

Evaluation of the Statewide Education and Training Partnership (Cluster) Project

Prepared for

**Mental Health Branch
Department of Human Services**

Prepared by

**Dr Anne Forwood
Cheryl Reed
David Roose
Rowan McClean**

June 2007

Table of Contents

Executive Summary	i
Introduction.....	i
Evaluation objectives	i
Evaluation method	i
Conclusions	i
Evaluation questions	ii
Recommendations	iv
1. Introduction	1
1.1 Background.....	1
1.2 Evaluation project objectives.....	2
2. Evaluation method	3
2.1 Literature review	3
2.2 Case studies	4
2.3 Interviews.....	4
2.4 Focus groups	4
2.5 Online survey	5
3. Summary of online survey	6
3.1 Survey method	6
3.2 Overview of results	8
3.3 Cluster participation.....	9
3.4 Course marketing and awareness	9
3.5 Training assessment and planning.....	10
3.6 Participation in training activities	11
3.7 Training selection and approval	11
3.8 Quality of cluster training activities.....	13
3.9 Overall cluster performance.....	15
4. Appropriateness	17
4.1 How well do the cluster priorities align with local needs, the strategic directions of partnering organizations?	17
5. Efficiency	21
5.1 How have the different clusters been established, operated and maintained?	21
5.2 What factors (positive and negative) have affected implementation?.....	23
6. Effectiveness	25
6.1 What are the major outcomes that have been achieved from cluster-based groupings?	25
6.2 How have these outcomes contributed to short, medium and longer-term outcomes?.....	27

6.3	Have clusters resulted in more effective resource sharing between partnering organizations?	29
6.4	What similarities and differences exist in the content and methods of education and training delivered across the clusters?	33
6.5	What is the optimal cluster size and configuration to support ongoing education and training needs?	36
6.6	What factors are important to maximise sustainable models of education and training into the future?	37
6.7	What are the key areas, indicators and methods for ongoing performance monitoring?	41
APPENDICES		44
7.	Literature review	45
7.1	Scope and structure of the literature review	45
7.2	The policy context	45
7.3	Three models of education and training in mental health	47
7.4	England	48
7.5	New Zealand	49
7.6	New South Wales Institute of Psychiatry	51
7.7	Conclusions	53
8.	Case studies	57
8.1	North East Victoria Innovative Learning Cluster case study	57
8.2	Western cluster case study	61
8.3	SETC cluster case study	65
9.	Reported cluster outcomes	71
10.	Summary of interviews	78
10.1	NEVIL summary of interviews	78
10.2	Western summary of interviews	83
10.3	SETC summary of interviews	86
11.	Summary of focus groups	90
11.1	Overview of results	90
11.2	General issues	91
11.3	Cluster awareness	92
11.4	Participation in training	93
11.5	Training content	94
11.6	Training delivery	96
12.	Workforce development models	97
13.	References	100

Index of Tables

Table 1:	Outcomes by cluster (average ratings)	3
Table 2:	Participation by agencies	6
Table 3:	Employment characteristics of sample	7
Table 4:	Demographic characteristics of sample	7
Table 5:	Decision to apply for training.....	12
Table 6:	Training approval process.....	13
Table 7:	Overall quality by cluster (average ratings).....	14
Table 8:	Outcomes by cluster (average ratings)	16

Index of Figures

Figure 1:	Usual method of obtaining information about cluster training activities.....	9
Figure 2:	Participation in formal assessment of training needs in the last three years	10
Figure 3:	Have an individual training plan.....	11
Figure 4:	Quality of training offered by clusters (average ratings)	14
Figure 5:	Cluster outcomes (average ratings).....	16
Figure 6:	McCracken & Wallace model (2000)	97

Executive Summary

Introduction

This report presents the findings of the evaluation of the Statewide Education and Training Partnership Project (the clusters) submitted to the Department of Human Services Mental Health Branch by Dench McClean Carlson.

Evaluation objectives

The specific objectives of the evaluation project include assessment of:

- The **appropriateness** of the Education and Training Partnership project;
- The **effectiveness** of the Education and Training Partnership project; and
- The **efficiency** of the Education and Training Partnership project.

The conclusions are outlined below.

Evaluation method

An evaluation framework developed by the Department of Human Services guided the evaluation method. This framework included key questions in appropriateness, efficiency and effectiveness as outlined in the introduction.

To address the evaluation questions it was necessary to draw evidence from a number of research methods, including:

- A review of literature and documents to develop an understanding of alternative models of education and training (particularly involving a cluster or partnership approach) in the mental health workforce
- Case studies of each cluster
- Interviews with the Department of Human Services Mental Health Branch, cluster project officers, cluster committee members and other agency representatives
- Focus groups with a range of mental health professionals
- An online survey of mental health professionals.

Conclusions

The general conclusions from the evaluation are:

- The clusters were a good idea.
- The clusters are worth preserving and should be converted from project to ongoing program status.
- The clusters have made remarkable progress.
- Overall the clusters have performed well against their Key Performance Indicators, although there are some gaps in activities and in reporting.
- The model has been generally well accepted by the agencies and their staff in each cluster.
- There has been a significant commitment to the clusters by many people.
- The cluster model would benefit from increased cooperation, resources and support.

Evaluation questions

In reporting on this project, the consultants were required to answer a series of evaluation questions. The following is a summary of the findings against each of the evaluation criterion.

Appropriateness

How well do the cluster priorities align with local needs, the strategic directions of partnering organizations?

The degree to which cluster priorities align with local needs and the strategic directions of their organisations ranges from low to high across organisations within the clusters.

How well cluster priorities align with local needs and the strategic directions of partnering organisations is influenced by a number of factors: the cluster's approach to education and training needs analysis; the partnering organisation's education and training infrastructure; the partnering organisation's approach to identifying their education and training needs; and the cluster project officer and Steering Group's ability to translate those needs into a training program.

Efficiency

How have the different clusters been established, operated and maintained?

The clusters were purposefully established, operated and maintained as separate entities, resulting in differences between them and some inefficiency across the system.

There are potential benefits to the system in the clusters collaborating on joint projects of common interest.

What factors (positive and negative) have affected implementation?

Positive factors affecting implementation of the cluster project included:

- Strong leadership and clear roles and responsibilities.
- The ability to leverage off existing networks
- The sense of goodwill and co-operation amongst agencies
- The time and resources available through the nurse educator positions

Negative factors affecting implementation included:

- Perception of the clusters as being dominated by the interests of nurses
- Limited guidance and options from the Department in establishing the clusters
- Lack of clear boundaries on the role of clusters
- Limitations of non-recurrent project funding
- DHS not building in clear expectations and strategies to assist closer collaboration between clusters from the project onset
- Size of the Western cluster.

Effectiveness

What are the major outcomes that have been achieved from cluster-based groupings?

Although there are some gaps, all three clusters have increased the capacity to meet both statewide and local education and training priorities.

One of the major outcomes to have been achieved from the cluster based grouping is interest in co-operation and sharing of resources between agencies.

How have these outcomes contributed to short, medium and longer-term outcomes?

The desired outcomes from workforce education and training programs are: development of knowledge and skills, changes in behaviour, improvements in workplace performance and improvements in workplace outcomes.

The contribution of the discernable outcomes from the clusters' activities on short, medium and longer-term outcomes for member agencies and the system overall are not measured through the clusters.

Have clusters resulted in more effective resource sharing between partnering organizations?

The structure of the funding and governance arrangements of the cluster project has meant the agencies have to share resources to access training funding and programs.

As goodwill and co-operation has increased between agencies within clusters, there is evidence of increased sharing of resources and ideas outside of cluster fostered activities. For example, several agencies reported making their internal training activities open to other cluster members.

There was a clear sentiment that resource sharing could be made more effective if there was a greater focus on collaboration between clusters.

What similarities and differences exist in the content and methods of education and training delivered across the clusters?

As required by DHS, there are some core similarities in the content of education and training delivered across clusters.

Increased portability of skills between agencies would benefit the system and the individuals working in it.

Education and training methods provided through the clusters would benefit from modernisation of learning methods and technologies employed.

What is the optimal cluster size and configuration to support ongoing education and training needs?

There is no magic number in cluster size. The optimal cluster size will be determined by the geographic proximity of agencies and agency size to ensure a critical mass particularly in regional areas.

Western appears to be too big to have established and maintained an active and engaged management committee. Similarly NEVIL activities could benefit from additional mass in the regional area.

What factors are important to maximise sustainable models of education and training into the future?

The clusters have made significant progress since they began in 2004 within the levels of resourcing, guidance and support provided.

Clarification and development of the clusters' roles would increase the sustainability of their contribution to provision of education and training across the system.

Currently there is no statewide mental health education and training strategy to assist clusters to align their programs with Commonwealth and State policies, or with a system-wide workforce management plan.

What are the key areas, indicators and methods for ongoing performance monitoring?

The existing performance monitoring requirements do not adequately provide the clusters or the Department with the capacity to evaluate the impact of education and training programs on workplace outcomes or their contribution to the development of the mental health workforce more broadly. Key areas, indicators and methods for ongoing performance monitoring should focus on outputs that are linked with the workforce outcomes described in the relevant policies and standards.

Recommendations

Strategic Direction 1: Frameworks and guidelines

It is recommended that:

A statewide workforce strategy is developed that addresses the key workforce skill shortage and mobility issues (with an associated education and training plan for mental health), enabling strategic alignment of the clusters' education and training

Clusters adopt a common framework for the development of local education and training priorities that reflect member services' strategic priorities as well as statewide priorities.

The clusters adopt a common training needs analysis framework to assist in the assessment, delivery, and evaluation of education and training.

The MHB strengthens cluster guidelines and communicates these to sector and the clusters, with emphasis on:

- Ensuring greater clarity of cluster purpose, scope and responsibilities
- Clarifying KPI's and accountability requirements
- Identifying communication opportunities and resources to support cluster collaboration on joint projects (e.g. evaluation tools, program delivery infrastructure)

Strategic Direction 2: Future resources and support

It is recommended that:

The MHB convert the cluster initiative from project to ongoing status to allow progressive development and strengthen their forward planning and evaluation capacity.

The clusters are resourced to a level that enables cluster collaboration on common projects and training.

Strategic Direction 3: Evaluation, accountability and reporting

It is recommended that:

The MHB and the clusters develop an evaluation framework (linked to a statewide workforce strategy and education and training plan) that measures short, medium and long term impact and outcomes to evaluate the extent to which clusters are addressing identified workforce development, recruitment and retention issues.

The MHB and clusters develop improved key performance indicators (KPIs) and ensure they are directly linked to strategic objectives and enable effective measurement of output achievements and progress.

The MHB establish a common template for reporting for all clusters for reporting against the KPIs.

Strategic Direction 4: Partnerships and collaboration

It is recommended that:

The MHB, with the clusters, investigate the opportunities for improved partnerships arrangements between services including alternate cluster configurations if relevant.

Where appropriate, clusters encourage cross-cluster representation in training activities.

The clusters collaborate to ensure that training priorities, evaluation frameworks and modules establish staff skills and knowledge that are transportable across agencies.

Strategic Direction 5: Contemporary learning issues

It is recommended that:

The clusters identify options to strengthen training delivery through the modernisation of learning resources and infrastructure (e.g. e-learning infrastructure and resources).

The clusters are supported to ensure that programs are delivered in accordance with learning approaches that are problem-focused, student centred and include active learning methods.

1. Introduction

Dench McClean Carlson was commissioned by the Victorian Department of Human Services (DHS) Mental Health Branch to evaluate the Statewide Education and Training Partnership (Cluster) Project. The aim of the evaluation was to establish progress of the project against key performance indicators and to assess the extent to which key program activities have been achieved.

1.1 Background

The Statewide Education and Training Partnership (Cluster) Project, which emerged from mental health sector consultation, aims to improve opportunities for service managers, clinical leaders and senior educators across the sector to work together, to access quality post employment education and training for mental health staff. It was intended that cluster-based education and training would ultimately lead to improved workforce recruitment and retention, safer clinical practice, and better patient outcomes in mental health settings across the state.

Over the last three years, DHS funded and facilitated the formation of regional clusters to improve and streamline education and training in the mental health sector. A key aim of the Education and Training Partnership Project is to improve the quality and accessibility of education and training across the clinical mental health sector in Victoria through formation of partnerships between multiple service providers.

The specific objectives of the partnership project are to:

- provide regular access to structured education and training activities that meet the needs of staff,
- address Statewide and local priorities in education and training in the clinical mental health sector, and
- use existing expertise and resources to develop sustainable education and training activities.

The resources supporting the Education and Training Partnership Project initiative across the three clusters included an allocation of approximately \$1.82 million over five years, in addition to existing sector education and training resources.

This project resulted in the establishment of three separate education and training clusters:

- North Eastern Victoria Workforce Development Cluster (NEVIL) combines Austin Health, Eastern Health, Forensicare, St. Vincent's Health, Goulburn Valley Health, and North Eastern Health (Wangaratta and Wodonga);
- Southern Education and Training Cluster (SETC), incorporates the agencies Bayside Health, Latrobe Regional Hospital, Mental Health Program, Peninsular Health Psychiatric Services, and Southern Health; and
- The Western cluster includes South West Area Mental Health Service (Werribee Mercy); NorthWestern Mental Health incorporating Mid West AMHS, Inner West AMHS, Northern AMHS, North West AMHS, Aged Persons' MHP and ORYGEN Youth Health; The Barwon Health Mental Health Service; Glenelg (South Western) Area Mental Health Service (Warnambool); Ballarat (Grampians) Health Psychiatric Service; Loddon Campaspe/Southern Mallee Mental Health Service (Bendigo and Swan Hill); Northern Mallee Mental Health Service (Mildura), and the Royal Children's Hospital Mental Health Service.

To date, each cluster has established a management committee consisting of representatives of member agencies and stakeholder groups, and fostered cooperation between agencies to develop and conduct education and training programs to meet both state and local training priorities.

1.2 Evaluation project objectives

The specific objectives of the evaluation project include assessment of:

- The appropriateness of the Education and Training Partnership program in relation to:
 - How well do the cluster priorities align with local needs, the strategic directions of partnering organizations?
- The efficiency of the Education and Training Partnership program in relation to:
 - How have the different clusters been established, operated, and maintained?
 - What factors (positive and negative) have effected implementation?
- The effectiveness of the Education and Training Partnership program in relation to:
 - What are the major outcomes that have been achieved from cluster-based groupings?
 - How have these outcomes contributed to short, medium and longer-term outcomes?
 - Have clusters resulted in more effective resource sharing between partnering organizations?
 - What similarities and differences exist in the content and methods of education and training delivered across different clusters?
 - What is the optimal cluster size and configuration to support ongoing education and training needs?
 - What factors are important to maximise sustainable models of education and training into the future?
 - What are the key areas and indicators and methods for ongoing performance monitoring?

2. Evaluation method

The evaluation method was guided by an evaluation framework developed by the Department of Human Services. This framework included key questions in appropriateness, efficiency and effectiveness as outlined in the accompanying table.

Table 1: Outcomes by cluster (average ratings)

Appropriateness	How well do the cluster priorities align with local needs, the strategic directions of partnering organizations?
Efficiency	How have the different clusters been established, operated, and maintained? What factors (positive and negative) have effected implementation?
Effectiveness	What similarities and differences exist in the content and methods of education and training delivered across different clusters? Have clusters resulted in more effective resource sharing between partnering organizations? What are the major outcomes that have been achieved from cluster-based groupings? How have these outcomes contributed to short, medium and longer-term outcomes? What is the optimal cluster size and configuration to support ongoing education and training needs? What factors are important to maximise sustainable models of education and training into the future? What are the key areas and indicators and methods for ongoing performance monitoring?

To address these evaluation questions it was necessary to draw evidence from a number of research methods, including:

- A review of literature and documents to develop an understanding of alternative models of education and training (particularly involving a cluster or partnership approach) in the mental health workforce
- Case studies of each cluster
- Interviews with the Department, cluster project officers, cluster committee members and other agency representatives
- Focus groups with a range of mental health professionals
- An online survey of mental health professionals

Each of these methods is further discussed in this section.

2.1 Literature review

The purposes of the literature review were to outline the policy context in which the Education and Training Partnership (Cluster) project operates and to briefly describe examples of other mental health education and training partnerships that are based on cluster arrangements between service organisations. The review is divided into two main sections. The first outlines the policy context. The second explores practice examples of approaches to education and training in the mental health workforce from within Australia and overseas.

This is not intended to be an academic literature review. Although rigorous in approach, it has a practical orientation. Hence the review includes information from non-refereed material, as well as that from policy documents.

The structure for the literature review was developed in consultation with the Department. Additional information about the literature review, including a summary of the findings, is included in Section 7 of this report.

2.2 Case studies

The case studies were designed to draw largely on documentary evidence, supported by the interviews and feedback from project officers, in order to provide a brief description of each cluster. The structure for the case studies was developed in consultation with the Department.

2.3 Interviews

A series of depth interviews were conducted to explore stakeholders' experiences and attitudes to the clusters. In total 29 people were interviewed from 17 agencies:

- NEVIL – 11 people interviewed from 5 agencies
- SETC – 8 people interviewed from 4 agencies
- Western – 10 people interviewed from 8 agencies

This included 6 agencies in regional Victoria and 11 agencies in metropolitan Melbourne. In addition, interviews were conducted with cluster project officers and Departmental staff.

On average, interviews lasted for approximately one hour. Most interviews were conducted face to face at the participants' place of work. Using the contact lists provided by the Department, candidates were sent an email invitation including a brief summary of the project. Interview times were scheduled during follow-up telephone conversations and emails. This process often involved several points of contact to schedule all interested parties from an agency. In most cases interviews were conducted with a small group. The average number of participants per interview was 1.7.

The interviews were conducted against a loosely structured interview guide, approved by the Department. This guide was designed to closely follow the evaluation framework developed by the Department.

Additional information about the interviews with agencies' representatives, including a summary of results, is included in the Appendices (see Section 9- Summary of Interviews).

2.4 Focus groups

A series of focus groups were held with mental health workers to understand their experiences and attitudes to education and training in the mental health workforce. In several cases, agencies and staff expressed concerns about the identification of their comments disadvantaging them within the cluster. For this reason, agencies details are not provided in this section of the report. This information is also not sufficiently robust to allow reporting at the cluster level. Furthermore, as focus groups were conducted with only a small number of agencies, and were not designed to be representative of particular clusters, the analysis is taken at the project level. In addition, as the focus groups were recruited by agencies agreeing to participate in this stage of the research, the composition of focus groups was not entirely within the control of the evaluation team.

Three agencies agreed to facilitate focus groups with their staff. Two agencies were in metropolitan Melbourne and one agency was in regional Victoria. A total of 33 people participated in six focus groups. These groups included:

- 1 group with a CAMHS team
- 1 group with CAMHS, adult and aged inpatient mental health workers
- 2 groups with clinical leaders and senior practitioners
- 1 group with a CAT team
- 1 group with an educational/ clinical team

Participants included consumer and carer advocates, nurses, educators, psychologists, social workers, occupational therapists and registrars.

Additional information about the focus groups, including a summary of results, is included in the Appendices (see Section 10, Summary of Focus Groups).

2.5 Online survey

An online survey was used to provide mental health workers with the opportunity to comment on their experiences and opinions of education and training in the mental health sector and the impact of the cluster in meeting their education and training needs.

In March 2007, an online survey was conducted of mental health workers including nurses, medical staff, allied health professionals, managers, carer and consumer consultants, and psychiatric service officers.

An introductory email with an embedded link to an online survey, was distributed to committee members and key agency contact people provided by the cluster project officers. A copy of the project brochure, explaining the purpose of the evaluation, was attached to the initial email.

The email invitation was distributed on 16 March 2007 with the survey remaining open for ten days. During this period a reminder email was sent to all contact people. In addition, the cluster project officers were asked to distribute the survey link using their direct email lists. While the email invitation stressed that the survey was not an evaluation of the agency and that the individual results were confidential, the online survey also included additional information on confidentiality, privacy and the voluntary nature of participation. The survey took approximately 5 minutes to complete.

2.5.1 Sample

It is not possible to identify the exact response rate to the survey as the population size is unknown, nor did the evaluation team have full control over the implementation process. However, of the 21 agencies invited to participate, responses were received from 20 agencies. A total of 325 completed questionnaires were received. The number of participants from each agency ranged from 1 to 74.

Respondents were asked a number of demographic and employment questions to assist in the analysis of results and to allow the review of the representativeness of the sample. The survey reached a range of staff including the following:

- By age speciality – 148 respondents from adult services, 61 from CAMHS, 32 from aged and 7 from drugs and alcohol
- By profession – 167 nurses, 120 allied health professionals, 18 doctors and 1 other staff person
- By workplace role – 192 clinicians, 50 managers and 40 trainers
- By location – 252 respondents from metropolitan agencies and 67 from regional agencies.

Additional information about the online survey, including a summary of results, is included in the appendix.

3. Summary of online survey

An online survey was used to provide mental health workers with the opportunity to comment on their experiences and opinions of education and training in the mental health sector and the impact of the cluster in meeting their education and training needs. This section provides an overview of these results.

3.1 Survey method

In March 2007 an online survey was conducted of mental health workers including nurses, medical staff, allied health professionals, managers, carer and consumer consultants, and psychiatric service officers.

An introductory email with an embedded link to an online survey, was distributed to committee members and key agency contact people provided by the cluster project officers. A copy of the project brochure, explaining the purpose of the evaluation, was attached to the initial email.

The email invitation was distributed on 16 March 2007 with the survey remaining open for ten days. During this period a reminder email was sent to all contact people. In addition, the cluster project officers were asked to distribute the survey link using their direct email lists. While the email invitation stressed that the survey was not an evaluation of the agency and that the individual results were confidential, the online survey also included additional information on confidentiality, privacy and the voluntary nature of participation. The survey took approximately 5 minutes to complete.

3.1.1 Sample

It is not possible to identify the exact response rate to the survey as the 5,041 (headcount quoted in *The study Victoria's direct care mental health workers: The public mental health workforce study 2003-04 to 2011-2012* (DHS, 2006), nor did the evaluation team have full control over the implementation process. However, of the 21 agencies invited to participate, responses were received from 20 agencies. A total of 325 completed questionnaires were received. The number of participants from each agency range from 1 to 74 (see table below).

Agency	No. q's res submitted	% of sample
Alfred Psychiatry at Bayside Health	22	7%
Austin Health	40	12%
Ballarat (Grampians) Health Psychiatric Service	-	-
Barwon Health Mental Health Service	11	3%
Bendigo Health	5	2%
Eastern Health	53	16%
Forensicare	6	2%
Glenelg (South Western) Area Mental Health Service	1	0%
Goulburn Valley Health	10	3%
Latrobe Regional Hospital Mental Health Services	1	0%
Loddon Campaspe/Southern Mallee Mental Health Service	1	0%
North East Health Wangaratta	7	2%
Northern Mallee Mental Health Service (Mildura)	8	2%
NorthWestern Mental Health	74	23%
Peninsula Health Psychiatric Services	11	3%
Royal Children's Hospital Mental Health Service	8	2%
South West Area Mental Health Service (Werribee Mercy)	22	7%
Southern Health	6	2%
St Vincent's Health	24	7%
Western Health	3	1%
Wodonga Regional Health Service	12	4%

3.1.2 Sample characteristics

Respondents were asked a number of demographic and employment questions to assist in the analysis of results and to allow the review of the representativeness of the sample. The survey reached a range of staff including the following:

- By age speciality – 148 respondents from adult services, 61 from CAMHS, 32 from aged and 7 from drugs and alcohol
- By profession – 167 nurses, 120 allied health professionals, 18 doctors and 1 other staff person
- By workplace role – 192 clinicians, 50 managers and 40 trainers
- By location – 252 respondents from metropolitan agencies and 67 from regional agencies.

The accompanying tables show the key employment and personnel characteristics of the respondents as a percentage of the sample.

Table 3: Employment characteristics of sample

Characteristics	% (n=325)
Primary area of work	
Adult	46%
CAMHS	19%
Work across multiple areas	11%
Aged	10%
Drugs and alcohol	2%
Other	12%
Primary function at work	
Clinical care	59%
Management	15%
Staff training and education	12%
Administrative	3%
Other	10%
Professional background	
Registered nurse	51%
Allied health professional	37%
Doctor	6%
Non-registered care staff	1%
Other	6%

Table 4: Demographic characteristics of sample

Characteristics	% (n=325)
Highest level of education	
Some primary/ secondary	3%
TAFE course	4%
Undergraduate (including nursing)	28%
Postgraduate degree	65%
Hours worked	
Full time	74%
Part time	26%
Nature of position	
Permanent	88%
Contract	10%
Casual	1%
Other	1%
Location	
Metropolitan	78%
Regional	21%
Average experience in the mental health sector	15.2 years
Average length of service with current employer	6.3 years

3.1.3 Reading this report

When reading this report, where percentages do not add to 100% this will be due either to a rounding effect or multiple choice question. Generally, results in this section have been calibrated on those respondents eligible to answer a question (for example, questions on training experience are only asked of respondents who have participated in training and this figure is used as the base for calibration of proportions rather than the entire sample).

As a standard part of the analysis of results, explanatory variables have been used to explore respondents' answers. As a core group the explanatory variables used included cluster, location, age speciality and primary function at work. Other factors were reviewed where relevant. Only significant differences in results (>.05) are reported.

3.2 Overview of results

Receiving 325 responses, the online survey included a cross section of staff working in the mental health system. Respondents were highly experienced in the health sector with an average length of experience of 15.2 years generally and 6.3 years with their current employer.

By cluster, 140 responses were received from NEVIL, 145 responses were received from Western and just 40 responses were received from SETC. Consequently the results for SETC need to be treated with caution.

The results of the online survey show a strong degree of consistency with the findings of the qualitative research. To summarise:

- ✓ 55% of respondents had participated in cluster training activities.
- ✓ Email was the most common way of obtaining information about courses (68%) with training calendars and colleagues also proving to be important sources of information (53% and 36% respectively).
- ✓ 50% of respondents either had not participated in a formal assessment of their training needs in the last three years (44%) or were unsure if they had (6%).
- ✓ 29% of respondents had an individual training plan to guide their professional development.

Respondents who had participated in training were asked to rate a number of statements about their experiences with training on a scale from zero to ten. Based on the average scores:

- ✓ There was a high rating for the *level of support of management for participation in training activities* (7.5 out of 10) and for *the overall quality of training activities provided by the cluster* (7.4 out of 10).
- ✓ Lower ratings were provided for the *range of cluster activities available* (5.8 out of 10) and the *availability of training activities at the right level* (6.0 out of 10).

Respondents to the online survey were asked a series of questions relating to the outcomes of their participation in cluster training activities. Based on average scores out of a possible maximum of ten:

- ✓ The highest averages scores were awarded for the *opportunities to share ideas with colleagues from other agencies* (6.9) and *improved theoretical knowledge and understanding* (6.7).
- ✓ Clusters were rated as less successful in *improving capacity to work as part of a team* (5.7) and *reducing adverse practices or events* (5.6).

There was a tendency for respondents from regional agencies to report higher rates of participation in cluster training. However, this does not mean that more courses had been attended but rather that fewer people had attended no training. Regional respondents were also more likely to report barriers to training such as less support from management and lower accessibility and a lower general quality of training than were their metropolitan colleagues.

CAMHS staff consistently reported lower levels of participation in cluster training and lower ratings of training quality and appropriateness.

There was also a generally tendency for managers and trainers to report higher participation rates in training and more positive views of training quality and outcomes through the cluster than reported by clinicians.

Overall 51% of respondents considered that the clusters had made an improvement to the accessibility of training, while 18% did not think the clusters had such an impact and 31% were unsure.

3.3 Cluster participation

Over half of the respondents to the survey (55%) had participated in training activities organised by a cluster. In addition, respondents had held other roles in clusters including committee/working group member (21%), training facilitator (20%), and funding recipient (5%). Overall, one third of respondents (32%) had not participated in the cluster in any way.

- Respondents from NEVIL were more likely to have facilitated training themselves (28%) than had respondents from Western (13%).
- Conversely, NEVIL respondents were significantly less likely to have participated in training organised by the cluster (48%) than were respondents from Western (61%).

