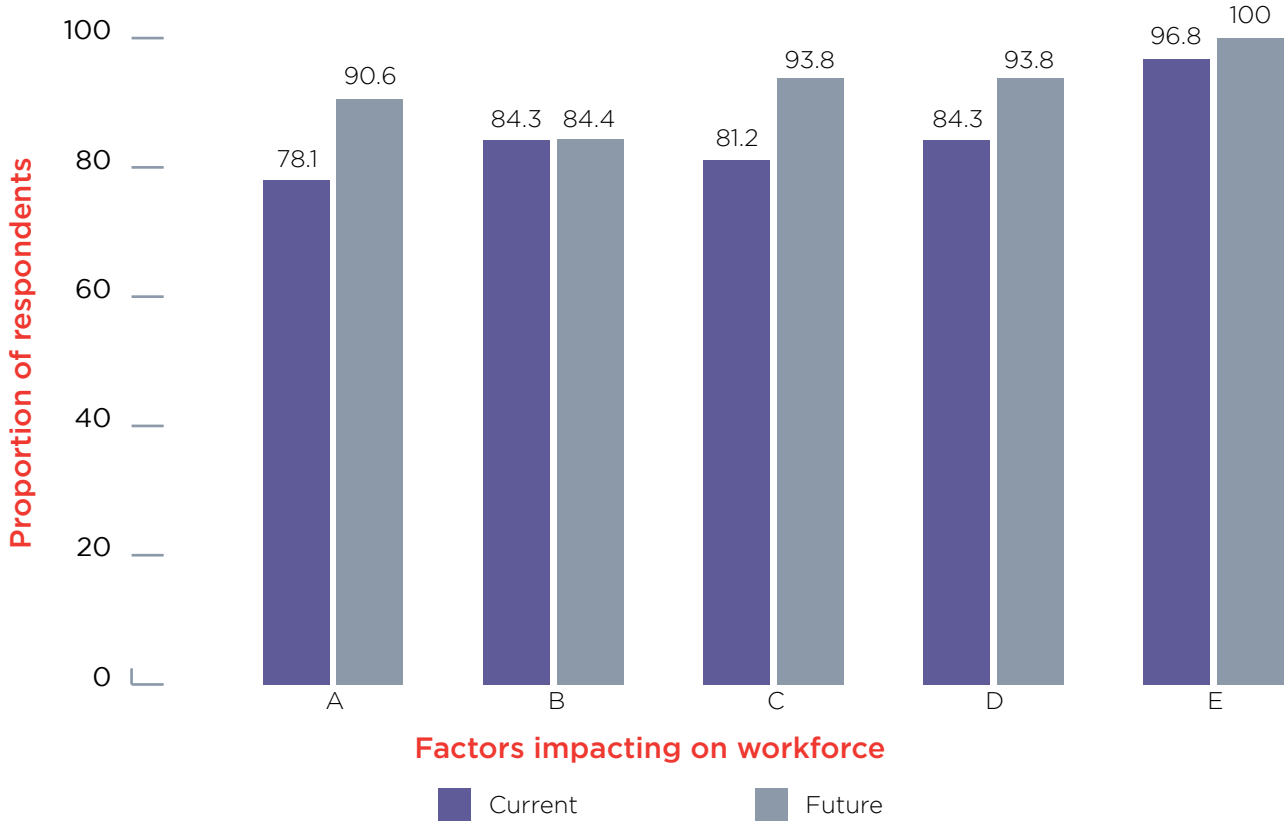
Type of factor influencing demand	Increased demand for skilled workers	Increased demand for less skilled workers	Reduced demand for skilled workers	Reduced demand for less skilled workers
MH reform environment at national and State/Territory levels	62.5	15.6	3.1	3.1
Service delivery in NDIS environment	59.3	31.3	9.4	6.3
Contestable tendering and funding environment	56.3	9.4	15.6	9.4
PHN commissioning of mental health services	68.8	6.3	12.5	6.3
Funding levels to recruit appropriate staff to meet service demand	65.6	25.0	12.5	9.4

Other, sometimes related but also quite specific factors, are identified by Survey respondents as influencing current workforce demand. These include:

- Funding has been targeting awareness and screening initiatives which has in turn increased demand on services. There is a limited pool of perinatal specialised clinicians available and therefore funding needs to be directed at workforce development to meet the demand.
- Some tenders are not funded adequately to be able to offer sufficient remuneration to attract appropriately trained and experienced staff given the complexity of the client cohort. This could result in a downward pressure on remuneration and consequentially a less than optimal match between staffing experience and ability and client need.

