Mental Health Non-Government Organisation Workforce Project

Final Report

Report by the National Health Workforce Planning & Research Collaboration

May 2011
## Contents

Preface  iv  
Acknowledgements  v  
1 Executive summary  vi  
  1.1 Project Objective  vi  
  1.2 Project Context  vi  
  1.3 Project methodology  vii  
  1.4 Landscape Survey results  viii  
  1.5 Workforce Survey results  x  
  1.6 Key issues and findings for future data collections  x  
  1.7 ERG recommendations for future studies of the sector  xi  
2 Introduction  13  
  2.1 Objectives of the project  13  
  2.2 Background to the project  13  
  2.3 Mental health – a national health priority area  13  
  2.4 Description and role of the Mental Health NGO sector  18  
  2.5 Mental Health NGO Workforce  21  
3 Project overview  24  
  3.1 Project outline  24  
  3.2 Definition of terms  25  
4 Identifying the number of Mental Health NGOs  27  
  4.1 Project method utilised for identifying Mental Health NGOs  27  
  4.2 Limitations of project method for identifying the number of Mental Health NGOs  29  
5 Landscape and Workforce Survey Methodology  31
<table>
<thead>
<tr>
<th>Appendices</th>
<th>Appendix 1</th>
<th>Service and program categories</th>
<th>92</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appendix 2</td>
<td>Workforce Survey results</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survey respondent profile and demographics</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survey respondent qualifications</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health training and education</td>
<td>108</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employment history</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current employment</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruitment and retention</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>Appendix 3</td>
<td>Feedback on the Landscape Survey data items</td>
<td>128</td>
</tr>
<tr>
<td></td>
<td>Appendix 4</td>
<td>Feedback on the Workforce Survey data items</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>Appendix 5</td>
<td>Landscape Survey Tool</td>
<td>145</td>
</tr>
<tr>
<td></td>
<td>Appendix 6</td>
<td>Workforce Survey Tool</td>
<td>161</td>
</tr>
<tr>
<td></td>
<td>Appendix 7</td>
<td>Expert Reference Group membership</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td>Appendix 8</td>
<td>References</td>
<td>175</td>
</tr>
</tbody>
</table>
Preface

In 2006 the Council of Australian Governments (COAG) agreed to a significant national health workforce reform package to enable the health workforce to better respond to the evolving care needs of the Australian community, while maintaining the quality and safety of health services. The COAG package included the establishment of the National Health Workforce Taskforce (NHWT) to undertake project-based work and advise on and develop workable solutions for workforce innovation and reform. The NHWT ceased operation with the establishment of Health Workforce Australia (HWA), which assumed responsibility for the ongoing commitments and work program of the Taskforce in 2010. HWA was established by COAG through its 2008 National Partnership Agreement on Hospital and Health Workforce Reform and tasked with facilitating more effective and integrated clinical training for health professionals, provide effective and accurate information and advice to guide health workforce policy and planning, and promote, support and evaluate health workforce reform.

The National Health Workforce Planning and Research Collaboration (‘the Collaboration’) was established by the former Taskforce. The Collaboration is a tri-partite partnership between the Australian Health Workforce Institute, PricewaterhouseCoopers (PwC) and the NHWT (now HWA), and was created to undertake a significant body of national health workforce research over a three-year period, including advice and development on future supply and demand models for the health workforce.

The ‘Mental Health Non-Government Organisation (NGO) Workforce Project’ was undertaken by the Collaboration to assist in improving the understanding of the existing non-government mental health sector and its workforce. To date there has been no national picture of the sector or its workforce. This project aimed to create a workforce planning tool for future planning, and to achieve a minimum dataset for the workforce, along with national data and information on the sector and its workforce. The views in this report are those of the authors and do not necessarily represent those of NHWT or HWA.
Acknowledgements

This project was funded by the National Health Workforce Taskforce and conducted as part of the National Health Workforce Planning and Research Collaboration program of work. Thanks to the members of the Expert Reference Group who provided extensive support and advice.
1 Executive summary

1.1 Project Objective

The Mental Health Non-Government Organisation (Mental Health NGO) Workforce Project was commissioned to assist in improving the understanding of the existing Mental Health NGO sector and its workforce. To date, there has been no national picture of Mental Health NGOs and this was hindering planning to support development of this important sector. The Mental Health Workforce Advisory Committee (MHWAC) therefore proposed a project to undertake a national study of this workforce.

This project aimed to:

- test a methodology and approach to workforce data collection for the Mental Health NGOs.
- to use this “pilot” process to provide a degree of greater understanding of the sector and its workforce.

Members of the Expert Reference Group (ERG) guiding this project felt that, although the data from the study may not be fully representative and definitive, the results obtained by this preliminary study were important information which would benefit the sector and its future workforce planning efforts and therefore should be communicated.

1.2 Project Context

Mental health is one of Australia’s eight national health priority areas. In recent years, there has been particular government focus aimed at reducing the burden and improving the lives of people affected by mental illness.

Mental Health NGOs are a vital part of Australia’s mental health system. The sector is diverse and delivers a wide range of services. Mental Health NGOs may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness and carers or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by these organisations include housing support, individual support, day programs, prevocational training, education, residential services, home based outreach and respite care.

Best estimates by mental health peak bodies are that there are approximately 798 “Mental Health Non-Government Organisations” (Mental Health NGOs) throughout Australia – an estimate by the project team and ERG of organisation numbers based on peak body membership and recipients of the Mental Health NGO Capacity Grants.

The project reports through Health Workforce Australia (HWA) to MHWAC and was commissioned by the Australian Health Ministers’ Advisory Council (AHMAC). The project was conducted by HWA and the National Health Workforce Research and Planning Collaboration. The ‘Collaboration’ is a partnership of the Australian Health Workforce Institute (the University of Melbourne and the University of Queensland) and PricewaterhouseCoopers.
1.3 Project methodology

As the first national Australian study of the sector, and with no national data on the sector or its workforce, the project sought to test the applicability of adapting the New Zealand NGOiT study methodology which focused on a similar sector and workforce.

Based on the New Zealand methodology, the project approach was to conduct two surveys of the sector:

- The ‘Landscape Survey’ - with the objective of determining organisation characteristics, service types and workforce size. This survey was distributed to managers and directors of Mental Health NGO organisations.

- A ‘Workforce Survey’ of individual staff – with the objective of testing and obtaining feedback on workforce data collection methodologies at an individual Mental Health NGO staff member level.

In testing this methodology broad inclusion and distribution criteria were utilised.

Distribution channels for the Landscape Survey were advised by the ERG. The following groups were among those utilised to distribute the Landscape Survey to their respective networks and members:

- ERG members including the Commonwealth Department of Health and Ageing and the Department of Families, Housing, Community Services and Indigenous Affairs representatives

- the eight state/territory Mental Health NGO peak bodies and to their members.

- the Mental Health Council of Australia to members and recipients of previous NGO Capacity Grants

- State and Territory Mental Health departments to funded NGOs

- other national peak bodies including drug and alcohol, disability, homelessness, employment and aged care

In the context of this report the Mental Health NGOs have been defined as: ‘not-for-profit, community-managed organisations that provide community support services for people affected by mental health problems and mental illness’. In utilising this broad definition, respondents self-selected their inclusion as a ‘Mental Health NGO’.

The distribution methodology for the second survey, the Workforce Survey, focused primarily on respondents from the Landscape Survey due to this group having demonstrated their engagement with the project. Managers from the Landscape Survey respondents group were utilised to communicate and distribute the Workforce Survey to their staff. However, completion of the Landscape Survey was not a prerequisite to participation in the Workforce Survey. The survey was open to other staff in Mental Health NGOs who were aware of the project through presentations at conferences and other on-line communication channels.

Feedback was sought from respondent front line staff in relation to the usability and appropriateness of the workforce survey tools.
1.4 Landscape Survey results

The Landscape Survey was conducted between 16th December 2009 and 7th May 2010. A total of 316 responses were collected in the online Landscape Survey tool between December and May 2010. After cleaning the dataset to adjust for duplication, incomplete and out-of-scope responses, a total of 268 valid responses were analysed. Based on the indicative population size of the Mental Health NGO sector the Landscape Survey coverage was estimated at 34% (268/798) of the sector.

This project provides the first national picture of the Mental Health NGO sector and provides evidence of an established and well-developed sector with a significant sized workforce contributing to the mental health and wellbeing of Australians.

The focus of the project was the testing of a methodology for future workforce studies of the sector. However, a range of data was gathered through the process which while not definitive or representative, provides insights on the sectors services, size and workforce. Highlights of the indicative results are detailed below.

Demographics

Of the responding organisations 84% of organisations operate in only one state with 9% operating nationally. 30% provide services only in capital cities. 19% of organisations operate in very remote areas, either exclusively, or in addition to other geographic areas. A large percentage of organisations (31%) reported that they directly support between 100 and 500 consumers annually with 7% supporting over 5,000 consumers annually.

The Mental Health NGO sector is well-established, with 42% of Landscape Survey respondents reporting that they have been in operation for more than 20 years. Organisations reported multiple funding sources, with 58% having between two and five funding sources. The majority of organisations (53%) reported annual budgets of greater than $1 million.

Service provision

Landscape Survey respondents reported a broad range of rehabilitation and recovery support services, mental health education, advocacy and public awareness activities were reported. In relation to the services these organisations provide, 46% classified themselves as primarily providing mental health services. 68% reported providing mental health along with another type of service such as welfare or other community services. A strong focus on the recovery journey of consumers was a feature with 49% of organisations providing recovery planning and care coordination. The sector was not only providing psychosocial support with 44% providing ‘therapeutic’ or ‘clinically based’ mental health services. 60% of organisations reported providing some form of co-morbidity services.

Workforce

Organisations were categorised as small, medium or large Mental Health NGOs based on the number of paid mental health staff. The ranges for the ‘organisation size’ categories were agreed by the ERG, based on the NgOIT study ranges, review of Australian Bureau of Statistics (ABS) categories for organisation size and the views on the experts regarding likely organisation workforce size. The ABS ranges were deemed too broad for application to Mental Health NGOs due to their small paid workforce numbers.
42% of respondents were small organisations (0 – 10 paid staff), 27% medium (11 – 50 paid staff) and 31% large (greater than 50 paid staff). The majority (58%) of Mental Health NGOs in the survey reporting between 2 and 25 paid mental health staff with a peak (23%) in the 6 – 10 mental health staff range. Only 15% reported having over 50 paid mental health staff. Due to the survey methodology estimation of the definitive size of the workforce was not possible. By conservative estimation methods, and extrapolating from the responses to the Landscape Survey, it is estimated that the Mental Health NGO workforce may range between 14,739 to 26,494 paid employees. This may be an underestimation due to large organisations being conservatively classified as having 50 paid employees. Future studies should include methods which more definitively define the classification of NGO as mental health providers and consider the ability to cover the exact number and FTE of paid employees.

Respondents reported the annual staff turnover rate is low for most organisations with 70% of respondents reporting a turnover rate of 5% or less, while, 30% reported a turnover rate of greater than 10%. 86% of organisations reported no staff vacancies for a period greater than six months.

A component of the Mental Health NGO Workforce is the emerging role of paid peer support workers, consumer workers and carer workers. 54% of respondents who completed that element of the question indicated that they employ consumer workers and 34% employ carer workers for their lived-experience of mental illness.

The vital role and contribution of volunteers is particularly strong in the sector with 77% of organisations reporting volunteers as part of their workforce. Smaller organisations reported the greatest utilisation of volunteers with 53.9% reporting having a volunteer workforce supporting their paid workers. 21% of all respondents to the volunteer question indicated that they have large volunteer workforces (i.e over 50 volunteers).

The majority (60%) of respondents indicated that they employ some clinical/health professionals on the basis of their health qualifications and others (80%) on the basis of their broader professional backgrounds. Clinical/health professionals employed in Mental Health NGOs included, psychologists (21%), occupational therapists (8%), social workers (24%) and registered nurses (13%). Only 3% of organisations reported having one or more psychiatrists employed.

Key findings from the Landscape Survey regarding training and education of the Mental Health NGO workforce identified that in 39% of organisations, staff who provide mental health services have a formal mental health qualification. 78% have a staff training and recruitment plan and/or workforce development plan. 55% of organisations who reported having a training and education budget stated more than 2% of their annual budget were spent on training and education.

Quality and outcomes

Quality and client outcomes are important to the sector - 88% of organisations reported gathering information on their consumer and carer experiences, the majority being through customer satisfaction surveys. 63% of organisations reported collecting some form of clinical or other outcome measures for the consumers and carers they have supported, the majority being six monthly evaluations of consumers’ progress.
1.5 Workforce Survey results

The Workforce Survey was conducted between 10\textsuperscript{th} May 2010 and 11\textsuperscript{th} June 2010. The Workforce Survey was designed to test the reliability of an approach to workforce data collection for the Mental Health NGO sector. This pilot survey was a convenience sample rather than a representative sample. The pilot provided interesting descriptive information from respondents but the key purpose of the survey was to pilot a methodology. To this end, the results informed the process for future data collections.

777 valid responses were received to the Workforce Survey (approximately 5\% of the workforce or below based on best estimates of the size of the workforce). The low response rate and survey methodology mean results could only be considered some representation of the sector’s workforce rather than a representative sample. Preliminary findings are included in Appendices for indicative purposes only.

Feedback gathered through the built-in evaluation component to the survey demonstrated positive support for repeating this type of special-purpose survey of the sector. Most respondents found the survey easy to understand and complete, relevant and of the appropriate length. Respondents identified data definitions within the survey structure to reduce misinterpretation of data items. The Workforce Survey captures unique data as the majority of respondents indicated that they were not asked to provide this type of data for other surveys.

1.6 Key issues and findings for future data collections

A key objective of this project and the surveys was to identify the issues which would need to be explored and developed before undertaking a more comprehensive and definitive survey of the sector.

Some examples of these issues were:

- The lack of a national data or register of Mental Health NGOs to allow distribution of relevant workforce surveys. Membership of peak mental health associations, or receiving a Capacity Grant, was used to estimate the number of organisations. This may have led to some organisations not being included in the organisation population estimates. The ability to survey a broader range of non-government than those who are members of mental health peak bodies was identified (using national databases of non-government organisations).

- The need to develop a categorisation system for Mental Health NGOs was identified. As an example of an approach a recent study of the NSW sector\textsuperscript{1}, provides a three level categorisation system of Mental Health NGOs for consideration in future studies of the sector. The Mental Health Coordinating Council (MHCC) suggests the following categorisation:
  
  - Category 1 - organisations providing mental health programs only
  - Category 2 – organisations providing mental health programs in addition to other programs

\textsuperscript{1} Mental Health Coordinating Council (2010). \textit{The NSW Community Managed Mental health Sector Mapping Report 2010}. NSW, Australia.
• Category 3 – organisations providing mental health support but no specific mental health programs.

• This project, along with recent work of the sector peak associations have contributed to preliminary definition of organisation and service type categories. However, further refinement, development and validation of the definitions will be required for future studies. A data item summary is provided at Appendix 3 and Appendix 4, highlighting areas for refinement for future studies.

Key findings from this project include:

1. Defining and measuring the Mental Health NGO workforce is more complex than for many workforces owing to variations in organisational funding and workforce structures, and also fluid boundaries within the sector.

2. Traditional labour force surveys are not able to be referenced for this workforce given the apparent lack of available national labour or service activity data. In the absence of this data for Mental Health NGOs and their workforces a ‘grass roots’ or special purpose survey is appropriate.

3. Prior to proceeding with any future studies, there should be development of consistent national categories for:
   a. the types of non-government organisations providing mental health support, and
   b. the types of service they provide.

4. There is support in the Mental Health NGO sector for future and ongoing collection of workforce data on their sector to assist in future workforce planning.

5. The Mental Health NGO peak bodies in each state/territory were vital in engagement with the sector and proved essential for credibility, endorsement of the study and encouraging responsiveness to the surveys.

1.7 ERG recommendations for future studies of the sector

There is support in the Mental Health NGO sector and the HWA Mental Health NGO Workforce Project ERG for future and ongoing collection of workforce data on their sector to assist in future workforce planning. The Mental Health NGO Workforce Project ERG’s recommendations are highlighted in Table 1 below:

Table 1. Mental Health NGO Project Expert Reference Group (ERG) recommendations

| 1. | Development of agreed national definitions and a data dictionary which includes a list of standard classifications for organisation, service, workforce and other related categories to describe the work of the Mental Health NGO sector. |
| 2. | Working with the Australian Bureau of Statistics (ABS), Mental Health Workforce Advisory Committee (MHWAC), Mental Health Information Services (MHIS) subcommittee of the Mental Health Standing Committee (MHSC) and other relevant government organisations to define and include relevant definitions for emerging workforces in data collection. |
requirements. For example:

i. Consider mechanisms for linking to funders’ and regulators’ performance reporting,

ii. incorporating in any future plans for Information collections for Non-Profit Institutions based on the 2010 Productivity Commission review of the Non-Profit Institution review and/or,

iii. developing ANZSCO codes for emerging workforces such as consumer and carer peer support workers.

3. Following the development of standardised data collection forms and methodologies, conduct a special purpose study of the mental health and Mental Health NGO sector with broad coverage of all non-government organisations in Australia (obtained through national databases of non-government organisations).

4. Analyse future data collections on the basis of the organisations and their workforces based on those who meet the agreed classification and service categories.

5. Engaging and supporting the sector and the peak bodies to conduct and complete future workforce surveys.

6. Continuing to offer multiple modes and methods of survey completion (on-line and paper based) to increase response rates and ease of survey completion.
2 Introduction

2.1 Objectives of the project

The Mental Health Non-Government Organisation (Mental Health NGO) Workforce Project was commissioned to assist in improving the understanding of the existing non-government mental health sector and its workforce. To date there has been no national picture of the sector or its workforce.

This project aimed to create a workforce planning tool for future planning, and to achieve a minimum dataset for the workforce, along with national data and information on the sector and its workforce. Therefore the project aims were defined as:

1. Test a methodology and approach to workforce data collection for the Mental Health NGOs.

2. Use these preliminary data results to provide some greater understanding of the Mental Health NGO sector and its workforce.

2.2 Background to the project

The Mental Health NGO sector provides a valuable and essential contribution to the mental health and wellbeing of Australians. The sector is broad, with Mental Health NGOs supported by other generalist NGOs with a broader focus on alcohol and other drugs, education, employment, accommodation and other community support services.

The project links to other jurisdictional and Commonwealth mental health initiatives, including the National Mental Health Workforce Strategy. The project reports through Health Workforce Australia (HWA) to the Mental Health Workforce Advisory Committee (MHWAC) and was commissioned by the Australian Health Ministers’ Advisory Council (AHMAC).

Health Workforce Australia (HWA) subsumed the National Health Workforce Taskforce (NHWT) and its activities from the 1st July 2010. HWA has assumed responsibility for the NHWT work program which includes this project. The project was conducted by Health Workforce Australia (HWA), in collaboration with PricewaterhouseCoopers (PwC) and the Australian Health Workforce Institute (AHWI). AHWI is a collaboration of the University of Melbourne and the University of Queensland.

2.3 Mental health – a national health priority area

Mental health is one of Australia’s eight national health priority areas. In recent years, there has been particular government focus aimed at reducing the burden and improving the lives of people affected by mental illness.

The latest National Survey of Mental Health and Wellbeing conducted in 2007 by the Australian Bureau of Statistics (ABS, 2008) estimates that 3.2 million, or 20%, of the population had experienced symptoms of a mental health illness in the 12 months prior to the survey. The report also identified the following key findings:

- 3.2 million (20%) of the Australian population experienced a mental illness in the 12 months prior to the survey.
- The most common mental illnesses were depression, anxiety, and other mood disorders.
- Mental health issues were more prevalent among women than men.
- Mental health issues were also more common among younger age groups.

These findings highlight the significant impact of mental health on the Australian population and the need for continued investment in mental health services and support.
to the survey. The survey found that almost half of the Australian population (45.5%) experience mental illness at some point in their lifetime.

Mental illness has significant mortality and morbidity impacts. The burden of disease and injury in Australia 2003 (Begg et al, 2007) estimates that mental illnesses are responsible for 13% of the total burden of disease and 24% of the non-fatal burden. This resulted in mental illness being ranked third among the major disease groups in the burden of disease rankings, behind cancer and cardiovascular diseases.

Since 1992, the National Mental Health Strategy has provided a framework for national reform. This reform aims to shift the model of care from an illness-oriented, medical model to a recovery-oriented consumer-focused model with an emphasis on support of the individual in the community. Recognition of the important role of medically based and inpatient care for some people with an acute mental illness remains. The strategy has been reaffirmed by the Health Ministers a number of times since 1992.

The National Mental Health Strategy is a commitment by the Australian and State and Territory Governments to improve the lives of people with a mental illness. It currently includes the:

- National Mental Health Policy (2008)
- Mental Health statement of rights and responsibilities (1991)
- National Standards for Mental Health Services (1996, revised in 2008)
- National Practice Standards for the Mental Health Workforce (2002)
- Australian Health Care Agreements.

**COAG National Action Plan for Mental Health**

A further renewed effort towards recovery-focused mental health services came in 2006 through the release of the Council of Australian Governments' (COAG) National Action Plan for Mental Health 2006-2011. The National Action Plan provides a strategic framework that emphasises coordination and collaboration between government and non-government providers in order to deliver a more seamless and connected care system, to enable people with mental illness to better participate in the community. The Plan outlined 17 measures over five years to improve services for people with a mental illness, their families and carers, through:

- increasing clinical and health services available in the community and providing new team work arrangements for psychiatrists, general practitioners, psychologists, occupational therapists, social workers and mental health nurses

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4 DHA National Mental Health Strategy p 10 CSHISC
• providing new non-clinical and respite services for people with mental illness and their families and carers
• providing an increase in the mental health workforce
• providing new programs for community awareness.

At the Australian Health Ministers’ Conference (AHMC) in November 2009, the Health Ministers reaffirmed their commitment to improving the mental health and wellbeing of all Australians, recognising that one in five Australians continue to experience a mental illness in any given year. The Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014 (2009) was endorsed at this conference. A priority area identified in the Fourth National Mental Health Plan is to develop and commence implementation of a National Mental Health Workforce Strategy that provides standardised workforce competencies or roles in clinical, non-government community support and peer support.

At the February 2011, COAG agreed consider plans for mental health reform at its meeting.

National Practice Standards for the Mental Health Workforce

The Second National Mental Health Plan 1998–20035 highlighted the need for the introduction of education and training initiatives to ensure an appropriately skilled workforce. Practice Standards6 were developed as a result.

Health professionals working in mental health are from a range of disciplines, and with a range of qualifications and skills. Some professionals work in teams, while others work in private practice and consult with, or refer to, other service providers. All contribute to the vast array of services and interventions required by people with mental health problems and mental disorders, and their family members and carers.

The National Practice Standards for the Mental Health Workforce consist of twelve practice standards and these relate to the professional groups including: psychiatry, nursing, social work, psychology and occupational therapy. The Practice Standards are intended to complement each of the professional groups’ discipline-specific practice standards or competencies and address the shared knowledge and skills required when working in a multidisciplinary mental health environment.

Mental Health Funding

National recurrent expenditure on all mental health related services in Australia in 2007–08 was estimated to be $5.3 billion, according to the Australian Institute of Health and Welfare’s (AIHW) Mental health services in Australia 2007-08 report. The report shows that of the $5.3 billion, about 60.5% came from state and territory governments, 36% from the Australian Government and 3.5% from private health insurance funds. Patient out-of-pocket expenses are not included in this figure.

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Expenditure on state and territory mental health services increased on average by almost 6% per year (after adjusting for inflation) between 2003–04 and 2007–08, to $3.323 billion. The policy shift towards providing more care in the community has also flowed through to relatively more investment in community based mental health care delivery as compared to hospital-based delivery. The figure below illustrates the change in state/territory mental health spending between community and inpatient mental health services from 1992-93 to 2007-08.  

Figure 1. Community-based services as percentage of total state and territory spending on mental health services

In Table 2, recurrent state/territory expenditure for 2007-08 is further broken down to show the funding for inpatient and community services. Note that community mental health care services, residential mental health services and grants to NGOs make up the 51% of all recurrent state/territory funding on mental health services which was deemed “community-based services” in Figure 1 above. The remaining funding allocations make up hospital services.

Table 2. Recurrent expenditure ($’000) on specialised mental health services, states and territories in 2007–08

<table>
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<tr>
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<th>2007-2008 recurrent expenditure ($’000)</th>
<th>% of total state/territory funding</th>
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<tr>
<td>(1) Public psychiatric hospitals</td>
<td>$447,360</td>
<td>13.5%</td>
</tr>
<tr>
<td>(1) Specialised psychiatric units or wards in public acute hospitals</td>
<td>$1,021,505</td>
<td>30.6%</td>
</tr>
<tr>
<td>(2) Community mental health care services</td>
<td>$1,268,301</td>
<td>38.2%</td>
</tr>
<tr>
<td>(2) Residential mental health services</td>
<td>$189,258</td>
<td>5.7%</td>
</tr>
<tr>
<td>(1) Other expenditure</td>
<td>$171,346</td>
<td>5.2%</td>
</tr>
<tr>
<td>(2) Grants to non-government organisations</td>
<td>$225,448</td>
<td>6.8%</td>
</tr>
<tr>
<td>Total state/territory recurrent expenditure</td>
<td>$3,323,219</td>
<td>100.0%</td>
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Fourth National Mental Health Plan. An agenda for collaborative government action in mental health 2009-2014
Prepared by: Fourth National Mental Health Plan Working Group. 2 June 2009
The Prime Minister announced new Commonwealth funding of $1.9 billion over five years as part of the COAG National Action Plan for Mental Health package announced on 5 April 2006. These new funds were in addition to existing Commonwealth funding and measures previously announced. The COAG National Action Plan on Mental Health places priority on the role of the Mental Health NGO sector, and approximately 45% ($800 million) of the Australian government’s $1.9 billion commitment under the COAG National Action Plan is being delivered by the NGO sector.

More than $800 million over 5 years has been committed to funding Mental Health NGOs as a result of the COAG National Action Plan. Over $500 million was allocated to mental health community sector recovery programs to be administered by Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and an additional $300 million was directed at community sector services in programs administered by the Department of Health and Ageing (DoHA). Funding was also provided through the Department of Education, Employment and Workplace Relations (DEEWR) for a range of initiatives to improve access to employment for people with mental health problems. Current FaHCSIA programs include the Personal Helpers and Mentors Program, the Mental Health Respite Care Program and the Mental Health Community Based Program. Current Department of Health and Ageing programs include the Support for Day to Day Living in the Community Program and the National Suicide Prevention Strategy.8

The $5.3 billion in recurrent funding for 2007-08 captures some but not all of the new initiatives funded by COAG. For example the 2007–08 data include the introduction of the Medicare-subsidised Better Access to Psychiatrists, Psychologists and General Practitioners and expenditure on national programs and initiatives managed by Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), including the funding outlays on three new initiatives funded by the Australian Government under the COAG Action Plan on Mental Health. These programs are ‘Personal helpers and mentors’, ‘More respite care places to help families and carers’ and ‘Community based programmes to help families coping with mental illness’.

Commonwealth funding of the Mental Health NGO sector is a new initiative since 2006 as a result of the COAG National Action Plan and there is an anecdotal hypothesis that this has contributed to an increase in the size of the sector nationally. There has also been additional state/territory funding injected into the Mental Health NGO sector, although these amounts still represent a small proportion of total state/territory funding. For the 2007-08 financial year, state/territory grants to NGOs totalled $225 million or 6.8% of total state/territory spending (see Table 2 above).9 This is an increase from 2004-05 when state/territory grants to NGOs totalled $130 million or 5.5% of the total mental health budget and 1992-93 when NGO grants totalled $28 million or 2%.10

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8 Mental Health RICH. Briefing paper prepared by Community Mental Health Australia National Leadership Committee CMHA 2008.
10 Note that in the AIHW Mental health services reports grants to NGOs expenditure excludes funding of staffed residential services managed by NGOs. These are included in residential mental health services.
The establishment of a National Health and Hospitals Network called for an additional $174 million to improve our mental health system, including $115 million in new funding (from 1 July 2010). This includes:

- $78.3 million over four years to deliver up to 30 new youth-friendly services and to provide extra funding for the existing 30 headspace sites.

- Funding of $24.8 million over four years will be provided to expand the Early Psychosis Prevention and Intervention Centre (EPPIC) model, building on the successful implementation of this model in Victoria. With state/territory contributions this will mean that up to 3,500 young people aged between 16 and 25 years and their families will benefit from improved detection of, and earlier treatment and support for, early psychosis.

- A further $13 million over two years will be provided to employ an additional 136 mental health nurses and provide an estimated 11,700 extra services. The Mental Health Nurse Incentive Program is demand-driven and the places will be available nationally.

- Some $57.4 million over four years will be directed to care packages to better support up to 25,000 people with severe mental illness, to be delivered by Access to Allied Psychological Services arrangements. Funding and packages will be broadly distributed to services on a per capita basis.

In addition, COAG agreed, with the exception of Western Australia, that the significant investment in sub-acute care of $1.62 billion will also support the provision of additional ‘step up, step down’ sub-acute services for people with mental health needs, easing their transition from acute care to the community.  

### 2.4 Description and role of the Mental Health NGO sector

#### The continuum of mental health care

Australia continues to work towards the provision of community-based models of mental health care and move away from the more traditional model of hospital-based care for mental illness. Mental health policy has been shifted from a purely illness-oriented, medical model to a more balanced recovery-oriented approach. Through COAG’s National Action Plan for Mental Health (2006) a range of community-based programs are now being delivered through a ‘social model of health care’ lens. This compliments a broad range of existing and long standing state-based initiatives.

