mental health
community coalition ACT

HUMANCAPITAL
Alliance
Creating workforce solutions

ACT community-managed mental health workforce profile 2023

Report preparation

ACT community-managed mental health workforce profile 2023 was prepared by Human Capital Alliance (International) Pty Ltd (HCA) for the Mental Health Community Coalition ACT to report on the findings from the ACT community-managed mental health workforce survey 2022.

Acknowledgements

We acknowledge all Aboriginal and Torres Strait Islander Traditional Custodians and Country and recognise their continuing connection to land, sea, culture and community. We pay our respects to their Elders, past and present.

We also acknowledge the individual and collective expertise of those with a living or lived experience of mental health. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

HCA would also like to acknowledge the time and effort provided by those representatives of the community-managed mental health organisations who completed the mental health workforce survey for this project. Your collaboration and contributions have further improved the understanding of the size, composition and needs of the community-managed mental health workforce in the ACT.

The 2022 survey project and its development were supported by invaluable advice from staff within MHCC ACT, in particular Ben Mathews, Sector Development and Lived Experience Officer.

MHCC ACT also thanks the Mental Health Coordinating Council (NSW) for its advice and support in initiating this project.

Photography on front cover and inside report from iStock.com; back cover photograph from Dave Jenkins – Ghetto Media.

Design and layout by Limegreentangerine.

Citation

Author: Lee Ridoutt, Rob Curry, Saoirse Prince, Corinne Dobson and Jon Lawrence, (2023). *ACT community-managed mental health workforce profile 2023*. Mental Health Community Coalition ACT, Canberra.

ISBN 978-0-6457527-1-7

ACT community-managed mental health workforce profile 2023

Foreword

This report into the ACT community-managed mental health workforce comes at a critical juncture. Communities are experiencing increasing mental health need after enduring years of the COVID-19 pandemic, successive natural disasters, rising costs of living, and other socio-economic pressures. The growing demand for mental health services across the ACT highlights the need for a robust and inclusive system of care – a system of care that in turn relies on a high quality, capable and sustainable workforce.

While governments have devoted significant attention to clinical mental health services, the crucial contribution made by the community-managed mental health workforce has not received the same level of acknowledgment or support. Community-managed mental health services operate in various community settings and across the mental health continuum – from mental health promotion and education, early intervention, through to support for people with severe and complex mental health issues. What distinguishes these services from more clinical models of care is their focus on wellbeing rather than illness, and provision of practical supports to help people connect with their communities and live well.

The workforce delivering these services encompasses a wide range of roles. They might facilitate group therapy sessions, conduct home visits, provide rehabilitation programs, deliver peer support, or offer practical assistance to individuals as they strive towards recovery. They may also deliver mental health promotion and education in community settings to raise awareness, reduce stigma and promote wellbeing. They may also serve as advocates, empowering people to navigate complex systems, access appropriate resources, and exercise their rights within the mental health landscape. By working closely with individuals, families, and communities, this diverse workforce supports recovery, social inclusion, and resilience.

Despite their immense contribution, the community-managed mental health workforce often operates in the shadows, with their contribution overlooked and undervalued by governments. A key factor contributing to this is the lack of data about the community-managed mental health workforce**.** Basic information about the size and composition of the community-managed workforce remains incomplete, and is especially limited when compared to the information available about the private clinical workforce and the public sector mental health workforce. The absence of comprehensive data and research on the scope, nature, and needs of this workforce is a fundamental impediment to the development of evidence-based policies and initiatives. It also contributes to the relative invisibility and marginalisation of the community-managed sector in workforce planning and related government policy processes.

This report aims to address this critical knowledge gap by detailing the findings of a survey of the community-managed mental health workforce in the ACT. As the peak body representing the community-managed mental health sector in the ACT, the Mental Health Community Coalition ACT (MHCC ACT) engaged Human Capital Alliance to undertake a survey of the sector's workforce in November 2022.

The findings of this survey provide invaluable and unprecedented insights into the size, nature and context of the community-managed mental health workforce, demonstrating both the valuable contribution of the workforce and the myriad challenges it is currently facing. As this report reveals, the workforce encompasses a diversity of roles, is primarily female and strikingly young. It makes a substantial contribution to mental health care in the ACT, comprising an estimated 60% of the overall mental health workforce.

This report also highlights some fundamental issues that need to be tackled if the ACT is to have a sustainable and effective mental health workforce into the future. Of particular concern is the alarmingly high rates of workforce casualisation and job insecurity – which is in turn contributing to difficulties attracting, recruiting and retaining an appropriately skilled and experienced workforce. Organisations with difficult-to-fill vacancies reported stress and burnout among their staff, along with increased service waiting lists and turn away rates. Organisations also indicated they were facing increased demand for skilled workers, and that this demand is only set to intensify as both the ACT and federal government seek to implement a range of reforms to the mental health system. Such findings point to the urgent need for a clear roadmap to ensure a sustainable and skilled mental health workforce now and into the future.

It is my hope that this report will contribute to the development of this roadmap, along with funding and policy settings that support and sustain our workforce. By better understanding the scope, nature, and needs of the community-managed mental health workforce, I believe we can collectively work towards a more inclusive, responsive, and holistic mental health care system in the ACT.

And by prioritising the regular collection of comprehensive data and research on the community-managed mental health workforce, governments can ensure that this invaluable sector of the mental health system receives the recognition, resources, and support it deserves.

Finally, I want to extend my deep gratitude to all those organisations who contributed to our survey, and to all of those working in community-managed mental health services across the ACT. You are the core of our mental health service system and I thank you for commitment to bringing hope, healing, and empowerment to those who need it.

Corinne Dobson
Acting Chief Executive Officer,
Mental Health Community Coalition ACT

Acronyms and abbreviations

ACCHOs	Aboriginal Community Controlled Health Organisations
ACNC	Australian Charities and Not for Profits Commission
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ANZCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industrial Classification
CALD	Culturally and linguistically diverse
CHS	Canberra Health Services
CMO	Community-managed organisation
FTE	Full-time equivalent
HR	Human resources
HRIS	Human Resources Information Systems
HCA	Human Capital Alliance
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual and other sexuality or gender diverse (+)
MHCC ACT	Mental Health Community Coalition ACT
MHCC	Mental Health Coordinating Council (NSW)
MH NGOE NBEDS	Mental health non-government organisation establishments National Best Endeavours Data Set
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NHWPRC	National Health Workforce Planning and Research Collaboration
NSC	National Skills Commission
NSW	New South Wales
OSR	Online Services Report
QAMH	Queensland Alliance for Mental Health
PHN	Primary Health Network
VET	Vocational Education and Training
WAAMH	Western Australian Association for Mental Health

Executive summary

Background

Nationally, the community-managed mental health sector is recognised as a significant component of the total mental health workforce. Yet information about the size and composition of the community-managed workforce remains incomplete, including in the ACT.

Accordingly, the Mental Health Community Coalition ACT (MHCC ACT) engaged Human Capital Alliance (HCA) in 2022 to undertake an employer workforce survey of the ACT community-managed mental health sector to better understand and support decisions about the workforce in the ACT.

Method

In November 2022, an online survey was administered to all 49 member organisations of MHCC ACT, and to an additional 50 non-member community-managed mental health organisations known to MHCC ACT. The survey tool was modified from a tool used by the NSW Mental Health Coordinating Council (MHCC) to survey the NSW community-managed workforce in 2021 (Riddout & MHCC 2021).

A total of 55 organisations responded to the ACT survey, with 51 respondents answering most (if not all) of the survey questions with 'viable' responses. This response rate was considered good to excellent and was slightly higher than the 2021 NSW surveys response rate.

Findings

The survey findings revealed a number of features about the community-managed mental health workforce in the ACT.

- **Workforce size:**
  The total number of workers employed by respondent organisations for the delivery of direct care mental health services was 1069. When extrapolation techniques were applied to this data, an estimate of 1,730 workers was obtained for the total direct care mental health workforce in the ACT.

  This raw head count estimate translates into 1,038 full-time equivalent (FTE) workers when applying an FTE conversion factor of 0.6.

  When the estimated non-direct care support workforce and the volunteer workforce are included, the total workforce headcount was 2,051 paid workers and 1,143 volunteer workers, and an FTE of 1,231 paid workers and 1,364 FTE total (paid and unpaid) workforce.

  These findings demonstrate the community-managed workforce makes a substantial contribution to mental health service delivery in the ACT, accounting for an estimated 60% of the total ACT mental health workforce.

- **Workforce composition:**
  Approximately 61% of the workforce were female, 37% male, and 2% reported a non-binary or gender-diverse identity. In relation to age distribution, nearly 70% of workers were less than 45 years of age. This points to a feminised workforce of younger than average workers.

- **Categories of worker:**
  Survey respondents noted over a dozen different categories of worker in their direct mental health workforces, the most prominent category being mental health support worker (26% of all workers).

  A much lower proportion were support coordinators (9%), counsellors (7%), consumer peer workers (6%) and social workers (6%). Other worker categories represented less than 5% of the total workforce.

  The worker profile of the ACT community-managed mental health workforce varies significantly from the ACT public sector workforce, which is characterised by high nurse employment and is more highly reliant on a clinical or professional workforce than the community-managed sector.

- **Lived experience (peer) workers:**
  Despite many years of promoting the value of lived experience or peer workers in the mental health workforce, less than one in ten (7.6%) of the ACT workforce were in designated peer worker roles.

- **Conditions of employment:**
  Approximately half (51%) of the paid workforce were employed on a permanent basis, nearly 20% were employed under fixed-term (temporary) contracts, and another 30% were paid as casuals on an hourly rate.

  This indicates there is a higher proportion of temporary or casual workers in the ACT community-managed mental health workforce than in the total Australian workforce. The casualisation of the workforce is also substantially higher than the ACT public sector mental health workforce.

- **Workforce diversity:**
  Less than half of respondent organisations advised they kept detailed workforce data about workforce diversity. Of those that did, 1.5% of the workforce was Aboriginal or Torres Strait Islander, around 15% were from culturally and linguistically diverse (CALD) backgrounds, and 5.4% were LGBTQIA+ people.

- **Current workforce adequacy and recruitment:**
  Nearly half of the survey respondents have had vacant positions in their established direct support mental health workforce in the past six months, and over half of these indicated these vacancies were difficult to fill.

  A key factor perceived to be contributing to these recruitment difficulties is the inability of employers to offer permanent contracts and competitive salaries. These recruitment difficulties are manifested by a lack of qualified applicants in some job categories.

  Organisations reported a range of negative consequences of difficult-to-fill vacancies, including increasing stress on the current workforce, increased waiting lists for services, and having to turn people away from services. For those organisations with difficult-to-fill vacancies, several were concerned about the wellbeing and levels of stress/burnout among current staff.

- **Demand:**
  According to respondents, the most significant factors affecting their ability to meet workforce demand were inadequate funding to recruit appropriately qualified staff, and issues around tendering and the commissioning of ACT Government funded services. As a consequence of these factors, there is unmet demand for skilled workers. Organisations believe the demand for a skilled mental health workforce will continue to increase in the ACT.

Perceptions of the future

It is clear community demand for mental health services in the ACT will grow into the future, with consequent implications for workforce planning and demand pressures.

A range of factors outside the scope of this study are likely to increase demand for the community-managed mental health workforce, including demographic pressures, an underlying increase in mental health need across the community, and policy changes at the ACT and national levels.

There has been strong growth in the community-managed mental health workforce since earlier studies undertaken by MHCC ACT over a decade ago (MHCC ACT 2009, 2012). While this may in part be attributed to substantial growth in both ACT and Commonwealth investment into the sector between 2011 and 2015, government investment subsequently declined as ACT Government funding for the sector was rolled into the NDIS and major Commonwealth programs (such as Partners in Recovery and Personal Helpers and Mentors) were phased out. Workforce growth would have also been affected by the introduction and expansion of the NDIS, however this is perceived to have less influence on workforce growth into the future.

Most surveyed organisations believe future growth in demand will strongly favour higher skilled workers. However, future funding sources to sustain service growth (and therefore workforce demand) are uncertain.

To support workplace planning and projections, future data collection should be extended and undertaken regularly to gain a better insight into service (and therefore workforce) demand, as well as estimating supply.

In addition to considerations around the growth of the workforce, this study suggests structural changes in the community-managed mental health workforce are required.

The high rate of insecure employment conditions is of particular concern and is not conducive to workforce commitment and loyalty. This could have (if it is not already having) a detrimental effect on workforce retention and/or the quality of care. Such detrimental effects are likely to be more pronounced if low unemployment rates persist, together with ongoing wage disparities between the community-managed and public and for-profit sectors.

The workforce is young, which may suggest the community-managed mental health sector is a good place to begin, but not finish, a career. While the community-managed sector might be regarded as an appropriate entry level to the mental health workforce, it is possible experienced workers are seeking more highly remunerated and/or more stable employment in other sectors.

Efforts need to be made to retain workers longer in the sector through:

i. ensuring career pathways with interesting and challenging roles and competitive salaries (vis-à-vis the public sector)

ii. providing non-graduate career entry workers with greater and more structured career development support (MHCC ACT 2012)

iii. greater security of employment for workers across the sector.

Two components of the workforce warrant particular focus in future workforce development and planning.

The designated peer workforce in the ACT accounts for only 7.6% of the total community-managed workforce. Arguably, this proportion should be much higher to achieve the desired influence of lived experience on the sector's culture, service design and service delivery.

The proportion of organisations with a volunteer workforce is comparatively small compared with other community sector workforces. Additional consideration should be given to ensuring the volunteer workforce is adequately supported to provide an effective contribution to community-managed mental health services across the ACT.

Contents

Introduction

Information on the community-managed mental health workforce

Nationally, the community-managed mental health sector is recognised as a significant component of the total mental health workforce. Yet, information about the size and composition of the community-managed workforce remains incomplete in terms of both state/territory and organisational coverage (Ridoutt and Cowles 2019; Productivity Commission 2020; Queensland Alliance for Mental Health [QAMH] 2021; Cleary et al. 2020; WAAMH 2017).

The community-managed mental health workforce is not captured in other standard data collections such as the Australian and New Zealand Standard Industrial Classification (ANZSIC) or Australian and New Zealand Standard Classification of Occupations (ANZSOC), nor does the National Mental Health Services Planning Framework code specifically for community-managed mental health workers. Even the National Disability Insurance Agency, which collects vast amounts of information on participants and service providers, does not collate useful information on the community-managed mental health workforce.

