AMHS training, education and workforce development scoping

Prepared by Jo Stubbs and Jeffrey Weitzel

Learning and Practice Development Coordinators, CMHL

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Introduction

This report outlines the work of the Centre for Mental Health Learning (CMHL) in scoping the learning, training and workforce development of the publicly-funded clinical mental health services across the state of Victoria. This work was undertaken by the Learning and Practice Coordinators (LPDC) at the CMHL throughout 2021 and into 2022. Most services participated in the project, only one service did not submit the requested template. The CMHL thanks those participating agencies and staff for their time in providing this information.

Background

The CMHL is a Victorian Department of Health (DH)-funded central agency for public mental health workforce development in Victoria. The CMHL has a vision to be the centrepiece for mental health learning in Victoria, leading and driving innovation that strengthens and sustains a flexible, curious, knowledgeable and recovery-focused workforce.

One of the CMHL's main functions is to support the learning and development of the public mental health workforce in Victoria. The CMHL needs to understand the expectations and requirements of the mental health workforces, how those needs are understood and met by existing workforce development programs, and areas to support growth and collaboration to fulfil this function.

The services in scope of this project are the 21 Area Mental Health Services of Victoria (AMHS), including the Royal Children's Hospital, and the Victorian Institute of Forensic Mental Health (Forensicare). As a baseline, this scoping project sought to gather point-in-time data about the learning and development programs, personnel and resources of each AMHS as well as the processes that guide decisions about their development and deployment.

The vast majority of Victoria's mental health workforce are employed and work across the state's AMHS and Forensicare. AMHSs' governance and internal structures are linked to a larger healthcare service. In Victoria there are 21 adult AMHS, 17 aged person's mental health services, and 13 child and adolescent mental health services plus Forensicare. Victoria's AMHS services can cover an entire healthcare provider region or there can be more than one AMHS located within a single healthcare provider service, and in the case of some age-specific services one AMHS may overlap across two or more healthcare service providers. While all services are required to meet certain standards and report uniform data, there are few mechanisms or systems which span or connect services. As such, current mental health workforce training is fragmented and non-uniform, or duplicates effort. Training programs range in focus, content, and deployment of personnel. These inconsistencies can lead to processes which have non-uniform content and training offerings and differing requirements of mandatory training. This can lead to extra work for each AMHS, stretching personnel, and create inconsistencies in workforce knowledge and practice.

In Victoria, there has not been a single agency which works to consolidate and standardise the training delivered to the workforce. Our hope is that the development of CMHL's role as a centralised training support service will thus create benefit to the workforce.

Aims

The aims of the scoping project were to:

1. Build relationships between CMHL (specifically LPDCs) and staff employed in training and development roles in AMHS
2. Collect point-in-time information on education workforce profile, education data collection, workforce training activities, and planning, development and evaluation from each AMHS
3. Review the processes for decision making, and suggest tools and other resources which can assist services to perform these tasks
4. Collect contact information and enhance collaboration
5. Lay the ground work for future collaboration of training resources through shared resources, support in resource development and laying groundwork for other initiatives such as a community of practice.

What we did

This project was led by the two Learning and Practice Development Coordinators (LPDC) at the CMHL. The project involved some early consultation and piloting, then data collection and meetings, and wrapped up with consolidation and confirmation.

Early dialogue with the sector began in late 2020. Prior to commencement of the project, the LPDC presented the project outline to the CMHL's Workforce Development Committee. This committee has representatives, often occupying senior positions such as Director of Nursing, from each AMHS. Post-presentation the LPDC emailed the same committee members seeking the most appropriate contact person for the project within each AMHS.

In January and February of 2021, a data collection tool was developed and then piloted with representatives from two AMHS to determine fit for purpose. Based on feedback from those representatives and further discussions with the DH, the tool was adjusted and scoping with other services began in March 2021. The reworked tool was used with the remainder of the services while the two initial pilot services were given the opportunity to check the accuracy of their service's data as it appeared in the reworked version.

