Phase 2 Workshops:

Thoughts & Experiences of the Psychosocial Workforce

NDIS Provider and Worker Feedback

National Codesign Workshop Series

December 2021

NDIS Recovery Oriented Psychosocial Delivery Support Project

Growing National Workforce Capability

MentalHealth Victoria

Collaboration • Knowledge • Leadership

NDIS ROPDS Project
Growing National Workforce Capability

MentalHealth Victoria

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Thank you for sharing your experiences and contribution for making a positive difference in the NDIS environment.

About Mental Health Victoria

Mental Health Victoria (MHV) is the peak body for the mental health sector in Victoria. Our members include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments, and other bodies across the health and related sectors.

Our aim is to ensure that people living with mental health issues can access the care they need, when and where they need it. Our view is that all Australians should have access to a core suite of services that they can choose from – be they delivered in the home, community, or hospital.

Our vision is for a mental health system that

- involves people with lived experience, including unpaid family and friend carers, in decisions which affect their lives
- provides tailored, high-quality supports to people with different care needs and at different life stages
- wraps around a person, ensuring all their needs can be met
- is easily navigated, providing continuity of care
- is outcomes-focused
- is adequately and sustainably resourced to meet current and future needs including demand.

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Disclaimer

The information provided in this report is intended as a deliverable of the *Good Practice Psychosocial Support for NDIS Participants – Growing Workforce Capability* project. It does not constitute formal advice and does not take into consideration the circumstances and needs of your organisation or yourself. Every effort has been made to ensure the accuracy and completeness of this document at the date of publication.

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Glossary of terms & abbreviations

Codesign	"Designing and delivering services and systems in an equal and reciprocal relationship between professionals, people using services, their families and their community" (New Economics Foundation, 2011). "Codesign is about working together. It is based on the simple acknowledgement that consumers, carers, families, and community know what works best for them." (CESPHN)
Coproduction	'In simple terms it means consumers from the very beginning: seeking their expertise in the process of framing problems, setting priorities, designing solutions and evaluating their effectiveness. Co-production seeks to create a culture where all types of expertise are valued equally and recognises that the quality of services is improved by the input of the people who use them.' 2018 © Cath Roper, Flick Grey & Emma Cadogan
Family or Carer	In this report, 'family or carer' refers to a family member or informal carer who provides care to a person who is an NDIS participant.
Key population groups	Key population groups that this Project focuses on include Aboriginal and Torres Strait Islander NDIS participants, families and communities, NDIS participants, families and carers from CALD backgrounds, NDIS participants who identify as LGBTIQ+, and NDIS participants living with dual disability, dual diagnosis, and/or complex support needs.
NDIS	National Disability Insurance Scheme
NDIS participant	A person who meets the NDIS access requirements (NDIA).
Psychosocial disability	Psychosocial disability is the term used to describe disabilities that may arise from mental health issues. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage. (NSW Health)
Recovery Oriented Practice (ROP)	Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. (Department of Health, A National Framework for Recovery-oriented mental health services: Guide for Practitioners and Providers, 2013)
ROPDS	Recovery-oriented psychosocial disability support, a term developed by the NDIS ROPDS Project to define recovery-oriented NDIS supports delivered to NDIS participants with psychosocial disability.

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Project context

About the workshops

In Phase 1, Mental Health Victoria (MHV) led a National partnership with State and Territory based host organisations to facilitate our codesign workshops. These events were designed to hear from NDIS participants with psychosocial supports in their plan, and family members/carers of participants with psychosocial supports.

The aim of the workshops was to understand the current experiences of people receiving NDIS psychosocial supports, and how NDIS providers and workers (including support workers, support coordinators, allied health providers, recovery coaches, and other NDIS services) could best deliver Recovery Oriented Psychosocial disability support (ROPDS).

In Phase 2, MHV led a series of online national codesign workshops with NDIS providers and frontline workers, to understand their current experience of providing NDIS supports to NDIS participants and carers. We asked questions to discover the current barriers and enablers to providing ROPDS in the NDIS environment.