Data on the sector is especially limited when compared to information available about the workforce providing public sector mental health services. Data on the public sector workforce (and the workforce in larger private sector facilities) is collected routinely by the Australian Institute of Health & Welfare (AIHW) through the *National Mental Health Establishments Database and Private Health Establishments Collection*.

Over a decade ago, the AIHW attempted to rectify the disparity between sectors through the introduction of routine data collection in the community-managed sector. In consultation with the community-managed mental health sector, the Mental health non-government organisation establishments National Best Endeavours Data Set (MH NGOE NBEDS) was developed during 2009-2010. Unfortunately, at the time of this report, this collection has only been initiated in Western Australia and Queensland, and no substantive data is publicly available.

The most recent national assessment of the community-managed mental health workforce remains a survey of the mental health non-government organisation (NGO) workforce by the National Health Workforce Planning and Research Collaboration (NHWPRC), which was conducted in 2009–2010 and reported on in 2011 (NHWPRC 2011). Just over one-third of the community-managed[1] mental health sector (based on a population estimate of 798 organisations) was able to be surveyed.

1 In the NHWPRC report, the descriptor non-government organisation (NGO) is used instead of community-managed organisation.

Based on this data, the size of the national community-managed mental health workforce was conservatively estimated to range from 14,739 to 26,494 paid employees. The survey data also indicated the community-managed mental health workforce was predominantly characterised by roles such as support workers and peer workers. Some organisations also employed workers for clinical roles, including psychologists, counsellors, registered nurses and occupational therapists.

In the past, information about the size and composition of the community-managed mental health workforce could only be extrapolated from the NHWPRC data. In recent years, some state and territory peak bodies for the community-managed sector have attempted to collect data on their sector's workforce.

For instance, in NSW, surveys of community-managed organisations were undertaken in 2019 and 2021 to capture data on the size, composition (gender, age, educational qualification, etc.) and geographic distribution of the workforce, as well as current and future workforce demand (Ridoutt and Cowles 2019; Ridoutt 2021).

In Queensland, a similar attempt was made, but with greater reliance on qualitative data collected from service managers, frontline workers and human resources (HR) practitioners working in the community-managed sector (QAMH 2021). The QAMH report also notes attempts to describe the community-managed mental health workforce in Victoria (Resika et al. 2019) and Western Australia (WAAMH 2017).

In the ACT, the most recent attempt to describe the community-managed mental health workforce composition (but not the size) was through a 2011 employer survey (MHCC ACT 2012). This survey built on a prior employer survey (MHCC ACT 2009).

Given this context, the Mental Health Community Coalition ACT (MHCC ACT) initiated an employer workforce survey of community managed organisations delivering mental health services in the ACT to better understand and support decisions about the workforce.

MHCC ACT is the peak body representing the community-managed, not-for-profit mental health sector in the ACT. MHCC ACT's purpose is to support a strong and sustainable community-managed mental health sector that delivers quality, sustainable, recovery-oriented services to support people with mental health issues and their carers.

Improving data about the community-managed mental health sector is critical to inform policy development and advocacy. The need for such data is particularly pronounced in a context where a range of strategic policy and planning relating to the mental health workforce is in development.

At the time of writing, the *National Mental Health Workforce Strategy 2021–2031* is awaiting sign-off by the Commonwealth Government, following public consultation around a draft strategy (Commonwealth Department of Health 2021).

A recent review of mental health workforce planning policies, commissioned by the National Mental Health Workforce Taskforce, identified the ACT as the only jurisdiction in Australia without a current workforce policy (Institute for Social Research 2020). Since this review, the ACT Government has developed a Mental Health Workforce Strategy (ACT Government 2022), with an associated implementation plan under development at the time of writing.

Method overview of the survey

The survey was administered to:

- all 49 current MHCC ACT members at the time of administration (11 November 2022)
- non-members, made up of past affiliated organisations, known non-members providing mental health services, Aboriginal Community Controlled Health Organisations (ACCHOs), alcohol and other drug organisations, and education providers with counselling services (50 surveys in total).

The survey tool was modified from a tool used by the NSW Mental Health Coordinating Council (MHCC) to survey the NSW community-managed workforce in 2021 (Ridoutt and MHCC 2021). This ensured consistency of data collection between the NSW and ACT surveys, thus facilitating comparisons between ACT and NSW data.

Every attempt was made to optimise the response rate achieved for this project through consistent and high-level promotion of the survey and repeated follow up of non-responding organisations.

A total of 55 organisations responded to the survey. Of the responses, all responded to the question on the number of workers (question 7 of the survey detailed in Appendix 2). A total of 51 respondents answered most (but not all) of the remaining survey questions with 'viable' responses. There were 32 responses (including 4 incomplete) from MHCC ACT members (response rate=65.3%) and 23 responses from non-members (response rate=46.0%).

These response rates are laudable in a context of survey fatigue and declining response rates. The non-member response rate was adversely affected by administration to a number of inappropriate subjects, including several schools and other educational institutions. Moreover, it is most likely that the bulk of the non-respondent organisations are small and employ very few, if any, workers. The overall response rate was slightly higher than for the NSW workforce surveys.

For more details on the response rate and the survey method, see Appendix 1 . The survey instrument is included at Appendix 2.

Data limitations

Employer or employee surveys are a common means of undertaking workforce research to understand workforce supply (HCA 2013) but have several limitations (Ridoutt & MHCC 2021). They are most often used where no other option is available, such as when a workforce is unregistered or there is no professional association coverage.

The primary concern with an employer survey method relates to estimating key workforce variables, such as workforce size, that are highly sensitive to population sampling (*have all possible employers been included in the survey administration?*) and the survey response rate (*were the responding employers different to the non-responding employers?*). The process of extrapolating from the survey results to obtain total population estimates is detailed later in this report.

As noted above, 55 organisations responded to the survey. Not all of them, however, completed the survey in full. Indeed, several respondents only completed up to Question 7 (which sought the number of employed direct care workers). Consequently, although the overall response rate is comparatively high for a survey of this nature, for some questions the response rate was much lower, and caution is advised when interpreting findings where the number who answered a particular question (the 'n' value) is low.

In addition, approximately half of the respondent organisations (51%, n=53) indicated they maintained good workforce data in a human resources information systems (HRIS) and used this source to estimate responses to the questions. The other 49% advised they kept only some workforce data that is not well maintained, or they kept very limited workforce data. This included some large and medium-sized (see below) organisations.

In cases where limited data was maintained, the research team advised organisations to provide a 'best guess'. Accordingly, the numbers for workforce composition breakdown do not always align with total workforce size estimates and may need to be interpreted with caution. Based on conversations with respondents, the proportional values are considered good estimates.

Survey findings

Workforce size

The total number of workers (head count) employed by the responding organisations for delivery of *direct care mental health services* was **1069**. This represents an average of 19.4 workers (n=55) specifically delivering mental health services in each responding organisation. However, this average affords limited insight as just over half (53.3%) of all workers employed by responding organisations work with just four organisations (7.3% of the responding organisations).

This is demonstrated in Table 1, which shows the average number of workers in each of the different organisational-size categories, where organisation size is estimated based on annual turnover/revenue[2].

Table 1: Average workforce numbers employed by different-sized organisations

Organisation size	Annual turnover/ revenue	Average for members responding	Average for responding non-members	Average for all respondents
Small	$100,000 to $500,000	6.2	2.9	3.9
Medium	$500,000 to $2 million	11	8.1	9.7
Large	$2 million to $10 million	31.6	18.7	26.8
Very Large	>$10 million	60.5	-	60.5

A 2011 study of the NGO mental health sector (NHWPRC 2011) found the majority (58%) of non-government organisations reported between 2 and 25 paid mental health staff, with a peak (23%) in the 6 to 10 mental health worker range.

In order to obtain an estimate of the total ACT community-managed workforce size, extrapolated from the survey respondent data, three measures were adopted:

1. The average workforce numbers for each different-sized **member** organisation were applied to similar-sized non-respondent member organisations. So, for instance, for all 'medium'-sized non-respondent organisations, it was assumed their number of workers was 11.
2. The average workforce numbers for each different-sized **non-member** organisation were applied to similar-sized non-respondent non-member organisations. So, for instance, for all 'large'-sized non-respondent non-member organisations it was assumed their number of workers was 19.
3. Where available, secondary data sources were used instead of relying on the assumptions detailed above—for instance, staffing numbers for ACCHOs were drawn from the AIHW's annual survey, the Online Services Report (OSR) for Indigenous primary health care (AIHW 2023).

2 Size estimates were made based on organisational website searches and review, and details from the Australian Charities and Not for Profits Commission.

Applying the above methods, the extrapolated workforce numbers are shown in the tables below.

Table 2: Extrapolated workforce numbers for non-responding members

	Small	Medium	Large	Very large
Responding members	6 (19.4%)	11 (35.5%)	5 (16.1%)	10 (32.3%)
Non-responding members	5 (27.8%)	3 (16.7%)	6 (33.3%)	4 (22.2%)
Calculation	5 x 6.2	3 x 11	6 x 31.6	4 x 60.5
Workforce numbers	31	33	190	242

This provides a total estimated additional workforce (headcount) of 496. As the table above shows, the respondent population was over-represented by 'Very large' organisations, possibly because of superior HR systems from which to elicit workforce data.

Table 3: Extrapolated workforce numbers for non-responding non-members

	Small	Medium	Large	Very large
Responding non-members	13 (56.5%)	7 (30.4%)	3 (13%)	0
Non-responding non-members[3]	13 (54.2%)	9 (37.5%)	2 (8.3%)	0
Calculation	13 x 2.9	9 x 8.1	2 X 18.7	0
Workforce numbers	38	73	37	0

This provides a total estimated additional workforce (headcount) of 148. In the case of surveyed non-members, the non-respondent and respondent populations are similar.

3 ACCHO non-respondents are covered in (3).

For ACCHO organisations, data on workforce numbers can be extracted from the Online Services Report (OSR) for Indigenous primary health care annual data collection reports (AIHW 2023). For the 2021–22 financial year, there were an estimated 101 social and emotional wellbeing workers in NSW/ACT[4], 228 Aboriginal and Torres Strait Islander health worker/practitioners (some of whom would be working in mental health), and 43 substance misuse/drug and alcohol workers. Assuming one tenth of NSW/ACT workers work in the ACT, then a crude estimate of total numbers would be 16 to 17 workers.

Based on the above assumptions and the extrapolation calculations, a more accurate estimate of the community-managed sector workforce **headcount** in the ACT is likely to be **1,730** (1069 + 661).

There is little published data against which to compare this estimate. In 2011, a conservative estimate of the national mental health NGO workforce (NHWPRC 2011) suggested it was between 14,739 to 26,494 paid employees. Since this same source estimated the ACT accounted for 2.2% of the total NGO mental health workforce, then the estimated ACT workforce size at that time lay between 324 and 583. Other examinations of the NGO mental health workforce (such as Ridoutt 2021) have indicated that the workforce has been growing very rapidly over the last five years. Accordingly, the 2011 estimate was likely conservative and the workforce would have changed significantly since that previous estimate.

The raw head count estimate translates into **1,038 full-time equivalent (FTE) workers**, derived by applying an FTE conversion factor of 0.6. This conversion factor is in turn derived from analysis of survey responses, which has then been applied to the estimated workforce size.

The FTE conversion factor is lower than the factor estimated for the NSW workforce of 0.67 (Ridoutt 2021). As a comparison, the registered working psychologist population has an FTE conversion factor of 0.85, the total mental health nurse workforce has an FTE conversion factor of 0.95, and the working psychiatrist workforce has an FTE conversion factor of 0.97[5]. Given the nature of the work in the community-managed sector, a higher proportion of the workforce working part-time is anticipated (see later sections).

In addition to the estimated direct support workforce, the respondent organisations (n=45) identified that 162 workers were working in non-direct support roles. If an adjustment to these numbers is made for missing values (10 respondents who did not answer this question spread fairly evenly over the different organisation sizes) and then extrapolated to a full workforce estimate using the same proportions as for the direct support workforce, then the estimated workforce numbers can be derived, as shown in Table 4 below. This estimates the administrative workforce at just over 15% of the total paid workforce.

Table 4: Estimated total number of workers employed in direct and non-direct support roles (n=37)

Direct support role	Number of estimated workers (headcount)
Direct support workforce	1,730
Non-Direct support roles	**Number of estimated workers (headcount)**
Management[6]	134
Administrative support staff	160
Technical support staff (e.g., IT)	27
Total non-direct workforce	321

In addition to the paid workforce, 13 organisations (28.9%, n=45, missing values=10) indicated they use volunteer staff. This is a much lower proportion of organisations using volunteers than NGOs in NSW, where the proportion was over 60%.

In total, there were **579 volunteers (head count)** contributing to the delivery of mental health services in these 13 organisations. This equates to **67.6 FTE volunteers**.

4 Data is not published for ACT alone.

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

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

Using the same approach to extrapolation as that for non-direct support staff above (potentially problematic but defendable), this translated into an estimated **1,143 volunteers** and **133.4 FTE**. By headcount, volunteers account for an estimated 39.8% of the community-managed workforce, but by FTE that proportion reduces to just 9.8%. This figure does not include unpaid carers or people with lived experience participating in self-help groups.

While the proportion of ACT organisations using volunteers was comparatively low, the volunteer proportion of the total ACT community-managed mental health workforce in terms of headcount and FTE is quite similar to that in NSW, with 42% and 8% respectively.

The total number of persons estimated to be working to deliver mental health services in the ACT community-managed sector is therefore **2,051 paid workers** and **1,143 volunteer workers** (for a total of **3,194 paid and unpaid workers**). In terms of the paid workforce, this translates into an **FTE of 1,230.6 workers**, and **for all workers (paid and unpaid) an FTE of 1,364**.

To place this into perspective, the FTE number of workers employed in the specialised mental health workforce, based on data provided by the Canberra Health Services (CHS), is 810.09[7]. While this does not include all public sector mental health workers currently employed in the ACT, it does cover the bulk of inpatient and community rehabilitation services and includes both direct care workers and administrative staff.