The scoping meetings were arranged by the LPDC via email with the designated contacts for each AMHS. The meetings were scheduled as a 90-minute session with the two LPDC (when available) and appropriate staff from the AMHS. The data collection tool was sent to the key contact in advance to be completed to the best of their ability and reviewed in the meeting.

The main objectives of the meetings were to build relationships between CMHL and the AMHS, to go through the questions on the tool and provide an opportunity for the service to expand on and the LPDC to clarify any answers. Most of the meetings were conducted via an online platform due to COVID-19 and some service consultations took more than one meeting. There were a small number of meetings that were conducted face-to-face at the AMHS. LPDC contacted and met with the services in a staged manner across the calendar year, with the final consultation taking place in January of 2022.

Of the 19 health services contacted, 18 of the services completed and returned data collection tools. Subsequently eighteen services were met by the LPDC to review the information. Those numbers include two health services which house two AMHS each and North Western Mental Health, an amalgamation which covers North West AMHS, Inner West AMHS, Mid-West AMHS,

Northern AMHS and a separate Aged Person's MHS for the entire area. A separate template and consultation was completed with Orygen Mental Health due to their unique arrangements for their workforce learning and development based on federal and state funding arrangements. Since disaggregation, each of the AMHS comprising North Western Mental Health have been met with separately, although that data is not included in this report.

What we heard

The data collection tool used in this project had four distinct sections: Education workforce profile, Data collection, Workforce training activities, and Planning, development and evaluation. The information gathered in response specific questions in these four areas is described below.

Education workforce profile

The data collection tool took a point-in-time snapshot of the AMHS education workforce profile*. With the great variance in service workforce size and geographic area, the LPDC wished to gain an understanding of the people on and scope of each education team. This would facilitate a better understanding of the service and put the subsequent answers into perspective. It could also help the LPDC to gauge support needs and explore innovative practices. The LPDC's task of communicating with and being able to understand the strengths and challenges each service faces began with the personnel. How did a service utilise their education teams and who was a part of those teams? Who did they report to? What external services had the AMHS partnered with to develop their staff?

Does your AMHS have a mental health specific education team?

A primary goal of this scoping was to build links and understand the structures of the education teams supporting the AMHSs across the state. The scoping revealed many similarities across the state, with all but two services having a dedicated mental health education team. The majority of these teams were comprised mostly of nurses and reported to the Senior Nurse or Director of Mental Health Nursing.

The education teams across the state had different levels of EFT, some including allied health (some as discipline-specific and some as 'allied health'). The size of the AMHS and the size of the larger health service was often reflected in the size of the education team. Some larger services had larger development units which had the benefit of consolidating resources. Two services reported not having their own mental health education team. One of those services relied on an alliance of specialists to deliver training and education within the service. Many services shared some aspects of education with other parts of the hospital / health service.

Services which had a more defined structure to their education teams, made it clear that this was intentional. Long-term planning included dedicated focus on developing program governance and a dedication of their own funding to develop positions that met the needs of the plan.

Roles and responsibilities varied as much as the teams. Some examples of the types of roles that sat within education teams are listed below.

Senior Mental Health Nurse/Education team manager
Undergraduate Nurse Coordinator
Clinical Nurse Consultants

Psychiatric Nurse Educator (Undergraduate Nurse Program)
Psychiatric Nurse Educator (Post graduate)
Clinical Nurse Educator
Mental Health Educator (lifespan specific)
MH Graduate Clinical Nurse Educator
Specialist Family Violence Advisor to Mental Health
Family Violence Advisor
Administration

*This snapshot of education workforce will be shifting with the investments of Allied Health and Nursing graduate and transition educators and any new Lived Experience workforce educators funded under new initiatives as planned in the mental health reforms.

At the time of this snapshot, many of the education teams (particularly in the smaller teams) are predominantly made up of nurses, yet many are expected to provide workforce development for most of the mental health workforces (with medical/psychiatry being the exception).

Some services had responded to clinical needs by creating specialist roles to address the needs of their service. Some examples include reducing restrictive intervention specialist, cultural safety and diversity coordinator, and lived experience training project officer.

