Psychiatric Disability Services
of Victoria (VICSERV)

Community Mental Health Workforce Training & Development Analysis

Final Report

Exploring the needs of the Victorian Community Mental Health workforce in the new NDIS environment

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Executive Summary

Introduction

The delivery of community managed mental health (CMMH) services in Victoria is undergoing significant change as the National Disability Insurance Scheme (NDIS) progressively rolls out across the country. This is already resulting in a major shift in how services are delivered and received and impacting significantly on organisations and the current and emerging workforce.

For Victoria, the shift to NDIS has been made more challenging because of the Government decision in 2013 to progressively transfer state community mental health services funding to the NDIS, leaving gaps in the Victorian community mental health system.

In 2016, with funding through the Victorian Government's Transition Support Fund, VICSERV implemented the Workforce Training and Development Analysis Project to explore and make recommendations around the needs of the mental health workforce in Victoria resulting from the rollout of the NDIS.

Project Objective:

To conduct an analysis of Victorian community managed mental health services to identify the workforce development and training needs of their transitioning and emerging workforces providing psychosocial disability supports in the new NDIS environment.

Key Findings and Themes

NDIS requires fundamentally different service delivery models

- Victorian Community Managed Mental Health (CMMH) providers are faced with the realisation that the service delivery model under the previous Victorian government community mental health funding program is made redundant with the roll out of the NDIS.
- Effective transition requires re-design of organisational structures, workforce and service delivery models in order to become viable NDIS providers.
- Service delivery under NDIS compared with Mental Health Community Support Services (MHCSS) is not like-for-like.

The NDIS provides disability supports, not psychosocial rehabilitation

- The previously integrated mental health service system provided both psychosocial rehabilitation and disability supports. This has been replaced by a NDIS system delivering only disability supports to people with psychosocial disability.
- People with mental health conditions in Victoria have lost access to psychosocial rehabilitation services as a result of the Victorian Government's decision to transfer MHCSS funding to NDIS.
- CMMH providers and mental health workers are struggling to reconcile what it means to deliver only psychosocial disability supports without psychosocial rehabilitation.
- It is still to be determined whether the disability supports offered under NDIS achieve the same recovery outcomes for people with psychosocial disability as previously under MHCSS.

Different job roles are required for the provision of NDIS supports for participants with psychosocial disability

- The MHCSS job roles and classifications do not translate across to the roles of providing psychosocial disability supports under the NDIS.
- CMMH providers generally are not able to reposition all their mental health workforce under the new system, or afford to remunerate them at the same levels.

- Working under NDIS requires a major shift in thinking, culture and practice for community mental health workers.
- The nature of the job roles required for the delivery of NDIS disability supports indicates a shift away from a distinctive mental health focus towards a more generalist disability focus in which the 'market' drives the role of the worker and the focus of the work.
- Managers who support or coordinate front line workers may face significant changes to their roles and responsibilities under the NDIS system.
- The nature and role of peer work under the NDIS remains unclear and uncertain.

The Victorian CMMH sector stands to lose parts of its experienced and skilled MH workforce as a result of the transition to NDIS

- To date, many community mental health workers have opted to exit the system rather than take up roles under NDIS.
- The new way of working under NDIS is not seen as a desirable professional opportunity by portions of the traditional mental health workforce who are committed and trained to work within a recovery-oriented rehabilitation framework.
- The significant reduction in role, classification and conditions for the Disability Support Worker role compared to the MHCSS role, is likely to act as a disincentive or barrier for experienced mental health workers to take up these NDIS roles.
- The potential loss of sections of the highly skilled and qualified MHCSS workforce is particularly concerning in an environment which offers less opportunities for replacing them and for upskilling new workers.

Existing Certificate III level qualifications are inadequate for working with NDIS participants with psychosocial disability

- The Certificate III in Individual Support qualification currently offers no mental health or psychosocial disability specialism, and only one mental health elective.
- If this qualification is to be a main channel for recruiting a future workforce of Disability Support Workers, then it needs to be tailored to include a core psychosocial disability unit and specialism.

Changes to work structures and processes are required for CMMH providers to operate a new NDIS workforce

- Mental health workers will be employed and deployed differently.
- Tighter management margins, increased worker-to-management ratios, and less travel allocation are just some of the changes that are impacting on workforce and work structures.
- The new system presents challenges for providers around risk management.
- The most common changes to workers' conditions are reflected in the DSW role: casual positions, required to work flexible shifts, and use own car for work purposes, lower classifications, and part of a mobile workforce.

Providers are identifying challenges in upholding safety and competence requirements stipulated in the NDIS Code of Conduct

- The combination of factors such as limitations of the pricing structure, skill level of the DSW role, mobile workforce, and the potential complexity of working with psychosocial disability, all contribute to the challenges of managing risk and delivering quality services to participants with psychosocial disability.

The effective provision of training and professional development under the NDIS is at significant risk

- NDIS pricing structure is inadequate to cover the costs of training and ongoing professional development activities including supervision.
- There are limited training offerings that focus on workers' transition needs or issues specific to the mental health or psychosocial disability context.
- Attracting a highly skilled workforce with mental health capabilities may prove challenging in the NDIS market environment, and could potentially result in long term de-skilling of the workforce.

Recommendations

1. Development of a new practice model for workers delivering psychosocial supports under the NDIS.

   A practice model which distinguishes between delivering psychosocial supports under NDIS, and psychosocial rehabilitation, and can operate within the goals of the NDIS, the restraints of the pricing structure, yet is recovery-oriented and trauma informed, and recognises the distinct needs of people with psychosocial disability.

2. The development (and implementation) of an evaluation framework to determine the recovery outcomes for NDIS participants with Psychosocial Disability.

3. The development and provision of new learning and development products to support managers and supervisors of the NDIS support workers providing psychosocial disability supports, in their adaption to the new NDIS operational environment and associated business process requirements.

   This may require further consultation with providers delivering psychosocial supports to better determine systems and practices needed to deliver effective management in the new environment.

4. The impact of the NDIS on the peer workforce is monitored to determine any:

   - new workforce trends occurring both within the NDIS space and more generally in mental health providers
   - tensions between employing a 'lived experience' workforce and a 'peer work' workforce.

5. The NDIA and the community mental health sector to explore the potential, and clearly articulate the role of peer work as a unique way of working within the NDIS.

6. That the Victorian Government lead and support efforts to retain the capabilities of the mental health workforce not transitioning to NDIS, allowing them to be retained within the broader community services and health sectors.

7. Development of new supervision models to meet the needs of a mobile workforce working with people with psychosocial disability.

8. Strategies for mitigating risks associated with an increasingly mobile workforce be implemented, such as safety and risk management training for the new or less skilled NDIS support workers employed to deliver supports to participants with psychosocial disability.

9. Development and provision of new learning and development products to prepare and orientate the existing Victorian community mental health frontline workforce ahead of the transition to NDIS, with a focus on exploring the differences at both the system and practice levels resulting from the transition.

10. That new workforce entrants (without experience or training in mental health) receive training and ongoing professional development to ensure they have the necessary mental health knowledge and capabilities to operate within the NDIS environment and to provide supports to people with psychosocial disability.

11. That NDIA planners and LACs, across all regions, be trained in mental health awareness to understand the specific needs of participants with psychosocial disability.

    This recommendation supports Recommendation 7 of the 'Psychosocial Supports Design Project' which reads:

    "7. The NDIA to consider developing specific staff training for staff about recovery and trauma based approaches to working with people with psychosocial disability." (NDIA & MHA, 2016 p 35)

    This recommendation also reflects Recommendation 9 of the Joint Standing Committee Report on NDIS, which reads:

    "The committee recommends the NDIA, in conjunction with the mental health sector, creates a specialised team of NDIS planners trained and experienced in working with people who have a mental health condition as their primary disability." (JSC, 2017 p xiv)

12. As part of their commitment to ensuring safe and quality services, and a sustainable and skilled mental health workforce, State and Federal Governments must ensure that mental health providers under the NDIS are adequately resourced to provide supervision and training to their workforces.

13. That the Certificate III in Individual Support (CHC33015) be revised to include a Psychosocial Disability core unit and specialism.

    The Psychosocial Disability Core Unit would complement the unit HLTAAP001 *Recognise healthy body systems*, and ensure that skills and knowledge relevant to both physical and psychosocial disability are included in the qualification.

    The competencies making up the specialism could include:

    - CHCMHS001 Work with people with mental health issues
    - CHCMHS003 Provide recovery oriented mental health services
    - CHCMHS011 Assess and Promote social, emotional and physical wellbeing
    - CHCMHS007 Work effectively in trauma informed care (this unit may need to be adapted to better suit a Certificate III level).

Introduction

The delivery of community managed mental health services in Victoria is undergoing significant change as the National Disability Insurance Scheme (NDIS) progressively rolls out across the country. This is already resulting in a major shift in how services are delivered and received and impacting significantly on organisations and the current and emerging workforce.

For Victoria, the shift to NDIS has been made more challenging because of the Government decision to transfer state community mental health services funding to the NDIS, leaving gaps in the Victorian community system. In comparison, a number of other states have continued to operate their state-funded community mental health services, with the NDIS services becoming an addition, or complement to the state funded mental health services.

Currently in the NDIS space, sector-wide workforce training and development opportunities for organisations and personnel are focused predominantly on organisational change and the implementation of disability supports. An analysis and recommendations around the emerging needs of the mental health workforce in Victoria as the NDIS rolls out has not yet been undertaken, VICSERV has responded to this gap with the Workforce Training and Development Analysis project in 2016.

This project was funded through the Victorian Government's Transition Support Program funding received by VICSERV.

Project Objectives

To conduct an analysis of the Victorian community managed mental health services to identify the workforce development and training needs of their transitioning and emerging workforce providing psychosocial disability supports in the new NDIS environment.

Project Scope

Analysis of the transition support requirements of the current MHCSS workforce* as a result of the removal of MHCSS funding.

Analysis of the 'new' (emerging) workforce providing psychosocial disability supports, created as result of NDIS rollout.

* Workforce will include the federally funded community mental health programs, PHaMs and Partners in Recovery (PIR).

Methodology

Objectives of the Workforce Analysis Project

To conduct an analysis of community managed mental health (CMMH) services to identify the workforce development and training needs of their transitioning and emerging workforce providing psychosocial disability supports in the new NDIS environment.

Within this analysis, 'transitioning workforce' refers to the workforce employed under the 'defined' programs of the MHCSS, that is, the programs whose funding is in scope to transition to the NDIS. In addition, some federally funded community mental health programs were also included: Partners in Recovery, and Personal Helpers and Mentors. The analysis included those who, for whatever reason did not or would not transition to the new system. The 'emerging workforce' refers to the new workforce providing psychosocial disability supports, created as a result of the NDIS rollout.

Research Question:

What are the workforce training, and professional development needs of the transitioning and emerging workforces providing psychosocial disability supports in the NDIS environment, in particular, those not being addressed by current training and development options?

Overview of Methodology

Identification of the workforce development and training needs of the CMMH workforce transitioning to the NDIS involved two parts, and used a combination of data gathering techniques, as outlined in the following methodology:

Part 1 Background Review

Part 2 Data gathering, Discussions and Findings

a. Consultations using standardized open-ended interviews
b. Collection and analysis of Position Descriptions (Providing NDIS supports)
c. Audit of training offerings
d. Other sources of data collection

Environment

Due to the scale of this national reform, the NDIS environment is in a state of constant change and subject to multiple reviews, inquiries, and developments throughout the implementation period.

Hence although the information in this document relating to NDIS processes and Pricing, was correct at the time of undertaking the consultations and analysis, it is subject to change.

Methodology

Part 1. Background Review of relevant reports and government documents

This review scoped the most relevant and current reports, data and other information to ascertain what had already been learned from the experience of community managed mental health (CMMH) service providers during the implementation of the NDIS regarding workforce-related issues, changes and impacts. The purpose of the review was to gain background context, identify insights, and help inform the focus of the data collection in the following phase of the project.

Initial scans of the literature identified the following key themes:

- Impacts on the existing Victorian MHCSS workforce and service providers
- Impact on the nature of the work being performed and the resulting changes in skill requirements (including 'new work roles')
- Changes to work models
- Workforce transition issues

It was beyond the scope of this project to fully explore all of these themes in the short time frame, however the background review touched on each of these to help give a broader context for the workforce analysis. It also provided a general comparison of how the work context has changed for the community managed mental health workforce.

The data collection for this project focused only on the impact of the NDIS on the nature of the work performed in providing psychosocial supports, what the new work roles look like, and on the training and development needs of this workforce.

Part 2. Data gathering, Discussions and Findings

a) Consultations

Consultations took the form of standardised, open ended questions (see appendix for list of questions), plus data gathered from one verbal presentation at a VICSERV forum.

Initially it was hoped to consult three stakeholder groups from organisations that have already transitioned, or are in the process of transitioning to become an NDIS provider, namely from the Barwon trial site, North East Melbourne and Central Highlands areas:

- High level managers responsible for NDIS transition
- First line managers who supervise support workers
- Frontline workers providing psychosocial disability supports in the NDIS system

Gaining access to groups of frontline workers to interview, who had previously been engaged as a MHCSS worker and were now working under the NDIS system proved too difficult, and therefore restricted the number of potential interview options.

Breakdown of consultations

Category	Total
Organisations represented	8
Regions covered	7 regions
Stage of transition to NDIS	Fully rolled out x4 2017 roll out x4 2018/19 roll out x3
Type of worker	9x Managers 3x Coordinators 1x Frontline worker
Consultations	7x face to face interviews 3x phone interviews 1x presentation (with PowerPoint notes)

b) Job Profiles

The objective of this data gathering process was the identification and analysis of the emerging support roles providing psychosocial supports within NDIS environment.