3.4 Course marketing and awareness

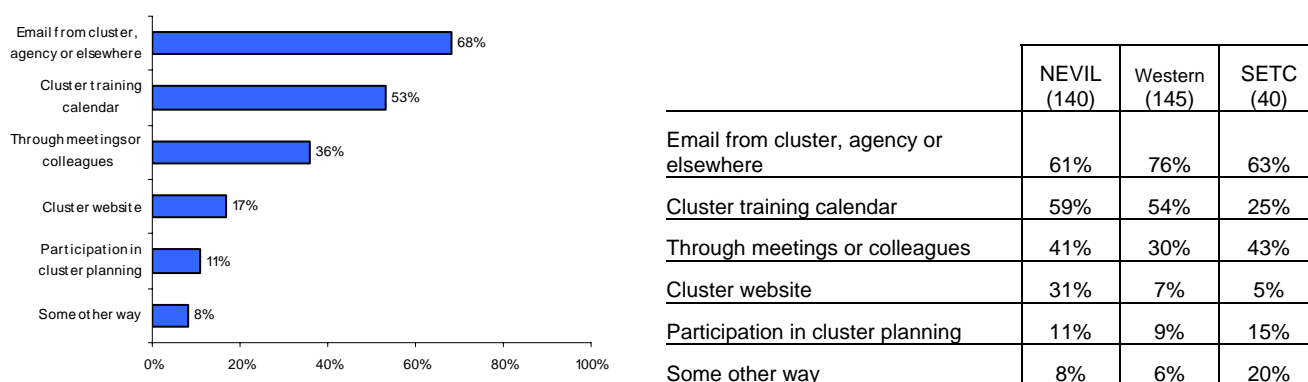
Respondents to the survey were asked how they usually obtain information about training activities. Two thirds of respondents (68%) reported usually obtaining information about cluster training activities by email, with the cluster training calendar also playing a role (53%). This is consistent with the focus groups where staff stated a clear preference for email information about training activities and reminders of upcoming events.

With 76% of respondents from the Western cluster reporting seeing emails about cluster activities, Western is performing particularly well on this metric.

Obtaining information through meetings and colleagues (36%) was more commonly reported as a source of information about cluster training activities than was the cluster website (17%).

Respondents from the NEVIL cluster showed a particularly strong use of the cluster website as a source of information about training (31% compared to 7% for Western and 5% for SETC).

Figure 1: Usual method of obtaining information about cluster training activities



3.5 Training assessment and planning

Respondents were asked if they had participated in a formal assessment of their training needs in the last three years. Half of the mental health workers surveyed either had not participated in a formal assessment (44%) or were unsure (6%).

Respondents from metropolitan Melbourne were more likely to report no formal training needs assessment in the last three years than were their colleagues from regional Victoria (47% compared to 33%).

Respondents working in CAMHS were particularly likely to have had a training needs assessment in the last three years (62%).

The 50% of respondents that had participated in a formal assessment of their training needs in the last three years were more likely to report this was conducted through the staff appraisal system (40%) than through a questionnaire (15%) or another method (12%).

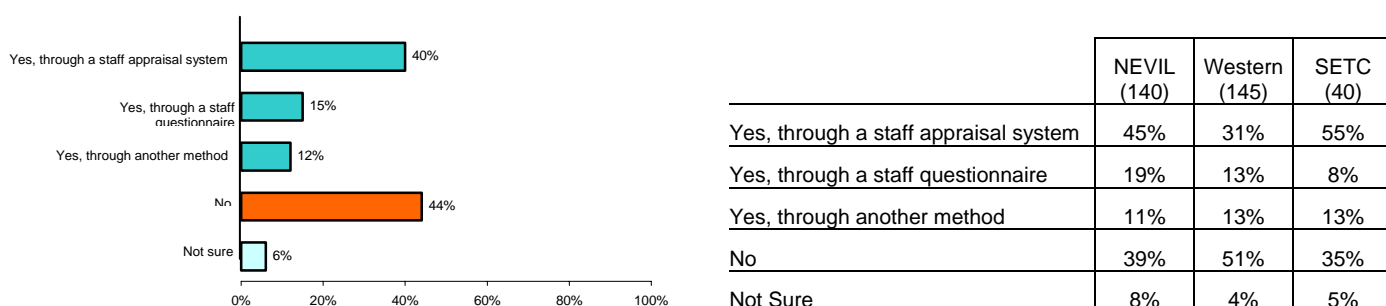
Respondents from NEVIL (54%) and SETC (60%) were more likely to have participated in some form of formal assessment than had respondents from Western (45%).

Registered nurses were more likely to report participation in a formal training needs assessment than were their colleagues in allied health (56% compared to 43%).

Figure 2: Participation in formal assessment of training needs in the last three years

Q6. Have you participated in a formal assessment of your training needs in the last 3 years?

Base=325



Just less than one third of respondents (29%) had an individual training plan to guide their professional development.

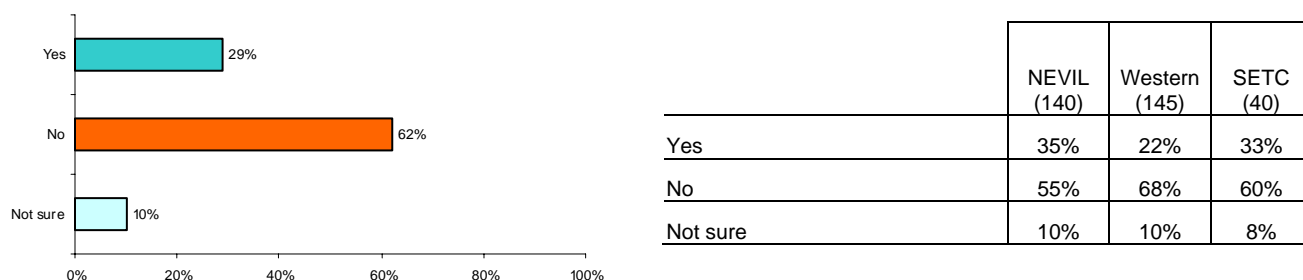
Respondents from Western were the least likely to report having an individual training plan (22%).

As would be expected, respondents who work in the area of staff training were more likely to report having a training plan (43%) than were either clinicians (26%) or management (38%).

Figure 3: Have an individual training plan

Q7. Do you have an individual training plan to guide your development?

Base=325



3.6 Participation in training activities

Respondents were asked to describe their participation in training activities provided by the cluster. In reading this section it is important to note that through the qualitative research it was apparent that many people were not able to clearly identify cluster-initiated training activities. Hence these figures are likely to under-report actual participation.

Over one quarter of respondents (28%) had not participated in any training activities offered by the cluster. The 72% of respondents who had participated in cluster training activities were more likely to have attended a workshop (51%) or lecture/ presentation (33%) than a conference (19%) or practical skills demonstration (7%).

Between clusters, participation in training was highest in Western (77%). Western respondents were more likely to have participated in a workshop (60%) than a lecture/ presentation (27%).

Respondents working in regional agencies reported higher levels of participation in cluster training activities than did their metropolitan colleagues (31% and 18% respectively).

CAMHS staff had lower levels of participation in training than did staff from aged services (61% compared to 88%).

Respondents in clinical care had lower levels of participation in training than did respondents working in management or training (69% compared to 88% and 76% respectively).

By professional area of interest, nurses had higher participation rates than either allied health professionals or doctors (76% compared to 69% and 61% respectively).

3.7 Training selection and approval

Respondents were asked two open-ended questions regarding their selection and agency approval of staff participation in training programs. The specific purpose of these questions was to identify the extent to which structured identification of staff training needs drives the selection and approval of training activities. As demonstrated in the following section, there was little formal reliance on identified need, with most training decisions made by individuals based on relevance to work, interest and discussions with managers and supervisors.

3.7.1 Selection of training activities by staff

Respondents were asked what factors they considered when deciding for which training activities to apply. Most respondents provided multiple reasons for their training selections. The most frequently mentioned reasons were relevance to work/ job (53%), area of interest (26%) and area of need/ deficit/ professional development (19%). Comments mentioned by 2% or less of the total respondents are included in ‘other’.

It is of particular interest that just 2% of respondents linked their selection of training back to a formal training plan, professional development plan or staff appraisal. Similarly, informal discussion with managers and supervisors was mentioned by 4% of the respondents.

Table 5: Decision to apply for training

Q4. How do you decide what training activities to apply for?	TOTAL n=321	Cluster		
		NEVIL n=138	Western n=144	SETC n=39
Relevant to work/job	53%	57%	49%	56%
Area of interest	26%	22%	33%	10%
Area of need/ professional development	19%	13%	28%	3%
Time available/ work release	11%	14%	8%	10%
Topic NFI	8%	4%	9%	15%
Relevant to profession/ discipline	5%	5%	5%	8%
Not too far away/ convenient	5%	4%	7%	-
Location NFI	5%	4%	7%	-
Discussed with manager/ supervisor	4%	7%	3%	3%
Don't do training	4%	5%	3%	5%
Relevant to organisation	4%	4%	6%	-
Look for new areas/extend skills	4%	4%	3%	8%
Relevant to age specialty	3%	4%	3%	3%
Recommendation from peers	3%	3%	3%	3%
Presenters/ facilitators	3%	2%	4%	-
Suitability of times	3%	4%	1%	5%
Compulsory/ mandatory	3%	4%	-	8%
No training in area	3%	4%	1%	3%
Other	17%	13%	21%	21%
Don't know	1%	0%	2%	-

3.7.2 Training approval by organisation

Respondents were asked to describe the agencies approval process for training. Almost one in five respondents (18%) did not know the agency's process for approving training. Most commonly respondents mentioned a need for training to be relevant to their area of work (21%) or raised by them with their manager/ supervisor (15%). Thirteen percent of respondents considered that training was up to the individual to approve. Twenty percent of respondents commented that training was either identified/ directed by their manger/ supervisor (10%) or compulsory (10%).

Table 6: Training approval process

Q5. How does your agency decide what training you should do?	TOTAL n=321	Cluster		
		NEVIL n=138	Western n=144	SETC n=39
Relevant to work/job	21%	25%	17%	26%
Raised by staff and discussed with manager/ supervisor	15%	12%	17%	18%
Up to the individual	13%	14%	12%	11%
Identified/ directed by manager/ supervisor	10%	9%	12%	11%
Compulsory/ mandator for organisation	10%	14%	6%	13%
Interest/ personal interest/ professional interest	9%	7%	11%	13%
Training plan/ professional development plan/ staff appraisal/ performance review	8%	10%	4%	13%
Relevant to organisation/ team	7%	7%	9%	5%
Area of need/ professional development	7%	7%	9%	3%
Time available/ work	4%	4%	6%	3%
Agency encouraging/	4%	4%	6%	3%
Cost/ training credits	3%	4%	3%	0%
Availability of replacement staff	3%	1%	6%	3%
Other	16%	13%	18%	21%
Don't know	18%	17%	20%	16%

3.8 Quality of cluster training activities

Respondents who had participated in training were asked to rate a number of statements about their experiences with training on a scale from zero to ten. Based on average scores out of a possible maximum of ten:

- There was a high rating for the level of support of management for participation in training activities (7.5 out of 10) and for the overall quality of training activities provided by the cluster (7.4 out of 10).
- Lower ratings were provided for the range of cluster activities available (5.8 out of 10) and the availability of training activities at the right level (6.0 out of 10).

Figure 4: Quality of training offered by clusters (average ratings)

Q9. Overall, thinking of all the training activities you have attended through the cluster, how would you rate the following areas? (0= very low, 10=very high)

Base =204 to 230

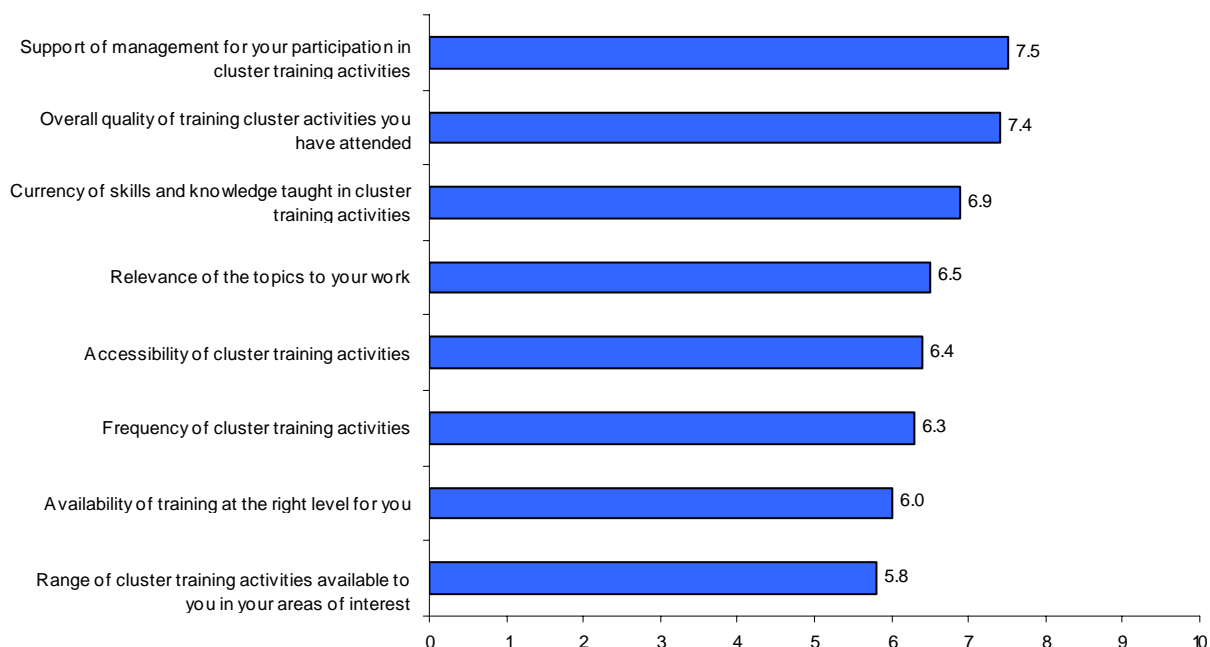


Table 7: Overall quality by cluster (average ratings)

Q9. Overall, thinking of all the training activities you have attended through the cluster, how would you rate the following areas? (0= very low, 10=very high)	Cluster		
	NEVIL n =91 to 96	Western n =101 to 109	SETC n =24 to 26*
Support of management for your participation in cluster training activities (for example, availability of time release, funding for expenses, etc)	7.3	7.6	8.0
Accessibility of cluster training activities (eg. don't have to travel too far)	6.6	6.2	6.8
Range of cluster training activities available to you in your areas of interest	5.9	5.7	5.5
Relevance of the topics to your work	6.5	6.5	6.2
Availability of training at the right level for you	5.9	6.1	5.8
Frequency of cluster training activities	6.5	6.4	5.7
Currency of skills and knowledge taught in cluster training activities	6.8	7.2	6.1
Overall quality of training cluster activities you have attended	7.2	7.6	6.9

*Low sample size

Reviewing the ratings by cluster, there were generally few significant differences. While SETC achieved the highest scores for *management support of training* and *accessibility of activities*, SETC was also the lowest rated cluster in all other areas. Both NEVIL and Western clusters received similar ratings to each other.

Location was a factor affecting many of the ratings. In all cases, residents from metropolitan agencies offered higher ratings than did respondents from regional agencies.

Age specialisation was also found to affect some ratings. Respondents working in CAMHS consistently provided the lowest average ratings for training on each dimension. Respondents working in the adult area consistently provided higher ratings.

3.9 Overall cluster performance

All respondents to the online questionnaire were asked if they considered that the cluster approach had improved their access to training and education. Just 51% of respondents considered that the clusters had made an improvement to their access, while 18% did not think the clusters had such an impact and 31% were unsure.

By cluster, respondents from SETC were the least likely to agree that the cluster approach had improved their access to training and education (35%).

Similarly, respondents who worked in CAMHS were less likely to agree than were respondents working in adult or aged (39%, compared to 56% and 66% respectively).

Respondents working in clinical areas were less likely to have agreed that their access to training had improved than were trainers or managers (43% compared to 68% and 62% respectively). Clinicians were also likely to express a higher degree of uncertainty (38%).

3.9.1 Cluster outcomes

Respondents to the online survey were asked a series of questions relating to the outcomes of their participation in cluster training activities. Based on average scores out of a possible maximum of ten:

The highest averages scores were awarded to the opportunities to share ideas with colleagues from other agencies (6.9) and improved theoretical knowledge and understanding (6.7).

Clusters were rated as less successful in improving capacity to work as part of a team (5.7) and reducing adverse practices or events (5.6).

Reviewing the ratings by cluster, there were no significant differences in average scores. However, as is apparent from the accompanying table, SETC achieved the lowest average rating in all areas. These results need to be treated with caution due to the low sample size.

Location was a factor affecting many of the ratings. In general, there was a tendency for respondents from metropolitan agencies to offer higher ratings than did respondents from regional agencies.

Age specialisation was also found to affect ratings with respondents working in CAMHS tending to provide the lowest average ratings on each dimension. Respondents working in the aged area tended to provide the highest ratings.

Figure 5: Cluster outcomes (average ratings)

Q10. How would you rate the extent to which your access to training and education through the cluster has assisted you in the following areas? (0= very low, 10=very high)

n =204 to 230

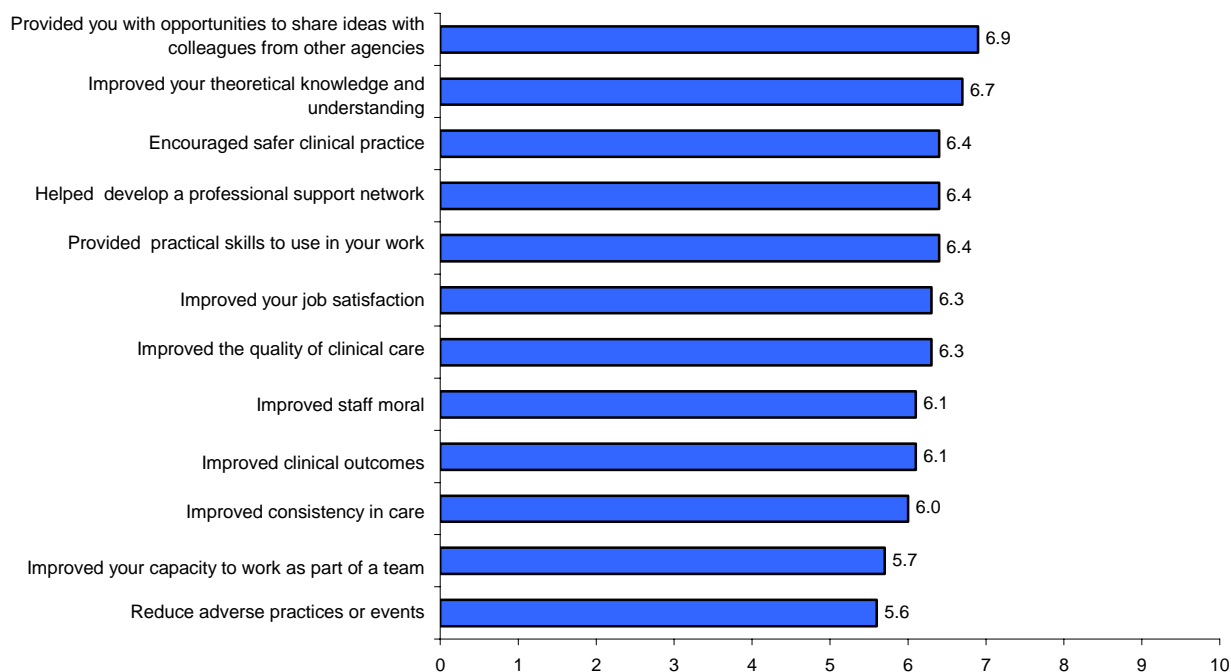


Table 8: Outcomes by cluster (average ratings)

Q9. Overall, thinking of all the training activities you have attended through the cluster, how would you rate the following areas? (0= very low, 10=very high)	Cluster		
	NEVIL n =85 to 96	WETS n =94 to 108	SETC n =24 to 26*
Provided you with practical skills to use in your work	6.2	6.7	6.0
Improved your theoretical knowledge and understanding	6.6	6.8	6.2
Improved your capacity to work as part of a team	5.5	5.9	5.4
Provided you with opportunities to share ideas with colleagues from other agencies	6.9	6.9	6.5
Helped you develop a broader professional support network	6.4	6.4	6.2
Encouraged safer clinical practice	6.6	6.3	6.2
Improved clinical outcomes	6.2	6.1	5.9
Improved the quality of clinical care	6.3	6.3	6.0
Reduced adverse practices or events	5.7	5.5	5.8
Improved consistency in care	6.1	5.9	5.8
Improved staff morale	6.0	6.1	5.8
Improved your job satisfaction	6.3	6.5	6.0

*Low sample size

4. Appropriateness

4.1 How well do the cluster priorities align with local needs, the strategic directions of partnering organizations?

Conclusions:

- The degree to which cluster priorities align with local needs and the strategic directions of their organisations ranges from low to high across organisations within the clusters.
- How well cluster priorities align with local needs and the strategic directions of partnering organisations is influenced by a number of factors:
 - the cluster’s approach to education and training needs analysis;
 - the partnering organisation’s education and training infrastructure;
 - the partnering organisation’s approach to identifying their education and training needs; and
 - the cluster project officer and Steering Group’s ability to translate those needs into a training program.

Recommendation:

Clusters adopt a common framework for the development of local education and training priorities that reflect member services’ strategic priorities as well as statewide priorities.

Evidence base

The degree to which cluster priorities align with local needs and the strategic directions of organisations vary from low to high across organisations within the clusters.

Evidence from both the document analysis and interviews with project officers and cluster Steering Group members indicated that cluster priorities varied in the extent to which they addressed partnering organisation’s strategic goals. Some service managers interviewed were positive about the match of cluster training priorities with their agency’s, indicating that the training needs identified were taken up by the cluster.

Training needs (passed on to the cluster) are determined in response to local needs, e.g. performance appraisals, audit results, incident reports, problems with documentation, and system changes.

Others were highly critical of cluster training priorities, stating that both the content and approach were inappropriate for a modern mental health workforce and did not match the rhetoric around training.

The approach to education and training employed in the cluster comes from a false hypothesis: that all staff are skilled to the required level. The research, for example Gavin Andrew’s, shows that they are not. Half the workforce doesn’t come near the National Practice Standards. Staff all need skilling up to be able to do their job.

During interviews, some senior managers from different larger organisations, with their own internal education and training infrastructure, found involvement with a cluster to be more of an imposition than a benefit.

Another important difference between agencies noted as impacting on the matching of education and training priorities was whether the agency’s workforce operated as ‘mental health professionals’, or as separate categories of professionals; nurses, psychologists, social workers etc. When asked to rate

cluster outcomes out of a possible score of ten, participants gave clusters the highest scores for ‘opportunities to share ideas with colleagues from other agencies’ (6.9) and ‘improved theoretical knowledge and understanding’ (6.7). Cluster ratings for ‘improving capacity to work as part of a team’ (5.7) and ‘reducing adverse practices and events’ (5.6) were lower. These findings are consistent with a comment from senior managers:

There is a gap between the training delivered and the results of evaluations of practice, and the management of its implementation. Where is the clinical audit process that shows that standards are being applied? (Interview)

How well cluster priorities align with local needs and the strategic directions of partnering organisations is influenced by the cluster’s approach to education and training needs analysis.

Information about clusters’ approaches to education and training needs analysis came from a range of sources, including progress reports from the clusters to DHS and interviews with project officers and members of cluster management committees.

In Western, training needs were identified through a survey form which was distributed to individuals in organisations through their representative on the Steering Group. In addition, the cluster management committee holds six monthly planning meetings to decide training priorities.

Basic needs analysis forms are sent to all individuals across the cluster. These ask the following: What are your individual training needs/priorities for the next 12 months? Please indicate topics for future cluster workshops. Please indicate possible speakers/presenters to deliver workshops. (Interview)

In SETC, six monthly audits of training needs were conducted, which quantified numbers of new employees in various professional categories who had and had not participated in particular mandatory training programs. In addition, discussions to identify projects to meet the needs of cluster members provides the opportunity for exploration of individual organisation’s training needs in terms of their strategic direction.

The NEVIL cluster established local training priorities through a planning process.

The Management Committee brainstorms priorities; the members (Senior Clinicians) bring needs of their organisations to the table; the Committee identifies priorities, reflecting on needs identified and DHS priorities; the Committee identifies when training should take place, and potential presenters; and priorities are handed over to the Project Officer who negotiates with presenters. (Interview).

Approaches which relied too heavily on employee preferences were criticised.

Currently the training needs analysis employed is based on what people want or would like. It is not based on a critique of practice. (Interview)

How well cluster priorities align with local needs and the strategic directions of partnering organisations is influenced by the partnering organisation’s education and training infrastructure

Evidence gathered during interviews with senior managers and focus groups indicated that there are considerable differences in the level of education and training infrastructure in member organisations. Sometimes this is associated with the size of the organisation. In other agencies, it was perceived as a matter of what the organisation had been prepared to invest in the development of its own workforce.

Some organisations saw the cluster money as an opportunity to catch up, because they hadn’t invested in training in their own organisations. Others wanted to focus to be on development of skills needed to ensure clinical practice was to the required standard. There were considerable tensions and resentment. (Interview)

Another criticism from a group of senior managers was that some agencies were using the cluster to provide basic training which should have been supplied internally, while others wanted to ensure their staff were trained to the national standards.

The original idea was excellent, "How do we address education and training?" But people shape, sort and twist it into what they want. At the outset, services had agendas about spending money rather than opening up the debate about what was needed across the cluster. (Interview)

In some instances, the opinion was that it was a difference in approach to training that was the issue. Managers from one of the large agencies commented that they had combined their operational and educational hierarchies (all operational managers are senior nurses), focusing on the distinction between academic and operational service-driven paradigms.

Having the clusters driven by Nurse Educators comes with a risk; the loss of the operational perspective. Operational managers can be left out of the communication loop. This becomes a barrier, although it is less of a problem for smaller services that don't separate these functions. (Interview)

Some of the views countered preconceptions that regional agencies are disadvantaged in terms of training compared to those in regional or rural areas.

There was a sense that in some regards the metropolitan services were in an advantaged position and would assist rural and regional services. This was a disservice to those non-metropolitan services. We were following State and National policies by implementing evidence-based practice in a family-centred way. Others were focusing on dealing with aggression and violence control. (Interview)

Likewise, large agencies were not necessarily considered to be at an advantage over smaller ones.

Often, smaller more compact services do it better. (Interview)

How well cluster priorities align with local needs and the strategic directions of partnering organisations is influenced by the partnering organisation's approach to identifying their education and training needs

Information about how partnering organisations identified their education and training needs was obtained through interviews with cluster management committee members, agency managers, and through information from focus group and survey participants. This indicated that approaches varied across agencies. There were also some differences between the perceptions of senior managers, from interviews, and those of staff, from the survey and focus groups.

At one end of the scale, managers stated that training needs were determined based on workplace performance indicated in reports and other documentation.

Training needs are determined in response to local needs, e.g. performance appraisals, audit results, incident reports, problems with documentation, and system changes. (Interview)

At the other end, senior managers in other organisations stated that training needs were based on a survey of staff in which they indicated their preferences. In these cases there appeared to be little recognition of the limitations of this approach. This approach was describe as, in some cases, very informal.

Managers generally know the training priorities for their staff. They know what goes wrong and what the training issues are.

The online survey results indicated that half the respondents had participated in a formal training assessment in the past three years.

Clusters are to a considerable extent dependent on the variable appropriateness and effectiveness of the education and training needs analysis practices employed by their member agencies. Some agencies are

collecting needs data based on staff preferences, others based on performance appraisals and work performance documentation.

How well cluster priorities align with local needs and the strategic directions of partnering organisations is influenced by the cluster project officer and Steering Group's ability to translate those needs into a training program.

The different approaches employed by the clusters to design training programs is influenced by the expertise and preferred approach of each of the project officers and members of the cluster management committee.

DHS had a good idea. They put it out, but with no guidelines. The loudest voices in particular areas dominate. You end up with different ways of operating in different areas, and no consistency across the system. (Interview)

From the project's commencement, the Department was keen for clusters to autonomously develop models that suited their local environment and members' needs. However, it was noted in interviews that the project officers had minimal guidance and no professional development or support in this area, and this resulted in lack of consistency across the system.

5. Efficiency

5.1 How have the different clusters been established, operated and maintained?

Conclusions:

- The clusters were established, operated and maintained as separate entities resulting in differences in structure, programs and operation.
- There are potential benefits to the system in the clusters collaborating on joint projects of common interest.

Evidence base

The clusters were established, operated and maintained as separate entities, resulting in differences in structure, programs and operation.

The case studies provide information about each of the clusters. They are all similar in that they operate as a partnership of member agencies, each of whom is represented on the management committee. Although two clusters began with both a governing board and a management committee, two have streamlined procedures and now have just the management committee. One of the most significant differences between the clusters is their initial approach to provision of education and training services. SETC deliberately based their approach on a stage, developmental model; gradually building trust amongst members and focusing on supporting those members to develop their internal training and development infrastructure and expertise through a range of funded projects. The other two clusters began as 'organisers of training and development', based on local and state priorities. NEVIL has moved toward supporting training and development activities within member organisations. There is growing awareness across the clusters of the need for improvement to the relevance and standard of needs assessment, training program development, delivery and evaluation.