Context

A key aspect of the ROPDS Project is that it is codesigned with NDIS primary stakeholders and people with lived experience at all critical points throughout the project lifecycle.

The Phase 1 Codesign Report incorporated a codesign approach to reach across all States and Territories as part of the codesign and coproduction approach to delivering ROPDS Project outputs, particularly with NDIS consumers and their carers nationally.

This Phase 2 Codesign Report engaged with NDIS frontline workforces and their providers nationally.

MHV recognises that coproduction is best practice, and that codesign is an element of coproduction. The Project's intent is to align as closely as possible to coproduction principles, while acknowledging the constraints related to the project budget, resources, and timelines, particularly in the context of the remote working environment. To address these constraints, for the purposes of this project a codesign process will be taken.

Methodology

Workshop program design

A total of 6 virtual workshops were designed and conducted for a three-and-a-half-hour duration across the nation.

Activities were designed slightly different between worker and provider sessions, however both programs were designed based off the following:

What we wanted to know from the NDIS Workforce:

Activities were designed to engage attendees, and spark conversation with the following underlying questions:

a) Testing evidence-base Workforce and Organisational Capabilities.
b) Strawman for project outputs
    1. Guides to Good Practice
    2. Digital Information Hub
    3. PD/Training in ROP
c) New / good examples of 'good' recovery-oriented practice.

Out of scope:

Experiences of gaining access to the NDIS or the NDIS planning processes is considered out of the scope of this project.

Advantages of the tailored worker and provider approach to program design:

- An opportunity to hear different perspectives of how workforce issues and gaps are impacting NDIS psychosocial service delivery.
- Provided a better opportunity for those from less populated or smaller States and Territories, and for smaller and sole providers to be heard.
- Building on extensive stakeholder consultation undertaken by the Project.

Key considerations

There is a risk that communicating the intent of the project and the purpose of the co-design consultations is diluted or lost in translation, or in retelling. In other words, it is a challenge to contain and difficult to concentrate on one aspect without talking about the latest most controversial NDIS issues.

National Project considerations: We wanted to maximise the reach into communities and regions across all States or Territories, particularly remote and very remote areas.

Information gathering

Information gathered from the workshops added to the Project's analysis of current participant and family experiences of receiving recovery-oriented NDIS psychosocial supports and guides our efforts to improve the capacity of the psychosocial workforce in the delivery of recovery-oriented supports. Information for all activities was gathered through the following methods:

Preliminary survey using SurveyMonkey to capture quantitative data about the different individuals

Scribe notes paraphrased quotes from attendees during the workshop to capture a complex level of qualitative data communicated through conversation. Scribes were predominantly MHV project team members.

Mentimeter was used to capture numerical data such as polls and generate word clouds for specific questions.

Zoom chat captured qualitative data for attendees who couldn't verbally respond or had certain points they wanted to raise during the discussions.

Sessions were recorded via Zoom to ensure all the data was captured.

Coproduction & Codesign approach

The Project's evidence-base to recovery-oriented practice (ROP) and workforce capability building approaches are informed by the direct input from primary stakeholders, there were two of this:

1. **Lived Experience Coproduction:**

The codesign approach for the stage 1 workshops comprised of three main stages:

I. **Design of workshop content**

The Project team worked closely with the LEAG to coproduce the workshop content for the Phase 1 workshops. Key outcomes produced included:

- A definition of codesign and coproduction in relation to this project.
- Train-the-facilitator sessions.
- Slides and materials to be used in all codesign sessions, template available upon request.

II. **Workshop facilitation and content delivery**

Workshop content was delivered via Zoom by 3 lived experience facilitators:

Provider forums were

Worker forums: a member from the LEAG dialling in via Zoom if the session was conducted virtually. To ensure safety, a peer worker was available to workshop participants for debriefing and support. A full list of peak body lived experience organisations can be seen in Appendix 1.