Mental health-related services are provided in Australia in a variety of ways – from hospitalisation and other residential care, hospital-based outpatient services and

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12 Environmental Scan 2009, Community Services and Health Industry Skills Council, Department of Education, Employment and Workforce Relations. March 2009.
community mental health care services, through to consultations with both specialists and general practitioners (GPs).\(^{13}\)

As with general health care, the continuum of care for mental health is critical to ensuring optimal access and outcomes for consumers. The World Health Organisation (WHO) has developed a model describing their view of the optimal mix (and location) of mental health services. The WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health (see Figure 2 below) proposes one model for the integration of mental health services with general health care. Integrated primary mental health care is a fundamental component of this model, and is supported by other levels of care including community-based and hospital services as required.\(^{14}\)

The WHO model works on the premise that no single service setting can meet all population mental health needs. Furthermore support, supervision, collaboration, information-sharing and education across the various levels of care are integral to the system. The model promotes the involvement of consumers in their own recovery and self-care continues at all levels, which in turn promotes and encourages recovery and better mental health.

**Figure 2. WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health**

Who is the Mental Health NGO sector?

The Mental Health NGO sector in Australia is diverse and delivers a wide range of services. In the context of this report Mental Health NGOs have been defined as: “not-for-profit, community-managed organisations that provide community support services for people affected by mental health problems and mental illness”. Mental Health NGOs

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\(^{13}\) Australian Institute of Health and Welfare 2009. Mental health services in Australia 2006–07. Mental health series no. 11. Cat. no. HSE 74. Canberra: AIHW.

may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness and carers or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, individual support, day programs, prevocational training, residential services, outreach and respite care. The Mental Health NGO sector assists consumers and carers to maximise recovery, independent or supported living and active participation in the community leading to the delivery of recovery-focused mental health care. There is little argument from mental health experts regarding the need for continued emphasis on the delivery care within the least restrictive and most appropriate setting. However, the organisational structures, philosophies and models of care may vary. Mental health services based in the community may be provided by the public sector (such as the community mental health team based in a community health centre), private providers (such as private psychiatrists, psychologists and/or general practitioners) or non-government, not-for-profit mental health organisations. A number of terms have been used to describe the latter sector including:

- the Mental Health NGO sector (MH NGO)
- mental health community and not-for-profit sector
- the Third sector – as defined by Lyons (2003) and as utilised in the National Compact
- mental health community managed organisations (CMOs).

The terminology seeks to identify the sector and organisations which are non-government and not profit–for-purpose. In the context of this report the term ‘Mental Health NGOs’ has been used. However, it is recognised the more recent term of ‘community managed’ has been supported and adopted by a number in the sector in order to better recognise the focus on the tailored support provided to individuals to connect and reconnect them to their communities. Community Mental Health Australia (a coalition of the eight jurisdictional mental health non-government peak organisations) held a Roundtable in June 2010 where the majority of Mental Health NGO participants supported the “community managed” term.

These agencies provide essential core services to support thousands of mental health consumers and their families in Australia each year. Community managed mental health organisations provide valuable community based support options that are flexible, cost effective and essential to prevention and recovery. The sector works in partnership with and compliments the work of public and private mental health service providers, drug and alcohol services, and other health and community sectors including general practitioners, housing, disability and employment services.

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15 Fourth National Mental Health Plan An agenda for collaborative government action in mental health 2009-2014
2.5 Mental Health NGO Workforce

2.5.1 National policy context

Building a sustainable health workforce is a high priority for Australian Health Ministers. The National Health Workforce Strategic Framework was developed in 2004.\textsuperscript{16} The framework was designed to guide national health workforce policy and planning and inform health workforce investment over the coming decade. The mental health workforce is a key component of this framework with three expected outcomes articulated:

- improved attitudes, values, knowledge and skills of the mental health workforce
- improved supply and distribution of the mental health workforce
- improved workforce environment.

In 2006 COAG agreed to a significant national health workforce reform package to enable the health workforce to better respond to the evolving care needs of the Australian community, while maintaining the quality and safety of health services. The COAG package included the establishment of the National Health Workforce Taskforce (NHWT) - now subsumed by Health Workforce Australia (HWA) – to undertake project-based work and advise on and develop workable solutions for workforce innovation and reform. One aspect of this work program has been establishment of the National Health Workforce Planning and Research Collaboration (the Collaboration). This Mental Health NGO project formed part of the NHWT work program (subsumed by HWA from 1\textsuperscript{st} July 2010) and is being completed through the Collaboration.

The Collaboration between the NHWT and a consortium (comprising of the Australian Health Workforce Institute (AHWI) and PricewaterhouseCoopers (PwC)) has a substantial program of national health workforce planning and research projects to complete within the three year scope of the current agreement (2008-2011). AHWI itself is a consortium of the University of Melbourne and the University of Queensland and for the purposes of this Collaboration has established links with the Australian National University, the University of Adelaide and Monash University.

In parallel to this project on the Mental Health NGO workforce, the Mental Health Workforce Advisory Committee (MHWAC) is developing the National Mental Health Workforce Strategy and Plan in conjunction with the consultants Siggins Miller. The workforce strategy development and planning is a major outcome of the Fourth National Mental Health Plan. The process has included a major literature and document review of international peer-reviewed literature and policy approaches and initiatives in Australia and in comparable jurisdictions; organisation and facilitation of national consultation workshops with stakeholders; strategy development and production of an implementation plan. The Mental Health NGO workforce project will provide important data for inclusion in the national strategy and plan.

2.5.2 The need for a NGO mental health workforce project

A 2008 initial scoping of member organisations by Community Mental Health Australia (an alliance of the eight state/territory community Mental Health NGO peak bodies) for

the Mental Health Workforce Advisory Committee (MHWAC) indicated there may be in excess of 900 independent organisations and total staff across the sector was estimated to be greater than 5000-6000 full time equivalents depending on how the sector was defined. This workforce figure was noted to likely be an underestimate as it was based on extrapolations from some state/territory workforce studies with variable methodologies conducted prior to 2006-07. It was also noted that when new Commonwealth funding to the sector through the COAG National Action Plan for Mental Health was fully implemented that the workforce would likely exceed 12,000 full time equivalents. The staff qualifications range from university and/or vocational education qualified to unqualified staff, of which there is a large proportion. Again, these figures are estimates only as quantified and nationally consistent workforce data is not readily available.

The lack of reliable data relating to the provision of mental health related services by NGOs in Australia is a major challenge to the development of an accurate picture of the current mental health sector workforce. At this point in time there is little representative national data routinely collected by NGOs that identify the community based mental health services currently provided or the workforce composition. Subsequently, it is difficult to assess the level and nature of skills shortage which exists at a national level. It is recognised that reliable data are critical to the future of this sector and support for an initiative to progress the collection of workforce data and clarify the nature of funding arrangements is undisputed.

Access to reliable national Mental Health NGO workforce data would assist the sector to formulate evidence-based workforce policy and lead to improvement in service outcomes and efficiency of investment in the sector.

State-based workforce studies have recently been conducted in NSW, Victoria, Western Australia, Queensland, ACT, Tasmania and South Australia. While there have been a number of informative and interesting findings from these studies there still remains a lack of national data to estimate the size of the mental health workforce in each state/territory or nationally. The shift to more appropriate community based recovery focused mental health care models means the sector workforce must be sufficiently knowledgeable and skilled to deliver the required services to ensure optimal client care and outcomes. A number of the studies referred to above also incorporated aspects of workforce training and skills development in the absence of any national focus for training and development in the Mental Health NGO workforce and some data can be inferred at the jurisdictional level.

In parallel to the state/territory studies the Community Services and Health Industry (CHSI) Skills Council has undertaken a large body of work related to workforce training. This work focused on fieldwork research conducted in community mental services provided by government and not-for-profit organisations and detailed in the published report, Mental Health Articulation Project Report.\(^\text{17,18}\) The aim of this report was to examine strategies to expand the capacity for the delivery of key services in the mental health sector by identifying a framework of skills articulation between Vocational Education and Training (VET) and the higher education sectors. Articulation is just one of the measures needed to improve skills in the mental health sector. Articulation strategies identified as a result of this research will support future targeted delivery of

\(^{17}\) Mental Health Articulation Research Project Services and Workforce Study, Community Services and Health Industry Skills Council Ltd, Strawberry Hills, 2009.

VET and higher education programs to supply the mental health workforce needed in the short, medium and long term. To achieve a high quality integrated mental health service the following were suggested to be addressed: 19

- Better integration of workforce development into service agreements, including funding for training, back-fill of positions, and recognition of qualification and experience reflected in rates of pay
- Inequalities in pay and development opportunities between government and NFP services to gain greater traction
- Establishment of a coherent, cross-sector workforce development strategy for the community mental health sector
- Funding for system research and evaluation to create a unified body of post psychosocial rehabilitation practice to improve the service quality and enable development of an evidence-based workforce strategy
- Consideration be given to the establishment of a minimum qualification of Certificate IV in mental health to provide a baseline for skills growth funding and industrial arrangements are also addressed to ensure labour supply to the sector is not adversely affected.

Moving forward, the Community Services and Health Industry Skills Council will identify new mental health national competency standards for development as part of the continuous improvement of Training Packages. The aim of new national competency standards will include:

- a review of the qualifications and competency standards in the CHC08 Community Services Training Package and their capacity to address potential skill gaps identified in the mental health articulation project (eg psycho-social and rehabilitation); including potential for Vocational Graduate level components
- addressing skills gaps identified by VET and university trained workers
- building on recommendations from the CHC02 Community Services Training Package Review (to develop vocational graduate level qualifications)
- providing a skills framework to address and/or reduce fragmentation across different employer profiles
- providing new skills driven by client and community mental health needs rather than available occupational frameworks; and provide new options for job redesign to better support service delivery

3 Project overview

3.1 Project outline

As noted previously, the project aims to improve the understanding of the existing non-government mental health sector and to test a methodology for future studies of its workforce. The Mental Health NGO sector provides a valuable and essential contribution to the mental health and wellbeing of Australians. To date there has been no national picture of the sector or its workforce and this project sought to be a first step in gaining this understanding. The project recognised Mental Health NGOs are supported by other NGOs with a broader remit and focus in areas such as alcohol and other drugs, education, employment, disability, accommodation and other community support services.

This is the first national Australian study of the sector, and with no national data on the sector or its workforce.

The project adopted the New Zealand NGOiT study methodology which focused on a similar sector and workforces. The project sought to test the applicability of adapting the New Zealand surveys to the Australian context. The project approach was to conduct two surveys of the sector:

**Phase 1: The Landscape Survey** – The Landscape Survey focused on obtaining information from managers/executives of Mental Health NGOs providing support to mental health consumers and carers. This survey commenced 16th December 2009 and closed on the 7th May 2010.

**Phase 2: The Workforce Survey** – The second survey is directed at a sample of individual staff members within organisations captured in the Landscape Survey who provide direct and indirect support to mental health consumers and carers. This second survey commenced on 10th May 2010 and concluded on 11th June 2010.

A summary comparison of the Landscape and Workforce Surveys is presented in Table 3 below. Additional details about the design and coverage of the Landscape and Workforce Surveys are presented Section 5.

Table 3. Summary of the Landscape Survey and Workforce Survey

<table>
<thead>
<tr>
<th></th>
<th>Landscape Survey</th>
<th>Workforce Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Provide a snapshot of Mental Health NGO sector, including profile of services, high level workforce and data collection practices</td>
<td>Pilot the survey to determine suitable process and data elements for administering the tool going forward. Data will not be statistically significant</td>
</tr>
</tbody>
</table>
| **Distribution**      | Rounds 1-3: Emailed to all NGOs who are members of Mental Health NGO peak bodies (approx 800 in-scope NGOs)  
                       | Round 4: In addition to Mental Health NGO peak bodies, the survey was sent to funders of MH services and additional peak bodies | Workforce Survey was sent to all NGOs that completed the Landscape Survey  
                       | The link to the survey was also available on the HWA website                      |
At the outset of this project, definitions of key terms were agreed in consultation with the ERG. Definitions provide clarification of the scope and purpose of this project as well as further explanation for the relevant questions in the Landscape and Workforce Surveys. The majority of these definitions are from the 4th National Mental Health Plan unless otherwise stated.

**Carer** - a person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer.\(^\text{20}\)

**Consumers** - a person who uses or has used a mental health service\(^\text{20}\).

**Mental Health NGO Sector** – not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care.\(^\text{21}\)

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\(^{21}\) This definition of the non-government mental health sector has been taken from the Fourth National Mental Health Plan (2009) with the exception that the word “private” has been removed from the description. In the
Mental Health Services – refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.

Peer Support – Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

Full Time Equivalent (FTE) – The FTE of a full-time staff member (ie one who works 40 hours per week) is equal to 1.0. The calculation of FTE for part-time staff is based on the proportion of hours they work per week. For example a part-time staff member who works 20 hours per week is equivalent to 0.5 FTE (20/40 hours per week).

Fourth National Mental Health Plan the non-government mental health sector is described as “private, not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers.”

Source: Australian Bureau of Statistics. FTE definition varies between services and sectors.
4 Identifying the number of Mental Health NGOs

4.1 Project method utilised for identifying Mental Health NGOs

Identifying the number and location of NGOs providing mental health services in Australia was a vital first step in describing the sector as well as determining methods for distributing the surveys. A variety of methods for counting and classifying Mental Health NGOs were discussed by the ERG. Variation in methods may result in different estimates to the results below.

An initial search of the publicly available literature and data revealed a range of estimates:

- The 2007 National Mental Health Report estimates that approximately 400 NGOs were involved in delivering community mental health services in 2005
- The Australian Bureau of Statistics estimates that there are between 794 to 919 health NGOs in 2006-2007 – these are not all mental health specific organisations
- There were a total of 925 organisations listed on the publicly available membership directories for the state/territory Mental Health NGO peak bodies (most lists were from 2008).

As there was no consensus view on the number of Mental Health NGOs, the project team used an iterative process to formulate an estimate for 2009-2010. The Mental Health NGO sector is defined as detailed in the full definition see Section 3.2.

In the absence of a national register of Mental Health NGOs and standardised service categories a practical approach to estimating the number of Mental Health NGOs was utilised. This included:

1. estimate from the NGO state/territory membership lists
2. an estimate of the relevant non-member population based on the result of a cross-check with MHCA NGO capacity grant recipients provided by the Mental Health Council of Australia. This review determined approximately one-third of grant recipients were not members of a Mental Health NGO peak body.

It should be noted that the estimated non-member population most likely does not include all mental health service providers. However the methodology used was deemed to be a practical approach for identifying the relevant NGOs.

A number of categories were deemed to be out-of-scope for this project:

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- Government departments or health services
- Private, for-profit health services
- Individual service providers
- Members of multiple state/territory peak bodies (only counted once to avoid duplication).

For national organisations with multiple offices and programs there could be up to one national head office and one additional office per state/territory. However additional branch offices or programs were not counted to avoid overstating the number of NGOs.

The project team presented a first draft of the estimate to the ERG in February 2010 which was based on the publicly available membership lists. Following the meeting, the project team asked the state/territory peak bodies to validate their respective membership lists by classifying members based on type of organisation and estimated size and by identifying any members who were not included on the original lists. Based on this validation, the number of Mental Health NGOs in Australia is estimated to be 798 for 2009-2010. The results are summarised in the table below.

### Table 4. Number of Mental Health NGOs in Australia by state/territory, 2009-2010

<table>
<thead>
<tr>
<th>State/territory</th>
<th>(1) Member NGOs (first version)</th>
<th>(2) Net change in members</th>
<th>(3) TOTAL Members</th>
<th>(4) Estimated non-member population</th>
<th>(5) TOTAL Mental Health NGO population</th>
<th>(6) % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>35</td>
<td>5</td>
<td>40</td>
<td>13</td>
<td>53</td>
<td>7%</td>
</tr>
<tr>
<td>NSW</td>
<td>118</td>
<td>0</td>
<td>118</td>
<td>39</td>
<td>157</td>
<td>20%</td>
</tr>
<tr>
<td>NT</td>
<td>23</td>
<td>1</td>
<td>24</td>
<td>8</td>
<td>32</td>
<td>4%</td>
</tr>
<tr>
<td>QLD25</td>
<td>176</td>
<td>0</td>
<td>176</td>
<td>57</td>
<td>233</td>
<td>29%</td>
</tr>
<tr>
<td>SA</td>
<td>23</td>
<td>4</td>
<td>27</td>
<td>9</td>
<td>36</td>
<td>4%</td>
</tr>
<tr>
<td>TAS</td>
<td>31</td>
<td>2</td>
<td>33</td>
<td>11</td>
<td>44</td>
<td>5%</td>
</tr>
<tr>
<td>VIC</td>
<td>111</td>
<td>0</td>
<td>111</td>
<td>36</td>
<td>147</td>
<td>19%</td>
</tr>
<tr>
<td>WA</td>
<td>36</td>
<td>36</td>
<td>72</td>
<td>24</td>
<td>96</td>
<td>12%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>553</td>
<td>48</td>
<td>601</td>
<td>197</td>
<td>798</td>
<td>100%</td>
</tr>
</tbody>
</table>

Explanation of data in the table:

Note that the number of NGOs who are members of the peak body, Queensland Alliance, is higher in Queensland than for any other state/territory. This does not align with the population as Queensland has the third highest population of any state/territory in Australia, behind NSW and Victoria. The reason why the number of NGOs in Qld is higher cannot be determined from the publicly available data.
(1) Column 1 contains the number of NGOs from the original membership lists. Subsidiaries/programs have not been included in the estimate of the number of NGOs to avoid duplication and confusion.

(2) Column 2: Net changes in members reported during the validation of membership lists with the peak bodies.

(3) Column (1) + Column (2) = Column (3)

(4) Column 4: The estimated non-member population has been increased from the original estimates based on cross-checking completed by the Mental Health Council of Australia (MHCA) between membership lists and recipients of NGO capacity grants. The cross check revealed that approximately one third of Mental Health NGOs that received grants were not members of any of the state/territory peak bodies. We have applied this one-third estimate to the Mental Health NGO population as a whole although it is likely that there is some variation in this percentage by state/territory.

(5) Column (3) + Column (4) = Column (5)

(6) Column 6: Percentage of total Mental Health NGO population estimate.

4.2 Limitations of project method for identifying the number of Mental Health NGOs

The methodology described above primarily captures those NGOs who self-identify as a ‘Mental Health NGO’ regardless of the type or extent of services they provide. The approach was deemed appropriate by the ERG in the absence of a national register of Mental Health NGOs or an agreed national classification system describing the characteristics of organisations and standard services they provide. The project contributed to this discussion with working definitions and service categories developed for the purposes of the project. However, further definitional work related to organisation classification and service categories is required for future studies of the sector.

The NSW Mental Health Coordinating Council (MHCC) examined the issue of the classification of Mental Health NGOs in the NSW Community Managed Mental Health Sector Mapping Report 2010. The report, completed subsequent to the survey development for this Mental Health NGO Workforce Project, categorised NGOs into three categories from more specialised to generalised as follows:

- Type 1 – providing mental health programs only
- Type 2 – providing mental health programs in addition to other programs
- Type 3 – providing mental health support but no specific mental health programs.

The Sector Mapping Survey of NSW Mental Health NGOs found that 14.2% of respondents were Type 1, 41.3% were Type 2 and 44.5% were Type 3. Based on feedback from the ERG it is suggested that the type of NGOs identified in this project includes primarily Type 1 and Type 2 organisations as it was hypothesised that these organisations were more likely to be members of a peak body given that they are potentially more likely to self-identify as a Mental Health NGO. Providing a specific mental health program was also a requirement to receive an NGO Capacity Grant which
further supports the hypothesis that predominately Type 1 and Type 2 organisations were included in the sample.

Therefore the estimate of 798 Mental Health NGOs most likely does not capture all NGOs that provide mental health services and caution should be used in generalising results from this sample to any other sample of Mental Health NGOs.

The MHCC classification systems provide a possible classification system for Mental Health NGOs and future studies of the sector and should be considered in the development of future sector and workforce studies.
5 Landscape and Workforce Survey Methodology

5.1 Landscape Survey design

The Landscape Survey was designed to test a methodology for obtaining descriptive data on Mental Health NGOs and other NGOs supporting mental health consumers and carers.

As this was a voluntary survey the respondent group may not include all organisations that provide mental health services in Australia and therefore conclusions cannot be made from the results about all mental health service providers. However, the ERG saw benefit in this initial national study of the sector and the indicative results are included in this project report for information purposes.

The Landscape Survey included questions which covered six major topics:

- size, location and type of organisation
- services provided by the organisation
- income and funding sources
- profile of the non-government mental health workforce, including staff categorisation, distribution, qualifications and participation characteristics
- workforce planning and training
- data collection, reporting and quality improvement

A copy of the Landscape Survey tool is provided in Appendix 2. The Landscape Survey was designed through a literature scan and stakeholder consultations:

1 Literature scan – The purpose of the literature scan was to review key policy documents and strategies in the Mental Health NGO sector as well as identify and locate existing tools across the various jurisdictions (nationally and internationally) used to capture data on the Mental Health NGO workforce. Previous Workforce Surveys of the sector which formed the basis of review include New Zealand’s NgOIT survey and state/territory-specific workforce studies conducted in Australia. (Refer to the Reference List for specific studies included in the literature scan.)

2 Stakeholder consultations – Consultations were held with state/territory peak bodies, the New Zealand Platform team who conducted the NgOIT landscape and workforce surveys in New Zealand. These surveys focused on a similar population to the in-scope population for the Australian project and the survey methodology was adapted with permission. The project’s ERG was a key consultation group, particularly in relation to the appropriateness of the survey methodology. The membership list, including the project team, is attached in Appendix 7. The consultation process provided guidance on question nomenclature, the service categories and the most appropriate means of administering the survey. More detail on the sources of the service categories is provided in 0.
Together the information obtained from the consultations and literature scan was used to guide the development of the Landscape Survey tool.

The Landscape Survey was targeted at non-government organisations providing support to mental health consumers and carers that were identified through the sample as defined in Section 4. It was requested that the survey be completed by only one person employed at each NGO at executive/management level. This was to assist in minimising duplication particularly for large multi-site organisations or a state/territory branch. It was acknowledged that the survey information may be gathered from different people within the organisation prior to data entry.

Multiple communication and survey distribution channels were utilised. The survey was provided as an online tool with the website address distributed via email to individual organisations and through a variety of state, territory and national peak body organisations. These included mental health, drug and alcohol and disability peaks. The survey link was made available on the HWA website and paper-based options were also available. The survey commenced in December 2009 and concluded in May 2010 and was conducted through four rounds. Data were captured in the online survey tool and downloaded in Excel format.

5.1.2 Landscape Survey coverage

The methodology for Rounds 1-3 of the Landscape Survey focused on distributing the survey through the Mental Health NGO peak body in each state/territory. Discussion of initial data analysis with the ERG and other key stakeholders revealed that some segments of the sector reported that they may not have been adequately represented in the data set or would have liked more time to complete the survey.

In order to provide optimal opportunity for the sector to input into the project and increase the coverage of the Landscape Survey, the survey was extended for a 4th round from 15th April to 7th May 2010. In particular, the 4th round of the survey focused on supporting an increase in the response rate from small and medium sized community managed mental health organisations and those with mixed service provisions (such as alcohol and other drug services, disability and community support organisations who also provide mental health services). The survey was distributed via email through a wider network including Commonwealth and state/territory funders of mental health services, peak bodies for drug and alcohol, homeless, disability, employment and aged care, the Department of Education, Employment and Workplace Relations, Mental Health Council of Australia and state/territory mental health peak bodies.

A total of 316 responses were collected in the online survey tool. After cleaning the dataset to adjust for duplication, incomplete and out-of-scope responses, a total of 268 valid responses were analysed. All valid responses were members of the NGO peak bodies and/or MHCA NGO Capacity grant recipients in keeping with the sample used to identify the Mental Health NGO population.

Based on the calculation of the sample size of the Mental Health NGO sector we calculate that the overall Landscape Survey coverage for Rounds 1-4 is 34% (268/798) of this total sample used for this project. However, it should be noted that most likely not all mental health service providers or NGOs providing some level of support to mental health consumers and carers were captured through this sample. Therefore, results should be seen as indicative and not be generalised to describe all NGOs providing mental health services.
5.2 Workforce Survey design

The Workforce Survey was the second phase of this workforce project and followed the Landscape Survey. The survey captures information from individuals working in the sector about their working patterns, expertise and their perceived needs. The purpose of the Workforce Survey was to pilot a survey tool and data collection process is to determine suitable process and data elements for administering like surveys in the future. In this sense, the sample size for the Workforce Survey was intended only to be a convenient sample, sufficient to test the tools and methods. The data from the Workforce Survey is from a ‘representation’ of the Mental Health NGO workforce and therefore may not be representative sample of the workforce as a whole.

The survey was structured into the following sections:

- ‘About you’ – age, gender, Aboriginal and Torres Strait Islander status, country of birth, language, previous employment
- Current employment – location, status, paid hours, length of employment, proportion of time (employed vs. mental health), multiple employers, direct vs indirect work, voluntary, professional registration, primary role, etc
- ‘What do you do?’ – mental health rehabilitation and support, therapeutic, mental health education and awareness, co-morbidity, administration and management, population focus
- Education and Training – highest qualification, mental health qualifications/training, continuing education
- Optional comments section, including questions related to recruitment and intention to remain in the sector (retention)
- A feedback section of the Workforce Survey tool

A copy of the Workforce Survey tool is provided in Appendix 6.

Similar to the Landscape Survey, the Workforce Survey was designed through a literature scan, stakeholder consultations and the expert advice of the project reference group. The experience gained from conducting the Landscape Survey assisted to refine the approach for the Workforce Survey. In particular, some refinement to the service categories used to describe the services that people provide to clients occurred. Respondents were asked to select the top three service categories in which the respondent as an individual worker was involved. This allowed a better indication of where the majority of the individual’s work was undertaken. More detail on the sources of the service categories is provided in 0.

Where possible, questions were aligned with relevant existing data collections to assist in comparison of results. The “About You” section includes questions on year of birth, gender, country of birth and primary language and utilised categories from the Australian Bureau of Statistic (ABS) Labour Force Surveys and the ABS Census of Population and Housing. An evaluation component was built into the survey through the “What did you think of the Workforce Survey” section.

The Workforce Survey has been directed primarily at a sample of individual staff members within organisations captured in the Landscape Survey who provide direct and
indirect support to mental health consumers and carers. The survey was provided as an online tool via email to those organisations that provided responses to the Landscape Survey.

Similar to the Landscape Survey, multiple communication and survey distribution channels were utilised including through the Mental Health NGO peak bodies. Participation was self-selected and possibly broader than those who completed the Landscape Survey. The survey link was made available on the NHWT website. Printable and paper-based options were also available. The survey was completed in one round from 10 May to 11 June 2010. Data were captured in the online survey tool (including manual entry by the project team of completed hard copy surveys) and downloaded in Excel format.

5.2.1 Workforce Survey coverage

The estimated workforce for the 798 Mental Health NGOs is conservatively estimated to be between 14,739 and 26,494 paid employees as discussed in Section 6.1. This is a conservative estimate based on the staff size reported by respondent organisations.

777 valid responses were received for the Workforce Survey. Based on the estimated workforce size of 14,739 to 26,494 paid employees for the entire Mental Health NGO workforce, the 777 responses to the Workforce Survey are estimated to cover 3-5% of the total number of paid employees in the Mental Health NGO sample as defined for this project. Note that these figures are estimates only as the true employee population size is not known.

The main purposes of the workforce survey were to test the appropriateness of the methodology and survey design. Strong caveats are placed on the resulting data from the Workforce Survey given its low coverage of the Mental Health NGO sector’s workforce, and the use of convenience sampling to obtain responses. Therefore the results should be seen as indicative of one section of the workforce and the ability to extrapolate the results with confidence is limited. For further discussion of the limitations of the data refer to Section 5.4 and the disclaimer at the beginning of Appendix 2.

5.3 Communication strategy

Strong engagement with the sector was promoted through a number of communication channels and methods. The work of the ERG, mental health peak associations and other stakeholder organisations greatly assisted in achieving a positive response rate to both the Landscape Survey and the Workforce Survey.

Activities that were undertaken in order to encourage maximum engagement with the Landscape and Workforce Surveys included:

- publicity emails and multiple reminders including 3,2,1 countdown in the final days of both the Landscape and Workforce Surveys
- approximately 700 phone calls to NGOs to follow-up for the Landscape Survey. Approximately 250 phone calls were conducted for the Workforce Survey
- project hotline number with daily support
- update newsletters
outcomes from the Landscape and Workforce Surveys will be fed back to sector through this Final Report.

promotion of the project at the Psychiatric Disability Services of Victoria (VICSERV) and Lesbian Gay Bisexual Transsexual and Intersex (LGBTI) in Health Conferences in April and May 2010 – paper-based surveys were distributed at these events.

Figure 3 below displays the number of responses to Rounds 1-3 of the Landscape Survey along with the communication methods utilised. This highlights the positive effect that promotion of the project has on the number of survey responses.

Figure 3. Rounds 1-3 Mental Health NGO Landscape Survey Communication and Number of Survey Responses

5.4 Limitations of the data

The data collected have provided a high level snapshot of Mental Health NGO sector. A number of limitations are associated with these data.

Based on our estimate of the Mental Health NGO population (798) the response rate to the Landscape Survey is estimated to be 34% which is an appropriate sample size for the population size. Given the limited existing information about the profile of the sector, it cannot be determined if the survey sample is representative of the population based on variables such as size, geographic area, etc. (ie has the survey captured an accurate mix of small, medium and large organisations). However, the ERG stated the information obtained through the process was important to the sector and should be communicated.