At the project commencement, the Department deliberately allowed the clusters to develop their partnerships and service models according to local preferences and environmental factors. Overall, the establishment of the clusters as individual entities has had advantages and disadvantages. Evidence from the interviews with senior managers and focus groups indicates that, to a large degree, trust and collaboration between agencies has been established, and this has furthered discussion of education and training issues without the complications imposed by the accountabilities of the clinical situation.

Contentious issues can be raised in the education and training context in a way that they cannot be within the clinical context, with all its accountabilities, for example drug management and monitoring. (Interview)

On the other hand, some inconsistencies in goals, content and delivery of education and training, both across the system and within clusters have emerged.

There are potential benefits to the system in the clusters collaborating on joint projects of common interest.

During the focus groups, the need for greater co-ordination of training centrally was raised, particularly the use of education and training to shape the direction of the mental health sector. Some form of central co-ordination was also seen as a way to improve quality control of training content and to improve focus on recognition and transferability of training, and sharing of training materials across the sector. (Focus Groups)

Some agency representatives indicated that they did not want one cluster model across the system, because what suited some locations would not necessarily suit others. (Interview)

We don't want a Statewide footprint. (Interview)

This statement supports the Department's initial approach of enabling services to develop their own models.

5.2 What factors (positive and negative) have affected implementation?

Conclusions:

- Positive factors affecting implementation of the cluster project included:
- Strong leadership and clear roles and responsibilities.
- The ability to leverage off existing networks
- The sense of goodwill and co-operation amongst agencies
- The time and resources available through the nurse educator positions

Negative factors affecting implementation included:

- Perception of the clusters as being dominated by the interests of nurses.
- Limited guidance and options from the Department in establishing the clusters
- Lack of clear boundaries on the role of clusters
- Constraints of non-recurrent project funding
- Not building in clearer expectations and strategies to assist closer collaboration between clusters from the project onset
- The large size of the Western cluster.

Recommendations:

The MHB and the clusters develop an evaluation framework (linked to a statewide workforce strategy and education and training plan) that measures short, medium and long term impact and outcomes to evaluate the extent to which clusters are addressing identified workforce development, recruitment and retention issues.

The clusters are resourced to a level that enables cluster collaboration on common projects and training.

Evidence base

Positive factors affecting implementation of the cluster project included:

Strong leadership and clear roles and responsibilities.

The ability to leverage off existing networks and a sense of goodwill and co-operation from agencies

The time and resources available through the nurse educator positions

In addition, there was clearly an advantage where the leadership team – the lead agency and the project officer – were seen as providing effective leadership and maintaining a focus on the vision and goals of the cluster. In interviews committee members often specifically mentioned their confidence in the project officers.

“[Our project officer] is well respected and [the lead service] is seen as a good leader generally...” (Interview)

“[The project officer] is a successful organiser and was able to spread resources across the services and across professions.” (Interview)

“[A leader in our cluster] had the model. By the third meeting, with enquiries from members, he had articulated its features: the sense of engagement and listening, growing it slow, the skills inventory. This was very well done.” (Interview)

The use of existing networks by SETC and NEVIL were reported to have provided a clear boost to these clusters in their establishment. There was a sense of goodwill and co-operation already in place.

The nurse educator positions were seen as a workforce with sufficient time to invest in the clusters. This was seen as a specifically positive given that nurses are a substantial proportion of the workforce and were seen as particularly in need of education and training.

Negative factors effecting implementation included:

Perception of the clusters as being dominated by the interests of nurses.

Limited guidance and options from the Department in establishing the clusters

Lack of clear boundaries on the role of clusters

The large size of the Western cluster

While the nurse educator positions as a resource have provided greater capacity to the clusters, they have also impacted on the approach to education and training employed. There is a perception by some that the interests of nursing dominate the clusters. Similarly, there is a view that specific engagement with medical and allied health professionals is required. It was suggested that similar positions for medical and allied health professionals would be advantageous to the system.

“[The project officer] is not a nurse which is a good thing in my view ‘cause it provides an alternative reality of what’s pursued and what’s not. The other thing is that the investment in nursing development and education is phenomenal and there is a part of the universe who aren’t nurses saying, ‘Well hello what about the rest of us!’.”
(Interview)

Funding to the clusters was criticized as being minimal. Through both the focus groups and interviews, staff (senior managers, committee members and other agency staff) spoke of making substantial contributions of both their work and personal time in cluster activities.

“Our rep on NEVIL is very active. She has had the support of the organization, a lot of her time is now spent on NEVIL issues and she is the director of nursing. I think we’ve had a lot of input in development, perhaps the outcomes haven’t been as desirable as they could have been.” (Interview)

“The cluster has made a lot of work. People spend a lot of their own, unpaid time, developing the courses and co-ordination.”(Focus group)

“We put other things aside; work on our own time.” (Focus group)

As mentioned throughout this report, there are a number of areas where cross-cluster engagement could improve the overall framework for service delivery and monitoring for the cluster partnership project. The level of collaboration between clusters has been limited, with a general recognition now that there is room for a closer relationship while still maintaining the identity of individual clusters.

Establishing group cohesion has been most difficult for Western, no doubt due in part to the geographic spread of the cluster and the number of agencies and the populations supported. Earlier identification and remediation of this problem may have further increased the success of Western.

6. Effectiveness

6.1 What are the major outcomes that have been achieved from cluster-based groupings?

Conclusions:

- Although there are some gaps, all three clusters have increased their capacity to meet both statewide and local education and training priorities.
- One of the major outcomes to have been achieved from the cluster-based grouping is interested co-operation and sharing of resources between agencies. There is also a focus on the next steps needed to better inform and evaluate activities.

Recommendation:

The MHB and the clusters develop an evaluation framework (linked to a statewide workforce strategy and education and training plan) that measures short, medium and long term impact and outcomes to evaluate the extent to which clusters are addressing identified workforce development, recruitment and retention issues.

Evidence base

Although there are some gaps, all three clusters have increased their capacity to meet both Statewide and local education and training priorities.

The regular cluster reports to the Department provide evidence of each clusters' performance against the KPIs. A summary of these reports is provided in Appendix 8 - Reported Cluster Outcomes. In addition, section 3.9.1 highlights significant cluster outcomes as identified through the online staff survey.

Since their inception, all three clusters have increased their capacity to meet both statewide and local education and training priorities, as indicated by performance against Key Performance Indicators. There are some gaps, both in terms of priorities met and detail reported about activities. However, the overall the achievements are considerable, particularly given the limited time and resources available, and the complexity of the task of achieving collaboration between member agencies (in some cases former competitors). In addition, the evaluation identified evidence of the other achievements outside the KPIs.

The guidelines provided to the clusters directed them to undertake activities that would result in particular outputs and outcomes: efficiently run education and training partnerships and enhanced practices and service quality. The Stage 2 Guidelines focused on programs delivered systematically and consistently across agencies, on increased access and efficiencies, and on the implementation of standards and guidelines informed by collective expertise and agreed best practice. Targets were expressed in terms of '100% of eligible staff trained within timeframes' for example. In the Stage 3, the Guidelines focused on trialling of education and training activities using consistent and coordinated approaches, identifying benefits to members, documenting successful strategies and models and the development of strategies for sustaining successful cluster activities and approaches. Targets were expressed in terms of a coordinated, consistent and training program, accessible to all services staff within three months of employment. The KPIs should however, be directly linked to strategic objectives, and enable measurement that the activities scheduled were conducted within budget and within the specified timeframe, and that the intended outputs were achieved.

One of the major outcomes to have been achieved from the cluster based grouping is interested co-operation and sharing of resources between agencies.

While greater co-operation and sharing of resources was mentioned through interviews with project officers and cluster committee members, mental health workers spoke of a change in attitude within the sector in relation to the clusters and other policy initiatives.

Mental health workers who had been in the system for a while described a ‘silo mentality’ and ‘competitiveness’ between agencies as dominating the culture of the system. Staff moving between agencies were described as ‘going to the enemy’. This was seen as function of a broader policy environment. The clusters were seen as rebuilding ‘lost relationships in many cases’.

“The public sector reforms during the Kennett years devolved responsibility for education and training to the services and brought in competitive tendering. Cooperation through the clusters recreates the collegiality which existed before this.”

In the online survey, respondents rated highly the contribution the clusters had made to their opportunities to share ideas with colleagues from other agencies (6.9 out of 10) and improved theoretical knowledge and understanding (6.7 out of 10).

There is also a focus on the next steps needed to better inform and evaluate activities.

There was a very positive view from all clusters on the work that had been achieved. People spoke of making a high personal investment and commitment in the cluster system. However, there was also a strong sense that the basics had been mastered, and there was now a need for focus on strategic and ‘big picture issues’ like outcome evaluation and competency standards that had been seen as too hard earlier in the cluster project. This future work and focus was seen as having the potential to make a substantial contribution to both workforce and client outcomes.

“Its become apparent to us that we’re not strategic enough in our education and training planning, so when you get to see the paper work through [the project officer] we’ve got some strategic priorities for the next 3, 5 years and we’ve broken them up into areas, three major areas with subgroups, its about us thinking strategically and proactively rather than reactively.”

“The first step is to identify priority areas of core skill development for clinicians. We need a shared view around the key areas that are knowledge and skill based. We need to set standards and train to those standards and evaluate our success. This can lead to a quick turn around in patient recovery.” (Focus group)

6.2 How have these outcomes contributed to short, medium and longer-term outcomes?

Conclusions:

- The contribution of the discernable outcomes from the clusters' activities on short, medium and longer-term outcomes for member agencies and the system overall are not measured or evaluated through the clusters.
- The desired outcomes from workforce education and training programs are: development of knowledge and skills, changes in behaviour, improvements in workplace performance and improvements in workplace outcomes.

Recommendation:

The MHB and the clusters develop an evaluation framework (linked to a statewide workforce strategy and education and training plan) that measures short, medium and long term impact and outcomes to evaluate the extent to which clusters are addressing identified workforce development, recruitment and retention issues.

Evidence base

The contribution of the discernable outcomes from the clusters' activities on short, medium and longer-term outcomes for member agencies and the system overall are not measured or evaluated through the clusters.

The DHS guidelines for the establishment of the clusters included the requirement for each cluster to develop an evaluation framework. However, evaluation has generally been interpreted at a basic level and most has involved documenting and collating participants' responses to training activities.

Those both designing and delivering education and training programs must have a sound understanding of best practice in mental health if these programs are to contribute to the development of best practice in the workplace. However, information from some interviews with managers indicated that, in some instances, training providers do not have an adequate understanding of this.

Training institutions, including the cluster, don't have a shared view of what good practice is. (Interview)

People don't know how to talk about evidence based practice. If they can't talk about it, they can't do it. If they are not informed about evidence-based practice, then on what basis are they making treatment decisions? (Interview)

The desired outcomes from workforce education and training programs are: development of knowledge and skills, changes in behaviour, improvements in workplace performance and improvements in workplace outcomes.

Some criticism was levelled at the relevance of state wide priorities, because they did not address key workforce issues.

We don't have targeted education and training based on skill deficits. Recognised state wide deficits should be the input to training and development needs analysis. The statewide clinical audit from the Office of the Chief Psychiatrist (1998) identified areas of deficit which have not been addressed and still exist. These areas were not even contemplated when the cluster was planned. Audits could have formed the basis on which to establish training priorities. (Interview)

Staff in focus groups also indicated that they wanted their training to be updated and consistent with new practices.

We want specialist, evidence based, innovative, training based on the latest research. (Focus Group)

People who work as a team should train as a team. (Focus Group)

Decisions about which longer term outcomes to evaluate necessarily follow from identification of what outcomes are desired.

Reforms to mental health internationally and locally have focused on improving the quality of service delivered to clients and their carers through changes to practices guided by application of national standards. Leading edge approaches to mental health workforce development is geared to building a strong workforce by not only developing knowledge, skills and ensuring they are applied, but by also focusing on work and organisational systems of services. (Literature review)

6.3 Have clusters resulted in more effective resource sharing between partnering organizations?

Conclusions

- The structure of the funding and governance arrangements of the cluster project has meant the agencies have had to share resources so as to access training funding and programs.
- As goodwill and co-operation has increased between agencies within clusters, there is evidence of increased sharing of resources and ideas outside of cluster fostered activities. For example, several agencies reported making their internal training activities open to other cluster members.
- There was a clear sentiment that resource sharing could be made more effective if there was a greater focus on collaboration between clusters.

Recommendations:

The MHB, with the clusters, investigate the opportunities for improved partnerships arrangements between services including alternate cluster configurations if relevant.

The clusters collaborate to ensure that training priorities, evaluation frameworks and modules establish staff skills and knowledge that are transportable across agencies.

Where appropriate, Clusters encourage cross-cluster representation in training activities.

Evidence base

The structure of the funding and governance arrangements of the cluster project has meant the agencies have to share resources to access training funding and participate in programs.

As demonstrated from the cluster reports to the Department and the depth interviews with senior managers, all clusters have developed arrangements where training needs are identified at a central level and individual agencies develop proposals for meeting these needs with funding provided by the cluster.

There was a general consensus from interviews with senior managers that these arrangements were equitable and balanced issues such as agency location and size.

However, there was discussion in the focus groups that on some occasions agencies hosting an event may have an over representation of their staff in the enrolments. In some cases this may be due to the location of the activity and lack of interest from other agencies, or may reflect greater local awareness of the activity. In several cases during the interviews committee members were clearly aware of these issues and spoke of efforts to balance participation across agencies.

From the focus groups in particular, mental health workers who had been in the system for a while saw a general change in the relationships between agencies and considered that this was a result of the cluster approach and general focus on cooperation between agencies. Prior to the establishment of the clusters, participants spoke of a 'silo mentality' and 'competitiveness' between agencies. Staff moving

between agencies were described as ‘going to the enemy’. This was seen as function of a broader policy environment. The clusters were seen as rebuilding ‘lost relationships in many cases’.

As goodwill and co-operation has increased between agencies within clusters, there is evidence of increased sharing of resources and ideas outside of cluster fostered activities. For example, several agencies reported making their internal training activities open to other cluster members.

In both SETC and NEVIL, the clusters were able to build on existing relationships to some extent. In these cases in particular there was a strong relationship between agencies and a sense of working together and collegial support. In NEVIL there was a blurring between cluster funded activities and agency-based training activities. The cluster communication system was used by agencies to advertise capacity on internal training programs.

“Some of the training would take place, but the cluster relieves the member agencies of some of the workload.” (Interview)

“When we have vacancies on internal training program we open them up to the other agencies. In our [withheld name] course recently we had about 20% of people from outside [our agency] attend. It was a very big group but that was okay for the topic. It makes us feel good and look good when we can say that other people recognise what we do in this area. And our staff will go to their courses.” (Interview)

In some cases, senior staff were unable to identify if a course was internal to an agency or funded through the cluster.

“Hang-on. I think we sent people to that because they had vacancies and we need to do some work in triage. I don’t think that was an official cluster thing. I’d have to check.” (Interview)

Some clusters were clearly more advanced in the level of co-operation and collaboration that occurred outside of the cluster activities than were others. The sentiment from interviews and focus groups was that this may relate to competition between cluster management, with some clusters seen as using arguments around intellectual property to avoid sharing of resources.

In the online survey respondents attributed the major outcomes of the cluster (as determined by performance scores) to be the opportunities to share ideas with colleagues from other agencies (6.9 out of 10) and improved theoretical knowledge and understanding (6.7 out of 10).

In addition, there was a clear sentiment that resource sharing could be made more effective if there was a greater focus on collaboration between clusters.

The benefits of increased collaboration between clusters was raised by senior managers in interviews and in staff focus groups from each cluster. In some cases clusters’ leadership teams were seen as competitive and creating a ‘silo mentality’ between clusters. In one case ‘intellectual property’ was used to block agencies from sharing their cluster funded projects with agencies from other clusters. While it was also considered that agencies still maintain some of this competitiveness, particularly around training packages, this was seen as something that had a bigger impact on agencies historically in an environment of competitive tendering and decentralisation. For this reason, it was seen as particularly important that the clusters leadership teams play a stronger role in working cooperatively together, providing a role model for agencies.

“We are happy to share our resources, if we develop something. But there is some issue from the cluster. Intellectual Property or something. I think it is really about competitiveness. The clusters compete with each other. Some of them anyway.”(Focus group)

“The cluster is competitive. They don’t want to share the work they do. The clusters should be made to work together more.”(Focus group)

Similarly, it was noted in both the depth interviews and focus groups that one of the main advantages of the cluster approach is to provide a critical mass of participants to make training more economical and consequently more accessible. It was suggested that most agencies have a critical mass of nurses needed to run training in-house. Whereas allied health professionals were seen as particularly benefiting from the critical mass offered by the cluster. However, it was also noted that the small numbers of consumer and carer consultants will not reach 'critical mass' within the cluster and a cross-cluster approach may be required to meet their needs. There were not enough consultants within agencies or clusters to offer courses for consumer or carer consultants. A similar argument was suggested for the training of specialist groups such as CAMHS and drug and alcohol workers.

In addition, interviews with project officers and committee members revealed a number of areas where work is being duplicated by clusters, particularly plans for developing IT infrastructure, video conference or video production of training materials. Pooling of resources may make these long term plans come into fruition earlier.

Similarly, in interviews and focus groups with education teams and mental health workers issues were raised around the need for quality assurance of training, accreditation and recognition to allow portability of training across the state. While agencies may link some of the training to their organisational accreditation system, at the moment training is not seen as portable 'even within the cluster'.

"You can't just throw training at people. There needs to be follow-up and back-up and quality assurance to make sure you are doing it right" (Focus group)

It was also apparent from interviews with project officers, committee members and senior agency staff that the input to the cluster, particularly around needs analysis, are very variable and dependent largely on internal agency practices. In the online survey mental health workers 44% indicated that they had not been part of a formal assessment of their needs (including through an appraisal system or survey) in the last three years. Further, 62% of respondents to the online survey did not have an individual training plan to guide their development. This does not provide a common base for clusters to accurately identify training needs, plan training and evaluate outcomes overtime. The development of a comprehensive approach to needs analysis includes a number of complexities around the use of competencies and measurement systems. This project is likely to go beyond the current funding and capacity of clusters, but may be feasible with additional DHS funding.

"Currently the training needs analysis employed is based on what people want or would like. It is not based on a critique of practice." (Interview)

"At my level of experience and knowledge, I think I have a really good sense of what the staff need. Though, we don't do enough surveying. That is something that we could do better I think. It really comes down to how well the agency reps know the staff needs." (Interview)

"The first step is to identify priority areas of core skill development for clinicians. We need a shared view around the key areas that are knowledge and skill based. We need to set standards and train to those standards and evaluate our success. This can lead to a quick turn around in patient recovery." (Focus group)

Similarly, through the interview with senior managers all clusters identified that there was a need for a stronger focus on the program evaluation. As demonstrated by the cluster reports, there was a reliance on participant feedback through surveys or telephone calls, and numbers of participants and programs delivered.

"There is no baseline of current skills and knowledge, no link between needs and training and no vision of the future." (Interview)

*“There is a gap between the training delivered and the results of evaluations of practice, and the management of its implementation. Where is the clinical audit process that shows that standards are being applied?”
(Interview)*

Workplace implementation of learning is not measured, and perhaps for this reason, several course participants commented on lack of an implementation focus and workplace follow-up in program design and delivery. In addition, there was seen to be a need for a stronger focus on outcome measures more generally rather than outputs.

“It’s not just about the training. It’s as much about how to bring the learning into your work and your workplace.” (Focus group)

6.4 What similarities and differences exist in the content and methods of education and training delivered across the clusters?

Conclusions:

- As required by the DHS, there are some similarities in the content of education and training delivered across clusters
- Increased portability of skills between agencies would benefit the system and the individuals working in it.
- Education and training methods provided through the clusters would benefit from modernisation of learning methods and technologies employed.

Recommendations:

The clusters identify options to strengthen training delivery through the modernisation of learning resources and infrastructure (e.g. e-learning infrastructure and resources).

The clusters are supported to ensure that programs are delivered in accordance with learning approaches that are problem-focused, student centred and include active learning methods.

Evidence base

There are some similarities in the content of education and training delivered across clusters.

Progress reports from the clusters to DHS indicate training content that is common across clusters as required by the Department's project guidelines. This is not surprising given that, for the clusters, a key focus of their activities has been statewide training priorities, against which their performance is measured. In various forms, all clusters are delivering orientation programs, risk management and suicide prevention training. Other topics that have been presented in different clusters are leadership, train the trainer and some allied health related topics.

SETC has developed a set of standards for the development of training packages, available to all staff in the cluster that are responsible for training and the development of training packages. (Interview)

Two managers from regional services commented that there has been some attempt by their cluster to broaden the training calendar. However this appears to be management driven and not needs based. There has been some limited focus on performance management and review, and on individual service needs, but again, this has more of a metropolitan focus. (Interview)

No lower level training needs analysis has been conducted, content is based on DHS expectations and other courses are driven by steering committees and project manager. (Interview)

Increased portability of skills between agencies would benefit the system and the individuals working in it.

In the literature review, staff turnover was identified as a cost to the mental health system. This was one of the issues that the Education and Training Partnership Project was intended to address. Some focus group participants believed that improved quality control of training content and improved focus on recognition and transferability of training were needed and some form of central co-ordination was suggested as a means to achieving this. Currently, skills are not portable across clusters, much less across the system.

Consistency of training was identified as an issue.

There is no quality control. Trainers put their own interpretation on (materials) and you lose the consistency. (Focus Groups)

Linking in to projects to develop training resources that contextualise the National Standards and involve identification of core skills, including how they are applied and measured, would be a top-down approach to increasing portability and quality control.

Victoria has signed up to the National Standards, around which there has been considerable work at the national level, around education and training. All States and the Commonwealth have agreed to common online training programs. We are about to undertake a project to contextualize the standards to different work situations (Interview)

Education and training delivery provided through the clusters would benefit from modernisation

a) learning methods

The World Health Organisation (WHO) guidelines for establishing Human Resource policy in mental health, cited in the literature review, recommend problem-focused, student-centred, active learning in preference to a move away from traditional didactic and lecture-based methods.

Senior managers commented that learning provided through the cluster was neither flexible in delivery nor sufficiently directed towards improving practice. There needed to be an increase in focus on education that will change practice here and now. (Interview)

Greater academic links to university faculties were identified as a way in which, through the clusters, agencies could keep up-to-date with changes in thinking in adult education, social sciences, psychology, as well as innovative e-learning approaches. (Interview)

Access to Professor Gavin Andrew's learning modules on mental health were identified by a number of managers as a worthwhile investment. They were described as both effective learning materials and cost effective because they are self-paced audio visual materials which free up mental health professionals. (Interviews)

There was a lot of discussion on the difference between providing training and implementing it in the workplace – “bedding down training” was mentioned a lot – as something that is not happening. There was seen to be a need for a fundamental shift in the way training is delivered. (Focus Group)

If a training session involved an expert panel rather than one expert presenter, it could be relevant across program areas (such as CAMHS and adult) and this would provide a more dynamic discussion. Similarly, when looking at specific topics, participants suggested a multidiscipline approach – so for autism spectrum disorders including Occupational Therapists, neurologists and others. (Focus Group)

b) technologies employed

The potential contribution of using audiovisual facilities across the clusters and the system was raised on a number of occasions.

A group of senior managers commented that provision of education and training services would be improved by increasing the use of technology; using audio visual, video, video conferencing, broadband facilities instead of meetings and educational forums in central locations, adding that there was a lack of strategic thinking around the use of information technologies. (Interview)

They have video conferencing equipment but haven't used it. Apparently there is a cost involved. No one was aware of any online or flexible delivery of training. (Focus Group)

The spread and distances within the clusters made it essential that training products were adaptable to different locations, including remote areas.

The clusters are still in the early stages of their development and progress reports indicate that, in some instances, there are moves toward modernising the way in which learning is delivered. Both SETC and NEVIL, to different degrees, are beginning to work with their member organisations to improve the standard of training needs assessment, delivery and evaluation within those organisations.

The Audio-visual and Teleconferencing initiative was outlined in the SETC Progress Report (December 2006). The SETC International Medical Graduates (IMG) sub committee surveyed existing teleconferencing equipment and gained funding for audio-visual and teleconferencing equipment. This is an example of a highly innovative approach to learning which has the potential to not only make training opportunities more available, across distance and time, but to ultimately result in savings through resource sharing and reduced travel cost and time. This project is set to commence in 2007. In 2006, focus was on recording Southern Health Grand Rounds and making the DVD's available to IMG's at Latrobe Regional Hospital.

Longer term, this approach has the potential to operate across the system if the necessary co-ordination and funding is put in place. These facilities could be utilised for other human resource and other management communication purposes, not just education and training.

6.5 What is the optimal cluster size and configuration to support ongoing education and training needs?

Conclusion

- There is no magic number in cluster size. The optimal cluster size will be determined by the geographic proximity of agencies and agency size to ensure a critical mass particularly in regional areas.
- Western appears to be too big to have established and maintained an active and engaged management committee. Similarly, NEVIL activities could benefit from additional mass in the regional area.

Recommendation:

The MHB, with the clusters, investigate the opportunities for improved partnerships arrangements between services including alternate cluster configurations if relevant.

Evidence base

There is no magic number in cluster size. The optimal cluster size will be determined by the geographic proximity of agencies and agency size to ensure a critical mass, particularly in regional areas.

In discussing cluster size, it was raised several times by interview participants that this issue is relationships, and critical mass in the right places, to allow the efficient delivery of programs. While both NEVIL and SETC clusters were seen to have received a boost in implementation from leveraging off existing relationships between committee members, it was considered important that ongoing relationships are maintained that go beyond an individual level.

Western appears to be too big to have established and maintained an active and engaged management committee. Similarly, NEVIL activities could benefit from additional mass in the regional area.

Establishing group cohesion has been most difficult for Western. Undoubtedly this is partly due to the geographic spread of the cluster and possibly the size the number of agencies and the populations supported.

During in-depth interviews, several agencies from Western commented on feeling a closer relationship with members of NEVIL due to other associations and working arrangements.

A review of the activities and minutes of Western, as well as interviews with management groups, suggest that there have been ongoing issues in ensuring consistent participation in meetings.

The current configuration of NEVIL was commented on as contributing to the capacity to have an engaged and active management group. The current configuration of NEVIL was also commented upon, with respondents reporting that some regional activities have been affected by a lack of participation and have not been able to be offered. Several interview participants suggested that NEVIL has capacity to support additional 'one or two' agencies, particularly if they were in the regional area.

If, in the future, mental health services across the system are to be clustered in line with alternate boundaries or configurations, it would seem logical that education and training clusters were included in this configuration. (see Literature Review)

6.6 What factors are important to maximise sustainable models of education and training into the future?

Conclusions:

- The clusters have made significant progress since they began in 2004 within the levels of resourcing, guidance and support provided.
- Clarification and development of the clusters' role would increase the sustainability of their contribution to provision of education and training across the system.
- A statewide mental health education and training strategy may assist clusters to align their programs with Commonwealth and State policies.

Recommendations:

A statewide workforce strategy is developed that addresses the key workforce skill shortage and mobility issues (with an associated education and training plan for mental health), enabling strategic alignment of the clusters' education and training activities.

The MHB strengthens cluster guidelines and communicates these to sector and the clusters, with emphasis on:

- *Ensuring greater clarity of cluster purpose, scope and responsibilities*
- *Clarifying KPI's and accountability requirements*
- *Identifying communication opportunities and resources to support cluster collaboration on joint projects (e.g. evaluation tools, program delivery infrastructure)*

Evidence base

The clusters have made significant progress since they began in 2004 within the levels of resourcing, guidance and support provided.

During interviews with senior managers, comments were made about the considerable achievements of the clusters, given the funding levels, guidance and support that they received at the outset.

The clusters were established as an ambivalent response to the situation created by the centralised and service-based system: a compromise. No thought was given to a governance model. There was very little investment in terms of funding and very little driven from DHS. (Interview)

One manager commented that the clusters are well in the activities being undertaken. However, there are areas that are not being addressed and contributions are not even or clear across and within clusters. The best people for a particular task should be identified and they should be used as widely as is practical.

One senior manager stated that the level of funding provided to the clusters was insignificant given the performance tasks they were being assessed against.

The cluster's infrastructure and activities are trivial and can't do anything substantial, for example programs for overseas doctors. This needs hundreds of thousands of dollars.

The cluster should get back to doing what it is supposed to do, but how can it do this given the funding provided? (Interview)

During interviews, a number of agency managers stated that their organisation did not get back as much as it invested in the cluster. Some of its programs were useful, but the clusters were under

resourced and not sufficiently focused on providing quick response to training needs. The network of people actively involved in developing training for their cluster is thin. In addition, these highly valued people are shared or part-time. Just getting them together to meet, much less undertake cluster projects, is difficult: interconnecting across sites used up resources. This was emphasised as a major issue.