Who does your AMHS education team collaborate/partner with?

Mental health consumers are individuals, with unique life experiences. While the mental health workforce primarily uses a medical lens to view consumers' descriptions and experiences, to work effectively is to recognise the heterogeneity of those coming into contact with services: consumers, family, carers, and their networks. A responsive and effective workforce requires subject matter experts in an array of speciality areas and organisations with an ability to translate that knowledge to the workforce. Performing this across a multi-disciplined and varied workforce is a huge task. Education teams often utilise individuals and teams both internal and external to their services to provide a robust and comprehensive training and development program. Collaborating with local and regional partners can help the clinical MH workforce learn how that speciality knowledge looks and works in other contexts – increasing exposure to services available, access pathways, connections to local communities and supports and the likelihood of collaborative care. All of these reasons prompted the CMHL LPDC to enquire about each service's local collaboration partnerships. All services had a healthy mix of academic and local/regional agency partnerships.

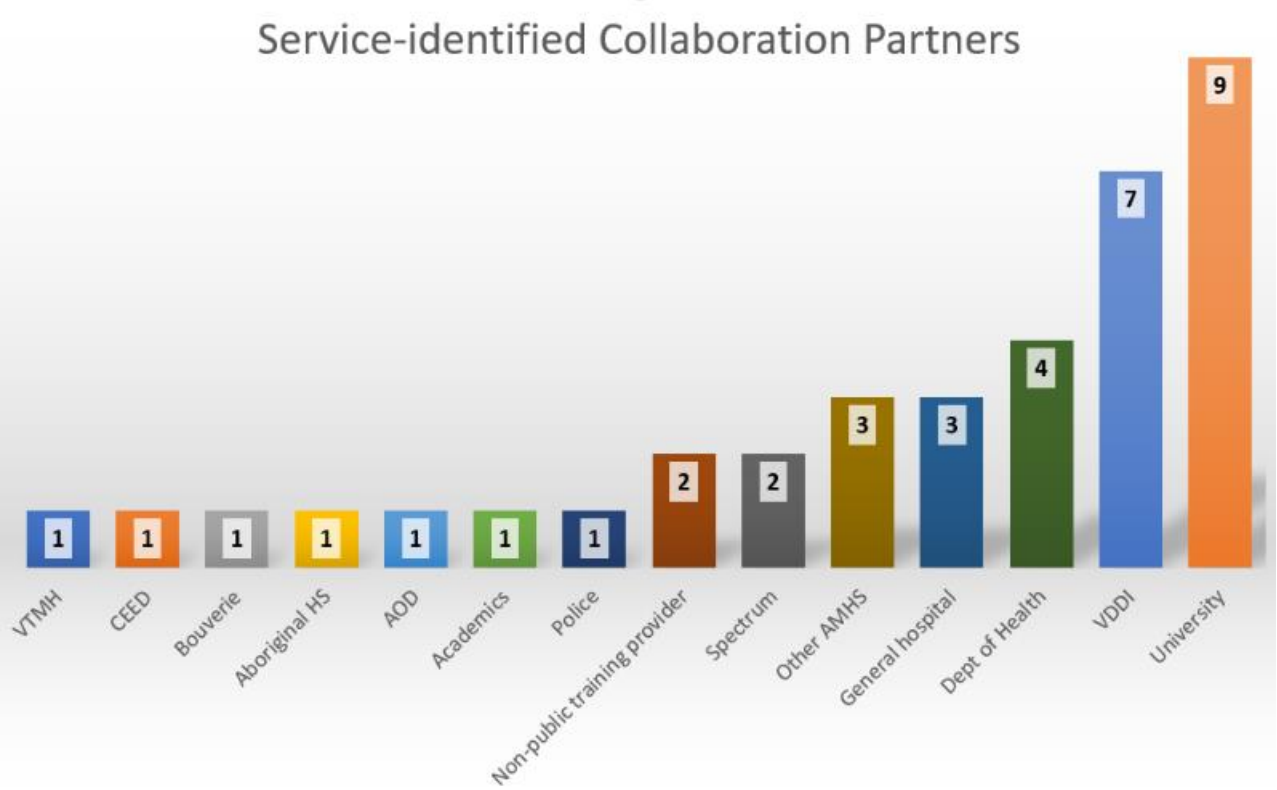

***Figure 1**: service-identified education team collaboration partners*

Many services reported links to universities, often those with local campuses, with which they had developed good symbiotic relationships of sharing and teaching. Another important local 'link' was with local or service-connected Victorian Dual Diagnosis Initiative (VDDI) teams. Statewide specialist services such as Spectrum were also frequently mentioned. These services often supported both the general AMHS clinicians as well as specially developed services within a local AMHS/health service.

Data collection

Data can support decisions, be used for accountability and measure practice change. Gaining a broad, baseline understanding of AMHS data collection is another step in planning for standardisation, evaluation, or change implementation. Therefore, an overview of the what, when and how of data collection for each service provides a baseline for the planning of further evaluation and data collection projects.

What data do you collect about participants, how do you collect and store it?

We asked each service about the data they collected about their staff's professional development. Services may be required to capture certain data for various reasons which could include internal and/or external reporting or benchmarking, tracking adherence to mandatory training, and individual professional skill and knowledge development. Part of the survey enquired about what training registrant data was recorded and how it was captured.

Almost all services captured basic demographic data of training attendees either at registration or at commencement of the event. It was common for services and teams to capture additional data if this was part of a larger audit or in order to meet certain standards for safety. This at times included the requirements of the broader health service to report and benchmark training attendance.