On this basis, the community-managed mental health workforce makes up an estimated 60% of the total mental health workforce currently employed in the ACT.

Community-managed sector description and workforce functions

Community-managed organisations that specialise in providing mental health services in the ACT are in the minority. Of the 55 respondent organisations, 13 (24%) were focused on providing just mental health services, 25 (45%) provided mental health programs in addition to other programs/services, and 17 (31%) provided support services but not specifically in the mental health area. This finding is similar to the organisational profile in NSW (Ridoutt & Cowles 2019).

Organisations 'providing mental health programs/services only' ('specialist' mental health organisations) account for only 14% of the total community-managed workforce. The bulk of the total ACT community-managed mental health workforce (74.3%) are working in organisations 'providing mental health programs in addition to other programs/services'. In these organisations, mental health workers comprise on average 51.2% of the workforce (ranging from 10% to 90%). For organisations 'providing support but no specific mental health programs/services', the mental health workforce component on average is 38.2% (ranging from 10% to 90%).

Organisations receive funding from various sources, with some (generally larger) organisations receiving funding from multiple funding bodies and program streams. Most of the respondent organisations (51%, n=55) receive some funding from the ACT Government, with other prominent funding sources being the NDIS and charitable donations and philanthropy (see Figure 1).

The main source of funding for just over one third of organisations (34.5%, n=55) is the ACT Government (ACT Health Directorate). For another 18.2% of organisations, the main funding source was identified as 'Other', which included education sources and fee-for-service (see Figure 2). The NDIS was the main source for 16.4% of organisations, and the local Primary Health Network (PHN) (Capital Health Network) was the main source for 12.7% of organisations. While 23.6% of organisations collected charitable donations, this was a primary source of revenue for only 9.0%.

7 Data from Canberra Health Services (CHS) Division of Mental Health. Data is reflective of paid FTE as of 18 January 2023.

Figure 1: Source of funding of responding organisations (n=55, multiple funding sources possible)

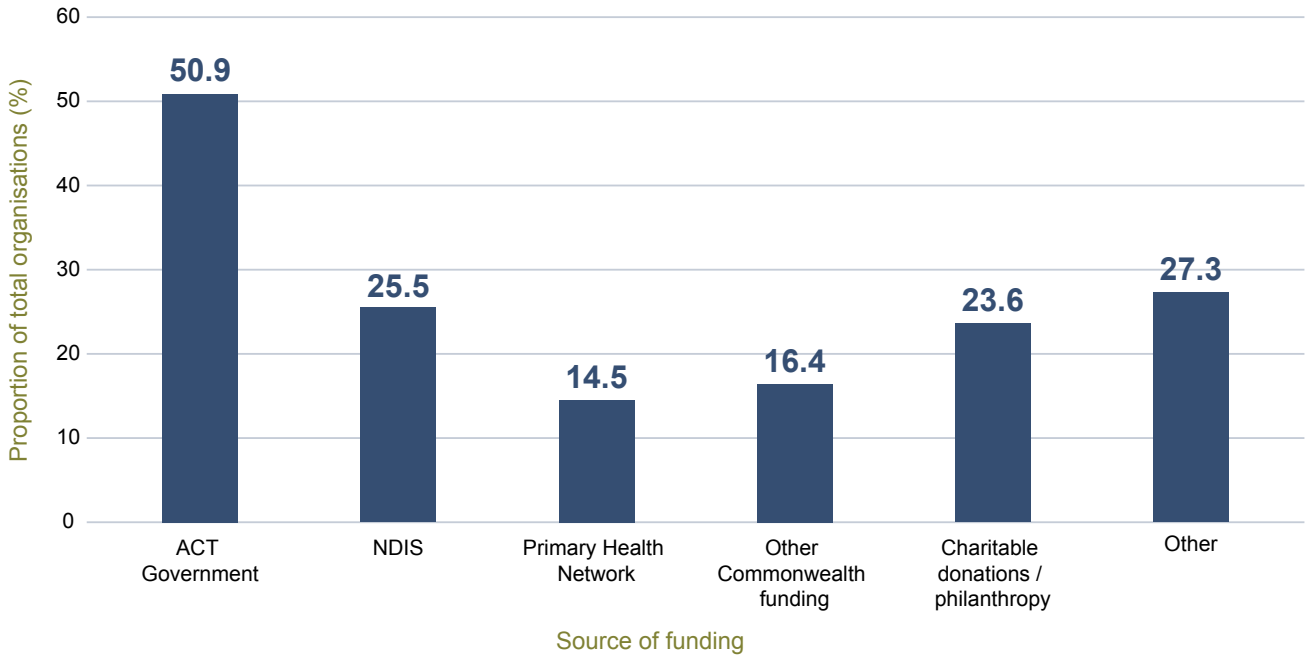
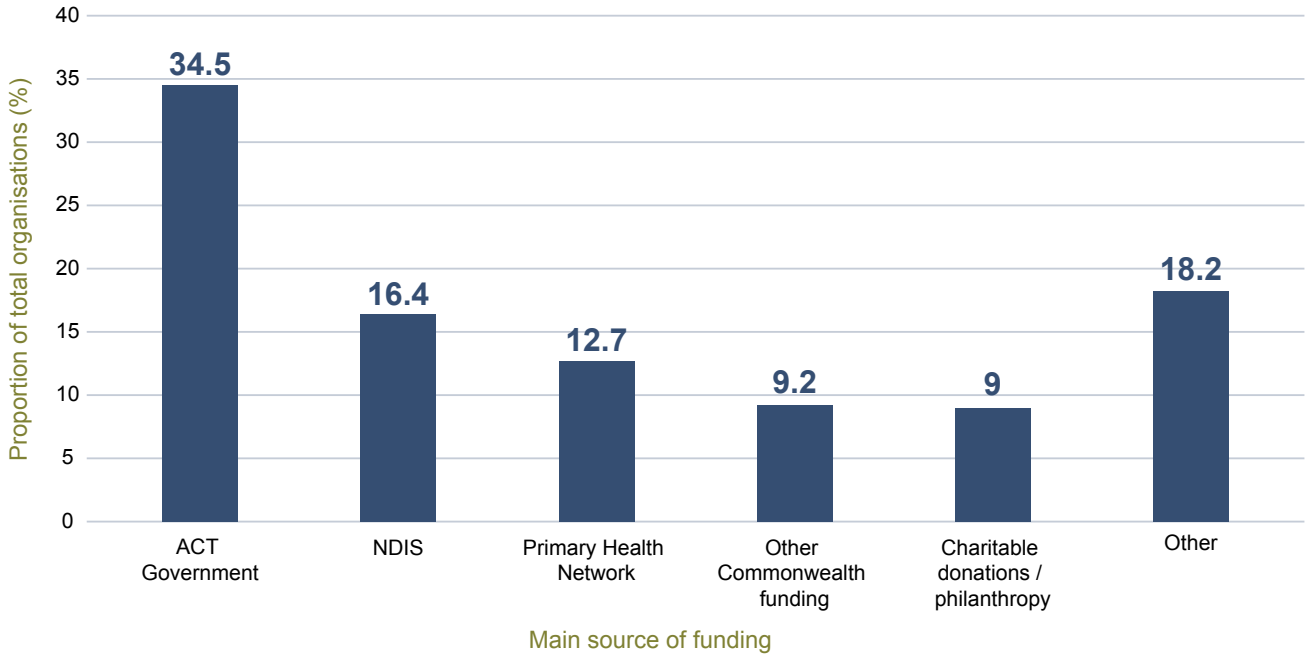


Figure 2: Main source of funding (n=55, only one choice possible)



The top five types of services provided by the paid community-managed workforce in the ACT (in order of most commonly provided) were:

1. Intake / assessment / triage for referral to other services
2. Counselling, support, information and referral – telephone
3. Counselling (face-to-face)
4. Group support activities
5. Mental health promotion.

The full range and distribution of services types offered by community-managed organisations in the ACT is provided in Figure 3.

Figure 3: Types of mental health services provided by ACT community-managed organisations (n=54)

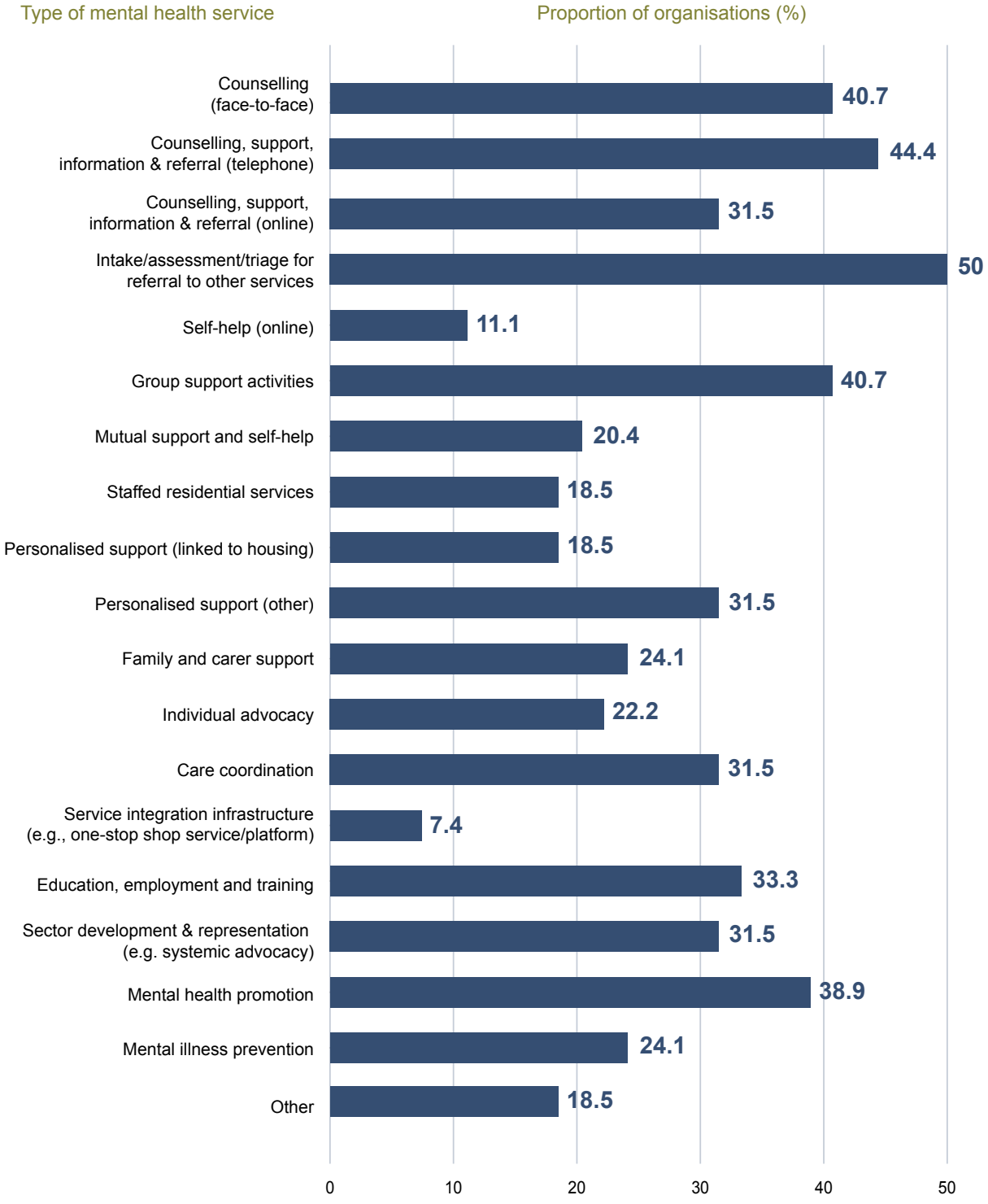
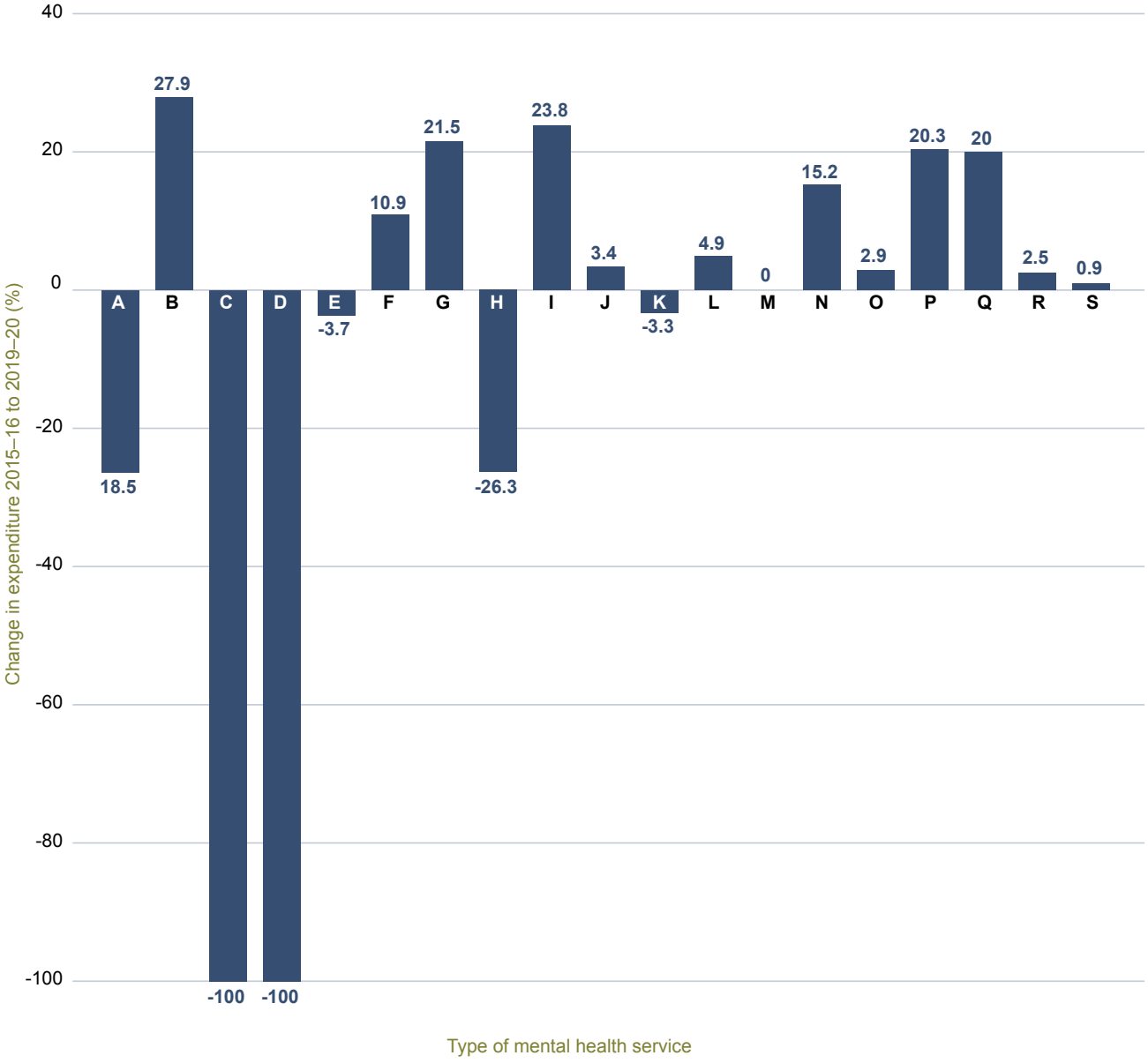


Figure 4 details the changes in expenditure across mental health service types since 2015. It shows that some of the more prevalent services offered, namely ‘counselling (face-to-face)’ and ‘group support activities’, have experienced reductions in funding support, while funding for other prevalent services has increased, such as for ‘counselling, support, information and referral (telephone)’ and ‘mental health promotion’.