Data was gathered from the following sources:

- Interviews
- Position Descriptions for advertised jobs with key mental health providers in Victoria
- NDIS documentation, in particular relating to Support Coordination
- Disability Services Consulting – Online Bulletins and Support Coordination webinar

The two key emerging job roles identified were:

- Disability Support Worker/ Support Worker (aligned with the core support items in the NDIS Price Guide)
- Support Coordinator (aligned with the support items in the NDIS Price Guide under the category of Coordination of Supports)

Composite job profiles were created outlining the purpose of each role, conditions of employment, responsibilities and qualifications, skills and attributes required. (See appendices 2 and 3 for full outline of the profile).

c) Audit of existing training offerings

Desktop audit of existing training packages, materials, online resources and training which:

- Support the workforce to transition to the new NDIS system
- Offer specific training for the emerging workforce within the NDIS system

d) Other sources of data

Data gathering was expanded to include other sources of information and consultations:

- VICSERV Member forums and stakeholder engagement meetings
- Peak Body and State Government Submissions and Discussion Papers
  - VICSERV submission to the Joint Standing Committee on the NDIS for people with psychosocial disabilities related to a mental health condition
  - CMHA submission to the Productivity Commission: NDIS Costs Issues Paper (Draft);
  - VICSERV submission to the Productivity Commission Inquiry into NDIS costs
  - VCOSS submission to the Joint standing committee on the NDIS
  - NDIS Code of Conduct Discussion Paper
- Online bulletins (NDS, Disability Services Consulting, Pro Bono Australia)
- *newparadigm:* The Australian Journal of Psychosocial Rehabilitation.

A full reference list of sources used to gather data can be viewed under the Bibliography section of this report.

Part 1
Background Review

Part 1
Background Review

Aim of Background Review

The aim of the background review was to ascertain what has already been learned from the experience of community managed mental health (CMMH) service providers during the early years of implementation of the NDIS regarding workforce-related issues, changes and impacts.

Time limitations for this project did not allow for a comprehensive review of all the literature pertaining to workforce issues resulting from the implementation of the NDIS. The goal was to examine the findings identified in a range of key project reports by state and federal government, peak bodies and other organisations involved in the implementation of the NDIS, in particular the NDIS trial sites across Australia. These reports span a three year period between 2014 and the end of 2016. The findings allow for the identification of some of the key themes emerging in the NDIS and mental health space, and help shape the focus of this workforce analysis.

Key issues pertaining to the existing Victorian Mental Health Community Support Service (MHCSS) workforce and service providers in the context of the NDIS initial trial period, include:

1. Change to the service delivery model
2. Impact on the delivery of psychosocial rehabilitation and recovery-oriented services
3. New emerging job roles
4. Changes to skills, qualifications and attribute requirements
5. Changes to work structure and processes

Key Issues from Background Review

1. NDIS requires a radically different service delivery model

The implementation of the National Disability Insurance Scheme (NDIS) is having significant impact on the community managed mental health sector bringing about changes and challenges at all levels of organisations including leadership, operations, workforce, service delivery and business models.

The shift from block funding to an individualised support system represents a significant paradigm shift. According to the VICSERV report on the Barwon trial site, "The change is not a simple transition from one model to another – the change is more accurately characterised as transformational, some have referred to the process as 'disruptive innovation' (VICSERV 2015 p.8). The impact of this transformation on the mental health workforce is also significant, requiring major adjustments to how workers engage in their work, how they relate to the people they support, and how they deliver services.

Implications, considerations, and further exploration

The full extent of the impact of changes to the service delivery model is still to be seen, especially in such a fluid and changing environment. As organisations transition to the NDIS they will need to adapt and change, and find innovative solutions to meet the challenges.

Exploration of the extent and nature of changes to the recovery-oriented psychosocial rehabilitation service delivery model will form a major focus throughout the course of this project.

Part 1
Background Review

2. Impact on the delivery of psychosocial rehabilitation and recovery-oriented services

According to a number of sources, there has been a fundamental shift in the focus of the work from a strong emphasis on psychosocial rehabilitation and recovery-oriented services, to providing only those supports which relate to psychosocial disability (CMHA 2015; Baxter 2015; Roberts & Fear 2016).

MHCSS workers from the Barwon trial site, when interviewed, highlighted that they felt they were being "forced to practise in a way that was not recovery-focussed and holistic" (Baxter 2015 p.18). An example given was in the context of outreach support, where family and carer work, therapeutic responses, grief and loss and shared care practice were not funded under the NDIS supports, but were seen as relevant recovery-focussed supports that had previously been an essential part of the work done by MHCSS workers. Some expressed concerns that "NDIS funded mental health supports now represented the work of personal care attendants and not social work, psychology or peer work" (p.19).

Under the MHCSS programs, the delivery of psychosocial rehabilitation involves an integrated and flexible approach that is recovery-oriented, person-centred, family-inclusive, culturally secure and trauma-informed. The engagement phase is seen as a crucial and often slow process, allowing for the development of a relationship built on trust and rapport. These relationships form the basis of the ongoing work of assessment and "exploration of personal values, strengths and dreams, and opportunities to explore different ways of thinking about mental health." (Daya 2015 p.12). Under this approach relationships remain stable and consistent, and the delivery of services is holistic and integrated.

In contrast, the current NDIA system of providing supports is more disjointed; it separates various functions into distinct processes: access, being plan ready, planning, plan implementation and review. More specifically, access and planning is now the responsibility of NDIA/ LAC staff, and support coordination must be offered separately to the delivery of core and other supports in a participant's plan. A participant may have a number of support workers at one time delivering a range of supports.

Another point of difference between the MHCSS recovery-oriented approach and the NDIS approach relates to the engagement (outreach) phase and the level of 'readiness' or 'preparedness' of the person to begin the access and planning process. The NDIS approach assumes participant readiness, whereas the experience of the MHCSS program has been that many people with psychosocial disability require an investment of time, relationship building and other capacity building activities before they can identify their recovery goals and how best to make use of the NDIS supports to achieve these goals and aspirations (Roberts & Fear 2016 p.44-45). This has implications for people with psychosocial disability gaining access to the Scheme.

Daya (2015 p.12) gives a reflection on the NDIA's new system of assessment: "An appreciation that assessing a person's mental health needs and goals in a 1-2 hour session, with a complete stranger, once a year, is almost diametrically opposed to recovery-oriented practice in mental health. In fact, this process is often the core work of recovery and rehabilitation programs, not what happens at the entry point."

Psychosocial disability supports available under the NDIS

In an effort to help address some of these concerns, the NDIA together with Mental Health Australia implemented the 'Psychosocial Supports Design Project', with the view to identify optimal packages of support for NDIS participants with a psychosocial disability.

As part of the project the following list of supports were identified by stakeholders as necessary options for participants needing psychosocial disability supports. These were recommended as options for NDIA's consideration. Feedback was given by NDIA as to whether these supports already mapped to the price guide, or whether they were the responsibility of other mainstream services (Roberts & Fear 2016 p.21).

- Advanced care planning
- Crisis planning
- Hoarding and squalor
- Individual advocacy

- Assistance to access and navigate the legal system
- Emergency step-down services upon hospital discharge
- Support items triggered at points of transition
- Support coordination
- Peer worker support
- Supports integration
- Supportive escorting
- Planning for next plan
- 'Hospital in the home' support
- Life skills training and coaching
- Access to psychological therapies
- Building relationships
- Support to gain work readiness skills
- Capitalising on periods of wellness
- Carer support
- Loading for special needs (such as Aboriginal and Torres Strait Islanders, culturally and linguistically diverse communities, involuntary treatment order, post-discharge, comorbidity)

Some of the above supports were able to be clearly mapped to the NDIS Price Guide, such as 'Support to gain work readiness skills', 'Improved relationships' and 'Support coordination". Other support suggestions were clearly considered the responsibility of other mainstream services ('Hospital in the Home', 'Access to psychological therapies', and 'carer support'), or were partially or indirectly addressed by the current support items available in the price guide (such as 'Advanced care planning', and 'individual advocacy').

Implications, considerations and further explorations

What is clear is that the NDIS offers disability supports, and not recovery-oriented psychosocial rehabilitation. The full impact of this for the community mental health sector is still unfolding as the sector struggles to find its place in the new system. In addition, this presents challenges to MHCSS workers who have been trained and are committed to particular practice frameworks, work culture and values that are not as relevant in the new system.

The COAG document, 'Principles to determine the responsibilities of the National Disability Insurance Scheme (NDIS) and other service systems' clearly delineates the responsibilities of the various service systems. It stipulates that the responsibility for psychosocial 'rehabilitation, recovery and early intervention supports' are considered the responsibility of the mental health system, and not that of the NDIS. (Council of Australian Governments, 2015)

Consequently, certain functions or aspects of recovery-oriented psychosocial rehabilitation are not included as support items in the Price Guide, such as carer support, supportive escorting, recovery planning, relapse planning and crisis response coordination and support (Roberts & Fear 2016).

Given the particular situation of Victoria in which three of the largest Mental Health Community Support Services programs – Individualised Client Support Packages, Supported Accommodation Services, and Adult Residential Rehabilitation Services – will no longer be funded after the full roll-out of NDIS, the future of those aspects of psychosocial rehabilitation services which are not included in NDIS support options is uncertain. It raises the question of how these services will be offered, if at all, and who will have responsibility for funding and managing them.

Part 1
Background Review

3. New job roles

New job roles emerging from the division of labour created by NDIS support categories

The NDIA Price Guide for Victoria has already begun to have a strong influence on the nature of the work roles being created by providers for the provision of disability supports under the NDIS system. NDIA pricing differentiates levels of support work and the NDIA 'Guide to Suitability' stipulates the qualification, experience levels and professional registration required for workers providing specific support services under the NDIS (NDIS 2016b). This is particularly impacting on the nature of the job roles for those delivering supports for people with a psychosocial disability, as providers struggle to reconcile what it means to deliver psychosocial disability supports as opposed to psychosocial rehabilitation.

An *early* indication of the new work roles suggests an emerging division of labour based on whether the worker is offering supports under the 'Core' or 'Capacity building' categories listed in the NDIA Price Guide (CMHA 2015).

Definitions of these categories according to the NDIS Price Guide are:

"Core – A support that enables a participant to complete activities of daily living and enables them to work towards their goals and meet their objectives" (NDIS 2016a p.4). The types of support included in the role of a support worker offering Core Supports include assistance with daily personal activities, and assistance with social and community participation. These are funded at the lowest level, purportedly requiring less skilled workers than the capacity building categories, and hence the minimum level of qualification for this work role is a Certificate III in Disability.

"Capacity Building – A support that enables a participant to build their independence and skills" (NDIS 2016a p.4). Examples of the support categories included in this job role are: support connection, coordination of supports, life transitions, improved relationships, improved health and wellbeing, finding and keeping a job, and assistance with accommodation and tenancy obligations.

Although the capacity building category of supports is funded at a higher level, and hence would allow for the employment of higher skilled workers, there are still questions as to how much work will actually be generated for this level of worker, especially given that the Local Area Coordination (LAC) services will also have a role to play in providing support coordination. The statistics from the NDIA's Q1 Quarterly Report on the NDIS, tend to support the belief that the bulk of the demand for supports will come from the core supports category. Just over 69% of the committed supports allocated in plans in the first quarter, fell under the core support categories of *Daily Activities*, and *Community*, and only 3.5% fell under the capacity building category of *Support Coordination* (Naufal 2016).

The pricing of NDIS supports was identified in various reports as creating tension related to the financial viability of the pricing of services and supports, and the implications this has for the wages of the new workforce providing psychosocial disability supports. In the report, *Developing the workforce*, the Chair of the CMHA quoted,

"Although NDIS pricing does not officially set mental health sector workers' wages; NDIS pricing does have an extremely significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders argued that the pricing is not sufficient to purchase a suitably skilled workforce that engages in complex 'cognitive behavioural interventions' as well as direct personal care." (Crowther, quoted in CMHA 2015, p1)

Since undertaking this background review, there have been changes made to the NDIS Price Guide which may have addressed the above concerns to some degree by introducing three levels of 'Support Coordination' within the Capacity Building Support category. These support items allow for variations in the intensity of support needs, and offer higher hourly rates which reflect the specialist/ professional skills needed to offer the intensive level of support coordination.

Implications, considerations and further explorations

Whether the introduction of additional levels of Support Coordination costed at higher levels is sufficient to enable organisations to continue to employ a suitably skilled workforce is still to be seen, and will continue to be a focus of interest for this project.

Identification of the NDIS job roles that are affordable, viable and appropriate for the provision of supports for participants with psychosocial disability is crucial for organisations on many levels. In particular whether the new NDIS roles are suitable and attractive propositions for their existing mental health workforce, and whether employers can continue to offer their workforce continuity of employment under the same conditions of employment.

Another potential area of concern relates to risk management. Concerns may arise from the situation in which less skilled staff are supporting people with high level and complex needs, mostly as sole workers working within participants' homes.

Mental Health Peer Workforce

The implications for the role and place of the mental health peer workforce within the NDIS system, is of particular interest to VICSERV, and to other parties within the community managed mental health sector.

The findings of a number of key reports around workforce-related issues identified that peer workers were considered uniquely suited to working with people with mental health issues (Roberts & Fear 2016), and could well become "a workforce of choice that not only taps into new pools of workers, but also supports the NDIS objectives of increasing economic participation and independence of participants" (Windsor & Assoc, and NDS 2014 p.20). Flourish Australia reported that peer work roles in the Hunter trial site were very effective in undertaking outreach and engagement to enhance NDIS access (quoted in MHCC 2016 p 12), and that "… the value of peer work is unquestionable, and it sits well with the NDIS notions of choice and control and responsive, respectful service tailored to the needs and goals of the individual" (Quilty 2017 p23).

Some organisations involved in the trial regions have identified that the growth under the NDIS has allowed for an increase in their peer workforce. In the case of Flourish (Quilty 2017 p. 24) their strong commitment to growing their peer workforce stems from the value base of the organisation and their belief in the benefits of peer support for the people with mental health issues as well as for the service as a whole. This is a deliberate organisational choice, and central to their value proposition under the NDIS.