The Workforce Survey was designed to test the reliability of an approach to workforce data collection for the Mental Health NGO sector. The survey aim was to test the approach and content of the survey rather than obtain a representative sample (eg random or stratified sampling). The primary aim was not to gather statistically significant data on the Mental Health NGO workforce. The estimated population coverage, at 5% or less, is low. Responses to the Workforce Survey
may not represent the actual characteristics of the Mental Health NGO workforce and results should not be used to represent the workforce.

- The Workforce Survey is based on a smaller sample of the Mental Health NGO population. Those organisations that completed the Landscape Survey were the primary target to complete the Workforce Survey. However the Workforce Survey was also promoted at public conferences and through the online link on the NHWT/HWA website. Therefore respondents may not necessarily have been employees working in the Mental Health NGO sector and results may not reflect the Mental Health NGO workforce population. This combined with low coverage of the Workforce Survey, mean that conclusions should not be drawn from the Workforce Survey results presented in Section 8 and Appendix 2. Inclusion of results is for illustrative purposes and to highlight comparability to other studies.

- The nature of these surveys is self-reported data and those who filled out the survey had the option to participate. Several workforce questions were mandatory for completion of the survey online but participants could choose to continue or stop the survey at any time.

- Varied interpretation of questions and data items could lead to incorrect and/or inconsistent responses. In particular, interpretation of the definition of full-time equivalent (FTE) may have varied amongst responders. The definition provided as a reference in the surveys is from the Australia Bureau of Statistics and can differ to the definitions provided by other sources.

- The Landscape and Workforce Survey data is descriptive in nature and cannot provide evidence of cause and effect. Therefore recommendations for workforce development require further input and consultation with the sector and other key stakeholders.
6  Landscape Survey results

This section includes results and a narrative summary for the Landscape Survey and is comprised of the following sections:

- survey response demographics
- NGO mental health service provision
- funding the Mental Health NGO sector
- description of the Mental Health NGO workforce
- training and education for the Mental Health NGO workforce
- performance monitoring and improvement.

6.1  Survey response demographics

Key findings regarding Landscape Survey response demographics:

- 84% of organisations operate in only one state
- 9% operate in all states and territories
- 30% operate only in capital cities
- 19% of organisations operate in very remote areas, either exclusively, or in addition to other geographic areas
- 42% have been in operation for more than 20 years

National response profile

A total of 315 survey responses were received. Some of these responses may have been partially completed or duplicate entries from the same organisation (e.g., where a regional office and national office completed the survey for the same organisation). After accounting for duplicate or partial responses, the results of 268 organisations have been analysed. As previously stated, this represents 34% of the estimated Mental Health NGO sample (see Section 5.1.2).

A key method for communicating and distributing the survey was through each of the state and territory peak body organisations. Therefore, it was possible for respondents, if a member of multiple peaks, to complete the survey on behalf of a regional branch. 245 provided detail of the regional nature of their response. 92.8% of these respondents completed the survey for the whole organisation as opposed to a branch of the organisation.

State response profile

247 organisations gave information regarding the states/territories in which they operate. 84% indicated that they operate in only one state, 8% operate in multiple (but not all) states/territories, and the remaining 9% operate in all states and territories. Figure 4 shows that higher numbers of organisations operate in NSW, QLD, VIC and WA than the remaining states / territories.
Geographic location

247 organisations gave information regarding the geographic location in which they operate. 30% of organisations indicated that they operate only in capital cities, and 13% operate across all geographic locations (capital and major cities, regional, remote and very remote areas). 19% of organisations operate in very remote areas, either exclusively, or in addition to other geographic areas.

Organisation size

For some of the analysis, organisations that responded to the survey have been segmented into small, medium and large categories based on the total number of paid staff:
Small: 0 – 10 staff
Medium: 11 – 50 staff
Large: greater than 50 staff

These staff groupings were an adjusted categorisation based on those utilised in the New Zealand NgOIT surveys (2005, 2007) which bucketed respondents into size categories based on total FTEs employed by the organisation and total FTEs employed for mental health and or addiction services:

- Very small – less than 2
- Small – more than 2, less than 5
- Medium – more than 5, less than 10
- Large – more than 10, less than 50
- Very large – more than 50

Due to the diverse range of NGO operating locations and staff numbers some categories were amalgamated. These groupings are smaller than those used by the ABS which generally categorises employment size for a broader base of organisations.

The respondent organisation size profile is detailed below in Table 5. The table demonstrates a high proportion of Mental Health NGOs have low numbers of paid staff. 42% of respondent organisations have less than ten paid staff, 27% have 11-50 and 31% have more than 50 paid staff.

**Table 5. Organisation size**

<table>
<thead>
<tr>
<th>Size</th>
<th>Number of respondent organisations</th>
<th>Percentage of respondent organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (0 – 10 paid staff)</td>
<td>98</td>
<td>42%</td>
</tr>
<tr>
<td>Medium (11 – 50 paid staff)</td>
<td>62</td>
<td>27%</td>
</tr>
<tr>
<td>Large (greater than 50 paid staff)</td>
<td>72</td>
<td>31%</td>
</tr>
</tbody>
</table>

**General characteristics of Mental Health NGOs**

On the basis of the results of the Landscape Survey, example profiles for small, medium and large organisations were developed and are outlined in subsequent sections of this chapter.

Table 6 below. In order to maintain the confidentiality of respondents an ‘average’ of organisations in the category was utilised. Further analysis of results from the Landscape Survey is included in subsequent sections of this chapter.
Table 6. Selected characteristics of small, medium and large organisations

### Small organisations (0-10 paid employees)

**Services**
Most small organisation provide mental health services as their primary focus (49% of small organisations provide mental health services as their primary service).

**Consumers supported**
Most small organisations support 100 or fewer consumers directly per year (54% of small organisations support 100 or fewer consumers directly per year).

**Funding**
Most small organisations earn less than $500,000 per annum (77% of small organisations earn less than $500,000).

**Volunteers**
Small organisation have a volunteer workforce but this workforce is of low numbers of individuals (69% of small organisations have a small volunteer workforce – less than 10 volunteers).

**Staff profile**
The small organisation by definition has 10 or fewer paid staff.

### Medium organisations (11-50 paid employees)

**Services**
Over half of the medium organisation provide mental health services as their primary function (51% of medium organisations provide mental health services as their primary service).

**Consumers supported**
Most medium organisations (58% of respondents) support between 101 and 1000 consumers directly per year.

**Funding**
55% of medium organisations earn between $500,000 and $3m per annum.
<table>
<thead>
<tr>
<th>Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average medium organisation has a small volunteer workforce (55% of medium organisations have a volunteer workforce of less than 10 individuals).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medium organisation by definition has between 11 and 50 paid staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Large organisations (greater than 50 paid employees)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>48% of large organisations who responded (those with more than 50 paid staff) provide mental health services as their primary service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumers supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority (62%) of large organisations support a range of between 101 and 1000 consumers directly per year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average large organisation earns over $3 million per annum (100% of large organisations earn over $3m per annum).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large organisations have arrange of volunteer workforces – with 37% of large organisations reporting a small volunteer workforce and 35% of large organisations reporting having a volunteer workforce greater than 50 individuals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>The large organisation by definition has over 50 paid staff.</td>
</tr>
</tbody>
</table>

### Number of paid employees

Following data cleansing there were 268 cleaned responses to the Landscape Survey. By a conservative estimate this equates to between 4,950 and 8,898 paid employees who work for those organisations who responded to the Landscape Survey only (ie the estimates are only the total workforce size for 268 organisations), as displayed in Table 7 below. These workforce estimates are based on the organisation profile of the number of paid employees reported in the Landscape Survey. A workforce range of 4,950 to 8,898 has been given. The estimates have been computed for the minimum number of paid employees in each size band (ie 0, 11 and 50 employees) and a conservative
midpoint (ie 5, 19.5 and 50 employees) and conservative maximum number of paid employees (ie 10, 50 and 50 employees). Given that the largest size band is greater than 50 paid employees, the conservative estimate used 50 for minimum, midpoint and maximum.
Table 7. Estimated total workforce of organisations that responded to the Landscape Survey (268 organisations)

<table>
<thead>
<tr>
<th>Size</th>
<th>% of respondent organisations (see Table 4)</th>
<th>Minimum paid employees (0, 11, 50)</th>
<th>Midpoint paid employees (5, 19.5, 50)</th>
<th>Conservative maximum paid employees (10, 50, 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (0 – 10 paid staff)</td>
<td>42%</td>
<td>0</td>
<td>563</td>
<td>1,126</td>
</tr>
<tr>
<td>Medium (11 – 50 paid staff)</td>
<td>27%</td>
<td>796</td>
<td>1,411</td>
<td>3,618</td>
</tr>
<tr>
<td>Large (greater than 50 paid staff)</td>
<td>31%</td>
<td>4,154</td>
<td>4,154</td>
<td>4,154</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>4,950</td>
<td>6,128</td>
<td>8,898</td>
</tr>
</tbody>
</table>

The figures presented above in Table 7 are estimates of the number of employees who are employed by those organisations who completed the Landscape Survey only. The figures have been scaled up to estimate the entire Mental Health NGO paid workforce in Table 8 below. This is based on the total number of Mental Health NGOs which is estimated to be 798 (see Section 4). The Landscape Survey response coverage is estimated to be 34% of this total (268/798, see Section 5.1.2). Therefore, based on the extrapolation of the Landscape Survey data, the entire Mental Health NGO workforce is estimated to be between 14,739 and 26,494 paid employees as displayed in Table 8 below. Again this is a conservative estimate which uses 50 paid employees for minimum, midpoint and maximum estimation of staff size for large organisations.

Caution is needed in utilising the above figures for definitive workforce planning because the estimates are based on banded, self-reported figures of a sample of the sector and are conservative in nature. For example the Australian Bureau of Statistics analysis of not-for-profit organisations (ABS, Not-for-Profit Organisations, Australia, 2006-07, Re-Issue in 2009) estimated 794 health not-for-profit organisations (not including hospitals) with a total of 99,665 employees as at 30 June 2007. The estimates presented in Table 8 represent less than 15-27% of this workforce figure.

Table 8. Estimated workforce based on estimated Mental Health NGO population (798 organisations)

<table>
<thead>
<tr>
<th>Size</th>
<th>% of respondent organisations (see Table 4)</th>
<th>Minimum paid employees (0, 11, 50)</th>
<th>Midpoint paid employees (5, 19.5, 50)</th>
<th>Conservative maximum paid employees (10, 50, 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (0 – 10 paid staff)</td>
<td>42%</td>
<td>0</td>
<td>1,676</td>
<td>3,352</td>
</tr>
<tr>
<td>Medium (11 – 50 paid staff)</td>
<td>27%</td>
<td>2,370</td>
<td>4,201</td>
<td>10,773</td>
</tr>
<tr>
<td>Large (greater than 50 paid staff)</td>
<td>31%</td>
<td>12,369</td>
<td>12,369</td>
<td>12,369</td>
</tr>
<tr>
<td>Size</td>
<td>% of respondent organisations (see Table 4)</td>
<td>Minimum paid employees (0, 11, 50)</td>
<td>Midpoint paid employees (5, 19.5, 50)</td>
<td>Conservative maximum paid employees (10, 50, 50)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>14,739</td>
<td>18,246</td>
<td>26,494</td>
</tr>
</tbody>
</table>

Legal entity

245 organisations reported their organisation’s legal entity status. 67% reported being an incorporated association and 22% reported being a company. Note that there were some inconsistencies amongst duplicate responses for this question and therefore the accuracy of these results should be interpreted with caution. However, a Queensland Alliance baseline survey of the mental health community sector in 2006-07 found that 70% of respondent organisations were incorporated associations which serve to corroborate the validity of the results from this national Landscape Survey. The Queensland Alliance survey was based on the successful New Zealand NgOIT survey which was also used to inform the methodology for the national Landscape Survey.

Aboriginal organisations

Two of the 245 organisations (0.8%) giving entity information reported being an Aboriginal corporation.

Time in operation

249 organisations provided information on the years they had been in operation. 79.9% of respondents have been in operation for 11 years or longer. 42.2% of respondents have been in operation for more than 20 years and 37.8% of respondents have been in operation for 11-20 years.

16.9% of respondent organisations have been in operation for 10 years or less. This can be further broken down as 10.8% of organisations have existed for 6-10 years and only 6.0% of organisations have been in existence for five years or less. The results are shown below in Figure 6.
Based on discussions with stakeholders and the ERG, there was it was felt recent funding streams directed to NGOs may have driven the creation of new organisations to take advantage of these opportunities. Some stakeholders reported a perception regarding Mental Health NGO as having been only recently established with possible sustainability risks. Based on the 2007 analysis of Australian businesses, the ABS concluded that over the short to medium term, business survival is related to the age of a business – i.e. the longer a business survives, the greater its chances of continuing survival (ABS, Selected Characteristics of Australian Business, 2007-08, published 2009). The response to this survey question demonstrates that the sector is well-established and has longevity, as 42% of respondents have been in operation for more than 20 years.

Other recent studies of the sector reinforce the longevity of the sector. In 2008, the Mental Health Council of Australia (MHCA) was commissioned by the Department of Health and Ageing (DoHA) to establish a grant program to fund Mental Health NGOs with annual budgets of less than $3 million dollars.

As part of this NGO Capacity Development Project, MHCA (2009) conducted an online survey26 of grant recipients which found that the majority of the agencies came into existence during the 1980s (33.13%) and the 1990s (32.5%). A small percentage of agencies (15.63%) came into existence in 1979 or earlier; and 17.5% came into existence during the present century. Similarly, the 2005 Queensland Alliance sector survey which generated 70 responses found that 48% of the organisations were established between 10 to 20 years ago. (Note that the corresponding figure from the national Landscape Survey is 37.8% for the similar longevity period) The average organisation was 23.75 years old.

The results of this study in relation to organisation longevity indicate the recent policy and funding responses have not necessarily provided incentives for the creation of new organisations. However, data from this Landscape Survey does not provide the level of detail to explore whether established community services organisations have made a

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26 160 responses (76.6%) were received from a total of 209 successful applicant agencies.
move into the mental health service area (eg a longstanding organisation may have only recently begun offering mental health services but this cannot be determined from the survey results).

The estimated Mental Health NGO population (see Chapter 4) is higher than previous estimates such as the 2007 National Mental Health Report which estimated that approximately 400 NGOs were involved in delivering community mental health services in 2005. A number of hypotheses exist. These changes indicate some Mental Health NGOs may not have been accounted for in other data collections or that longstanding organisations have recently moved into mental health service provision, amongst other hypotheses. However, the figure of 400 NGOs does not include residential facility data as discussed in the Mental Health Report 2007 (see Chapter 4).
6.2 NGO Mental Health service provision

Key findings from the Landscape Survey regarding Mental Health NGO service provision:

- 46% of organisations classified themselves as primarily providing mental health services
- 68% reported providing mental health along with another form of service such as welfare or other community services
- 49% provide recovery planning/care coordination with other health/service providers
- 44% provide ‘therapeutic’ or ‘clinically based’ mental health services
- 60% provide some form of co-morbidity services
- 31% directly supported between 101 and 500 consumers in the previous 12 months

Service mix

One of the key attributes of Mental Health NGOs is their ability to respond to the unique needs of individuals and to provide a broad service offering based on the local communities’ needs.

No two responding organisations to the Landscape Survey were the same in structure, service delivery offering or workforce. Service types varied with some responding organisations may have had a mental health as their primary focus while providing other co-morbidity or social support services. Conversely, organisations may have seen themselves predominately as a community services organisation which provided a range of drug and alcohol, disability and mental health support services.

The Landscape Survey attempted to establish this focus and mix by asking organisations to estimate the percentage of their organisation’s services which were considered mental health, drug and alcohol, community and disability. The services that organisations offer were categorised as ‘primary’ (more than 50% of all service offerings), ‘mixed’ (25-50%) or ‘some’ (0-25%). The service mix is detailed below in Figure 7.

Service type definitional issues exist and respondents self selected their service type. Refinement of service definitions was identified as a requirement for future studies. 86% of the 244 organisations providing information on service mix indicated that they provide mental health services (either primarily, mixed or some). 68% reported providing mental health plus another form of service. This broad service provision would be expected from a sector that promotes itself as having a focus on tailoring services to respond to their local community and individuals’ needs.

The majority (53%) of organisations who reported providing mental health services indicated that this service is their main organisational focus (ie 46% of 244). Another large area of service provision is community support. Of the 64% of organisations who reported providing community support, half indicated that they provide it primarily (ie 32%). In addition, responding organisations reported:

- 33% offer drug and alcohol services. Of those that do, 53% provide ‘some’ drug and alcohol services (18% of the total 244 respondents).
- 33% offer physical and intellectual disability services. Of those that do, 48% provide ‘some’ physical and intellectual disability services (16% of the total 244 respondents).
41% also provide other services outside the given categories, and 16% of respondents provide mental health services plus unspecified other services.

Figure 7. Services provided

Organisations who indicated that they provide a service primarily (eg comprising over 50% of the organisations’ services) were broken down by size. 42% of total respondents to the Landscape Survey were small organisations (0-10 paid staff). The results shown below in Table 9 indicate that smaller organisations are more likely to provide specialised services, concentrating on one type of service as opposed to providing a variety of service types. The proportion of small organisations presented in Table 9 below ranges from 43.2% (for “other”) to 50.0% (for physical and intellectual disability) depending on the type of service provided.

Table 9. Services that are provided primarily (over 50% of services) by organisation size

<table>
<thead>
<tr>
<th>Services, if comprising over 50% of the organisations’ services</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>49.5%</td>
<td>25.8%</td>
<td>24.7%</td>
<td>100%</td>
</tr>
<tr>
<td>Drug and Alcohol</td>
<td>45.5%</td>
<td>36.4%</td>
<td>18.1%</td>
<td>100%</td>
</tr>
<tr>
<td>Community Support</td>
<td>49.3%</td>
<td>25.4%</td>
<td>25.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Physical and Intellectual Disability</td>
<td>50.0%</td>
<td>20.0%</td>
<td>30.0%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>43.2%</td>
<td>27.0%</td>
<td>29.8%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Service activity and type

Figure 8 below details the types of mental health rehabilitation and support services that are provided by respondents. Three groups of service type were utilised to categorise the range of mental health services provided by NGOs nationally:

- rehabilitation and support services,
- therapeutic services (e.g. ‘counselling’, ‘talking therapies’, etc)
- mental health education and public awareness.

The service type categories were determined in consultation with the ERG to take into account the variety of services that Mental Health NGOs provide. The MHCC NSW Community Managed Mental Health Sector Mapping Project 2010 and the 2008 Mental Health Funding Methodologies Discussion Paper were used as an initial basis for formulating the list of services. Further detail identifying the sources for these service categories is provided in 0.

**Rehabilitation and support services**

Of the 243 responding organisations to this question (multiple answers could be selected), 49% provide recovery planning/care coordination with other health/service providers. 44% provide education and training support for consumers and carers. 42% provide peer support.

**Figure 8 – Response count of type of mental health rehabilitation and support services**

<table>
<thead>
<tr>
<th>Mental Health REHABILITATION and SUPPORT services provided by MH NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Education and training support</td>
</tr>
<tr>
<td>Research and evaluation</td>
</tr>
<tr>
<td>Leisure/ recreation / aerobic physical...</td>
</tr>
<tr>
<td>Employment support and individual...</td>
</tr>
<tr>
<td>Financial literacy and counselling</td>
</tr>
<tr>
<td>Justice/ Forensic Mental Health</td>
</tr>
<tr>
<td>Family support and interventions</td>
</tr>
<tr>
<td>Carer networks</td>
</tr>
<tr>
<td>Peer support</td>
</tr>
<tr>
<td>Consumer networks</td>
</tr>
<tr>
<td>Early intervention</td>
</tr>
<tr>
<td>Mental illness prevention</td>
</tr>
<tr>
<td>Telephone-based support (eg helplines)</td>
</tr>
<tr>
<td>Crisis support</td>
</tr>
<tr>
<td>Recovery planning/ care coordination...</td>
</tr>
<tr>
<td>Centre-based program</td>
</tr>
<tr>
<td>Respite care</td>
</tr>
<tr>
<td>Home-based outreach services</td>
</tr>
<tr>
<td>Supported accommodation</td>
</tr>
<tr>
<td>Accommodation and housing provision</td>
</tr>
<tr>
<td>N/A - NO Mental Health REHAB</td>
</tr>
</tbody>
</table>

**Therapeutic services**

Definition of this category proved challenging. Therapeutic services were seen to be ‘counselling’ or ‘talking therapies’. Details of the mental health therapeutic services

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provided by NGOs are shown in Figure 9. 44% of respondents provide individual therapeutic mental health services, 39% provide none, or not applicable, 37% provide counselling and 37% provide group therapy (multiple answers could be selected).

An anecdotal hypothesis was that Mental Health NGOs provide social and rehabilitation support services only. Therapeutic or “Clinical” services (usually provided by registered health professions such as nurses and psychologists) were seen to be more the remit of public mental health services or delivered by private providers. However, 27% of the 243 organisations recording a response (or 24% of the 268 total respondents to the survey) described themselves as providing ‘talking therapies’ which is often viewed as a “clinical” service.

Figure 9. Response count of type of therapeutic mental health service

Table 10. Therapeutic services by organisation size indicates small organisations were less likely to provide therapeutic mental health services.

Table 10. Therapeutic services by organisation size

<table>
<thead>
<tr>
<th>Type of therapeutic service</th>
<th>Small org</th>
<th>Medium org</th>
<th>Large org</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A – No therapeutic mental health services</td>
<td>50.6%</td>
<td>24.7%</td>
<td>24.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Mental Health education and public awareness

243 organisations reported the types of health education and/or public awareness provided (multiple answers could be selected). The types mostly selected are as follows:

- 60% provide individual advocacy for consumers (e.g. accessing services)
- 60% provide community events for mental health awareness
- 56% provide staff training and professional development services
- 55% provide mental health information pamphlets or newsletters
- Only 29% provide web-based mental health information.

The results are summarised in Figure 10 below.

The role of Mental Health NGOs in the education on prevention area is emerging. However, there does appear to be a relevant base on which to extend this direction and remit in line with the 4th National Mental Health Plan.
Comorbidity programs

Of 243 respondents, 60% of organisations reported providing one or more comorbidity programs. The programs most reported were (multiple answers could be selected):

- 41% (of 243 respondents) provide a program for people with mental health problems and substance use
- 28% provide a program for people with mental health problems and a complex or exceptional need
- 22% provide a program for people with mental health problems and intellectual disability.

Figure 11. Comorbidity programs

Consumer and carers

The number of consumers and carers that organisations supported in the previous 12 months is displayed below in Figure 12. Direct service provision was defined as
telephone or face-to-face. Indirect service provision was defined as web/online support, mail or advertising. In summary:

- A large percentage of organisations (31%) reported directly supporting between 100 and 500 consumers annually
- A small percentage of organisations (7% of those responding to this section of the question) reported providing direct support to over 5,000 consumers annually
- 29% of organisations support 1-50 carers directly
- 25% and 29% of organisations reported indirectly supporting (ie through websites or on-line support) 1-50 consumers and 1-50 carers respectively.

Table 11 below shows the numbers of consumers directly supported broken down by organisation size. The general trend is that smaller organisations appear to support less consumers directly than large organisations.

<table>
<thead>
<tr>
<th># consumers supported directly:</th>
<th>Small org</th>
<th>Medium org</th>
<th>Large org</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 50</td>
<td>64.1%</td>
<td>23.1%</td>
<td>12.8%</td>
<td>100%</td>
</tr>
<tr>
<td>51 – 100</td>
<td>56.0%</td>
<td>16.0%</td>
<td>28.0%</td>
<td>100%</td>
</tr>
<tr>
<td>101 – 500</td>
<td>30.9%</td>
<td>32.4%</td>
<td>36.8%</td>
<td>100%</td>
</tr>
<tr>
<td>501 – 1000</td>
<td>18.8%</td>
<td>28.1%</td>
<td>53.1%</td>
<td>100%</td>
</tr>
<tr>
<td>1001 – 5000</td>
<td>31.8%</td>
<td>18.2%</td>
<td>50.0%</td>
<td>100%</td>
</tr>
<tr>
<td>&gt; 5000</td>
<td>33.3%</td>
<td>33.3%</td>
<td>33.3%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Extrapolating for the population who responded to the survey, this may equate to between 123,300 and over 264,350 consumers and between 32,593 and over 89,600 carers receiving direct support annually. Due to the self reported survey utilised for this project, extrapolation to the whole Mental Health NGO population (and therefore the whole of Australia) is not possible with acceptable confidence. However, with a response rate of 34% it is valid to consider this to be a small proportion of the total number of people supported by Mental Health NGOs annually.
Population focus

Mental Health NGOs provide support to diverse population groups. 236 organisations reported providing services to specific populations. These are displayed in Figure 13 below.

Those who reported providing specific support to only one or two population groups (10% and 4% of respondent organisations respectively) included (in order of frequency):

- Gay, Lesbian, Bisexual and Transgender (GLBT) communities
- Single people
- Older people
- People with intellectual disabilities
- People with physical disabilities
- Families
- ATSI: Aboriginal and Torres Strait Islander people
- CALD: Culturally and Linguistically Diverse Backgrounds
- Unemployed
- Carers.
233 organisations reported the specific age ranges of their target population groups. The results are displayed below in Figure 14. Multiple answers could be selected. 57% of organisations reported providing services to all ages. Of the organisations not providing services to all ages, only 7% (of 233) reported providing services to people under the age of 15.
When specific age groups were analysed the following was reported:

- 1.5% provided services specifically to child and adolescents (only 0 to 25 years)
- 2.6% provided services specifically to children (only under 15 years)
- 8.6% provided services specifically to adolescents (only 15 – 25 years)
- 0.7% provided services specifically to older people (only 65+ years).
6.3 Funding the Mental Health NGO sector

Key findings from the Landscape Survey regarding funding of the Mental Health NGO sector:

- The highest respondent counts for annual income were for the $1m - $3m and the $100,000 - $499,999 bands
- The lowest respondent count for annual income was for the $30,000 - $99,999 band
- 37% received 76-100% of their total annual income for mental health services
- 58% receive funding from the state/territory health department
- 35% receive the majority of their funding from the state/territory health department
- 58% have 2 - 5 funding sources

The total annual income from all sources and programs in the last financial year was reported by 215 organisations. The results are shown graphically below in Figure 15. In summary:

- 7% of organisations had an annual income of less than $30,000
- 5% of organisations had an annual income between $30,000 and $99,999
- 22% of organisations had an annual income between $100,000 and $499,999
- 13% of organisations had an annual income between $500,000 and $999,999
- 23% of organisations reported that they had an annual income in the $1 million to $3 million band
- 14% of organisations had an annual income in the $3 million to $10 million
- 16% of organisations had an annual income of greater than $10 million

Figure 15. Total annual income for the last financial year
Results from the 2008 Queensland Alliance survey indicate a similar income profile as displayed in Figure 16 below. Twenty organisations (29%) reported that they had an income between $1 million and $3 million, as compared to 23% in the Landscape Survey. Overall, 57% of the Queensland sample reported a total income of over $1 million. This is a t higher proportion than the 53% of Landscape Surveys respondents who indicated that they have total annual incomes of more than $1 million. The key differences in results between the two studies indicate the Landscape Survey has a higher proportion of respondents in the $100,000-$499,000 bracket and the >$10 million bracket. The higher response count in the >$10 million may be due to the Landscape Survey captured more large national organisations which have higher budgets.

Figure 16. Organisation total income

The percentage of the organisation’s annual income which was for mental health services is shown below in Figure 17 for the 218 organisations who responded to this question. 37% of respondents indicated that they receive 76-100% of their total annual income for mental health services.
The organisations reporting less than 10% of their total annual income for mental health services were broken down by size. 40% were large, 35% were small, and 26% were medium sized organisations. For those organisations that receive a large proportion of their income for mental health services (76-100%) there was a definite trend in size. The majority of these organisations (52%) were small, 27% were medium and 21% were large organisations.

This result is corroborated by the 2008 Queensland Alliance survey which found that as total organisational income increases, the percentage of that income devoted to providing mental health services decreases. They concluded that this reflects that some smaller services have been established to largely provide mental health programs, while larger established organisations may have begun to incorporate these services alongside established programs.

The percentage of mental health funding which was for short term project-based (eg less than two years) services or programs in the last financial year is shown below in Figure 18. Excluding those organisations reporting ‘not applicable’, 40% of respondents received 5% or less of their funding for short term programs.

The Landscape Survey results show that the majority of mental health funding is for longer term services or programs. This is contrary to results from the MHCA NGO Capacity Development Project which found that the majority of Mental Health NGO funding is short-term in nature. The NGO Capacity Development Project survey found that 62.7% of the agencies reported having some element of their funding agreements which lasted for less than one year, and that this supplied almost 39.0% of their annual funds – an expected result given the target group of the grant funding was smaller or developing organisations. At the other end of the spectrum, some agencies had sources of income which were not time limited. That is, there was no end point for some of their funding agreements. 26.8% of agencies reported having some funds from such a source, and it supplying 49.5% of their income.
Figure 18. Percentage of total mental health funding for short term projects

The Landscape Survey results were further broken down to show the percentage of total mental health funding that is for short term projects for organisations that earned less than $3 million last financial year (Figure 19) and those that earned greater than or equal to $3 million per year (Figure 20). It was hypothesised that the high proportion of short term funding for recipients of the NGO Capacity Development grants was due to the fact that organisations were smaller (because they earned less than $3 million per year). Analysis of the Landscape Survey results show no clear trend based on income, although there is some indication that organisations earning less than $3 million receive a slightly higher proportion of their funding as short term funding. In Figure 19, respondents who selected ‘not applicable’ or 0-10% of their funding was for short term projects made up 74% of total respondents whose organisations earned less than $3 million per year. For organisations earning $3 million or more per year, this proportion is slightly higher at 83%, as displayed in Figure 20. Given that no clear trend emerges, the reasons for the variance between the Landscape Survey results and the NGO Capacity Development Project cannot be determined from the currently available data.