Figure 4: Changes in expenditure between 2015–16 and 2019–20 on different service types offered in the community-managed mental health sector (Source: AIHW 2022)



Key: Types of mental health services (note: these vary slightly from categories used in the survey)

A. Counselling (face-to-face)

B. Counselling, support, information and referral (telephone)

C. Counselling, support, information and referral (online)

D. Self-help (online)

E. Group support activities

F. Mutual support and self-help

G. Staffed residential services

H. Personalised support (linked to housing)

I. Personalised support (other)

J. Family and carer support

K. Individual advocacy

L. Care coordination

M. Service integration infrastructure (e.g., one-stop shop service/platform)

N. Education, employment and training

O. Sector development & representation (e.g. systemic advocacy)

P. Mental health promotion

Q. Mental illness prevention

R. Other and unspecified services

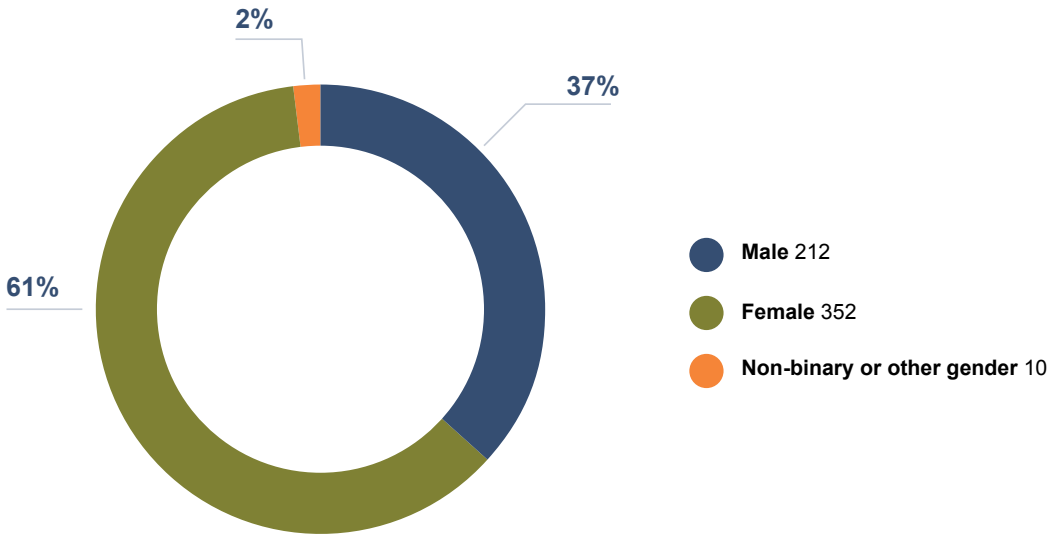
S. NGO residential mental health services

Workforce composition

Gender and age distribution

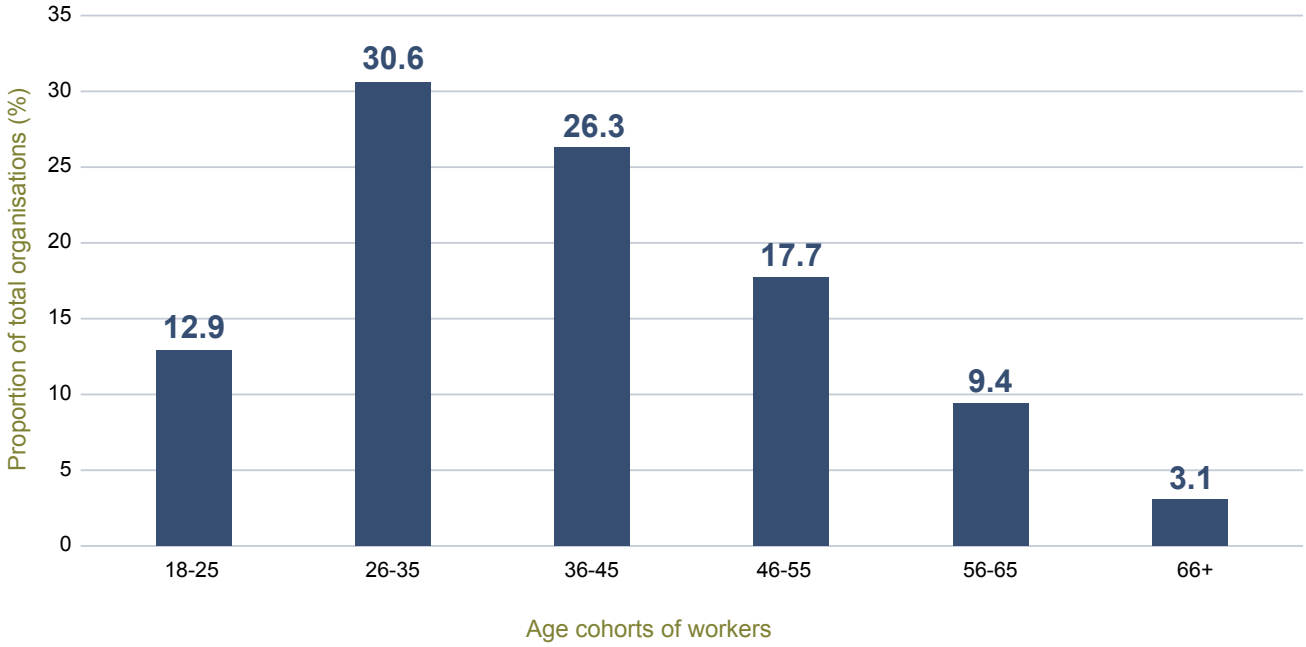
Several organisations advised they did not hold accurate records of the gender of their workforce. However, for those that did and responded in the survey (n=43), approximately 61% were female, 37% male, and 2% were reported as non-binary or other gender.

Figure 5: Distribution of the ACT community-managed mental health workforce by gender (n=43)



The age distribution of the community-managed workforce was skewed towards a younger age profile, with nearly 70% less than 45 years of age (n=45). This makes the community-managed mental health workforce younger overall than the wider Australian workforce, the wider community sector workforce in the ACT (Rosenberg et al. 2019), and other sections of the health workforce (Jobs & Skills Australia 2023).

Figure 6: Distribution of the ACT community-managed mental health workforce by age (n=45)



Categories of worker

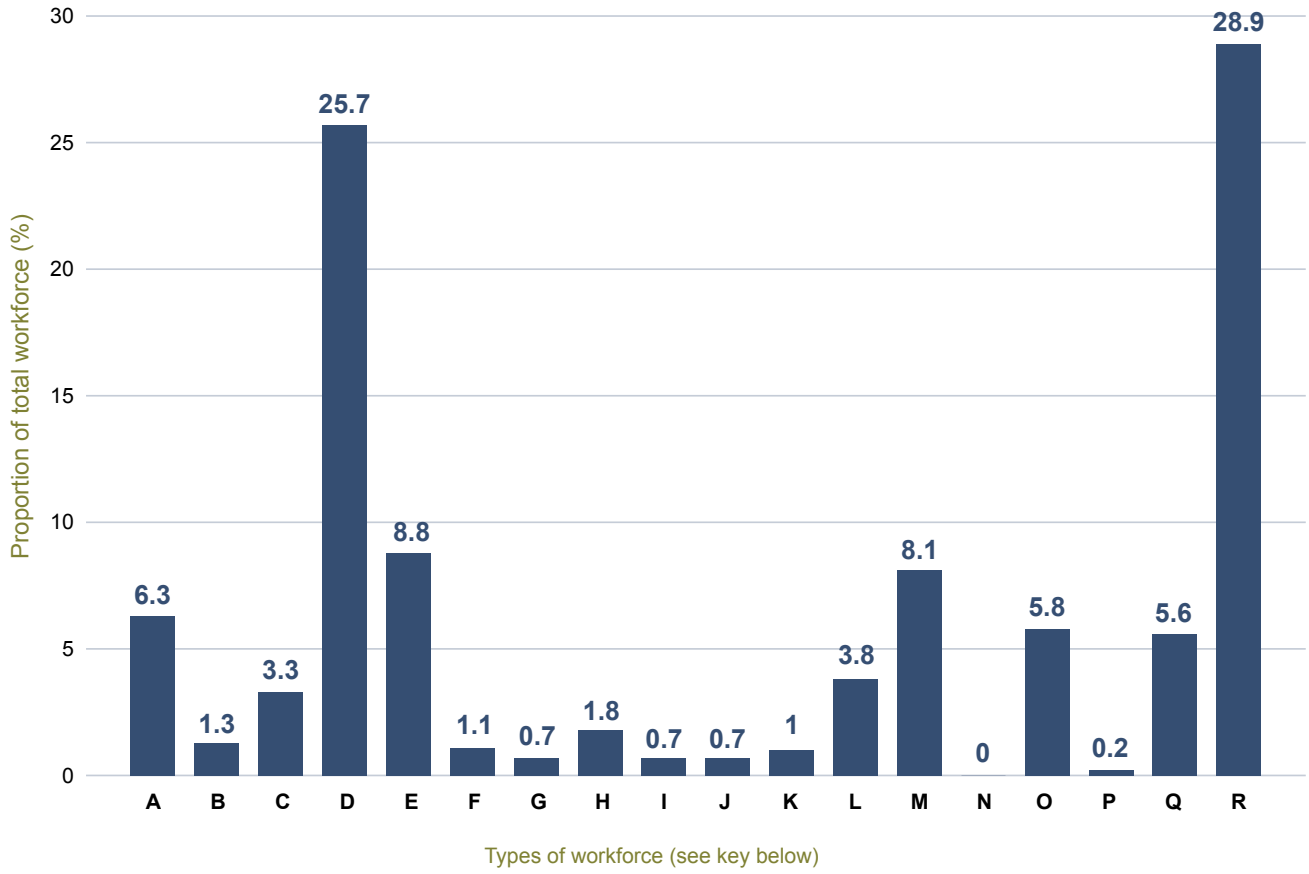
The survey findings demonstrate the diversity and breadth of roles and occupational categories across the community-managed sector. The most prominent type of worker category is the mental health support worker (26% of all workers). A much lower proportion of the total workforce are support coordinators (9%), counsellors (7%), consumer peer workers (6%) and social workers (6%). Most other types of workers represent less than 5% of the total workforce (see Figure 7).

Almost a third of the workers were categorised as 'other'. When survey respondents classified their workers into different role categories, in some cases they were overly literal in their interpretation of the list of categories specified in the survey (for instance, not identifying 'direct support workers' as 'Mental Health Support Workers'). In other cases, a generic category (such as 'Social Worker') was not used in favour of an in-house job title (such as Mental Health Recovery Worker). Some of the worker categories that were arguably genuinely different to those in the listed survey categories included:

- Policy and programs officer
- Community education coordinator
- Research coordinator
- Head of data and insights
- Lived experience speaker[8]
- Youth worker
- Intake officer
- Team coordinator
- Warehouse logistics
- Mentoring and education coordinator
- Systemic advocacy officer
- Employment coach
- Mental health assistant.

8 One could argue that these workers are part of the 'Identified Consumer Peer worker' category, however we accepted the survey respondent's decision to separate this type of worker.