Data was captured in various ways ranging from manual sign-in sheets to electronic registration using a learning management system (LMS). Storage of that training data also varied from service to service, with some utilising their LMS to capture and record all training activity, others custom-designed databases, while others kept excel spreadsheets. Each method relayed to the LPDC had pros and cons, and often the need for expediency or ease of use would inversely affect the amount or accuracy of the data collected.

All methods and tools required some level of manual input and/or oversight (nothing was found to be 100% automated) and no service found that their tool was a perfect fit for all that they wished to capture or understand.

Workforce training activities

One of the main drivers of having a centralised, state-wide learning and development body was to be able to connect services around the training they deliver to collaborate, share best practice knowledge and resources. With an interest in similarities and areas of expertise, the LPDC enquired about the training programs that services had developed and were delivering.

The LPDC started with a wide-focus, ascertaining what training packages a service delivered in-house to their staff. Additionally, understanding the mandatory training requirements of the workforce also helps to inform CMHL how much time people in the workforce may have for other training. Exploring how services determine what training to provide and determining which training is mandatory, the LPDC were hoping to understand how services set their priorities and respond to needs. It could also provide a rough benchmarking and start to get a picture of both their training strengths and where they might be interested in further collaboration.

What training packages do you provide to your workforce? How do you decide what training is mandatory?

Most services described using a service-designed information matrix to cross-reference which training packages were offered, mandatory and/or recommended for particular staff. Mandatory packages are part of what is required for all employees of a healthcare services. Internal processes and decision-making at services appeared to be a major factor in determining what is considered mandatory training. A few services do not have any additional ‘mandatory’ tags on training specifically for mental health staff, and only include those required by the larger health service. Others have a hybrid model which allocates an employee’s mandatory training based on where they work, for instance someone in a designated mental health role may have an additional mandatory training suite, and more specialised branches could even then have additional requirements.

The learning and development training expectations were guided by a mix of external practice initiatives (e.g., Safewards, Reducing Restrictive Interventions (RRI), Family Violence), clinical practice needs (e.g., Mental Status Examination (MSE), managing suicide risk, de-escalation and aggression management) and explicit directives from the department of health /

government (e.g., MARAM framework). Some services offer a suite of introductory packages as an orientation to Mental Health that run from two to five days. Other services have days made up of small but specific training modules such as on the mental health tribunal.