There appears to be a perception among some stakeholders that the clusters have absolute responsibility for education and training of the mental health workforce, rather than being responsible for the coordination and consolidation of specific training priorities.

A senior manager added that he believed that the local cluster needed an injection of resources. Response time to training issues was not fast enough. It could take up to 18 months, so the cluster needs to deal with long term issues. Agencies must respond immediately to local issues. (Interview)

The cluster program was described as seriously under resourced. (Interview)

For a small investment, we could get better co-ordination across the state. It would need to be external to government. You could create a virtual mechanism between the Department, the clusters and the agencies; an agency with more strategy, dealing with standards, evaluation etc, and with links to the various stakeholders in the unions etc. (Interview)

Project officers commented on the difficulty of operating under a twelve month funding cycle, with uncertainty about the DHS's commitment to the clusters, their own future employment and levels of funding for the next year. A permanent budget line, with a three to five year commitment before the next review, would be ideal given the time required to change an organisation's training culture. (Interview)

Clarification and development of the clusters' roles, to date unclear, would increase the sustainability of their contribution to provision of education and training across the system.

Best practice in mental health education and training partnership programs, identified in the literature review, indicated that the design of these programs is built around the fundamentals of the system which they are to support. The training program operated by the National Institute for Mental Health in England (NIMHE) supports the implementation of changes to workplace roles through team building and leadership programs. In addition, NIMHE supports a network of change managers who assist local agencies to implement initiatives which change the way services are delivered to clients in line with both national policies and national and local needs. The New Zealand approach defines training and development as incorporating all aspects of education and training, hence is employing an organisational system approach which considers recruitment and retention, leadership and management, and organisational culture, rather than gaps between workforce demand and supply.

A lack of consistency and coherence has been identified in the approach employed by DHS.

In most documents from DHS, education and training is presented as a priority. However, there is still avoidance of discussion of the core skills and knowledge required to deliver a treatment service, and how we develop them. (Interview)

Education and training priorities are set based on the latest crises, rather than being based on strategic planning to prevent or reduce the number of crises. (Interview)

The Department made the decision to allow each cluster to determine their own relationship with their membership.

The clusters have not worked out where they fit with client needs and the provision of other services. There is not duplication so much as dilution of the resources available. (The cluster) works across all programs in theory, but the material works best if it is directed to the needs of the clientele you deal with. (Interview)

SETC was based on an approach which defined that cluster's role in developing the education and training capabilities of its member organisations. The other two clusters commenced on a far more ad hoc basis. Although concentrating primarily on the delivery of a program of training activities, the other two clusters have, to differing degrees, become more involved with the education and training processes internal to their member organisations.

We didn't know about other models and options. We could use this now. Like improving training organisations – we don't know how to do that. We started by pooling expertise within the cluster. We were going to look at other clusters...but that never really happened. (Interview)

A number of interviews, from staff who work in Child and Adolescent Mental Health Services commented that MINDFUL offers better specialist courses, for example in the areas of eating disorders and aggression management.

Clarification of role – medical training has been dropped. e.g. Melbourne health program with David Barton – thought we would get close relationship with this – didn't happen. Doctors don't come to meetings."

Nurses, who dominated in numbers in aged and adult services, were seen as much better organized and motivated. (Interview)

"Those groups haven't got their act together. There has been a lot of talk, no action. Or the cluster really hasn't got the engagement and commitment of the relevant groups. The current cluster model has tried to address this but it's like it hasn't got any traction, or not enough traction."

A number of ways that the clusters could more effectively contribute to education and training across the system were identified. These include the following: refinement of approaches to professional development in the mental health sector; maintenance of Quality Assurance processes on training programs; and ensuring that training is at the appropriate level for different participants. It was stated that the clusters could have a greater education training role: e.g. professional development of trainers and moderation of training programs, now that they had established momentum, they could tackle more complex education and training issues in the future. (Interview)

Currently there is no statewide mental health education and training strategy to assist clusters to align their programs with Commonwealth and State policies, or with a system-wide workforce management plan.

Explicit reference to the value of a statewide training strategy was made during interviews.

We really need an education and training strategy, so decisions are not made in isolation from the broader landscape. People are not even making good decisions about what is education and training and what is practice and procedures etc. There has been a huge investment, with a lot of non-strategic activity, resulting in poor penetration: there is very little evidence that the education and training provided is contributing to behaviour change. (Interview)

The literature review provides evidence to support the recommendation to develop an education and training strategy linked to workforce management. World Health Organisation (WHO) guidelines for establishing Human Resource (HR) policy in mental health state that every mental health service should develop a sound policy and effective plan for staff development, including continuing education and training.

The study *Victoria's direct care mental health workers: The public mental health workforce study 2003-04 to 2011-2012* (DHS, 2006), which supported cluster-based approaches to delivery of training, identified development and implementation of a post employment, Statewide Education and Training Strategy as one of the ways to reduce future workforce shortages and staff turnover. This strategy was to be applicable to all direct care staff in public mental health services, informed by evidence-based models of

care, aligned to current initiatives and national practice standards, supported by additional resources, based on improved linkages across metropolitan and rural services.

In the two examples of international best practice in mental health workforce development that were identified, education and training were located within the context of the overall mental health policy system, supported by an implementation strategy and tool kits and guidelines for training professionals.

Focus groups discussed the move towards ‘mental health professionals’, while many cluster training activities focused on discipline specific areas of interest.

Practice development, conversion of knowledge into skills and how the transition occurs and is managed, are really important. The mental health treatment and care systems are changing and becoming highly specialised but there is not sufficient capacity for the system to consider how this will play out and how support can be provided to staff to develop the skills needed. (Interview)

Serious workforce management issues, and the impact on their work practices, were raised by focus group participants.

It's not that we are over trained it's that we are under resourced. We do the bare minimum to help patients survive. There just isn't enough time to do all the things we could do. We often have to fall back on to medication because there isn't time to take another, better approach. (Focus Group)

In interviews, it was noted that 70 percent of senior nurses will be retiring from the sector in the next 3 years. This has implications for the running of the clusters and nurse education generally. Various initiatives are in place to deal with this transition, including networking and co-presenting at conferences, however this transition has considerable implications for education and training in the sector. (Interview)

Focus group participants suggested some ways to improve transferability of skills to the workplace, including better use of case studies in training and access to trainers after initial training to answer follow-up questions as new knowledge is implemented in the workplace.

The first step is to identify priority areas of core skill development for clinicians. We need a shared view around the key areas that are knowledge and skill based. We need to set standards and train to those standards. This can lead to a quick turn around in patient recovery. (Interview)

There was also a discussion that training is embedded in a philosophy or culture that includes policies and procedures.

The lead agent imbeds their values in the training. No one checks that they get it right. (Training is about the implementation of policy and procedures to some extent. Eg acceptability of different types of restraint or the three second rule.) (Focus Group)

Need guidelines, policies, boundaries for consistency and quality control. (Focus Group)

6.7 What are the key areas, indicators and methods for ongoing performance monitoring?

Conclusion:

- The existing performance monitoring requirements do not adequately provide the clusters or Department with the capacity to evaluate the impact of education and training programs on workplace outcomes or their contribution to the development of the mental health workforce more broadly. Key areas, indicators and methods for ongoing performance monitoring should focus on outputs that are linked with the workforce outcomes described in the relevant policies and standards.
- The clusters commenced with a lack of baseline information on the skills and knowledge of their staff and the education and training priorities identified by the MHB were not based on identified gaps in clinical practice.

Recommendations:

The clusters adopt a common training needs analysis framework to assist in the assessment, delivery, and evaluation of education and training.

The MHB and clusters develop improved key performance indicators (KPIs) and ensure they are directly linked to strategic objectives and enable effective measurement of output achievements and progress.

The MHB establish a common template for reporting for all clusters for reporting against the KPIs.

Evidence base

The existing performance monitoring requirements do not adequately provide the clusters or Department with the capacity to evaluate the impact of education and training programs on workplace outcomes or their contribution to the development of the mental health workforce more broadly. Key areas, indicators and methods for ongoing performance monitoring should focus on outputs that are linked with the workforce outcomes described in the relevant policies and standards.

The Department guidelines identify an expectation that the clusters will collect data and report on activity to enable consistent monitoring and evaluation of activities. Further, they were to evaluate their workplans drawing upon the agreed data collection and reporting arrangements. Subsequently, cluster evaluation has consisted of compilation of responses from participants in training activities, with little or no account of the impact of learning in terms of skills acquired, changes to behaviour or changes to workplace practices.

Performance monitoring – get little on this as part of the governance group. Feel like I am the only one with this problem. I have suggested ways these reports could come to the governance committee. Systems are primitive and not satisfactory. We had indicative measures of success and outcomes – I never felt our reports met the standards. But we are actually working on this.

*There is a gap between the training delivered and the results of evaluations of practice, and the management of its implementation. Where is the clinical audit process that shows that standards are being applied?
(Interview)*

The targets provided to the clusters by the Department for each of the three stages reflected their stage of development, indicating progress from establishment through identification and systematic delivery

of programs across member agencies, to increased focus on co-ordination, demonstration of the benefits of co-operation to members and the documentation of successful strategies and models for sustainable clusters.

Evidence from the case studies and Section 9 - Reported cluster outcomes indicates that the different approaches taken by each of the clusters to the recording of progress against targets have been a reflection of the partnership model adopted by, or evolving within, the cluster. This, in turn, is affected by cluster size. Western, with eight member agencies, has focused on supporting training within member agencies. Hence, the reports focus on tabulating information about those activities. NEVIL, with six members and an increasing focus on combining both cluster and member organised activities, reports on both these. SETC, with four member agencies and with a collaborative, developmental model, has focused primarily on commonly negotiated (but agency-led) joint projects. To a considerable degree, SETC's reports have focused on the development of these projects.

The clusters' ability to report accurately on all education and training taking place has been limited by the quality of the information provided to them by their members, and the level of expertise in program evaluation within their own cluster management groups. All clusters have had to deal with the issue of inconsistent reporting of training activities by member agencies. Western described the lack of timely and accurate information about member agencies' training activities as one of the threats to its future. SETC indicated that one of their key goals was the development of a more systematic and formal approach to monitoring training across the clusters. This would be linked to initiatives to develop standard approaches to training packages, moderating training, and other means of providing encouragement and support to staff involved in the development of training programs. NEVIL indicated that it has begun discussions towards improving the implementation of NEVIL training. This will involve development of a training curriculum across the work life of mental health staff, development of alternative means of delivery, and improved training outcomes measurement that include workplace behavioural and attitudinal change.

All three clusters have indicated the importance of improving the consistency and quality of reporting about education and training activities by their members. At least two have commenced the process for improving this situation. The development of a clear and consistent approach for clusters to use by the Department (in collaboration with the clusters), on collecting data about agencies education and training activities, is an area that would have the likely positive flow-on effect of more consistent and better quality reporting about activities from the three clusters to DHS.

The clusters commenced with a lack of baseline information on the skills and knowledge of their staff and the education and training priorities identified by the MHB were not based on identified gaps in clinical practice.

In interviews with both agency managers and focus groups, concern was expressed about the lack of centralised quality control through evaluation to ensure that the integrity of training was not compromised. There was also concern that training could be imbued with the specific value system, philosophy or culture of the agency delivering it, which is not shared by other participating agencies.

More specifically, in an interview, a group of managers raised concerns that the operation of their cluster assumed that all clinical staff had acquired the skills and knowledge they needed to meet standards, and that the role of the cluster was to provide education and training which assisted in the maintenance and upgrade of these. However, these managers stated that as many as half the staff in the system do not have levels of competence at the required levels, and need basic training to reach these. Because the education and training priorities established by the cluster were not based on identified gaps in clinical practice, funds were being wasted on training activities which did not address these gaps.

The approach to education and training employed in the cluster comes from a false hypothesis: that all staff are skilled to the required level. The research, for example Gavin Andrew's, shows that they are not. Half

the workforce doesn't come near the National Practice Standards. Staff all need skilling up to be able to do their job. (Interview)

There has always been rhetoric around education and training, but the growth and management of intellectual capital within the organisation is the real challenge.

APPENDICES

7. Literature review

The Statewide Education and Training Partnership (Cluster) Project funded three clusters (groupings of area mental health services) to provide cluster-based education and training. The project, which emerged from mental health sector consultation, aims to improve opportunities for service managers, clinical leaders and senior educators across the sector to work together, to access quality post employment education and training for mental health staff. It was anticipated that these improvements would impact positively on recruitment and workforce retention, and practice and service quality. The objectives of this initiative are to:

- provide regular access to structured education and training activities that meet the needs of staff
- address Statewide and local priorities in education and training in clinical mental health sector
- use existing expertise and resources to develop sustainable education and training activities.

The aim of the evaluation is to establish progress of the project against key performance indicators and to assess the extent to which key program activities have been achieved.

7.1 Scope and structure of the literature review

The aims of this literature review are to outline the policy context in which the Education and Training Partnership (Cluster) program operates and to briefly describe examples of other mental health education and training partnerships that are based on cluster arrangements between service organisations. The review is divided into two main sections. The first outlines the policy context and the second describes three examples of approaches to the provision of education and training in mental health. The second explores practice examples of approaches to education and training in the mental health workforce from within Australia and overseas.

This is not an academic literature review. Although rigorous in approach, it has a practical orientation. Hence the review includes information from non-refereed material, as well as that from policy documents.

7.2 The policy context

This section introduces the international, Australian and State Government policy framework within which education and training in mental health operate in Victoria. The international policy context is identified through documents from the World Health Organisation (WHO).

7.2.1 *International – The World Health Organisation*

In *Human Resources and Training in Mental Health* (2005), the World Health Organisation (WHO) provides guidelines for establishing Human Resource (HR) policy in mental health, linking it to HR planning, appropriate management strategies, and training, including continuing education, training and supervision (ibid, p.2). It states that education and training should follow logically from the targets set by HR planning. Every mental health service should develop a sound policy and effective plan for staff development, including continuing education and training. The guidelines note that recent developments in mental health training show “a move away from traditional didactic and lecture-based methods towards problem-focused, student-centred, active learning methods” (ibid, p.13). Evaluation of the outcomes of workforce development is emphasised, because “The purpose of developing HR

for mental health is, after all, not simply to build a workforce, but ultimately to improve the mental health of the population that it serves” (Ibid, p.4)

The Mental Health Action Plan for Europe (WHO European Ministerial Conference on Mental Health, 2005) identified, as one of its 12 areas for action, the need to *Create a sufficient and competent workforce*. Amongst the eleven actions presented are the following: the recognising the need for new staff roles and responsibilities across the specialist and generic workforce; plan and fund, in partnership with educational institutions programs that address the education and training needs of both existing and newly recruited staff; addressing the lack of expertise in new technologies of present trainers and support the planning of “train the trainer” programs; educating and training mental health staff about the interface between promotion, prevention and treatment; creating an expert workforce by designing and implementing adequate specialist mental health training for all staff working in mental health care; developing specialist streams for the areas requiring high levels of expertise such as the care and treatment of children, older people and people suffering from a combination of mental health problems and substance use disorder (Ibid, pp. 8-9).

These two documents provide an overview of the WHO’s interpretation of the fundamentals required for a modernised mental health education and training system in the twenty-first century.

7.2.2 *Australia*

The direction for reform of mental health services in Australia was established in 1992 with the adoption, by the Federal and State Health Ministers, of the *National Mental Health Strategy*. This strategy provided the framework for collaboration between the Federal and State governments to undertake a program of reforms which would promote mental health, improve services provided to people with a mental illness, and reduce the impact of mental illness for individuals, their families and the community. The *Second National Mental Health Plan* (1998) expanded the first plan, including increased focus on mental health promotion, mental illness prevention and how the public mental health sector could maximise treatment outcomes and opportunities for recovery through links with other sectors (Australian Health Ministers, 2003, p.6).

The *National Mental Health Plan* (2003-2008) is very specific about aspects of education and training to be addressed. The Plan focuses on four key priorities: promoting mental health and preventing mental health problems and mental illness; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability (Australian Health Ministers, 2003, p.16). The priority *strengthening quality* is expanded to include specific outcomes and key directions under the subheading Workforce. Outcome 32: *Improved attitudes, values, knowledge and skills of the mental health workforce* is supported by five key directions. These key directions relates to the following: implementation of the National Practice Standards for the Mental Health Workforce; increasing the role of consumers and carers working in the system through increased training and support; promotion of the development and delivery of undergraduate, postgraduate and ongoing training for specialist mental health workforce, general practitioners and other primary care providers and non-government sector workers to improve knowledge and skills in specific areas; training in the interrelatedness of physical and mental illness; and increasing cultural competency within the mental health workforce (ibid, p.26).

In July 2006, the Council of Australian Governments (COAG) presented the *National Action Plan on Mental Health 2006-2011*, which outlines the initiatives, totally approximately \$4 billion, to be implemented by both the Commonwealth and State Governments. The plan notes that there are serious workforce shortages across all mental health professional groups, including nurses and psychiatrists. Amongst the aims is improving the care system through better co-ordination and by building workforce capacity (COAG, 2006, p.i). Commonwealth initiatives contributing to achieving this aim include Additional Education Places, Scholarships and Clinical Training in Mental Health, Mental Health in Tertiary Curricula, and Improving the Capacity of Health Workers in Indigenous Communities.

7.2.3 Victoria

Over the past 20 years, considerable progress has been made in the delivery of mental health services in Victoria. However, success in addressing the considerable social and economic costs of mental illness to the Victorian community depends, not only on additional funding, but also on commitment to improving the mental health workforce capacity and capabilities, and to more effective collaboration across the system (Boston Consulting Group, 2006).

The Victorian Government, the force behind the COAG decision to move to a Third Wave of National Reform for Australia, has committed \$4.4 million to Enhancing Workforce Capacity. This will fund clinical training and a range of graduate and postgraduate supports for students, ongoing education and training for mental health professionals, and training for frontline workers in improving service integration by training both health and non-health sectors in early recognition and intervention of mental health problems.

A recent study (DHS, 2006, *Victoria's direct care mental health workers: The public mental health workforce study 2003-04 to 2011-2012*) found that the Victorian mental health workforce would need to expand if it was to meet project service growth to 2011-12. Increased FTE requirements were 31 per cent increase in medical staff, a 25 percent increase in Division 1 and 3 nursing staff, an 18 per cent increase in Division 2 nursing staff, and a 25 per cent increase in allied health staff. In addition, the financial and associated costs of high staff turnover was and increasing strain on the system. One of the strategies, identified by stakeholders, for reducing future workforce shortages and staff turnover was the development and implementation of a post employment, Statewide Education and Training Strategy. This strategy was to be applicable to all direct care staff in public mental health services, informed by evidence-based models of care, aligned to current initiatives and national practice standards, supported by additional resources, based on improved linkages across metropolitan and rural services and supporting cluster-based approaches to delivery of training.

A document from the Victorian Government Ministerial Advisory Committee on Mental Health Service Structures and Partnerships Subcommittee (date unknown), addressing possible ways of improving the operational efficiency and viability of services and the facilitating linkages between services, has implications for the future configuration of the Education and Training Project clusters. This document presents a possible hierarchy of public mental health services, which distinguishes low/volume/high cost/Statewide and specialist elements from high volume/low cost/locally accessible elements. It also includes a preferred model for the clustering of mental health services, which aligns clusters to local government boundaries and links metropolitan and rural clusters.

7.3 Three models of education and training in mental health

This section provides an overview of three approaches to mental health education and training. Two involve partnership arrangements between service organisations and one does not. Although there are a number of partnership or cluster programs in mental health, or health generally, that bring together organisations from different sectors, there are very few which involve clusters of mental health service organisations. This review identified two national programs, one in England and the other in New Zealand. This section also includes an overview of the NSW Institute of Psychiatry's program, as it provides an example of an Australian organisation supplying a comprehensive program of education and training in mental health on a Statewide basis.

7.4 England

In England, workforce development for mental health is organised through the National Institute for Mental Health in England (NIMHE) which is part of the Care Services Improvement Partnership (CSIP) that operates across regions within a locally devolved National Health Strategy.

More than 85 per cent of the National Health Strategy budget is distributed, at the local level, through 152 primary care trusts (PCTs) which run some primary and community services or commission them from other providers, and largely commission secondary care. PCTs main functions are improving the health of the community, developing primary and community health services, and commissioning services, either by themselves, in partnership with a local authority, or through devolving budgets to commissioned agencies. PCTs work collaboratively, involving patients, the public, GP practices and partners. They must co-ordinate all agencies delivering healthcare in their area and across, where necessary across boundaries. (<http://www.nhsconfed.org/primary-care-trusts/primary-care-tr-1762.cfm>)

PCTs are responsible for commissioning all mental health services. There are 43 specialist mental health trusts that provide a range of services. Statutory mental health services employ about 80,000 staff.

7.4.1 Care Services Improvement Partnership

The Care Services Improvement Partnership (CSIP), a cross discipline and service partnership, was commissioned in 2005 by the UK Department of Health to improve services, implement policy and promote the health and wellbeing of people in England by working with health, local government, public, voluntary and private sectors. CSIP is a devolved organisation, providing support through eight regional development centres work. These centres work with local stakeholders and national partners to improve services, addressing both local and national priorities for their region. CSIP is made up of networks, some connecting the organisation internally, others connecting with external organisations. These networks operate both face-to-face and online.

CSIP aims to improve the quality and efficiency of services through client and carer oriented, evidence based approaches and methods that promote new and effective ways of working. The CSIP national programs are Children and families; Health and social care in criminal justice; Integrated Care Network; Learning disabilities; Older people and physical disability; Social Care; and Mental Health. The CSIP Mental Health program is through the National Institute for Mental Health in England (NIMHE).

7.4.2 NIMHE

The National Institute for Mental Health in England (NIMHE), whose aim is to improve the quality of life of people who experience mental distress, provides a focal point for the development of the whole mental health workforce through its National Workforce Programme (NWP). NIMHE achieves this through three strategic priorities: system transformation, workforce development and changes to practice. (<http://nimhe.csip.org.uk/about-nimhe.html>, 4 Mar 2007). The NWP National Mental Health Workforce Strategy (2004) outlines six aims: to improve workforce design and planning, embedding it in local service planning; improving ways to recruit and train; to facilitate new ways of working across professional boundaries; create new roles so as to tap into new recruitment pools; develop the workforce through education and training at both pre- and post-qualification levels; and to develop leadership and change management skills

(<http://www.skillsforhealth.org.uk/mentalhealth/nwp.html>).

The majority of NIMHE's work is delivered through a network of eight regional development centres, which support the activities of the Care Services Improvement Partnership.

7.4.3 *New Ways of Working*

Responding to address shortages in consultant psychiatrists, the report *New Ways of Working for Psychiatrists* (2005) declares that it is “about big culture change... not just tinkering at the edges of service improvement” (Ibid, p.3). The New Ways of Working report outlines how the skills, knowledge and expertise of consultant psychiatrists can be best used if they concentrate on service users with the most complex needs, act as consultants to multidisciplinary teams, promote distributed responsibility and leadership across teams. The approach focuses on those capabilities and competencies, rather than the number of particular professions, required for the system to function effectively. It redefines work roles and outlines strategies for the professional development associated with its implementation.

This report will very soon be complimented by the New Ways of Working for Everyone report which builds on the work above to explore what NWW means for all practitioners/ professionals and primary care. The initiatives described in these reports have considerable implications for the professional development of mental health workers, and for the operation of multi-disciplinary teams.

A major part of this new report will be to provide overall guidance on new ways of working for everyone in mental health care, across all care settings. The guidance will be underpinned by a detailed and supportive Implementation Guide for plan that guides NHS Trusts and other organizations thru a process from Board level to clinical and service delivery levels. One of its key approaches will be to provide an off the shelf toolkit called Creating Capable Teams Approach, which provides a stepped programme for teams to review, identify gaps in the competencies, mix, and roles of staff, and to enable the workforce to meet the needs of service users and their carers. CCTA roll-out will be supported by a National, and regional programme that inducts facilitators and works with local trusts to implement this approach in their chosen service areas. There will also be other support for the implementation of this report including Regional events, Learning sets, a new website and work during 2007/8 to plan for the longer term this work will be lead by a small National New ways of working team with the support of the professional bodies, and organisations involved in mental health care.

7.4.4 *NIMHE in summary*

The NIMHE services a population almost ten times the size of that of Victoria. The eight regional centres through which it operates are on a more comparable scale to the Victorian system.

The approach to provision of learning and development provided by through the NIMHE is comprehensive, with modernisation of the mental health workforce a key focus. The issue of workforce shortages has been tackled head on, with workplace competencies and capabilities required to achieve national standards clearly defined and work roles redefined to free up highly skilled professions and strengthen teams. This work has been supported by the National Mental Health Workforce Strategy, which articulates how the vision for the workforce is translated into measurable workforce planning targets and what actions will be undertaken to achieve those targets.

The NIMHE, operating through the eight CSIP regional centres, has assisted services to adapt to these considerable changes through a networking and facilitating approach. NIMHE helps services to develop by providing specialist training to support organisational change and team growth, and by facilitating change management projects which address both national and local priorities.

7.5 **New Zealand**

Education and training for the mental health workforce in New Zealand provide an example, on a smaller scale, (England’s population is more than ten times that of New Zealand’s) which also involves partnership arrangements and is undergoing modernization.

New Zealand has a mental health and addiction workforce of approximately 8,000 (Ministry of Health, New Zealand, 2005. p.7). This includes nurses, addiction practitioners, psychiatrists and other medical

practitioners, psychologists, social workers and support workers. The national workforce plan *Tauanwhitia te Wero, National Mental Health and Addictions Plan 2006-2009* outlines the approach to mental health workforce planning and development and describes key project areas for the next three years.

Within the plan, training and development is defined as including “all aspects of education and training focused on developing the knowledge, skills, attitudes of people to work in mental health and addiction services, as well as ongoing training and development once people are working in the sector” (Ministry of Health, New Zealand, 2005. p.25). However, the plan presents a whole system approach which, rather than identify the gap between workforce demand and supply, focuses on how each part of the system interacts. Hence, education and training are not considered in isolation from say recruitment and retention, leadership and management, and organisational culture (Ministry of Health, New Zealand, 2005).

The national plan is intended to provide direction on key issues. Detailed workforce development and planning are outlined by the national mental health and addiction programmes and centres, District Health Boards, non-government organisations and regional mental health and addiction workforce co-ordinators. The Mental Health Workforce Steering Committee has strategic oversight of all mental health and addiction workforce development.

Workforce development in New Zealand is supported by a national workforce infrastructure, which includes national centres and programmes: Te Pou, the national centre for mental health research and workforce development; The Werry Centre for mental health child and youth workforce development; Te Rau Matatini for development of the Maori mental health workforce; Matua Raki for the development of the addictions workforce. They also support regional co-ordinators.

The infrastructure covers some priority mental health service and workforce areas for Maori, child and youth, addictions as well as general strategic issues which affect all service areas and groupings. The Ministry of Health funds this workforce infrastructure to support the work being done through mental health and addictions services. In addition, the Clinical Training Agency (CTA) which is part of the Ministry of Health purchase psychiatrist training and conduct a number of post entry clinical training programmes for nursing, alcohol and drug, allied health, Maori mental health and child and youth as well as forensic. In future CTA will no longer manage these particular programmes but will retain the psychiatrist training.

The total budget from both the Clinical Training Agency (for mental health and addiction programs) and the Mental Health Directorate (for mental health and addiction Post Entry Clinical Training programs and mental health and addiction workforce development) for 2004-05 was \$25.77 million. (Ministry of Health, 2005, *Tauanwhitia te Wero – Embracing the Challenge: National mental health and addiction workforce and development plan 2006-2009*, Wellington: Ministry of Health, p.9).

During 2007, the Ministry of Health will oversee a review of education programmes and development of a national training plan through Te Pou, the national centre for mental health and workforce development. This will also link with the development of a competency framework to guide training and education. The approach to the development of the national training plan is outlined in the document *Mental Health Programmes 2006-2007: Delivering Now and Shaping the Future* (Te Pou, 2006). The key aspects of this approach are presented in the next section.

7.5.1 Te Pou

In late 2005, the Ministry of Health selected Wise Trust, a charitable trust, as the host organisation for Mental Health Programmes, previously managed by the Health Research Council. Wise Trust set up Mental Health Programmes Limited (MHP) to hold all contract funding for the programmes. Wise Management Services is another charitable trust wholly owned by Wise Trust. Wise Management Service is assisting MHP with establishment of structures and systems and will, in the future, enter into a formal agreement with MHP to provide a suite of management services (*Mental Health Programmes*

2006-2007: *Delivering Now and Shaping the Future* (Mental Health Programmes Limited, 2006). This programme is now known as Te Pou.