Figure 7: Distribution of the ACT community-managed mental health workforce by category of worker (n=36 responding organisations)



Key: Types of workforce

A. Identified Consumer Peer Workers
B. Identified Carer Peer Workers
C. Recovery Coaches
D. Mental Health Support Workers
E. Support Coordinators
F. Mental Health Nurse
G. Enrolled Nurse
H. Registered Nurse
I. Psychiatrist
J. Other medical practitioner
K. Occupational Therapist
L. Psychologist
M. Counsellors
N. Dietitians
O. Social Workers
P. Aboriginal and Torres Strait Islander Mental Health Workers
Q. Other allied health professionals
R. Other

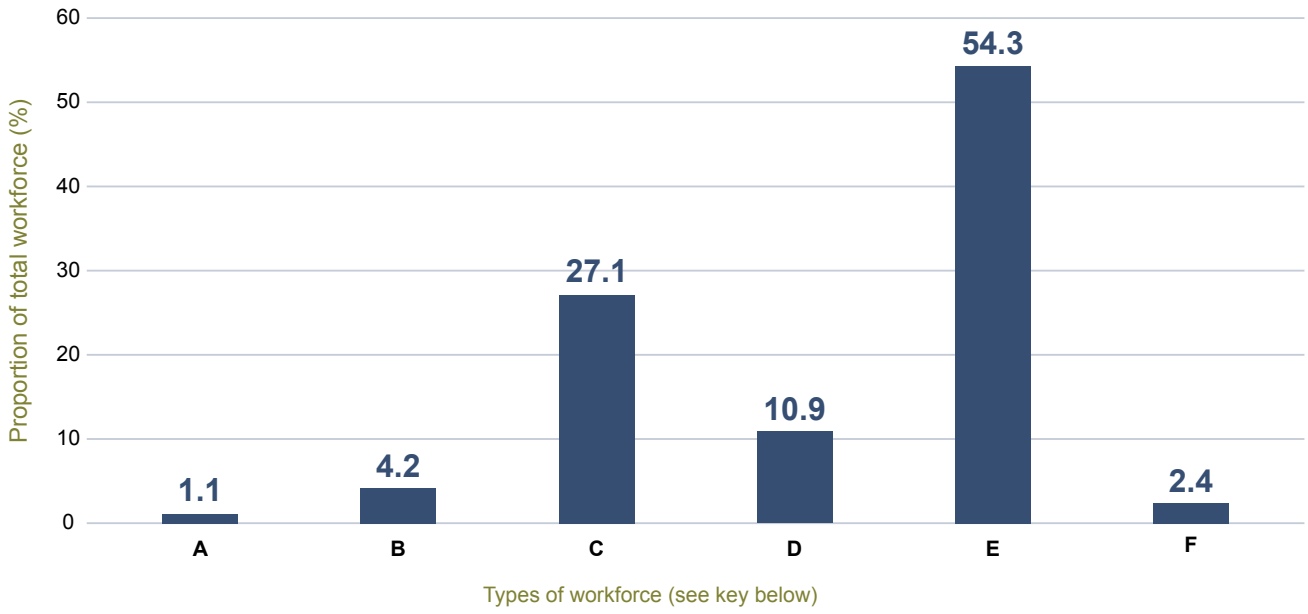
The workforce composition of some respondent organisations does not align to these prescribed worker categories. For instance, one organisation stated they are entirely volunteer based. Another organisation noted:

> " ... we provide mental health education programs and do not provide direct support (i.e. the specified roles do not align with our program provision / staff functions)."

The FTE conversion factor varies considerably between types of workers, with some occupational categories being employed more frequently on a part-time basis than others. For example, mental health support workers are more commonly employed on a part-time basis (their FTE conversion factor is 0.37, compared to the total workforce conversion factor of 0.6). On the other hand, professional worker categories such as nurses, allied health professionals and counsellors tend to have higher-than-average FTE conversion factors.

A direct comparison between the community-managed mental health workforce and that employed by CHS is difficult because the latter delineates fewer categories of worker. However, from Figure 8, it is clear that there is a much higher representation of professionally qualified workers, especially nursing staff (54% vs 1.8%), when compared with the community-managed sector.

Figure 8: Workforce composition of the CHS Division of Mental Health



Key: Types of workforce

A. General Service Officers & Equivalent

B. Health Assistants

C. Health Professional Officers

D. Medical Officers

E. Nursing Staff

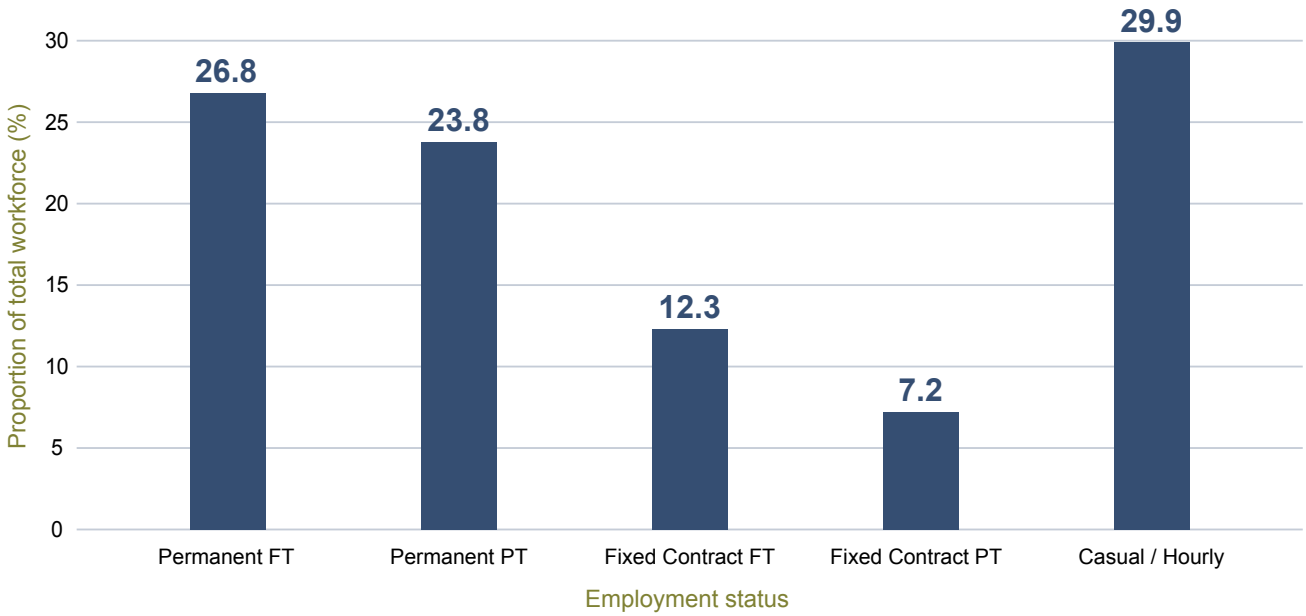
F. Senior Officers

Conditions of employment

Approximately half (50.6%) of the paid workforce is employed on a permanent basis, with the remainder employed on fixed-term contracts or casually on an hourly basis. Of the permanent workforce, 53% are full-time. Nearly 20% of paid workers are employed under fixed-term (non-ongoing) contracts, and another 30% are paid as casuals on an hourly rate.

The proportion of the community-managed mental health workforce employed on a fixed-term contract or casual basis is substantially higher than in the wider Australian workforce. Around 23% of Australian workers are employed on a casual basis, while employees on fixed-term contracts account for around 3.4% of the total Australian workforce (Gilfillan 2021; ABS 2022b).

Figure 9: Distribution of the ACT community-managed mental health workforce by employment status (n=45 respondent organisations)



As a point of comparison, the CHS data indicates 1.7% of the public sector mental health workforce are casual, 15.7% are temporary and 82.6% are permanent. This shows a notably lower rate of casualisation and temporary employment when compared with the community-managed sector (see Figure 10).

The degree of staff casualisation varies according to the main funding source, as shown in Table 5. Organisations funded primarily from 'other' sources tend to have lower levels of workforce casualisation (27%), whereas organisations whose main funding source is the NDIS tend to have higher levels of workforce casualisation (59%), although the numbers are too low to draw statistically significant inferences. However, the finding of high casualisation of the NDIS workforce (mental health or otherwise) is consistent with findings from previous studies (e.g., Cortis & Blaxland 2017; Cortis & van Toorn 2020).

Figure 10: Distribution by employment type of the CHS mental health workforce

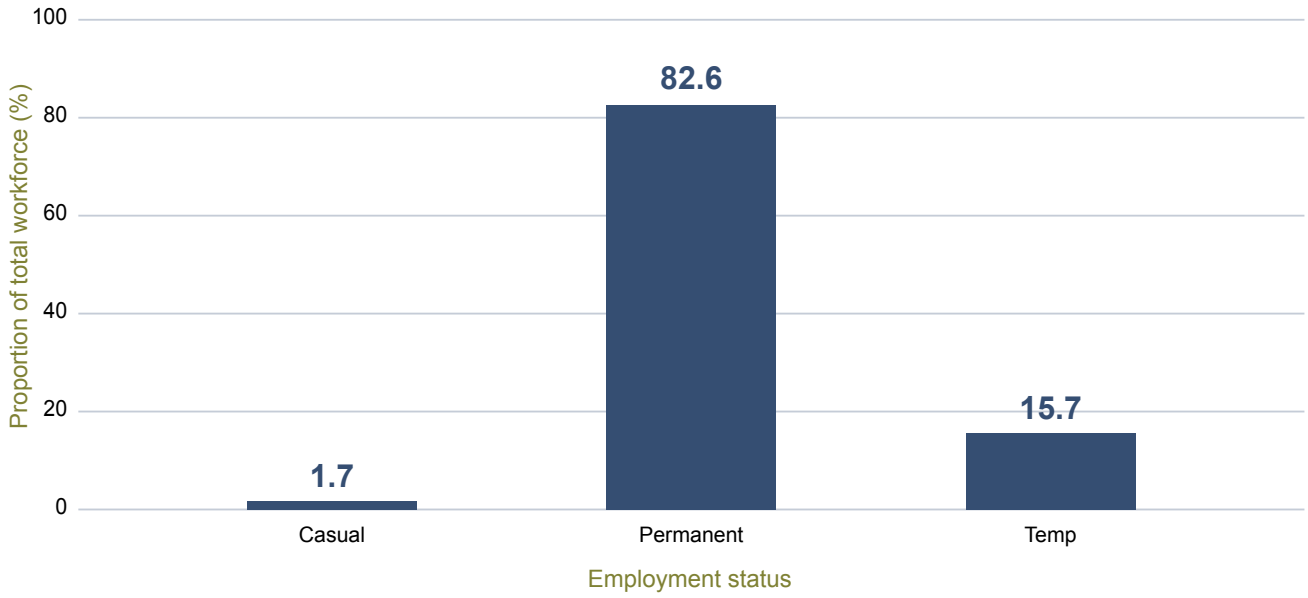


Table 5: Average proportion (%) of the community-managed mental health workforce employed non-permanently by main source of funding

Main funding source	Number of respondents*	Average % of total workers not on permanent employment arrangements
ACT Government (ACT Health Directorate)	14	37.9
Charitable donations / philanthropy	4	41.8
NDIS	7	58.7
Other	8	27.3
PHN & other Commonwealth funding (not NDIS)	10	35.9

* Number of respondents to the question of employment status (n=43, 12 missing values)

Perhaps contrary to expectations, it is the larger organisations that are more likely to employ workers on a non-permanent basis, as shown in Table 6. The numbers, however, are too low to draw statistically significant inferences.

As noted previously, the workforce has a comparatively low FTE conversion factor of 0.6, implying a high number of workers in the sector are working part time (approximately 61%). By way of comparison, the part-time 'Share of Employment' in the total Australian workforce in December 2022 was 30%, and the proportion of persons working part-time in the 'Health care and social assistance' industry was 44.3% (ABS 2022a). This places the community-managed mental health workforce high in the rankings of part-time employment.

Table 6: Average proportion (%) of the mental health workforce employed non-permanently by size of organisation

Organisation size	Number of respondents	Average % of total workers not on permanent employment arrangements
Small	14	21.5
Medium	16	41.4
Large	6	42.7
Very Large	7	66.9

Workplace diversity

Less than half (41%) of respondent organisations indicated they keep good data on the cultural background, gender and/or lived experience of their workers. Further, only 35 (64%) respondents answered the question on the background of their workforce. Extrapolating from this data to develop estimates for the broader workforce is therefore difficult, and as a consequence such estimates should be interpreted with caution.

With this caveat, the estimated proportion of the total ACT community-managed mental health workforce of different population groups is:

- Aboriginal and/or Torres Strait Islander: 1.5%
- Culturally and linguistically diverse: 15.1%
- LGBTQIA+: 5.4%

While these figures need to be interpreted with caution, they diverge significantly from the proportion of these groups in the wider ACT population and call into question whether the workforce has the diversity needed to best represent and serve the community. This is of particular concern given that these three groups have been identified as experiencing disproportionate levels of unmet mental health needs and inequitable mental health outcomes, with Aboriginal and Torres Strait Islander people in the ACT experiencing poorer overall mental health outcomes than in any other state and territory (ABS 2019b).

Volunteer workforce

As noted previously, the volunteer workforce FTE conversion factor is 0.12, unsurprisingly indicating a particularly high rate of part-time engagement of the volunteer workforce. Less than one quarter of the responding organisations advised they used volunteers in their service programs (n=55). The types of work undertaken by volunteers were listed as:

- events support
- representation/systemic advocacy (such as committee work, forums etc.)
- management, financial, support to attendees in person or via email, phone etc.
- mental health education to schools or community groups
- delivery of education programs that focus on their lived experience
- telephone crisis support / telephone counselling
- assistance with events and activities
- companionship with program participants
- participant support in daily living
- support for groups.

Requirements regarding qualifications for volunteers are minimal. Among the organisations who responded to the question about minimum qualifications for volunteers working in mental health, most indicated no qualification was required.

Perspectives on current workforce adequacy

In the past six months, 42% of respondent organisations (n=45) have had vacant positions in their established direct support mental health workforce. Of the organisations with vacancies, 63% (27% of total organisations) advised that these vacancies were difficult to fill with appropriately qualified people. In total, 52 difficult-to-fill vacancies were reported (approximately 5% of the total workforce), with most of these vacancies being mental health support worker roles.

Challenges in filling direct mental health support vacancies were reported as having a range of negative impacts on service delivery in mental health, including:

- increased stress and/or workload for existing staff (76% of organisations reporting difficult to fill vacancies, n=19)
- longer waiting lists for services (59% of organisations, n=17)
- having to turn people away seeking assistance (41% of organisations, n=17).

However, few organisations (18% of organisations with vacancies) reported an actual reduction in the quality of services or programs provided as a result of the vacancies.

The main reasons for these positions being difficult to fill were given as (n=17):

- insufficient numbers of workers available with the relevant qualifications for vacant positions (30%)
- only being able to offer short term contracts for applicants (22%)
- unable to offer competitive salaries for prospective workers (22%).

For those organisations with difficult-to-fill vacancies, most were concerned about the wellbeing and levels of stress/burnout among staff. This ranged from ‘Extremely concerned’ or ‘Very concerned’ (35%, n=17), to ‘Moderately concerned’ (59%).

Demand

Most (45) of the 55 respondents completed the survey questions relating to current and future workforce needs (*Section 4*), although many indicated that the categories were not applicable to their situation.

The most influential factor shaping current workforce demand appears to be ‘funding levels to recruit appropriate staff to meet service demand’ (53% of respondents, n=45), followed by ‘ACT Commissioning, contestable tendering and funding environment’ (36%) (see Table 7).

Table 7: Factors currently influencing workforce demand in the community-managed mental health sector (n=45). More than one factor could be selected.