The scoping briefly explored how a service determines when and how to explore a new topic for training, which includes focusing resources on updating or re-writing a package/program. Often this is driven by having someone join the team with expertise or interest in a particular area or responding to a new framework or initiative. Most services, though, shared that they generally did not have time or resources to develop new packages or significantly review existing work.

Under-resourced services who may not have the EFT in their training department or expertise in certain fields / subjects may wish to find avenues to collaborate. This collaboration could come in terms of other AMHS, university partnerships or other local specialist services. The scoping uncovered some potential pathways for collaboration and sharing of knowledge across Victoria, between statewide training providers and AMHS, and amongst AMHS themselves. This has informed the way CMHL works together with services with training development, training delivery, and train-the-trainer packages, CMHL is also implementing other ways to communicate and share priorities and areas of expertise to facilitate greater collaboration.

What are your services' areas of expertise? Where might you be interested in collaboration and what current or future projects should we know about?

The CMHL can have a primary role in helping to identify areas of strength and expertise across the state, with the potential for service collaboration. The scoping project sought to identify areas of expertise, services that were interested in collaboration, and upcoming learning and development projects.

Areas of expertise varied from service to service, often depending on historical topics the service has prioritised or had strong drivers for change in. Services have a limit to their capacity, which means collaboration and development may be limited in scope.

Asking each service about these three things has helped the LPDC develop a living document that can be shared with services so that they can consider future areas for collaboration and speak to services who are at the forefront of particular service innovation in Victoria. The LPDC broke down the responses in this section into themes in a bid to identify areas of possible collaboration. After a brief thematic analysis, 16 topic areas emerged. Some may fall outside the remit of the CMHL, however having this breakdown could lead to increased cooperation, sharing of resources, and bring more coherent understanding and practice. Themes that emerged can be seen in the table following.

CAMHS / CYMHS specific	Core Skills; Developmental Psychology; Eating Disorders;
Suicide prevention	Suicide Risk (NWMH), ASAP, Forensicare, ASIST
Mental Health First Aid	Mental Health First Aid (MHFA), Older Person MHFA, Youth MHFA
Leadership	Graduate & Post-grad support, Preceptorship, Shift leader & ANUM training, transition to MH
Forensic	Forensic Assessment, Forensic-specific programming
Rural Specific	Disaster support and community mental health collaboration
Safewards / RRI	Aggression Management, RRI, Workplace Safety, Sexual Safety
Trauma-Informed Care	Trauma-informed Care training programs
Clinical Supervision	Clinical supervision, Supervision
Triage and Other Workforce	Specifics for Triage, administration workers, front-of-house staff

Family / Carer	Working with Families and Carers
Alcohol and Other Drugs	Dual Diagnosis, Harm Reduction, NSP & Naloxone training
Physical Health	Diabetes; Equally well; Sexual health & MH
Transition to Community	Case mgmt.; Partnering with other agencies; Transitioning to Community MH
Therapeutic techniques	Psycho-therapeutic essentials; hearing voices; therapeutic engagement;
LEW	Developing and integrating the LEW workforces
Wellbeing	Staff Wellbeing
Recovery & Cultural Safety	Recovery, supporting cultural safety for specific groups
MSE ECT	Mental State/status Examinations and planning; ECT protocols
Group Facilitation	Facilitating Groups for multiple disciplines

Table 1: *Themes which emerged as areas of expertise, special programs and/or possible collaborations*

Planning, develop and evaluation

The final section of the scoping sought to gain an understanding of the larger strategies the AMHS used to plan the direction and priorities for the service's personnel development and leadership development. Some services had opportunities for staff to participate in their organisation's leadership programs, several services offered leadership/management training for shift leaders and Associate Nurse Unit Managers (ANUMs). Services spoke about planning days organised as required for teams/programs, whilst some teams/programs also had regular reflective practice sessions.

Developing a training and development strategy (including leadership development)

While there were overarching themes that emerged from how the services planned, developed or maintained fidelity to a particular strategy, each service had a unique matrix of activities and considerations that influenced their goals, resourcing and activities. Factors often included size of workforce, management and oversight structure, interconnectedness with training and service priorities of the healthcare service at large, and availability of local programming.