Figure 19. Percentage of total mental health funding for short term projects – organisations earning less than $3m
Respondents receive funding from a number of sources:

- 58% of organisations have 2-5 funding sources
- 28% of organisations have only one funding source. Of these,
  - 35% received their funding from the state/territory health department
  - 15% from other state/territory department
  - 15% from the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA),
  - 13% from ‘other’
  - 12% from the Commonwealth Department of Health and Ageing (DoHA)
  - 5% from the Commonwealth Department of Education, Employment and Workplace Relations (DEEWR)
  - 5% from fundraising or donations
- 10% of organisations have 6-10 funding sources
- 2% of organisations reported not receiving funding specifically for mental health
- Medicare funded services specific to mental health are provided by 10% of organisations. 45% of these organisations are large, 27% medium and 27% small.

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28 By comparison, Queensland Alliance found that 21% of organisations reported having just one source of funding.
216 organisations responded with details of their funding sources. Of these, 58% receive funding from the state/territory health department. 35% receive the majority of their funding (over 50%) from the state/territory health department. Other top funders were state/territory other department, Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Commonwealth Department of Health and Ageing (DoHA).

Table 12. Size of organisation receiving funding from funding source below shows the size of organisations to where governments provide funds. A relatively even spread across small medium and large for state/territory funders and DoHA was seen. More large organisations report receiving funds from FaHCSIA. The majority of small organisations reported receiving funding from fundraising. Table 13 below shows that for the organisations receiving the majority of their funding from a particular source, the percentage which are small, medium and large organisations. Medium size organisations reported DoHA as their prime funding source. Large organisations received the majority of their funds from FaHCSIA with small organisations receiving funding from a mix range of sources but having fundraising and non-health state and territory government departments as their primary funding sources.

Table 12. Size of organisation receiving funding from funding source

<table>
<thead>
<tr>
<th>Funder:</th>
<th>Small org</th>
<th>Medium org</th>
<th>Large org</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State/Territory - Health department</td>
<td>39%</td>
<td>26%</td>
<td>34%</td>
<td>100%</td>
</tr>
<tr>
<td>State/Territory - Other department</td>
<td>41%</td>
<td>27%</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td>Commonwealth – FaHCSIA</td>
<td>20%</td>
<td>23%</td>
<td>57%</td>
<td>100%</td>
</tr>
<tr>
<td>DoHA</td>
<td>26%</td>
<td>37%</td>
<td>37%</td>
<td>100%</td>
</tr>
<tr>
<td>Fundraising or donations</td>
<td>54%</td>
<td>24%</td>
<td>23%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note that this figure is similar to the MHCC project which found that 54% of Mental Health NGOs from the NSW Department of Health.
### Table 13. Size of organisation receiving the majority of their funding from funding source

<table>
<thead>
<tr>
<th>Majority funding from source:</th>
<th>Small org</th>
<th>Medium org</th>
<th>Large org</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State/Territory - Health department</td>
<td>42%</td>
<td>23%</td>
<td>35%</td>
<td>100%</td>
</tr>
<tr>
<td>State/Territory - Other department</td>
<td>53%</td>
<td>32%</td>
<td>16%</td>
<td>100%</td>
</tr>
<tr>
<td>Commonwealth – FaHCSIA</td>
<td>10%</td>
<td>20%</td>
<td>70%</td>
<td>100%</td>
</tr>
<tr>
<td>DoHA</td>
<td>12%</td>
<td>65%</td>
<td>24%</td>
<td>100%</td>
</tr>
<tr>
<td>Fundraising or donations</td>
<td><strong>100%</strong></td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The results from the Landscape Survey mirror some of the broad themes from the Productivity Commission’s research report on the Contribution of the Not-for-Profit sector (2010) which found that government funding is the largest share of income for not-for-profits involved in health, social services and education and research. While precise estimates are not possible, anecdotal evidence suggests most of this funding is provided to support service delivery. Three-quarters (74.2%) of total government funding to not-for-profit health organisations was volume based funding (for example, granted on a per client basis) based on the ABS not-for-profit organisations data analysis.

The MHCA NGO Capacity Development Project (MHCA, 2009) also found that agency income came most frequently from state and territory governments, although self generated funds and the Federal government also made major contributions. State or territory funding was both the most frequent (82.2% of agencies) and the largest contributor to agency funding (55.3%). Federal government funding supplied 58.6% of agencies with 36.0% of their funding; self generated funding supplied 71.7% of agencies with 23.0% of their funding; and private funding supplied 24.3% of agencies with 19.4% of funding. The Capacity Grant project report concluded that in general this data suggests that the Mental Health NGO sector is primarily supported by government funding, but substantially supplemented by other sources.

### 6.4 Mental Health NGO Workforce - description

**Key findings from the Landscape Survey regarding the Mental Health NGO workforce:**
- 42% have 0-10 paid employees, 27% have 11-50, and 31% have >50
- Of the organisations that reported mental health employee numbers, 62% have 0-10 paid mental health employees
- 77% or organisations utilise volunteers

**Employees**

A number of questions in the Landscape Survey related to the staffing of the Mental Health NGOs completing the response. Respondents were asked to report the total number of paid staff for their organisation as at 30 November 2009 (both mental health and non-mental health). The workforce results in this survey indicated:
• 42% of the 232 respondents to that part of the question are small organisations that consist of 0-10 paid employees (total number). 9% had no paid employees.\(^{30}\) 27% of respondents are medium organisations which consist of 11-50 paid employees (total number)

• 31% of respondents are large organisations which consist of >50 employees (total number).

The classification of organisations into small, medium and large was developed in consultation with the ERG as described at the start of the previous section. It was hypothesised that more organisations with smaller numbers of employees operate in the Mental Health NGO sector as compared to all businesses.

The vast majority of employing businesses in Australia (90%)\(^{31}\) employ fewer than 20 employees. Within this 90% of businesses, 70% of businesses reported 1-4 employees and 30% businesses reported 5-19 employees. There were also 9% businesses with 20-199 employees and <1% businesses with 200 or more employees (ABS data, 2007). Based on this data, organisations in the Mental Health NGO sector tend to have more employees than the average employing business in Australia. Individual practitioners were not included as in-scope for the Landscape Survey which affects the comparability of the Landscape Survey results with the ABS data.

As organisations may have been providers of services other than mental health (eg employment services or broader welfare support), respondents were subsequently requested to indicate the number of paid mental health staff for their organisation. Figure 21 presents the percentage of respondents (for the respective element of the question) indicating that range of paid mental health staff numbers at their organisation. The graph demonstrates the majority (58%) of non-government organisations in the survey reporting between 2 and 25 paid mental health staff with a peak (23%) in the 6 – 10 mental health staff range. Only 15% reported having over 50 paid mental health staff.

\[\text{Figure 21. Mental Health staff number ranges*}\]

\[\text{The proportions of paid staff numbers of those organisations who provide Mental Health services as at 30 November 2009:}\]

\[\begin{array}{ccccccccccc}
\text{Percent of respondents} & 0\% & 5\% & 10\% & 15\% & 20\% & 25\% \\
\text{Zero} & 12\% & & & & & \\
\text{1} & 6\% & 21\% & 23\% & & & \\
\text{2-5} & & & & & & \\
\text{6-10} & & & & 14\% & & \\
\text{11-25} & & & & & 9\% & \\
\text{26-50} & & & 8\% & & & \\
\text{51-100} & & 7\% & & & & \\
\text{>100} & & & & & & \\
\end{array}\]

* based on the percentage of respondents completing the respective element of the question. A total of 189 organisations responded to this part of the question.

\(^{30}\) Organisations with zero paid employees were more likely than the average responding organisation to rely on volunteers. 95% of the organisations with zero paid employees utilise volunteers.

\(^{31}\) Australian Bureau of Statistics data on business as at 30 June 2007.
A unique component of the Mental Health NGO Workforce is the emerging role of paid peer support workers, consumer workers and carer workers. The ERG provided advice around the terminology regarding the unique basis of employing these staff for their personal experience of mental illness rather than professional background. The 4th National Mental Health Plan (2009) recommends increasing consumer and carer employment in clinical and community support settings.

Table 14 includes survey results regarding the basis for employing particular categories of employees. 54% of respondents who completed that element of the question indicated that they employ consumer workers and 34% employ carer workers for their lived-experience of mental illness. The majority indicated that they employ clinical/health professionals on the basis of their health qualifications and others on the basis of their broader professional backgrounds.

**Table 14. Employment basis**

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Workers for their lived-experience of mental illness</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Carer Workers for their lived-experience of mental illness</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Clinical/health professionals on the basis of their health qualifications</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Others on the basis of their professional backgrounds</td>
<td>84%</td>
<td>16%</td>
</tr>
</tbody>
</table>

*Based on percentage of respondents completing the respective element of the question. There were a total of 239 responses to the overall question with a range of 196 to 213 response counts for each element of the question.

Volunteers

Many NGOs rely on the substantial contribution of volunteers. In 2006-07, a total of 4.6 million people volunteered for 623 million hours in the not-for-profit sector (equivalent to 317 000 full-time positions) (ABS 2009c). NGOs in the community or social services sector involved around 1.5 million volunteers.

Stakeholders consulted as part of this project noted that the volunteer workforce is an important adjunct to the paid Mental Health NGO workforce. 77% of the 229 organisations who reported this information utilise volunteers as part of their workforce. In some organisations this workforce was substantial.

Other studies of the sector have also found widespread use of volunteers:

- The MHCA NGO Capacity Development project (2009) concluded that the volunteers make a major contribution to the group of agencies receiving grants.
- The 2008 Queensland Alliance survey found that 65% of respondents reported utilising the services of volunteers. On average, these organisations engaged nearly 61 volunteers, with a median of 40 volunteers.
- The 2008 VICSERV Sector Snapshot found that over 80% of responding organisations use volunteers compared to nearly two-thirds in 2000. Over 91%
of these organisations now have policies and procedures guiding their work. The number of volunteers in each organisation ranges from 1 to 500 and the hours worked by each volunteer vary from 1-2 hours a week to 38 hours a week.

Respondents to the Landscape Survey were asked to approximate the total number of volunteers in their organisation as at 30 November 2009. Respondents were also asked to estimate this as an equivalence to a full time employee and to provide an estimate of the percentage of volunteers with a formal clinical health qualifications.

Figure 22 displays the percentage of respondents to each element of the question who have volunteers in the relevant ranges. The results can be summarised as follows:

Organisations with a small volunteer workforce:

- 53.9% of respondents to the total volunteer headcount element of the question indicated that they have 10 or fewer volunteers
- 34% of respondents to the total volunteer headcount element of the question indicated that they have 5 or fewer volunteers
- 69% of respondents to the total volunteer FTE element of the question indicated that this equates to 5 or less full time equivalent staff.
- 84% of respondents to the total volunteers with clinical health qualifications component indicated that they have 5 or fewer volunteers with these qualifications

Organisations with a medium volunteer workforce:

- 25.6% of respondents to the total volunteer headcount element of the question indicated that they have 11-50 volunteers
- 22% of respondents to the total volunteer FTE element of the question indicated that this equated to 11-50 full time equivalent staff.
- 16% of respondents to the total volunteers with clinical health qualifications component indicated that they have 6-50 volunteers with these qualifications

Organisations with a large volunteer workforce:

- 20.6% of respondents to the total volunteer headcount element of the question indicated that they have >50 volunteers
- 9% of respondents to the total volunteer FTE element of the question indicated that this equated to more than 50 full time equivalent staff.

None of the respondents to the total volunteers with clinical health qualifications component indicated that they have >50 volunteers with these qualifications.
Staff classification categories

Respondents to the Landscape Survey were asked to provide a profile of the types of paid staff categories who provide mental health specific services in their organisation. Table 15 displays the percentage of total respondents to the question (238 respondents) who indicated that they have one or more paid staff members who provide mental health specific services. The results indicate that the majority of organisations employ one or more administration (58%) or management staff (68%). A significant proportion of organisations have paid support workers on staff – 31% employ consumer workers, 19% employ carer workers and 55% employ support workers. 21% employ one or more psychologists and 3% employ psychiatrists. 13% of organisations employ one or more registered nurses.

Table 15. Percentage of respondents who have one or more of the following staff by staff category

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Respondents with paid staff in category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>58%</td>
</tr>
<tr>
<td>Management</td>
<td>68%</td>
</tr>
<tr>
<td>Consumer worker</td>
<td>31%</td>
</tr>
<tr>
<td>Carer worker</td>
<td>19%</td>
</tr>
<tr>
<td>Support worker</td>
<td>55%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3%</td>
</tr>
<tr>
<td>Other doctor besides psychiatrist</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Figure 22. Volunteer characteristics***

***Based on percentage of respondents completing the respective element of the question. There were a total of 187 responses to the overall question with a range of 150 to 180 response counts for each element of the question.
Respondents were also asked to provide further detail in relation to the full-time equivalent (FTE) of mental health specific service staff. Table 16 displays the percentage of total respondents to the question (238 respondents) who indicated that they have one or more paid FTEs who provide mental health specific services. The FTE proportions for each staff category are in-line with the number of staff in Table 15 above.

Table 16. Percentage of respondents who have 1 or more FTE in each staff category

<table>
<thead>
<tr>
<th>Staff Category</th>
<th>Respondents with paid FTE in category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>44%</td>
</tr>
<tr>
<td>Management</td>
<td>55%</td>
</tr>
<tr>
<td>Consumer worker</td>
<td>25%</td>
</tr>
<tr>
<td>Carer worker</td>
<td>14%</td>
</tr>
<tr>
<td>Support worker</td>
<td>47%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3%</td>
</tr>
<tr>
<td>Other doctor besides psychiatrist</td>
<td>3%</td>
</tr>
<tr>
<td>Counsellor</td>
<td>16%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>19%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>6%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>21%</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>11%</td>
</tr>
</tbody>
</table>
### Staff turnover and vacancies

The annual staff turnover rate is low for most organisations, as shown below in Figure 23. The lowest staff turnover category (0-5%) was reported by 31% of respondents, and comprised of 48% small organisations, 34% medium and 18% large. However, 30% reported a turnover rate of greater than 10%. An extrapolation (assuming 'not applicable' does not mean zero) resulted in an average turnover of 12.2% plus or minus 4.3% (7.9% to 16.5%).

Although it is difficult to find comparable figures, the voluntary staff turnover rate for small companies was 9% per annum in 2009 and 12.7% per annum in 2008 according to the Australian Institute of Management’s (AIM) National Salary Survey. The survey found that the top reasons for staff resignations from small companies were to pursue a new challenge (in 64.7 per cent of small companies) and to obtain better pay (in 51.8 per cent of small companies).

The average turnover reported in the Landscape Survey, at 7.9% - 16.5%, is close to the AIM study of all small companies and is lower than other figures from similar sectors:

- **The Australian Community Sector Survey 2010 Report (ACOSS, 2010)** presents the findings of the Australian Community Sector Survey conducted in November and December of 2009. The report provides information on service provision, income, expenditure, and operational, policy, and workforce issues for the community services and welfare sector (completed by 582 agencies). In this report staff turnover is a function of the number of staff leaving over the number of staff employed. In 2008-09, respondent agencies employed 5934 FTE staff and lost 4644 FTE staff. Average staff turnover across respondent agencies was therefore equivalent to 29%.

- A Victorian study of the public mental health workforce (Victorian Department of Human Services, 2005) found that annual staff turnover was estimated to be up to 22% in some occupational groups.\(^{32}\)

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32 For the purpose of this study, turnover was defined as the annual measure of the number of staff who have left a post and moved to another organisation or have left the service system. (Kings Fund, 2002,3).
86% of organisations reported that they did not have ongoing vacancies of more than six months as displayed in Figure 24. As the response to this question was a simple “yes” or “no” further analysis is not possible. The project is unable to determine whether staff employed have the right skills and training to be competent in the role in which they are employed. Variations may also exist in staff vacancies dependant on the role. There is also the possibility that a six month vacancy timeframe is too long to capture workforce shortage. Future Workforce Studies might want to consider a similar question which includes bands of time for vacancies (eg 1 month, 3 months, 6 months).

Figure 24. Ongoing vacancies
6.5 Mental Health NGO Workforce – Training and Education

Key findings from the Landscape Survey regarding training and education of the Mental Health NGO workforce:

- 39% of organisations reported that the majority of their staff who provide mental health services have a formal mental health qualification.
- 78% have a staff training and recruitment plan and/or workforce development plan.
- 31% have an annual staff turnover of 0-5% of total staff.
- 86% of organisations did not have ongoing vacancies of more than 6 months.

Formal mental health qualifications

Mental health training and education has been a key focus of recent mental health reforms. The Certificate IV in Mental Health was upgraded and restructured in 2008. One of the indicators proposed by the 4th National Mental Health (2009) is the proportion of front-line workers within given sectors who have been exposed to relevant education and training. However, it was noted that no existing data sources are available to monitor this indicator and that new ways of quantifying exposure to education and training in different service sectors would need to be explored. To date, the mental health workforce is largely classified based on experience in the field rather than training. For example, the ANZSCO definition of a registered mental health nurse is based on the principal area of nursing activity not the qualification of the nurse.\(^{33}\)

Respondents to the Landscape Survey were asked to estimate the percentage of paid staff providing mental health specific services who have attained formal mental health qualifications at the Vocational Education Training (VET) or university level. Of those who responded to the question, 39% indicated that over half of their paid mental health staff have formal mental health qualifications. There were 22% of respondents with 10% or fewer employees with mental health qualifications. The results are displayed in Table 17.

Table 17. Percentage of paid staff providing mental health specific services with formal mental health qualifications

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Response percent</th>
</tr>
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<tbody>
<tr>
<td>N/A</td>
<td>22%</td>
</tr>
<tr>
<td>&gt;0-10%</td>
<td>22%</td>
</tr>
<tr>
<td>11-25%</td>
<td>7%</td>
</tr>
<tr>
<td>26-50%</td>
<td>10%</td>
</tr>
<tr>
<td>51-75%</td>
<td>13%</td>
</tr>
<tr>
<td>76-100%</td>
<td>26%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^{33}\) ANZSCO code 254422 – Registered nurse (mental health): Treats and cares for people with mental illness, disorder or dysfunction, or those experiencing emotional difficulties, distress or crisis, in hospitals, nursing homes and the community.
Staff recruitment, training and development

78% of the 217 respondents indicated that they have staff training and recruitment plans and/or workforce development plans (refer to Figure 25 below). The 2008 Queensland Alliance sector survey found similar results with 71% of participating organisations reporting they had a workforce development plan or similar.

Figure 25. Percentage of respondents who have a staff training and recruitment plan / workforce development plan

Figure 26 shows the percent of an organisation’s total annual budget that is allocated to workforce training and development. The majority of the 186 respondents to this questions indicated they spend less than 10% of their total annual budget on training and development. The ABS (2003) reports net direct training expenditure averaged $383 (2002 figures) per employee and 1.2% of total gross wages and salaries in the health and community services industry. During the year ended June 2002, 85% of health and community services employers provided structured or unstructured training to employees.
55% of organisations who reported having a training and education budget stated more than 2% of their annual budget was spent on training and education. The organisations with less than 2% of their annual budget allocated to workforce training and development were broken down by size. 42% were small, 26% were medium, and 32% were large sized organisations.

The organisations with a larger portion (3-10%) of their annual budget being allocated to workforce training and development 43% were large, 26% were medium and 30% were small organisations.

The majority of organisations that allocated greater than 10% of their annual budget to workforce training and development were small (50%), followed by medium and large both at 25%. However this category was based on a small response count (only 8 respondents were in this category).

These results are in-line with ABS figures (2003) which show that the amount and proportion of spending on training is higher for larger businesses. Within the Mental Health NGO sector, the MHCC NSW Training Needs Assessment concluded that survey and interview feedback indicated there was a difference in the staff training opportunities available through the larger, well resourced NGOs, and smaller NGOs with access to very limited resources.

Landscape Survey respondents were asked to select all barriers related to training and development which they felt were applicable to their organisation (refer to Figure 27 below). The most common barrier selected was the inability to backfill staff when undertaking training followed by difficulty in accessing training / development and lack of budget for training / development. Only 16% of respondents indicated they thought inappropriate training was offered.
Figure 27. Current barriers to training and development

The additional free text comments reiterate the overall themes of barriers faced in relation to training and development:

- Lack of funding and time
- Difficulties in accessing training, particularly in rural and remote locations. Because training is often located in capital or major cities the cost of transport and accommodation limits the amount of training staff can attend
- Training is sometimes too basic or does not address the variety of individual skill levels.

These barriers are common themes arising in other studies of the sector as well.
6.6 Performance monitoring and improvement

Key findings from the Landscape Survey regarding performance monitoring and improvement:

- 23% are accredited with mental health specific standards
- 32% have no form of accreditation
- 91% undertake quality improvement or evaluation activities
- 45% collect staff and/or workforce data
- 88% gather information on their consumer and carer experiences

Accreditation

Figure 28 shows the forms of accreditation that organisations have attained. Of the 216 NGOs providing information on forms of accreditation, 23% reported being accredited with mental health specific standards. Given the recent revision of the Mental Health standards, the result provides a basis for the development of further accreditation and standards work in relation to the application and implementation of the relevant Mental Health NGO standards.

Figure 28. Accreditation of organisations

Quality improvement activities

91% of respondents indicated that they undertake quality improvement or evaluation activities to determine if their services are working well. Respondents listed a variety of mechanisms and modes in the free text field with some of the most common ones listed being:

- Client satisfaction surveys or feedback forms (both paper-based and online)
• Internal audits and assessments
• External audits or evaluations
• Community feedback
• Complaints registers
• Reference groups
• Quality improvement and review process for accreditation
• Monitoring of performance against indicators.

Approximately half of respondents indicated that they collect staff and/or workforce data. For respondents who listed the type of data collected the most common forms were staff satisfaction surveys, staff demographics, staff turnover rate and/or training participation.

Consumer and carer outcome measurement

88% of organisations reported gathering information on their consumer and carer experiences - the majority being through customer satisfaction surveys with regularity varying with three monthly, six monthly, annual and surveys every two years all featuring amongst responses.

63% of organisations reported collecting outcome measures for the consumers and carers they have supported, the majority being six monthly evaluations. Many used measurement tools such as DASS, WHOQoLs, HoNOS, Basis 32, LSP, K10 and CANSAS.

Of the 37% of respondents who answered ‘No’ to collecting outcome measures, 56% were small organisations, 31% were medium and 13% were large.

Not all tools listed as outcome measurement tools in the survey results are actually outcome tools. (This was a free text question.) The 2008 Queensland Alliance sector survey concluded that there was no consistent understanding of outcome measurement across the sector. Almost half of respondents reported using an outcome measurement tool, only two were provided as examples, and of these only one was an outcome measurement tool. The researchers concluded that, “there is a multitude of data collection methods being utilised in the sector for a variety of reasons including reporting, quality improvement and audit reports. Less evident is the use of these measurements to inform service users and providers of the efficacy of programs.”

6.7 Descriptions of achievements and challenges

The Landscape Survey provided respondents with the option to highlight some qualitative information on their organisations’ achievements and challenges.

Achievements which were frequently listed include:
• Improving access to and quality of care for consumers
• Improvements in consumer outcomes such as placing clients with mental illness in long term employment
• Providing flexible services which are responsive to consumer and carer needs
• Longevity of service provision and providing long term support to clients
• Ability to include innovative workforce models (e.g., peer support workers)
• Providing services across a range of locations
• Serving diverse client groups
• Recovery-oriented and real focus on the individual
• Moving from a volunteer to a funded service.

The Productivity Commission (2010) reported that in the community services sector, participants identified a number of key workforce issues that influence the effectiveness of not-for-profits, including:

• the impact of professionalisation on costs of delivering services
• difficulties attracting and retaining employees due to low wages
• high levels of employee turnover within the sector
• a lack of career paths and training opportunities.

The Landscape Survey touched on some of these issues and found that although there are difficulties in accessing training, staff turnover does not appear to be higher than for other businesses. Other barriers cited by respondents include:

• “The needs of the sector are vast and there are not enough resources. Synergies are also limited because networks are not well established.”
• “There can be professional conflicts between different groups (e.g., psychiatry vs psychology, nursing vs social work).”
• “The need for more leadership towards harmony of approach that values true community development for best recovery outcomes.”
• “Funding and red tape can be a problem, particularly for entirely volunteer organisations.”
• “Difficult to find funding for prevention and promotion work which many organisations indicated they would like to provide more service offerings in.”
• “Community organisations provide high quality cost effective services but are not adequately supported or funded appropriately. Small NGOs need to be retained to provide diversity and choice in service delivery.”
• “There are multiple surveys of the sector currently taking place which can be confusing and require additional time.”
7 Illustrative findings from the Workforce Survey

This section includes a summary of the indicative findings from the Workforce Survey. Extensive caveats surround the Workforce Survey results which are presented in this section and should not be seen as representative of the sector. The Workforce Survey was designed to test the reliability of an approach to workforce data collection for the Mental Health NGO sector. The focus was not on obtaining statistically significant data on the Mental Health NGO workforce.

The estimated response rate (based on estimates of the total Mental Health NGO workforce from conservative extrapolation of the Landscape Survey results) mental health workforce is low at approximately 5%. Therefore, the ability to extrapolate the results is limited.

Analysis supplied in this section is illustrative only and provided in order to establish the appropriateness of the survey methodology for future studies. However, in many instances, the indicative results of this Workforce Survey have aligned with results from other studies of the sector or related groups. This, along with the evaluation component of the survey, suggests the Workforce Survey is a reliable method for workforce data collection on the Mental Health NGO sector if future studies could obtain greater coverage of the workforce. A larger sample size and an appropriate sampling methodology are needed in order to obtain results which accurately represent the Mental Health NGO workforce.

7.1 Respondent profile

777 valid responses were received to the Workforce Survey (approximately 5% of the workforce or below based on best estimates of the size of the workforce). The Workforce Survey was targeted at all paid employees in an organisation that completed the Landscape Survey.

72% (of 768 respondents to that question) are female which is a trend seen in the overall health workforce which is also predominately female. However the average age of respondents is 42 years which is younger than other health professionals (759 respondents provided year of birth). The majority of Workforce Survey respondents were born in Australia, with the next highest birth country being the United Kingdom followed by New Zealand. (765 respondents provided information on country of birth.)

Respondents cover a wide geographic focus with respondents from all states and territories. 67% of 694 respondents’ current roles were focused in the states of New South Wales, Queensland and Victoria.

7.2 Qualifications, training and education

Half of 756 respondents indicated that they have a health professional qualification in the medical, nursing, Allied Health or ‘other’ fields. An individual’s interpretation of ‘tertiary’ and ‘qualification’ may have influenced the response to the ‘other’ field. A third of 462 individuals with a health professional qualification indicated that they are currently registered in their profession.
The data indicate high numbers of employees are engaged in, or already holding, high-level qualifications (Bachelor degree or above). 43.4% of 719 respondents have a bachelor degree or higher tertiary qualification which is a larger proportion than the general population (26.4%) and on par with the healthcare and social assistance sector (reported by the Australian Bureau of Statistics to be 40.6%). The indicative Workforce Survey results counter anecdotal perceptions of low level qualifications within the workforce.

Further analysis of highest educational qualifications indicated 32.8% of respondents hold a mental-health specific qualification, 22.0% hold a health qualification, 18.8% hold a leadership and management qualification and 26.5% hold ‘other’ qualifications. The Certificate IV in Mental Health makes up almost 30% of mental health qualifications. In addition, the survey identified that 19% of workers had no post-school qualifications.

21% of 743 respondents are currently studying for a mental health qualification. Overall, 80% of 620 respondents have undertaken some form of mental health training in the last two years.

68.9% of respondents have received their highest qualification within the last 10 years. Given that the average age of respondents is 42 years this suggests that a significant proportion of respondents have decided to undertake further studies later in their careers.

### 7.3 Employment and role

The average length of experience in a paid mental health role for survey respondents was 6.3 years, and the median 4 years. (756 individuals responded to this question). Although the length of experience in paid mental health roles is lower for respondents to this national Workforce Survey when compared to most other workforce surveys of related sectors, it does not necessarily indicate that there is less longevity in the Mental Health NGO sector.

When asked about current role, 79.1% of 675 respondents indicated that they began within the last 5 years. Just over half of 694 respondents of the respondents to this question reported being in permanent full-time roles. These findings contrast with the results of other workforce studies which have found a high proportion of part-time and/or casual staff in the not-for-profit or community services sector.

For primary job role, 34.9% selected the role of support worker. The next highest response was a management role, with 23.9% of respondents selecting this category. 3.1% of respondents indicated that their primary role is as a consumer worker and 3.3% as a carer worker. Although consumer and carer involvement in others’ recovery journeys is a longstanding practice, paid roles for consumers and carers is an emerging and unique trend. These workers can be employed in a broad range of other roles including direct support work, training and secondary consultation.

The average hours worked per week by all respondents at primary and other organisations (if applicable) is 34.4 hours (685 responded to this question). Respondents provide a diverse range of services. 92.2% (out of 688 individuals) indicated that they provide mental health rehabilitation or support services. Recovery planning/care coordination with other health/ service providers, home-based outreach services and

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34 673 respondents provided information about primary job role.
activities of daily living skills were the most frequently selected services. Mental health therapeutic services (e.g., Cognitive Behavioural Therapy approaches or other ‘talking therapies’) were provided by 44.5% of 658 respondents and 57.9% of 670 reported providing co-morbidity services.

Respondents selected “doing work of value to society” and “contributing to client outcomes” as the top reasons that drew them to their current role and keep them in their current role. The major reasons which would influence their future in the sector include better remuneration and more funding for service delivery.