According to the Section 4.4 Registration Groups in the NDIS Provider Toolkit Module 4 (NDIS 2016b), the industry experience or qualification of a Mental Health Peer Worker is recognised as valid for registration under the profession of 'Disability Support Worker'. Other than this, peer work is not given any other recognition as a distinct way of working with people with psychosocial disability. Where 'Peer Support' is mentioned as a line item in the NDIS Price Guide, this refers to informal support provided by peers in community settings.

Part 1 Background Review

Implications, considerations and further explorations

At present the status of peer work within the NDIS environment is still unfolding, and the actual definition of 'peer work' or 'peer support' is cloudy. What remains unclear is whether peer workers are being employed for roles which allow them to utilize their lived experience to build authentic and hope-generating relationships, or because peer work is seen as a valuable lens through which to deliver NDIS supports, or whether they are being employed as general Disability Support Workers delivering general disability support items.

The choice to employ peer workers appears to be dependent on the organisation's commitment to peer work as a beneficial and preferred way of delivering recovery-oriented psychosocial supports. In future, providers may find this proves to be a valuable 'point of difference' in a competitive business environment.

4. Changes to skill and qualification requirements

The degree of change being driven by the implementation of the NDIS has implications for the skills, capabilities and qualification levels required to carry out the new job roles. The full extent and nature of these changes are still unfolding, and have been explored and projections made in a number of key reports. The areas identified in the literature to date which are of particular relevance to this project are:

- Skills and capabilities pertaining to the new NDIS system
- Customer service
- Minimum qualification levels

Skills and capabilities

Given the significance of the change facing workers in transitioning to the new system, it was anticipated that workers would need to develop new skills and capabilities pertaining to understanding the new NDIS system and processes. In particular, the following were seen as essential skill development areas required for delivering NDIS services:

- Understanding of the NDIS; its goals, how the scheme works, new terminology and pricing systems
- Individualised funding management
- Customer service
- Knowledge and skills required to work effectively in an insurance context.

(Victorian Government 2016 p 12; CMHA 2015 p 52).

In the early days of the trials, National Disability Services (NDS) consultations with Disability Support agencies in the trial sites identified that the NDIS has implications for *all* disability support worker roles including those providing more complex support. The most frequently cited examples of emerging, or increasing relevance of existing skills identified were:

- personal accountability and reporting
- implementing participant plans, monitoring progress and gaining participant feedback
- strategies to actively promote choice and control
- person-centred approaches that draw on a rights-based framework
- facilitating learning to support self-care and independent living, including task analysis
- facilitating and supporting community engagement into integrated/mainstream groups and universal settings
- working independently/unsupervised
- negotiating boundaries with participants and others who play a significant role in the participant's life
- assessing and managing workplace health and safety risks at the same time as respecting that the workplace may be a participant's own home
- interpreting safeguarding policies and practices in ways that respect the rights of participants to make choices about reasonable, age-appropriate risk.

(Windsor & Assoc and NDS, 2014 p23)

Implications, considerations and further explorations

Given that the focus of the consultations identifying these skills was primarily around disability support workers, further consultation is required to validate or refine this list of skills to determine their relevance for workers delivering supports for people with psychosocial disabilities.

Customer service skills

Customer service skills were identified in a number of sources as being an important requirement for frontline support workers facing a new customer-focussed business model in which the customer has more choice and control, and can easily change workers or providers if they are not happy with the service. Online training specifically developed for NDIS frontline workers, states that frontline workers now need to take more of a role in soft marketing, and have more responsibility for organisational success. "Frontline workers are responsible for giving the service to clients that they want and value; frontline workers directly influence the success of the service and the organisation" (NDS, 2016)

This view is echoed by the General Manager of NDIS for Flourish Australia, after three years of experience as an NDIS provider,

In a competitive marketplace, it is the frontline staff who embody the 'brand' essence and who are crucial to attracting and retaining new business. They are the ones who connect, listen, and build relationship. (Quilty, 2017 p. 23)

This new skill area has also been flagged by the Industry Reference Committee for Direct Client Care and Support as a result of the trend to consumer directed care across the health and community services sectors.

… a different culture of customer service will become essential across the health and community services sectors, as clients become individual customers with greater choice and autonomy over that choice … Workers will need to interact differently and much more closely with the people they support, contribute differently to the process of providing support within a person-centred approach; and adopt a new role as the face of the organisation within a new marketplace. (SkillsIQ 2016 p.18)

Minimum qualification requirements

The impact on the minimum qualification level for support workers still has a degree of uncertainty and may become clearer with time. Difficulties have arisen as a result of the tension between pricing constraints in the Price Guide, and the skills and experience required to work with people with psychosocial disability. Traditionally, providers were committed to employing MHCSS staff with the minimum level of qualification – Certificate IV in Mental Health, however, some providers reported that, under the NDIS pricing arrangement they were unable to pay salaries required to attract and retain workers with the minimum workforce qualification standards (CMHA 2015 p. 60). The impact of this tension on the traditional MHCSS workforce is particularly significant given the fact that this workforce is highly qualified. According to a survey conducted by VICSERV in 2016 which assessed the capabilities of the MHCSS workforce, 90% of respondents identified that they had a qualification of Diploma or higher (VICSERV 2017 p. 15). Potentially, these workers are over-skilled and over-qualified for the NDIS support worker roles, especially the role delivering core supports.

Implications, considerations and further explorations

This situation raises concerns about the potential loss of highly skilled, experienced and qualified mental health workers from the Victoria community mental health sector. In addition, opportunities for work in the sector will continue to be impacted as the MHCSS funding shifts to the NDIS, resulting in reduced work options. The full impact of this on the community mental health workforce is still to be determined.

Part I
Background Review

5. Changes to Work Structure and Processes

The new NDIS system has meant significant changes are required in order for providers to adapt to the shift from block funding to individualised funding, to the new NDIS insurance model, and to operating within a competitive business environment. In particular the perceived constraints of the pricing structure of the NDIA Price Guide have influenced the way some providers are deploying and managing their workforce.

A trend towards a new work model is becoming evident, one which requires more flexible workforce approaches, characterised by a more casualised, mobile, and less well-paid workforce (MHCC, 2016 p 10, and Neami 2016 p.12). It can include a change towards "having a 95% direct service provision model with little margin for non-direct service work", and "a pricing structure that makes very little allowance for induction, training, development, collaboration, and innovation, and routine administration" (CMHA 2015 p. 4). The trend towards casualisation is also reflected in the most recent evaluation survey of the NDIS Trial sites (Mavromaras et al 2016) which identified decreases in the number of employees in the Disability sector defined as being under permanent or continuing contracts.

This new model is also mirrored in another organisation's response to becoming an NDIS provider and employing frontline support staff. BreakThru have documented this shift to a new way of working in "Evolution of the Employee" a document which identifies some of the key changes in their working model for the disability support worker role:

Change from:

- Working 9-5 → working anytime
- Working in a corporate office → working anywhere
- Using company equipment → using any device
- Focus on inputs → focus on outputs
- Climb the corporate ladder → create your own ladder

(BreakThru, 2016)

The most recent evaluation report of the NDIS (Mavromaras et al 2016), explored the impact the NDIS has had on the disability sector workforce in the trial sites, however it qualifies that the results are still 'non-generalisable' data. The final results will be available in 2017, and should assess the impact of the NDIS on the workforce in a statistically meaningful manner. However the data is still helpful in highlighting some trends which could be further explored.

The trends demonstrated in the trial sites are:

- Decrease in opportunities for training, student placements, and supervision, and the future impact this may have on the skilling of the workforce, and the ability to attract new workers
- The increase in use of lower skilled staff who may not have the skills and experience to provide more complex supports, and the impact this could have on the quality of care and outcomes for the participants
- Employee recruitment and retention; increased turnover and churn
- Unfunded work, more casual and less well-paid work

(Mavromaras et al 2016, p. xii)

Implications, considerations and further explorations

These trends have potential implications for the ongoing training and professional development needs of the new workforce, not just in terms of what skills training is needed, but also in terms of who will carry the cost of this training and how best it can be delivered.

Questions are raised as to whether the models of training currently offered by employers, training organisations and peak bodies will continue to serve this new workforce, and if new models need to be developed, then how the workforce will adapt to learning in different ways.

Again, implications for risk management, safety factors, and quality control are flagged given the combination of factors identified in the trends from the trial sites listed above. The combination of lower skilled workers lacking the experience and skill to deal with participants with complex needs, working in off-site environments, together with the decrease in opportunities for supervision, support and training, may lead to increased risks for workers and participants, as well as potentially impacting the quality of the service and participant outcomes.

Emerging themes from Background Review

The background review has revealed the following themes and considerations regarding workforce and transition issues arising from the implementation of the NDIS.

NDIS requires a radically different service delivery model

- Exploration of the extent and nature of the changes to the service delivery model under NDIS compared to the MHCSS model of delivering recovery-oriented psychosocial rehabilitation will form a major focus of the VICSERV Workforce Development Analysis project.

Impact on the delivery of psychosocial rehabilitation and recovery-oriented services

- Certain functions or aspects of recovery-oriented psychosocial rehabilitation are not included as support items in the NDIS Price Guide.
- The future delivery of community based rehabilitation services in Victoria, which are not included in NDIS support options, is uncertain. It raises questions about whether these services will continue to be delivered, and who will take responsibility for them.

New job roles

- An early indication of the new work roles suggests an emerging division of labour based on whether the worker is offering supports under the 'Core' or 'Capacity building' categories listed in the NDIS Price Guide.
- Community managed mental health providers are being presented with a challenge in reconciling what it means to deliver psychosocial disability supports under the NDIS as opposed to psychosocial rehabilitation, and the type of workforce needed to do this work.
- Identification of the NDIS job roles that are affordable, viable and appropriate for the needs of participants requiring psychosocial disability supports is proving to be challenging for some mental health providers. It has implications for their capacity to redeploy the existing workforce under the new NDIS system, to retain their conditions of employment, and to continue ensuring safety and quality standards.
- The status of peer work within the NDIS environment and the full implications for peer work as a unique approach to providing recovery support are still unfolding. Whether peer work finds its place within the NDIS, or whether it becomes lost in the role of Disability Support Worker remains to be seen.

Changes to skill and qualification requirements

- The changes to job roles and qualification requirements, together with the reduced opportunities for highly paid roles under the NDIS, could see a loss of highly skilled, experienced and qualified mental health workers from the sector.

Changes to work structure and processes

- The effective provision of ongoing training, supervision and professional development for the new workforce is proving challenging for providers under the NDIS pricing restraints.
- Risk management, safety factors, and quality control within the new system are presenting as challenges due to a combination of factors.
- Further exploration is needed to determine whether the models of training currently offered by employers, training organisations and peak bodies will continue to serve this new workforce.

These themes set the framework for the data gathering and analysis phases of this project. Some of the issues and questions raised here will be explored in more detail in Part 2 of this Report.

Part 2
Data, Discussions and Findings

What follows is a discussion of the findings gleaned from the consultations and other sources, and from the analyses of job descriptions.

Part 2
Data, Discussions and Findings from Workforce Analysis

1. NDIS requires a fundamentally different service delivery model

"The organisational structures and service delivery models required for the viable delivery of NDIS supports need to be fundamentally different to the models we have traditionally used to deliver block funded services." (Tobias, 2017 p21)

Community managed mental health (CMMH) providers are realising the necessity of making significant changes to their business and service delivery models as they prepare to transform into NDIS providers. Faced with the loss of their primary funding source, namely state funded community mental health programs, Victorian community mental health providers have been left with limited funding options, the most prominent being the NDIS.

They need to make a shift from operating under a block funded human service model to an individualised support system within a commercial and competitive marketplace. A system in which the control of the resources is no longer in their hands, but in the hands of the 'customer'.

This shift brings a very different way of operating, and attempting to recreate the previous community mental health service delivery and workforce models under the new NDIS system, rather than recognising that the NDIS is a completely different model, will make the transition more challenging for providers. This point is brought home strongly by the experience of Pathways, a main provider of mental health recovery services and psychosocial support in the Barwon trial site, that became financial unviable in the NDIS environment and had to close its doors.

One of the providers interviewed had responded to the need for new service delivery models by committing significant resourcing and using a whole-of-organisation approach to create a viable business model with a suite of new 'products'. This model was a 'one-stop-shop' providing a range of services and activities delivered by specialist practitioners.

The mental health workforce under NDIS is moving to a closer relationship with the disability sector. Some organisations have made the decision to become NDIS providers with a focus on generalist disability as well as psychosocial disability, others have retained their mental health specialism but will include participants with dual-disability.

Implications and issues

The removal of Victorian mental health funding and registering as an NDIS provider shifts parts of an organisation's service delivery away from mental health into a national disability insurance system. The shift represents a move from one programmatic framework and distinctive purpose (MHCSS) to another (NDIS) and creates a gap in community mental health service offerings in Victoria.

2. Impact on the delivery of psychosocial rehabilitation and recovery-oriented services

2.1 Psychosocial rehabilitation and psychosocial supports

One of the factors impacting on the Mental Health sector as a result of the transition to NDIS is the fact that the NDIS system offers only disability supports, not psychosocial rehabilitation.

Significant debate, and some confusion have arisen around the difference between psychosocial disability supports and psychosocial rehabilitation, and which of these the NDIS is offering (CMHA 2017 p 3). The NDIA states that it has no responsibility in the domain of rehabilitation supports, as this is the responsibility of the mainstream mental health system (Council of Australian Governments, 2015 p 6). This is particularly concerning for the Victoria community mental health system which now has gaps in community rehabilitation services resulting from the MHCSS funding moving to the NDIS.

The new system leaves community managed mental health providers with the challenge of reconciling what it means to deliver psychosocial disability supports under the NDIS as opposed to psychosocial rehabilitation. It also raises questions for providers about the type of workforce needed to do this work and what the new services or 'products' should look like.