Survey respondents appear to believe that the five factors currently influencing the workforce demand shown above will be even more influential in the future (see Figure 5). Over 8 out of 10 CMOs consider all five factors will be influential in the future although some, the 'Mental Health reform agenda', 'Contestable tendering' and 'PHN commissioning' could become more influential than currently experienced.

Figure 5: Proportion (%) of respondents selecting factor as having an impact on current and future workforce demand (n= 32)



Key to factors:

A = Mental Health reform environment

B = Service delivery NDIS environment

C = Contestable tendering and funding environment

D = PHN commissioning of mental health services

E = Funding level to recruit appropriate staff to meet demand

In a similar way to current influence of the selected factors on workforce demand, future influence is strongly considered to increase demand for skilled workforce (see Table 8).

Table 8: Factors that will influence workforce demand in future in the CMO sector (n = 32)

Type of factor influencing demand	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	84.4	18.8	3.1	3.1
Service delivery in NDIS environment	56.3	34.3	6.3	6.3
Contestable tendering and funding environment	75.0	28.1	12.5	6.3
PHN commissioning of mental health services	84.4	28.1	3.1	3.1
Funding levels to recruit appropriate staff to meet service demand	75.0	40.6	6.3	3.1

Survey respondents identify as possible influences on demand some other factors, other than the five key factors noted above:

" Reduced block funding dollars... organisations being asked to do more for less funding "

Some other broader comments are made by respondents to the issue of factors impacting on workforce demand. Some of these comments reinforce the factors of influence already canvassed above while others highlight other, but still related issues below:

" Competitive tendering and insecurity with Government contracts reduces capacity of organisations to recruit more permanent workforces. Recruitment of suitably qualified people will remain a challenge unless more on the job training is supported in the sector. "

" A small CMO is challenged on multiple fronts. It is extremely difficult to compete with the private sector for resources (they pay much higher salaries) and with large charities for grant and government funding (they have dedicated fundraising resources). We find ourselves investing heavily in interns and student placements only to have them poached by the private sector or government organisations, soon after they get registered. This impacts our financial sustainability and our ability to yield a good return on the investments we make. Yet the efficiency and effectiveness of grass root organisations should not be under-estimated. Community mental health organisations need to also build financial sustainability plans which means finding a balance between accessibility and affordability (for clients) and sufficient revenue (through multiple streams) to attract and retain quality talent. "

" ... mental health funding for specialist LGBTQ+ service delivery is sparce. And we know the community wants to have service choice - specialists LGBTQ+ services and inclusive general service providers. For this reason, the community managed mental health sector would benefit from inclusive practice training to ensure services are inclusive of people of diverse gender and sexualities and their families/carers. "

" It should be a rosy future, with CMO's providing the variety of options that facilitates engagement and recovery but the whole MH sector needs to become a lot more accountable for outcomes along with public run services operated directly by Health that CMOs should be collaborating with in care delivery. "

Discussion

Employer surveys are a common but may be imperfect means of undertaking workforce research (HCA, 2013). Nevertheless, they are often used where no other option is available (e.g., when a workforce is unregistered). The primary concern with an employer survey method relates to estimating key workforce variables such as workforce size, that are highly sensitive to population sampling (have all possible employers been included in the survey administration?) and survey response rate (did all surveyed employers respond?).

The response rate is important particularly because (1) there is often concern that the non-respondent population is different to the respondent population which then means (2) that it is difficult to extrapolate the findings to the entire population.

In the case of the NSW CMO sector mental health workforce, in the absence of a comprehensive and routinely collected data set like the Mental health non-government organisation establishments National Best Endeavours Data Set (MH NGOE NBEDS), and whilst acknowledging the above flaws, an employer survey still represents the most viable option.

Every attempt was made to optimise the response rate achieved for this project. A response rate of 52% of MHCC membership is very reasonable by most survey standards. Moreover, it is most likely that, except for the three previously noted CMOs, the bulk of the non-respondent CMOs are small and not employing or employing very few workers. Therefore, and despite all the caveats that need to be taken into account in interpreting the findings from survey collected data, the 2021 CMO Mental Health Workforce Survey findings provide strong support to the validity of new and 2019 Survey data.

The composition of the CMO Mental Health sector workforce remains female dominated (like much of the rest of the health workforce) and comparatively young when compared with other mental health sector workforces. The cause of the comparative youth of the workforce was not explored through the survey but it could be hypothesised that the CMO mental health sector is seen as an appropriate entry level to the mental health workforce, both for VET and degree qualified workers. The relative youth of the workforce is then maintained through turnover as experienced workers seek higher remunerated and/or more stable employment in other sectors. Retaining workers for longer in the sector poses a genuine challenge.