7.4 Feedback from respondents on the Workforce Survey format, mode and process

Key findings regarding the administration and content of the Workforce Survey:

- Most respondents would prefer to complete the survey online
- Most respondents indicated that the survey was easy to understand, easy to complete, relevant and of the appropriate length
- Most respondents indicated ‘no’ or were ‘not sure’ if the Workforce Survey should be integrated with other surveys
- About two-thirds of respondents indicated that they were not asked to provide this type of data for other surveys

The Workforce Survey was designed to test the reliability of an approach to workforce data collection for the Mental Health NGO sector. This pilot survey was not a representative sample. The pilot provided interesting descriptive information from respondents but the key purpose of the survey was to pilot a methodology.

Feedback gathered through the built-in evaluation component to the survey demonstrated positive support for repeating this type of special-purpose survey of the sector. Most respondents found the survey easy to understand and complete, relevant and of the appropriate length. Respondents identified data definitions within the survey structure to reduce misinterpretation of data items. The Workforce Survey captures unique data as the majority of respondents indicated that they were not asked to provide this type of data for other surveys.

The vast majority of respondents (92.3%) would prefer to conduct similar workforce surveys online, as displayed in Figure 29 and Figure 30 below.
80-90% of respondents strongly agreed/agreed that:

- The questions were easy to understand (85.7% agreed or strongly agreed)
- The survey was easy to complete (90.4% agreed or strongly agreed)
- The questions were relevant (80.5% agreed or strongly agreed)
- The length of the survey was appropriate (88.1% agreed or strongly agreed).

**Figure 29. Preferred survey completion option**

**Figure 30. Rating aspects of the survey**
80% of respondents indicated that there were no more questions they would add to the survey. The remaining 20% suggested questions relating to funding, eligibility, pay, out of hours work, numbers of clients, professionalism, trauma, work/life balance, reasons for potentially leaving the sector and whether the size of the mental health sector is sufficient for community needs.

Several respondents noted that they would have liked questions which acknowledged the personal experience of a mental health problem or issue, would have liked a greater variety of role descriptions to select from and would like more questions/data collection which focuses on outcomes measurement.

The majority of respondents indicated they were not sure how the survey should be administered in the future and only 6.3% of respondents thought that the Workforce Survey should be integrated with other surveys as displayed in Figure 30 below. For those who advocated for integration, a common theme was that the Workforce Survey should be integrated with other surveys of the health and community sector (eg drug and alcohol, disability, youth and housing, public mental health workforce) to avoid creating “silos” for roles as there is the perception that many workers move between related sectors.

Figure 31. Possible integration of survey with other surveys or mental health data collection

The vast majority of respondents (94.9%) indicated that they were not asked or were unsure if they were asked to provide this data for other surveys. For those who indicated “yes”, the most common types of other surveys listed were internal staff satisfaction surveys and state/territory specific surveys of the sector.
Figure 32. Respondents being asked to provide this type of data in other surveys

Provided data for other surveys

- No: 62%
- Not sure: 32%
- Yes: 5%
- No: 62%
8  Key issues and findings for future surveys of the sector

Although the data garnered through the Landscape and Workforce Surveys provided interesting results, the primary purpose of this project was to design and test a methodology for data collection about the Mental Health NGO sector. It is important to note that respondents overwhelmingly indicated that future data collection on the sector is necessary. Therefore this section discusses lessons learnt about the process and methodology used for the Landscape and Workforce Surveys which should be considered for future data collection on the sector.

This section includes feedback based on discussions with the ERG and analysis of:

- Free text comments in both the Landscape and Workforce Surveys
- Feedback on the Workforce Survey gathered through the evaluation component which was included in the survey tool
- Input from the ERG

Mental health is a national priority area which spans across the patient care continuum. The increased focus on the mental health has highlighted definitional issues which make data collection and comparison for the Mental Health NGO sector difficult. In part, this reflects the nature of mental health as it overlaps the social and clinical determinants of health and wellbeing.

The policy shift from a purely medical model to a more balanced, recovery-oriented approach has acknowledged that there are numerous providers of mental health services (eg public community mental health services and those provided by NGOs). However there is a lack of clarity around terminology and in particular how specific terms are used to describe the Mental Health NGO sector and the services they provide.

The definitional issues and lack of clarity emerged from consultation with the ERG, discussions with other stakeholders as part of this project, during the drafting of the Landscape and Workforce Surveys. It was suggested that standardisation must balance the need for clarity with recognition that the sector is diverse and does not take a “one size fits all” approach to service offerings.

The following four subsections highlight in detail some of limitations and challenges of the study methodology. This is followed by some suggested areas for future investigation by the ERG and recommendations for future workforce studies of the sector.

8.1  Defining and measuring the sector

The project demonstrated defining and identifying the organisations within the Mental Health NGO sector is complex. In large part this was due to limited agreed national definitions data which describes the sector and its service categories. Given that many large NGOs provide services to a broad range of client groups, it was difficult to define those organisations which constitute a ‘Mental Health NGO’. The project, along with recent work by peak mental health organisations, has contributed to a greater understanding of the Mental Health NGO sector. This has included recent developments by NSW MHCC in relation service categories and organisation classification.
As described in Section 4.2, the Mental Health NGO sample which was used for this project most likely does not include every NGO that provides a mental health service in Australia. Rather this project focussed on capturing data from Type 1 and Type 2 organisations that are more specific to mental health.

Standardisation of terminology used to describe the sector and the types of services organisations would be beneficial. The MHCC classification system could be refined and applied nationally following validation.

8.2 Mental health NGO service categories

The list of service categories that were used for the project was developed in consultation with the ERG and is an area that has also been recommended for further refinement. Analysis of survey responses indicated that there was variability in how respondents interpreted some questions. For example 14% of respondents to the Landscape Survey stated that they do not deliver any mental health services. These responses were not filtered out because of the nuances which became apparent in trying to define a "mental health service". This is evidenced by the fact that most of the 14% of respondents mentioned above later ticked that they provided a mental health rehabilitation and support service, therapeutic service, mental health education and public awareness service or co-morbidity program.

In particular there may be a mismatch between the type of service provided and the client group being served in some cases. For example an NGO could provide housing support to people with mental health problems but not identify this as a "mental health service" as the housing support is provided to other client groups besides mental health consumers.

8.3 Response rate and bias

Response rates were computed for both the Landscape and Workforce Surveys based on the Mental Health NGO sample identified for this project. There are a number of limitations in interpreting the results of both the surveys which is discussed in Sections 5.4 and 7. This is the first national data collection on the sector and as such there is limited national data which can be used to compare results. The ERG recommended 'casting a wide net' to test the methodology. This approach may have led to organisations self determining if they considered themselves a Mental Health NGO.

Analysis of non-respondents was challenging in the absence of national data on Mental Health NGOs. High level analysis indicated some large Community Service and Mental Health NGOs may not have completed the survey. However, the use of the above mentioned classification system and distribution to all NGOs (through available national databases of non-government organisations) was suggested as an additional method to distribution through the mental health and other community services peak bodies.
Large community service organisations provide a wide number of services and to a variety of client groups. These may include mental health services. However, the community service organisation may not classify itself as a Mental Health NGO and therefore may be less likely to respond to a survey of this kind. This bias may be somewhat mitigated through refinement of definitions as discussed.

A common theme that emerged from Landscape and Workforce Survey free text fields is that the sector is overloaded with surveys and data collection, which most likely impacted on the response rates to the surveys conducted for this project. Regular feedback and the availability of regular workforce data may provide an incentive for sector participation. If the sector sees a ‘value add’ in participating this may assist in greater participation in future studies. However further support and incentives may be required to assist organisations to participate further in workforce and other data collections. A number of stakeholders and respondents reported the added burden of multiple surveys can be a challenge and may distract the sector from its primary role of supporting consumers and carers.

While incentives for survey completion at the individual staff or organisation level may be cost prohibitive or unpalatable, greater support to the peaks (or other appropriate bodies) to engage the sector and administer the survey may increase completion rates.

The vast majority of respondents to the Workforce Survey indicated that their preferred survey option is online (refer to Section 8). The experience of this project shows that multiple survey formats (eg online, hard-copy, fax-back) and distribution methods (eg email, mail-outs, conference attendance, etc) provide flexibility which makes it easier for people to respond.

The Mental Health Council of Australia NGO Capacity Development Project conducted an online survey to evaluate the program which had a response rate of 76.6%. Note that completion of the survey was not a requirement of receiving grant funding. However involvement with the project may have been a strong factor in encouraging responses. Similar methodologies which link to grant and other sector support activity may increase response rates.

For example completion of a survey could be a condition of funding, part of the accreditation process, etc. An alternate would be the requirement to collect workforce data as part of regular performance or funding reporting requirements or as part of a mental health or Mental Health NGO minimum data set.

8.4 Question format

It was recognised the survey questions structures allowed some subjective interpretation. The project has allowed identification of the questions for future refinement and these are contained in Appendix 3 Appendix 4
9 ERG recommendations for future workforce studies of the sector

Based on analysis of benefits, limitations and challenges of the approach and methodology utilised in this project, the ERG and key project stakeholders provided suggestions around improvements for any future studies of the sector.

There is support in the Mental Health NGO sector and the Mental Health NGO Workforce Project ERG for future and ongoing collection of workforce data on their sector to assist in future workforce planning. The Mental Health NGO Project ERGs recommendations are highlighted in Table 18 below:

Table 18. Mental Health NGO Project Expert Reference Group recommendations

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<table>
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<tbody>
<tr>
<td>1.</td>
<td>Development of agreed national definitions and a data dictionary which includes a list of standard classifications for organisation, service, workforce and other related categories to describe the work of the Mental Health NGO sector.</td>
</tr>
<tr>
<td>2.</td>
<td>Working with the Australian Bureau of Statistics (ABS), Mental Health Workforce Advisory Committee (MHWAC), Mental Health Information Services (MHIS) subcommittee of the Mental Health Standing Committee (MHSC) and other relevant government organisations to define and include relevant definitions for emerging workforces in data collection requirements. For example:</td>
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<td></td>
<td>i Consider mechanisms for linking to funders’ and regulators’ performance reporting,</td>
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<td></td>
<td>ii incorporating in any future plans for Information collections for Non-Profit Institutions based on the 2010 Productivity Commission review of the Non-Profit Institution review and/or,</td>
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<tr>
<td></td>
<td>iii developing ANZSCO codes for emerging workforces such as consumer and carer peer support workers.</td>
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<tr>
<td>3.</td>
<td>Following the development of standardised data collection forms and methodologies, conduct a special purpose study of the mental health and Mental Health NGO sector with broad coverage of all non-government organisations in Australia (obtained through national databases of non-government organisations).</td>
</tr>
<tr>
<td>4.</td>
<td>Analyse future data collections on the basis of the organisations and their workforces based on those who meet the agreed classification and service categories.</td>
</tr>
<tr>
<td>5.</td>
<td>Engaging and supporting the sector and the peak bodies to conduct and complete future workforce surveys.</td>
</tr>
<tr>
<td>6.</td>
<td>Continuing to offer multiple modes and methods of survey completion (on-line and paper based) to increase response rates and ease of survey completion.</td>
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9.1 ERG suggestions on areas for further investigation

The data obtained from this project are largely descriptive in nature. Results from the surveys, as well as discussions with the ERG, have highlighted a number of areas for further investigation and exploration. Some of these do not relate directly to workforce supply and development; however they are of interest in supporting the broad work of the sector. These suggestions are detailed in Table 19 below. Literature searches conducted for this project have also highlighted the lack of evaluation and outcomes measurement that has been undertaken on the sector – a theme which also emerged from survey free-text fields and discussions with stakeholders.

Table 19. Areas for further investigation

<table>
<thead>
<tr>
<th>Areas for further exploration suggested by the ERG</th>
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<tbody>
<tr>
<td>• Explore capacity building for Mental Health NGO peak bodies – useful suggestions may come from other sectors</td>
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<tr>
<td>• Explore ongoing and specific workforce development capacity</td>
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<tr>
<td>• Examine short-term versus longer term funding for organisations and its role in providing workforce stability, retention and sustainability</td>
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<tr>
<td>• In future data collections include questions and analysis which examines skill gaps and lived experience across all job roles</td>
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<tr>
<td>• Further explore the expanding nature of organisations and how long existing organisations have been providing mental health services</td>
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<tr>
<td>• Investigate the definition of “clinical role” in greater detail – how much clinical work is being done in this sector.</td>
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</table>

Hands-on engagement with the sector has proved essential for encouraging responsiveness. A key method for involving the sector in this project was the support, endorsement and engagement of the Mental Health NGO peak bodies in each state/territory to promote and distribute the Landscape Survey. Going forward, it was suggested that the peak bodies would continue to play a pivotal role in education, training, strategy, promoting a recovery-based approach, benchmarking of standards and benchmarking of services. Their role in workforce development and workforce surveys would enhance the effectiveness of the engagement of the sector in future studies.
10 Conclusion

The HWA Mental Health NGO Workforce Project tested an approach and methodology to collecting service and workforce data from this vital sector. The results, while not necessarily definitive, did provide some indicative data which was seen to be of benefit to the sector even if for information purposes only. The project also highlighted a number of the challenges in definitions and data collection of this agile and evolving sector.

Key findings from this project relevant to the design of future studies include:

1. Defining and measuring the Mental Health NGO workforce is more complex than for many workforces owing to variations in organisational funding and workforce structures, and also fluid boundaries within the sector.

2. Traditional labour force surveys are not able to be referenced for this workforce given the apparent lack of available national labour or service activity data. In the absence of this data for Mental Health NGOs and their workforces a ‘grass roots’ or special purpose survey is appropriate.

3. Prior to proceeding with any future studies, there should be development of consistent national categories for
   a. the types of non-government organisations providing mental health support, and
   b. the types of service they provide.

4. There is support in the Mental Health NGO sector for future and ongoing collection of workforce data on their sector to assist in future workforce planning.

5. The Mental Health NGO peak bodies in each state/territory were vital in engagement with the sector and proved essential for credibility, endorsement of the study and encouraging responsiveness to the surveys.

The Productivity Commission (2010) has also documented a number of key points regarding the difficulties in data provision for the not-for-profit sector, including:

- Although there have been improvements to the sector’s knowledge base, more could usefully be done. In particular there is limited data at a disaggregated level.

- Data available for undertaking measurement and evaluation is of variable quality and typically not available on a regular or timely basis.

- There is no common measurement and reporting framework which would facilitate data and information collection and assist in assembling evaluations of the contributions of NFPs on a coherent basis for comparison.

- Support for evaluation in the sector is lacking, and sharing of findings is limited.

These data limitations also apply to the Mental Health NGO sector and one of the primary reasons for conducting this project was to design a tool which can produce accurate data about the sector and its workforce.
This report provides the first national picture of the Mental Health NGO sector in Australia. The ERG and other stakeholders felt there would be benefit in ongoing data collection on the sector. This would provide longitudinal data for trend analysis, assist future workforce planning and contribute to assessing the achievement of the sector against the 4th National Mental Health Plan and the National Mental Health Workforce Strategy and Plan.
## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Service and program categories</td>
<td>92</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Workforce Survey results</td>
<td>99</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Feedback on the Landscape Survey data items</td>
<td>128</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Feedback on the Workforce Survey data items</td>
<td>137</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Landscape Survey Tool</td>
<td>145</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Workforce Survey Tool</td>
<td>161</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Expert Reference Group membership</td>
<td>174</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>References</td>
<td>175</td>
</tr>
</tbody>
</table>
Appendix 1   Service and program categories

This Appendix includes several sources of service and program categories which were used to inform the development of the service categories listed in the Landscape and Workforce Surveys. The service categories, which were further developed and refined in consultation with the project’s ERG, are listed in Questions 8-11 of the Landscape Survey tool (Appendix 2) and Questions 24-27 of the Workforce Survey tool (Appendix 6). The two key sources of information were the Mental Health Coordinating Council’s (MHCC) 2010 Report of the New South Wales Community Managed Sector Mapping Project and the 2008 Mental Health Funding Methodologies Roundtable Discussion Paper which was co-sponsored by the Australian Healthcare and Hospitals Association, The Mental Health Services Conference of Australia and New Zealand (TheMHS) and PricewaterhouseCoopers. This work may provide the basis for future work in relation to data dictionary development an agreed set of standardised service categories.

MHCC Sector Mapping Project

The Mental Health Coordinating Council have recently conducted a service mapping project outlining seven core service areas which broadly describe the types of services provided by the community-managed mental health sector, as detailed in Figure 33 below.

1  Accommodation support and outreach
2  Employment and education
3  Leisure and recreation
4  Family and carers
5  Self-help and peer support
6  Helpline and counselling services
7  Prevention and promotion
Mental Health Funding Methodologies Roundtable Discussion Paper

Table 20 highlights the interventions and delivery systems that are evidence-based and required in a comprehensive mental health care system. This table was developed for the Mental Health Funding Methodologies Roundtable Discussion Paper and includes some source material from Alan Rosen’s 2008 *Evidence Based and Promising Components of Mental Health Services: Interventions and Delivery Systems*. The categories within this paper assisted in an initial classification of service components which was later refined by the project ERG.

While this discussion paper focused on specialised mental health services, a comprehensive services continuum needs to extend beyond primary health care and mental health to services such as housing, employment, education, and leisure activities available locally or provided from other sectors and local authorities. While it is important to identify and provide accurate costings for evidence based interventions which should be provided by all comprehensive mental health services (see column 1), it is equally important to identify and cost the essential infrastructure and evidence based vehicles or sub-systems which allow them to be appropriately accessed and delivered to the appropriate people in a timely manner at the most effective site (column 2).

Table 20. Evidence-based Components and Continuum of Care

<table>
<thead>
<tr>
<th>Evidence-based (or promising) Interventions ie contents or care</th>
<th>Evidence-based (or promising) Delivery Systems ie facilities or vehicles for care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GP liaison and shared care</td>
<td>1. Primary care mental health liaison team and supported transfer of care coordination</td>
</tr>
</tbody>
</table>

---


<table>
<thead>
<tr>
<th>Evidence-based (or promising) Interventions (ie contents or care)</th>
<th>Evidence-based (or promising) Delivery Systems (ie facilities or vehicles for care)</th>
</tr>
</thead>
</table>
| 2. Public health proactive approach to prevention, early detection and intervention seeking | 2a) Mental Health First Aid Course  
2b) telephone help lines, web-based mental health information and brief intervention services  
2c) Prodromal assessment, monitoring and support service  
2d) Early intervention team in youth health centre context |
| 3a) Crisis and family intervention  
3b) Home visit assessments, interventions and reviews  
3c) Acute respite care  
3d) Emergency psychiatric services in general hospital emergency departments, including effective triage and brief, targeted, behavioural interventions as required | 3a) & b) 24 hours or extended hours mobile community-based crisis intervention services  
3c) 24 hour supervised community-based residential respite facility, as alternative to hospital admission, plus step up and down care  
3d) eg 24 hour roster of psychiatric triage nurse consultants in busy emergency departments – emerging evidence of effectiveness, though should not replace crisis services. eg psychiatric emergency centres approximated to or in emergency departments – very costly, yet no evidence to support any advantage over less restrictive alternatives, such as 3.c) above. eg brief intervention clinic or role of crisis team in delivering repertoire of behavioural interventions following emergency dept presentation—emerging evidence. |
| 4a) Active-response intake and mobile care coordination (case management) sub system  
4b) Assertive/Intensive community care management for individuals with persistently severe disabilities | 4a) Local community-based mental health centre near shopping and transport hubs  
4b) Assertive community treatment team, meeting international fidelity criteria |
| 5. Biological Interventions.  
5a) Medications and other technologies  
5b) Attending properly to physical care of individuals with mental illness | 5. Biological Intervention Systems  
5a) Monitoring and adverse effects/interactions/polypharmacy minimizing risk management system, community pharmacist consultation and liaison service  
5b) Protocols, monitoring and intervention systems to minimize physical illness and risk factors in individuals with mental illness eg CVS and diabetes regular risk factor monitoring system  
eg aerobic exercise and weight monitoring |
<table>
<thead>
<tr>
<th>Evidence-based (or promising) Interventions</th>
<th>Evidence-based (or promising) Delivery Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evidence-based (or promising) Delivery Systems</td>
</tr>
<tr>
<td></td>
<td>projects, individual and group</td>
</tr>
<tr>
<td><strong>6. Psychological Interventions</strong></td>
<td><strong>6. Psychological Interventions</strong></td>
</tr>
<tr>
<td></td>
<td>Delivery and supervision network, plus monitoring for fidelity.</td>
</tr>
<tr>
<td></td>
<td>- CBT</td>
</tr>
<tr>
<td></td>
<td>- DBT</td>
</tr>
<tr>
<td></td>
<td>- IPT</td>
</tr>
<tr>
<td></td>
<td>- neurocognitive remediation</td>
</tr>
<tr>
<td></td>
<td>- supportive psychotherapy</td>
</tr>
<tr>
<td><strong>7. Social Interventions</strong></td>
<td><strong>7. Social Intervention Systems:</strong></td>
</tr>
<tr>
<td><strong>7a) social</strong></td>
<td><strong>7a) eg clubhouse or equivalent</strong></td>
</tr>
<tr>
<td></td>
<td>- leisure</td>
</tr>
<tr>
<td></td>
<td>- education</td>
</tr>
<tr>
<td></td>
<td>- work</td>
</tr>
<tr>
<td></td>
<td>- financial</td>
</tr>
<tr>
<td><strong>7b) Residential</strong></td>
<td><strong>7b) A range of supervised residential facility options</strong></td>
</tr>
<tr>
<td></td>
<td>Living in your own home wherever possible</td>
</tr>
<tr>
<td></td>
<td>- A range of different levels of supervision in residential settings</td>
</tr>
<tr>
<td><strong>7c) Inpatient Interventions</strong></td>
<td><strong>7c) (Evidence sparse for optimal characteristics &amp; effectiveness)</strong></td>
</tr>
<tr>
<td></td>
<td>On general hospital site</td>
</tr>
<tr>
<td></td>
<td>- Medical technologies, eg ECT, TMR, etc require up to date</td>
</tr>
<tr>
<td></td>
<td>- Equipment, regular staff training and refreshers, daily pharmacist input</td>
</tr>
<tr>
<td></td>
<td>- Minimize or eliminate restraint and seclusion</td>
</tr>
<tr>
<td></td>
<td>- Minimize involuntary care</td>
</tr>
<tr>
<td></td>
<td>- Psycho-education and adaptive communication and problem solving skills on an individual, group and family basis</td>
</tr>
<tr>
<td></td>
<td>- Supportive psychotherapies on an individual group and family basis</td>
</tr>
<tr>
<td></td>
<td>- Attractive, welcoming spaces, softly furnished, calming use of colours.</td>
</tr>
<tr>
<td></td>
<td>- Modularized unit, allowing separate safe spaces for vulnerable or dangerous inpatients</td>
</tr>
<tr>
<td></td>
<td>- Supportive psychotherapies on an individual group and family basis</td>
</tr>
<tr>
<td>Evidence-based (or promising) Interventions</td>
<td>Evidence-based (or promising) Delivery Systems</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>As there is little evidence to support inpatient admissions generally, seek less restrictive alternatives asap, whether for acute short term or supervised extended stay residential care</strong></td>
<td><strong>sub-unit and unlocked subacute sub-unit</strong></td>
</tr>
<tr>
<td><strong>Evidence-based (or promising)</strong></td>
<td><strong>Maximise staff: inpatient ratio and interaction</strong></td>
</tr>
<tr>
<td><strong>Delivery Systems</strong></td>
<td><strong>Minimise use of locked doors, restraints, seclusion, and restriction of leave.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Maximise indoor and outdoor spaces, so agitated inpatients do not feel so cooped up</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Separate bedrooms with good sightlines for staff with acute observation inpatients</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Minimise hanging points and other dangerous environmental features</strong></td>
</tr>
<tr>
<td><strong>8. Cultural Interventions</strong></td>
<td><strong>8. Unobtrusive but effective duress alarm system for service providers, inpatients and visitors</strong></td>
</tr>
<tr>
<td>8a) Microcultural:</td>
<td><strong>8a) Individual family intervention at home</strong></td>
</tr>
<tr>
<td>– Family education support and communication and problem solving skills intervention, including surrogates, confidantes and support persons.</td>
<td>– Multiple family group intervention conducted by team which can systematically provide staff to work with families out of office hours</td>
</tr>
<tr>
<td>8b) Macrocultural:</td>
<td><strong>8b) Community awareness local</strong></td>
</tr>
<tr>
<td>– Community awareness</td>
<td>– Meetings/local action committees</td>
</tr>
<tr>
<td>– Community education</td>
<td>– Mental Health First Aid courses</td>
</tr>
<tr>
<td>– Challenging stigma and discrimination</td>
<td>– Community awareness public/</td>
</tr>
<tr>
<td></td>
<td>– Media campaigns</td>
</tr>
<tr>
<td></td>
<td>– Challenging stigma local public media campaigns</td>
</tr>
<tr>
<td></td>
<td>– Challenging stigma workplace</td>
</tr>
<tr>
<td></td>
<td>– Programmes</td>
</tr>
<tr>
<td><strong>9. Comorbidities</strong></td>
<td><strong>9. Comorbidity Service Systems for a) to g).</strong></td>
</tr>
<tr>
<td>9a) Dual interventions for:</td>
<td><strong>Service delivery system with professional expertise and facilities which will address both problems simultaneously, not making the treatment of one problem conditional and secondary to treatment of the other.</strong></td>
</tr>
<tr>
<td>Substance abuse and mental illness</td>
<td><strong>h) Consultation-liaison psychiatric team for each general hospital facility – evidence that these significantly reduce lengths of hospital stay</strong></td>
</tr>
<tr>
<td>Intellectual disability and mental illness</td>
<td></td>
</tr>
<tr>
<td>Specific learning disability and mental illness</td>
<td></td>
</tr>
<tr>
<td>Brain injury and mental illness</td>
<td></td>
</tr>
<tr>
<td>Severe physical disability and mental illness</td>
<td></td>
</tr>
<tr>
<td>Eating/dieting disorders, physical and psychiatric components</td>
<td></td>
</tr>
<tr>
<td>Evidence-based (or promising) Interventions</td>
<td>Evidence-based (or promising) Delivery Systems</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>g)</strong> Forensic problems and mental illness</td>
<td><strong>10. Comprehensive Service Systems</strong></td>
</tr>
<tr>
<td><strong>h)</strong> Consultation-liaison psychiatric services to medical and surgical wards</td>
<td><strong>10a) Integrated at several levels:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>i</strong> care coordinator/case manager working closely together with service-users and family, to develop and review an individual care plan</td>
</tr>
<tr>
<td></td>
<td><strong>ii</strong> interdisciplinary mental health team</td>
</tr>
<tr>
<td></td>
<td>– with coordinated delegation of</td>
</tr>
<tr>
<td></td>
<td>– tasks around service-user needs,</td>
</tr>
<tr>
<td></td>
<td>– encapsulated in an individual care plan,</td>
</tr>
<tr>
<td></td>
<td>– which is regularly reviewed</td>
</tr>
<tr>
<td></td>
<td><strong>iii</strong> collaborative planning between:</td>
</tr>
<tr>
<td></td>
<td>– primary care, acute mental health</td>
</tr>
<tr>
<td></td>
<td>– care and longer term rehabilitation</td>
</tr>
<tr>
<td></td>
<td>– recovery work and specialist</td>
</tr>
<tr>
<td></td>
<td>– health services</td>
</tr>
<tr>
<td></td>
<td><strong>iv</strong> coordinated planning and service</td>
</tr>
<tr>
<td></td>
<td>– delivery between public</td>
</tr>
<tr>
<td></td>
<td>– private and NGO mental health</td>
</tr>
<tr>
<td></td>
<td>– services</td>
</tr>
<tr>
<td></td>
<td><strong>v</strong> coordinated planning and service</td>
</tr>
<tr>
<td></td>
<td>– delivery between mental health</td>
</tr>
<tr>
<td></td>
<td>– and all other relevant agencies, eg housing, work, education,</td>
</tr>
<tr>
<td></td>
<td>– welfare, financial/benefits,</td>
</tr>
<tr>
<td></td>
<td>– recreation and leisure – ie integrating efforts of State and Commonwealth funded agencies, with a coordinated all of government response</td>
</tr>
<tr>
<td><strong>10b)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>i</strong> Consumer peer support specialists</td>
</tr>
<tr>
<td></td>
<td>– certified training and placement in</td>
</tr>
<tr>
<td></td>
<td>– clinical teams</td>
</tr>
<tr>
<td></td>
<td><strong>ii</strong> Recovery oriented experiential</td>
</tr>
<tr>
<td></td>
<td>– workshop training for service</td>
</tr>
<tr>
<td></td>
<td>– users, providers and families</td>
</tr>
<tr>
<td></td>
<td><strong>iii</strong> Working with communal</td>
</tr>
</tbody>
</table>
| Evidence-based (or promising) Interventions  
| i.e. contents or care | Evidence-based (or promising) Delivery Systems  
| i.e. facilities or vehicles for care |
|---|---|
| iv | Coping, resilience, buoyancy, work/life balance, hope instilling etc. skills training for service users, providers and families |
| v | Consumer & Carer participation in service management, recruitment etc |
| vi | Consumer choices take precedence, where possible, in drawing up own individual plan |
| 10c) Age-appropriate interventions provided specifically for each age group wherever possible | 10c) Age-appropriate delivery systems provided specifically for each age group wherever possible. |
Appendix 2  Workforce Survey results

This section includes results for the Workforce Survey from a total of 777 survey respondents, including a narrative summary of results. The survey sought to collect data in a number of categories to pilot a Workforce Survey for future data collection and analysis. These categories are as follows:

- survey respondent profile and demographics
- survey respondent qualifications
- mental health training and education
- employment history
- current employment
- recruitment and retention
- feedback on the Workforce Survey.