III. **Post workshop debriefing**

The LEAG members were consulted after the workshops to ensure information was accurately captured, and appropriately represented in a meaningful way to inform the next phases of the codesign – Stage 2 Workshops with NDIS frontline worker and provider groups.

2. **Codesign workshop feedback directly provided by NDIS participants and carers/family (primary stakeholders).**

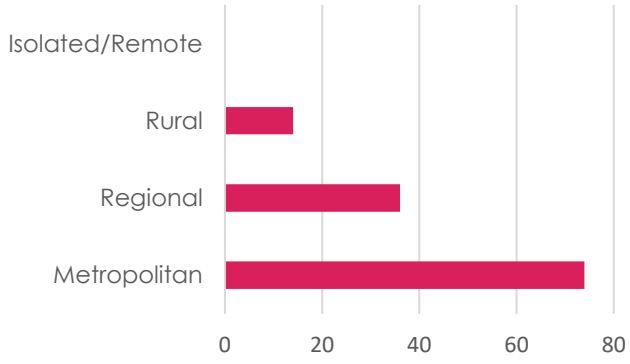
Current NDIS participants with psychosocial supports in their plans, and their carers/family.

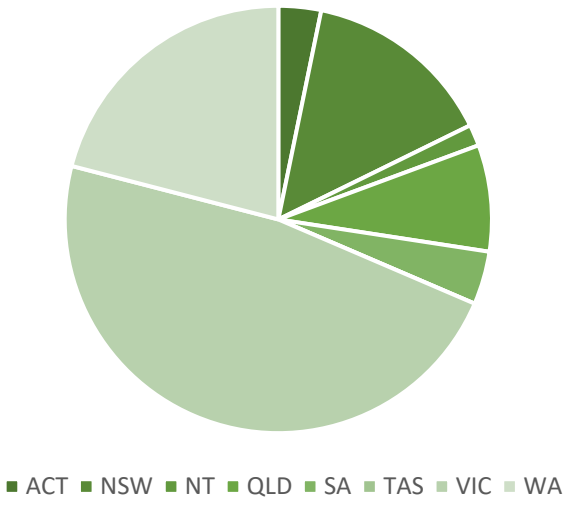
Engagement Strategy

The engagement strategy to the target audience consisted of two parts:

1. **Preliminary survey** using SurveyMonkey featured questions to capture information such as NDIS provider or direct worker ID, State/Territory, locations of service, level understanding of recovery-oriented service and used as an Expression of Interest, capturing contact details for those who were interested in participating in the workshops. The survey was disseminated through peak body and government and other key catchment organisations. Demographic responses can be seen in figure X and X, n=127 responses approx.
2. **Virtual workshops** held via zoom with the duration of 3.5 for each session. NDIS provider and direct worker sessions were structured differently, to generate conversation and capture specific information from each group.

Results from preliminary survey:





NDIS Provider Workshops

The project approached a range of people in management, supervision, and leadership roles in a range of organisations that are delivering NDIS Psychosocial services.

Audience demographic:

Approximately 36 representatives from NDIS providers attended over 2 designated workshops. Organisations ranged from large national mental health community providers that had been specialist mental health service providers prior to the development of the NDIS.

- Organisations that had previously specialised in Aged and / or other disability support services and who since the emergence of the NDIS have begun to deliver Psychosocial support services.
- Start-up organisations that have emerged due to the opportunities of the NDIS market.
- Peer led/managed organisations

Provider workshop sessions:

The sessions were co-facilitated by Gareth Edwards and Kieran Halloran with assistance from the ROPDS project team.

Participants were provided with a pre-information pack outlining key tasks for each of the four activities, and re-reading material about identified barriers of ROP and workforce and organisational capabilities drafted from the stage two synthesis report, including 16 key capabilities selected by the Project Reference Group (PRG).

The sessions involved four activities and breakout sessions structured around the key areas to focus during the discussion.