It is intended that Te Pou will build strong relationships with key stakeholder individuals and agencies and will work closely with organisations that contract the Ministry to provide complementary workforce development and or research programmes, or who may assist in advancing initiatives. Te Pou has begun with eight full-time positions, including a National Workforce Manager, Service User Development, Human Resource Project Development, Nursing Framework Development, Administration (2), Communications, and Project Development. It is envisaged that this will increase as programmes develop. Te Pou will support the Regional Workforce Development Co-ordinators through two way communication, collaboration, and by providing resources.

The range of programmes that Te Pou are undertaking include: mental health leadership, national resource group for service improvement, development for service users working in mental health, consumer advisor training, dialectic behaviour therapy training, Asian mental health workforce development, recruitment tools, managing risk, skill advancement for funders and planners, whole-of-system approach to acute solutions, among others. In addition there is to be an international workforce conference organised for 2008.

The focus of research supported by MHP will be on achieving the objectives of the mental health sector, investigating ways to improve practice and the system. This will be linked to the work in the workforce development and outcome measurement areas.

7.5.2 *Te Pou in summary*

Te Pou services a population which is comparable in size to that of Victoria, hence offers a case for comparison in terms of scale. The organisational structure of Te Pou, located within a charitable trust, provides arms-length operation from government, without the complications of a commercial operation. Te Pou's education and training program will be enhanced by the organisation's research program. There is a clear statement that the approach to education and training is to have a practice rather than an academic orientation. In addition, education and training provided are to be systems based, focusing on organisational change, not solely on individual development.

At this point in time, MHP is in the process of establishing its organisations and programs. It will provide an interesting case study in the implementation of an education and training program within an integrated approach to workforce development in mental health.

7.6 New South Wales Institute of Psychiatry

Although it relies on partnerships and collaboration with other organisations, the New South Wales Institute of Psychiatry (NSWIOP), unlike the two examples described above, does not operate through clusters of service organisations. NSWIOP is included here because it offers an example of an Australian organisation providing a comprehensive program of education and training on a state wide basis.

7.6.1 *Legal status and governance*

The NSWIOP is a long-standing and highly formally structured organisation. It was established in 1964 under and Act of Parliament which prescribes the Institute's objects and the composition of its governing board.

The Act specifies that the board must consist of the Director of the Institute, and ten members appointed by the Minister. Three are to be the chairperson of the Institute, a member of the business community, and a person who has a demonstrated interest in mental health to represent consumer interests. Six members are to be: a psychiatrist (selected from nominations from the NSW Branch of the Royal Australian and New Zealand College of Psychiatrists); a health professional engaged in

mental health services work (selected from two nominees from each of the NSW Branch of the Australian Psychological Society, the NSW Branch of the Australian Association of Social Workers, and the Australian Association of Occupational Therapists); a mental health nurse (nominated by the Australian and New Zealand College of Mental Health Nurses), and three academic psychiatrists (selected from a panel of nominees from the University of Newcastle, the University of New South Wales and the University of Sydney). One is to be a senior officer of the Department of Health, or a chief executive officer of an area health board (*New South Wales Institute of Psychiatry Act 1964 No 44*).

The objects outlined in the Act include the following: fostering and co-ordinating research the causes, prevention, diagnosis and treatment of mental illnesses and disorders and post-graduate education and training in psychiatry; prescribing training programmes, including psychiatry for medical practitioners to meet the requirements and standards of authorities recognised by the Institute, psychiatry for medical practitioners, and for other persons approved by the Institute, and mental health for non-medical groups approved by the Institute; awarding fellowships for training or research in psychiatry or allied disciplines; and promoting visits from other States or countries by lecturers in psychiatry or allied disciplines, and mental health education in the community.

7.6.2 Organisational structure

The structure of the Institute consists of the following: an Academic Board answerable directly to the board; four directors who report through the Institute Director (Director of Clinical Teaching and Research Unit Adult Psychiatry, Director of Training Adult Psychiatry, Director of Training Child, Adult and Family Psychiatry, and Programme Director); the Research Director who reports through the Director of Clinical Teaching and Research Unit Adult Psychiatry; four Standing Committees (Research, Multidisciplinary, Training of Psychiatrists and Community Education and Outreach); two committees (Ethic and Finance); and a manager. (NSWIOP, 2007, *The New South Wales Institute of Psychiatry 2006 Annual Report*).

The Institute receives its revenue from both State government and other sources. In 2006, of total revenue of just under \$5.9 million, approximately \$2.3 million came from the State government, approximately \$1.4 million from courses and workshops and just under \$1.8 million was project income, with the remainder coming from other sources. (Ibid).

7.6.3 NSWIOP programmes

The Institute's approach to fulfilling its obligations under the Act is captured in its mission statement which states the following:

NSWIOP is committed to providing a quality learning and research environment based on the principles of academic integrity, fairness, equity and mutual respect. The Institute strives to provide a distinctive clinical orientation to address the needs of a diverse mental health workforce and to promote the advancement of mental health education in the community. The NSWIOP encourages an educational culture of innovative thinking and critical analysis of mental health paradigms and practice. NSWIOP programs aim to provide an integration of contemporary theoretical frameworks with clinical skills and ethical practice.

(<http://www.nswiop.nsw.edu.au/pages/about/mission.php>, Accessed 28 Feb 2007)

The Institute offers courses at Graduate Certificate, Graduate Diploma and Masters levels, workshops and other short programmes of continuing professional development, courses customised specifically for organisations, flexible course delivery, distance education and accredited self-paced study. Broad content areas covered include Community, Consumer and Carer Programmes, Medical Practitioner Courses, Graduate Programmes and Continuing Professional Development. The specific programs and courses provided by the Institute are too numerous to list, however information about them is available from the Institute's handbook and website (www.nswiop.edu.au).

In addition, the Institute has established a clinic to provide students with the opportunity to integrate mental health theory and practice, and the application of course-based knowledge to clinical assessment and intervention (NSWIOP, 2007, *The New South Wales Institute of Psychiatry 2006 Annual Report*).

7.6.4 Links with other organisations

The Institute has extensive networks with both government and non-government organisations through which it participates in joint projects and programs. Examples are Aggression Training and the Statewide School-Link Training Program to improve mental health outcomes for adolescents and their families. Approximately 400 expert lecturers, from the academic, public, private, government and voluntary sectors are involved in teaching and conducting Institute courses. (NSWIOP, 2007, *The New South Wales Institute of Psychiatry 2006 Annual Report*). Other recent collaborators organisations include the ARC, the Australian Mental Health Outcomes and Classification Network.

In 2005, the Institute was contracted by the South Australian Government to work with their Department of Health to establish the South Australian Mental Health Training Centre, through which a calendar of short training programs for mental health practitioners is organised.

The NSWIOP provides a very wide range of education and training programs, from accredited postgraduate qualifications to short course for mental health workers at a variety of levels, as well as its research and other activities which promote the quality of the workforce. Based on its reputation for excellence, the Institute has gained Federal Government support for its programs and, despite being based in New South Wales, has been commissioned by the South Australian State Government to provide training in their state.

7.6.5 NSW Institute of Psychiatry in summary

Fostering research, developing high quality, accredited post-graduate programs and awarding fellowships in psychiatry and allied professions are not just a priority with the NSWIOP, but a statutory requirement. This is an organisation, with high order academic standing, which also provides a range of standard and tailored learning programs across a range of levels to address workforce development needs of the mental health workforce.

7.7 Conclusions

Collaboration between Federal and State Governments since 1992 and the commitment of the State Government have resulted in considerable progress in the modernisation of the mental health system in Victoria, and with this, the approach to education and training for the sector. However, the examination of other systems undergoing similar processes of modernisation provides information about other ways of integrating education and training into a program of workforce development, and how establishing an education and training strategic plan can potentially strengthen the appropriateness of education and training to the needs of the community and the effectiveness and efficiency of that education and training program in addressing those needs.

	England NIMHE	New Zealand Te Pou	NSW Institute of Psychiatry	Victoria Education & Training Partnerships
Level	National	National	State	State
Population	50,094,000 (2004)	4,179,000 (2007)	6,720,000 (2004)	4,963,000 (2004)
History	NIHME was established in June 2002, with eight development centres, a research network and small central team. NMHIE now operates through the Care Service Partnership (CSIP) which was established in 2005.	During 2007, through <i>Te Pou</i> , MOH will review education programs and develop a national training plan, linked to the development of a competency framework.	Established in 1964 under an Act of Parliament.	In 2003/04, DHS established a project to identify opportunities for, and ways of, improving workforce quality through the use of multiple service (cluster) partnerships to plan and deliver post employment education and training.
Purpose	To improve the quality of life of people who experience mental distress and provide a focal point for the development of the whole mental health workforce through its <i>National Workforce Programme (NWP)</i> .	<i>Tauanwhitia te Wero, National Mental Health and Addictions Plan 2006-2009</i> covers “all aspects of education and training focused on developing the knowledge, skills, attitudes of people to work in mental health and addiction services, as well as ongoing training and development once people are working in the sector”.	...fostering and co-ordinating research into the causes, prevention, diagnosis and treatment of mental illnesses and disorders and post-graduate education and training in psychiatry; prescribing training programmes, including psychiatry ...to meet requirements and standards... awarding fellowships for training or research in psychiatry or allied disciplines; promoting visits... by lecturers in psychiatry or allied disciplines, and mental health education in the community.	Improve workforce recruitment and retention and provide a structure and framework for improving practice and service quality more broadly, through more effective and efficient, less variable education and training across the system.

Approach	<p>NIMHE achieves its aims outlined in the <i>National Mental Health Workforce Strategy</i> (2004) through three strategic priorities: system transformation, workforce development and changes to practice. Key focus is on modernizing services.</p> <p><i>Mental Health Policy Implementation Guide: A Learning and Development Toolkit for the whole of mental health workforce across both health and social care</i> (2007) sets out the priorities that local health and social care organisations should take into account in developing learning and development strategies.</p>	<p><i>Tauwhitia te Wero, National Mental Health and Addictions Plan 2006-2009</i> presents a whole system approach which, rather than identify the gap between workforce demand and supply, focuses on how each part of the system interacts.</p>	<p>Committed to providing a quality learning and research environment based on the principles of academic integrity, fairness, equity and mutual respect.</p>	<p>Formation of 3 separate partnerships or cluster arrangements between multiple service providers. Each cluster developed its own approach.</p>
Standards and Competencies	<p><i>NHS Knowledge and Skills Framework: A Framework for the whole of the Mental Health Workforce</i> (2004)</p>	<p>In 2006-07, first sets of dual competencies developed as part of the <i>Let's Get Real</i> (Core Competency Development) program.</p>	<p><i>National Practice Standards for the Mental Health Workforce</i> (2002)</p>	<p><i>National Practice Standards for the Mental Health Workforce</i> (2002)</p>
Governance	<p>The National NIMHE board oversees issues at the national level. In each of the regions, NIMHE programs are overseen by a local regional board.</p>	<p>The <i>Mental Health Workforce Steering Committee</i> has strategic oversight of all mental health and addiction workforce development.</p> <p>Programs funding is managed through a charitable trust.</p>	<p>Overseen by the NSWIOP board, the composition of which is specified under the Act and includes representation from professional and academic groups.</p>	<p>Each cluster is managed by a steering or management committee, composed of representatives from member services.</p>
Infrastructure	<p>NIMHE has a small national team which works with local services. It operates through CSIP, a devolved organisation, providing support through eight regional development centres.</p>	<p>Includes national centres and programs, as well as regional co-ordinators. MOH funds this workforce infrastructure to support the work being done through mental health and addictions services. The Clinical Training Agency (CTA) will retain the psychiatrist training.</p>	<p>Academic Board, four directors, four Standing Committees, and approx 400 expert lecturers.</p>	<p>Cluster project officers for each cluster, with some administrative support.</p>

Relationship to services	CSIP is made up of networks, some connecting the organisation internally, others connecting with external organisations., which operate both face-to-face and online.	Te Pou will build strong relationships with key stakeholders and will work closely with organisations that contract the Ministry to provide complementary workforce development and or research programs, or who may assist in advancing initiatives.	Links with government and non-government organisations through projects and programs, and through part-time expert staff.	Each cluster is a partnership between member services.
Activities	<p>Through regional development centres, works with local stakeholders and national partners.</p> <p>A Key program is <i>New Ways of Working</i> - how the skills, knowledge and expertise of professionals can be best used. The approach focuses on competencies required for the system to function effectively, redefines work roles and outlines strategies for the professional development associated with its implementation.</p>	Range of programs will include: mental health leadership, national resource group for service improvement, development for service users working in mental health, consumer advisor training, dialectic behaviour therapy training, Asian mental health workforce development, recruitment tools, managing risk, skill advancement for funders and planners, whole-of-system approach to acute solutions, among others.	A wide range of education and training programs, from accredited postgraduate to short courses.	<p>Guidelines specified the following:</p> <ul style="list-style-type: none"> ▪ Establish partnership and governance. ▪ Conduct planning ▪ Implement communication resources ▪ Provide education & training ▪ Incorporate knowledge into organisational systems. <p>Focus differs across clusters. NEVIL and Western clusters focus on coordinating calendars of training activities. SETC has a greater emphasis on building training capacity within organisations through projects to meet specific learning needs.</p>

8. Case studies

This section includes a brief case study of each cluster.

8.1 North East Victoria Innovative Learning Cluster case study

North East Victoria Workforce Development Cluster (NEVIL) was established in 2004. The following agencies comprise the cluster –

- Austin Health
- Eastern Health
- Forensicare
- St. Vincent's Health
- Goulburn Valley Health
- Northeast Health Wangaratta

The cluster is auspiced by St. Vincent's Health.

8.1.1 Approach (underpinning philosophy)

NEVIL describes as its mission -

To provide Victorian mental health clinicians with evidence based, world's best practice knowledge and skills in the diagnosis, assessment, treatment, rehabilitation and recovery care of people with mental illness.

To achieve this, NEVIL member agencies have a joint commitment to establish partnerships around both education and professional development.

There is some recognition of the differences in need and therefore approach between metropolitan and rural services and consequently NEVIL strives to ensure representation from all areas in its decision making processes.

8.1.2 Organisational structure

Initially, two separate committees operated within the NEVIL cluster, one with a governance function and the other with a management function. Considerable overlap in the membership and function of these two groups saw their amalgamation into a single management committee in early 2006. Now the NEVIL management committee comprises representatives from each of the six member agencies together with consumer and carer consultants. Many of the member agency representatives are the agencies senior psychiatric nurses. Other disciplines currently represented on the committee are occupational therapists, social workers and psychologists. There has never been a medical officer on the committee.

Whilst the permanent chair of the committee is the representative from St Vincent's Health as the auspice agency, the location and chair of individual committee meetings is rotated on a monthly basis. Meetings discuss and make decisions on the full range of cluster activities, including current and future training design and development, finance, administration, correspondence, liaison with other clusters and organisations and internal governance.

The management committee has established a number of working parties:

- Allied Health
- Aged Psychiatry
- CAMHS

These working parties are represented on and inform the management committee on specific education and training needs of staff from these segments of the workforce and assist in the implementation of training delivery for these groups. Whilst the Allied Health and Aged Psychiatry working parties are active and involved in training needs assessment and training delivery, the CAMHS group has not met for many months. The committee is reviewing the CAMHS working party and seeking to determine how the training needs of this workforce can best be met. This may involve Mindful, the statewide CAMHS training organisation based at Austin Health.

Co-ordination of the cluster is managed by the Senior Project Officer, employed full time through St. Vincent's Health. In an administrative capacity, the Senior Project Officer acts as secretary to the management committee and the working parties. Following direction from the committee, the Senior Project Officer develops the training calendar and coordinates the promotion, delivery and evaluation of training activities.

8.1.3 Funding and resources

From 2003-2008, the NEVIL cluster has received \$557,000 from the MHB for activity and infrastructure (project officer) to operate the cluster. The NEVIL cluster has been funded approximately \$150,000 per year, comprising \$90,000 for infrastructure and \$60,000 for training delivery. There may have been variation to this dependent on the phase of the project and expenditure patterns. It may be of interest to note training dollar per staff member for the six months July – December 2006. Of the actual expenditure of \$78,463, assuming 1,500 staff members, this equates to \$52.30 per staff member. Of this expenditure, excluding staff wages, meetings and resource equipment, the actual spend per staff member on actual training for the period was \$12.82.

8.1.4 Planning processes

NEVIL had, and continues to have as its main focus, the State-wide priorities of Orientation to Mental Health, Dual Diagnosis, Graduate training and Suicide Prevention. This training has been offered in both metropolitan and regional areas. Aggression Management training has been conducted by individual agencies due to requirements for consistency of training within each agency. The other state-wide priority area, Overseas Trained Medical Staff training, has been funded and delivered separately from NEVIL activities.

In addition, the management committee plans training activities across the cluster at monthly meetings. All proposals for training delivery to cluster wide staff are presented to the management committee for consideration. The committee reviews each proposal and evaluates the extent to which it conforms with the priority training areas identified by DHS and the cluster, the quality of the training and training outcomes. Value for money is also considered, as are location and duration.

As well as training proposals received, the management committee undertakes two other activities to inform its training priorities and curriculum. It conducts a biannual planning day and it develops and distributes a list of potential training topics for its staff to indicate training needs and preferences. The current training calendar (February – June 2007) is reflective of the committee's planning activities.

A benefit of the relationship building aspect of the cluster arrangement is that individual member agencies have begun to offer locally initiated training opportunities to other cluster member agencies.

8.1.5 Workforce development

The main focus of NEVIL is the development and delivery of professional development education and training to approximately 1,500 mental health staff within the cluster's geographic area. Education and training activities identified through the planning processes described above are promoted via poster calendars, the dedicated website and email distribution to managers and staff.

A 12 month graduate nursing program, accredited by the University of Melbourne, RMIT and Latrobe University has been developed and commenced in February 2007. The program incorporates structured supervision together with intensive block workshops. This program further aims at workforce development through the incorporation of allied health graduate opportunities.

8.1.6 *Cluster outputs and outcomes*

The cluster offers training and development opportunities to member agencies through:

- A published training calendar, both in hard copy at sites and through the NEVIL website.
- Training aimed at meeting both state training priorities and management committee determined needs.
- Relationships with external training agencies that meet specific sub group training needs eg. Mindful for CAMHS workers.

In addition to core training, cluster priorities have been identified by the management committee and training offered in these areas. These priorities include:

- Borderline Personality Disorder Training
- Forensic Mental Health Training
- Dual Diagnosis Training
- Consumer and Carer Consultant Training
- Eating Disorders Training
- Legal Issues in Mental Health
- Aged Psychiatry
- Family Sensitive Training

All of these additional training priorities were addressed during 2006 with over 20 workshops conducted.

In addition, a unique area of NEVIL success is the opening up of internal agency training activities to other cluster members. The “host agency” notifies the NEVIL Project Officer of capacity in an internal activity and the activity is then advertised on the website and circulated via email to the representatives of the other agencies. For such events, registrations will be managed by either the host agency or NEVIL.

As part of the monitoring process, the host agency collects and collates evaluation data and attendance sheets, providing these to NEVIL staff for forwarding to the management committee.

8.1.7 *Future directions*

NEVIL will continue to develop and deliver mental health professional development education and training to address both statewide and locally determined priorities. The cluster will continue to utilise existing organisational structures, including working parties (Aged Psychiatry, Allied Health and CAMHS), as well as further develop links with external training organisations (such as VICSERV, the major training provider for PDRS, Spectrum and Mindful), to meet its training obligation.

Discussion has taken place regarding three fundamental improvements to the implementation of NEVIL training. The first is development of a cohesive and highly structured curriculum of training, across the whole of work-life of mental health staff. Moving even further away from the individual, unlinked training activities that have been offered, it is hoped that training activities will become further integrated with one another, providing a platform of sequential and stepped learning for staff. The second is adoption of alternative means of training delivery. Most NEVIL training is currently face-to-

face workshop or lecture based. Options for on-line learning, particularly addressing theoretical and knowledge-based subject matter, are to be considered. The third consideration NEVIL has discussed is improved training outcome measurement. The desire for the future is to better monitor and assess the workplace behavioural and attitudinal changes that hopefully derive from training involvement in the medium and longer term.

8.1.8 Issues and challenges to the cluster's future

NEVIL management has identified the following as threats to the ongoing viability and success of the cluster:

- Non-recurrent funding arrangements
- Ongoing issues with DHS funded state-wide agencies charging fees to the cluster for training they are funded to deliver.
- In addition, the lack of more consultative training needs analysis amongst staff working in the field, as opposed to management determined training need, has been identified by some staff as an issue for ongoing viability.

8.1.9 Summary of strengths and limitations

The obvious strength of the NEVIL cluster is the commitment and ownership of the cluster by the agencies represented. Almost all senior staff interviewed identified the co-operation between agencies and the auspicing body as a real strength.

A further strength is the commitment of the management committee to ensure regional representation through membership and rotation of management committee meetings.

In addition, the quality of education and training provided was highly regarded. Including both content, delivery and administrative arrangements (such as the online booking process).

The relationship with the University of Melbourne, RMIT and Latrobe Universities creates strong opportunities to explore new and best practice opportunities.

An identified limitation is the lack of consultation with staff of cluster members regarding their training needs. At this point program content is determined by the management committee, and whilst there is some described discussion with staff, no detailed needs analysis is conducted.

8.2 Western cluster case study

The Western Cluster commenced operation in 2004. The appointment of Western Cluster's Project Manager was delayed (until August 2004) due to the financial issues which effected NorthWestern Mental Health Services (NWMH). As a result there was a corresponding delay in the assessment, planning and implementation of education and training. The Western Cluster is unique amongst the clusters in that its member agencies include 52% of the Victorian population in their catchment areas. The Western Cluster agencies have a strong base in regional Victoria with 70% of the total regional population. In excess of 2400 staff are employed in the Western Cluster. Of these, over 1600 plus employed within NWMH. Western Cluster includes five of the 13 metropolitan area mental health services and the three largest regional centres in the State. Agencies in the Western Cluster are:

- South West Area Mental Health Service (Werribee Mercy)
- NorthWestern Mental Health incorporating Mid West AMHS, Inner West AMHS, Northern AMHS, North West AMHS, Aged Persons' MHP and ORYGEN Youth Health.
- The Barwon Health Mental Health Service
- Glenelg (South Western) Area Mental Health Service (Warrnambool)
- Ballarat (Grampians) Health Psychiatric Service
- Loddon Campaspe/Southern Mallee Mental Health Service (Bendigo and Swan Hill)
- Northern Mallee Mental Health Service (Mildura)
- Royal Children's Hospital Mental Health Service.

8.2.1 Approach (underpinning philosophy)

The Western Cluster undertakes a particular approach to the provision of cluster-based training. An annual training calendar is developed collaboratively with each member service, discipline and speciality area representatives. In addition, services have requested to operate a number of the core training and education programs independent of cluster activities (e.g., aggression management, orientation). Services considered that they were running successful programs in these areas that contributed to the culture of the member services. For these activities, the cluster project manager collects data in a consistent format from all of these individual services and this data forms part of the reporting mechanism to DHS. There have been some difficulties in gathering this data from one agency.

8.2.2 Organisational structure

The cluster has two distinct committees overseeing its work. The steering committee meetings are scheduled monthly, and a governance group is scheduled to meet four times per year.

The members of the steering committee decided to meet in the metropolitan area, and the location chosen was The Royal Children's Mental Health Service (RCHMHS), due to its geographical location and accessibility. For remote services such as Mildura travelling to Melbourne is easier as Melbourne airport is located only 15 mins from Travancore. Some financial assistance is available for air travel.

Being a member of the Western Cluster has accelerated the redevelopment of video-conferencing facilities at the RCHMHS Travancore Campus. From mid 2007 state of the art video-conferencing facilities will be utilised for WETS committee meetings (replacing tele-conferencing facilities). The RCHMHS Travancore campus conference room has been refurbished, with the intention of utilising the location more frequently for Western Cluster activities. This is coupled with the new video conferencing facilities for education sessions/activities.

8.2.3 Funding and resources

From 2003-2008, the WETS cluster has received \$530,000 from the MHB for activity and infrastructure (project officer) to operate the cluster. The WETS cluster funding allocation was modelled as comprising \$120,000 for infrastructure and \$120,000 for training delivery. However, due to delays in the employment of a project officer and the commencement of expenditure on training, the WETS cluster budget was adjusted over subsequent years according to an acquittal process.

8.2.4 Planning processes

The steering committee originally determined the first training priority was to meet the DHS requirements. A survey was completed by member agencies to identify what training already existed that would be useful to the entire cluster. The steering committee then used this information to undertake a gap analysis of existing training opportunities against DHS required training. A planning process was established to ensure equitable sharing of cluster training resources across member services.

The cluster also identified a number of non-core training areas that demanded training and educational input. These included:

- Aged Care
- CAMHS
- Youth Health
- Eating Disorders
- Neuropsychiatry
- Leadership Development
- Supervision Development
- Division 2 (nurses) Workforce Planning

The planning framework allowed for identifying shared needs and also accommodated specialised training needs eg Mildura having indigenous mental health needs. While the Steering Committee is scheduled to meet monthly to review, co-ordinate and plan activities, a dedicated planning day is conducted every six months to decide program priorities. Each agency completes their own training needs analysis to identify training needs, future workshop topics and recommended speakers. Agencies develop proposals for training activities and submit them to the Steering Committee. In addition, following each training event participants are able to contribute to future training options by completing evaluation sheets.

8.2.5 Workforce development

The steering committee identified workforce development activities that were the most difficult to provide by agencies individually eg leadership, supervision and performance management. These activities are offered in all locations throughout the cluster. The cluster allocates a number of workshops for particular disciplines and specialist areas eg schema focussed therapy for psychologists.

In regards to orientation programs and aggression management training, each agency has their own needs and therefore conducts and evaluates their own established programs.

8.2.6 Cluster outputs and outcomes

To date, the Western Cluster has met the initial guidelines provided by DHS for the establishment of the cluster program that included the following: establish partnership and governance, conduct

planning, implement communication resources, provide education and training and incorporate knowledge into organisational systems.

A published calendar is available in hard copy and electronic format as a dedicated web page on the Melbourne Health site. The training is offered by month and by subject matter, with venues in both regional and metropolitan areas.

The 2007 calendar offers some 40 courses, totalling 70 training days with 13 of those offered in regional locations.

The project manager collects attendance and evaluation data on all training provided by the cluster with this data reported to DHS in progress reports.

Of courses offered in 2006, in excess of 1,700 attendances were reported.

Course flyers are distributed electronically four to six weeks prior to commencement

Course evaluations are reviewed and actions taken as necessary eg some have been repeated due to positive outcomes.

8.2.7 *Future directions*

The WETS committee will continue to address statewide priorities as well as the Western cluster priorities. In 2007 the steering committee planned for a significant shift in regards to the role out of education and training.

In 2007 Western Cluster has provided specific training in the identified areas such as aged psychiatry and CAMHS. It is intended to continue to utilise the planning framework to support decision-making and ensure equitable distribution of training across member services, and across age related service groups and disciplines.

Training will continue to be targeted at areas otherwise unavailable to member services eg leadership.

In 2007 Western Cluster demonstrated increased collaboration with the Nevil cluster (eg. outcome measures) and intends to further develop this relationship.

8.2.8 *Issues and challenges to the cluster's future*

The operation of programs across an area that encompasses sixty to seventy per cent of the landmass of Victoria presents real challenges.

The sheer geographic size was initially seen as a significant threat to the functioning of the cluster. A further threat involved inclusion of rural services in decision-making processes. With the reporting of difficulties attending committee meetings due to distance, and further reports of the perceived difficulties of relevance when attending via teleconferences.

However these challenges has been addressed through:

- Additional funding of approximately \$10,000
- Development of the RCHMHS video-conferencing facilities
- Facilitating and supporting travel and accommodation from/to rural services
- Repeating programs that are run in both rural and metropolitan areas
- Tele-conferencing had been an issue with poor quality facilities, but now rectified

In regards to providing alternative teaching methods there are limitations in regards to the infrastructure that currently exists:

- Inability to provide on line training due to the infancy of the project and level of funding
- Limited ability to provide video conferencing to all services as some do not have the technology.

- Inability to access appropriate /adequate training facilities

Whilst the decision of the cluster to allow individual services to continue to operate and conduct their own training in both core and non-core areas is practical, it poses some threat to the cohesiveness of the cluster system of training delivery. .

8.2.9 *Summary of strengths and limitations*

The vast majority of courses are attended by participants from both rural and metropolitan services. A lot of time has been spent in ensuring rural services are offered an equal share of training. For each workshop, each member service is allocated an equitable number of places for their staff.