Part 2 Data, Discussions and Findings from Workforce Analysis

Impact on the delivery of psychosocial rehabilitation and recovery-oriented services (cont.)

The previous MHCSS role under the Victorian government program funding was a distinct and clearly defined role delivering recovery-oriented psychosocial rehabilitation as well as disability support. Workers' practice encompassed holistic, strengths-based, person-centred and trauma informed approaches

The fact that the NDIS only focuses on disability supports – and not psychosocial rehabilitation supports – created confusion for some providers who are still coming to terms with the implications of the change. This was evident in a number of ways:

- Positions classified and remunerated at levels 2 and 3 of the SCHADS Award, yet in some instances the capability expectations are still at a level similar to that of the MHCSS role, for instance to 'provide support to people with complex and multiple needs', and 'understanding of trauma informed care'.

  One example from a Position Description for a support worker stipulated a key responsibility as 'provide direct support and rehabilitation to participants' which involved working with participants with complex and multiple needs, coaching, supporting recovery goals, encouraging self-advocacy, and planning and facilitating groups. This role was classified at level 3, and no minimum qualification level was stipulated.
- Mismatch between what NDIS offers and what providers consider to be *necessary service provision* to adequately meet the needs of the participants with psychosocial disability, that is, the evidence-based recovery-oriented practice that guided their work under the MHCSS program.
- Providers expressing concerns about the gaps in overall service delivery under the NDIS, such as the lack of funded supports for outreach work or pre-planning to support consumers to access the Scheme, and the lack of emphasis on relationship building as an essential part of the recovery work.

There are variations in the ways that providers are responding to the loss of psychosocial rehabilitation supports:

- One provider's response to continue addressing the recovery and psychosocial rehabilitation needs of participants was through the creative restructuring of the workforce to include a range of multi-discipline roles as well Disability Support Worker roles.
- Some providers indicated that they are committed to providing recovery-oriented psychosocial rehabilitation when providing NDIS supports, however they are still exploring what this might look like.

It is telling that under the NDIS Provider Registration guidelines (NDIS 2016b, p 18) mental health support workers (including Peer Workers) are not recognised in their own right, and instead have been grouped under the vocational profession of Disability Support Worker (DSW). Therefore the registration category does not change to accommodate different types of disabilities, it is a generic category. Workers providing NDIS supports to people with psychosocial disabilities are therefore seen as equivalent to other disability support workers in the work they do. This signifies a shift away from a distinctive mental health focus towards a more generalist disability focus.

There is an argument that this dismantling of the MHCSS role allows for a more financially efficient segmentation of skills in which the lower end skills are carried out by lower paid workforce, and the higher end skills are left to specialist and highly qualified workforce. This breakdown of skills is made clear in the NDIS Price Guide by the costing of the different categories of supports:

- Lower level of skill required, as reflected in the core supports category which is funded at the lowest level
- Mid-range of skill required, as reflected in the capacity building supports category
- Higher level of skills required for intensive work, as reflected in supports requiring specialist/professional qualifications, and which are funded accordingly.

Comparison of the MHCSS role functions with the NDIS system of providing supports

"Many people require considerable hours of outreach, engagement and functional assessment activities over an extended period of time to consider and make an NDIS access request. People with mental health conditions can be overwhelmed and/or distressed by the level of complexity that can sometimes accompany making an access request…" (CMHA, 2017b p 11)

A table was produced as part of the data gathering process which attempts to map and compare the key functions of the MHCSS role with the NDIS system of providing disability supports to people with psychosocial disability (see Appendix 1 for the full table).

When comparing how, and by whom, the functions of the work are carried out under the NDIS, it appears that the functions of the MHCSS role do not seamlessly translate across to the NDIS model. Some of the most obvious differences or gaps in the new system are:

Table 1 Comparison of MHCSS role functions with NDIS system of providing supports

Function	Differences
Engagement (or outreach) work	Not included as a funded support in the NDIS price guide. This precludes the opportunity to build a trusting relationship with the consumer prior to exploring their goals. In comparison, this was considered a crucial aspect of the work of the MHCSS worker.
Pre-Planning	No funded support to assist NDIS applicants to prepare for the planning meeting or to assist them to explore and unpack their needs and goals. Some interim measures have been taken to address this gap through the funding of specific short term programs, or by utilising the existing funded programs that have not yet transitioned. However, this gap has been recognised by the NDIA and solutions are being explored, in particular as to how LACs can carry out the function of supporting access to the scheme, as was their original brief.
Planning	General shift in focus away from 'recovery planning' towards having a disability support plan with goals to help achieve greater participation in community, social and civic life, and "to live an ordinary life". However, providers are making creative efforts to continue providing recovery-oriented approaches in their service, for instance having job roles such as 'Mental Health Coach', and continuing to use recovery planning tools. The MHCSS worker had a focus on encouraging consumers' self-determination and self-management of their own *mental health and well-being*, that is, directing their own *lives*. The role of a support coordinator under NDIS is to encourage self-direction and self-management of participants' own *NDIS plans*, that is, their own care plan.
Holistic approach	Where previously the MHCSS worker supported the consumer at all stages along the recovery journey – from outreach to establishing a relationship to supporting the consumer to identify and implement their recovery goals, to working with carers and family and community supports – under NDIS the work is divided up in a more piecemeal approach and focuses only on disability supports. A participant may have a range of workers providing supports: some functions are carried out by NDIA or LAC staff; support coordination is delivered by workers with higher level skills, and must be delivered separately to core supports. Under the NDIS: • No funded supports to work with family and carers • The Support Worker's time is highly structured and task focussed, and restricted by the requirement for 95% direct service delivery (billable hours)
Travel	Limited allocation for 'Participant travel' in participants' plans can impact on workers' capacity to provide supports requiring transporting participants. Provider travel allocation is more restricted under the NDIS pricing arrangements.
Support for workers	Margins in the pricing structure limit the capacity of organisations to offer the same levels of supervision, reflective practice and training previously offered under a block funded model. Consequently this impacts on the quality and safety of the service and ongoing development and wellbeing of the worker.

Implications and issues

- It is still to be determined whether the disability supports offered under NDIS achieve the same recovery outcomes for people with psychosocial disability as previously under MHCSS.
- The shift towards more generalist disability supports, and the loss of the psychosocial rehabilitation focus, impacts on the overall effectiveness and integration of Victorian community mental health service offerings.
- These changes are contributing to the reasons why some workers are choosing to exit the system, to not take up roles under the NDIS, which in turn raises the concern about the loss of highly skilled and experienced mental health workers from the Victorian community mental health sector.

Part 2 Data, Discussions and Findings from Workforce Analysis

Impact on the delivery of psychosocial rehabilitation and recovery-oriented services (cont.)

2.2 Recovery-oriented goals and practice

The following Table attempts to show a comparison of recovery oriented practice according to the Victorian Framework for recovery-oriented practice, with the purpose and goals of the NDIS.

Table 2 Comparison of recovery oriented practice framework with aspects of the NDIS purpose and goals

Recovery-oriented practice in mental health service delivery (Dept of Health, 2011)	NDIS Purpose, goals and practice
Definition of Personal Recovery: Personal recovery refers to a unique personal experience, process or journey that is defined and led by each person in relation to their wellbeing. It is an ongoing holistic process of personal growth, healing and self-determination.	Definition of Recovery: Recovery is about achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from a mental health condition. (NDIS 2016c)
The aim of a recovery-oriented approach to mental health service delivery is to support people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness.	The aim of the funding of supports to participants is to increase their independence, inclusion, and social and economic participation. There are 8 domains which cover the life areas in which goals can be made: Daily living; Home, Health and well-being, Lifelong learning, Work, Social & community participation, Relationships, Choice and control.
Encourages self-determination and self-management of mental health and well-being.	Encourages self-direction and self-management of NDIS plan by the participant. Encourages choice and control over services.
Involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences	Involves tailored, personalised supports that are deemed 'reasonable and necessary' to achieve participants goals for a 'normal' life.
Supports people to define their goals, wishes and aspirations	Supports people to define their goals relating to disability support which build skills and capabilities to participate in the community and employment
Involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education, and employment, and family and social relationships	NDIS funds supports that assist a person to undertake activities of daily living. Such as assistance to build capacity to live independently, and to engage in community activities such as recreation, education, training and employment
Supports people's social inclusion, community participation and citizenship	Supports people's choice and control; and their right to live an ordinary life, and to participate in community and employment.

The NDIS document, 'Psychosocial disability, recovery and the NDIS' clearly spells out the commitment of the NDIS to a recovery-oriented approach,

"We are committed to ensuring that recovery and hope restoring recovery practice are supported for participants with psychosocial disability through the design and implementation of the NDIS." (NDIS 2016c)

Table 2 shows some elements and themes that are common to both the existing recovery-oriented framework and the NDIS. There are common definitions of recovery and underpinning principles of recovery, such as recognising hope and optimism, choice and control, encouraging self-determination, and increasing social and economic participation.

However there are also differences between the two frameworks, in particular the Recovery-oriented approach has a strong emphasis on working holistically, whereas the NDIS has a much narrower purpose and focus on specific goals relating to disability supports. The Recovery- oriented framework has a more holistic focus on encouraging individual's self-management of their mental health and well-being (i.e. their life), compared with the more specific focus of encouraging the self-management of their NDIS plan (i.e. their supports and services).

It is still early days in terms of NDIS roll out, and whether the existing recovery-oriented practice framework remains relevant in the new context will become clearer with time and experience.

Recommendation 1

Development of a new practice model for workers delivering psychosocial supports under the NDIS.

A practice model which distinguishes between delivering psychosocial supports under NDIS, and psychosocial rehabilitation, and can operate within the goals of the NDIS, the restraints of the pricing structure, yet is recovery-oriented and trauma informed, and recognises the distinct needs of people with psychosocial disability.

Recommendation 2

The development (and implementation) of an evaluation framework to determine the recovery outcomes for NDIS participants with Psychosocial Disability.

3. Workforce and new job roles

3.1 Workforce profile

According to the VICSERV Capability Framework Survey Report, (2017) the profile of the Victorian MHCSS workforce prior to the rollout of the NDIS indicated that:

- 75% were female
- 60% were over 40 years of age
- 90% had a Diploma or higher qualification

In the new environment of 'Choice and Control', participants receiving NDIS plans are now able to request support workers with specific characteristics, skills or interests which better align with their own needs and interests. Hence providers are finding that they will need a more diverse workforce in order to respond to customer demands.

The diversity needed also extends to the value base and attributes of the worker. The differences in the new service delivery and work models required for the NDIS are presenting professional conflicts for some of the mental health workforce who are facing the prospect of transition to NDIS. Core aspects of their role

Part 2 Data, Discussions and Findings from Workforce Analysis

Workforce and new job roles (cont.)

and professional training, and in some cases the value base from which they work are being challenged. One Coordinator of a PIR program explained that some of her workers were resigning even before the NDIS roll out because of this perceived difference:

"These workers are saying that they don't want to work in the NDIS environment because they believe in the importance of the relationship and the holistic, recovery approach".

According to some managers, the transition to NDIS represents a 'shift in thinking', which is much harder for the existing mental health workers to make than for workers entering the NDIS without the MHCSS legacy.

"Experienced mental health staff have had the most difficulty adjusting to the new way of doing things" (Manager)
"The whole change to the NDIS system can be difficult for staff who are trained in a specific way…" (Manager)

Implications and issues

- The new models of working required under the NDIS may not be seen as appropriate or desirable by portions of the traditional mental health workforce who are committed and trained to work within a recovery-oriented rehabilitation framework.
- Workforce requirements for providers delivering NDIS supports for people with psychosocial disabilities do not fully align with the previous MHCSS workforce profile, and hence:
  - Providers in the process of transitioning may not be able to reposition all their workforce under the new system, or afford to remunerate them at the same levels
  - The mental health sector stands to lose parts of its experienced and skilled mental health workforce as a result of the full roll out to NDIS.
- The NDIS workforce profile will need to be more diverse than the profile of the traditional MHCSS workforce, especially in terms of gender and age balance.

3.2 Support Coordination

Support Coordination was identified by mental health providers as one of the NDIA support categories most 'relevant' or closely aligned to the MHCSS and PIR roles and level of skills and expertise. The support items within this category that are most likely to be included in the plans of participants with psychosocial disability are

- Support connection (funded at $57.71/ hour)
- Coordination of Supports (funded at $94.06/ hour)

The NDIS Price Guide for Victoria (NDIS 2017 p 45) defines the three types of supports included under Coordination of Supports as:

Support Connection is time limited assistance to strengthen participants' ability to connect with informal, mainstream and funded supports, and to increase their capacity to maintain support relationships, resolve service delivery issues, and participate independently in NDIA processes.

Support Coordination is made available to those participants with higher needs than those receiving support connection. It provides:

"Assistance to strengthen participant's abilities to connect to and coordinate informal, mainstream and funded supports in a complex service delivery environment. This includes resolving points of crisis, developing capacity and resilience in a participant's network and coordinating supports from a range of sources".

Specialist support coordination (the highest funded support in this category) is reserved for participants with intensive needs involving situations of complexity and high risk, and must be delivered within a specialist therapeutic framework. NDIS documentation stipulates that this support will be rarely allocated.

Support Coordinator Job Role

All the providers interviewed in this project indicated that they would be creating Support Coordination positions under the NDIS with the hope that this would assist them to continue the work of providing psychosocial supports, and provide somewhat equivalent job opportunities for their existing mental health workforce. For a generic profile of the job role for Support Coordination see appendix 2.

Some providers saw this role as a significant part of their service delivery model, and are relying on, or have expectations that the support coordination income stream will continue.

However, all interviewed providers are showing caution about the future of support coordination by only offering fixed-term contracted positions for Support Coordination roles. The caution is based on the strong indications given by the NDIA that this support is time-limited and will not be built into participants' second year plans.