Focus for the provider workshops:

We wanted to hear from leaders and supervisors regarding:

- Their **understanding of recovery-oriented practice** and how to lead this in their organisations.
- Their **current concerns about the barriers** to ROPDS in the NDIS service delivery context.
- **Ideas regarding good practice** related to ROPDS in the NDIS service delivery context.
- What they identify as the **key organisational enablers** of ROPDS.
- What they identify as the key **workforce enablers** of ROPDS.

We also tested (via a strawman exercises) the key outputs for the RPDS project - the Good Practice Guides, the Hub, the training proposals and sought advice from them regarding how these products could be most usefully utilised by the current NDIS workforce.

During the sessions attendees were asked to identify which diverse communities is included in their service, results were recorded via Mentimeter, seen in figure 1 below:

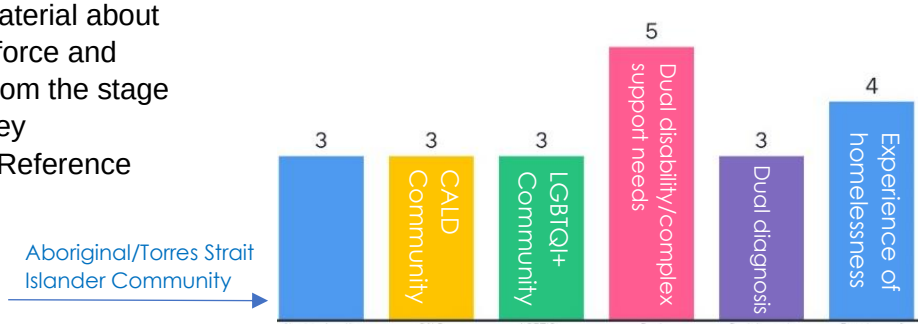


Figure 1: Organisations who work with diverse communities

What we heard from NDIS Providers

Barriers to ROPDS

Activity description: Workshop participants were asked to identify key barriers to ROPDS, as a group, using the Mentimeter word cloud function. Results from both workshops were collated into an infographic where participants were asked to discuss their answers. The following findings depict the collated word cloud and accompanying commentary of the key points from discussions about the barriers activity.

Figure 2: Barriers to Recovery Oriented NDIS Psychosocial Service Delivery – Providers – n=2 workshops

There was a wide-ranging discussion about what makes ROPDS service difficult from the providers perspective. There are many parallels that can be drawn between these versions of barriers and the versions that have been discussed by Participant, Carer and direct NDIS workers.

- There are not enough service providers in regional/rural areas leaving NDIS participants with a lack of real **choice and control** (and **supported decision making**) regarding the quality of their service provider.

- **Resources** and shortage of resources that make it really hard to do that. It can take up to a year or longer to build trust with support coordinator, and then start working on **supported decision making**. [The NDIS] System is not set up to help this.

- '**We keep talking and inputting but not being heard**'. NDIS receiving a deluge of advice through consultation processes and then a perception that re-action is slow, or advice is ignored.

- Psychosocial agencies need to also act as **Social Change Agents** to truly align with the needs of participants and carers. NDIS has made this difficult. Community engagement and activism (even attending local cultural events, forums, conferences) is not possible. This is particularly for front line workers, (due mainly to the **billable hours restrictions** on what a worker can claim) who are the workers who need to better understand the needs of their clients and their communities.

- **Fee for service model** – last thing NDIA want to hear it will just take time, however that is the reality. NDIA need to recognise that **ROPDS takes time** and is different for each person. Related to this there were statements about the need to minimise the casualisation of the workforce.

- Psychosocial voice is small in the **advocacy** space. **Systemic advocacy** is also difficult for rural regional and smaller providers (no resources to do this effectively). There was also a claim that the NDIA has 'instructed' organisations not to advocate.

- Workers are less able to support Participants who require support to attend **groups and culturally significant events**. e.g., LGBTIQ individuals who want to participate in a pride event.