There was also a strong sense of good will and collaborative relationships have been formed across many member services within the Cluster.

With a number of remote sites (eg. Mildura and Warrnambool) the lack of facilities to present courses via any means other than face to face teaching is a significant limitation. Interview respondents identified that videoconferencing or web based learning opportunities would greatly enhance their learning opportunities. Similarly focus group participants spoke of training models that employed videoconference for workplace follow-up or for facilitation of multiple small groups working remotely with their own local moderators. Indeed there are many practical models to support new technologies in education and training. The Western Cluster would need access to expertise to introduce these technologies successfully.

A further limitation for Western is the lack of a detailed staff training need analysis across all services. It would appear from reports and interviews that training content is determined by the steering committee with reference to feedback forms completed by agencies. Agency conduct of staff level needs analysis is variable, with most appearing to use a qualitative line-management reporting system to identify perceived training needs. However, there was also evidence of some agencies using a structured, rigorous approach to needs analysis that incorporated staff performance appraisals, staff surveys, quality reviews and other feedback to identify training needs at the individual, team and agency level. It is unclear the extent to which this is utilised in the planning for future programs.

8.3 SETC cluster case study

Southern Education and Training Cluster (SETC) was established in 2004. Four area mental health services (AMHS) are included in the SETC cluster. These are:

- Bayside Health
- Latrobe Regional Hospital, Mental Health Program
- Peninsula Health Psychiatric Services
- Southern Health,

The four area mental health services all provide comprehensive integrated community based public mental health services 24 hours a day, seven days a week.

Although the smallest of the three clusters in Victoria, Southern Education and Training Cluster (SETC) is diverse, covering both metropolitan and regional geographic areas and includes both large and smaller agencies.

8.3.1 *Approach (underpinning philosophy)*

The approach employed by SETC is based on evidence of how partnerships or coalitions between organisations are established and developed, involving building of trust and collaboration through gradual program of cooperation to meet common needs.

The emphasis in the SETC approach is on building the education and training capacity of member agencies through collaborative projects which meet common needs and provide education and training at a range of levels and across disciplines.

The approach to the establishment of SETC was based on an initial research project, reported in “Workforce Development Initiative: Proposed Education and Training Project Cluster Partnerships” (Julian and Turner, 2004). A summary of some information from this project, based on this report, is provided in Section 7.3.12 of this case study.

8.3.2 *Organisational structure*

The organisational structure which comprises Southern Education and Training Cluster consists of the Steering Group, which has delegate representatives from all services. The project officer attends and co-ordinates attendance by other contract employees, both research and administrative, as well as services of educationalists supplying training programs.

Unlike the other clusters, whose auspice agency is one of their members, the auspice service for the SETC is technically held by Southern Health, but by common agreement of all agencies, the project is managed through the through their associated agency “Southern Synergy”, the Southern Health Adult Psychiatric Research Training and Evaluation Centre, within the Department of Psychological Medicine at Monash University.

8.3.3 *Governance*

Southern Education and Training Cluster is overseen by a Steering Group. The function is to provide a reflective point in training issues, oversee the projects and specific training programs directed at Statewide and local cluster priorities. Unlike the other two clusters, SETC has always combined its primary policy development, program overview development function and governance into the one committee.

The Steering Group is made up of two members from each area mental health service who are nominated by their service. An additional two positions are available to be filled by a consumer and carer representative (one each) but only one nominee was received for these positions in 2007. There

has also been one representative from allied health attending as an invitee of the steering group. Recently the group has extended positions by two to include two aged care services. The SETC Steering Group has an independent chair, Professor Graham Meadows, Director, Southern Synergy. Hence, the number now totals 14 including the chairperson.

In the two years since SETC was established, there have been a number of changes to the membership of the Steering Group. Aged care representatives have been added so that more attention is paid to this field. Peninsula now also includes an administrative member of staff to ensure the interests of this group are considered.

Steering Group meetings (eleven per year on a monthly basis) are held at Southern Health, with telephone conference access available for those who cannot attend in person. Generally each area mental health service has at least one representative in attendance. Recently, the cluster has had to move to a larger meeting room due to increased attendance as debate on educational development has increased and become more sophisticated.

8.3.4 Funding and resources

From 2003-2008, the Southern cluster has received \$645,740 from the MHB for activity and infrastructure (project officer) to operate the cluster. Of this, \$83,740 was a non-recurrent equipment grant in 2005-2006. The Southern cluster has been funded approximately \$170,000 per year, comprising \$90,000 for infrastructure and \$80,000 for training delivery. There may have been variation to this dependent on the phase of the project and expenditure patterns.

SETC's relationship with Southern Synergy and Monash University has been an important factor in the success of projects conducted through the cluster. The current twelve month funding cycle under which clusters have been operating would have made the completion of projects difficult or impossible without management of funding through Monash University, which enables project funds to be carried over into subsequent years allowing for projects to be well planned.

8.3.5 Planning processes

The approach taken to planning within SETC was described as directed towards State priorities and workplace issues and problems. Priorities are decided by consensus of the Steering Group. This was described as "a painful process", complicated by the need for members to consult with their organisations, but ultimately worthwhile. A range of options for projects are explored over several months. Steering group members provide information about education and training needs identified in their agencies (see 1.6 Workforce development, below). The situations giving rise to these needs are discussed in order to clarify the nature of problems and issues, before a possible response is decided. Associated skill gaps and potential difficulties with projects are explored until all agree on what would be a useful thing to do.

This process was described as sometimes difficult, but ultimately highly productive, leading to innovative solutions. This approach is highly consistent with the philosophy on which the cluster was based.

8.3.6 Workforce development

As outlined in the description of how SETC was established, the cluster began with research into training needs against the National Practice Standards for the Mental Health Workforce, across member agencies. This research also explored how services identified training needs and the following were identified as common approaches:

- Expected to actual performance appraisal
- Interviews, including staff appraisal systems
- Feedback from supervisors/managers,

- Workplace documentation: incident reports, and
- National Mental Health Standards Reviews.

In addition to the information from the initial research, information from the member agencies, gathered through these approaches and others, is brought to the steering group by their representative on the steering group.

SETC conducts six monthly training audits to collect data about the number of staff, including overseas trained medical staff employed in the preceding six months, who have and have not attended Orientation and Risk Management. The audit also collects information on the numbers participating in Graduate Programs. New staff and Graduate Program participants are audited by professional group.

8.3.7 *Cluster outputs and outcomes*

The initial guidelines provided by DHS for the establishment of the cluster programme included the following: Establish partnership and governance; Conduct planning; Implement communication resources; Provide education & training; and Incorporate knowledge into organisational systems.

The model on which SETC was based focused on development of SETC through education and training services to its members through the following types of outputs:

- Projects in respond to both Statewide and local training needs. These are based on proposals prepared by an agency. They are prioritized/approved by the steering group. A lead agency is selected based on appropriate in-house resources to successfully complete each project, and representatives from this agency work collaboratively with representatives from other agencies to complete each project.
- A calendar of training activities. These are categorised as either “Mandatory” or “Discipline Specific & General”. The calendar is based on “common days”: i.e. training that individual services are able to offer to other services, within the cluster, that provide “agreed, consistent standards of training across the sector”, in particular in areas such as orientation and risk management. The number of such “common days” has increased from 2 to 3 in the cluster’s first year to 45 in 2007. This is taken as an indication of the degree to which compatibility has been achieved in that time. The calendar also includes training activities provided by Statewide training providers, for example the Victorian Dual Disabilities Unit.
- Training activities database. The cluster project officer regularly provides information, via email, about activities currently provided by member agencies and other external organisations, training and other, that are available to cluster members.

The SECT Annual Report (December 2006) provides information on the following outputs from these areas:

Review and Networking Opportunities. Senior staff and trainers have been provided with a forum in which to discuss training and related workforce development issues.

Orientation to Mental Health in Victoria. A common two hour introduction to the Statewide mental health system has been developed and implemented. This is designed to be incorporated into staff introductory programs by each cluster members.

RiSCE (Risk Identification, Safety, Containment and Environment). This is a new resource provided to members to assist them in educating staff in regard to aggression management. SETC estimates this will potentially saves cluster members thousands of dollars in licensing fees for commercial packages used previously. The work has also been one factor in raising debate in regard to aggression management, training and training quality in some cluster agencies to a significantly higher level.

CRISISS (CRisis Intervention, Safety, Implementation in Suicide and Self-harm package). This is a 'suicide management' flexible training program, designed at a higher level than community based training programs that have been previously used and specifically for clinicians. In 2007 all cluster members will have the option of providing all staff (especially new graduates and RN Div 2s) the Asist program, then the new 'Suicide Management for Mental Health Clinicians' for more experienced clinicians. A third stage is being considered.

Psychopharmacology Unit. This was developed to address short-coming in the knowledge, attitude and skill base of undergraduate and graduate nurses, and providing a common training base in the workforce for all professional groups.

Allied Health. SETC supported the establishment of an Allied Health network and provided 'seed' funding for them to develop their own discipline-specific training in addition to two major conferences in 2006. Southern Health is the agency leading this initiative and is currently developing of a nine-day, modular, graduate program in Allied Health, which can be delivered to groups or on a one-on-one, so is particularly useful for agencies too small to run a course in-house.

International Medical Graduates. SETC arranged a regular sub committee meeting between La Trobe University and SETC to set up supervision for overseas psychiatrists who are accepted as candidates for the College and who need considerable mentoring.

Funding for Audio-visual and Teleconferencing. The SETC International Medical Graduates sub committee surveyed existing teleconferencing equipment and successfully gained funding for audio-visual and teleconferencing equipment. This program is now set to commence in 2007. In addition to this, in 2006, focus has been on recording Southern Health Grand Rounds and making the DVD's available to IMG's in at Latrobe Regional Hospital.

Train the Trainer programs. Plans are being developed for regular 'Brief the Trainer' programs. This follows a successful initial 'Train the Trainer' in December 2006, used to launch the RiSCE Package. The major approach being used to date is a 'moderation' model as employed elsewhere in adult education in Victoria where trainers are assisted in developing constructive networks where they can present their work for review.

Leadership Training. This project, lead by Southern Health, resulted in a ten module program which was delivered over 10 training days (2 full days and 8 half days) between February and November 2006. Originally designed for 40 participants, the enrolment was increased to 52 when 100 subscribed.

Training Calendar and Email Newsletter. SETC has produced a calendar of programs, distributes a regular email newsletter of training opportunities, and is considering plans to develop its website to make it more accessible and relevant. Other initiatives for 2007 are still being planned, but include development of a common introduction to mental health for administrative staff and implementation of the allied health graduate program.

8.3.8 Self evaluation

Developing a system for monitoring training across Southern Health is a key goal of the cluster, implemented through initiatives to the develop of standard approaches to training packages, moderate training, and by providing encouragement and support to staff developing programs. In addition, the cluster asks the services to complete a census on what risk and orientation training has occurred. This provides a base for future evaluation. With regard to training programs, more formal evaluation of cluster training activities is being introduced, with participants asked to assess training in terms of usefulness rather than satisfaction with further developments to be encouraged slowly. In addition, after a training event a sample of participants is contacted by phone seeking their comments on usefulness and the extent to which the training met their needs.

Evaluation of the SETC program overall is conducted through the six-monthly reports to DHS, which are based on each cluster members reflections on projects. A formal evaluation of the various projects and activities is conducted, with each group within the Steering Group reporting.

8.3.9 Future directions

SETC's strategy is directed towards long term strengthening of the workforce development capability of organisations within the cluster. Hence SETC's priorities for the future include ensuring the following:

- education and training is linked to the National Practice Standards for the Mental Health Workforce;
- fostering within member agencies the capacity of trainers to develop, deliver and evaluation learning programs; and
- development of e-communication infrastructure across the cluster in order to assist a range of workforce management functions, including education and training.

8.3.10 Issues and Challenges to the Cluster's future

A number of threats to SETC's viability were identified in interviews with members of the SETC Steering Group and the cluster project officer:

- The 12 month funding cycle threatens the viability of the cluster management and makes planning of both project work and training activities difficult,
- Severe under-funding and over-reliance on goodwill, volunteer labour and already over-extended staff with the skills to develop programs are not sustainable.
- Larger member organisations, with their own education and training infrastructure who feel they are contributing more than they are receiving from the cluster, might withdraw their active support.
- The removal or reduction of project funding would jeopardize the cluster's value to, and bargaining power with, member agencies.
- A heavy-handed approach to centralising, co-ordination or resource sharing across the clusters, could damage the trust and alliances that have been gradually built up between the members of the cluster.

8.3.11 Summary of strengths and limitations

The SETC provision of project funding as part of its internal system was been a key factor in SETC's success to date. The project funding used by SETC allows cluster members to apply for funds for specific project and this has provided clear reason and encouraged agencies to 'come to the table' and participate in the first instance. It has uniformly been an important structural determinant of the success of the initiative and the sustainability of cluster activity, participation and goodwill. The project funding allows:

- all cluster members to gain funds to undertake training or projects;
- through this participation all cluster members gain experience of management of specific projects, and increase skills of their staff in this work;
- this in turn generates an atmosphere of mutual respect and interdependence, so encouraging all involved to be less restrictive in their attitude to their intellectual property (IP) rights.

Were cluster members to retreat from the established collaborative stance in regards to the cluster, and particularly in regards to IP, the work program would lose momentum, and perhaps in time come to a halt.

Other factors which have contributed to SETC's success have been the independent chair, the communication skills of the project officer, and the staged, developmental model on which the cluster was originally based.

9. Reported cluster outcomes

The reports of each of the clusters indicate that they have, in a relatively short time, been able to deliver against the KPIs. With a minority of exceptions, all clusters have implemented activities in the designated areas. Summaries of the outputs for Stages 2 and 3, primarily in terms of Statewide and local priorities, are provided in the tables in this section.

The Guidelines

The guidelines provided to the clusters, particularly once the establishment stage was completed, directed the clusters to undertake activities which would result in particular outputs and outcomes: efficiently run education and training partnerships and enhanced practices and service quality.

The Stage 2 Guidelines focused on programs delivered systematically and consistently across agencies, on increased access and efficiencies, and on the implementation of standards and guidelines informed by collective expertise and agreed best practice. Targets were expressed in terms of 100% of eligible staff trained within timeframes dependant on the priority. Outputs were reported by 'number and percentage of eligible staff by discipline and program profile' as reported by member services to the auspice.

Building on Stage 2, the objectives in the Stage 3 Guidelines focused on trialling of education and training activities using consistent and coordinated cluster approaches, identifying the benefits of cluster approaches to members, documenting successful strategies and models to enhance practice and service quality, and the development of strategies for sustaining successful cluster activities and cluster approaches. The targets for Stage 3 were expressed in terms of "a coordinated and consistent training program that is accessible to all services staff within three months of employment". Reporting was to include number of programs, profile, member services represented and location. Additional description was to be provided about the role of the cluster and the lead agency responsible, distribution of training programs across member services, collaborations and partnerships to achieve priorities and interface with dual diagnosis training activities.

Stage 2 and 3 Reports

Western, the largest of the three clusters, has taken the approach of supporting training activities provided by member agencies. Reports tend to focus on tabulating information about each area of training activity, including overview of the model, host agency and numbers in each professional group attending.

NEVIL, with six member agencies, has worked to achieve cooperation amongst agencies that have, in some instances, expressed differences in approach to implementation of priority activities. NEVIL has increased its efforts in terms of developing both cluster wide training activities and supporting those provided by member organisations.

SETC took a developmental approach to increasing the education and training capacity within its four member agencies from its commencement. SETC's reports provide detailed information about the processes through which innovative education and training programs are initiated and developed through projects auspiced by lead agencies.

Reports from the different clusters vary in both coverage of and detail about activities. An issue for all three is the accessibility and quality of information provided by member agencies.

Future Directions

More consistent reporting, using a reporting template common across the clusters, would assist with more accurate assessment of progress against KPIs within specified timeframes and with collation of achievements across all three clusters.

Education & Training Partnerships (Cluster) Reports Summary, Final 2005

ACTIVITIES/TARGETS	Western	SETC	NEVIL
<p>Risk Management</p> <p><i>Risk management training</i> <i>Suicide prevention</i> <i>Aggression management</i> <i>Dual diagnosis interface</i> <i>A coordinated and consistent training program is accessible to all cluster services staff (CAMHS, Adult, Aged) within three months of employment in the sector.</i></p>	<p><i>The Western report explains that late commencement of Stage 2 due to internal problems with the auspice agency resulted in major under expenditure. The Western plan for 2006 outlined activities and costs for both Stages 2 and 3, which the cluster intended to run concurrently over the next 12 months.</i></p> <p><u>In Plan for Stage 2</u> ASIST Train the Trainer, 5 days x 1, 7 participants ASIST Training, 2 days x 6, 120 participants</p>	<p>Risk Management - major activity was the development of a project plan agreed by cluster members. Project led by Peninsula.</p> <p>Performance against KPIs is reported for all services except Southern Health, for both Suicide Prevention and Aggression Management, including number of new staff, number trained and percentage trained., percentage attending Suicide Prevention (45%); attending Aggression Management (73%). Against KPIs, of 57 eligible new staff, 46 (81%) trained in Aggression Management. Of 68 new staff, 36 (53%) trained in suicide prevention.</p>	<p>Stage 2 Interim report included detailed reports, inc (%) numbers, discipline and program profile, for period 1 Jan to 1 Aug provided by 3 of 6 members only: Goulburn Valley AMHS St Vincent's Health Forensicare.</p> <p>Suicide Prevention not delivered in Stage 2. Cost of ASIST identified as an issue for some members. Cluster Steering Committee agreed that each service should conduct its own training. CAMHS Working Party considering a more age appropriate response. Some services do not conduct training in this area. Action to redress this gap recommended for Stage 3. Aggression Management training to remain a service specific activity due to differences in content and delivery. St Georges offered places to rural staff from NE Hume. Gap in reporting mechanism which captures numbers requiring refresher training.</p>
<p>Orientation of New Staff</p> <p><i>100% of new staff have completed a comprehensive orientation program within 3 months of employment in the sector.</i></p>	<p><u>In Plan for Stage 2</u> Orientation, 1 day x 3, 60 participants</p>	<p>Provides overview of Orientation Task Group activities Level of cluster involvement is indicated in Expenditure. Project Officer is a member of the Task Group. Performance against KPIs is reported, including Number of New Staff, Number trained and percentage trained. Percentage attending Induction to their organisation (100%; attending Orientation to Mental Health (91%).</p>	<p>Introduction to Mental Health, three x 3 day workshops, at Austin Repat Heidelberg. (both for new staff and a refresher for experienced staff). 63 participants (80% new)</p> <p>Report includes some general information on the nature of the program and plans to issues for delivery to suit medical staff and rural services.</p>
<p>Graduate Programs</p>	<p><u>In Plan for Stage 2</u></p>	<p>Provides overview of activities for a project,</p>	<p>Each service report included numbers of</p>

**Evaluation of the Statewide Education and Training Partnership (Cluster) Project
Mental Health Branch**

<p><i>100% of all graduate positions employed into by March 2005. Allied Health graduate programs established by 2005.</i></p>	<p>Graduate nurse & Allied Health symposium, 1 day x 1, 100 participants</p>	<p>lead by Bayside, to develop and pilot a Graduate Program acceptable to Nursing and Allied Health Staffing. Reported under headings: Activities undertaken so far; interim performance or outcomes measures, expenditure of cluster project funds; activities to be undertaken in the next 6 months. Level of cluster involvement is indicated in expenditure.</p>	<p>Graduate Nurses actually employed, as well as place available. Allied Health working group formed.</p>
<p>Support for OS trained medical staff <i>100% of overseas trained staff involved in orientation.</i></p>	<p><u>In Plan for Stage 2</u> Very basic information about availability and issues in each agency tabulated. No details. Budget allocation of \$10,000</p>	<p>Provides overview of activities of Overseas Psychiatrists Training Initiative, including video conferencing initiative, under headings: Activities undertaken so far; interim performance or outcomes measures, expenditure of cluster project funds; activities to be undertaken in the next 6 months. 5 Overseas Trained Medical Staff employed in member agencies in the past 6 months. 100% have attended orientation program.</p>	<p>3 of the 6 members have OS trained medical staff: 2 at Goulburn Valley Health, 3 at NE Hume, 2 at Wangaratta, 1 at Wodonga. Development of a formal training and education plan agreed by the Cluster Steering Committee. Propose framework is outlined.</p>
<p>Other Activities</p>	<p><u>In Plan for Stage 2</u> Orientation to Leadership & Management, 2 days x 3, 75 participants Preceptorship training, 2 days x 1, 20 participants Clinical Supervision for Psychologists, 2 days x 1, 60 participants Clinical Supervision for Psychiatric Nurses, 4 days x 1, 25 participants Clinical Supervision Training, 3 days x 3, 90 participants Clinical Supervision, 5 days x 1, 3 participants Shape Up The Trainer, 1 day x 1, 20 participants Cross Cultural/Trans-Cultural Mental Health Training, 2 days x 1, 30 participants Group Programs in Mental Health Services, 1 day x 1, 24 participants Motivational Interviewing, 2 days x 1, 24 participants</p>	<p>Planning and design of projects from the previous period continued, looking towards implementation in 2006/2007. Allied Health Project. Development of the Allied Health Network, subgroup networks in OT, Psychology, Social Work, Speech Therapy and Physiotherapy to be developed in 2006. Data Base Information Projects:</p> <ul style="list-style-type: none"> ▪ Accountability & planning ▪ Information re education and professional development ▪ Webpage include calendar ▪ Cluster issues ▪ Collaboration with others <p>Leadership Training (led by Peninsula Consumer & Carer consultants: 2 places on steering committee; training organised Older Persons: an Aged Psychiatry delegate to be invited to meetings Train the Trainer: linked to implementation</p>	<p>Psychiatric Triage Workshop, 23 participants (80% skilled clinicians with extensive experience), St Vincent's Health and Goulburn Valley Health for all service components of the cluster. ECT Workshop, 20 participants (medical and allied health), at Austin Clinical Supervision, 25 participants, Austin and Eastern Health HDU, 10 participants, St Vincent's Mental Health OT Study Day – Evidence Based Practice, 17 OTs from the cluster Risk Assessment, 22 participants, Forensicare Psychiatric Triage Forum for MH workers, Rural Goulburn Valley Health & NE Hume Psychology Workshop, Eastern Health. DBT Training, 48 participants, St Vincent's Aged Psychiatry Workers Forum - Working with Families/Carers: Perspectives in Aged</p>

Evaluation of the Statewide Education and Training Partnership (Cluster) Project
Mental Health Branch

	<p>AMPS Training for OTs, 5 days x 5, 5 participants Certificate IV Training, 6 days x 1, 13 participants.</p>	<p>of new RISCE and Risk (suicide management) Management training programs.</p>	<p>Psychiatry, 20 participants CEED Eating Disorders course, Module A, 17 participants Hepatitis C Education Workshops, a series held in 2005, St Vincent's Mental Health</p>
--	--	---	---

Education & Training Partnerships (Cluster) Reports Summary, Final 2006

ACTIVITIES/TARGETS	Western	SETC	NEVIL
<p>Risk Management</p> <p><i>Risk management training</i> <i>Suicide prevention</i> <i>Aggression management</i> <i>Dual diagnosis interface</i></p> <p><i>A coordinated and consistent training program is accessible to all cluster services staff (CAMHS, Adult, Aged) within three months of employment in the sector.</i></p>	<p>Total Attendances: Aggression Management, 1271 participants</p> <ul style="list-style-type: none"> ▪ Prevention and Management of Aggression – 150 participants (Bendigo) ▪ Professional Assault Response Training – 81 participants (Mildura and Southwest) ▪ Management of Clinical Aggression – 2 days plus 1 day – 767 participants <p>Suicide Prevention, 334 participants</p>	<p>The allocated budget was spent on risk management activity, and the SETC report indicates that much of the activity was in planning and design as opposed to course delivery.</p> <p>The cluster has decided to develop its own training packages where possible rather than paying providers.</p> <p>Some programs will be trialled in 2007, including:</p> <ul style="list-style-type: none"> • a program concerned with managing risk in workplaces and a program for Graduate Nursing Development. • A new risk package RISCE was piloted for roll-out in 2007. • A new ‘Suicide and its Management’ program was also trialled. <p>The cluster participated in two Mental Health Legal Issues conferences. 80 people attended the first conference</p>	<p>Suicide Intervention - 2 x 2-day programs with 50 participants</p> <p>Aggression Mgt - 2 x 1-day programs, with 39 participants</p> <p>Dual Diagnosis - one workshop, involving 32 participants. A seminar was also held (number of attendees not provided)</p> <p>Dual Disability - collaboration with VDDS for 3x1-day workshops involving 15 participants</p>
<p>Orientation of New Staff</p> <p><i>A comprehensive orientation program is accessible to all new staff within three months of employment in the sector via a cluster coordinated training program.</i></p>	<p>Orientation, 1 x 1 or 1.5 days – 133 participants (Ballarat and Werribee)</p>	<p>Two-hour introduction developed for cluster members. Participation not reported</p>	<p>1 workshop for 14 new people (no comparison made with number of new starters for %)</p>
<p>Graduate Programs</p> <p><i>Cluster wide allied health and nursing graduate programs established.</i></p>	<p>Tailored, generally long programs for needs e.g. Werribee/Barwon 17 study days – 67 participants</p>	<p>Work continued on Allied Health Graduate Program (lead agency Alfred Psychiatry) Little action on Graduate Nursing Development.</p>	<p>No program activity</p>

<p>Support for Overseas Trained Medical Staff</p> <p><i>A cluster coordinated orientation-training program is accessible to overseas trained medical staff. Provision of regular supervision and peer support activities to overseas trained medical staff supported and coordinated/ supported by clusters (where not occurring as part of a formal training program).</i></p>	<p>Werribee (14 OTMS). Service funds extra supervision, internal academic program, and orientation.</p> <p>Ballarat (6 OTMS) Program provided by David Barton delivered.</p> <p>South West Health (3 OTMS). Mix of internal and external training and supervision. Two recent arrivals attended David Barton’s program.</p>	<p>Regular subcommittee meetings between La Trobe University and Southern, to set up supervision for OS psychiatrists accepted as candidates for the College.</p> <p>Quotations for audio-visual equipment obtained and forwarded to Mental Health Branch.</p> <p>Commencement of project to explore difficulties of recently arrived OS trained staff and develop a draft information booklet.</p>	<p>No separate reporting</p>
<p>Other Activities</p>	<p>Shape Up Train the Trainer, 17 participants Leadership Orientation, 89 participants Motivational Interviewing, 38 participants Group Programs in Mental Health, 16 participants Leadership – Change Management, 17 participants Preceptorship, 20 participants Certificate IV Training & Assessment, 12 participants Introduction to Social Work Supervision, 12 participants Advanced Clinical Supervision for Social Workers, 23 participants Clinical Supervision for Nurses, 20 participants Clinical Supervision for Psychologists, 68 participants Pinnacles and Pitfalls of Group Supervision, 15 participants Inside Work Conference, 83 participants Cross Cultural Training, 8 participants (details of services & numbers from each are provided)</p>	<p>Allied Health Project. Development of the Allied Health Network: Two Allied Health staff conferences conducted.</p> <p>Data Base Information Projects:</p> <ul style="list-style-type: none"> ▪ Accountability & planning ▪ Information clearinghouse re education and professional development activities, inc emails, calendars and flyers ▪ Collaboration with other parties <p>Leadership Training: 10 modules over 8 days between February and November. Course greatly oversubscribed, with 52 participants. Detailed evaluation provided. Feedback positive.</p> <p>Consumer & Carer consultants: 2 places on steering committee; training intended but lapsed due to difficulties identifying dates.</p> <p>Older Persons: an Aged Psychiatry delegate to be invited to meetings</p> <p>Train the Trainer: linked to implementation of new RISCE and Risk (suicide management) Management training programs.</p>	<p>Consumer and Carer Consultant Training – 1 x 1-day program for 15 participants Spectrum BPD - 4 days of outsourced training for 10 participants Forensic Mental Health workshop – one conducted (number of participants not noted), and a second cancelled because of insufficient registrations. Eating disorders – 4 x 1-day workshops with 69 participants Legal issues in mental health – 2 x 3 hour workshops (participants unknown)</p>

10. Summary of interviews

This section provides a summary of the interviews conducted for each cluster. In total 29 people were interviewed from 17 agencies:

- NEVIL – 11 people interviewed from 5 agencies
- SETC – 8 people interviewed from 4 agencies
- Western – 10 people interviewed from 8 agencies

This included six agencies in regional Victoria and 11 agencies in metropolitan Melbourne. In addition, interviews were conducted with cluster project officers and Departmental staff.