Type of factor influencing demand	Increased demand for skilled workers	Increased demand for less skilled workers	Reduced demand for skilled workers	Reduced demand for less skilled workers	No impact or N/A
Mental health reform environment at national and state/territory levels	26.7	11.1	2.2	0	60.0
Service delivery in NDIS environment	28.9	4.4	4.4	2.2	60.0
ACT commissioning, contestable tendering and funding environment	35.6	4.4	2.2	0	53.3
PHN commissioning of mental health services	26.7	15.6	0	0	57.8
Funding levels to recruit appropriate staff to meet service demand	53.3	11.1	6.6	0	31.1

Irrespective of the type of factor impacting current workforce demand, the overwhelming outcome appears to be an increased demand for skilled workers. Paradoxically, these same factors also increased demand for less skilled workers in about 10 to 15% of organisations. This was especially the case with ACT commissioned funding.

Other, sometimes related, factors identified by survey respondents as influencing current workforce demand include unfunded increases to the cost of delivering services, inadequate indexation of grant funding, and the inability to offer competitive wages:

"It's very difficult to recruit skilled workers with qualifications to provide support coordination when the NDIS has not given the level of funding any increases in 3 years, and costs have gone up. How do you attract skilled people when you can't offer a competitive salary."

"No change to core funding means no ability to increase wages of retained staff."

"We have just recruited to a full workforce as we are a new service. Funding absolutely determines who we recruit, how skilled & what we can afford but we have not had difficulties recruiting to date."

Survey respondents appear to believe the five identified factors currently influencing workforce demand will become even more influential in the future (see Table 8). In the case of 'mental health reform agenda', 'contestable tendering' and 'funding levels to recruit appropriate staff to meet service demand', a majority of respondents believe these factors will be important and could become more influential than currently experienced.

In a similar way to how the selected factors are seen to influence current workforce demand, the *future* influence of these factors is strongly considered to *increase* the demand for skilled workers (see Table 8).

Table 8: Factors that will influence workforce demand in future in the community-managed sector (n=45). More than one factor could be selected

Type of factor influencing demand	Increased demand for skilled workers	Increased demand for less skilled workers	Reduced demand for skilled workers	Reduced demand for less skilled workers	No impact or N/A
Mental health reform environment at national and state/territory levels	55.6	11.1	0	2.2	31.1
Service delivery in NDIS environment	37.8	4.4	0	2.2	31.1
ACT commissioned contestable tendering and funding environment	62.2	13.3	0	0	26.7
PHN commissioning of mental health services	48.8	11.1	2.2	0	44.4
Funding levels to recruit appropriate staff to meet service demand	62.2	13.3	0	0	26.7

Several additional factors were identified as influencing workforce demand. For example:

"Across the board, the demand for workers to have formal qualifications or extensive skills is going to increase to meet the demands of the expectations of all the above listed [factors]."

"Two factors: Funding… has been cut for our organisation and we work in an education environment that requires not only relevant qualification to deliver support services but a good understanding of the tertiary education sector."

Discussion

Validity of results

The response rate to the survey was 46% and 65% for non-members and members respectively. This response rate – the result of strong promotion by MHCC ACT and vigorous and persistent follow up of non-respondents by the researchers – was quite high by modern survey standards and in a context of declining response rates (Czajka & Beyler 2016; Wu et al. 2022). Survey industry practitioners (including market researchers) consider an online survey response rate ranging between 5% and 30% to be 'good', and an 'excellent' response rate to be 50% or higher (Chung 2022).

The high response rates should promote confidence in the validity of the results and extrapolation of the results to total population estimates. The most sensitive of the extrapolated estimates is for workforce size. This is because the non-respondent population in workforce studies is often believed to be biased towards lower workforce participation, although this conception is more applicable to employee (rather than employer) surveys. In any case, using organisation size rather than simple non-response percentages to calculate estimates should afford greater confidence in the outcome.

Nevertheless, a one-off survey is not an optimal approach to studying the community-managed mental health workforce. A comprehensive and routinely collected data set, such as the *Mental health non-government organisation establishments National Best Endeavours Data Set* (MH NGOE NBEDS), would be ideal and, given the relative size and importance of the community-managed workforce, appropriate.

Workforce size

Based on the extrapolation calculations, an estimate of the community-managed direct care workforce headcount in ACT is 1,730. This is considerably higher than any previous estimate of the community-managed mental health workforce in the ACT (based on the NHWPRC report in 2011), although the mental health services landscape has changed considerably over the past decade.

Added to the direct care workforce are support staff (managers, administrators, IT personnel, etc.) and volunteers. Together, these workforce components total an estimated headcount of 2,051 paid workers and 1,143 volunteer workers.

In terms of the paid workforce, this translates into an FTE of 1,231 workers, and for all workers (paid and unpaid) 1,364 FTE (the volunteer workforce almost exclusively works part time).

If this estimate is accurate, then the community-managed mental health workforce is larger than the public sector mental health workforce and comprises around 60% of the overall mental health workforce. To place the community-managed workforce into further context – and based on 2019/20 Medicare occasions of service data for 'Clinical psychologists', 'Other psychologists', and 'Other allied health providers' – the equivalent workforce in the private non-government sector is estimated to amount to between 40 and 70 FTE.

In short, the community-managed mental health workforce makes a substantial contribution to mental health care and is a significant part of the total ACT mental health workforce.

Workforce composition

The ACT community-managed mental health workforce is characterised by three features:

- it is predominantly female (61% of the direct care workforce)
- it is comparatively young (nearly 70% being less than 45 years of age)
- it has a high proportion of workers in casual or temporary employment (51% are employed on a casual or fixed-term basis)

The feminised nature of the workforce is not dissimilar to the other parts of the ACT mental health workforce, and to the health workforce in general. The degree of gender segregation, however, is lower than in the wider health and community sector in the ACT, which was found to be 74% in the 2021 Census.[9]

On the other hand, the composition of the ACT's community-managed mental health workforce is comparatively young (70% under 45 years old) when compared with the total Australian health workforce (57% under 45 years old) and other mental health sector workforces.

The cause of the comparative youth of the workforce was not explored through the survey, but one hypothesis is that the community-managed mental health sector is perceived to be an appropriate entry level to the mental health workforce, both for vocational education and training (VET) and degree-qualified workers. The relative youth of the workforce is then maintained through turnover as experienced workers seek higher remunerated and/or more stable employment in other sectors. Retaining workers for longer in the sector poses a significant challenge – and a challenge that needs to be overcome if the ACT is to have an appropriately skilled and sustainable workforce able to meet the growing mental health needs of the community. Reducing attrition rates is also vital to avoid the high costs of recruiting, onboarding and training replacement workers.

An MHCC ACT report in 2012 advocated for actions to address this issue and increase workforce retention, suggesting that the ACT community-managed sector "become a model sector for Australia" through the development of a sector-wide employment structure with multiple career entry points and potential career paths, and including full integration of the lived experience workforce.

The survey findings also suggest that further work is needed if the ACT is to become a "model sector for Australia" in relation to the inclusion of the lived experience (peer) workforce. A thriving mental health lived experience workforce is considered a vital component of quality, recovery-focused mental health services. Currently, peer workers comprise a small fraction of the ACT workforce, with 7.6% employed in designated lived experience roles – approximately half of the proportion reported in NSW (14.3%).

Possibly one of the most important features of the workforce is the high level of employment insecurity, with just over half of the workforce having permanent employment status. As noted previously, the community-managed mental health workforce in the ACT compares unfavourably with the broader health workforce on both permanency (low) and rates of part-time employment (high). This means any efforts to improve recruitment and retention across the community-managed sector might be undermined by perceptions of the unstable or temporary nature of employment (contract and casual).

9 ABS 2022c, *Census of Population and Housing: Income and work data summary, 2021*, Table 8. Industry of employment by sex by state and territory

Recruitment

In the past six months, almost half the respondent organisations had experienced vacant positions in their established direct support mental health workforce. Of these vacancies, 63% were difficult to fill with appropriately qualified people.

While an estimate of the vacancy rate was difficult to establish, it seems that the number and type of vacancies is not especially high, despite a probable growth in the workforce size. The survey findings, however, suggest that when vacancies do arise they are likely to be difficult to fill. Further, anecdotal reports from MHCC ACT, based on member feedback, suggest the vacancy situation could be more challenging than represented above.

In a previous ACT study (MHCC ACT 2009), 85% of survey respondents reported difficulties recruiting staff, and 55% indicated there were no suitable career pathways in the community-managed mental health sector to attract and retain qualified staff. A subsequent study (MHCC ACT 2012) reported 80% of surveyed organisations experienced difficulty recruiting staff in the past 12 months because of the lack of relevant skills (71.4%), uncompetitive remuneration (63.4%), lack of career pathways (50%) and perceptions of the sector as unattractive (50%).

Data from the Internet Vacancy Index, a count of skilled workforce vacancies maintained by the National Skills Commission, shows the vacancy rate at a near all-time high for key mental health professions. For instance, since 2018, the Internet Vacancy Index has gone up by 87% for psychologists, 122% for social workers, 136% for registered nurses and 234% for occupational therapists. Hence, it is likely to be increasingly difficult to recruit workers in these and similar professional categories in the future.

Volunteers

A key difference between the community-managed mental health workforce and the wider workforce is the participation of volunteers. While the number of volunteers working is large, their actual FTE contribution is small. This issue was not explored further in the survey, however it could be that more value could be extracted from this workforce through stronger human resource management. The current approach to qualifications for volunteers is minimal, which possibly reflects the generally lax approach (with some organisational exceptions) to volunteer training and deployment in the sector.

In a separate report on the ACT community sector, Rosenberg et al. (2019) estimated that 70% of community sector agencies have at least some volunteers (this compares with an estimate of less than 25% of mental health organisations responding to the survey). Rosenberg et al. (2019) also noted there are wide differences in how volunteers are engaged and that volunteer induction, management, support and training is generally poor.

A potential implication of these findings is the need for a more detailed study of the current recruitment, training and deployment of volunteers across the community-managed mental health sector, including how workforce participation (time and quality) could be improved and better linked to career pathway initiatives.

Demand factors

Community-managed mental health organisations believe the most influential factor on current demand for workers is 'funding levels to recruit appropriate staff to meet service demand' (53% of respondents), followed by 'ACT commissioning, contestable tendering and funding environment' (36%). The overwhelming direction of this influence has been to drive increased demand for a more skilled workforce at all existing levels of worker skill.

Most of the surveyed organisations feel that a further increase in workforce numbers, with higher skill levels, will be demanded in the future. From their perspective, this will be primarily shaped by the mental health reform agenda, contestable tendering from the ACT Government, and the adequacy of funding levels to recruit appropriate staff to meet service demand.

These findings suggest the gap between workforce supply and demand may become more pronounced into the future, especially if funding support is not increased at a rate commensurate with the growth in demand. The main source of funding, the ACT Government, has indicated there will be no overall increase to funding for mental health services as part of the current commissioning process.

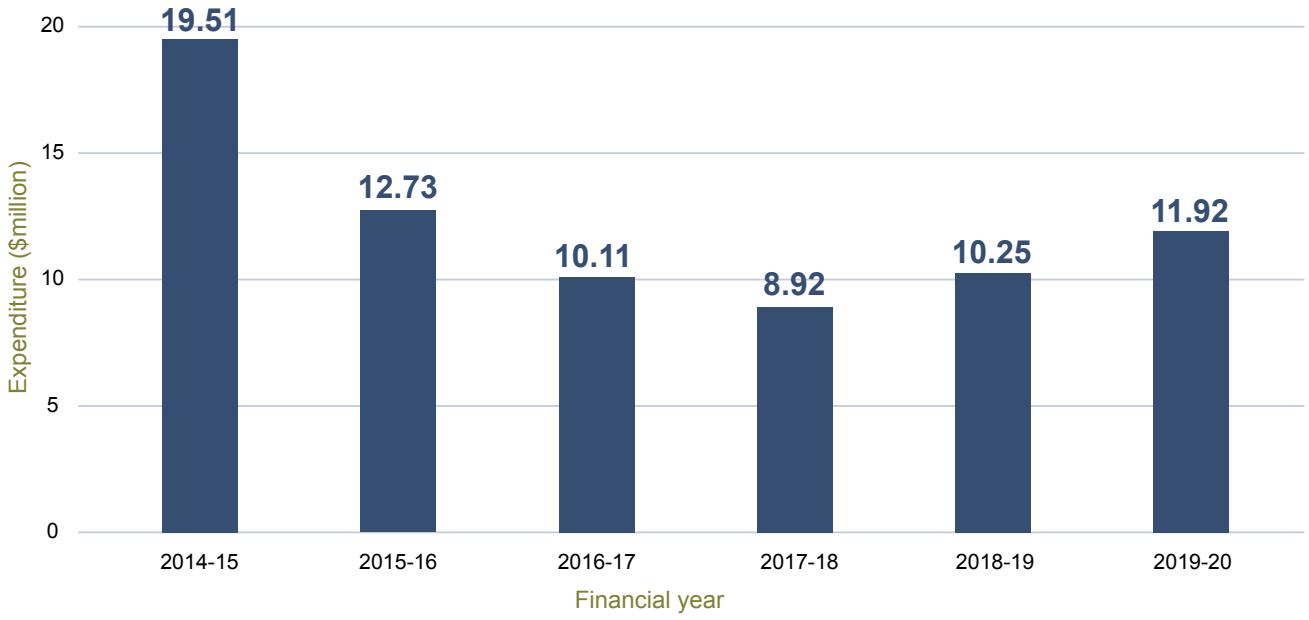
The National Skills Commission (NSC) labour market study of the care workforce (NSC 2021) identified a number of pressures in the mental health workforce, and these were expected to grow in a context where a significant workforce 'gap' is forecast across the wider care and support workforce. In this study, the Commission suggested that the mental health occupations involved in providing early intervention, prevention, and community-based mental health care and support "may be where the largest workforce gap emerges within the mental health workforce, particularly if all programs and services across aged, disability, veteran and mental health care and support are competing for the same pool of potential workers".

Australia wide, between the financial years 2015–16 and 2019–20, total expenditure on mental health to NGOs slightly decreased (by 0.5% per annum)[10].

Figures for the ACT tell an even more serious story. Between the financial years 2014–15 and 2019–20, total expenditure on mental health services delivered by NGOs decreased at a much higher rate (AIHW 2022). There was a drop of more than 50% between the 2014–15 and 2017–18 financial periods, after which there was an increase, however expenditure remains 39% down on 2014–15 levels (see Figure 11).