Caveats around the Workforce Survey results presented in this appendix:

The Workforce Survey was designed to test the reliability of an approach to workforce data collection for the Mental Health NGO sector. The focus was not on obtaining statistically significant data on the Mental Health NGO workforce. Caveats have been placed around the data from the Workforce Survey given its low coverage of the whole Mental Health NGO sector’s workforce, and the use of convenience sampling to obtain responses. The estimated response rate (based on estimates of the total Mental Health NGO workforce from conservative extrapolation of the Landscape Survey results) mental health workforce is approximately 5%. Responses to the Workforce Survey may not represent the actual characteristics of the Mental Health NGO workforce because convenience sampling rather than representative sampling was utilised. Therefore the results presented below should be seen as indicative of one section or a representation of the workforce and not necessarily a true representative sample. The ability to extrapolate the results with confidence is limited.

Analysis supplied in this section is indicative of the comparisons that can be made with more robust data, in order to further the knowledge base on the sector. In many instances, the indicative results of this Workforce Survey have aligned with results from other studies of the sector or related groups. This, along with the evaluation component of the survey, indicates that the Workforce Survey is a reliable method for workforce data collection on the Mental Health NGO sector. However a larger sample size and probability-based sampling methodology (eg random or stratified) is needed in order to obtain results which accurately represent the Mental Health NGO workforce.

Survey respondent profile and demographics

Key findings regarding Workforce Survey respondent profile:

- The average age of respondents is 42 years which is younger than other health professionals
- 73% of respondents are female
- 73% of respondents were born in Australia
- 96% of respondents spoke English as their primary language at home

759 Workforce Survey responses were received for year of birth, and 768 for gender questions. Of the respondents providing gender information, 72.8% are female. Based on AIHW and ABS labour force surveys, the health workforce is predominately female as displayed in Table 21 below. The exception is psychiatrists with two-thirds being male. State-specific studies of the community mental health workforce have found similar gender distribution patterns to this national Workforce Survey. For example, the
Mental Health Council of Tasmania conducted a 2009 survey of their membership and found that 70% of employees were female (refer to Table 21 below).

### Table 21. Comparisons between studies of employed workforce by gender

<table>
<thead>
<tr>
<th>Study Description</th>
<th>% Female</th>
<th>% Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Psychiatrists</td>
<td>35.3%</td>
<td>64.7%</td>
<td>100%</td>
</tr>
<tr>
<td>(2) Mental Health Nurses</td>
<td>66.9%</td>
<td>33.1%</td>
<td>100%</td>
</tr>
<tr>
<td>(3) Psychologists</td>
<td>80%</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>(3) All health workers (AIHW)</td>
<td>75%</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>(4) Total Employed in Healthcare and Social Assistance (ABS)</td>
<td>67.0%</td>
<td>33.0%</td>
<td>100%</td>
</tr>
<tr>
<td>(5) Mental Health Council of Tasmania 2009 Workforce Study</td>
<td>70%</td>
<td>30%</td>
<td>100%</td>
</tr>
<tr>
<td>(6) NHWPRC Workforce Survey</td>
<td>72.8%</td>
<td>27.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>


The age profile of respondents to the Workforce Survey is shown below in Figure 34. 50.9% of respondents are in the 30 to 49 year age bracket, and 92.7% fall in the 20 to 59 age bracket. The proportions by generation for pre-Baby Boomers, Baby Boomers, Generation X and Generation Y are 0.7%, 29.4%, 53.0% and 17.0% respectively.

---

In this report Pre-Baby Boomers are defined as those people born between 1925 and 1942 inclusive (in 2010 this would include an age range of 68-85 years). Baby Boomers are defined as those people born between 1943 and 1960 inclusive (in 2010 this would include an age range of 50-67 years). Generation X is defined as those people born between 1961 and 1981 inclusive (in 2010 this would include an age range of 29-49 years). Generation Y is defined as those people born between 1982 and 2005 inclusive (in 2010 this would include an age range of 5-28 years).
The average age of respondents to the Workforce Survey is 42.0 years which is less than the 45.8 years for mental health nurses, 48.5 years for psychiatrists and 43.7 years for all enrolled and registered nurses (AIHW Labour Force Surveys, 2007). However a 2007 study of the mental health community services workforce in South Australia also reported a profile of the workforce that was relatively young, with the average age between 35-40 years (Mental Health Coalition of South Australia, 2007). A 2009 survey conducted on the community mental health workforce in Tasmania concluded that their survey results did not indicate as high a proportion of employees aged over 46 as the national and state trends in community services (Mental Health Council of Tasmania, 2009). The Workforce Survey results corroborate the state/territory specific surveys which found that the age of the Mental Health NGO employee population is younger on average than other health professional groups or community services.

As with the general nursing population, the mental health nursing workforce is ageing, with the average age increasing from 44.6 in 2003 to 45.8 years in 2007. Because the Workforce Survey is the first national review of the Mental Health NGO workforce in Australia, it is unclear if similar trends of an ageing workforce can be seen in this sector as well. However it does appear that the Mental Health NGO workforce is younger on average than other health workers (albeit still potentially ageing).

2.4% of Workforce Survey respondents identified as Aboriginal or Torres Strait Islander. This is considerably higher than the 0.3% of medical practitioners employed in medicine who identified themselves as Indigenous (AIHW Medical Labour Force Survey, 2007) and 0.8% of employed nurses who are Indigenous (AIHW Nursing and Midwifery Labour Force Survey, 2007). Aboriginal and Torres Strait Islander people represent 2.5% of the Australian population but their use of mental health services is greater than this proportion. They accounted for 5.6% of the mental health-related emergency department occasions of service, and 4.4% of all emergency department occasions of service (AIHW, 2010).

The majority of Workforce Survey respondents were born in Australia (72.9%), with the next highest birth country being the United Kingdom (8.5%) followed by New Zealand (4.4%). The proportions can be seen in Figure 35 below, with a total of 35 countries listed as options in-line with the ABS Population of Census and Housing. 5.2% of respondents selected ‘other’.
Additional information was provided about the primary language spoken at home. 96.3% of respondents to this question spoke English as their primary language at home. Each of the other 30 languages listed were selected by less than 1% of respondents, with 0.8% selecting ‘other’. Respondents were also asked to indicate the country where they received their highest educational qualification. 90.8% of respondents received at least one of their highest qualifications in Australia, followed by the UK (3.5%) and New Zealand (1.7%). Given that over one quarter of respondents were born outside of Australia, this result indicates that most people are conducting at least some of their education in Australia, regardless of where they were born.

Figure 35. Country of birth, legend only showing countries of highest response

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>43.2%</td>
</tr>
<tr>
<td>Canada</td>
<td>4.3%</td>
</tr>
<tr>
<td>Germany</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hong Kong (SAR of China)</td>
<td>2.3%</td>
</tr>
<tr>
<td>India</td>
<td>2.3%</td>
</tr>
<tr>
<td>Ireland</td>
<td>2.3%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2.3%</td>
</tr>
<tr>
<td>Malta</td>
<td>2.3%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2.3%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2.3%</td>
</tr>
<tr>
<td>Philippines</td>
<td>2.3%</td>
</tr>
<tr>
<td>South Africa</td>
<td>2.3%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2.3%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2.3%</td>
</tr>
<tr>
<td>United States of America</td>
<td>2.3%</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Survey respondent qualifications

Key findings regarding Workforce Survey respondent qualifications:

- 43% of respondents hold a bachelor degree or higher tertiary qualification (i.e. postgraduate certificate or diploma, Masters degree or PhD) indicating that the workforce has a higher level of education qualification on average than the general population
- 19% have no post-school qualifications
- 54% of respondents have a health professional qualification
- 31% of respondents with a health professional qualification were registered in that profession
- 33% of respondents have a mental health qualification as one of their highest qualifications
- 22% of respondents have a health qualification as one of their highest qualifications

Health professional qualifications

54.4% of respondents indicated that they have a health professional qualification in the medical, nursing, Allied Health or ‘other’ fields. Of those selecting ‘other’, respondents reported a range of degrees and qualifications related to residential support, welfare and community workers and counsellors. An individual’s interpretation of ‘tertiary’ and ‘qualification’ may have influenced the response to the ‘other’ field.
The profile of health professional qualification responses is shown in Figure 36 below, with 24.3% selecting ‘other’, 13.8% selecting social worker, 7.8% selecting psychologist and 6.3% selecting registered or enrolled nurse. There was only one respondent who indicated that they are a doctor.

**Figure 36. Health professional qualification**

34.9% of individuals with a health professional qualification indicated that they are registered in their profession. For the professions listed below in Figure 37, the proportion registered is shown graphically. 46% of psychologists indicated that they are registered and 38% of registered nurses, 31% of enrolled nurses, 37% of social workers, 36% of occupational therapists and 30% of ‘other’ professions indicated that they are registered in their respective fields.
The registration requirements and process differ by health profession and recently significant changes were made to the legislation. From 1 July 2010 the National Registration and Accreditation Scheme (NRAS) for health professionals took effect in Australia, replacing the previous state and territory registration boards with national profession-specific boards. The 10 health professions captured under the national scheme as of 1 July 2010 are chiropractors, dental care practitioners, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. Four additional health professions will join the national scheme on 1 July 2012, including: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.

One would expect that in the future the proportion of registered professionals in the relevant NRAS professions (eg medical, nurses, psychologists and occupational therapists from 2012) would increase. The fact that the registration rates were below 50% in the Workforce Survey may also indicate that respondents hold health professional qualifications but are not be currently practising in that field.

### Highest educational qualifications

719 individuals responded with their highest educational qualification obtained. A total of 1187 qualifications were logged; therefore many respondents had multiple qualifications at their highest level. The breakdown of highest educational qualifications held is shown below in Figure 38. 18.9% of respondents indicated that they have no post school qualifications. 43.4% of the 1187 qualifications logged are a bachelor degree or higher tertiary qualification (ie postgraduate certificate or diploma, Masters degree or PhD). For other higher education, 17.9% have a vocational graduate certificate or diploma or other advanced diploma/diploma. 19.9% have a Certificate III or IV.
Further analysis of highest educational qualifications indicates that 32.8% of respondents hold a mental-health specific qualification, 22.0% hold a health qualification, 18.8% hold a leadership and management qualification and 26.5% hold ‘other’ qualifications. Note that these categories were self-selected by the respondent (e.g. the respondent determined whether their Certificate IV was mental health specific, health, leadership, management or ‘other’).

The mix of qualifications specific to health and mental health compared with the remaining mix of qualifications in leadership, management and ‘other’ is displayed in Table 22 below. For example those qualifications that were considered to be mental health (as selected by the respondent) were broken down by type of degree (e.g. PhD, Bachelor Degree, Certificate IV, etc.) as a percentage of total mental health qualifications. Note that those respondents with no post school qualifications are not included in this analysis because, in general, a high school diploma cannot be categorised as mental health, health, leadership, management, or other. The results in Table 22 show that Certificate IV makes up a substantially higher proportion of mental health highest qualifications than for either health of leadership/management/other qualifications (27.7% as compared to 13.5% and 18.1% respectively). This higher proportion may be due to additional employees undertaking the Certificate IV in mental health in recent years although this cannot be determined definitely from the data.

**Table 22. Proportional breakdown of qualifications by type**

<table>
<thead>
<tr>
<th>Highest qualification</th>
<th>Mental health qualifications</th>
<th>Health qualifications</th>
<th>Leadership, Management and ‘Other’ qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhD</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>9.7%</td>
<td>6.0%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>
Workforce Survey results

<table>
<thead>
<tr>
<th>Highest qualification</th>
<th>Mental health qualifications</th>
<th>Health qualifications</th>
<th>Leadership, Management and ‘Other’ qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Graduate Certificate/Diploma</td>
<td>15.8%</td>
<td>9.5%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Vocational Graduate Certificate/Diploma</td>
<td>1.9%</td>
<td>3.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Bachelor Degree</td>
<td>31.6%</td>
<td>40.5%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Advanced Diploma</td>
<td>2.3%</td>
<td>4.5%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Diploma</td>
<td>8.1%</td>
<td>18.0%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Certificate IV</td>
<td>27.7%</td>
<td>13.5%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Certificate III</td>
<td>2.6%</td>
<td>5.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

A number of state/territory-specific workforce studies have examined the educational qualifications for their respective Mental Health NGO workforce. Summarised results from these surveys are displayed in Table 23 below. Note that the sampling and methodology differed somewhat between the surveys so the results are not directly comparable. However some clear trends emerge from these surveys which corroborate the results of the national Workforce Survey.

In particular, the data indicate that high numbers of employees are engaged in or already holding high-level qualifications (Diploma/Bachelor or above). Results from all surveys indicate that the Mental Health NGO workforce is more educated than the general population given that 26.4% of employed people aged 15-74 years have a Bachelor degree or above as their highest qualification (ABS Education and Work, May 2009). Note that 40.6% of those people aged 15-74 who are employed in healthcare and social assistance hold a Bachelor degree or higher as their highest qualification (ABS Education and Work, May 2009). This is on par with the Workforce Survey results which found that 43.4% of respondents have a bachelor degree or higher tertiary qualification. The ABS “healthcare and social assistance” industry category encompasses a broad range of employment which varies to other groupings of the health workforce (for example AIHW labour force surveys). However the Workforce Survey results indicate that the survey respondents have educational attainment levels which are in-line with those of the ABS healthcare and social assistance workforce.

These results contradict previous reported perceptions of low levels or absence of qualifications within the workforce that were raised by many respondents to the state-territory specific surveys. The WA Workforce in Crisis report (2008) claims that the high ratio of workers in the sector with post-school qualifications indicates the complexity of the work undertaken and the growing level of professionalism across the surveyed service sectors.

Table 23. Summary of state/territory-specific mental health workforce surveys for post-school qualifications

<table>
<thead>
<tr>
<th>State/territory</th>
<th>Survey results of Mental Health NGO and/or community services: post-school qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) ACT, 2009</td>
<td>• 60% of staff held tertiary qualifications</td>
</tr>
<tr>
<td></td>
<td>• 27% were identified as health related qualifications</td>
</tr>
<tr>
<td></td>
<td><strong>Mental health qualifications:</strong></td>
</tr>
<tr>
<td></td>
<td>• 14% of staff were identified as holding some form of Mental Health qualification</td>
</tr>
<tr>
<td>(2) TAS, 2009</td>
<td>• 6% had a post graduate degree</td>
</tr>
</tbody>
</table>
Workforce Survey results

<table>
<thead>
<tr>
<th>State/territory</th>
<th>Survey results of Mental Health NGO and/or community services: post-school qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 34% had a tertiary qualification</td>
</tr>
<tr>
<td></td>
<td>• 22% had a VET Diploma</td>
</tr>
<tr>
<td></td>
<td>• 19% had a VET Cert IV</td>
</tr>
<tr>
<td></td>
<td>• 10% had a VET Cert III</td>
</tr>
<tr>
<td></td>
<td>• 3% of people were non-accredited</td>
</tr>
<tr>
<td></td>
<td>• 7% were enrolled in related qualification</td>
</tr>
<tr>
<td></td>
<td>• 9% of people had multiple qualifications</td>
</tr>
<tr>
<td>(3) QLD, 2008</td>
<td>• Approximately 47% of employees had earned TAFE Certificates</td>
</tr>
<tr>
<td></td>
<td>• 28% had received undergraduate degrees</td>
</tr>
<tr>
<td></td>
<td>• 2% of employees had received a Masters degree and less than</td>
</tr>
<tr>
<td></td>
<td>• 0.5% had received a PhD qualification</td>
</tr>
<tr>
<td>(4) VIC, 2008</td>
<td>• 20% of employees held post-graduate degrees as their highest level qualification</td>
</tr>
<tr>
<td></td>
<td>• A further 15% held post-graduate diplomas</td>
</tr>
<tr>
<td></td>
<td>• 33% held undergraduate degrees</td>
</tr>
<tr>
<td></td>
<td>• 24% held Diploma level qualifications</td>
</tr>
<tr>
<td></td>
<td>• 8% held Certificate level qualifications</td>
</tr>
<tr>
<td>(5) WA, 2008</td>
<td>• 85% of workers held post-school qualifications</td>
</tr>
<tr>
<td></td>
<td>• 45% of employees held Bachelor degrees or higher</td>
</tr>
<tr>
<td></td>
<td>• 16% had no post school qualifications</td>
</tr>
<tr>
<td>(6) SA, 2007</td>
<td>• 40% of all staff across the sector held a university level qualification</td>
</tr>
<tr>
<td></td>
<td><strong>Mental health qualifications:</strong></td>
</tr>
<tr>
<td></td>
<td>• Just under half of all staff had a qualification specifically related to mental health</td>
</tr>
<tr>
<td>(7) NSW, 2006</td>
<td>• 96% of agency managers held a tertiary level qualification (Bachelors degree or higher)</td>
</tr>
<tr>
<td></td>
<td>• 70% of staff held a tertiary qualification</td>
</tr>
<tr>
<td></td>
<td>• 21% of agency managers had a Certificate IV</td>
</tr>
<tr>
<td></td>
<td>• 52% of staff held a health-related tertiary qualification</td>
</tr>
<tr>
<td></td>
<td><strong>Mental health qualifications:</strong></td>
</tr>
<tr>
<td></td>
<td>• 32% of staff held a mental health related tertiary qualification</td>
</tr>
<tr>
<td></td>
<td>• 5% of had a Certificate IV (non-clinical mental health)</td>
</tr>
</tbody>
</table>


Year of qualification

Figure 39 displays the year qualified for the highest qualification received. Interestingly 43.7% of respondents received their highest qualification in 2005-2009 and a further 25.2% received theirs in 2000-2004, indicating that 68.9% of respondents have received their highest qualification within the last 10 years. Given that the average age of respondents is 42.0 years this suggests that a significant proportion of respondents have decided to undertake further studies later in their careers.

19.9% of respondents have received their highest qualification in the 1990s and a further 6.9% have received theirs in the 1980s. Only 5.0% of respondents received their highest qualification in 1979 or earlier.
Figure 39. Year of qualification

Mental health training and education

**Key findings regarding Workforce Survey respondents’ mental health training and education:**

- 21% of respondents are currently studying for a mental health qualification
- Overall, 80% of respondents have undertaken some form of mental health training in the last two years

20.7% of respondents are currently studying for a mental health qualification. Of those that are, over a third are undertaking a Certificate IV qualification. There have been a number of changes to the Certificate IV in Mental Health in the last few years. In 2008 the Certificate IV in Mental Health Work (non-clinical) was upgraded and restructured to create the new Certificate IV in Mental Health. This qualification defines the knowledge and skills required by support workers and case workers who work autonomously under the broad guidance of others in delivering services to clients with mental health issues. It refers to specific knowledge of appropriate intervention processes applied in residential and community settings.\(^{38}\)

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Overall, 79.8% of respondents have undertaken some form of training and education related to mental health in the last 2 years. Interestingly the definition of a mental health worker often relates to the current area of work rather than holding mental health related qualifications. For example in the AIHW’s Mental Health Services in Australia 2007-08 report, the definition of mental health nursing is based on a self-identified principal area of nursing activity rather than the qualification of the nurse.

Other key findings regarding mental health training and education from the Workforce Survey include:

- 73.5% of respondents have undertaken mental health education in the last two years that was run by the organisation they work for.
- 75.0% of respondents have undertaken mental health education in the last two years that was run by an outside organisation.
- 31.0% of respondents are required to participate in continuing education.

High proportions of those undertaking mental health training were also reported by the state/territory-specific workforce studies. For example the MHCC Mental Health Training Needs Analysis (2006) found that 88% of survey respondents reported that mental health staff in their organisations had undertaken training in the last 12 months.
Employment history

Key findings regarding Workforce Survey respondents’ employment history:
- 39% of respondents had one or two years in a paid mental health role
- The mean experience was 6.3 years, and the median 4 years
- 66% of respondents were employed in health and/or community services prior to their current employment

Experience in paid mental health role

20.5% of respondents have up to one year of experience in a paid mental health role, and 16.8% have two years experience as displayed in Figure 41 below. The mean experience is 6.3 years, and the median 4 years. The mean finding is lower than the length of service seen in the public mental health sector. A study conducted by the Victorian Department of Human Services (2005) found that at 30 June 2002 staff averaged 11.8 years in the Victorian public mental health sector and 13.7 years in the mental health sector overall. However the Workforce Survey results are in-line with a sector snapshot conducted by VICSERV in 2008 which found that there was an increase in the average number of years worked in the psychiatric disability rehabilitation and support sector (PDRSS) from 4.0 years in 2000 to 6.0 years (SD±4.5) in 2007. The largest increase was in the group of staff who have worked in the sector between five and ten years, which had increased from 16% to 36%. Similarly, the percentage of staff who have worked in the sector for over ten years increased from 7% to 17%.

Note that other state/ territory specific studies of the community mental health workforce have also indicated that there is longevity in the Mental Health NGO sector. For example, the Mental Health Community Coalition ACT 2009 workforce survey found that senior managers completing the survey were highly experienced and qualified in terms of years of service within the mental health community sector (mean average of 8 years). The Mental Health Coordinating Council’s 2006 Sector Training Needs Analysis found that agency managers were highly qualified with an average 14 years industry experience.

Although the length of experience in paid mental health roles is lower for respondents to this national Workforce Survey when compared to other surveys except the VICSERV study, it does not necessarily indicate that there is less longevity in the sector. Because the mean (6.3 years) is higher than the median (4 years) this may indicate growth in the sector as a significant number of new people commence work in the sector.
Prior employment

66.1% of respondents were employed in the health and community services sector, prior to their current position. 20.9% were employed in another sector, 8.8% were unemployed or undertaking education and 4.9% fell into the volunteer category. The fact that the majority of respondents were employed in the health and community services sector prior to their current role is consistent with a 2005 study of the public mental health workforce conducted by the Victorian Department of Human Services (now the Victorian Department of Health). While the researchers concluded that it was not possible to accurately determine where staff departing a public mental health employer went, data collected suggested that up to two-thirds may move to another public mental health employer. Similarly VICSERV’s 2008 study of the PDRS sector concluded that staff had a broad range of experience prior to entering the PDRS sector with many working in other areas of mental health or general health care. Over a quarter of staff had previous experience in the mental health sector and similarly, over a quarter in the community welfare sector and over a quarter in the disability sector (some of these may be the same staff with previous experience in more than one sector).

The response count is displayed in Figure 42 below for those who indicated that they were employed in the health and community services sector prior to their current role – either in a mental health role or a non-mental health role. 26.2% of respondents who were previously employed in the health and community services sector were employed as a support worker. The next highest prior employment response in the health and community services sector fell under management with 17.4% selecting this category.
Current employment

Key findings regarding Workforce Survey respondents’ current employment:

- 67% of respondents’ current roles were focused in the states of NSW, Qld and Vic
- 31% of respondents began their current role in the last year
- 8% of respondents began their current role over ten years ago
- 86% of respondents are in some form of permanent employment
- The average number of hours worked at the primary organisation is 32.7 hours per week

Geographic focus

The geographic focus of the respondent’s current role is shown graphically below in Figure 43. The most populous states (NSW, QLD, VIC and WA) have the most representation. However, there are a higher proportion of respondents from Victoria (24.5%) and Queensland (23.8%) than NSW (18.3%) even though NSW has the largest population in Australia. Note that respondents to the Workforce Survey represent a sample of those who responded to the Landscape Survey and therefore do not exactly mirror the distribution of NGOs across Australia (see Section 6.1 for the response count of organisations by state/territory).
Role

79.1% of the 675 respondents providing the date of employment commencement began their current role within the last five years. This figure can be further broken down as follows: 31.0% began their current role within the last year, 19.3% began their current role within the last 1-2 years and 28.9% began their role 2-5 years ago. 8.1% of respondents began their current role over ten years ago. A graphical presentation of commencement of current employment is shown below in Figure 44.
Workforce Survey results

Figure 44. Commencement of current employment

The breakdown of employment status is show below in Figure 45. 56.3% of respondents are in a permanent full time role and 29.8% are permanent part time, indicating that 86.2% of respondents are in a form of permanent employment.

Figure 45. Employment status

These findings contrast with the results of other workforce studies which have found a high proportion of part-time and/or casual staff in the not-for-profit or community services sector:
Workforce Survey results

- ABS analysis of not-for-profit organisations (NFPs) found that for health NFPs only 24.7% of employees were permanent full-time. 58.0% of employees were permanent part-time and 17.3% were casual employees (ABS, Not-for-profit Organisations, Australia, 2006-07).

- The Mental Health Council of Tasmania’s workforce study also found a high proportion of part-time workers which was consistent with the national community services workforce profile (ACOSS, 2010) and the Tasmanian community sector workforce profile (TasCOSS, 2008).

The reasons for the variation between previous studies and this Workforce Project cannot be determined from the current data, and would require further data collection and analysis of a larger sample which is selected with the aim of being representative of the Mental Health NGO workforce. Results may relate to more full time staff having the inclination and time to complete the survey. Unsurprisingly given the high proportion of permanent staff, 88.2% of respondents are not employed by multiple organisations as displayed in Figure 46 below.

Figure 46. Multiple employment

<table>
<thead>
<tr>
<th>Response count</th>
<th>Multiple employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>600</td>
<td>No</td>
</tr>
<tr>
<td>400</td>
<td>Yes, but this is the only organisation where I am employed in a mental health role</td>
</tr>
<tr>
<td>200</td>
<td>Yes I am employed by multiple organisations in multiple mental health roles</td>
</tr>
</tbody>
</table>

Primary job role information was given by 699 respondents with 34.9% falling under the role of support worker. The next highest response was a management role, with 23.9% of respondents selecting this category. 3.1% of respondents indicated that their primary role is as a consumer worker and 3.3% as a carer worker. Although consumer and carer involvement in others’ recovery journeys is a longstanding practice, paid roles for consumers and carers is an emerging and unique trend. These workers can be employed in a broad range of roles including direct support work, training and secondary consultation.

18.5% of respondents specified ‘other’ role, these being mostly a range of workers (for example: field, rehabilitation, community, project).
Workforce Survey results

Figure 47. Primary job role

![Primary job role diagram]

Figure 48. Working hours in a typical week

![Working hours diagram]

Working hours

685 respondents provided their working hours in a typical week. 96.9% of respondents work 40 or fewer hours per week in their primary job. 34.5% work 38 hours, on average. 14.3% work 40 hours on average. 8.1% work 30 hours. The breakdown is shown below in Figure 48.

Working hours were broken down into 5 hourly time bands, and analysed by employment role. A graphical representation of the hours worked, broken down by roles is shown below in Figure 49. Findings from this breakdown are:
• 54.0% of respondents work 36 to 40 hours in a typical week
• 10.8% work 26 to 30 hours, and the same percent again work 31 to 35 hours
• 79.5% of managers work 36 to 40 hours in a typical week. Managers also make up the largest proportion of employees who work more than 40 hours per week
• 52.6% of support workers work 36 to 40 hours in a typical week.
Overall, the average number of hours worked at the primary organisation is 32.7 hours per week. Filtering out respondents who work for more than one organisation (10% of total), the total hours worked is 33.8 hours per week at the primary (ie only) organisation. The overall average number of hours worked for all respondents to this question (including hours at primary and additional organisations) is 34.4 hours.
Managers work 38.3 hours per week on average and support workers work 34.1 hours. Because of the small sample of respondents for other professional groupings, these average hours are not displayed for the Workforce Survey.

Table 24 displays the average hours worked per week by health professional group based on data from AIHW and ABS labour force surveys. The average hours worked by respondents to the Workforce Survey (34.4 total hours for all respondents to this question) is higher than the average hours worked by all health workers as per AIHW and psychologists and social workers. This may be due to the high proportion of managers who responded to the Workforce Survey, and tend to work longer hours. Note that the ABS labour force data indicates that psychiatrists and mental health nurses work longer average hours at 40.1 and 36.7 hours per week respectively.

**Table 24. Average hours worked per week by health professional group**

<table>
<thead>
<tr>
<th>Health professional group</th>
<th>Average hours worked per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Psychologists</td>
<td>31.4</td>
</tr>
<tr>
<td>(1) Social Workers</td>
<td>31.3</td>
</tr>
<tr>
<td>(2) Psychiatrists</td>
<td>40.1</td>
</tr>
<tr>
<td>(3) Mental Health Nurses</td>
<td>36.7</td>
</tr>
<tr>
<td>(1) All health workers (AIHW)</td>
<td>31.7</td>
</tr>
<tr>
<td>(4) Workforce Survey (all – primary organisation only)</td>
<td>32.7</td>
</tr>
<tr>
<td>(4) Workforce Survey (respondents working only at one organisation)</td>
<td>33.8</td>
</tr>
<tr>
<td>(4) Workforce Survey (all – primary and other organisations)</td>
<td>34.4</td>
</tr>
<tr>
<td>(4) Workforce Survey (Support Workers)</td>
<td>34.1</td>
</tr>
<tr>
<td>(4) Workforce Survey (Managers)</td>
<td>38.3</td>
</tr>
</tbody>
</table>


Paid work respondents who indicated the hours they spent in broad types of work are shown below in Figure 50, broken down by mental health client contact work, mental health work which is non-contact or administrative or other non-mental health work. Figure 50 indicates that many respondents undertake a range of activities in their roles, although non-mental health work makes up a smaller component.
Workforce Survey results

Figure 50. Hours worked by type of work

![Graph showing working hours by broad type of work]

Services - Rehabilitation, Support, Therapeutic, Co-morbidity programs

Of 688 respondents employed in a mental health role, the vast majority – 92.2% – reported that they provide mental health rehabilitation or support services. Respondents were asked to select their top 3, a breakdown of which is shown below in Figure 51. The highest responses were for recovery planning/care coordination with other health/service providers, home-based outreach services and activities of daily living skills. In particular recovery planning/care coordination was also frequently selected by respondents to Landscape Survey. Interestingly 42% of respondents to the Landscape Survey indicated that their NGOs provide peer support but only 5.6% of respondents to the Workforce Survey indicated that peer support was one of the top 3 services that they provide in their role. Again, this may relate to the convenience sample nature of the project.
Mental health therapeutic services were provided by 44.5% of the 658 respondents to this area of interest. Of those providing therapeutic services, 69.9% registered these services under talking therapies, other psychotherapies and counselling.