- Generalist providers – lack of boundaries. Professional boundaries important for safety and keeping staff and consumers safe and well. **Lack of specialist knowledge** from generalist providers.

- **COVID-19** has made the processes starting with participants far more complicated and is having an impact on some of the key ROPDS related engagement stages.

- NDIS plans and **clarity regarding the expectation of the role** of the Psychosocial worker. The lack of flexibility and the need to negotiate how hours of support are to be utilised can lead to confusion for both participant and the worker/service.

Key Organisational Capabilities

In breakout rooms the participants were presented with 8 key organisational capabilities to discuss. Each room contained a facilitator who led the discussion and a scribe to capture key talking points. The following discusses the findings from the breakout rooms of Activity 2 from the workshop.

- **Diversity and inclusion;** NDIS has made this difficult. Community engagement and activism (even attending local cultural events, forums, conferences) is not possible. This is particularly for front line workers.

- **Lived experience and codesign;** Employment of recovery coaches and peer workers experiences is a high priority for agencies.

- **Safety and trauma-informed practice;** Training focus on this should be a high priority for the workforce as it is a common ROPDs issue.

- **Recovery-oriented leadership;** Organisations need to include **ROP in their commitment to quality practice**. They need to make it a key criterion in the selection of their leaders, managers, supervisors.

- **Ongoing ROP training** Really focussed on training, upskilling debriefing at team meetings, reflective practice, what has worked with certain clients.

- Understanding how we can leverage **technology to better connect with people** – create real time notes for handovers in consultation with consumer, use to communicate with families/carers.

- **Communities of Practice** are very powerful ways to develop support networks and collaboration with other organisations. Support can reach **smaller organisations through forums and Communities of Practice.** Organisation and practitioners gain a lot by talking with others and sharing ideas on how to tackle shared problems and challenges. Especially helpful for regional and remote providers.

- Monitoring quality of support / capabilities is tricky when supporting diverse workforce. How do we build support framework that is more clinically informed? Organisational capability that can provide that support.

Key Workforce Capabilities

In breakout rooms the participants were presented with 8 key organisational capabilities to discuss. Each room contained a facilitator who led the discussion and a scribe to capture key talking points. The following discusses the findings from the breakout rooms of Activity 3 from the workshop.

- **Identity, power, social determinants;** Empowering our workers (background TAFE) show workers how they can advocate on their own behalf so they can empower consumers. Includes showing them how the NDIS works and, legislation, etc.

- **Collaborating and coordinating with other services** Works well when you have a team that can come together and when roles and responsibilities chart for the individual, so they know who to go to for what, good for consumers and for us, need to be vigilant around

- "When we collaborate with other organisations, we found this was good for development but also we're able to find the right fit for clients"

- **Reflective practice;** not just with staff, but with consumer as well. Having conversation with consumers, what was a good outcome, what they would change, what was good for them. Really good learning opportunity for everyone.

- **Peer-to-peer support** is vital. Education with different cultural groups who can then share within own communities. Having difficult conversations, not pretending to know and understand it all.

- **Building trust and being respectful** same with anyone, you're not going to be friends with everyone, might need to try out a few support coordinators/workers before one really fits. True access and control means being able to speak up and say you're not a bad person but you're not going to work for me, but there isn't that option of workers. Same issues when staff move on or leave. Lack of job security doesn't help with that at all. And breaking trust/abandonment/let down when staff member leaves can add to trauma/issues. Need a backup of people they know like and trust, but staff shortages make that really difficult. Finding the staff that tick those boxes of what/who the person relates to. Shadow worker/two-worker model is ideal if you can have that extra, but hard to get and find that staff.

- **Small acts of engagement**. It was acknowledged in many of the forums with different stakeholders that the engagement phase, or the start of the working relationship with participants and workers and organisations is a crucial time and one that needs to be carefully considered. Starting well is very important and there were many accounts from participants and carers that highlighted where an ill-informed worker can make a lot of initial mistakes.