In 2019–20, state and territory spending on community-managed mental health care services accounted for almost $2.6 billion of recurrent spending.

Figure 11: ACT non-government organisations mental health service expenditure ($million), constant prices, 2014–15 to 2019–20



10 It is possible that some of this decrease in funding was compensated by NDIS growth, however this may have also been offset by the withdrawal of Commonwealth funding to programs such as Partners in Recovery and Personal Helpers and Mentors (PHaMs).

Conclusion

Through this survey, MHCC ACT and the community-managed mental health sector will be able to consolidate their understanding of the size, nature and context of the workforce and the factors driving growth in demand.

In a context where data on the community-managed mental health sector is scarce, the findings provide an invaluable insight into the relative role of the community-managed sector within the broader mental health workforce. The sector's workforce encompasses a diversity of roles, is primarily female and strikingly young. It makes a substantial contribution to mental health care in the ACT, comprising a substantial proportion of the overall mental health workforce.

Despite its relative size and contribution, the community-managed mental health workforce appears to be under-valued and faces a range of potential challenges into the future. The findings provide some vision for immediately appropriate workforce work allocation and development strategies and potential comparative advantages to other sectors that could be explored.

Critically, to support and sustain a thriving community-managed mental health workforce into the future, it is imperative robust and comprehensive data on the workforce is regularly collected. Interventions for building the community-managed mental health sector's capacity to regularly collect and use data on their own workforce should be explored, and it is recommended that either the AIHW and/or ACT Government provide investment into ongoing mental health workforce data collection by the sector. By strengthening our understanding of the community-managed mental health workforce and prioritising its growth, we can improve workforce planning and ultimately create a more inclusive, person-centred, and resilient mental health system that better supports the diverse needs of individuals and communities.

References

ACT Government, (2022). *A Framework for Change: ACT Mental Health Workforce Strategy*. ACT Government, Canberra. https://www.parliament.act.gov.au/__data/assets/pdf_file/0006/2081499/A-Framework-for-Change-ACT-Mental-Health-Workforce-Strategy.PDF

Australian Bureau of Statistics (ABS), (2019a). *Labour Force* (trend and annual averages of original data); ABS, Education and Work; Department of Jobs and Small Business, Employment Projections. https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/dec-2019

Australian Bureau of Statistics (ABS), (2019b). *National Aboriginal and Torres Strait Islander Health Survey 2018-19*. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey

Australian Bureau of Statistics (ABS), (2022a). *Labour Force, Australia, December 2022.* https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia

Australian Bureau of Statistics (ABS), (2022b). *Working arrangements*. https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/working-arrangements/latest-release.

Australian Bureau of Statistics (ABS), (2022c). *Income and work: Census 2021.* https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/income-and-work-census/latest-release

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

Australian Institute of Health and Welfare (AIHW), (2022). *Mental health services in Australia: Expenditure on mental health services*. https://www.aihw.gov.au/mental-health/topic-areas/expenditure

Australian Institute of Health and Welfare (AIHW), (2023). *Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections*. https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osr-nkpi

Chung, L., (2022). *What is a good survey response rate for online customer surveys?* https://delighted.com/blog/average-survey-response-rate#:~:text=So%2C%20what%20is%20a%20good,rate%20is%2050%25%20or%20higher.

Cleary, A., Thomas, N., and Boyle, F., (2020). *National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews inquiries*. Institute for Social Science Research, University of Queensland, Brisbane. https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.pdf

Commonwealth Department of Health, (2021). *National Mental Health Workforce Strategy Taskforce*. Australian Government Department of Health, Canberra. https://www.health.gov.au/committees-and-groups/national-mental-health-workforce-strategy-taskforce?utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation [Last updated 1 October 2021].

Cortis, N., & Blaxland, M., (2017). *Workforce issues in the NSW community services sector*. Social Policy Research Centre, University of NSW, Sydney. https://www.unsw.edu.au/content/dam/pdfs/unsw-adobe-websites/arts-design-architecture/ada-faculty/sprc/2021-06-Workforce_Issues_in_the_NSW_Community_Services_Sector_FINAL.pdf

Cortis, N., & van Toorn, G., (2020). *Working in new disability markets: A survey of Australia's disability workforce.* Sydney: Social Policy Research Centre, University of NSW, Sydney. http://doi.org/10.26190/5eb8b85e97714.

Czajka, J. and Beyler, A., (2016). *Background Paper: Declining Response Rates in Federal Surveys: Trends and Implications*. Submitted to Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, June 15, 2016. https://aspe.hhs.gov/sites/default/files/private/pdf/255531/Decliningresponserates.pdf

Gilfillan, G., (2021). *Recent and long-term trends in the use of casual employment*. Parliamentary Library Research Paper. Parliament of Australia, Canberra. https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2122/TrendsCasualEmployment

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

Jobs and Skills Australia, (2023). *Labour Market Insights (LMI) website*. Australian Government. https://labourmarketinsights.gov.au/

Mental Health Community Coalition of the ACT (MHCC ACT), (2012). *A Real Career: A Workforce Development Strategy for the Community Mental Health Sector of the ACT*. MHCC ACT, Canberra.

Mental Health Community Coalition of the ACT (MHCC ACT), (2009). *Workforce Development: 2009 Survey Report.* MHCC ACT, Canberra.

National Skills Commission, (2021). *Care Workforce Labour Market Study: Final Report*. September https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/Care%20Workforce%20Labour%20Market%20Study.pdf

National Health Workforce Planning and Research Collaboration (NHWPRC), (2011). *Mental Health Non-Government Organisation Workforce Project Final Report*. Health Workforce Australia, Adelaide. https://www.voced.edu.au/content/ngv%3A53788

NSW Mental Health Commission, (2014). *Living Well: A Strategic Plan for Mental Health in NSW, 2014-2024*. NSW Mental Health Commission, Sydney. https://www.nswmentalhealthcommission.com.au/sites/default/files/old/Living%20Well%20-%20A%20Strategic%20Plan%20full%20version.pdf

Productivity Commission, (2020). *Mental health: Productivity Commission inquiry report.* Report No. 95. Productivity Commission, Canberra. https://www.pc.gov.au/inquiries/completed/mental-health/report

Queensland Alliance for Mental Health (QAMH), (2021). *The Community Mental Health Workforce Project*. QAMH, Brisbane. https://www.qamh.org.au/wp-content/uploads/Community-Mental-Health-Workforce-Report.pdf

Resika, K. C., Mallyon, A., & Petrakis, M. (2019). Community mental health staff perspectives of the impacts of transition to the National Disability Insurance Scheme (NDIS) on consumers, carers and workforce in Victoria. *Australian Journal of Community Work, 1*, 1–14. https://www.acwa.org.au/wp-content/uploads/2021/01/AJCW-2019-2020-KC-Mallyon-Petrakis.pdf

Ridoutt, L. and Cowles, C., (2019). *The NSW CMO Mental Health Workforce: Findings from the 2019 MHCC Workforce Survey*. Mental Health Coordinating Council (MHCC), Sydney. https://mhcc.org.au/wp-content/uploads/2020/01/WorkforceSurvey2020.pdf

Ridoutt, L. and Mental Health Coordinating Council (MHCC), (2021). *Mental Health Workforce Profile: Community Managed Organisations Report 2021.* MHCC, Sydney. https://mhcc.org.au/wp-content/uploads/2021/09/MHCC_WorkforceSurvey_2021.pdf

Rosenberg, S., Delaney, K., Church, L., (2019). *ACT Community Services Industry Workforce Data and Community Needs Analysis*. Insight Consulting, Canberra. https://www.actcoss.org.au/sites/default/files/public/publications/2019-ACT-Community-Services-Industry-Workforce-Data.pdf

Western Australian Association for Mental Health (WAAMH), (2017). *Workforce Development in Community Mental Health Project Report*. WAAMH, Perth

Wu, M., Zhao, K. and Fils-Aime, F., (2022). Response rates of online surveys in published research: A meta-analysis. *Computers in Human Behavior Report,* 7(August): 100206.

Appendix 1: Method

Survey design

A single survey was developed comprising a total of 32 questions of fixed and open-response style. The Workforce Survey was intended to be completed by Service Managers, HR Managers, or CEOs of MHCC ACT member organisations (the person best placed within the organisation to provide workforce information). The questions were designed to flow into each other, with relevant questions grouped by sections so that respondents could exit the survey and return to where they left with ease. The survey had an approximate length of 30 minutes.

The initial Survey draft was developed from the 2021 CMO Mental Health Workforce Survey undertaken by the NSW Mental Health Coordinating Council, and revisions were informed by the results from the 2021 Survey. The draft version of the survey was piloted online using SurveyMonkey with three member organisations. The focus of pilot testing was to assess language and terminology, relevance of the questions, and structure and flow of the survey. The survey was then further revised and finalised based on pilot testing and feedback from the MHCC ACT and pilot testers. The final version of the Survey as it was administered is provided as Appendix 2.

Process

As much as possible, the 2022 Survey design remained consistent with the 2021 NSW Survey to allow comparative analysis. The Survey was administered to 67 community-managed organisations, of which 49[11] were MHCC ACT members. This sample population was considered representative of the majority of community-managed organisations delivering mental health services in the ACT. A range of initiatives was implemented to maximise the response. A response rate of 55.1% was obtained from the MHCC ACT surveyed population.

Table 9: Member organisation response breakdown

	No.	Percentage
Total member organisations	49	100%
Completed the survey	27	55.1%
Did not do the survey	18	36.7%
Incomplete attempt at survey	4	8.2%

For some of the 32 questions, especially those that explored more detailed elements of an organisation's staffing, only estimates (or non-responses) were provided by some respondents. These respondents tended to possess unsophisticated human resource information systems or limited methods for collecting Human Resources (HR) information

11 At the time of the survey administration. Some 'members' have since become non-financial. Some 'non-members' have since become members.

.The sample population

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

- all MHCC ACT member organisations,
- non-member community mental health sector organisations identified by MHCC ACT, and
- selected Aboriginal Community Controlled Health Services.

Promotion and administration of the survey

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

Promotion

The survey was promoted on social media by MHCC ACT and via MHCC ACT newsletter.

The survey was sent to MHCC NSW, ACTCOSS, Capital Health Network and the ACT Office for Mental Health and Wellbeing to be included in their respective newsletters.

The survey was promoted at MHCC ACT's End-of-year forum.

Administration

The survey was sent out to all identified organisations from 11 November 2022, with a deadline of 16 December 2022.

Follow up

Email reminders were sent to organisations two weeks and one week prior to the survey deadline.

Follow-up phone calls were conducted to entice organisations to finish the survey, and to provide advice on filling out the survey from 21 November until the revised deadline.

The survey deadline was extended until 23 December 2022 to allow time for as many organisations to complete as possible.

Response rate

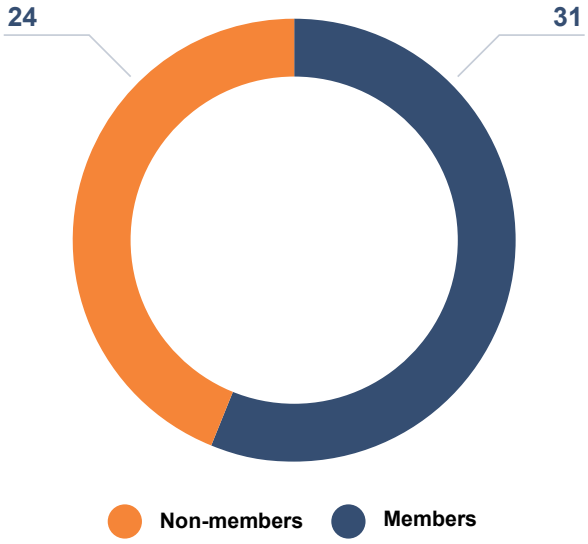
A total of 55 organisations responded to the survey. Of these responses, 45 were complete, while 10 were incomplete. Fortunately, as determined by completed responses to question 7 of the survey (which asked respondents to provide a headcount and FTE of all staff working in direct support roles), 51 respondents' (if not all) responses were considered 'viable'.

Table 10: Response rates by response type

	No.	Percentage
Total survey responses (31 members / 24 non-members)	55	100%
Total complete (27 members / 18 non-members)	45	82%
Total incomplete (4 members / 6 non-members)	10	18%

Most of the responses (n=31) were from MHCC ACT members. Therefore, based on MHCC ACT members only, this represents a survey response rate of 56% (n=55).

Figure 12: Response rate by organisation type (n=55)



The response rate was slightly higher than the 2021 survey undertaken by the NSW Mental Health Coordinating Council This is considered a huge success due to the population differences in the ACT and NSW.

Based on knowledge of the sector from the 2021 NSW Survey, most large community-managed organisations that are direct support providers of psychosocial rehabilitation and recovery support services (with several notable exceptions) are captured through the Survey, and therefore the findings presented in this report are representative of the sector.

Apart from non-responses, there are also limitations to the data collected in relation to the quality of some respondent's human resources information systems (HRISs) or human resource data. Some survey respondents advised that some information requested through the survey was difficult to acquire from their existing records, or, in some cases, was not collected systematically (or at all). In such cases, respondents were asked to provide an estimate.

Data analysis

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

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

Appendix 2: Survey tool

The survey was administered online, via Survey Monkey. The following pages list the survey questions, and are displayed according to the order, format and layout used in the online survey. The light blue-shaded bars represent breaks between pages on the online survey.

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

1

Thank you for participating in the ACT Community-Managed Mental Health Workforce Survey 2022. By completing this survey you are helping us to produce, for the first time, empirical data about the size and nature of this workforce. This data will be invaluable in informing our input into mental health workforce planning activities with both ACT and Federal governments.

Responses to this survey are confidential and no identifiable information about participating organisations or respondent individuals will be reported in the findings of this survey. Data collection is subject to the MHCC ACT Privacy Policy. If you have any questions, concerns or feedback about this survey, please contact us at: policy@mhccact.org.au

*1. Please complete the following contact details.

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

Name	
Position	
Organisation	
Email address	
Phone number	

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

2. SECTION 1: Details about your organisation

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

* 2. Which of the following definitions most closely describes your organisation's **operations in the ACT**? Please choose only one organisation type that you think fits best.