Of 688 respondents employed in a mental health role, 16.1% reported providing no mental health education or public awareness services. The remaining provided their top 3, a breakdown of which is shown below in Figure 52. The highest responses are for individual advocacy for consumers and community events for mental health awareness. These categories were also frequently selected by respondents to the Landscape Survey.
Workforce Survey results

Figure 52. Mental health education and public awareness services

Of 670 respondents employed in a mental health role, 57.9% reported providing co-morbidity services. Respondents were asked to list their top 3, a breakdown of which is shown below in Figure 53. The highest responses were for substance use and mental illness, and complex or exceptional needs.

Figure 53. Co-morbidity programs

The top 3 administration / management areas that 604 respondents in a mental health role were involved in for their primary organisation are shown below in Figure 54. General team support and program development were the most frequently selected roles.
Population groups

The top 3 population groups that 691 respondents in a mental health role were involved in as part of their current role for their primary organisation are shown below in Figure 55. All population groups except international students were selected by at least some respondents. Women, men and the unemployed were the most frequently selected population groups.

Figure 55. Service provision recipients - Population groups
Recruitment and retention

Key findings regarding recruitment and retention:
- Respondents are attracted and remain in their roles because they are doing work of value to society and are contributing to client outcomes
- Better remuneration and more funding for service delivery would encourage people to stay in the sector
- Within the 10 year timeframe, respondents would prefer to stay in the sector

Recruitment

Respondents were asked to rate the top reason for choosing their current role. The 629 respondents selected “doing work of value to society” and “contributing to client outcomes” as the top reasons that drew them to their current role, as shown below in Figure 56.

**Figure 56. Reasons for choosing current role**

The top reason for 696 respondents that keeps them in their current role is shown below in Figure 57. Again, contributing to client outcomes and doing work of value to society were the most frequently selected reasons, albeit in reverse order to above.
Retention

691 employees logged at least one time frame preference indicating their likelihood of changing sectors in the future. In all cases except for the 10 year timeframe, the preference was against changing sectors. A sector change was more likely for the 10 year time frame, with 34.4% indicating a change of sector, 39.4% undecided and 26.2% unlikely or definitely not changing sectors. The results are shown below in Figure 58.
The preferences for change were analysed by age for the 12 month option. With the exception of the preference to not change for 26 year olds, there is little evidence that age is a factor in the decision to change sectors in the next 12 months, as shown below in Figure 59.
682 employees provided an indication of reasons that would influence their future in the sector. The major reasons were better remuneration and more funding for service delivery. The results are shown graphically below in Figure 60.
Feedback on the Landscape Survey data items

Appendix 3  Feedback on the Landscape Survey data items

Table 25 below is a comprehensive list of the data items (ie the survey questions) which were included in the Landscape Survey. For each data item the following types of information are listed:

- Type of question (eg multiple choice, free text, etc)
- The source of information which was used to develop the data item, if applicable
- Areas identified for further refinement to the survey tool.

The areas for further refinement were identified through analysis of the Landscape Survey results, free text comments included in the survey responses and discussions with the ERG. Key areas identified for further refinement include:

- Service categories are non-standard are
- Geographic areas of operation (Question 3)
- Service categories which are non-standard (Questions 6, 8, 9, 10, 11)
- List of population groups (Question 12)
- List of age groups (Question 13)
- Calculation of proportion of funding from various sources (Question 17)
- Non-standard list of professions (Question 23, 24, 25)
- Calculation of annual staff turnover rate (Question 30)
Feedback on the Landscape Survey data items

- Timeframe for ongoing vacancies (Question 31).

Refer to Appendix 4 for additional details on each data item. A copy of the Landscape Survey tool is included in Appendix 5.

Table 25. Data Items included in the Mental Health NGO Landscape Survey including type, source and suggested areas of refinement for future data collections

<table>
<thead>
<tr>
<th>Mental Health NGO Landscape Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Introduction</strong></td>
</tr>
<tr>
<td><strong>Section notes:</strong></td>
</tr>
<tr>
<td>- Type: Information for respondents – no questions included in this section</td>
</tr>
<tr>
<td>- Source: not applicable</td>
</tr>
<tr>
<td>- Areas for refinement: not applicable</td>
</tr>
<tr>
<td><strong>2. Glossary of key terms</strong></td>
</tr>
<tr>
<td><strong>Section notes:</strong></td>
</tr>
<tr>
<td>- Type: Information for respondents – no questions included in this section</td>
</tr>
<tr>
<td>- Source: The majority of definitions included in this section are from the Fourth National Mental Health Plan</td>
</tr>
<tr>
<td>- Areas for refinement: not applicable</td>
</tr>
<tr>
<td><strong>3. Profile of your organisation</strong></td>
</tr>
<tr>
<td><strong>1. General details:</strong></td>
</tr>
<tr>
<td><strong>Question notes:</strong></td>
</tr>
<tr>
<td>- Type: Self-reported free-text fields</td>
</tr>
<tr>
<td>- Source: not applicable</td>
</tr>
<tr>
<td>- Areas for refinement: no changes to question required.</td>
</tr>
<tr>
<td><strong>2. Are you completing this survey for the whole organisation or a state/territory branch?</strong></td>
</tr>
<tr>
<td><strong>Question notes:</strong></td>
</tr>
<tr>
<td>- Type: multiple choice (only one answer) and free text comment field</td>
</tr>
<tr>
<td>- Source: not applicable</td>
</tr>
<tr>
<td>- Areas for refinement: no changes to question required.</td>
</tr>
</tbody>
</table>
| **3. In which areas in the states/territories does your organisation operate?**
| Please tick all that apply.       |
| **Question notes:**               |
| - Type: matrix of choices (multiple answers per row) |
| - Source: based on Australian Standard Geographic Classifications |
| - Areas for refinement: Consider derived question based on postcode information rather than self-selected geographical location. Could potentially ask for top 3 locations in which organisation operates. |
| **4. What is the legal entity of your organisation?** |
| **Question notes:**               |
| - Type: multiple choice (only one answer) |
### Mental Health NGO Landscape Survey

- Source: Adapted from New Zealand NgOIT survey and Australian state-based surveys
- Areas for refinement: no changes to question required.

5. How long has your organisation been in existence?

**Question notes:**
- Type: multiple choice (only one answer) and free text field for those in operation > 20 years
- Source: Adapted from New Zealand NgOIT survey and Australian state-based surveys
- Areas for refinement: no changes to question required.

4. Services your organisation provides

**6. How would you describe the services that your organisation provides? Please tick all that apply.**

**Question notes:**
- Type: matrix of choices (multiple answers per row). * denotes mandatory question
- Source: not applicable
- Areas for refinement: Confusion apparent in answering this question for some respondents. In particular percentages between primarily, mixed and some services did not add up to 100% in all cases (eg respondent may have rated 3 types of services as “primarily” which is greater than 50% and therefore not possible for 3 services). Consider non-matrix version of question which asks respondent to rate the top 3 type of services provided.

7. How many Mental Health consumers and carers did your organisation support in a DIRECT (ie via telephone or face-to-face) and INDIRECT (eg web/online support, mail, advertising) capacity during the last 12 months?

**Question notes:**
- Type: matrix of choices (only one answer per row)
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys
- Areas for refinement: no changes to question required.

**8. What type of Mental Health REHABILITATION and SUPPORT services does your organisation currently provide? Please tick all that apply.**

**Question notes:**
- Type: multiple choice (multiple answers) and free text field for “other” * denotes mandatory question
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input. Mental Health Funding Methodologies Roundtable Discussion Paper (2008) and MHCC Report of the NSW Community Managed Sector Mapping Project (2010) used as source information.
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services.

**9. What type of THERAPEUTIC Mental Health services does your organisation currently provide? Please tick all that apply.**

**Question notes:**
- Type: multiple choice (multiple answers) and free text field for “other” * denotes mandatory question
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input. Mental Health Funding Methodologies Roundtable Discussion Paper (2008) and MHCC Report of the NSW Community Managed Sector Mapping Project (2010) used as source information.
### Mental Health NGO Landscape Survey

- **Areas for refinement:** Non-standardised list of services which may have led to confusion about definitions of services. Service categories are not mutually exclusive. "Therapeutic" or "clinical" services (usually provided by registered health professions such as nurses and psychologists) were difficult to define.

**10. What type of Mental Health EDUCATION and/or PUBLIC AWARENESS does your organisation currently provide? Please tick all that apply.**

**Question notes:**
- Type: multiple choice (multiple answers) and free text field for "other" * denotes mandatory question
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input. Mental Health Funding Methodologies Roundtable Discussion Paper (2008) and MHCC Report of the NSW Community Managed Sector Mapping Project (2010) used as source information.
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services

**11. What COMORBIDITY programs does your organisation currently offer for people with Mental Health problems or illness and the following comorbidities? Please tick all that apply.**

**Question notes:**
- Type: multiple choice (multiple answers) and free text field for "other" * denotes mandatory question
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input. Mental Health Funding Methodologies Roundtable Discussion Paper (2008) and MHCC Report of the NSW Community Managed Sector Mapping Project (2010) used as source information.
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services

**12. Which population groups does your organisation service? Please tick all that apply.**

**Question notes:**
- Type: multiple choice (multiple answers) and free text field for "other"
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input
- Areas for refinement: the population groups listed were not mutually exclusive. Many organisations ticked all groups indicating that in the future in might be useful to make this question more targeted (eg select top 3 population groups).

**13. Does your organisation serve specific age groups? Please tick all that apply.**

**Question notes:**
- Type: multiple choice (multiple answers)
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input
- Areas for refinement: Many respondents ticked all groups indicating that in the future in might be useful to make this question more targeted (eg select top 3 age groups).

**5. Funding for your organisation**

**14. What was your organisation's total annual income from all sources and for all programs for the last financial year?**

**Question notes:**
### Mental Health NGO Landscape Survey

- **Type:** multiple choice (only one answer)
- **Source:** Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys
- **Areas for refinement:** no changes to question required.

#### 15. What percentage of your organisation’s total annual income was for MENTAL HEALTH SERVICES last financial year?

**Question notes:**
- **Type:** multiple choice (only one answer)
- **Source:** Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys
- **Areas for refinement:** no changes to question required.

#### 16. What percentage of total MENTAL HEALTH funding was for short-term project-based (eg less than 2 years) services or programs in the last financial year?

**Question notes:**
- **Type:** multiple choice (only one answer)
- **Source:** defined by the ERG
- **Areas for refinement:** no changes to question required.

#### 17. Please tick ALL SOURCES of funding that are for MENTAL HEALTH SERVICES and rate the approximate percentage of total MENTAL HEALTH funding for your organisation for the last financial year. (THE TOTAL SHOULD ADD UP TO 100%).

**Question notes:**
- **Type:** matrix of choices (only one answer per row) and free text “other” field
- **Source:** Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys
- **Areas for refinement:** Total percentage did not add up to 100% for all respondents. Consider adding error message if selection does not sum to 100%. Alternatively question could be worded as “rank top 5 funding sources”.

#### 18. Does your organisation offer Medicare-funded services specific to Mental Health?

**Question notes:**
- **Type:** multiple choice (only one answer) and free text comments field
- **Source:** defined by the ERG
- **Areas for refinement:** no changes to question required.

### 6. Staffing of your organisation

*19. Please indicate the number and full-time equivalent (FTE)* of PAID staff for your organisation as at 30 November 2009:

**Question notes:**
- **Type:** matrix of choices (only one answer per row) * denotes mandatory question
- **Source:** Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input
- **Areas for refinement:** no changes to question required.
**Mental Health NGO Landscape Survey**

*20. Does your organisation employ: Consumer Workers for their lived-experience of mental illness, Carer Workers for their lived experience of mental illness, Clinical/health professionals on the basis of their health qualifications, Others on the basis of their professional backgrounds.*

**Question notes:**
- Type: matrix of choices (only one answer per row) * denotes mandatory question
- Source: defined by the ERG
- Areas for refinement: no changes to question required.

21. **Does your organisation utilise VOLUNTEERS?**

**Question notes:**
- Type: multiple choice (only one answer)
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input
- Areas for refinement: no changes to question required.

22. **If yes to the previous question, what was the approximate total number/FTE of VOLUNTEERS as at 30 November 2009?**

**Question notes:**
- Type: matrix of choices (only one answer per row)
- Source: Adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input
- Areas for refinement: no changes to question required.

*23. What was the total NUMBER of PAID staff providing MENTAL HEALTH SPECIFIC SERVICES (full-time, part-time, casual) employed by your organisation as at 30 November 2009?*

**Question notes:**
- Type: matrix of choices (only one answer per row) * denotes mandatory question
- Source: Adapted from New Zealand NgOIT workforce survey and ERG input
- Area for refinement: List of professions is non-standardised. Consider developing standardised list of professions with definitions.

*24. How many PAID full-time equivalent (FTE) * staff provided MENTAL HEALTH SPECIFIC SERVICES for your organisation as at 30 November 2009?*

**Question notes:**
- Type: matrix of choices (only one answer per row) * denotes mandatory question
- Source: Adapted from New Zealand NgOIT workforce survey and ERG input
- Area for refinement: List of professions is non-standardised. Consider developing standardised list of professions with definitions.

25. **What percentage of your paid staff who provide MENTAL HEALTH SPECIFIC SERVICES have attained formal MENTAL HEALTH qualifications at the Vocational Education Training (VET) or university level as at 30 November 2009?**
## Mental Health NGO Landscape Survey

### Question notes:
- Type: multiple choice (only one answer)
- Source: Input from ERG
- Areas for refinement: Self-reported percentages which may be difficult to calculate. Consider derived version of question. For example, respondent selects number of paid staff who provide mental health specific services and then selects number who have formal mental health qualifications. Survey tool calculates percentage.

### 26. Please select the forms of accreditation that your organisation has. Please tick all that apply.

#### Question notes:
- Type: multiple choice (multiple answers) and free text comments field
- Source: Input from ERG
- Areas for refinement: Some forms of accreditation listed may be ambiguous, eg “mental health-specific standards”. Consider refining list accreditation categories.

### 7. Workforce planning and training

#### 27. Does your organisation have a staff training and recruitment plan/workforce development plan?

#### Question notes:
- Type: multiple choice (only one answer)
- Source: Adapted from Australian state-based surveys and ERG input
- Areas for refinement: no changes to question required.

#### 28. If yes to the previous question, what percentage of your total annual budget is for workforce training and development?

#### Question notes:
- Type: multiple choice (only one answer)
- Source: Defined by the ERG
- Areas for refinement: no changes to question required.

#### 29. What are the current barriers that your organisation faces related to training and development? Please tick all that apply.

#### Question notes:
- Type: Multiple choice (multiple answers) and free text comments field
- Source: Adapted from Australian state-based surveys and ERG input
- Areas for refinement: no changes to question required.

#### 30. What is your approximate annual staff turnover rate (as a percentage of total staff)?

#### Question notes:
- Type: multiple choice (only one answer)
- Source: Adapted from Australian state-based surveys and ERG input
- Areas for refinement: Potential for confusion over how to calculate annual staff turnover rate. Consider
### Mental Health NGO Landscape Survey

including instructions in question or making the question a derived calculation based on inputs from respondent.

#### 31. Do you have ongoing vacancies of more than 6 months per role/position?

**Question notes:**
- Type: multiple choice (only one answer)
- Source: Adapted from Australian state-based surveys
- Areas for refinement: Comments from ERG that 6 month timeframe may not be appropriate for this workforce. Consider including range of vacancy timeframes (eg 1-3 months, 3-6 months, 6-9 months, etc).

#### 8. Data collection, reporting and quality improvement

#### 32. Does your organisation collect staff/workforce data?

**Question notes:**
- Type: multiple choice (only one answer) and free text comments field
- Source: adapted from Australian state-based surveys
- Areas for refinement: no changes to question required.

#### 33. Does your organisation gather experiences of consumers and carers you support (eg customer satisfaction surveys)?

**Question notes:**
- Type: multiple choice (only one answer) and free text comments field
- Source: Input from ERG
- Areas for refinement: no changes to question required.

#### 34. Does your organisation collect outcome measures for the consumers and/or carers you support?

**Question notes:**
- Type: multiple choice (only one answer) and free text comments field
- Source: Input from ERG
- Areas for refinement: Not all answers listed in free text field are outcome measurement tools. Consider adding list of outcome measurement tools to choose from.

#### 35. Do you undertake any quality improvement or evaluation activities to determine if your service is working well?

**Question notes:**
- Type: multiple choice (only one answer) and free text comments field
- Source: adapted from New Zealand NgOIT landscape survey and Australian state-based surveys and ERG input
- Areas for refinement: no changes to question required.

#### 9. Other comments

#### 36. Please describe an achievement of your organisation:
**Mental Health NGO Landscape Survey**

**Question notes:**
- Type: free text comments field
- Source: ERG input
- Areas for refinement: no changes to question required.

### 37. In what areas (geographic and/or service type) would you like to EXPAND services? Why?

**Question notes:**
- Type: free text comments field
- Source: ERG input
- Areas for refinement: no changes to question required.

### 38. In what areas (geographic and/or service type) would you like to REDUCE services? Why?

**Question notes:**
- Type: free text comments field
- Source: ERG input
- Areas for refinement: no changes to question required.

### 39. Please feel free to enter any other comments!

**Question notes:**
- Type: free text comments field
- Source: Not applicable
- Areas for refinement: no changes to question required.

### 10. Thank you

**Section notes:**
- Type: Information for respondents – no questions included in this section
- Source: not applicable
- Areas for refinement: not applicable
Appendix 4  Feedback on the Workforce Survey data items

Below is a comprehensive list of the data items (ie the survey questions) which were included in the Landscape Survey. For each data item the following types of information are listed:

- Type of question (eg multiple choice, free text, etc)
- The source of information which was used to develop the data item, if applicable
- Areas identified for further refinement to the survey tool.

The areas for further refinement were identified through analysis of the Landscape Survey results, free text comments included in the survey responses and discussions with the ERG. Key areas identified for further refinement include:

- Aboriginal or Torres Strait Islander status (Question 3)
- Professional registration (Question 7)
- Service categories which are non-standard (Questions 24, 25, 26, 27)
- Non-standard list of professions (Question 10, 20)
- CPD and CME requirements (Question 14)

Refer to Table 26 for additional details.

Table 26. Data Items included in the Mental Health NGO Workforce Survey including type, source and suggested areas of refinement for future data collections

<table>
<thead>
<tr>
<th>Mental Health NGO Workforce Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome!</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2. About you…</td>
</tr>
<tr>
<td>1. Please indicate your year of birth (eg 19XX):</td>
</tr>
<tr>
<td>Question notes:</td>
</tr>
<tr>
<td>• Source: Adapted from Australian Labour Force surveys</td>
</tr>
<tr>
<td>• Areas for refinement: No changes to question required</td>
</tr>
<tr>
<td>2. Gender: Male/ Female</td>
</tr>
<tr>
<td>Question notes:</td>
</tr>
<tr>
<td>• Type: multiple choice (only one answer)</td>
</tr>
<tr>
<td>• Source: not applicable</td>
</tr>
<tr>
<td>• Areas for refinement: No changes to question required</td>
</tr>
</tbody>
</table>
3. Do you identify as Aboriginal or Torres Strait Islander?

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: multiple choice (only one answer)</td>
</tr>
<tr>
<td>Source: not applicable</td>
</tr>
<tr>
<td>Areas for refinement: Question options to be changed to: yes - Aboriginal, yes - Torres Strait Islander, no</td>
</tr>
</tbody>
</table>

4. What is your country of birth?

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: multiple choice (only one answer) and “other” free text comment field</td>
</tr>
<tr>
<td>Source: Australian Census survey</td>
</tr>
<tr>
<td>Areas for refinement: No changes to question required</td>
</tr>
</tbody>
</table>

5. What is the primary language you speak at home?

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: multiple choice (only one answer) and “other” free text comment field</td>
</tr>
<tr>
<td>Source: Australian Census survey</td>
</tr>
<tr>
<td>Areas for refinement: No changes to question required</td>
</tr>
</tbody>
</table>

6. Do you have a health professional qualification?

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: multiple choice (only one answer) and “other” free text comment field</td>
</tr>
<tr>
<td>Source: ERG input</td>
</tr>
<tr>
<td>Areas for refinement: No changes to question required</td>
</tr>
</tbody>
</table>

7. Are you currently registered in the above profession?

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: multiple choice (only one answer) and free text comment field</td>
</tr>
<tr>
<td>Source: Adapted from NgOIT workforce survey</td>
</tr>
<tr>
<td>Areas for refinement: Update categories as per registration qualifications eg social workers are not registered</td>
</tr>
</tbody>
</table>

8. How many years experience have you had in a paid mental health role?

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: Free text field</td>
</tr>
<tr>
<td>Source:</td>
</tr>
<tr>
<td>Areas for refinement: No changes to question required</td>
</tr>
</tbody>
</table>

9. Where were you employed prior to the position you now hold. Please select the ONE most relevant response below.

<table>
<thead>
<tr>
<th>Question notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: multiple choice (only one answer) and free text comment field</td>
</tr>
<tr>
<td>Source: Adapted from Australian Labour force surveys</td>
</tr>
<tr>
<td>Areas for refinement: No changes to question required</td>
</tr>
</tbody>
</table>
10. If you were employed in the health and community services sector what was your primary job role prior the position you now hold:

**Question notes:**
- Type: multiple choice (only one answer) and free text comment field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Area for refinement: List of professions is non-standardised. Consider developing standardised list of professions with definitions.

11. What is your highest educational qualification in the following categories? For "highest qualification" categories please refer to question 12 below.

**Question notes:**
- Type: Matrix style question incorporating drop down menus for each and free text comment field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Areas for refinement: No changes to question required

12. Are you currently studying for a MENTAL HEALTH qualification? Indicate type of qualification:

**Question notes:**
- Type: multiple choice (only one answer) and free text comment field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Areas for refinement: No changes to question required

13. What types of mental health related training and education have you undertaken in the past 2 years?

**Question notes:**
- Type: free text comment fields
- Source: Adapted from Australian state based surveys
- Areas for refinement: No changes to question required

14. Are you required to participate in continuing education (eg CPD, CME or similar) programs as part of your professional registration?

**Question notes:**
- Type: multiple choice (only one answer)
- Source: Adapted from Australian Labour force surveys
- Areas for refinement: Definitions for CPD and CME not provided this may have led to some confusion. Provide further clarity and definitions

3. Current employment

15. In relation to your current role in mental health, what is the name of the primary organisation where you are employed?

**Question notes:**
- Type: Free text field
- Source: not applicable
- Areas for refinement: No changes to question required
16. What is the geographic focus of your current role?
Only select national if your role is specifically at this level or across more than one state.

Question notes:
- Type: multiple choice (only one answer)
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- No changes to question required

17. What is the postcode of your primary place of current employment?

Question notes:
- Type: Free text field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Areas for refinement: No changes to question required

18. What date did your employment commence with this organisation?

Question notes:
- Type: Free text field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Areas for refinement: No changes to question required

19. What is your current paid employment status with this organisation?

Question notes:
- Type: multiple choice (only one answer) and free text comment field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Areas for refinement: No changes to question required

20. What is your primary job role in this organisation:

Question notes:
- Type: multiple choice (only one answer) and free text comment field
- Source: Adapted from Australian Labour force surveys and NgOIT workforce survey with ERG input
- Area for refinement: List of professions is non-standardised. Consider developing standardised list of professions with definitions.

21. Are you employed by multiple organisations?

Question notes:
- Type: multiple choice (only one answer) and free text comment field
- Source: Adapted from Australian Labour force surveys
- Area for refinement: No changes to question required

22. How many paid hours do you work in a typical week?

Question notes:
- Type: Drop down menu
- Source: Adapted from Australian Labour force surveys
- Area for refinement: No changes to question required
23. In a typical week how much of your total paid work for all organisations would you spend in the following?

Question notes:
- Type: matrix with multiple choice (only one answer per row)
- Source: Adapted from Australian Labour force surveys and ERG input
- Area for refinement: No changes to question required

24. Which Mental Health REHABILITATION and SUPPORT services are you engaged in providing for the primary organisation where you are employed in a mental health role? Please select the TOP 3 that you are involved in.

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Categories from initial Landscape Survey
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services

25. Which Mental Health THERAPEUTIC services are you engaged in providing for the primary organisation where you are employed in a mental health role?

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Categories from initial Landscape Survey
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services

26. Which Mental Health EDUCATION and/or PUBLIC AWARENESS services are you engaged in providing for the primary organisation where you are employed in a mental health role? Please select the: TOP 3 that you are involved in.

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Categories from initial Landscape Survey
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services

27. Which COMORBIDITY programs are you engaged in providing for the primary organisation where you are employed in a mental health role? Please select the TOP 3 that you are involved in.

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Categories from initial Landscape Survey
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services
28. In which areas related to ADMINISTRATION/MANAGEMENT are you involved for the primary organisation where you are employed in a mental health role? Please select the TOP 3 that you are involved in.

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Categories from initial Landscape Survey
- Areas for refinement: Non-standardised list of services which may have led to confusion about definitions of services

29. Indicate the TOP 3 population groups you work with as part of your current role for the primary organisation where you are employed in a mental health role:

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Categories from initial Landscape Survey
- Area for refinement: No changes to question required

4. Further comments

30. What drew you to your current role? Please select the TOP 3 reasons.

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Adapted from Australian state based surveys and ERG input
- Area for refinement: No changes to question required

31. What keeps you in the role? Please select the TOP 3 reasons.

Question notes:
- Type: multiple choice (list top 3) and free text comment field
- Source: Adapted from Australian state based surveys and ERG input
- Area for refinement: No changes to question required

32. How likely are you to stay in the sector?

Question notes:
- Type: matrix with multiple choice (only one answer per row) and free text field
- Source: Adapted from Australian state based surveys and ERG input
- Area for refinement: No changes to question required
33. In your opinion what changes would encourage you to stay longer in this sector? Please select the TOP 3 reasons.

**Question notes:**
- Type: multiple choice (list top 3) and free text comment field
- Source: Adapted from Australian state based surveys and ERG input
- Area for refinement: No changes to question required

5. What did you think of the Workforce Survey?

34. What is your preferred option for completing a workforce survey such as this:

**Question notes:**
- Type: multiple choice (only one answer) and free text comment field
- Source: not applicable
- Area for refinement: No changes to question required

35. Rate the following aspects of this survey:

**Question notes:**
- Type: matrix with multiple choice (only one answer per row)
- Source: not applicable
- Area for refinement: No changes to question required

36. Do you think this Mental Health NGO Workforce Survey should be integrated with any other workforce surveys or mental health data collections?

**Question notes:**
- Type: Multiple choice (only one answer) and free text comment field
- Source: not applicable
- Area for refinement: No changes to question required

37. Are there any questions not included in this survey that should be added to ensure a complete picture of the workforce?

**Question notes:**
- Type: Multiple choice (only one answer) and free text comment field for “yes” responses
- Source: not applicable
- Area for refinement: No changes to question required

38. Are you asked to provide this type of data in any other surveys?

**Question notes:**
- Type: Multiple choice (only one answer) and free text comment field for “yes” responses
- Source: not applicable
- Area for refinement: No changes to question required
39. Please provide any other comments or suggestions regarding the survey method or questions:

Question notes:
- Type: Free text comment field
- Source: not applicable
- Area for refinement: No changes to question required

6. Thank you!
Appendix 5  Landscape Survey Tool

MH NGO Landscape Survey

1. Introduction

Welcome to the Mental Health NGO landscape survey!

Who should complete this survey?

The survey should be completed by one person employed at your NGO at executive/management level. The survey information may be gathered from different people within your organisation, particularly for large multi-site organisations. However it is important that only one person completes the online version for the whole organisation or a state/territory branch in order to minimise duplication.

How long will it take?

This survey contains seven sections with questions (sections 3-9). We anticipate that the survey will take approximately 30 minutes to complete.

Other instructions for completing the survey:

1. The survey will be open from Dec 16, 2009 - May 7, 2010.
2. The survey may be completed at different times - you can safely close the survey and re-open again on the SAME computer and any information that you have previously entered will be saved. Note that this feature only works if you use the SAME computer.
3. The survey data will not be submitted to us until you click "done" on the last page.
4. A hotline to answer any specific questions about the survey is available from Monday-Friday, 9am-5pm. The hotline number is 03 9092 2074.
5. You may also wish to print out a copy of the survey to assist you in obtaining the information to complete the survey prior to proceeding. This can be obtained at the NHWT website at www.nhwt.gov.au

Thank you for your participation!

2. Glossary of key terms

NON-GOVERNMENT MENTAL HEALTH SECTOR - private, not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care.

MENTAL HEALTH SERVICES - refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusivley focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.
MH NGO Landscape Survey

PEER SUPPORT - Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

FULL TIME EQUIVALENT (FTE) - The FTE of a full-time staff member (ie one who works 40 hours per week) is equal to 1.0. The calculation of FTE for part-time staff is based on the proportion of hours they work per week. For example a part-time staff member who works 20 hours per week is equivalent to 0.5 FTE (20/40 hours per week).

(The majority of these definitions are from the 4th National Mental Health Plan)

3. Profile of your organisation

1. General details:

   Organisation name: ____________________________

   Name of person completing the survey: __________

   Position: ______________________________________

   Email address: ________________________________

   Phone: ________________________________

   If we have any queries are you happy for us to contact you?