"… the NDIA intends for approximately 20-30 per cent of NDIS participants to receive funding for support coordination. Other participants will receive support via their LAC. It is understood that some regions in Victoria may currently have a higher percentage of participants with support coordination, and for this reason providers may need to expect a reduction of support coordination in plans in these regions. These may include NEMA and Barwon." (National Disability Services 2017)

So even though providers see the Support Coordination role as similar, the focus of the role is different to the MHCSS and PIR roles in that it is no longer a specifically defined mental health role. This role is a generalist capacity building role applicable to participants with any disability. What becomes obvious by looking at a number of position descriptions for Support Coordinators is that the mention of 'provision of psychosocial rehabilitation supports' or 'recovery oriented mental health' is minimal and only occurs in some PDs, namely those of providers who have chosen to continue to promote themselves as specialist mental health services.

Support Coordination roles, according to the training offered by Disability Services Consulting (DSC), should be mainly focused on capacity building; building the capacity of participants to self-direct and manage their own plans, and develop strong networks; it is meant to be a 'time-limited' relationship (DSC, 2017).

Support Connection may be made available to the participant in their first plan, either through direct LAC support or via an allocation in the participant's plan. Support connection is made available to support the participant to learn how to:

- Activate their plan (i.e. link to service providers)
- Monitor quality and spend of services
- Manage flexibility within the plan
- Prepare for review
- Address barriers to participation, and resolve service delivery issues

However, support connection will *not* be funded in regions which have a contracted Local Area Coordinator (LAC), as this function will fall under LAC responsibility. Even when funded in a participant's plan, the allocation is not high (although there is variation across plans) and often only a total of 10 hours ($565) is funded for the entire plan.

Implications and issues

- Given that the focus and outcomes expected when delivering Support Coordination are clearly spelled out by NDIA requirements, the job role is quite definitive, and there is very little room for providers to deviate from this role when developing their own job descriptions.
- Given the capacity building emphasis and the 'time-limited' nature of this support category, and the low allocation of hours for support connection, it could be concluded that the emphasis of the work is not on the development and maintenance of the relationship with the participant. This represents a significant shift away from the important emphasis given to developing trusting relationships within the MHCSS psychosocial rehabilitation approach.
- This has implications for the future of the community mental health sector workforce as the clearly defined mental health role with a recovery-oriented psychosocial rehabilitation focus is diluted, or subsumed into a generalist disability role within the disability sector. (See Section 2 on Impact on the delivery of recovery-oriented psychosocial rehabilitation)
- It may also mean the loss of significant parts of the defined, State-based, community mental health workforce and services.
- It is yet to be seen what the impact on service delivery models and workforce numbers will be if support coordination allocations in participants' plans drop after the first year.

Part 2
Data, Discussions and Findings from Workforce Analysis

Workforce and new job roles (cont.)

3.3 Direct support worker role

All the providers interviewed in this project indicated that the position of Disability Support Worker (DSW), or sometimes called Support Worker, would make up the bulk of their NDIS workforce. (See Appendix 3 for a generic profile of this job role). This position delivers 'core' supports. These generalist disability supports include:

- Assistance with daily living
- Transport
- Assistance with social and community participation

Key findings from the data collected about this job role indicated that:

- The DSW role is clearly about the provision of 'generalist disability supports'.
- There is a loose expectation that workers will have a Certificate III level qualification, although some providers are asking for Certificate IV. Minimum qualifications for this role are not stipulated, however in their advertised position descriptions, some providers are asking for a minimum of Certificate III in a relevant disability or community qualification.
- The DSW job role is generally classified at Level 2 or 3 of the SCHCDS Award, compared with the MHCSS job role which was classified at Level 4 or 5.
- Workers' conditions for the new role are very different to the MHCSS role:
  - part of a mobile team
  - have a more autonomous role, primarily working alone
  - expectation of 90 -95% client contact (billable) hours
  - less opportunities for support, training and supervision
  - casual or contracted position
  - lower skill requirements and hence lower classification
  - must have own car for work use
- Organisations are finding new strategies to address the challenge of the changing workforce demand. Two managers who were interviewed, advised that during the period prior to transition, their organisations had implemented a strategy of using the natural attrition of the workforce to employ replacement workers under different conditions more aligned to the future NDIS workforce requirements. This included offering limited contracts and reshaping the position descriptions to better suit the future requirements of the NDIS workforce, hence when it was time to fully rollout, it would be easier to reposition these workers into NDIS positions.

Implications and issues

The significant differences in role, classification and conditions of this role compared to the previous MHCSS role are likely to act as disincentives or barriers for experienced and highly skilled workers to take up these new roles under NDIS. In the long term, this may see a trend in providers employing less skilled and less experienced workers which has implications for the quality and safety standards of the services offered. There is a concern that although workers will have adequate skills to provide 'core' support work, in situations requiring a deeper understanding of mental health or complexity issues, their knowledge and skills may prove inadequate. This increases the safety risk for both workers and participants.

The nature of the job roles required for the delivery of NDIS disability supports indicates a shift away from a distinctive mental health focus towards a more generalist disability focus in which the 'market' drives the role of the worker and the focus of the work.

3.4 New recovery focused mental health roles

Not all providers are limiting themselves to the two main roles of 'Disability Support Worker' and 'Support Coordinator'. Instead, after focussed consultations with the consumers and carers using their current services, they created roles which were not purely determined by NDIS price guide, and which reflect the mid-level range of skills previously used by MHCSS workers in delivering psychosocial rehabilitation supports. These roles include peer education, group work, and mental health mentoring and coaching using recovery focussed approaches.

3.5 Role of first-tier Managers

Even though this was not part of the main research focus, the impact of the NDIS on the role of frontline managers was raised as a concern in a number of interviews, and warrants further exploration. Major change is anticipated to occur in the role of the first tier of managers (coordinators, team-leaders, operational managers). These changes may include:

- Shift in focus and culture to a more business and commercial focus
- Shift away from a clinical supervision role towards a more operational management role within a competitive commercial environment
- Having a higher ratio of staff to manage (1:25 was indicated by a number of managers), and at the same time have less resources to offer support and supervision to a mobile team of workers.
- New responsibilities for performance managing staff, developing service agreements, service bookings, rosters, and ensuring billable targets are met.
- In some cases their job classification may be lower.

"Managers who support or coordinate front line workers will have significant changes to their responsibilities and roles under the NDIS system. They may have more responsibility to manage work rosters, oversee invoices for billable hours, ensure accountability requirements are met, as well as monitoring staff performance in reaching targets." (Manager)

Implications and issues

Anecdotal evidence and the findings of this research indicate that the new management roles will be different and may have the following implications:

- Some managers may opt to leave
- There may be a reduction in management positions as organisational structures become flatter
- Stress and pressure on managers is likely to increase
- There may be a need for re-skilling of managers in areas of: managing and supervising mobile teams, performance management, using technology for supervision and support, working in a business/ commercial environment, business leadership skills, complaints management, and building resilience.

Recommendation 3

The development and provision of new learning and development products to support managers and supervisors of the NDIS workers providing psychosocial disability supports, in their adaption to the new NDIS operational environment and associated business process requirements.

This may require further consultation with providers delivering psychosocial supports to better determine systems and practices needed to deliver effective management in the new environment.

Part 2
Data, Discussions and Findings from Workforce Analysis

Workforce and new job roles (cont.)

3.6 Peer Workers

Even though a number of the organisations interviewed clearly have a commitment to employing people with lived experience and can see the value of peer work in supporting participants with psychosocial disability, the NDIS does not explicitly recognise peer work as a distinct approach for supporting people with psychosocial disability. Peer work experience and qualifications are acknowledged as relevant prerequisites for delivering NDIS supports according to the NDIS Guide to Suitability, however peer workers are classified as another type of Disability Support Worker who can deliver generalist supports. Providers did not see this as a true reflection of the unique role that peer work could play in supporting people with psychosocial disability, such as the intentional use of lived experience of mental distress to inspire hope and recovery.

In response to the question about whether there is a place for peer work in the new system, interviewees gave a mixed bag of responses:

"NDIS has muddied the waters where peer work is concerned, it has been diluted to become a Disability Support Worker."

"We have a commitment to peer work, but as a distinct way of working." This organisation held a definition of peer work distinctly different to what they saw as possible within the new system.

The NDIS provides entry level opportunities for the voluntary peer workforce to gain entry into the mental health field.

"We definitely hope to include paid peer work positions as part of our NDIS offerings".

"We see Peer Work as a unique 'product' to market within the NDIS".

One Manager indicated that a "lack of understanding of the peer model by NDIA staff" contributed to a reduction in the number of peer work positions in their workforce post rollout.

Some position descriptions highlighted that people with lived experience were encouraged to apply for the main NDIS support worker roles, more so to encourage diversity in their teams rather than for specific peer work roles. However, a number of providers expressed a strong commitment to insuring peer workers have a place in the new system, however they were not yet sure of how that would occur. Other providers saw Peer Work as an opportunity to offer a distinctive or specialist product to customers.

Implications and issues

The reduction in peer-work specific roles resulting from the roll-over to NDIS, coupled with the likely reduction in training budgets for providers, could seriously impact the growth and development of the qualified peer workforce. Recent years have seen the introduction of the Certificate IV in Mental Health Peer Work and the beginnings of growth of a qualified peer workforce. At this stage the qualification is only available to those currently employed as mental health peer workers, and hence any reduction in opportunities for peer work roles will reduce access to this qualification.

On the other hand, the NDIS has the potential to create more opportunities for people with lived experience to gain work as Support Workers; to gain entry to the mental health/ disability workforce. However, this is quite different to generating opportunities for an increase in peer work roles in which workers are specifically engaged in providing peer work related supports, role-modelling and sharing of lived-experience. Peer workers in the NDIS are required to meet the same working arrangements and KPIs as any other DSW.

Recommendation 4

The impact of the NDIS on the peer workforce is monitored to determine any:

- New workforce trends occurring both within the NDIS space and more generally in mental health providers
- Tensions between employing a 'lived experience' workforce and a 'peer work' workforce.

Recommendation 5

The NDIA and the community mental health sector to explore the potential, and clearly articulate the role of peer work within the NDIS as a unique way of working.

3.7 Exiting Workforce

There is no one pattern emerging from this analysis relating to the retention or loss of workers in the transition process. There are many factors influencing this process which differ greatly between organisations and contribute to how, and how many of the workforce can be repositioned, and the likelihood of existing workers choosing to take up new roles. Some of these factors include whether the organisation was a trial site, how the organisation restructured itself in preparation for the NDIS, the size of the organisation, and industrial relations issues such as existing Enterprise Bargaining Agreements.

It was very difficult to get accurate numbers of MHCSS workers not transitioning to the NDIS (whether by choice or redundancy) due to the fact that organisations are at different stages in the transition process and are facing many unknowns in terms of future revenue, how many staff will be needed and for what roles.

In response to the interview question "What percentage of your pre-NDIS MHCSS workforce did not (or will not) transition to the new system?" a varying range of responses were given from 'Not sure', through to the 'hope that 100% will transition'. Some examples of responses include:

"We are still transitioning and it is not yet know how it will pan out; there are lots of variables, partly dependant on income"

"60% of the original staff did not transition to the NDIS system, primarily because of the significant change to the work role and classification"

"None of the workforce transitioned across. Staff were offered a change in contract but decided to move on."

"… of the 21 existing staff, I estimate that only about 6-8 will transition to the new system"

Overall, the general feeling was that more workers will opt to leave than to transition to the new system. The reasons given for exiting, or considering it, included:

- Organisation cannot provide 'equivalent' positions for all staff
- Changes to the work role and classification are not considered acceptable by workers
- Workers not prepared to compromise their values and commitment to an holistic and recovery-oriented way of working
- Career paths in NDIS system are limited
- Workers want positions that offer more security
- Some see greater financial reward in registering as private practitioners

Loss of mental health expertise from the sector

Across many interviews, examples were given of workers already leaving the sector in search of better work opportunities even before the full roll out of the NDIS. The reality that many of the MHCSS workforce were qualified at Diploma or higher levels suggests that they are most likely overqualified for the 'Support Worker' roles and less likely to find them attractive employment options. On the other hand, the Support Coordination roles are more suited to their qualifications and experience, but there will be far fewer of these roles available and they do not necessarily offer long term job security. Hence the potential for many of the higher skilled mental health workers leaving the sector is a reality.

There is an impact of the NDIS pricing structure and its relationship to qualified mental health staffing, with a seeming misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports. Therefore, retaining a highly qualified mental health workforce for the NDIS is a concern. (CMHA 2017 p 4)

Part 2 Data, Discussions and Findings from Workforce Analysis

Changes to skill and qualification requirements

Implications and issues

The potential loss of mental health expertise from the sector will impact on the capacity of the future workforce to continue to provide quality psychosocial disability supports, which may in turn impact on providers' capacity to offer supports to those who need them. This is of particular concern in regional and isolated areas where the numbers of providers are limited, and the demand for skilled workforce is high.

The potential loss of the existing highly skilled and qualified MHCSS workforce is particularly concerning in an environment which offers less opportunities for replacing them and for upskilling new workers. Historically, providers' commitment to the ongoing training and development of workers has been an essential component in the creation of a workforce highly skilled in delivering recovery-oriented psychosocial rehabilitation. This further supports the recommendation on New Worker Upskilling (see Recommendation 10).

Recommendation 6

That the Victorian Government lead and support efforts to retain the capabilities of the exiting mental health workforce, not transitioning to NDIS, allowing them to be retained within the broader community services and health sectors.

4. Changes to skill and qualification requirements

4.1 Minimum qualification requirements

The *NDIS Provider Toolkit – Module 4 Guide to Suitability* (NDIS 2016b) outlines the quality, safeguarding and compliance obligations of providers of supports funded through the NDIS. This includes the minimum registration requirements for providers delivering particular 'Registration groups' including the specific qualifications and experience required by people providing the supports. During transition and until existing arrangements are fully replaced by the National Quality and Safeguards Framework, providers of NDIS supports are required to comply with existing Commonwealth, State and Territory standards and legislation. This Framework was released in February 2017, and a range of protections are currently being developed as a result. However, the Framework does not stipulate mandatory qualifications as these were considered inappropriate for this framework for a range of reasons.