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

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

3

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

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

- ◯ **10%**
- ◯ **20%**
- ◯ **30%**
- ◯ **40%**
- ◯ **50%**
- ◯ **60%**
- ◯ **70%**
- ◯ **80%**
- ◯ **90%**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

4

4. What sources of funding do you receive for the mental health services/programs you provide in the ACT (please select as many as are appropriate):

- ☐ **ACT Government (ACT Health Directorate)**
- ☐ **NDIS**
- ☐ **Primary Health Network (i.e. Canberra Health Network)**
- ☐ **Other Commonwealth funding (not NDIS or PHN)**
- ☐ **Charitable donations / philanthropy**
- ☐ **Other**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

5

5. Of these funding sources, which is your MAIN source of funding?

- ◯ **ACT Government (ACT Health Directorate)**
- ◯ **NDIS**
- ◯ **Primary Health Network (i.e. Canberra Health Network)**
- ◯ **Other Commonwealth funding (not NDIS or PHN)**
- ◯ **Charitable donations / philanthropy**
- ◯ **Other**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

6

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

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

- ☐ **Counselling — face-to-face**
- ☐ **Counselling, support, information and referral — telephone**
- ☐ **Counselling, support, information and referral — online**
- ☐ **Intake / assessment / triage for referral to other services**
- ☐ **Self-help — online**
- ☐ **Group support activities**
- ☐ **Mutual support and self-help**
- ☐ **Staffed residential services**
- ☐ **Personalised support — linked to housing**
- ☐ **Other (please specify)**

- ☐ **Personalised support — other**
- ☐ **Family and carer support**
- ☐ **Individual advocacy**
- ☐ **Care coordination**
- ☐ **Service integration infrastructure (e.g. one-stopshop service/platform)**
- ☐ **Education, employment and training**
- ☐ **Sector development and representation (e.g. systemic advocacy)**
- ☐ **Mental health promotion**
- ☐ **Mental illness prevention**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

7. SECTION 2: Details of current staffing

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

Please provide estimates if you do not have hard numbers available.

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

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

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

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

Number of staff (head count)	
FTE of staff	

* 8. In the previous question, what was the basis of your response?

◯ **Estimated using organisation's Human Resources data**

◯ **Estimated by other means**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

8

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

Please leave blank if there are no employees for a category.

The total number of staff should be the same as the HEADCOUNT number you provided in Question 7.

Identified Consumer Peer Workers		**Other medical practitioner**	
Identified Carer Peer Workers		**Occupational Therapist**	
Recovery Coaches		**Psychologist**	
Mental Health Support Worker		**Counsellors**	
Support Coordinator		**Dietitians**	
Mental Health Nurse		**Social Workers**	
Enrolled Nurse		**Aboriginal and Torres Strait Islander Mental Health Worker**	
Registered Nurse		**Other allied health professionals**	
Psychiatrist		**Other (please specify the number)**	

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

mental health
community coalition ACT

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

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

Please leave blank for those roles which are not in your organisation.

Identified Consumer Peer Workers		**Other medical practitioner**	
Identified Carer Peer Workers		**Occupational Therapist**	
Recovery Coaches		**Psychologist**	
Mental Health Support Worker		**Counsellors**	
Support Coordinator		**Dietitians**	
Mental Health Nurse		**Social Workers**	
Enrolled Nurse		**Aboriginal and Torres Strait Islander Mental Health Worker**	
Registered Nurse		**Other allied health professionals**	
Psychiatrist		**Other (please specify the number)**	

mental health
community coalition ACT

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

Please leave blank if there are no employees for a category.

The total number of staff should be the same as the number you provided for HEADCOUNT in Question 7.

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

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

Please leave blank if there are no employees for a category.

The total number of staff should be the same as the number you provided for the HEADCOUNT in Question 7.

Male	
Female	
Other identity	

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

Please leave blank if there are no employees for a category.

The total number of staff should be the same as the HEADCOUNT number you provided in Question 7.

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

mental health
community coalition ACT

* 15. Please indicate the number (headcount) of staff for each of the following types of nondirect support roles employed by your organisation **working in mental health programs in the ACT**.

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

We recognise that administrative and technical staff often work across multiple programs, some of which might not be mental health. Please include staff in the count only if they are working at least sometimes in mental health programs.

Management

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

Technical support staff (e.g. IT)

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

◯ **Yes good data is maintained**

◯ **Yes, but the data is not well maintained**

◯ **No**

Would you like to comment on your response?

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

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

Aboriginal and Torres Strait Islander

Culturally and linguistically diverse

LGBTQIA+

Unsure or our organisation does not collect this information

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

9

* 18. In this question we would like to understand the qualifications of the Lived Experience (Consumer) Workers, Lived Experience (Carer) Workers, Mental Health Support Workers and Support Coordinators employed by your organisation.

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

Please make sure each row adds up to 100%

	No formal relevant qualification	% with Certificate III	% with Certificate IV	% with Diploma	% with Advanced Diploma	% with Degree or higher
Lived Experience (Consumer) Workers						
Lived Experience (Carer) Workers						
Recovery Coaches						
Mental Health Support Workers						
Support Coordinators						

Comments

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

◯ **Yes**

◯ **No**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

10

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

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

Number of volunteers (HEADCOUNT)

FTE estimate for volunteer workforce

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

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

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

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

11. SECTION 3: Perspectives on current workforce adequacy and sustainability

In this section we would like to understand current vacancy rates in your organisation for mental health specific services/programs and your perspectives on workforce wellbeing and sustainability.

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

◯ **Yes**

◯ **No**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

12

* 24. Would you classify any of the vacant positions in Question 23 as '**difficult to fill**'? Difficult to fill positions might be those vacant for more than is normal with your human resource processes, positions that you had to fill with a less experienced or less qualified person than desired, or some other reason.

◯ **No**

◯ **Yes (Please provide the number in the box below)**

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

25. In this question, we want to understand whether difficulties filling vacancies have had any effect on service delivery or the wellbeing of your wider workforce.

Of the following statements, please indicate whether you agree or disagree that they have been a result of difficulties filling vacancies for direct roles.

	Strongly disagree	Somewhat disagree	Neutral	Agree	Strongly agree	Unsure or not applicable
Increased stress/ workload for existing staff	◯	◯	◯	◯	◯	◯
Longer waiting lists for services	◯	◯	◯	◯	◯	◯
Turning away people seeking assistance	◯	◯	◯	◯	◯	◯
Reduction in the quality of services/programs	◯	◯	◯	◯	◯	◯

26. Overall, how concerned are you about the wellbeing and levels of stress/burnout among staff working in mental health services/programs in your organisation?

Not concerned	Somewhat concerned	Moderately concerned	Very concerned	Extremely concerned	Unsure
◯	◯	◯	◯	◯	◯

Comments (optional)

mental health
community coalition ACT

27. Of the 'difficult to fill' vacancy numbers you specified above, please indicate the number of those vacancies for each of the following ROLE/OCCUPATIONAL categories?

Please leave blank if there are no vacancies.

The total number should be the same as the number you provided in the previous question.

Identified Consumer Peer Workers	
Identified Carer Peer Workers	
Recovery Coaches	
Mental Health Support Worker	
Support Coordinator	
Mental Health Nurse	
Enrolled Nurse	
Registered Nurse	
Psychiatrist	
Other medical practitioner	
Occupational Therapist	
Psychologist	
Counsellor	
Dietitian	
Social Workers	
Aboriginal and Torres Strait Mental Health Worker	
Other allied health professionals	
Other (please specify the number)	

mental health
community coalition ACT

28. For all of the 'hard to fill' vacancies you identified above, please indicate the main reasons that you believe have contributed to the vacancies being 'hard to fill'. You can choose one or more reasons or add more reasons.

- ☐ **Insufficient number of workers with relevant qualifications**
- ☐ **Insufficient number of workers with appropriate professional association membership**
- ☐ **Difficult to attract workers to the mental health sector**
- ☐ **Difficult to attract workers to the service location of the position**
- ☐ **Can only offer short term contracts**
- ☐ **Unable to offer competitive salary**
- ☐ **Delayed recruitment processes**
- ☐ **Other - please provide more information**

mental health
community coalition ACT

MHCC ACT Community-Managed Mental Health Workforce Survey 2022

13. SECTION 4: Future workforce needs

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

* 29. Please indicate how the following factors are affecting WORKFORCE DEMAND considerations RIGHT NOW in your organisation.

	Increased demand for skilled workers	Increased demand for less skilled workers	Reduced demand for skilled workers	Reduced demand for less skilled workers	No impact on worker demand	N/A
Mental Health reform environment at national and ACT levels (i.e. National Mental Health and Suicide Agreement; Office for Mental Health and Wellbeing Work Plan)	☐	☐	☐	☐	☐	☐
Service delivery in NDIS environment	☐	☐	☐	☐	☐	☐
ACT Commissioning, contestable tendering and funding environment	☐	☐	☐	☐	☐	☐
Canberra Health Network (PHN) commissioning of mental health services	☐	☐	☐	☐	☐	☐
Funding levels to recruit appropriate staff to meet service demand	☐	☐	☐	☐	☐	☐

If you would like to provide more of an explanation for your choices, please provide them here…

mental health
community coalition ACT

* 30. Please indicate how you think the following factors will affect WORKFORCE DEMAND considerations in the FUTURE in your organisation.

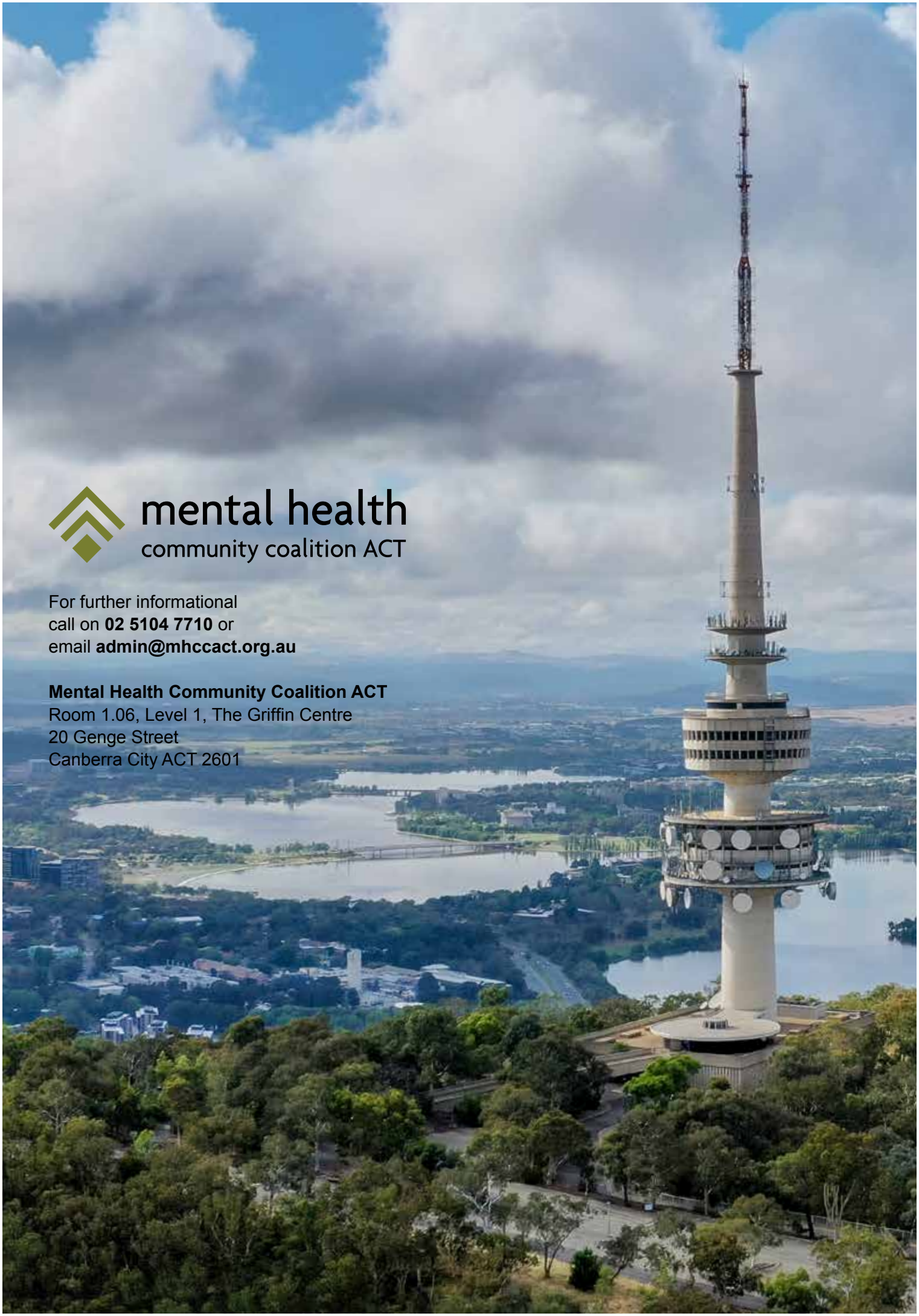
	Increased demand for skilled workers	Increased demand for less skilled workers	Reduced demand for skilled workers	Reduced demand for less skilled workers	No impact on worker demand	N/A
Mental Health reform environment at national and ACT levels (i.e. National Mental Health and Suicide Agreement; Office for Mental Health and Wellbeing Work Plan)	☐	☐	☐	☐	☐	☐
Service delivery in NDIS environment	☐	☐	☐	☐	☐	☐
ACT Commissioning, contestable tendering and funding environment	☐	☐	☐	☐	☐	☐
Canberra Health Network (PHN) commissioning of mental health services	☐	☐	☐	☐	☐	☐
Funding levels to recruit appropriate staff to meet service demand	☐	☐	☐	☐	☐	☐

If you would like to provide more of an explanation for your choices, please provide them here…

31. Some other factors influencing mental health workforce considerations could be...

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

This page is left intentionally blank.



mental health
community coalition ACT

For further informational
call on **02 5104 7710** or
email **admin@mhccact.org.au**

Mental Health Community Coalition ACT
Room 1.06, Level 1, The Griffin Centre
20 Genge Street
Canberra City ACT 2601