At a provider session an observation made is that if the person **"…hasn't received what they asked for in the first place, we have issues building relationship and trust."**

- **Collaborating with a person's supports -** Building relationships: Time/funding doesn't account for trauma-informed practice, participants say what they think they should say to get through planning meeting and goals, but really when you build a relationship over a year you start to unpack what they really need and want. Consumers and particularly indigenous consumers just say yes, yes, yes and come out with a plan they don't really want.
    - A related comment was that organisations should act to empower staff to understand NDIS and know how it all works and in turn participants. (Maybe better described as keeping staff and participants well informed of the NDIS. Supporting staff to work with participants in ways that empower effective choice and control and supported decision making.)
    - Communication and privacy. Co-location of services in the same building would be really beneficial. The official contacts are often not who you really need – it's often someone you know where you get somewhere. NDIA is the worst. Trying to find someone to respond to you is a nightmare, it's only by knowing someone that you can get in.

Other related feedback:

- **Building relationships:** Time/funding doesn't account for trauma-informed practice, participants say what they think they should say to get through planning meeting and goals, but really when you build a relationship over a year you start to unpack what they really need and want. Consumers and particularly indigenous consumers just say yes, yes, yes and come out with a plan they don't really want.
- **Sharing lived experience collaboration and codesign:** Train up participants and share lived experience with community to reduce stigma. Used 'Do no harm' framework that was codesigned. Purpose, context, audience focus, not triggering for person sharing and audience. Can also be tricky when balancing with dignity of risk. About empowerment, checking in and being mindful of own words and language.

Some key points on Cultural Safety and Competency:

- There is a need for at least a minimum level capacity within organisations for instance having Aboriginal health practitioner on staff.
- Acknowledging issues of displacement, and the need to be aware of links back to country - this has worked really well in some circumstances.
- Generational trauma. First 5-6 appts about building rapport, involve elders/family. Building level of respect within community.

Recommend Social and Emotional Wellbeing training, speaking with each community as each group is different, draw knowledge from community around you, be aware of history and generational trauma understanding.

NDIS Worker Workshops

The worker workshops target current and emerging frontline NDIS workers who work with people and their carers with psychosocial disability support in their plans. Approximately 45 direct workers attended, over 4 designated workshops. Job titles included psychosocial disability support workers, disability support workers, recovery coaches and support coordinators. Sole traders were given the option to registered either session with most attending the worker workshops.

Audience demographic:

Workshop attendees contained a range of direct service delivery roles, with majority being support and peer support workers, recovery coaches, support coordinators.

There was also a fair representation of sole traders across the four sessions.

Worker workshop sessions:

The sessions were co-facilitated by the LEAG members Dave Peters and Fiona Browning with Kieran Halloran with assistance from the ROPDS project team.

Participants were provided with a pre-information pack outlining key tasks for each of the activities, and re-reading material about identified barriers of ROP and workforce and organisational capabilities drafted from the stage two synthesis report, including 16 key capabilities selected by the Project Reference Group (PRG).

The sessions were conducted slightly different to the provider workshops as the activities were designed to spark discussion rather than directly speaking to the evidence-base and the key areas to focus during the discussion.

Focus for the worker workshops:

We wanted to hear from leaders and supervisors regarding:

- Their **understanding of recovery-oriented practice** and how they apply this in their service.
- Their **current concerns about the barriers** to ROPDS in the NDIS service delivery context.
- **A typical workday contrasted with an ideal workday** related to ROPDS in the NDIS service delivery context.
- What they identify as the **key workforce and organisational enablers** of ROPDS.

The strawman exercise of the project deliverables was also tested during the session.

What we heard from NDIS Workers

At the beginning of the session participants were asked to enter a word that best represents recovery-oriented practice via Mentimeter. Participants were then asked to elaborate on their chosen word as an ice-breaker activity for the session. Results were collated into the following word cloud.