Discussion of the 2019 Survey findings hypothesised that the CMO sector mental health workforce had grown by just under 2% per annum since 2011. The 2019 Survey estimated the size of the CMO sector mental health workforce to be 4,745 paid workers (this is both in direct support and managers/administrators). In full-time equivalents, the paid workforce was 3,464. The 2021 Workforce Survey estimates the full-time equivalent of the paid workforce is 3,911, meaning that the workforce has potentially grown by a considerable 12.9% or 6.5% per annum. CMOs believe recent demand for workforce is being driven most by the National Disability Insurance Scheme environment, a factor which will continue to be of influence in the future but not as strong.

Most of the surveyed CMOs still feel that a further increase in workforce numbers, with higher skill levels, will be demanded in the future. From their perspective this will be driven primarily by PHN commissioning of mental health services, and the ‘contestable tendering and funding environment’.

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 proportion of the non-qualified workforce. The increase in the relative vacancy rate between 2019 and 2021, while still manageable, could also undermine workforce growth in the future, especially for those categories of workforce currently with much higher levels of vacancies. Some of those categories, for example Peer Workers, are relatively important to the growth ambitions of the sector.

Through this Survey, MHCC and the CMO mental health sector, have consolidated their understanding of the size, nature and context of the workforce and the factors driving growth in demand. The findings provide an important insight into immediately appropriate workforce development strategies and interventions for building CMO capacity to collect and use data on their own workforce.

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 Mental Health Commission, Sydney.

Ridoutt, L. and Cowles, C. (2019). *The NSW CMO Mental Health Workforce: Findings from the 2019 MHCC Workforce Survey.* Mental Health Coordinating Council, NSW.

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

Appendix 1: Method

Survey design

A single survey was developed comprising a total of 28 questions of fixed and open response style.

The Workforce 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 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 3.

Process

A single survey was developed comprising a total of 28 questions of fixed and open response style (see Appendix 1 and Appendix 2). As much as possible the 2021 Survey design remained consistent with the 2019 Survey to allow comparative analysis. The Survey was administered to 105 CMOs, 78 of which were MHCC members. This sample population was considered representative of the majority, if not all, CMOs delivering mental health services in NSW. A range of initiatives was implemented to optimise the response. A response rate of 52.5% was obtained from the MHCC surveyed population.

For some of the 28 questions, especially those that explored more detailed elements of a CMO's staffing, only estimates (or non-responses) were provided by some CMOs. These CMOs tended to possess unsophisticated human resource information systems or limited methods for collecting Human Resources (HR) information.

The sample population

To gather the broadest understanding of the mental health workforce in New South Wales, the Survey was extended to:

- all Mental Health Coordinating Council member organisations,
- all organisations who completed the Survey in 2019
- non-member community mental health sector organisations identified by MHCC
- selected Aboriginal Community Controlled Health Services, and
- selected Primary Health Networks.

Promotion and administration of the survey

Creating awareness of the Survey and encouraging engagement to complete was carried out across multiple channels in the weeks leading up to and during the Survey.

Promotion

- Stories highlighted key findings from the 2019 Survey were shared on MHCC channels through a series of social media posts on Facebook, Twitter and LinkedIn, and published in the e-newsletter FYI in the three weeks prior to sending the Survey. The Survey was promoted in Mental Health Australia's e-newsletter CEO Update and the NCOSS Sector e-news in April 2021.

Administration

- The Survey was sent out to all identified organisations throughout April, with a deadline of 15 May 2021.

Follow up

- Email reminders were sent to organisations two weeks and one week prior to the Survey deadline. Further reminders were included in FYI. Large CMO employers and ones who completed the 2019 Survey were targeted for follow-up via telephone contact.
- The Survey deadline was extended until 21 May 2021 to allow time for as many organisations to complete as possible.

Response rate

A total of 47 organisations responded to the survey. Only 39 of these responses were 'viable' as determined by completed responses to question five of the survey (see Appendix 1) which asked respondents to provide a headcount and FTE of all staff working in direct support roles. Most responses (n=41 in total, n = 37 viable responses) are from MHCC members. Therefore, based on MHCC members only, this represents a survey response rate of 52.5% (n=78). The response rate was slightly lower than the 2019 Survey.