Personnel development in the form of leadership development activities ranged from programs bespoke to that AMHS, team or management level to attendance in programs offered by the health service in which they were located.

Training Needs Analysis (TNA)

Generally, this was an area that services felt they did not do particularly well and would like some support and guidance on. Few services regularly or formally analysed the training needs of their workforce. A number identified training needs at a more local level, by teams or areas (these could be divisions by aged range, service setting or another speciality area). This was often a practice in services which already had hierarchical organisational structures where some elements of training responsibility sat with teams and not all in a centralised education team.

The tools and methods used to gather information for regarding training needs often flowed on from other workforce development analyses, such as via annual appraisal, meetings between clinicians and managers and feedback from the workforce. Some services did do internal surveys to identify need.

Incorporating the consumer and family/carer voice in learning and development

Many services utilised committees (such as consumer advisory groups or CAGS) and consultant positions from within the Lived Experience workforces to inform and provide input into training and education. Most services stated they would like to do this better and have more input from their LEWs and have the processes in place to utilise LEWs in all aspects of training development. The demands within a service for input from LE consultant roles are high. In some service areas and notably in regional services the LEW EFT that does exist is also unfilled due to lack of local personnel. A small number of services have begun to incorporate Lived Experience roles into workforce development, with a few having specific LE educator positions. However, in many services these positions are still new and appropriate scope, responsibilities and processes stare still being established.

Evaluation of learning impact

The data collection tool concluded enquiring about evaluation practices and methodology.

Again, there was little uniformity across services in regards to practices. The most common method of evaluation, which all services used, was of post-training surveys which gauged participant reaction to the learning. More in-depth ways of measuring knowledge acquisition were competency assessments for early career clinicians and file audits.

Most services looked towards Kirkpatrick's 4 levels as a guiding methodology for their evaluation and in consultation spoke about opportunities that could exist for more robust evaluation of training practices and knowledge translation.

Discussion

Theme 1: Education teams

Our overview of education teams at the time of scoping indicated that the teams were predominantly made up of nurses. This was largely due to EBA-funded positions as well as nurses making up the majority of the workforce. It does, however, have the potential to create issues such as narrow workforce development focus, availability and relevance for allied health, lived experience and other workforces. Allied Health training and development was at times the domain of the Discipline Lead. While some services at the time of scoping had used existing funding tied to other projects or programs to bring non-nursing educator positions into existence, this is often not an option for all services based on availability of personnel.

Since our initial scoping, there has been DH funding for Allied Health Educators in AMHS. Services thrive on the input of multi-disciplinary teams and an agile workforce requires our education teams to be available to upskill all of the workforce. New educator roles in a range of disciplines should support learning to reflect the variety of voices and ways of working therein, including allied health, LLEWs (consumer and family/carer) and our medical workforce.

During the scoping we also heard of challenges to fill Clinical Nurse Consultant and Clinical Nurse Educator roles. When educators commence in roles, they usually need to hit the ground running. Services spoke about limited scope to build capacity for people moving into educator roles and developing their skill set once they are in those roles. The CMHL can be a central agency that develops resources to support people working in education roles.

Education teams are doing an amazing job but they are stretched and struggle to find time to develop their teams and fill roles as the workforce expands. There are knowledgeable clinicians, good trainers and subject matter experts. Education teams need the right balance of each to design and deliver training packages and workforce development programs, especially ones that they view as high priority. CMHL works to support education teams through the delivery of Train the trainer programs, development for educators, and delivering a free AMHS training calendar to cover a very wide variety of topics.

Theme 2: Lived Experience input

There have been many mentions of the need for direction by and inclusion of the lived experience voice in improving and rethinking mental health and wellbeing service delivery. We asked specifically about lived experience input into learning and development considerations. Very few education teams had dedicated lived experience roles and the education teams had varying degrees of access to lived experience workforce for input into design and delivery of training and strategic thinking for education teams about workforce development.