Figure 3: Key word to describing good ROP by workers – n=4 workshops

Barriers to ROP

To continue the discussion, participants were also asked to identify the barriers to recovery-oriented service delivery via a second Mentimeter word cloud, which can be seen in the following graphic.

Figure 4:Barriers to Recovery Oriented NDIS Psychosocial Service Delivery – Workers – n=4 workshops

Qualitative information was collected by documenting quotes and key talking points in the scribe notes. The following findings discuss key themes from all the workshops to identify barriers and enablers of ROPDS.

Flexibility

Workers identified flexibility as a key capability for the work they do. Given the nature of the work and the complexity of individual situations, workers emphasised the need to be adaptable to the changing needs of participants.

"Structure your day – a lot of the time you are not in control – need to be flexible."

"This is an outreach role"

"it varies, no two days are the same, we are supporting people who quite often have complex situations or distressing situations."

Communication and Engagement

Feedback was received on the need for workers to have effective communication and engagement with participants. Workers described authenticity and a person-centred approach as essential enablers for recovery-oriented practice.

"Look to the person to look what will work for them in terms of communication style, how often they want us to check in with them, really look to them".

"Meeting people where they are at on that day, if they are having a good day meet them there, or a bad day meet them there."

"Recovery is not a linear line its ups and downs and stops and starts, sometimes episodic and needs the holistic approach applied. We are working with people, and all their rich diversity and challenges."

Collaboration and coordination

Workers emphasised the importance of effective collaboration and teamwork. An effective collaborative approach was felt to be a necessary enabler for good practice. This included working with the participants to create a consistent support team and improving access to community and mainstream services.

"It's a collaborative approach we all have a piece of the puzzle, we all are skilled in our own areas, and we all need to work together to help make a robust recovery for the people we are working with."

"A consistent support team is very essential for stable and ongoing care and this network needs to be in regular contact with one another."

"Supporting people to prepare for plan reviews, assessments and report writing for plan reviews, helping client to work more effectively with other supports, working with client's other supports on client's behalf"

Networking and information sharing

Workers expressed the value of networking and information sharing, both internally and externally.

"Being social change agents in the community and advocating for change."

"Best to share resources and knowledge, people will do the same in return if you respond in that manner."

"The DSC newsletters provides helpful updates on NDIS news even if you can't afford to attend their training sessions."

Quality and Training

Workers expressed concern about the quality and training of workers, including the impact to participants. This was identified as a real barrier for creating a safe and skilled workforce.

"You are supposed to be using evidence based to be delivering service but it's not really happening, and a lot of people aren't aware of what those programs are and are not trained in. If training is not paid it won't happen and I don't think the NDIS has any way of keeping track of that anyway."

"We should be equipped with the tools to implement these therapies on the ground, but I do a lot of self-study, I will sign up for this and pay for it myself, but it would be great for everyone to have an upskill on these things."

Reflective practice and Supervision

A strong theme identified by the worker participants was the need for reflective practice and supervision. This was felt to be often inaccessible at times.

"Very little time for reflection or thinking, NDIS pressure with dollar and time."

"Allowance for self-care, vicarious trauma, having space, checking in with team leader, etc. This is a really important part of making your days productive and successful and making sure you have good outcomes for your participant and yourself."

"Layer of lockdowns and non office roles, has added complexities to a role that already might be quite isolated from colleagues and supervisors."

Role clarification

Feedback from the worker participants highlighted the importance of having role clarity with clear expectations. The lack of role definition for recovery coaches, and the expectation of recovery coaches to perform support coordination tasks, was felt to be a barrier in providing the face-to-face contact needed for supporting someone effectively.

"A big challenge that I face is the expectations, sometimes unrealistic expectations, lack of understanding or knowledge of services. Responding to these with the right services."

"It sounds like Recovery Coaches are doing a specialised support coordination role, not a Recovery Coach role"

"I see the role of a recovery coach as empowering someone with a mental health disability to reach THEIR own vision of optimal wellbeing."