According to the NDIS Guide to Suitability (2016), support connection and coordination of supports (excluding the intensive level) can be delivered by a range of professions including Disability Support Worker (which includes Mental Health Worker and Mental Health Peer Worker), Welfare Worker, and Social Worker. The registration groups stipulated to deliver Core Supports are Disability Support Workers (which includes Mental Health Worker and Mental Health Peer Worker), and Welfare Workers.

So technically, it is possible for someone with a Certificate III in Disability – with no experience or understanding of psychosocial disability or recovery to be employed to deliver core supports to a participant with psychosocial disability. This has implications for quality and safety.

With these requirements in mind, the onus falls on the provider to determine what level of qualification they are prepared, and able to pay for, whilst balancing this with the experience and skill levels required to deliver quality supports to participants, especially those with more complex needs.

Certificate III in Individual Support

The Certificate III in Individual Support had little prominence in discussions around qualifications or pre-requisites, nor was it indicated specifically in any positions descriptions for Support Workers. This could be because it is a relatively new qualification, or because its main focus is on disability, aged care and community care and hence is not seen as relevant for mental health work. However, two position descriptions did specify generally that a Certificate III level qualification (mental health, disability or aged care) was the minimum requirement.

However, two regional managers commented on how the local TAFEs are delivering the Certificate III in Individual Support and promoting it as an opportunity to gain employment with NDIS providers, especially for young people. One manager commented that the institution is "pumping them out", but he thought the graduates were not suitable – "We won't even offer them placements".

In contrast to this, another provider indicated that they would be looking to the local TAFE as a potential source for recruiting new workers, in particular the Certificate III and IV graduates.

Another manager stated that the Certificate III level of training was not adequate for working with participants with psychosocial disability. This comment supports the need for additional unit/s in the Certificate III in Individual Support which focus on psychosocial disability (refer to discussion under section 6.4 of this report).

Implications and issues

The flexibility in the vocational focus and levels of qualifications deemed suitable for delivering NDIS supports, could present a challenge for providers in light of the requirements set out in the NDIS Code of Conduct-Discussion Paper (Dept of Social Services 2017a). In particular ensuring that workers have the right skill set and knowledge to work with participants with psychosocial disability.

The Code of Conduct stipulates:
"2.4 Provide supports in a safe and ethical manner with care and skill"

This obligation includes the following expectations:

- A provider or worker must maintain the necessary competence in the types of supports and services they provide.
- A provider must offer reasonable supervision and take reasonable steps to ensure workers are competent and supported to perform their role"

(Department of Social Services 2017a, p22)

Recommendation 7

Development of new supervision models to meet the needs of a mobile workforce working with people with psychosocial disability.

4.2 General skill requirements

Support Worker (delivering NDIS core supports)

- According to a number of providers, participants are indicating that the support workers' skills and experience as mental health practitioners are less important than their 'likeability', personality or interest in similar activities. Other providers state that participants place more emphasis on the quality of the relationship they have with their workers rather than what qualifications workers hold. Given the emphasis on participant 'choice and control' within the NDIS, and the participants' right to pick and choose, some providers are indicating that the requirements of the 'customer' need to be given priority.
- Data gathered from interviews and PD analysis identified the following skills as requirements for the Support Worker role:
  - Ability to develop and maintain professional and trusting relationships
  - Self-management and time management skills
  - Ability to identify and manage risk (mentioned often)
  - Drivers licence (and willingness to use own fully insured car for work purposes)
  - Ability to work autonomously
  - Customer service
  - Customer-friendly and customer-focussed
  - Ability to manage boundaries

Part 2
Data, Discussions and Findings from Workforce Analysis

Changes to skill and qualification requirements (cont.)

Support Coordinator

The skill requirements for the Support Coordination role align in part with the skills of a care coordination role, in particular with the Partners in Recovery (PIR) role. Skills include:

- capacity building
- knowledge of disability and mental health service systems and how to navigate the support system
- person-centred strengths based planning

However, there are additional skill and knowledge requirements which relate specifically to the NDIS, such as:

- In depth understanding of NDIA service model, purpose of the NDIS, NDIS legislation and rules made under the NDIS Act
- Understanding of NDIS Price Guide and the flexibility within the price guide
- Understanding of what constitutes 'Reasonable and Necessary'
- Knowledge of informal, mainstream and community supports.

5. Changes to work structures and processes

As discussed earlier in this report, providers are saying that they need to create new service delivery models to better respond to the requirements of the NDIS system. This also requires corresponding changes be made to business models, work practices, workforce requirements, business systems and infrastructure (Tobias, 2017).

5.1 Work Model

Some examples of the changes that providers identified as impacting on workforce and work structures, include: tighter management margins, increased ratio of workers to managers, less travel allocation, increase in percentage of workers' time spent on direct service delivery (billable hours), and greater focus on marketing to customers. These are influencing the way providers are employing and deploying their new workforces.

There is a definite shift towards a mobile workforce, and moving away from office-based systems, with some providers indicating the need to downsize their office space. Of the organisations interviewed, 90% indicated that the workforce delivering core supports under NDIS had, or would, become a mobile workforce with dramatically reduced office contact. This is directly resulting from the unit pricing of core supports which has very slim margins for anything other than direct service delivery tasks.

Similarly, there was a significant shift towards front line worker positions being offered as casual or fixed-term contracts. In particular the direct support worker positions tend to be offered on a causal basis, whereas Support Coordination positions are more likely to be fixed–term contracts.

However this may prove to be a temporary measure as these temporary positions were mostly offered in reaction to the uncertainty during the transitional period. Providers are unsure of exactly what the volume of work and income levels will be, hence resorting to the use of contracted or casual positions as an interim measure.

Other identified changes to the work model:

- Need for more flexible service provision across evenings and weekends
- Increased use of mobile technology, such as tablets and apps (in lieu of being office based)
- Staff allocated by geography rather than suitability, especially in rural areas where distance and lack of provider options are factors.

Workers conditions have changed and it could be argued that this includes a loss of some conditions. The most common changes indicated in all interviews, and backed up by data gleaned from a range of position descriptions across many organisations, are:

- mainly casual or contracted positions
- requirement of the job to use own car for work purposes
- more likely to have to work flexible shifts (evenings and weekends)
- lower classifications
- less supervision and training, less opportunity for debriefing
- DSW role is more solitary/isolated
- some providers requiring workers to supply their own mobile devices (tablets or smart phones).

In its submission to the Productivity Commission's inquiry, the Health Services Union warned that a stripping of worker conditions was already under way in the sector. It stated that

"Individualisation of supports, coupled with low and capped pricing, is eroding workforce conditions and increasing income insecurity". (Quoted in Creighton, 2017)

5.2 New Challenges

Providers are recognising new challenges arising from the new business and service delivery models, and beginning to explore a variety of ways in which to address these. These challenges include:

- How to continue to deliver quality, recovery-oriented services
- How to ensure the safety of workers and customers
- How to continue to provide effective support, supervision and professional development to a mobile workforce, within a tight budget
- How to manage travel logistics and costs.

Safety of Workers

The safety of workers was raised as a concern by the majority of those interviewed, and also figured strongly in the literature. The concerns centred around a combination of factors, such as:

- New job roles may not attract highly skilled workforce with mental health experience
- Less skilled workers working alone in participants' homes
- At times workers are going into new situations with very little information about the participant or their background
- Less opportunity to provide debriefing or support to mobile workers
- Core supports only require lower skilled workers (and are priced at lower level) yet the participant's situation may be one of complexity and high needs
- Less opportunities for professional development and training.

One provider indicated that in future they may not be able to accept clients who have high levels of complexity and risk, because the pricing arrangements do not allow for sufficient resources (namely highly skilled staffing) to respond appropriately to these clients' needs.

The newly developed NDIS Code of Practice which is currently under discussion, clearly outlines the responsibilities of providers regarding issues of safety for staff and participants. Section 2.2 of the Code, stipulates the requirement to "Actively prevent all forms of violence, exploitation, neglect and abuse", which includes the following expectation:

"Providers need to ensure their staff have appropriate supervision and training to make sure workers are able to identify, monitor and act when situations arise which could lead to harmful incidents." (Department of Social Services 2017a p 16)

One common strategy being implemented to partly address these challenges, is the use technology such as apps for portable devices to provide support, monitoring and safety measures. Some of these are 'Staysafe', 'VisiCase', and a cloud-based Rostering system, EmpLive, which can be accessed via any tablet.

Some providers are developing more integrated and carefully thought out models which address a range of the challenges by doing things in new ways, such as using a call centre model as a central admin and staff support function. However, these providers have invested substantial resources and time to develop these creative new models. For other providers, their models are still unfolding and they are learning as they go.

The experiences of a NSW organisation, Flourish, which was part of the Hunter trial site showed that many of the workforce challenges presented by the NDIS are not insurmountable, according to an article by the General Manager, Ms Joanna Quilty (Quilty, 2017). Quilty outlines how her organisation has embraced and risen to the challenges of the commonly voiced concerns, such as "… that the NDIS will result in casualisation of the workforce, that it will mean lower wages and lower quality services, that it will be increasingly difficult for organisations to attract and retain high quality staff…". They have progressively addressed these challenges through a continuous process of trialling new approaches.

Some of their innovations included:

- Innovative recruitment processes to better

Part 2 Data, Discussions and Findings from Workforce Analysis

Changes to work structures and processes (cont.)

match people for specific jobs

- Greater use of technology and online resources to assist in staff support, connection and guidance
- Evolving a new workplace culture with less reliance on meetings, attendance at the office and face to face communications.

Implications and issues

- Increased workforce instability due to the need to employ people on casual or short contracted basis.
- Reduced likelihood of attracting a highly skilled workforce with mental health capabilities, potentially resulting in a long term de-skilling of the workforce.
- The new commercial environment brings with it an increase in competition and proprietary knowledge amongst providers, and a decrease in the sharing and evolving of best practice across the sector, as per historical practice.
- A re-skilling of management staff will be needed, in particular those who will be managing larger and more mobile teams, working under a new culture and business model, and facing challenges in providing support and supervision to staff.
- Ensuring safety of the mobile workforce may present challenges to providers.

Recommendation 8

Strategies for mitigating risks associated with an increasingly mobile workforce be implemented, such as safety and risk management training for the new or less skilled NDIS support workers employed to deliver supports to participants with psychosocial disability.

6. Training & Preparation for transition

Gaining detailed information from providers about their workforce training needs under the NDIS proved difficult for a number of reasons:

- So much about the future job roles still remained unclear for almost half of the providers interviewed, primarily because they were still in the preparation stages of transitioning, but also because they were facing so many unknowns.
- Training needs for a future workforce were not high on providers' agenda; they were still grappling with the implications of the massive reforms under NDIS, coming to terms with what the NDIS will mean to them organisationally and operationally.
- The existing mental health job roles do not translate readily to the new NDIS roles in terms of work role, and skill classification level, hence determining training need gaps is difficult.

"Previously training had been a process of ongoing development and improvement; now training is targeted at building up key skills as needed." (Support Worker)

6.1 Findings of Training Audit

The audit of existing training packages and resources looked at three categories of training and resources:

1. Training to support the existing workforce to transition to NDIS
2. Ongoing training specific to the new workforce
3. Relevance of existing training offerings to meet the needs of the emerging workforce

6.2 Training and resources to support the existing workforce in the transition to NDIS

External Training Offerings

There has been a proliferation of training programs in Victoria to help prepare organisations for the transition to NDIS, many of these being offered by National Disability Services (NDS) and NDIA, as well as additional providers coming on board, such as Disability Services Consulting (DSC).

The following table shows a breakdown of the training offerings according to the focus of the training and the intended audience.

Table 3 – Training offerings for transitioning providers and workforce

Focus of training	Audience	Number of training offerings
Supports Provider transition and NDIS 'readiness': Focus on preparing for change at levels of governance, finance, leadership, business and workforce planning	CEO, Executive managers, operations managers, HR, and leadership teams.	20
Support Coordination (Introductory focus, as distinct from 'practice' focus)	Support Coordinators	2 + online articles
Supporting frontline workers in the transition to NDIS (excludes support coordination training)	Frontline support workers	2

From the NDIS training identified, it is evident that:

- All the training offerings which are NDIS related are geared towards 'disability'; no distinctions are made between types of providers or the 'disability-focus' of their services. There are no training or resources that focus specifically on the transition needs or issues specifically relating to mental health or psychosocial disability.
- The training offerings are primarily focussed on the corporate and governance levels of organisations (20 compared with 4 for frontline workers) assisting them to become NDIS ready in the areas of business and governance, leadership, workforce and finances.
- Training for frontline workers initially focussed on Support Coordination. However in recent times new workshops have been developed by DSC and NDIA focusing on the basics of NDIS for frontline workers.

When asked what would have helped workers better prepare for the transition to NDIS, interviewees suggested that the fundamental training needs were an understanding of:

- NDIS processes and systems, language and terminology
- NDIS plans and price guide.

Since conducting these interviews this need has been partly addressed by the DSC developing and delivering new training workshops and webinars, such as 'ABCs of the NDIS' and 'NDIS Price Guide: 101'. However this training is NDIS-generic, and does not fully address the needs in a psychosocial context.

Even though new training offerings are continually emerging to better support the frontline workforce in understanding the NDIS system, processes and specific tools, this only partly addresses the needs of the transitioning mental health workforce. Comments from the sector repeatedly express that the existing

Part 2
Data, Discussions and Findings from Workforce Analysis

Training and preparation for transition (cont.)

'readiness' workshops are geared to general disability and so workers are left not fully comprehending the implications of the changes to the mental health workforce and the specific delivery of psychosocial rehabilitation supports.