On average, interviews last for approximately one hour. Most interviews were conducted face to face at the participants' place of work. Using the contact lists provided by the Department, candidates were sent an email invitation including a brief summary of the project. Interview times were scheduled during follow-up telephone conversations and emails. This process often involved several points of contact to schedule all interested parties from an agency. In most cases interviews were conducted with a small group. The average number of participants per interview was 1.7.

The interviews were conducted against a loosely structured interview guide, approved by the Department. This guide was designed to closely follow the evaluation framework developed by the Department.

10.1 NEVIL summary of interviews

There was a strong sense of goodwill and co-operation within the NEVIL cluster. The cluster was generally seen as very successful by agencies, with a view that this success was based on the strong relationship between committee members and agencies. By linking to existing relationships, the NEVIL cluster was seen as starting from a very positive base with a committed, energetic and enthusiastic core group of members.

NEVIL was seen as very proactive in engaging with regional agencies. While some agencies, both regional and metropolitan, had felt initial concern about the potential to focus on metropolitan agencies, there was a general view that “NEVIL has exceed expectations” and that regional agencies were well included in the cluster.

“We were concerned that it would be metro centric, but that hasn't happened. Other [metro] cluster members have very supportive.”

This was seen as driven both by the interest and engagement of regional services and the appreciation of the accessibility issues faced by regional agencies from their metropolitan colleagues. Regional services were heavily involved in the early implementation of the cluster. The rotation of meeting to include regional sites was seen as an important factor in this inclusiveness.

10.1.1 Appropriateness

Structurally, NEVIL communicates with agencies through their representatives on the management committee. The management committee has representation from all six member agencies and four Consumer and Carer consultants (2 of each) from different agencies. In addition, NEVIL has established three working parties to promote the specific interests in the sector. These are allied health, aged psychiatry and CAMHS.

Representatives from these working parties report to the Management Committee on specific needs of these three areas. These needs are addressed in the NEVIL training program. Most interview participants saw this system as new and still evolving. It was seen as a way of engaging with groups that are not well included in the cluster at the moment.

As NEVIL relies on the input of the agency representative to identify local agency needs, this process is very dependent on internal agency structures and the role and focus of the representative. One interview participant from an education team described the agency as having completed a formal needs analysis of its staff over seven years ago in developing its agency training plan. The need for orientation training, identified through this agency plan was seen as largely being delivered through NEVIL.

Other agencies reported a more informal analysis of their staff training needs, often using managers' assessment and informal observation of staff skills deficits.

"Managers generally know the training priorities for their staff. They know what goes wrong and what the training issues are. That gets reported up through our committee structure and eventually reaches me and I take it to the NEVIL Committee."

Operationally, the success and momentum of NEVIL was seen as being driven through the Nurse Educator positions. Several interview participants expressed concern that this had led to an over focus and dominance of issues relating to nursing. Nursing has the advantage of full-time professional development positions, resulting in more senior nurses on the committee. However, tempering this view, participants also noted that medical and allied health professionals were very hard groups to engage with generally, nurses account for the vast majority of the mental health workforce and initially the demand for training and education was particularly high in the nurse workforce. Despite this recognition, there was also common concern that engagement with medical and allied health professionals was less effective. The recent establishment of working groups to focus on these professional interests was seen as a very positive step and commitment to these workforces.

"Seemed like the cluster gave up on them [medical staff] at some point."

"Greg is not a nurse which is a good thing in my view 'cause it provides an alternative reality of what's pursued and what's not. The other thing is that the investment in nursing development and education is phenomenal and there is a part of the universe who aren't nurses saying, 'Well hello what about the rest of us!'"

Several participants also commented that the lack of engagement with the training needs of allied and medical professionals also reflected similar issues experienced within agencies – ie this is not just a cluster issue. Several participants commented that their agencies were 'getting better at working with allied health and medicos on their training needs' and that this would be 'plugged into the system' through the cluster committee structure.

"Need good cross discipline participation – not just nursing. Nurses were already big in education, they led the way but may also have taken over in the process. Senior medical staff are not highly involved. They are busy doing clinical work – it is always difficult."

There was concern that clusters have to provide training with a broad level of applicability to mental health workers. The specialty groups generally link into their own training networks that happen at a statewide level.

"NEVIL is focusing on general educational stuff. The lowest common denominator... which of course you've got to do. I think that there is an obvious need for good solid aggression management training, goods on orientation, all the different aspects that have been offered...but what that usually means is that the more specialized areas like SPECTRUM, CAMHS, drugs and alcohol miss out. They also have multiple degrees. Most of the training focuses on adult services."

An issue that arose several times throughout the NEVIL interviews was the ability of the cluster to meet the needs of speciality areas particularly CAMHS. There was seen to be a lack of clarity about 'learning goals'. The differences between each CAMHS service and the array of current training providers was seen as making this a complex issue. Mindful was repeatedly mentioned as a very credible and well-respected provider of training for CAMHS staff. While there is a relationship between the cluster and Mindful through participation in working groups, there was seen to be more scope for a closer working relationship.

NEVIL was described several times as ‘a whole lot better’ than the centralised DHS training unit that operated before the cluster arrangement. However, in a minority of cases participants suggested the clusters would be more appropriate if split by speciality across the state rather than by geographic location. Funding could then be allocated based on sector size. This was a perspective generally advocated by people without a direct role in the management of clusters, from areas such as CAMHS, where there was a sentiment that the cluster approach generally was not working. This view was not widely held with many people advocating a stronger emphasis on learning from across age specialties.

“I think there are some risks in this approach in that you end up kind of confirming the silo mentality and also you don’t get to use the expertise. So we’ve got people in kids and adolescent who’s job is to be the therapist. The model of care in child adolescent is a therapeutic recovery model, the model of care in adult and aged is not. It’s symptom relief. Fantastic, reasonable model, but it’s not a therapeutic recovery model. One can learn from the other. Some things are universal – like the management of aggression. Working with consumers is universal and working with family systems is universal. So if you do it in the little pod groups then you miss out on those things that are fundamental and also the different areas could really teach each other.”

In commenting on this view, several participants felt it was exacerbated by the difficulties of the cluster in engaging with allied health professionals and medicos. While NEVIL had working groups in these areas they were not very active and participation was patchy. Nurses, who dominated in aged and adult services, were seen as much better organized and motivated.

Some interview participants commented that agencies had taken a fragmented approach to their participation in the cluster – expecting the cluster to co-ordinate their input rather than managing this internally. This was highlighted when agency representatives on the management committee and working groups had very different views on issues and priorities, each area independently participated in working groups etc. Each area had ‘their own agenda and their own interests’. Despite this, the representative on NEVIL was seen as very active and pro-active.

“Our rep on NEVIL is very active. She has had the support of the organization, a lot of her time is now spent on NEVIL issues and she is the director of nursing. I think we’ve had a lot of input in development, perhaps the outcomes haven’t been as desirable as they could have been.”

It was also suggested that the cluster had been very focused on training rather than workforce development. To some extent this was seen as a developmental issue by agencies. One agency suggested that the next stage of development would be bringing in the cluster project officer into the agencies through participation on internal workforce planning committees. Other participants spoke of the cluster recognising a need to move beyond ‘event management’ to a more strategic role. There was general confidence in the project officer to achieve this.

10.1.2 Efficiency

Initially there was a management committee and a steering committee for the cluster, but because the membership was almost identical, it was determined to combine the committees for efficiency.

The management committee consists of representatives from the six agencies, four Consumer and Carer consultants (2 of each) from different agencies. NEVIL started with five members, later Forensicare also joined. Monthly meeting locations are rotated through agencies.

In terms of service models for the cluster, the strong impression from both committee members and other agency participants was that there was a limited notion of the options available on establishment. The cluster ‘just got in there and started doing the work’, identifying priorities and delivering programs without an understanding of possible alternative models and the implications of these for governance, engagement with agencies and program delivery.

“I’m not sure that it was a deliberate decision. We didn’t really know there were options. I’d like to hear about them now ‘cause I still don’t think we know what they are. We just got in and did what we had always done as a practice group- looked at needs and started running courses.”

Setting up NEVIL involved a lot of work on establishing relationships between agencies. In interviewing people, there was clearly a lot of goodwill and positive sentiment towards the cluster. People very clearly felt a strong sense of ownership and achievement ‘We are the best!’ The approach was seen as based on ‘pooling of agencies’ needs and providing programs not viable without the critical mass’ that the cluster provided.

“The cluster provides very local, sensible economies of scale.”

Before the cluster was established, cooperation between agencies was described as based on personal relationships and ‘patchy’. There was not a lot of trust and relationships were often competitive.

“To run the cluster required getting all the cluster members on side. There was a lot of talking and connecting.”

“The public sector reforms during the Kennett years devolved responsibility for education and training to the services and brought in competitive tendering. Cooperation through the clusters recreates the collegiality which existed before this.”

It was also clear from the interviews that the cluster is evolving and the model is changing. While the initial model was described several times as ‘event management’, there was a lot of talk on ‘being more strategic’ and measuring success on broader indicators than program outputs – ‘How do we know we are making a difference to clients in the end?’

“Its become apparent to us that we’re not strategic enough in our education and training planning, so when you get to see the paper work through Greg we’ve got some strategic priorities for the next 3, 5 years and we’ve broken them up into areas, three major areas with subgroups, its about us thinking strategically and proactively rather than reactively.”

There was also a lack of clarity around the future and boundaries of the cluster approach. Some interview participants felt that the Department had used the clusters reactively to ‘plug holes in the system’ without reflection to the broader implication for the viability of clusters or the development of the workforce. The clusters were seen as under-funded for the work achieved. There was also seen to be a need for commitment to ongoing funding from the Department.

“Not a lot of money bought into cluster. There is a whole lot of education and training happening outside of cluster. Department needs to decide the role of the cluster approach. Eg, training for medical staff is through different clusters.”

10.1.3 Effectiveness

The main focus of NEVIL was described as providing professional skills development, through the development and delivery of face-to-face training workshops. Currently these are generally stand-alone one-day workshops. In the future the cluster will ‘look at linking courses into sequential programs’. In addition, participants commented that trainers are now encouraged to identify ‘whether their courses are introductory, intermediate or advanced in preparation for this’.

The cluster was seen as mostly using internal expertise, with limited involvement from external experts.

“About 90% of the activities are conducted by staff who are internal to the cluster; presenting training is part of their job description. Three activities where trainers were brought in were ASSIST (Alcohol and Substance Use) and two CEED programs (Centre for Excellence in Eating Disorders) were very successful”.

The cluster provides critical mass; enough participants to justify running a course can be recruited from across the cluster. Some of the training would take place, but NEVIL relieves the member agencies of some of the workload. In addition, resources are shared between agencies and staff from different agencies attend other agency’s courses.

“The aim is to get to the situation where trainers from within the cluster just turn up to run programs and everything is in place for them.”

Attendance at courses was generally described as 'high' with positive feedback from participants. It was noted that some of the regional training is not well attended. This was seen as an issue reflecting the volume of mental health workers rather than reflecting on the specific topics. Conversely, in other areas there are waiting lists for vacancies in activities.

It was also raised by interview participants that there is no accreditation at present, but this is something to consider in the future. Agencies may link some of the training to their organisational accreditation system. However, at the moment, training is not portable 'even within the cluster'.

The project officers from the three clusters meet monthly to exchange ideas. Western Cluster, whose program is similar to NEVILs, and closest geographically, had been helpful, particularly in the early stages of the appointment of the current NEVIL Project Officer in April 2006. Increased co-operation was commonly mentioned as an area for improvement.

"There should be more higher level linkages between the clusters – a state wide approach. This may happen at the level of the area manager."

The number of agencies in the cluster was not seen as important as the geographical proximity of agencies to facilitate interaction.

"Meetings become unworkable with more than 15 or 16 people attending, so clusters should not be too large."

Several participants commented that NEVIL may have some capacity to expand. This would be particularly useful for regional services as some regional courses had been cancelled for lack of interest.

"One or two more services, particularly regional services, could be a good thing but no more."

When talking of the future of the cluster, the issue of leadership and the crucial role of the project officer were raised. It was seen as important that the project officer has good communication and administration skills, but also has a high level of understanding of workforce development, strategic management and education planning

"Our project officer is well respected and St Vincent's is seen as a good leader generally.."

Several committee members talked about the intention of the cluster to expand into online and other modalities in the future. Cost of the infrastructure was seen as one of the biggest hurdles to this in the short term. Several participants commented that NEVIL is also looking to develop resources (DVDs and videos) that trainers can use in courses (either locally manufactured or bought in from elsewhere) as a way of improving efficiency. However, this was not seen as appropriate to all topics.

"Because it is difficult to fully develop clinical skills using on-line learning, the intention is to identify what knowledge can be acquired in this manner, and what needs to be learned face-to-face."

Issues in implementing this approach were described as locating experts, "piggy-backing" on other modalities, and the level of funding required purchasing or developing materials. Due to these restraints, this was seen as a long term project unlikely to be 'tackled' until 2008.

"There should be greater academic links to universities. Some ways to link with academic education departments (to keep up-to-date with changes in thinking in adult education, social sciences, psychology academic education; innovative e-learning approaches and resources; shared data bases)"

Currently, evaluation of activities is based on satisfaction surveys completed by participants. Several committee members mentioned that the next stage in the development of evaluation is to identify changes in knowledge and skills. Measuring the impact on workplace behaviour was seen as a longer term goal. Several participants also commented on the need for better information to feed into the system.

"At my level of experience and knowledge, I think I have a really good sense of what the staff need. Though, we don't do enough surveying. That is something that we could do better I think. It really comes down to how well the agency reps know the staff needs."

“We are really just starting now to define KPIs and we still have room for improvement. This should have happened a lot earlier”

The overall feeling of the interviews in NEVIL was that there was high degree of enthusiasm and accomplishment. With little direction, the cluster has gone through a learning stage where the initial focus was on ‘getting bums on seats’ and now a more planning and co-ordinated stage is emerging. There was a lot of positive sentiment for the future of the cluster and confidence in the capacity of the project officer to assist the cluster to reach its vision.

10.2 Western summary of interviews

Several participants commented that they considered this evaluation to be “the last chance to get it right.” There were high expectations held of the cluster, with many people interviewed concerned that the management and organization of the cluster had not been effective.

10.2.1 Appropriateness

The steering committee holds a planning day every six months to decide program priorities. Each agency is provided with forms to identify training needs, future workshop topics and possible speakers. Information from the forms, combined with DHS priorities, is used to develop the program of activities. Agencies develop proposals for training activities and submit them to the Steering Committee.

Several interview participants commented on the lack of insight in the approach to education and training. The biggest concerns included a lack of consistency into the analysis of workforce needs and focus on the purpose of education and training.

“There is no baseline of current skills and knowledge, no link between needs and training and no vision of the future.”

“Currently the training needs analysis employed is based on what people want or would like. It is not based on a critique of practice.”

“It’s a wish list.”

In addition, many of the issues raised by participants were seen as reflective of their broader concerns with the State approach to workforce development. There was seen to be a lack of co-ordination and lack of understanding of core inputs to monitor the system. On several occasions the system was described as reactive rather than forward focused.

“We don’t have targeted education and training based on skill deficits. Recognised Statewide deficits should be the input to training and development needs analysis. The Statewide clinical audit from the Office of the Chief Psychiatrist (1998) identified areas of deficit which have not been addressed and still exist. These areas were not even contemplated when the cluster was planned. Audits could have formed the basis on which to establish training priorities.”

“In most documents from DHS, education and training is presented as a priority. However, there is still avoidance of discussion of the core skills and knowledge required to deliver a treatment service, and how we develop them.”

“Education and training priorities are set based on the latest crises, rather than being based on strategic planning to prevent or reduce the number of crises.”

Participants described agencies as having done their own ‘SWAT analysis’ and bringing this to the initial cluster meetings to develop the Western training plan. The resultant training plan was seen as a ‘compromise’ of needs across the agency, based on different levels of information from within agencies. One agency participant commented that the last needs analysis that had been completed for staff was over seven years ago, another participant commented on a needs analysis last being conducted over three years ago. In one case a rural agency had a very comprehensive annual approach to needs

analysis and training planning. In all cases, agencies considered that they had a reasonable idea of staff training needs through their line management arrangements. However, the cluster was generally not seen as having good relationships with agencies or an understanding of needs.

“Poor understanding of needs, poor consideration of members and poor consultation.”

“Western cluster is too big and the distances between member services too great.”

It was also noted that in delivering courses there is often duplication with external service providers and that greater co-ordination and analysis of existing programs is needed by the cluster. In addition, it was also comment that programs are not sufficiently updated between administrations and there is a lack of focus on quality assurance. In addition, it was suggested that the approach of agencies maintaining their internal programs was reflective of a lack of trust in the cluster.

Training activities were seen as very focussed on adult mental health, with little attention to the needs of younger or older people. However, it was also acknowledged that the bulk of the mental health workforce is in the adult sector. In addition, while the cluster was generally seen as meeting the state priorities, difficulties of engaging with doctors was seen as limiting the success of the cluster. There was also some concern that the committee has an over representation of nurses. There was thought to be more capacity to make the cluster representative of allied health and medical professions, though it was also noted that the cluster does offer training programs for staff from different disciplines. In addition, while the cluster offers some age specific programs, there was concern that the activities offered are generally too focussed on adult mental health.

10.2.2 Efficiency

The promotion of education and training by DHS as a high priority and the idea of clusters to address the needs in this area were seen as basically sound by participants. However, there was concern that DHS provided minimal implementation guidelines as to how the clusters should be organised. At project commencement, the DHS worked from a premise of wanting to enable the local clusters to develop their own approach and, in the spirit of a pilot project, it was recognised that varied practices may occur. Feedback through this evaluation reflects that this has resulted in agencies within the cluster pursuing their own interests, with some confusion and inconsistencies across the system.

“DHS had a good idea. They put it out, but with no guidelines. The loudest voices in particular areas dominate. You end up with different ways of operating in different areas, and no consistency across the system.”

“The original idea was excellent, “How do we address education and training?” But people shape, sort and twist it into what they want. At the outset, services had agendas about spending money rather than opening up the debate about what was needed across the cluster.”

The management of the cluster was often described by participants as fragmented and not part of a cohesive group with common goals and priorities. It was commented that at the initial meetings there was little agreement on what constitute training and education and how the funding should be used.

“In the initial meetings of the cluster, discussions demonstrated the disparity between what member organisations considered education and development priorities.”

“Some organisations saw the cluster money as an opportunity to catch up, because they hadn’t invested in training in their own organisations. Others wanted the focus to be on development of skills needed to ensure clinical practice was to the required standard. There were considerable tensions and resentment.”

Several interview participants who had been involved in the cluster from the inception felt that the cluster management had not appreciated that there were different ways they could have approached their role.

“We didn’t know about other models and options. We could use this now. Like improving training organisations – we don’t know how to do that. We started by pooling expertise within the cluster. We were going to look at other clusters...but that never really happened.”

It was also evident that some interview participants were very dissatisfied with the administration of the cluster, particularly in relation to communication and accountability. Administrative processes were seen as disorganised and insufficient to allow accountability. The failure to address these issues was described as ‘sapping the enthusiasm from committee members’ and reflective of difficulties in getting people to attend meetings. In addition, it was also suggested that the lack of consistent representation on the committee had made the group less cohesive – “What’s the point in going?”

“There are minutes but they don’t really track what happened. There are meetings where there is not even a corium.”

“We decide things and it either doesn’t happen or changes between meetings with no explanation.”

10.2.3 Effectiveness

Some interview participants expressed concern that the size of the lead agency may ‘swallow’ the interests of the cluster. In a smaller agency it was felt that the cluster leadership role may be given more of a priority and benefit from stronger more active leadership.

“Melbourne Health is very big – too big to be hands on enough as leader.”

The cluster was described as of greater value for smaller organisations. There was seen to be little incentive for NWMH to be involved in the cluster.

“NWMH is a substantial service provider, has a large training budget and has little to benefit from the cluster.”

“NWMH has a budget of \$130 million (1/4 to 1/5 of the State’s health resources). Now half of Western is NWMH.”

In addition, while the cluster was seen as contributing to some cost saving through resource sharing it was suggested that a lack of focus on the goals of the cluster has resulted in funding being spent on the wrong things. In addition, there was seen to be a lack of financial commitment by DHS.

“There was some cost sharing, but also waste of resources, because it is not used for what is needed. The National Practice Standards and the Mental Health Act are clear about what should be done. The money was used for entirely different things.”

“The cluster should get back to doing what it is supposed to do, but how can it do this given the funding provided?”

“The cluster’s infrastructure and activities are trivial and can’t do anything substantial, for example programs for overseas doctors. This needs hundreds of thousands of dollars.”

The cluster was seen as particularly offering regional services access to specific training opportunities that would not previously have been available to them. In addition, there was noted to be a better working relationship and networking between regional services. However, only having meetings in Melbourne was seen as a disadvantage to regional participants, particularly as video conferencing is not currently available. While several participants had linked into meetings through teleconferencing this was generally not seen as very effective.

“Can’t bear what is going on and it appears that you are forgotten – they talk over the top of you.”

Several interview participants mentioned that a rural/ metropolitan split had been considered in the past. However, it was suggested by several participants that a geographic split might not be the best method, despite many participants raising concern that the cluster was too metropolitan focused.

“Agencies have a broad range of needs, you should look at the natural relationships between agencies. For example, we get on with [some agencies and not others].”

Evaluation to date has focused on participant satisfaction though there has been some discussion of moving beyond this limited type of evaluation. However, many participants felt that there was still insufficient agreement on basic goals to identify a more effective evaluation process – ‘We don’t know what we want!’

Some interviewees focused on problems resulting from the basic premise on which the cluster operated and the way in which training priorities were determined. It was felt that the foundations were not in place and there was no real notion of what to evaluate. For example, one group of participants raised concern that the cluster assumed that all clinical staff had acquired the skills and knowledge they needed to meet clinical standards, and that the role of the cluster was to provide education and training which assisted in the maintenance and upgrading of these. However, it was felt that as many as half of the staff did not have the levels of competency required, and needed basic training. Because the education and training priorities established by the cluster were not based on identified gaps in clinical practice, there was concern that funding was not well directed, and there is no benchmark against which to evaluate effectiveness.

“There is a gap between the training delivered and the results of evaluations of practice, and the management of its implementation. Where is the clinical audit process that shows that standards are being applied?”

“Areas have never been made accountable. The KPIs don’t have anything to do with what the cluster has done.”

“The first step is to identify priority areas of core skill development for clinicians. We need a shared view around the key areas that are knowledge and skill based. We need to set standards and train to those standards and evaluate our success. This can lead to a quick turn around in patient recovery.”

The overall view from interview participants was that Western needs to improve its administrative and accountability process and develop a clear view for the future to guide its delivery of activities and evaluation framework. While reducing the size of the cluster was also suggested, many of the issues in administration, accountability, strategic planning and leadership reflect broader issues.

10.3 SETC summary of interviews

The SETC model was based on research conducted through the Southern Mental Health Evaluation, Research and Training Centre and implemented over a series of stages. There was a strong feeling from interview participants that the cluster was a success.

10.3.1 Appropriateness

Member agencies were described as bringing their locally identified training and development priorities to the cluster meetings, where they are discussed and prioritised. Interview participants reported using a range of methods for identifying local needs including quality feedback, complaints, incident reports, documentation, and risk analysis, as well as State priorities.

“We need a range of baseline training and development: mandatory training, training in response to our quality feedback, training to assist implementation of changes to practices.”

“Training needs are determined in response to local needs, e.g. performance appraisals, audit results, incident reports, problems with documentation, and system changes.”

In some cases participants noted that cluster activities were reported to various committees within the agency. This was seen as increasing awareness of the cluster and ensuring that service priorities were more strongly linked to cluster planning.

The overall approach of the cluster was described as capacity building, where agency strengths are used to develop resources for use across the cluster. The basic premise in starting SETC was described as start from the question, “What does each agency have to offer?”.

10.3.2 Efficiency

It was suggested by several interview participants that the cluster started very slowly and ‘seemed to take a long time to get off the ground’. Cluster management was perceived as ‘wasteful’ in the beginning, for example, long meetings in Melbourne which were reported to achieve little. However, participants generally considered the cluster was functioning well now administratively.

There was also some initial concern that the cluster arrangement was imposed by DHS, without consultation.

“When the clusters were set up DHS told us we would be a member and we were told that Southern Health would be the lead agency. There was not bidding process as there was with Quatro.”

However, it was also commented that the SETC was built on an existing strong network of psychiatric nurses. This was raised several times as an important factor in the success of the cluster and the maintenance of relationships. In addition, one of the outcomes of the cluster was seen as the further improvement of relationships between member agencies outside cluster activities.

“It (the cluster) has improved relationships between services outside cluster activities as well.”

“Relationships between members are good.”

The project officer was seen as very successful in his role and “a terrific communicator”. He was “the glue”; someone responsible for ensuring that things happened and very approachable if there was an issue. Interview participants reported that the email system of communicating events and news worked well.

In addition, the use of an external chair, instead of using one of the larger agencies in the cluster, was also seen as a very positive move. Several interview participants commented on competitiveness between agencies; this approach was seen as offering a neutral chair.

The SETC was described as employing a capacity building model, where a lead agency develops resources for use across the cluster.

“our lead agency had the model. By the third meeting, with enquiries from members, he had articulated its features: the sense of engagement and listening, growing it slow, the skills inventory. This was very well done.”

The focus on capacity rather than funding was seen as successful in side-stepping issues of financial competition. It was mentioned that this approach has the advantage of building on existing expertise within agencies, but the disadvantage of not getting buy-in from other cluster members.

“our lead agency made it clear that the cluster arrangement was not about competing for dollars. As soon as we understood that the cluster was about capacity building, we got over any rivalries and set about working out how to make it work for us and for the service. We became comfortable quite quickly.”

“Allocation of funds was not done selfishly. It was based on who had strengths and hence would be the lead agency on a project. Our project officer is a successful organiser and was able to spread resources across the services and across professions.”

Proposals for projects are submitted by agencies and need to be ‘thoroughly researched, justified and argued’. Some agencies that had led projects spoke of the additional workload it posed on the staff and differential up-take by other agencies. It was suggested that this approach develops experts within an agency rather than across a cluster and that other agencies may not know enough of the development process to be able to customise it to their needs. Issues of embedded agency ‘culture’ within a training program were also raised, as was the need for external validation and quality assurance.

Some agencies commented that they did not get back as much as they invested in the cluster. While some programs were useful, the cluster was seen as under resourced and not sufficiently focused on providing quick response to training needs, with learning that was flexible in delivery and sufficiently directed towards improving practice. The cluster program was described as seriously under resourced and reliant on agency staff giving up their own time. The role of the lead agency in developing resources was seen as very demanding on staff and under-funded.

Some participants commented that response time to training issues was not fast enough. It was noted that it could take over 18 months for a project to be implemented. It was suggested that the cluster needs to deal with long term issues while the agencies respond to more immediate priorities. There also appeared to be a need for more clarity on the boundary between agency and cluster responsibility for training to ensure an efficient approach. Several examples were given where agency internal training duplicated cluster training, for example, orientation training needed to be conducted monthly in some larger services rather than wait for the quarterly cluster programs.

“The idea of the cluster makes sense, but there will always be local issues that need to be dealt with.”

“If clusters could manage baseline training, it would be more cost effective. However, the cluster shouldn’t overtake what local services should be doing.”

“There needs to be a greater emphasis on training that will improve clinical practice here and now.”

In addition, several participants commented on the need for increased use of technology: audio visual, video, video conferencing, broadband, instead of meetings and educational forums in central locations. There was seen to be a need to diversify delivery methods to provide greater efficiency and effectiveness of resources.

Sharing of resources developed by the cluster was raised as an issue. While some agencies considered that resources should be shared with members from other clusters and favoured a stronger inter-cluster relationship generally, some members of the management group interviewed thought there may be issues with ‘Intellectual Property’.

“We develop resources and are happy to share them. But for some reason we can’t. Intellectual property or something. We should all be focused on the same thing – improved outcomes for clients.”

Related to this need for more collaboration, it was also suggested that the cluster project officers need to meet more often to provide stronger statewide co-ordination. One suggestion was that there should be state cluster meeting at least 3 or 4 times per year, with cluster chairs, project officers and representatives from Mental Health Branch.

It was also suggested that DHS needs to provide a clear commitment to the cluster approach to remove the “constant niggling” from aged services and CAMHS for age specific statewide clusters. This was seen as destabilising. It was felt that the clusters needed to be affirmed as ‘a long term strategy.’ Related to this there was also seen to be a need for ongoing funding commitment by DHS.

It was also raised that there has been some resistance from Nurse Trainers to involvement with cluster training standards and moderation. The previous standard was Workplace Trainer IV, in line with the EBA. There are no trainers in Allied Health because this role is not covered by their EBA. It was felt that the cluster could have a greater education and training role: e.g. professional development of trainers and moderation of training programs.