Based on knowledge of the sector from the 2019 Survey, most large CMOs (with several notable exceptions) that are direct support providers of psychosocial rehabilitation and recovery support services are captured through the Survey, and therefore the findings presented in this Mental Health Workforce Profile are representative of the sector.

Apart from non-responses, there are also limitations to the data collected in relation to the quality of some CMO 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.

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.

Appendix 2: Responding providers 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. co-existing conditions, alcohol and other drug services)

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

Most Survey respondents (63%, n=46) 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 under one quarter (24%) of the responding CMOs identified as Type 1. This finding is quite different to 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 CMOs were providing mental health programs in addition to other programs (Type 2 services), and
- 44.5% of CMOs were Type 3 mental health support providers.

The more focused nature of the survey sample population selection (on MHCC membership) in this study might help explain the large composition differences.

For this Survey an increasingly accepted and standardised taxonomy of service types was adopted - *the Mental health non-government organisation establishments National Best Endeavours Data Set* (MH NGOE NBEDS)[17]. 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 in the previous (2019) Survey was an 'Intake/assessment/triage service', and the least prevalent service was 'Service integration infrastructure'. In the 2021 survey the types of activities undertaken had changed considerably (see Table 3). The most prevalent areas of activity now were 'Group support activities' (70% of CMOs, n = 46), 'Counselling, support, information and referral-telephone' (67%), 'Mental health promotion' (61%), and 'Counselling-face-to-face' (59%).

[17] Metadata Online Registry, Accessed 05.07.2021, Available: https://meteor.aihw.gov.au/content/index.phtml/itemId/494729

Table 9: Types of mental health services delivered by respondent CMOs (n = 46)

Mental health services provided by CMOs	Number of CMOs	Proportion of total CMOs
Counselling-face-to-face	27	58.7
Counselling, support, information and referral - telephone	31	67.4
Counselling, support, information and referral - online	18	39.1
Intake / Assesment / Triage for referral to other service	20	43.4
Self-help - online	7	15.2
Group support activties	32	69.6
Mutual support and self-help	11	23.9
Staffed residential services	9	19.6
Personalised support - linked to housing	12	26.1
Personalised support - other	22	47.8
Family and carer support	22	47.8
Individual advocacy	18	39.1
Care Coordination	26	56.5
Service integration infrastructure	4	8.7
Education, employment and training	20	43.5
Sector development and representation	11	23.9
Mental health promotion	28	60.9
Mental illness prevention	24	52.2

Previous attempts to understand the nature of CMO sector service mix in NSW, albeit using a different list of service types, have found a similar emphasis on activities to the results of this Survey.

For instance, in 2010 a MHCC study identified ‘self-help group support’, ‘accommodation’ and ‘counselling’ as the main areas of program activity (MHCC, 2010). Nationally collected data though found the most prominent service area types were ‘recovery planning’, ‘education and training’ and ‘peer support’ (NHWPRC, 2011).

Based on these comparisons it seems that CMO service activity has changed over time, possibly in response to funding trends but maybe also as the understanding of 'best practice' evolves.

Twelve survey respondents nominated other mental health services being delivered, not from the 18 listed above. These included:

- Financial Counselling
- Homelessness
- Indigenous specific Mental Health support including Suicide Postvention
- Residential healing program
- Suicide prevention and postvention
- Systemic advocacy and representation

Appendix 3: Survey Tool

MHCC CMO Workforce Survey 2021

1.

Thank you for taking part in the CMO Mental Health Workforce Survey 2021. By completing the Survey you are helping deliver credible information to guide appropriate strategies and interventions for building CMO workforce capacity into the future.

* 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)	
Post Code of Respondent if not head office	
Email address	
Phone number	

MHCC CMO Workforce Survey 2021

2. SECTION 1: Details about your organisation

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

1

Appendix 3: Survey Tool

* 2. 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

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3.

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%

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4.

2

Appendix 3: Survey Tool

* 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

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MHCC CMO Workforce Survey 2021

5. 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.
For those organisations with significant staffing but without an accessible human resource information system, some of the following questions may be difficult to complete. We would prefer that you provide estimates if that is what is required rather than leaving questions uncompleted.

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Appendix 3: Survey Tool

* 5. What is the total number (head count) and Full Time Equivalent (FTE) of **all paid direct support staff employed by your organisation who are working in NSW in mental health specific services.**

Please include in the headcount all fulltime, part-time and casual staff or contracted staff.

**FTE is normally calculated by adding up hours worked by all staff (fulltime, part-time and casual) and dividing all hours worked by 38. FTE should not be greater than the head count. We accept that counting the hours of casuals might be difficult since their hours might vary from week to week. If that is the case just make an estimate of the average weekly hours of casuals.