2. Are you completing this survey for the whole organisation or a state/territory branch?

   □ Whole organisation

   □ State/territory branch

   Please specify which state/territory branch if applicable: ____________
MH NGO Landscape Survey

3. In which areas in the states/territories does your organisation operate? Please tick all that apply.

<table>
<thead>
<tr>
<th>ALL states/territories</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital cities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other major cities</td>
<td></td>
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<td></td>
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<tr>
<td>Regional areas</td>
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<td></td>
<td></td>
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<tr>
<td>Remote areas</td>
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<td></td>
<td></td>
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<tr>
<td>Very remote areas</td>
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</tr>
</tbody>
</table>

4. What is the legal entity of your organisation?

- [ ] Incorporated association
- [ ] Incorporated cooperative
- [ ] Aboriginal corporation
- [ ] Company (Incorporated under Corporations Act 2001)
- [ ] Partnership
- [ ] Sole trader
- [ ] Trustee or trust
- [ ] Other (please specify)

5. How long has your organisation been in existence?

- [ ] 1-5 years
- [ ] 6-10 years
- [ ] 11-15 years
- [ ] 16-20 years
- [ ] > 20 years

If greater than 20 years, please specify time in operation:

4. Services your organisation provides
6. How would you describe the services that your organisation provides? Please tick all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Mental Health services</th>
<th>Drug and alcohol services</th>
<th>Community support services</th>
<th>Physical and intellectual disability services</th>
<th>Other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily (more than 50%)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Mixed (25-50%)</td>
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<td>[ ]</td>
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<tr>
<td>Some (&gt;0-25%)</td>
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<td>[ ]</td>
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<td>[ ]</td>
</tr>
</tbody>
</table>

7. How many Mental Health consumers and carers did your organisation support in a DIRECT (ie via telephone or face-to-face) and INDIRECT (eg web/online support, mail, advertising) capacity during the last 12 months?

<table>
<thead>
<tr>
<th></th>
<th>Zero</th>
<th>1-50</th>
<th>51-100</th>
<th>101-500</th>
<th>501-1000</th>
<th>1001-5000</th>
<th>&gt;5000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers (direct support)</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Carers (direct support)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Consumers (indirect support)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Carers (indirect support)</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
</tbody>
</table>

In the next four questions we are going to ask you about the different types of services that your organisation provides for:
- Mental Health SUPPORT and REHABILITATION
- THERAPEUTIC Mental Health
- Mental Health EDUCATION and/or PUBLIC AWARENESS
- COMORBIDITY PROGRAMS
MH NGO Landscape Survey

* 8. What type of Mental Health REHABILITATION and SUPPORT services does your organisation currently provide? Please tick all that apply.

☑ N/A - NO Mental Health REHABILITATION and SUPPORT services provided
☑ Accommodation and housing provision
☑ Supported accommodation
☑ Home-based outreach services
☑ Respite care
☑ Centre-based program (eg day program, club house or art/music program)
☑ Recovery planning/ care coordination with other health/ service providers
☑ Crisis support
☑ Telephone-based support (eg helplines)
☑ Mental illness prevention
☑ Early intervention
☑ Other (please specify)

☐ Consumer networks
☐ Peer support
☐ Carer networks
☐ Family support and interventions
☐ Justice/ Forensic Mental Health (eg transitional support)
☐ Financial literacy and counselling
☐ Employment support and individual vocational placement programs
☐ Leisure/ recreation / aerobic physical activity program
☐ Research and evaluation
☐ Education and training support for consumers and carers

* 9. What type of THERAPEUTIC Mental Health services does your organisation currently provide? Please tick all that apply.

☑ N/A - NO THERAPEUTIC Mental Health services provided
☑ Talking therapies, eg cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), neuro-linguistic programming (NLP)
☑ Other psychotherapies
☑ Counselling
☑ Other (please specify)
10. What type of Mental Health EDUCATION and/or PUBLIC AWARENESS does your organisation currently provide? Please tick all that apply.

- N/A - NO Mental Health EDUCATION or PUBLIC AWARENESS provided
- Individual advocacy for consumers (eg accessing services)
- Individual advocacy for carers (eg accessing services)
- Advocacy to government
- Web-based Mental Health information
- Mental Health information pamphlets or newsletters
- Community events for Mental Health awareness
- Other Mental Health training (please specify)

11. What COMORBIDITY programs does your organisation currently offer for people with Mental Health problems or illness and the following comorbidities? Please tick all that apply.

- N/A - NO COMORBIDITY programs provided
- Substance use and mental illness
- Intellectual disability and mental illness
- Learning disability and mental illness
- Physical disability and mental illness
- Other (please specify)

- Brain injury and mental illness
- Eating/ dieting disorders and mental illness
- Forensic problems and mental illness
- Complex or exceptional needs (ie people with at least three presenting issues - eg substance use, mental health, intellectual disability, health/physical disability, brain injury & offending behaviours)
12. Which population groups does your organisation service? Please tick all that apply.

- Young people
- Women
- Men
- Mothers with babies
- Single people
- Families
- Older People/Aged
- Aboriginal and Torres Strait Islander (ATSI)
- Other (please specify)
- Culturally and Linguistically Diverse (CALD)
- Gay, lesbian, bisexual, transgender (GLBT)
- Unemployed
- Homeless
- People with intellectual disabilities
- People with physical disabilities
- People in or newly released from prison
- Carers

13. Does your organisation serve specific age groups? Please tick all that apply.

- <15 years
- 15-25 years
- 26-64 years
- 65+ years
- All ages

5. Funding for your organisation

14. What was your organisation's total annual income from all sources and for all programs for the last financial year?

- < $30,000
- $30,000 - $99,000
- $100,000 - $499,000
- $500,000 - $999,000
- $1,000,000 - $2,999,999
- $3,000,000 - $10,000,000
- > $10,000,000
15. What percentage of your organisation’s total annual income was for MENTAL HEALTH SERVICES last financial year?

- N/A
- >0-5%
- 6-10%
- 11-25%
- 26-50%
- 51-75%
- 76-100%

16. What percentage of total MENTAL HEALTH funding was for short-term project-based (eg less than 2 years) services or programs in the last financial year?

- N/A
- >0-5%
- 6-10%
- 11-25%
- 26-50%
- 51-75%
- 76-100%
17. Please tick ALL SOURCES of funding that are for MENTAL HEALTH SERVICES and rate the approximate percentage of total MENTAL HEALTH funding for your organisation for the last financial year. (THE TOTAL SHOULD ADD UP TO 100%).

<table>
<thead>
<tr>
<th>Source</th>
<th>0-10%</th>
<th>11-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth - Dept of Health and Ageing (DoHA)</td>
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<tr>
<td>Commonwealth - Dept of Families, Housing, Community Services &amp; Indigenous Affairs (FaHCSIA)</td>
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<tr>
<td>Commonwealth - Dept Education, Employment and Workplace Relations (DEWR)</td>
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<tr>
<td>Commonwealth - Office of Aboriginal and Torres Strait Islander Health (OATSIH)</td>
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<tr>
<td>State/ Territory - Health department</td>
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<td>State/ Territory - Other department</td>
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<tr>
<td>Local government</td>
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<tr>
<td>Mental Health Peak Body</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership fees or subscriptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundraising or donations</td>
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<tr>
<td>Other</td>
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<tr>
<td>If other, please specify:</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

18. Does your organisation offer Medicare-funded services specific to Mental Health?

- Yes
- No

If yes, please specify item numbers (optional):

6. Staffing of your organisation

* 19. Please indicate the number and full-time equivalent (FTE)* of PAID staff for your organisation as at 30 November 2009:

<table>
<thead>
<tr>
<th>Category</th>
<th>Zero</th>
<th>1</th>
<th>2-5</th>
<th>6-10</th>
<th>11-25</th>
<th>26-50</th>
<th>51-100</th>
<th>&gt;100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
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<td></td>
<td></td>
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<tr>
<td>Total FTE</td>
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<tr>
<td>Total number providing</td>
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<tr>
<td>Mental Health services</td>
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<td></td>
<td></td>
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<tr>
<td>Total FTE providing Mental Health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* 20. Does your organisation employ:

- Consumer Workers for their lived-experience of mental illness
- Carer Workers for their lived-experience of mental illness
- Clinical/ health professionals on the basis of their health qualifications
- Others on the basis of their professional backgrounds

21. Does your organisation utilise VOLUNTEERS?
- Yes
- No

22. If yes to the previous question, what was the approximate total number/FTE of VOLUNTEERS as at 30 November 2009?

<table>
<thead>
<tr>
<th>Total number</th>
<th>0</th>
<th>1</th>
<th>2-5</th>
<th>6-10</th>
<th>11-25</th>
<th>26-50</th>
<th>51-100</th>
<th>&gt;100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FTE*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of VOLUNTEERS with clinical health qualifications</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
**MH NGO Landscape Survey**

23. What was the total NUMBER of PAID staff providing MENTAL HEALTH SPECIFIC SERVICES (full-time, part-time, casual) employed by your organisation as at 30 November 2009?

<table>
<thead>
<tr>
<th></th>
<th>Zero</th>
<th>1</th>
<th>2-5</th>
<th>6-10</th>
<th>11-25</th>
<th>26-50</th>
<th>51-100</th>
<th>&gt;100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>Management</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Consumer worker</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Carer worker</td>
<td>☐</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>Support worker</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Psychiatrist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other doctor besides psychiatrist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>Counsellor</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>Psychologist</td>
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<td>☐</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>Social Worker</td>
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<tr>
<td>Registered Nurse</td>
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<td>☐</td>
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</tr>
<tr>
<td>Enrolled Nurse</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Researchers</td>
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<td>☐</td>
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<tr>
<td>Trainers</td>
<td>☐</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>Advocate</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family therapist</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>Other</td>
<td>☐</td>
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</tr>
</tbody>
</table>
24. How many PAID full-time equivalent (FTE)* staff provided MENTAL HEALTH SPECIFIC SERVICES for your organisation as at 30 November 2009?

- Administration
- Management
- Consumer worker
- Carer worker
- Support worker
- Psychiatrist
- Other doctor besides psychiatrist
- Counsellor
- Psychologist
- Occupational Therapist
- Social Worker
- Registered Nurse
- Enrolled Nurse
- Researchers
- Trainers
- Advocate
- Family therapist
- Other

25. What percentage of your paid staff who provide MENTAL HEALTH SPECIFIC SERVICES have attained formal MENTAL HEALTH qualifications at the Vocational Education Training (VET) or university level as at 30 November 2009?

- N/A
- >0-10%
- 11-25%
- 26-50%
- 51-75%
- 76-100%
MH NGO Landscape Survey

26. Please select the forms of accreditation that your organisation has. Please tick all that apply.

☐ None
☐ Australian Council on Healthcare Standards (ACHS)
☐ International Standards Organisation (ISO)
☐ Health and Community Services eg Quality Improvement Council
☐ Mental health-specific standards
☐ Profession-specific accreditation
☐ Australian General Practice Accreditation Limited (AGPAL)
☐ State/territory level accreditation
☐ Other (please specify)

*Full-time equivalent (FTE) - The FTE of a full-time staff member (ie one who works 40 hours per week) is equal to 1.0. The calculation of FTE for part-time staff is based on the proportion of hours they work per week. For example a part-time staff member who works 20 hours per week is equivalent to 0.5 FTE (20/40 hours per week).

7. Workforce planning and training

27. Does your organisation have a staff training and recruitment plan / workforce development plan?

☐ Yes
☐ No

28. If yes to the previous question, what percentage of your total annual budget is for workforce training and development?

☐ N/A
☐ >0-2%
☐ 3-5%
☐ 6-10%
☐ 11-20%
☐ >20%
29. What are the current barriers that your organisation faces related to training and development? Please tick all that apply.
- Difficult to access
- Unable to back fill staff when training
- No budget for training/development
- Inappropriate training offered

Please add other barriers or comments:

30. What is your approximate annual staff turnover rate (as a percentage of total staff)?
- N/A
- >0-5%
- 6-10%
- 11-25%
- 26-50%
- 51-75%
- 76-100%

31. Do you have ongoing vacancies of more than 6 months per role/position?
- Yes
- No

If yes, please specify the roles/positions:

8. Data collection, reporting and quality improvement
MH NGO Landscape Survey

32. Does your organisation collect staff/workforce data?
   - Yes
   - No
   If yes, please provide further information on the type of data collected, the purpose and how frequently the data are collected:

33. Does your organisation gather experiences of consumers and carers you support (eg customer satisfaction surveys)?
   - Yes
   - No
   If yes, please specify the mechanism/ mode and how frequently collected:

34. Does your organisation collect outcome measures for the consumers and/or carers you support?
   - Yes
   - No
   If yes, please specify outcome measurement tool(s) and how frequently collected:

35. Do you undertake any quality improvement or evaluation activities to determine if your service is working well?
   - Yes
   - No
   If yes, please specify mechanism/ mode and how frequently collected:

9. Other comments

36. Please describe an achievement of your organisation:
37. In what areas (geographic and/or service type) would you like to EXPAND services? Why?

38. In what areas (geographic and/or service type) would you like to REDUCE services? Why?

39. Please feel free to enter any other comments!

10. Thank you!

Thank you for taking the time to complete this survey!

Your responses will assist us to better understand the Mental Health NGO sector. The information gathered from this survey will be used to assist us in creating and piloting a workforce data set for the Mental Health NGO sector.

Please select "done" and your responses will be automatically forwarded to us.

If you have any questions about the survey please feel free to call our hotline which is available from Monday-Friday, 9am-5pm. The hotline number is 03 9092 2074.

Thanks again!
Appendix 6  Workforce Survey Tool

Print Version: MH NGO Workforce Data Survey

1. Welcome!

Welcome to the first mental health NGO workforce sector survey!

This Workforce Survey is a follow-on from the Landscape Survey conducted earlier this year that asked one manager from each NGO organisation providing mental health services to provide information about their workforce. The Landscape Survey provided us with valuable information regarding the sector as a whole and enabled us to build this Workforce Survey for individuals.

Along with other employees in the mental health NGO sector your cooperation in answering the following questions is needed because accurate information for workforce planning is vital to this sector.

The data is being collected by the National Health Workforce Planning Research Collaboration.

Please be assured that the information reported in this survey will be strictly confidential and only deidentified aggregate data will be used in any report.

How long will it take?
We anticipate that the survey will take approximately 20 minutes to complete.

Other instructions for completing the survey:
1. The survey will be open from 10 May until 11 June 2010.
2. Please complete and return this survey by: fax: 03 9092 2093 or email: taskforce@nhwt.gov.au or post: The National Health Workforce Taskforce Level 12, 120 Spencer St, Melbourne, VIC 3000.

Alternatively you can complete the survey online at http://www.nhwt.gov.au/NGO_survey.asp

3. A hotline to answer any specific questions about the survey is available from Monday-Friday, 9am-5pm. The hotline number is 03 9092 2074.

Thank you for your participation!

2. About you...

1. Please indicate your year of birth (eg 19XX):
   Year:

2. Gender:
   □ Male
   □ Female
Print Version: MH NGO Workforce Data Survey

3. Do you identify as Aboriginal or Torres Strait Islander?
- Yes
- No

4. What is your country of birth?
- Australia
- Bosnia and Herzegovina
- Canada
- China (excl. SARs and Taiwan Province)
- Croatia
- Egypt
- Fiji
- Former Yugoslav Republic of Macedonia
- Germany
- Greece
- Hong Kong (SAR of China)
- India
- Indonesia
- Iraq
- Ireland
- Italy
- Japan
- Korea, Republic of (South)
- Lebanon
- Malaysia
- Malta
- Netherlands
- New Zealand
- Papua New Guinea
- Philippines
- Poland
- Singapore
- South Africa
- South Eastern Europe, nfd
- Sri Lanka
- Thailand
- Turkey
- United Kingdom
- United States of America
- Viet Nam

Other (please specify)
Print Version: MH NGO Workforce Data Survey

5. What is the primary language you speak at home?
- English
- Arabic (including Lebanese)
- Australian Indigenous Languages
- Chinese Languages: Cantonese, Mandarin, Other
- Croatian
- French
- German
- Greek
- Hindi
- Hungarian
- Indonesian
- Other (please specify)

6. Do you have a health professional qualification?
- No, go to question 8
- Doctor
- Psychologist
- Occupational Therapist
- Registered Nurse (Div 1)
- Enrolled Nurse (Div 2)
- Social worker
- Physiotherapist
- Speech pathologist

7. Are you currently registered in the above profession?
- Yes
- No
- Not applicable, please state why:

8. How many years experience have you had in a paid mental health role?
State to the closest number of years:
9. Where were you employed prior to the position you now hold. Please select the ONE most relevant response below.

- Employed in health and/or community services sector
- Volunteer in health and/or community services sector
- Employed in other sector
- Volunteer in other sector
- Unemployed or undertaking education

If non-health or community sector selected above please specify

10. If you were employed in the health and community services sector what was your primary job role prior the position you now hold:

<table>
<thead>
<tr>
<th>Mental Health role</th>
<th>Health role (but non-mental health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td></td>
</tr>
<tr>
<td>Consumer worker</td>
<td></td>
</tr>
<tr>
<td>Carer worker</td>
<td></td>
</tr>
<tr>
<td>Support worker</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Other doctor besides psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Counsellor</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse (Div 1)</td>
<td></td>
</tr>
<tr>
<td>Enrolled Nurse (Div 2)</td>
<td></td>
</tr>
<tr>
<td>Researcher</td>
<td></td>
</tr>
<tr>
<td>Trainer</td>
<td></td>
</tr>
<tr>
<td>Advocate</td>
<td></td>
</tr>
<tr>
<td>Family therapist</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

Page 4
11. What is your highest educational qualification in the following categories? For “highest qualification” categories please refer to question 12 below.

<table>
<thead>
<tr>
<th>Highest qualification</th>
<th>Year qualified</th>
<th>Country in which qualification was gained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership and Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify qualification type)

12. Are you currently studying for a MENTAL HEALTH qualification?

Indicate type of qualification:

- [ ] No, I am not currently studying for a mental health qualification
- [ ] PhD
- [ ] Masters Degree
- [ ] Post Graduate Certificate/Diploma
- [ ] Vocational Graduate Certificate/Diploma
- [ ] Bachelor Degree
- [ ] Advanced Diploma
- [ ] Diploma
- [ ] Certificate IV
- [ ] Certificate III

Please specify the name of the qualification you are studying for:

13. What types of mental health related training and education have you undertaken in the past 2 years?

Internal education (run by the organisation you work for); please specify

External education (run by an outside organisation); please specify
Print Version: MH NGO Workforce Data Survey

14. Are you required to participate in continuing education (e.g., CPD, CME or similar) programs as part of your professional registration?
   - Yes
   - No

3. Current employment

15. In relation to your current role in mental health, what is the name of the primary organisation where you are employed?

16. What is the geographic focus of your current role?
   Only select national if your role is specifically at this level or across more than one state.
   - National
   - NSW
   - Qld
   - ACT
   - NT
   - WA
   - SA
   - Vic
   - Tas

17. What is the postcode of your primary place of current employment?

18. What date did your employment commence with this organisation?
   Specify month and year (e.g., 02 2010):

19. What is your current paid employment status with this organisation?
   - Permanent full-time
   - Permanent part-time
   - Contract full-time
   - Contract part-time
   - Casual
   - Other (please specify)
20. What is your primary job role in this organisation:
- Administration
- Management
- Consumer worker
- Carer worker
- Support worker
- Psychiatrist
- Other doctor besides psychiatrist
- Counsellor
- Psychologist
- Other (please specify)

21. Are you employed by multiple organisations?
- No
- Yes, but this is the only organisation where I am employed in a mental health role
- Yes I am employed by multiple organisations in multiple mental health roles, please specify how many:

22. How many paid hours do you work in a typical week?

Hours with the primary organisation where you are employed for a mental health role:

Hours with other organisations:

23. In a typical week how much of your total paid work for all organisations would you spend in the following?

<table>
<thead>
<tr>
<th>Mental Health work - client contact</th>
<th>1-9 hours</th>
<th>10-19 hours</th>
<th>20-34 hours</th>
<th>35-48 hours</th>
<th>41-44 hours</th>
<th>45-48 hours</th>
<th>49+ hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other non-mental health work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Print Version: MH NGO Workforce Data Survey

In the next four questions we are going to ask you about the different types of services that your primary place of employment provides for:

- Mental Health SUPPORT and REHABILITATION
- THERAPEUTIC Mental Health
- Mental Health EDUCATION and/or PUBLIC AWARENESS
- COMORBIDITY PROGRAMS

We are specifically interested in the areas that you work in.

**24. Which Mental Health REHABILITATION and SUPPORT services are you engaged in providing for the primary organisation where you are employed in a mental health role?**

Please select the TOP 3 that you are involved in.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A - NO Mental Health REHABILITATION and SUPPORT services</td>
<td></td>
</tr>
<tr>
<td>Accomodation and housing provision</td>
<td></td>
</tr>
<tr>
<td>Supported accomodation</td>
<td></td>
</tr>
<tr>
<td>Home-based outreach services</td>
<td></td>
</tr>
<tr>
<td>Respite care</td>
<td></td>
</tr>
<tr>
<td>Centre-based program (eg day program, club house or art/music program)</td>
<td></td>
</tr>
<tr>
<td>Recovery planning/ care coordination with other health/ service providers</td>
<td></td>
</tr>
<tr>
<td>Crisis support</td>
<td></td>
</tr>
<tr>
<td>Telephone-based support (eg helplines)</td>
<td></td>
</tr>
<tr>
<td>Mental illness prevention</td>
<td></td>
</tr>
<tr>
<td>Early intervention</td>
<td></td>
</tr>
<tr>
<td>Consumer networks</td>
<td></td>
</tr>
<tr>
<td>Peer support</td>
<td></td>
</tr>
<tr>
<td>Carer networks</td>
<td></td>
</tr>
<tr>
<td>Family support and interventions</td>
<td></td>
</tr>
<tr>
<td>Justice/ Forensic Mental Health (eg transitional support)</td>
<td></td>
</tr>
<tr>
<td>Financial literacy and counselling</td>
<td></td>
</tr>
<tr>
<td>Employment support and individual vocational placement programs</td>
<td></td>
</tr>
<tr>
<td>Leisure/ recreation / physical activity program</td>
<td></td>
</tr>
<tr>
<td>Research and evaluation</td>
<td></td>
</tr>
<tr>
<td>Education and training support for consumers and carers</td>
<td></td>
</tr>
<tr>
<td>Activities of daily living skills</td>
<td></td>
</tr>
<tr>
<td>Drug and alcohol</td>
<td></td>
</tr>
<tr>
<td>Group based recovery, psycho-education or personal well-being groups</td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)

**25. Which Mental Health THERAPEUTIC services are you engaged in providing for the primary organisation where you are employed in a mental health role?**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A - NO THERAPEUTIC Mental Health services</td>
<td></td>
</tr>
<tr>
<td>Talking therapies, Other psychotherapies, Counselling</td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)
26. Which Mental Health EDUCATION and/or PUBLIC AWARENESS services are you engaged in providing for the primary organisation where you are employed in a mental health role? Please select the TOP 3 that you are involved in.

- N/A - NO Mental Health EDUCATION or PUBLIC AWARENESS
- Individual advocacy for consumers (eg accessing services)
- Individual advocacy for carers (eg accessing services)
- Web-based Mental Health Information
- Mental Health Information pamphlets or newsletters
- Community events for Mental Health awareness
- Other (please specify)

27. Which COMORBIDITY programs are you engaged in providing for the primary organisation where you are employed in a mental health role? Please select the TOP 3 that you are involved in.

- N/A - NO COMORBIDITY programs
- Substance use and mental illness
- Intellectual disability and mental illness
- Brain injury and mental illness
- Eating/ dieting disorders and mental illness
- Forensic problems and mental illness
- Complex or exceptional needs (ie people with at least three presenting issues - eg substance use, mental health, intellectual disability, health/physical disability, brain injury & offending behaviours)
- Physical disability and mental illness
- Other (please specify)
28. In which areas related to ADMINISTRATION / MANAGEMENT are you involved for the primary organisation where you are employed in a mental health role?
Please select the TOP 3 that you are involved in.

- Membership / resource management
- Research / policy
- Marketing
- General team support
- Information technology
- Human resources / staff management
- Pay roll
- Communication development
- Program development
- Other (please specify)

29. Indicate the TOP 3 population groups you work with as part of your current role for the primary organisation where you are employed in a mental health role:

- Nil - not providing direct care
- Young people
- Women
- Men
- Mothers with babies
- Single people
- Families
- Older People/Aged
- Aboriginal and Torres Strait Islander (ATSI)
- Culturally and Linguistically Diverse (CALD)
- Other (please specify)

4. Further comments
Print Version: MH NGO Workforce Data Survey

30. What drew you to your current role? Please select the TOP 3 reasons.

- ☐ contribute to client outcomes
- ☐ one-to-one client interaction
- ☐ doing work of value to society
- ☐ opportunities for personal learning and growth
- ☐ opportunities for professional development
- ☐ relationship with current workers
- ☐ salary
- ☐ benefits
- ☐ career growth opportunities
- ☐ Other (please specify)

31. What keeps you in the role? Please select the TOP 3 reasons.

- ☐ contribute to client outcomes
- ☐ one-to-one client interaction
- ☐ doing work of value to society
- ☐ opportunities for personal learning and growth
- ☐ opportunities for professional development
- ☐ relationship with current workers
- ☐ salary
- ☐ benefits
- ☐ career growth opportunities
- ☐ Other (please specify)

32. How likely are you to stay in the sector?

<table>
<thead>
<tr>
<th></th>
<th>definitely change</th>
<th>likely to change</th>
<th>neutral/undecided</th>
<th>unlikely to change</th>
<th>definitely will not change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 years</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5 years</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 years</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Any further comments

Page 11
33. In your opinion what changes would encourage you to stay longer in this sector? Please select the TOP 3 reasons.

- Better remuneration
- Better award conditions
- More training/professional development
- Changes to workload, more workers employed
- More opportunities for promotion
- More supervision and support
- More funding for service delivery

Other (please specify)

5. What did you think of the Workforce Survey?

An important component of the Workforce Survey and its future use is the method used to collect the data. We are interested in your thoughts about how this can best be achieved.

34. What is your preferred option for completing a workforce survey such as this:

- online
- paper-based and post back
- paper-based and fax back
- Other (please specify)

35. Rate the following aspects of this survey:

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>neither agree or disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>the questions were easy to understand</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the survey was easy to complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the questions were relevant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the length of the survey was appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Print Version: MH NGO Workforce Data Survey

36. Do you think this Mental Health NGO Workforce Survey should be integrated with any other workforce surveys or mental health data collections?
   - No, it should remain a stand-alone survey
   - Not sure
   - Yes, please specify which survey this should be integrated with:

37. Are there any questions not included in this survey that should be added to ensure a complete picture of the workforce?
   - No
   - Yes (please specify)

38. Are you asked to provide this type of data in any other surveys?
   - No
   - Not sure
   - Yes (please specify)

39. Please provide any other comments or suggestions regarding the survey method or questions:

6. Thank you!
Thank you for taking the time to complete this survey!
Your responses will assist us to better understand the Mental Health NGO workforce.
If you have any questions about the survey please feel free to call our hotline which is available from Monday-Friday, 9am-5pm (EST). The hotline number is 03 9092 2074.
Thanks again!
## Appendix 7  Expert Reference Group membership

### Expert Advisory Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derek Wright (Chair)</td>
<td>Director, Mental Health, SA</td>
</tr>
<tr>
<td>Seb Rosenberg</td>
<td>Mental Health Council of Australia</td>
</tr>
<tr>
<td>Rachelle Irving</td>
<td></td>
</tr>
<tr>
<td>Sue Durham</td>
<td>Training Manager, VICSERV</td>
</tr>
<tr>
<td>Brooke McKail</td>
<td>CEO MHCC ACT</td>
</tr>
<tr>
<td>Tina Smith</td>
<td>MHCC NSW</td>
</tr>
<tr>
<td>Merilee Cox</td>
<td>NEAMI (proxy for Arthur Papakotsias)</td>
</tr>
<tr>
<td>Joe Calleja</td>
<td>Richmond Fellowship</td>
</tr>
<tr>
<td>Gerry Naughton</td>
<td>MIND Australia (proxy for J.Calleja at first meeting)</td>
</tr>
<tr>
<td>Susan Adam</td>
<td>Carer</td>
</tr>
<tr>
<td>Julie Anderson</td>
<td>Consumer</td>
</tr>
<tr>
<td>Deborah Winkler</td>
<td>Department of Families, Housing, Community Services and Indigenous Affairs FaHCSIA</td>
</tr>
<tr>
<td>Viv Miller</td>
<td>Mental Health Educator</td>
</tr>
<tr>
<td>Maureen McCarty</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>Madeleine Lawler</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>Laura A’Bell</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>Penny Tolhurst</td>
<td>Mental Health Workforce Advisory Group</td>
</tr>
<tr>
<td>Craig Gear</td>
<td>PricewaterhouseCoopers</td>
</tr>
<tr>
<td>Emily O’Donnell</td>
<td>PricewaterhouseCoopers</td>
</tr>
<tr>
<td>Christine Farraway</td>
<td>PricewaterhouseCoopers</td>
</tr>
</tbody>
</table>
Appendix 8 References


References


Department of Health and Ageing (DoHA). National Mental Health Strategy


Hickie, I. The Australian. (2010). Hospitals will ‘treat ’em and street ’em’

Mental Health Coalition of South Australia. (2008). Ensuring a Skilled, Motivated and Effective Workforce in the Community Mental Health Service Sector. MHCSA, Adelaide.


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