In addition, cluster activities were described as very ‘adult-centric’. While it was also commented that adult services account for the majority of the sector there was still seen to be more attention required to other sectors.

“Professional development for medical staff is resources separately (see EBA July 2006). The clusters could give some thought into tapping into that huge benefit. Doctors would have to elect to go to a cluster activity and pay from the benefit fund.”

10.3.3 Effectiveness

SETC was seen as having delivered a number of education and training packages that had saved agencies internal expenditure in development. Riske was mentioned several times, as were the staff orientation program and graduate programs among others. Many of these programs were seen as leading edge. In addition, the cluster was seen as providing a critical mass to justify the development and delivery of programs in very specific areas. This was seen as a particular advantage for smaller agencies.

“The cluster provides the forum for floating ideas which lead to initiatives.”

“Also, the cluster can support graduate programs in a way that many individual organisations couldn’t, by providing critical mass. This was the case with the Graduate Nursing Program.”

“The cluster provides bargaining power with training providers, where smaller services don’t have the capacity.”

“The project to support beginning psychiatrists, initiated in the cluster by Oakley Brown, is achieving the best results in Australia”.

The issue of the long-term impact of separating the management of education and training from the operation of the service was questioned. There was concern that the cluster would become driven by a nurse educator/ academic approach with the ‘loss of an operational perspective’. This was seen as a particular problem for larger agencies where there is more specialisation of function. This was also seen as related to the need for sound needs analysis of staff to ensure a focus on workplace knowledge and skills.

“Operational managers can be left out of the communication loop. This becomes a barrier, although it is less of a problem for smaller services who don’t separate these functions.”

It was also considered important that the clusters have sufficient funding to empower agencies while maintaining the diversity between services.

“We don’t want a statewide footprint. There is a need for core skills, but a service has to be innovative in the way it responds to local needs, for example by providing help beyond therapy and drugs.”

There was seen to be a need for greater emphasis on program evaluation in the future. This was generally understood by interview participants to be something that was going to happen. It was mentioned that projects such as Riske include an evaluation tool though its use is not consistent.

It was also reported that the cluster asks the agencies to complete a census on what risk and orientation training has occurred to provide a broad baseline for future evaluation. A sample of participants is also contacted by phone seeking their comments on the usefulness and the extent to which the training met their needs. Some participants also thought there might be written feedback forms provided to participants.

11. Summary of focus groups

A series of focus groups were held with mental health workers to understand their experiences and attitudes to education and training in the mental health workforce. In several cases, agencies and staff expressed concerns about the identification of their comments disadvantaging them within the cluster. For this reason, agency details are not provided in this section of the report. This information is also not sufficiently robust to allow reporting at the cluster level. Furthermore, as focus groups were conducted with only a small number of agencies, and were not designed to be representative of particular clusters, the analysis is taken at the project level. In addition, as the focus groups were recruited by agencies agreeing to participate in this stage of the research, the composition of focus groups was not entirely within the control of the researchers.

Three agencies agreed to facilitate focus groups with their staff. Two agencies were in metropolitan Melbourne and one agency was in regional Victoria. A total of 33 people participated in six focus groups. These groups included:

- 1 group with a CAMHS team
- 1 group with CAMHS, adult and aged inpatient mental health workers
- 2 groups with clinical leaders and senior practitioners
- 1 group with a CAT team
- 1 group with an educational/ clinical team

Participants included consumer and carer advocates, nurses, educators, psychologists, social workers, occupational therapists and registrars.

11.1 Overview of results

Several broad issues concerning training and education in the mental health workforce were raised across focus groups and agencies. There was seen to be a need for:

- ✓ Greater co-ordination of training centrally, particularly in the use of training to shape the direction of the mental health sector
- ✓ Quality control on training content and a greater focus on recognition and transferability of training
- ✓ Sharing of training materials between clusters.

The biggest barriers to participation in training were cost and time. Time was particularly an issue for senior clinicians concerned about the continuity of patient care and for regional participants where a substantial co-payment may be required to access training off-site.

The cluster approach was generally described as providing ‘a good basic introduction for new staff’. A large focus of the focus groups was on the ‘pitch’ of training. Training was described as focussing on ‘levels 1 and 2 that are already well supported within hospitals’.

In several groups the issue of broadening the perspective of training was raised – providing information for discussion rather than a single view. Training was seen as needing to focus on cross-age, cross-professional interests to be suitable for modern mental health teams.

It was also commonly discussed that training should include ‘practical approaches to client care?’ to facilitate transference to the workplace.

Suggestions to improve transference to the workplace included:

- ✓ More use of case studies in training activities
- ✓ Better written handouts and templates for forms and checklists
- ✓ Access to training providers after the initial training session to answer questions arising as new knowledge is implemented in the workplace
- ✓ Encouraging agencies to develop ‘implementation committees’ to support people bringing back new ideas to the agency.

Training delivery demonstrated little variance based on either cluster or locations. Most training was delivered through face-to-face presentations and workshops. There was reported to be no training through clusters delivered online or through video conferencing.

11.2 General issues

Several broad issues concerning training and education in the mental health workforce were raised across focus groups and agencies. A common issue was the need for central leadership and quality control across cluster activities. Participants raising this issue often referred to the role the former DHS Training Unit. The Unit was seen as providing common, portable minimum industry training standard. Attendance was described a ‘good because people thought they had to go.’

“There is still a role for central oversight.”

Without this central oversight function, training was not seen as portable between or even within clusters. In addition, several participants that had been directly involved in the development of training materials and activities expressed concern that their work is acceptable at face value, without any independent review of content. Similarly, there was concern that there is no quality control on training delivery to ensure the integrity of the content is maintained. For these reasons it was often suggested that staff were ‘better off doing a recognised course’. The Developmental Psychology Course (DPC) was often suggested for staff new to CAMHS, even though participants are likely to have to pay for the course personally.

“There is no quality control. Trainers put their own interpretation on [materials] and you lose the consistency.”

“We need guidelines, policies, boundaries for consistency and quality control.”

There was also discussion that training delivers content within a specific value system, philosophy or culture that includes policies and procedures. Some of this is agency specific (such as policies or procedures) and some of it is broader (such as the underlying philosophy of care). It was also comment that this ‘subtext of training’ can either lead the sector to new ways of think or reflect current ways of thinking. Several examples of this were given:

- The sector is moving towards ‘mental health professionals’ yet may cluster activities focus on specific areas of professional interest that could be left to associations
- Some topics could be embedded in training practice, such as working with families, rather than treated as if they are isolatable events
- Age specific training activities maintains old divides, and particularly isolates CAMHS, training could be designed to be cross age.

At a more specific level, examples were also given where the training developer embeds their values or expectations in the content. For example, one participant spoke of developing a course in aggression management for a cluster and making it relevant to the policies and procedures at the agency at which

she works while also being aware that there is a range of accepted practices and other agencies will adopt different thresholds and approaches.

Sharing of training materials between clusters was also raised. Some clusters' leadership teams were seen as competitive and creating a 'silo mentality' between clusters. In one case 'intellectual property' was used to block agencies from sharing their cluster-funded projects with agencies from other clusters. While it was also considered that agencies still maintain some of this competitiveness, particularly around training packages, this was seen as something that had a bigger impact historically. For this reason, it was seen as particularly important that the clusters play a stronger role in working cooperatively together, providing a role model for agencies.

"We are happy to share our resources, if we develop something. But there is some issue from the cluster. Intellectual Property or something. I think it is really about competitiveness. The clusters compete with each other. Some of them anyway."

"The cluster is competitive. They don't want to share the work they do. The clusters should be made to work together more."

Similarly, it was noted that one of the main advantages of the cluster approach is to provide a critical mass of participants to make training more economical and consequently more accessible. It was suggested that while most agencies have a critical mass of nurses needed to run training in-house, allied health professionals were seen as particularly benefiting from the critical mass offered by the cluster. However, it was also noted that the small numbers of consumer and carer representatives will not reach 'critical mass' within the cluster and a cross-cluster approach may be required to meet their needs. There was not seen an enough participants within agencies or clusters to offer courses.

In addition, participants involved in the direct development of training activities for the clusters commented on the amount of work this had generated. It was commonly accepted that this work was largely conducted after hours, on top of existing workloads. In some cases the workload was not seen as equitably distributed or sustainable.

"The cluster has made a lot of work. People spend a lot of their own, unpaid time, developing the courses and co-ordination."

"We put other things aside; work on our own time"

While there was some difference in opinion between groups, the general view was that the cluster had made a positive contribution to education and training of mental health workers.

11.3 Cluster awareness

In all groups there were some participants who were not aware of the cluster education training partnership program or their specific cluster. Generally these participants were also unaware of the websites and calendars. However, in all cases participants were aware of at least some training programs that had been offered by their cluster. The issue was lack of brand awareness rather than lack of program penetration.

"You can go to the cluster training without knowing it. I look at the topics not who is running the course."

"The cluster is not an agenda item per se. In our PD sessions we discuss training not the cluster."

In addition, where participants were aware of the cluster project, they also tended to be aware of the other agencies included with their cluster. When asked about the other clusters, most participants were not able to identify the name or composition of the other clusters. A minority of participants were not aware that there were other clusters.

In all focus groups there were differing degrees of recognition and awareness of the cluster training calendars. While the calendars were clearly used by some participants (particularly nursing staff and people working in the adult area) participants were more likely to identify email information as the most

useful and common way of receiving information about upcoming training activities (both cluster and non-cluster activities). Even when described, a few participants were unable to recall seeing the training calendar.

The training calendars were generally displayed on noticeboards and circulated through emails. Some participants who had received calendars by email observed that they are not very user-friendly to print through this method, as the font is too small when printed on A4 paper.

It was suggested that calendars could colour code activities by age group to make specific training more obvious to the target audience. Participants making this suggestion were likely to consider that most activities focused on the adult sector with other groups 'getting lost' when attempting to identify activities relevant to their age specialisation.

Participants most commonly had seen emails circulated about specific upcoming training activities. Calendars were looked at initially but the emails provided an ongoing reminder of training activities. In many cases team leaders reported printing flyers and emails to take to staff meetings.

"I take them to staff meetings with me and tell the staff what's on."

Email was also reported to be the method used to gain information about agency-based training. While email was clearly the most widely used and relied upon method of gaining information about training activities, calendars were also well used, particularly for planning upcoming training activities.

People asked if they can access other clusters calendars or if there was a way to participate in other clusters activities. It was noted that some people might actually live in one cluster's catchment and work in another area.

11.4 Participation in training

While most participants from the regional focus groups reported having been through a formal training needs assessment process on an annual basis with their current (and in some cases previous) employer, most participants in the metropolitan focus groups had not participated in a formal assessment. Several participants suggested that clusters or agencies should develop training plans for their staff as a way to meet organisational training needs and prioritise participants for specific activities.

Where conducted, education teams reported using training needs analysis for prioritising local training activities and application to clusters for funding for specific projects. The identification of staff to participate in training programs was generally less based on assessment and more a function of staff nomination (which may be informed from a training needs analysis or other motivations).

Clinical leaders and educators in regional areas also noted that in smaller settings there is less differentiation of clinical, management and educational roles. So the educators and management also perform 'hands-on' clinical roles. This provides an opportunity to gain an informal experiential view of the training needs of colleagues and teams. It also means that educators and managers are more able to 'casually tap someone on the shoulder and say, "Hey, this would be a good course for you. This is what we were talking about the other day".'

Generally, selection of training activities and training priorities by individuals was seen as a function of the interest in a topic, management agreement for the need to maintain currency in the topic and the value of the topic to the organization. These factors also interact with other demands such as workload, training already attended, and cost to the organization and the individual.

Even for metropolitan agencies it was noted that travel can 'eat into training' and that obtaining time release can be difficult. People were generally in favour of shorter, half-day sessions where this was feasible for the topic. Although it was also acknowledged that this was not suitable for regional participants or for all topics.

Cost was particularly an issue for participants from the regional agencies. The added expenses of travelling, including airfares, mileage allowance, accommodation and meal expenses were not fully subsidized by the agencies, with some payment by the staff required. In addition, this also coincided with additional time away from work that was seen as posing a strain on other staff and impacting on the continuity of care for patients.

“We can’t just scoot across Melbourne for a three hour course. Even attending a short course is likely to involve an airfare and accommodation. Blocks of time are much easier to attend than ‘split courses’.”

“Regional access to training is still ‘tokenistic’ to some extent. Maybe I am being unfair.”

Regional participants commented that they are still very reliant on education and training activities being delivered locally rather than staff travelling to Melbourne. Local training was seen as more customised, easier to access and more likely to provide transferable skills and knowledge to the workplace. It was noted that the more specialised training, particularly the clinical training, which has less relevance to all staff, is often only offered in Melbourne.

Because training is such a big expense and impost on the staff and agency, it was commented that ‘you almost need a peer review before you are willing to make a commitment’. It was thought that a participant rating, would help people decide if an activity was relevant to them and worth the allocation of personal and agency resources.

“You almost need to trial a course because it is so expensive for us...taxis...accommodation, food. It’s a pity there is not a critical reviewer available.”

Regional participants consistently raised the issue that they are ‘less experimental’ with the training they attend due to the time and cost issues involved.

“You never go to training and say ‘Yeah, maybe’ You have to be certain before you commit the money.”

It was also considered that training was better attended when offered by DHS centrally prior to the clusters. ‘We went because it was part of our job to go’. Now training was seen as more difficult as there were so many more demands on a clinician’s time. Even in regional areas it was raised that time and continuity of care for patients were bigger barriers to training than cost.

“It’s not that we are over trained, it’s that we are under resourced. We do the bare minimum to help patients survive. There just isn’t enough time to do all the things we could do. We often have to fall back on to medication because there isn’t time to take another, better approach.”

“Time factor is also more important than cost for senior clinicians.”

Under some models, courses were seen as very restricted in number and participants, with the host site eating up most of the available places so that there was not a lot of interagency interaction.

11.5 Training content

The cluster approach was generally described as providing ‘a good basic introduction for new staff’. A large focus of the focus groups was on the ‘pitch’ of training. Training was described as focussing on ‘levels 1 and 2 that are already well supported within hospitals’. The training was generally seen as very broad and ‘not offering much for people who are already trained beyond a basic level...most of our team have post grad qualifications so they are looking for more specialised training’. For this reason, cluster activities were often seen as more relevant to nursing staff.

“There is a lot of double up for allied health – like the graduate program. We run one and the cluster runs one too”

“There is nothing for doctors really”

It was also accepted that the clusters have been more successful in engaging with nursing staff than other mental health professionals. This was seen as arising for a combination of reasons, including the

number of nurses in the workforce, the time schedule and client commitments of medical and allied health professionals and the better organisation of the nursing workforce (including the dominance of nurses on cluster committees and in agency training teams through the nurse educator positions).

In several groups the issue of broadening the perspective of training was raised – providing information for discussion rather than a single view. It was suggested that training could be more meaningful if delivery moved away from the notion of one expert presenter to an expert panel, or from one age group or discipline to a cross-sector approach. Similarly, when looking at specific topics, participants suggested a multidiscipline approach.

“I did some training on legals...it was for adult, but it could easily have been applied to CAMHS or aged without losing anything. They just need to think about it. Many of the issues are the same and more information makes training more meaningful. I think sometimes people forget that kids with problems can grow up to be adults with problems and the service system should be more integrated.”

Some participants also suggested that training should focus on mental health professionals rather than ‘maintain professional silos’.

“People who work as a team should train as a team.”

Staff with postgraduate qualifications were particularly likely to identify a need for more training based on cutting edge research with practical guides for impact and implementation.

“We want specialist, evidence based, innovative, training based on the latest research”

It was also commonly discussed that training should include practical approaches to facilitate transference to the workplace. When back in the workplace, it can be hard to ‘make the strategic shift and implement new learning’. Sometimes this will be because new issues or questions arise or because people lack confidence or time to think through changes. Several participants commented that they supervise other staff and there is no one to supervise or mentor them. (There was seen to be a potential industrial issue if not handled carefully – focus on training not workplace supervision.)

“You can’t just throw training at people. There needs to be follow-up and back-up and quality assurance to make sure you are doing it right”

“Its not just about the training. Its as much about how to bring the learning into your work and your workplace.”

Suggestions to improve transference to the workplace included:

- More use of case studies in training activities. This was also seen as a usual way of showing how a technique or issue might apply in different circumstances or with patients in different age groups. It was also suggested that this may help presenters that find it difficult to answer questions related to specific cases without notice.
- Better written handouts and templates for forms and checklists. Where these resources were provided they were reported to be very useful and reduce staff time in ‘reinventing the wheel’. It was also noted that high quality resources will be kept as a reference for later use by the individual or the agency.
- Access to training providers after the initial training session to answer questions arising as new knowledge is implemented in the workplace. This was seen as something that could be done individually, though a phone call or email, or through a more structured approach such as a web forum or video conference.
- Encouraging agencies to develop ‘implementation committees’ to support people bringing back new ideas to the agency.

In addition, the issue was also raised of the Departments’ focus on ‘number counting’. That is, activities delivered and number of participants, meant that clusters were less likely to develop or delivery activities that focus on niche markets or more specialised topics.

“Focus is on getting the contacts the government wants. Other training, the higher skill stuff, falls of the agenda.”

11.6 Training delivery

Training delivery demonstrated little variance based on either cluster or locations. Most training was delivered through face-to-face presentations and workshops. There was reported to be no training through clusters delivered online or through video conferencing.

It was also noted that staff on night shift ‘can’t attend any training’ because of their shifts. Online training was seen as appropriate for these people but not available. It was also commented that online training is much more accepted in the regional areas as most of the graduate placements are generally studying online.

Participants in the regional focus groups were accustomed to using video conferencing for consultations with patients. They reported good acceptance of the technology for this purpose. However, it was generally considered that video conferencing would need to be carefully managed to work well in a training context. Use of a limited number of sites with small groups at each site was one suggestion to ensure participants did not ‘get lost or forgotten about’. Video conferencing was also seen as a way to do follow-up session with groups that had previously participated in training activities.

“You could use video conferencing to run implementation groups or to provide follow-up without people having to travel again.”

In several cases participants noted that they have access to video conferencing facilities but the cost was prohibitive.

12. Workforce development models

This appendix presents two very different models intended to inform the discussion of approaches to workforce development in the Victorian mental health sector. The first is *Strategic Human Resource Development*, which describes increasing maturity in approaches to workforce development within organisations. The second, for the purpose of this report titled *The Service Hierarchy*, provides a format for describing the allocation of core and specialists services across the mental health system.

Strategic Human Resource Development

The notion of Strategic Human Resource Development was developed in response to concerns that Human Resource Development (HRD) activities were marginal to organisations' key strategic goals. Organisations with high levels of flexible work practices were found to have a more strategic approach to Human Resource Management (Mayne, Tregaskis & Brewster, 1996). A 'new' model of Strategic HRD (McCracken & Wallace, 2000) provides an analysis of approaches to HRD in terms of the organisation's maturity as a learning organisation (see Figure 6).

Figure 6: McCracken & Wallace model (2000)

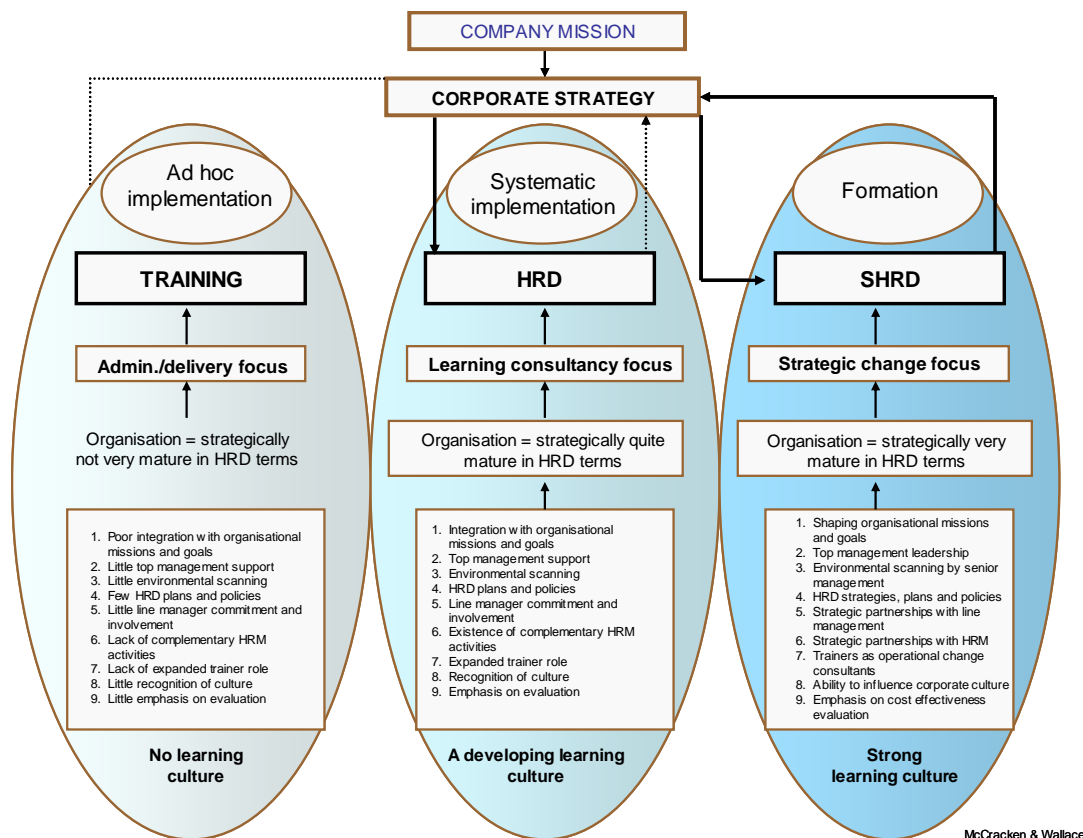


Figure 1 A model of SHRD

McCracken & Wallace (2001)

At the least mature level, HRD is seen as fulfilling an ad hoc and reactive role, by providing training support, primarily through an administrative function.

At the next level as the organisation is developing a learning culture, the HRD function acquires a consultancy focus and HRD programs mainly support rather than drive strategy.

In the most mature organisations, those with a strong learning culture, the Strategic HRD function is an active partner in both the shaping and implementation of strategic goals.

According to this model, HRD, in organisations with a strong learning culture HRD has the following characteristics:

- Integration with organisational missions and goals
- Strong support from top management
- Environmental scanning, providing continuous knowledge of the external environment
- HRD policies and plans, integrated with business plans and policies
- Line management commitment and involvement
- The existence of complementary HRM activities
- An expanded role for the trainer, as innovators and consultants
- Recognition of corporate culture and the need to match strategy with culture
- An emphasis on the evaluation of HRD activities in terms of organisational strategy.

HRD is seen as integral to an organisation and a key element in the implementation of change. In this context, the strategic plan is treated as a guide for managers who are expected to recognise and respond to opportunities as they emerge. Rigidly documented strategic plans can restrict flexibility and the capacity of effective managers to respond to day-to-day situations and opportunities.

Having HRD representatives involved, not only in the strategy planning process but also in those day-to-day decisions, helps ensure that workforce planning and development issues are given full consideration.

The Service Hierarchy

The Service Hierarchy table provides a means of representing the size of the area across which a service is provided, ranging from local (Area) to statewide, based on factors such as:

- Ease of geographic access to a service (accessibility),
- The time required by a service to provide a direct response (responsiveness),
- The size of the potential user population (volume),
- Cost (low to high), and
- Whether the service is core or specialist.

Although this model was developed to describe possible ways of allocating general services (Ministerial Advisory Committee on Mental Health Service Structures and Partnerships Subcommittee, 200xx), its format also has potential as a means of distinguishing between distribution of responsibility for education and training services across the system.

	Category	Description	Focus	Service Delivery Level		
				<i>Agency</i>	<i>Cluster</i>	<i>Statewide</i>
CORE SERVICES	A	CORE Low cost High volume Locally accessible and responsive	Area (approx 100,000 population)			
	B	CORE Higher Cost Lower volume Metropolitan Regional centres	Regional (approx 250,000 population)			
	C	SPECIALIST Higher Cost Low Volume Metropolitan Regional Centres	Supra-regional (approx 750,000 population)			
MOST SPECIALIST	D	SPECIALIST Higher Cost Low Volume Metropolitan	Statewide			

13. References

- Mayne, L., Tregaskis, O. and Brewster, C. (1996). A Comparative Analysis of the Link between Flexibility and HRM Strategy, *Employee Relations*, Vol. 18, No.3, pp.5-24.
- Meadows, G, Singh, B, Grigg, M (Editors) (2007). *Mental Health in Australia; Collaborative Community Practice*. 2nd Edition. Oxford University Press, South Melbourne.
- McCracken, M. and Wallace, M. (2000). "Exploring strategic maturity in HRD - rhetoric, aspiration or reality?" *Journal of European Industrial Training* Vol. 24 (No. 8): pp. 425-467.
- World Health Organisation (2005). *Human Resources and Training in Mental Health*. Geneva: World Health Organisation.
- World Health Organisation (2005). *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions*. Helsinki: WHO European Ministerial Conference on Mental Health.

Commonwealth of Australia

- Australian Health Ministers (1992). *National Mental Health Policy*. Canberra: Australian Government Publishing Service.
- Australian Health Ministers (1998). *Second National Mental Health Plan*. Canberra: Commonwealth Department of Health and Family Services.
- Australian Health Ministers (2003). *National Mental Health Plan (2003-2008)*. Canberra: Australian Government Publishing Service.
- Australian Health Ministers Advisory Council's National Mental Health Education and Training Advisory Working Group (2002). *National Practice Standards for Mental Health Workforce*. Canberra: Commonwealth Department of Health and Ageing.
- Council of Australian Governments (COAG) (2006). *National Action Plan on Mental Health 2006-2011*, July 2006.
- Commonwealth Department of Health and Aged Care (1999). *Learning together: education and training partnerships in mental health*. Commonwealth of Australia: Canberra.
- Department of Health and Ageing (Australia) (2003) *National Mental Health Plan 2003-2008*. Commonwealth of Australia, Canberra. Available online at:
[http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-ubs\\$FILE/nmhp0308.pdf](http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-ubs$FILE/nmhp0308.pdf)

New South Wales

- New South Wales Institute of Psychiatry (NSWIOP) (2007). *The New South Wales Institute of Psychiatry 2006 Annual Report*. Available at:
<http://www.nswiop.nsw.edu.au/pages/resources/resources/NSWIOP06AnnRpt.pdf>
- New South Wales Institute of Psychiatry Act 1964 No 44*.
- New South Wales Institute of Psychiatry (2007). *Mission Statement*. Available at:
(<http://www.nswiop.nsw.edu.au/pages/about/mission.php>, Accessed Feb 2007.

Victoria

Boston Consulting Group, 2006, *Improving Health Outcomes: the next wave of reform*, Boston Consulting Group, Melbourne.

Department of Human Services (Victoria) (2006) *Victoria's direct care mental health workers: The public mental health workforce study 2003-04 to 2011-2012*. Melbourne, Department of Human Services. Available online at: http://www.health.vic.gov.au/workforce/downloads/mh_workforce_study.pdf

Department of Human Services (Victoria) (2002) *New Directions in Victoria's mental health services: The next five years*, Government of Victoria, Melbourne. Available online at: <http://www.health.vic.gov.au/mentalhealth/publications/plan02/mhp.pdf>

New Zealand

Mental Health Programmes Limited (2006) *Mental Health Programmes 2006-2007: Delivering Now and Shaping the Future*. Auckland, Mental Health Programmes Limited.

Ministry of Health, New Zealand (2005) *Tauanwhitia te Wero – Embracing the Challenge: National Mental Health and Addictions Plan 2006-2009*. Wellington: Ministry of Health. (<http://www.nswiop.nsw.edu.au/pages/about/mission.php>, Accessed 28 Feb 2007)

Mental Health Programmes Limited (2006). *Mental Health Programmes 2006-2007: Delivering Now and Shaping the Future*. Auckland, Mental Health Programmes Limited.

United Kingdom

House of Commons Hansard Written Answers for 9 October 2006. Available at:

<http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm061009/text/61009w0129.htm>

National Institute for Mental Health in England (NIMHE). Available at <http://www.nimhe.csip.org.uk>

National Institute for Mental Health in England (2007). National Workforce Programme. Available at (<http://nimhe.csip.org.uk/about-nimhe.html>), Accessed Mar 2007).

Royal College of Psychiatrists, National Institute for Mental Health in England (2005) *New Ways of Working for Psychiatrists: Enhancing effective person-centred services through new ways of working in multidisciplinary and multi-agency contexts*. Available at:

<http://www.lincoln.ac.uk/ccawi/publications/NWW%20Psychiatrists.pdf>