Services were asking for more information on co-production and co-design. Most stated they would value extra resourcing to have lived experience educators within their teams, which in turn would help foster a workplace that can co-produce and co-design programs of work. True co-production and co-design are almost impossible within current EFT and time constraints.

Theme 3: Collaborations

Previously the clusters played a role in developing and supporting local collaborations. CMHL, with its broader, statewide perspective remains interested in fostering local and increasingly farther-reaching collaborations. With the uptake of online learning, the traditional 'tyranny of distance' which often plagues access from regional and remote areas has been lessened.

The LPDC are one of the main conduits of information between the AMHS and the CMHL. In line with several aims of this project, the LPDC asked specifically about both local collaborations and possible avenues for future collaborations. This scoping project is the first step in identifying new opportunities.

Most services had some link with universities - whether as part of their clinician development, an avenue for placements and potential workforce, or through direct ties with staff or departments. Several AMHS have links with statewide training providers through education agreements, fee-for-service arrangements, or as part of projects or initiatives.

We hope that with the LPDC roles, educator roles, the use of new technologies and ways of working that we can continue to interconnect services for future practice development projects or to support partnerships that are not limited by physical location.

Theme 4: Adult focus

Meetings had significant focus on the Adult (approx. 25-65 years) arm of AMHS, most likely due to funding tied to particular units. However, even if there were no positions designated to other areas of the lifespan, the teams still included other areas of the lifespan in their program. Some larger services had specific educators who focused on education and development of their Child/Adolescent/Youth workforces, or this might be the responsibility of team leaders / program managers. Older Adults at times had different oversight due to funding streams and clinical governance.

Smaller services could make good use of age-specific education and development support from a centralised agency due to less area-dedicated personnel EFT.

Theme 5: Medical representation

While the education teams are comprised mainly of nursing staff, very few AMHS identified the wider medical workforce (psychiatrists, psychiatric registrars, HMOs) within their training and education table. The medical workforce training programs for psychiatric registrars operate separately to the development of other disciplines. It was difficult to gauge how this would affect efforts at practice change and how services incorporate this into their development plans.

Theme 6: Competing demands

Workforce education has to happen. Clinicians have to understand person-centred, holistic and trauma-informed mental health and wellbeing. They have to gain expertise in counselling and interpersonal skills, increase their understanding of people and the complexities of people's lives, and treat each person and their experience as a heterogenous, unique experience. These are often skills that are outside of tertiary curricula.

Services and education teams seek to improve consumer experience and provide the best care they can. The demands to skill, upskill, coordinate, track, design, develop, deliver and evaluate can pull teams in all directions. Competing demands can mean that the service has to distribute its capacity amongst areas or workforce groups with perceived higher learning needs. Having a centralised agency such as the CMHL can support some of those priorities with positions or dedicated projects.

What's next for CMHL?

Building better relationships and deeper understanding of each AMHS operations and people were two of the most important outcomes of the scoping. Meeting individually with each service and having the service explain their activities in their own terms provided a base on which to build future communication channels and guide

The CMHL has a big role in coordinating people and expertise across learning and development programs in Victoria. The LPDC roles are new and have a broad scope. We plan to use this report to guide our three main areas of activity - the alignment, coordination and development of learning and workforce development across AMHS in Victoria. Preliminary data has been collected and a baseline determined. LPDC will now work to connect services to the relevant resources, data and partnerships available. As the LPDC knowledge grows, so does our ability to provide the right information, at the right time, to the right people. Future directions include programs of work in training and development evaluation and the development of high-need education packages and resources. Having dedicated and sustainable people and programs can provide longitudinal continuity as personnel move and programs shift to respond to local demands.

CMHL and the Learning and Practice Development team can be a support to people in education roles. We have already delivered a state-wide educator forum in 2021. CMHL are developing an educator section for the website and already have some educator resource videos online.

The LPDC will continue to connect regularly with AMHS and work closely with CMHL LEW workforce development coordinators to build to capabilities of the workforce.