"The NDS training didn't go into any real depth about the psychosocial disability aspects of the NDIS. As this is still an emerging part of the NDIS we are having difficulty finding professional development training that supports practice." (Project Worker, Eastern Region)

Recommendation 9

Development and provision of new learning and development products to prepare and orientate the existing Victorian community mental health frontline workforce ahead of the transition to NDIS, with a focus on exploring the differences at both the system and practice levels resulting from the transition.

Organisational responses to transition support needs of their workforces

Organisations are responding to the transition needs of their workforces in a range of ways:

- Change management strategies
- Encouraging staff to make use of the NDIS training and PD available offerings
- Providing internal training programs on Care- coordination, NDIS pricing and Dealing with Customers
- Engaging external providers to do in-service training on support coordination and translating plans into practice
- Recognising that some of the workforce will potentially not transition (either by choice or necessity) and supporting staff with additional upskilling to increase their employability in the job market

A number of managers interviewed noted that some MHCSS workers struggled with the significant 'shift in thinking' that was essential for adapting to the new individualised system and commercial model.

In addition to this, anecdotal evidence indicated that pockets of the existing mental health workforce are feeling overwhelmed, insecure, and/or confused about what the new changes will mean. In some instances, these workers (and providers) have been through (or are currently experiencing) other significant organisational changes which may still be impacting and compounding the effects of the NDIS changes.

A number of managers from organisations in the early stages of preparing to transition to NDIS, expressed their frustration at the lack of clear, accessible, and accurate information for frontline mental health workers. Some of the specific questions needing answers included:

- What does NDIS mean for the provision of recovery-oriented psychosocial rehabilitation?
- What will the new roles look like?
- How will the role be different in delivering psychosocial disability supports?
- How will service provision be different?
- What are the 'shifts in thinking' required to be able to adapt to the new ways?

Responding to these needs had proved difficult for many providers in the early stages of the NDIS rollout due to the lack of accurate information available, the constantly changing landscape, and the fact that the implications of the changes for the MHCSS workforce and delivery of psychosocial rehabilitation had not been explored in great depth.

Implications and issues

More needs to be done to support providers to meet the transition needs of frontline MHCSS workers in the initial stages of the transition process, in particular providing accurate and definitive information, exploring implications for work roles, and practice, and talking through the changes to values, culture, service delivery and work models. Although this could be seen as an organisational responsibility, it also has broader, sector-wide implications. This further supports the rationale for Recommendation 9

6.3 Ongoing training and development needs of the new workforce

Current situation for CMMH Providers

The general impression from interviewees was that future training and professional development needs were not on the agenda at the moment, especially for those providers still in the process of transition.

Providers indicated that they anticipate not having the budgets to provide the same level of training and professional development under NDIS that they previously offered to all staff. Neither will there be the same opportunities for ongoing development through supervision and reflective practice. Regular practice supervision, critical reflection and professional development, to date, have been essential elements of ensuring quality and safe service delivery and upholding a culture of continuous improvement.

"We won't have the budget to continue providing the levels of training, supervision and reflective practice that we would like." (Manager)

Previously, organisations had a strong culture around providing all workers with opportunities for a range of in-house and external training on Recovery, Mental Illness awareness, Applied Suicide Intervention Skills Training, Challenging Behaviours, Managing Risk, and Dual Diagnosis. For some organisations this was considered mandatory training for new workers.

Some expressed concerns about what the future implications of the reduction in training would mean for the quality and safety aspects of their service delivery, and for the skill development of future new workforce. There was particular concern about their capacity to upskill future new graduates and peer workers who traditionally received significant training and professional development on the job.

In addition, it was commonly agreed that the old training delivery models would no longer be appropriate or affordable. Providers stated that they are unlikely to send workers to all-day training programs (especially if it involves travelling distances), they would not be able to afford to backfill workers on training, and that traditional training providers may need to find more accessible and lower cost training offerings if they are to continue to be competitive.

"We will need to look at new models of training as the old ways are too time intensive. Maybe just have shorter training, online, using snippets of existing training or addressing only the most crucial aspects of need." (Manager)

Implications and issues

- Future training delivery models will need to address barriers of accessibility, cost and time-restraints if they are to remain responsive and relevant to the new requirements within the NDIS environment.
- Given the likelihood of providers losing a proportion of their skilled workforce, and consequently needing to recruit new workers to provide psychosocial disability supports; and given that these new workers will not necessarily have experience or training in mental health capabilities, the ongoing upskilling of their new workforce will be a necessity. In particular to ensure the ongoing quality and safety of services the new workforce will need to be competent in mental health capabilities, especially when working with people with severe and complex psychosocial disability. This may require an adaption of the existing training products and their delivery models to reflect the NDIS environment.

Recommendation 10

That new workforce entrants (without mental health experience or training) receive training and ongoing professional development to ensure they have the necessary mental health knowledge and capabilities to operate within the NDIS environment and to provide supports to people with psychosocial disability.

Part 2
Data, Discussions and Findings from Workforce Analysis

Training and preparation for transition (cont.)

Resourceful responses to offering training, professional development and supervision

Managers consistently expressed concerns about the challenges presented by the pricing structure of NDIS supports to adequately cover the costs of training and ongoing development activities including supervision. However providers are clearly committed to trying to find ways to continue offering training opportunities by exploring a range of solutions including technology and online platforms, offering more training online, group supervision sessions, and putting the onus on individual workers to undertake and pay for their own professional development.

Current training options for the new workforce providing psychosocial supports under the NDIS

Table 3 Training offerings for the new workforce operating under NDIS

Focus of training	Audience	Number of training offerings
Support Coordination (Practice- focussed)	Support Coordinators	5
Hazard Identification and Control in an NDIS environment	Frontline support workers Frontline Managers	1
NDIS Price Guide	Frontline Managers Support Coordinators	**1**
Certificate III in Individual Support (Pre-vocational)	Disability Support Workers	1 (delivered across many training providers)

Training needs for new workforce supporting participants with psychosocial disability

Under the NDIS, mental health providers are not the only ones providing support and working closely with participants with psychosocial disability. A new workforce of Local Area Coordinators (LACs) has emerged who will be responsible (amongst other things) for the development of plans for participants; a role previously the responsibility of MHCSS workers under the old system. LACs will conduct the initial planning meeting with participants regardless of the presenting disability. Organisations and participants have raised concerns that planners do not necessarily have adequate knowledge of the nature of mental illness and psychosocial disability which can potentially result in inappropriate plans. LACs and Planners could also benefit from knowledge of the types of support previously provided to people with mental health conditions, and the importance of recovery and trauma based approaches.

In August 2017, VICSERV was approached by NDIA Vic North to develop and deliver a pilot training package for LACs and Planners in Loddon region, with a focus on understanding psychosocial disability and the skills and knowledge needed to develop quality plans for participants with psychosocial disability.

Recommendation 11

That NDIA planners and LACs across all regions be trained in mental health awareness to understand the specific needs of participants with psychosocial disability.

This recommendation supports Recommendation 7 of the 'Psychosocial Supports Design Project' which reads

"7. The NDIA to consider developing specific staff training for staff about recovery and trauma based approaches to working with people with psychosocial disability." (NDIA & MHA, 2016 p 35)

This recommendation also reflects Recommendation 9 of the Joint Standing Committee Report on NDIS, which reads:

"The committee recommends the NDIA, in conjunction with the mental health sector, creates a specialised team of NDIS planners trained and experienced in working with people who have a mental health condition as their primary disability." (JSC, 2017 p xiv)

Recommendation 12

As part of their commitment to ensuring safe and quality services, and a sustainable and skilled workforce, State and Federal Governments ensure that mental health providers under the NDIS are adequately resourced to provide supervision and training to their workforces.

6.4 Relevance of existing training offerings

Certificate III in Individual Support (CHC33015)

The Certificate III in Individual Support (Disability) is clearly a relevant pre-vocational training program for the role of Disability Support Worker. However the qualification offers no mental health specialism, and only one mental health elective, CHCMHS001 *Work with people with mental health issues*. If this qualification is to become a significant channel for recruiting a future workforce for the role of Support Worker, then tailoring it to have additional mental health/ psychosocial disability units is essential. This could take the form of an additional core unit and the option of a psychosocial specialism. It has been proposed by the NDIS Mental Health Work Special Advisory Group that an additional core unit be added to complement the HLTAAP001 *Recognise healthy body systems*, which is focussed on physical disability. The addition of a psychosocial unit as a core unit would mean that regardless of specialisation, all who undertake the qualification would gain skills and knowledge relevant to both physical and psychosocial disability.

Recommendation 13

That the Certificate III in Individual Support (CHC33015) be revised to include a Psychosocial Disability core unit and specialism.

The Psychosocial Disability Core Unit would complement the HLTAAP001 *Recognise healthy body systems*, and ensure that skills and knowledge relevant to both physical and psychosocial disability are included in the qualification.

The competencies making up the specialism could include:

- CHCMHS001 Work with people with mental health issues
- CHCMHS003 Provide recovery oriented mental health services
- CHCMHS011 Assess and Promote social, emotional and physical wellbeing
- CHCMHS007 Work effectively in trauma informed care (this unit may need to be adapted to better suit a Certificate III level)

Part 2
Data, Discussions and Findings from Workforce Analysis

Training and preparation for transition (cont.)

Certificate IV in Mental Health Peer Work (CHC43515)

The Certificate IV in Mental Health Peer Work is recognised as a valid qualification for delivery of various core and capacity building supports, under the Disability Support Worker category in the NDIS Guide to Suitability (NDIS, 2016b p 18). However the roles that have been emerging for delivering NDIS supports are not specifically peer work roles.

Although the NDIS offers workers with lived experience the opportunity to be employed in support worker roles, these roles do not necessarily align with the work activities assessed in the Certificate IV Mental Health Peer Work. Hence these workers would not meet the eligibility requirements for application to the Certificate IV in MHPW as currently available in Victoria, nor would this qualification be aligned with their role expectations.

Subject to understanding how the use of lived experiences of workers emerges within the NDIS, the training and professional development needs of this group will need to be considered.

Certificate IV in Mental Health (CHC43315)

The Certificate IV in Mental Health is also a recognised qualification for delivery of certain supports according to the NDIA Professional Registration Groups (NDIS, 2016b)

However, there are still a number of questions to be explored to fully determine the relevance of this qualification for the NDIS workforce, both in terms of preparation for the job roles, and how well the competencies align with the roles. These questions include:

- Do the job roles and requirements for support workers in the NDIS environment align with the skills, knowledge, outcomes and performance criteria outlined in the core units of the Certificate IV in Mental Health?

- Would NDIS providers offer relevant and suitable work placement (or on-the-job training) opportunities for students undertaking the Certificate IV in Mental Health? Would students be able to demonstrate the assessment requirements within that work environment?

Conclusion

The initial aim of this workforce analysis was to identify the training and professional development needs of both the transitioning mental health workforce, and the new workforce delivering psychosocial disability supports under the NDIS in Victoria.

However this aim proved to be somewhat premature and not a priority concern for providers who are still coming to terms with the implications of the NDIS as a major reform to the way mental health services are being delivered, managed and paid for. Their priorities are focused on dealing with transition requirements and changes needed at all levels of their organisation: funding arrangements, business systems, operations and staffing.

This workforce analysis revealed that although still unfolding, the new workforce profile under the NDIS will look very different to the previous MHCSS workforce; new job roles emerging, new work structures being created, different qualification and skill requirements.

The analysis also identified the significant shift from workers delivering recovery-oriented psychosocial rehabilitation services, to the provision of disability supports. This shift in focus presents challenges for workers coming to terms with what this means in practice when working with people with psychosocial disability.

What could prove helpful to the mental health sector is to articulate how the new way of delivering psychosocial disability supports under the NDIS system differs to the previous system of delivering psychosocial rehabilitation under MHCSS, and the implications for the workers' role, practice, and capabilities. This is spelled out in Recommendation 1 which identifies the need to articulate a practice model which distinguishes between delivering psychosocial supports under NDIS, and psychosocial rehabilitation, and can operate within the goals of the NDIS, the restraints of the pricing structure, yet is recovery-oriented and trauma informed, and recognises the distinct needs of people with psychosocial disability.

Only then can the ongoing training and development needs of the new workforce delivering psychosocial disability supports under the NDIS, be fully determined.

The transition to NDIS has presented providers with significant workforce challenges that remain unresolved, in particular risks concerning their ongoing capacity to provide access to quality training and professional development for workers providing supports to people with psychosocial disability.

Although there have been various attempts by providers to address these risks, some of these adaptations could be seen as interim solutions that over time could lead to vulnerabilities as they are not structurally embedded in the broader service design.

The responsibility for addressing the challenges cannot be put solely in the hands of providers. Continuous improvement is also a responsibility of the NDIA as it implements a significant social reform, as seen in the recommendations made by the Joint Standing Committee on the National Disability Insurance Scheme.