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. In Question 5, what was the basis of your response?

- ○ Estimated using organisation's HRIS data
- ○ Estimated by other means

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Appendix 3: Survey Tool

* 7. 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 HEADCOUNT number you provided in Question 5.

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

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

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Appendix 3: Survey Tool

9. 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	
Recovery Coaches	
Mental Health Support Worker	
Support Coordinator	
Enrolled Nurse	
Registered Nurse	
Psychiatrist/other medical practitioner	
Other allied health professional	
Other (please specify the number)	

* 10. 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 for HEADCOUNT in Question 5.

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

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Appendix 3: Survey Tool

* 11. 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 for the HEADCOUNT in Question 5.

Male	
Female	
Other identity	

* 12. 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 HEADCOUNT number you provided in Question 5.

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

* 13. Please indicate the number (headcount) of staff for each of the following types of non-direct support roles employed by your organisation **working in mental health programs in NSW**.
We recognise that administrative and technical staff often work across multiple programs, some of which might not be mental health. Please include staff in the count only if they are working at least sometimes in mental health programs.

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

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Appendix 3: Survey Tool

* 14. 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?

15. Please indicate the number of **direct support staff** (full time, part time or casual) **working in mental health services in your organisation 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 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	

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* 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 qualification relevant to mental health** 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						
Recovery Coaches						
Mental Health Support Workers						
Support Coordinator						

Comments

* 17. Does your organisation utilise VOLUNTEERS (that is workers delivering support services but not being paid, including *pro bono* arrangements) to undertake mental health work?

- Yes
- No

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* 18. Please indicate the approximate NUMBER (headcount) of volunteers working for your organisation in NSW in the area of mental health services?

We realise it will be difficult to estimate an FTE for your volunteer workforce given total hours worked will be hard to calculate, but can you please also provide an FTE estimate for your volunteer workforce?

Number of volunteers (HEADCOUNT)

FTE estimate for volunteer workforce

19. Can you briefly describe the type of work that volunteers normally perform? For instance do volunteers support the paid workforce? Do they perform work that might otherwise be done by paid workforce?

20. Which of the following types of minimum qualifications does your organisation seek in your volunteers to work in the mental health area?

- [ ] No formal qualifications required
- [ ] Certificate qualification (III or IV)
- [ ] Diploma
- [ ] Degree
- [ ] Other (please specify)

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8. 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).

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Appendix 3: Survey Tool

* 21. Have you had any vacancies in funded **direct support** positions in your organisation in the last 6 months (that is, positions that have a defined and available budget) **to work in mental health services in NSW**?

- Yes
- No

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* 22. Would you classify any of the vacant positions in Question 21 as '***difficult to fill***'? Difficult to fill positions might be those vacant for more than is normal with your human resource processes, positions that you had to fill with a less experienced or less qualified person than desired, or some other reason.

- No
- Yes (Please provide the number in the box below)

Specify the number of 'difficult to fill' vacancies as a whole number

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Appendix 3: Survey Tool

23. Of the 'difficult to fill' vacancy numbers you specified in Question 22, 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.

Recovery Coach	
Peer Worker	
Carer Peer Worker	
Mental Health Support Worker	
Support Coordinator	
Psychiatrist/other medical practitioner	
Enrolled Nurse	
Registered Nurse	
Other allied health professionals	

24. Of the vacancies you specified in Question 22, 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	

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Appendix 3: Survey Tool

25. For all of the 'hard to fill' vacancies you identified in Question 22, please indicate the main reasons you believe have contributed to the vacancies being 'hard to fill'. 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
- [ ] Other - please provide more information
- [ ] Can only offer short term contracts
- [ ] Unable to offer competitive salary
- [ ] Delayed recruitment processes

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10. 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.

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Appendix 3: Survey Tool

* 26. From the following list of factors, please choose any of **these factors** that you think are having an influence ***NOW*** on current mental health workforce considerations in your organisation in NSW.

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

	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	☐	☐	☐	☐

Some other factors could be ...

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Appendix 3: Survey Tool

* 27. From the following list of factors, please choose any of **the factors** that you think will have an influence in the ***FUTURE*** (over the next five years) on mental health workforce considerations in your organisation in NSW.

Please also indicate if you think the factors will produce an impact that leads to an increase and/or decrease in skilled and/or unskilled workforce.

	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	☐	☐	☐	☐

Some other factors could be ...

28. 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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