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Appendix One

Comparison of MHCSS role with NDIS system

Comparison of the MHCSS role with the new NDIS system of providing supports

Function	MHCSS Recovery-oriented approach	How this function is addressed by frontline Support Worker/ Disability Support Worker	How this function is addressed by other workers/ or parts of the NDIS system	What is the gap or difference?
Access & Engagement (Outreach to disengaged consumers)	Time allowed to establish relationship; multiple visits to home; Flexible approach. Strong trusting relationship seen as the foundation for the ongoing work – a most important role. Assertive outreach to make contact with isolated, and disengaged clients	'Engagement' or outreach is not included as an NDIS support.	No outreach component. Initial contact via NDIA representative, often over the phone During transition period, interim measures have been put in place to fill the gap: • Short term funded programs • Providers using creative means to engage consumers and help them access NDIS (eg PHaMs)	**Gap**: No funded engagement work or assertive outreach. No opportunities for establishing trusting relationships prior to implementing plan
Assessment & Exploring needs and aspirations (Pre-planning)	An important part of the preparation process prior to commencing to develop a plan. At times this may require formal assessment methods, discussions with family and carers, and informal discussions with consumer. Psychosocial assessment	Pre-planning is not included as an NDIS support, Support workers are not involved in the planning process.	Initially expectation that participants will be ready to discuss their needs and goals at the first planning meeting. NDIA now recognising that participants need support – possible role for LACs. Assessment of eligibility, and level of supports, is determined by the NDIA	**Gap**: No funded support to prepare for planning meeting. No skilled assistance for participants to explore and unpack their needs and goals. NDIS assessment does not equal psychosocial assessment
Recovery Planning	Development of a narrative by consumer as to what recovery means to them. Planning for social and emotional wellbeing, and mental health recovery.	Some workers and providers are attempting to build recovery planning into their approach in delivering supports	Not considered a responsibility of NDIS.	Shift in focus away from recovery planning. Recovery planning is not considered to be an NDIS area of responsibility according to the COAG agreed Principles & Tables of Support.
Planning process	A collaborative endeavour between worker and consumer with a strong focus on recovery goals	Not part of the support worker role	Responsibility of NDIA planner or LAC. Plan is developed in one planning meeting. Focus of the plan is subject to the choice of the participant	

Function	MHCSS Recovery-oriented approach	How this function is addressed by frontline Support Worker/ Disability Support Worker	How this function is addressed by other workers/ or parts of the system	What is the gap or difference?
Psychosocial and recovery focus	Clearly defined role within a recovery framework; recovery-oriented discussion and focus. Worker's practice encompasses holistic, strengths-based, person-centred and trauma informed approaches. Skilled in working with complexity. Encourages self-determination and self-management of participant's own MH and well-being. Peer work recognised as uniquely suited, and a valuable contribution to recovery work.	Clearly defined and highly structured tasks. Focus not necessarily on 'mental health' or 'recovery', but determined by participant. Focus is on generalist disability supports. Person centred, customer-directed approach; individualised support. Workers with lived experience can be employed as Disability Support Workers.	Support Coordinators operate from a capacity building (community development) and person centred approach. In some instances, Providers have created distinct roles with a recovery & psychosocial focus. Support Coordinator role encourages participant to self-direct and manage their own NDIS plan	**Gap**: No funded supports for: • psychosocial rehabilitation; • relapse planning; • crisis support; • navigating between health systems; • periods of hospital or residential care. Core supports do not address issues of complexity or trauma-informed care. Peer work, as distinct from informal *peer support*, is not included as a funded support.
General characteristics	Flexible and responsive to changing needs of consumer. Working with family, friends and carers is important part of the process. Direct service delivery makes up 30-50% of worker's time, the rest includes administration, behind the scenes work, care coordination, supervision, PD and travel.	Piecemeal supports. Highly structured time according to billable hours Work with family and carers is dependent on what the participant stipulates in the plan. 90-95% of worker's time is direct service delivery (billable hours). Minimal time for supervision and professional development	Carers and family included in planning process subject to participant's choice. Support Coordinators aim to strengthen participant's informal supports (which includes family and friends) Support coordinators expected to achieve 80- 85% billable hours	**Gap**: Price guide does not include supports for working directly with carers or family. **Gap:** No funded opportunities for supervision, professional development and reflective practice
Plan Review	Review of goals can occur at any stage of the implementation of the plan, and there is flexibility to respond to changes in the participant's circumstances or state of health.	Frontline Support Worker is not involved in the participant's plan review	Plan Review is responsibility of the Support Coordinator or of the individual participant. This is done annually. Difficult to receive a plan review before this annual review.	**Difference:** Less flexibility for reviewing and refocussing the plan.
Travel	Travel to meet with participants in their homes, or to support them attending activities or appointments is an important part of the work, In regional areas up to 1/3 of a worker's time can be taken up with travel.	Travel for 'Participant Transport' is limited to the allocation in the participant's plan. 'Provider travel' – up to 20 minutes of travel time can be claimed between appointments	'Provider travel' – up to 20 minutes of travel time can be claimed between appointments. Can result in more phone-based contact by Support Coordinators	Limited travel budget can impact worker flexibility in delivering services, and limit the amount of face to face contact. Proving to be problematic

Appendix Two

Job Profile – Support Coordinator

Composite Job Profile – Support Coordinator (NDIS)

About the role

The Support Coordinator position is responsible for putting funded and mainstream supports in place according to the participants' individual NDIS plans. The focus of the role, initially, is to coordinate access to the required services, whilst working towards strengthening participants' abilities to coordinate and implement their own supports and participate more fully in the community.

Conditions of Employment

- Employed at Level 3 or 4 SCHADS award
- Contracts of 6 – 12 months, part time and full time.
- 80 – 86% of work hours must be billable
- Flexible working hours including weekends

Some positions are office-based, or at least partially, and may require travel to various locations to deliver services. Workers are required to use their own vehicles which must be roadworthy and covered by insurance.

Responsibilities

Work with a designated caseload to deliver support coordination services* consistent with the defined goals identified in the customers NDIS plans.

- Coordinate a range of supports including informal, mainstream and community supports
- Build capacity of participants to achieve greater independence, to self-direct and manage their own plan
- Management of multiple/complex supports from a range of providers which intersect with mainstream services
- Act as a central reference point for the participant, and all stakeholders in the coordination of the participant's NDIS plan
- Drawing up service agreements
- Crisis resolution
- Facilitating the development of resilience in participants
- Develop and foster partnerships with community services and mainstream agencies and programs
- Assist participants to prepare for plan review
- Regular monitoring and outcome reporting for the participant/NDIA
- Maintain reporting and information systems
- Provide support to support workers as required**
- Facilitate group supervision for Support Workers around mutual clients**

Role of the Support Coordinator when only delivering Support Connection is to assist participants to learn how to:

- Activate their plan (i.e. link to service providers)
- Monitor quality and spend of services
- Manage flexibility within the plan
- Prepare for review
- Address barriers to participation, and resolve service delivery issues

[* Intensive level Coordination of Supports is not included in this PD]

[** Included in some Position Descriptions, however, not considered best practice]

Expected Outcomes

- The participant has been supported to work towards their goals.
- The participant is well connected with informal and mainstream supports.
- The participant and their network better understand how to participate in the NDIA processes, such as establishing agreement with service providers, managing budget flexibility, and setting and refining goals, objectives and strategies.
- The participant's supports are managed within the budget parameters in the plan
- Participants have genuine choice and control of service providers
- Where possible a participant's or their nominees are confident at managing their support with no or a reduced need for support coordinator in subsequent plans.
- Participant is able to manage any issues that arise with service provision (including optimising service quality and effectiveness).
- Participants will address issues or barriers in accessing service provision within existing funded supports in the first instance. Requests for additional funded supports are made when there are significant change in circumstances. In these instances, the NDIA will review the plan as required.
- All task items are completed as required.

Source: Request for Service (Vic North) as quoted in DSC, 2017

Qualifications

Minimum qualification levels vary (across providers) from Cert IV to Degree, and include qualifications in:

- Mental health
- Mental health nursing
- Social work
- Occupational Therapy
- Psychology
- Disability
- Community

Qualification requirements can also depend on what is stipulated in the NDIA Registration Guide.

The Support Coordination training offered by DSC indicates that the minimum qual requirement is Cert III.

Skills and attributes

- Relationship building
- Knowledge of local community services, mainstream supports and programs
- In depth understanding of NDIA service model, NDIS legislation & rules made under the NDIS Act, pricing and the flexibility within the price guide, and what constitutes 'reasonable and necessary'.
- Communication skills
- Planning, organising and problem solving
- Ability to adapt to change
- Experience and skills working with people with all disabilities
- Community development/ capacity building skills
- Some providers are seeking more diverse attributes and characteristics in their workforces in order to better accommodate the range of requirements requested by participants, for example, workers from culturally diverse backgrounds.

Appendix Three

Job Profile – Disability Support Worker

Composite Job Profile – Disability Support Worker – Core Supports

About the Role

Disability Support Worker positions are responsible for the delivery of services purchased through the National Disability Insurance Agency (NDIA). The worker will deliver various support items in accordance with the participants' NDIS plan.

The role requires travelling to various locations to deliver services, as part of a 'mobile' team – non-office based – using own car and mobile phone/ tablet.

Communication with office is mostly via phone contact or online systems (eg intranets); documentation/ recording of hours and travel is done using technology.

Highly structured role, limited flexibility in delivering scheduled hours.

Customer load allocated by geographical area (in some providers).

Some roles have a specific Mental Health (and dual disability) focus, others have a general Disability Support focus which includes any participants regardless of their disability.

Supervision offered monthly, in groups, or via email (or combination of).

Daily support and debriefing via phone or email (often informal and minimal).

Administrative and scheduling functions mostly done by office-based staff.

Conditions of Employment

- Employed at Level 2-3 SCHADS award
- Casual or limited contract (some are employed as casual during transition period, with aim of becoming contracted once established)
- 85 – 95% client contact time (billable hours)
- Must be able to work flexible hours including evenings and weekends
- Criminal Records Check required
- Working with Children Check required

Responsibilities

Provide individual support items, such as:

- Assistance with daily life
- Assistance to access social, community and recreational activities
- Increased social and community participation
- Public transport training
- Social skills development
- Assistance with decision-making, daily planning, budgetting
- Assistance with self-care activities
- Individual skills development
- Domestic activities
- Personal grooming
- Minimal case notes and reporting

Qualifications, skills and attributes

- Minimum Certificate III; some have Cert IV as minimum (in Disability, Mental Health, HACC) – however it is *not* mandatory; sometimes employed without qualifications.
- Customer-service skills/ Customer focussed
- Ability to identify and manage risk
- Flexibility
- Time management
- Communication skills (interpersonal)
- Individual plan management (time, hours, budgeting)
- IT savvy
- Ability to manage boundaries
- Ability to work autonomously

** Customers are dictating the skills/ attributes required, such as 'personable' and 'like-able' (friendly, caring, can develop good relationships); often not concerned about qualifications.

Additional Information

This job role is seen as a potential pathway for entry into the mental health sector by

- Recent graduates of Diplomas and Degrees
- People with lived experience wanting to become Peer Support workers
- Young people completing the Certificate III in Individual Support
- Adults seeking re-training options

Appendix Four

Interview Questions

Interview Questions for Managers

1. What is your job title, and primary purpose of your position?
2. What are the **key job roles** that your organisation will be creating (or have already created) to provide psychosocial disability support in the new NDIS environment?
   - Job Title
   - Skills, knowledge, attitudes, values needed?
   - What level of qualification or competency/ capabilities are required?
   - Were these job roles shaped by the support categories- and pricing constraints- listed in the NDIS price guide
3. What are the most significant differences between this job role and the previous MHCSS (or other MH) support worker roles that your service employed?

   a) Has there been any change to the **delivery or nature of the recovery-oriented psychosocial support** services offered by your organisation since the transition to the NDIS?

   b) Has the focus of the job role **shifted** from psychosocial supports to general disability supports? If yes, then what is the new focus and to what extent?
4. Have there been any significant changes to the way your organisation **employs and deploys** its workforce as a result of becoming an NDIS provider?
5. **Exiting workforce:**

   a) What percentage of the pre-NDIS workforce did not (or may not) transition to the new system?

   b) Do you know for what reasons?

   c) Do you know what areas of work they went into?

   d) Was your organisation able to offer any out-placement support to this exiting workforce?
6. Can you see a place for peer workers in the new NDIS system?
7. **Training and Development needs:**

   a) In retrospect, what would you identify as the most useful areas for training and skill development for the MH workforce in preparing for the transition to the NDIS system?

   b) What would you consider to be the key areas for skill development and professional development for your new workforce operating under the NDIS?

   c) Which of these is your organisation able to respond to and how? (in-house, external training, online, written resources, specific workshops or training sessions, in supervision …

   d) Which of these is your organisation unable to respond to and why?

   e) What difficulties/ barriers does your organisation face, or is likely to face, in responding to the current or ongoing training and development needs of your workforce?

   f) To what extent will the onus be on the worker for ongoing PD? How else might these training needs be met?
8. What role would you like to see VICSERV play in supporting the training and development needs of your transitioning and/ or new work force in the NDIS environment?
9. What would suit your organisation's training and development needs in terms of cost, delivery method and external training options?
10. Have there been changes – or do you anticipate changes – to the position description of the first tier of management who support the NDIS workers?

    a) If so, what changes?

    b) What new training needs are needed for managers in the new system?

Interview Questions for Frontline Workers

1. What is your job title, and the main focus of your work?

2. The next questions will explore your job role in more depth:

   a) What are the main NDIS support categories that you deliver as part of your job role

   b) Can you describe an average day's work – key tasks, responsibilities, patterns of work

   c) In order to do your job well, what would you say are the most important skills, attributes or qualities needed for a worker?

   d) Does your organisation stipulate a minimum qualification level for workers to be employed in this role? In your opinion, is this an adequate qualification level?

3. The next questions will focus on comparing your current role as an NDIS Support worker with your previous role as a MHCSS support worker.

   a) Can you tell us about any differences between this job role and your previous role as a MHCSS support worker?

   b) More specifically, can you talk about how your new role compares to the way you delivered recovery-oriented psychosocial rehabilitation support in your previous role?

4. Can you describe any changes to your employment conditions, or the way your job is structure now that you are delivering supports under the NDIS system?

5. **Training and Development needs:**

   a) Learning from your experience in the early days of the trial, what do you think are the NEW skills, competencies or knowledge areas needed by workers to better equip them to transition across to the new system?

   b) Based on your experience in this new role, and your knowledge of other workers' experience, what would you say are the most challenging aspects of your role? (This may relate to aspects of service provision, daily operations, organisational systems & processes, or access to support and professional development…)

   c) What kind of training or professional development would be helpful to overcome the challenges you have just described?

   d) Are there any other areas of skill development, training or professional development that would assist workers to do their job more effectively and safely?

   e) Under the current conditions of your employment what training and professional development is available to you?

   f) What would be the ideal way for you to receive training or professional development? (For example, online or face-to-face? length of sessions? flexibility? On the job?)

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