Centre for Mental Health Learning, Victoria

Submission to the Royal Commission into Mental Health Services

Introduction and background information

The Centre for Mental Health Learning (CMHL), Victoria is pleased to provide the following submission to the Royal Commission into Mental Health Services.

Victorian mental health learning context in brief

The Victorian Government invests approximately $26 million per annum in mental health and related learning and development across Victoria[1]. The Victorian Mental Health Workforce Strategy,[2] published in 2016, in concert with initial priorities and actions, sets out five key objectives that aim to support and guide the foundations for sustainable workforce development'. These objectives include: 1. Workforce availability and skill; 2. Worker safety and satisfaction; 3. Workforce integration; 4. Co-design and co-delivery with consumers and carers; 5. And Workforce innovation. What is required to support this important work is a collective, coordinated, and cohesive approach.

However, the Victorian mental health learning and workforce development landscape is a complex and devolved system, where connected attention to workforce development activity relies largely on influence in the space, and informal, or some formal, networks; these networks are often based on individuals and organisations being well-connected and open to sharing.

Some of the aforementioned investment goes to funding approximately 21 mental health statewide training providers (SWTP), each operating independent of each other, delivering on separate service agreements, where duplication of effort and resources is inevitable. These 'delivery arms' aim to provide relevant and quality products to the mental health workforce in their designated areas of expertise, however until now, there has been no mechanism to facilitate statewide strategic planning that engages all of the providers in a collective conversation about how the workforce development needs of the sector are best met.

Although there is evidence of collaboration between some key mental health workforce development providers, prior to CMHL establishment there was no one single organisation in Victoria that connected and shared information, tools, resources and expertise amongst mental health services, learning and development providers, peak agencies, professional bodies and others. As a part of Government investment, the CMHL is now positioned as the central mechanism to facilitate alignment and growth, strategic planning, data gathering and analysis, and collective effort. The CMHL has undertaken significant work already within the mental health sector and with others, and even though the CMHL only commenced in March 2018, feedback from the sector regarding the value of current work, and the possibilities of what the CMHL could achieve to support the sector, has been overwhelmingly positive and affirming.

[1] DHHS Call for Submission papers (2017) Centre for mental health learning – Background Information

[2] Mental Health Workforce Strategy (2016). Victorian Government; Melbourne

About the Centre for Mental Health Learning, Victoria

The Department of Health and Human Services, Victoria (the DHHS) conducted an open tender process in July 2017 to identify a suitably qualified and experienced service provider to establish and manage the ongoing operation of the Centre for Mental Health Learning Victoria (the CMHL). In particular, the DHHS sought to fund a service provider to undertake the project across the following five (5) phases:

- Groundwork: Understand and establish the foundations for success
- Design: Develop and validate a model that accords with the available evidence and that meets the needs of the full range of stakeholders
- Establishment: Put in place the structures, policies, processes and relationships in readiness for go-live
- Delivery: Commence full operation of the CMHL's functions and services
- Evolution: Position and grow the CMHL for the future environment

NorthWestern Mental Health, a component of Melbourne Health, was the successful organisation in this process and is now the auspice agency for this initiative. The CMHL commenced operations in March 2018, with a mandate to establish fully over a three year period.

CMHL core functions

The role of the CMHL includes supporting the alignment of existing activity, innovation in new activity, and providing a central point of coordination and publishing of DHHS funded mental health learning opportunities, identifying and providing access to mental health learning and development resources, promoting a strategic and cohesive approach to mental health workforce development planning and implementation, and designing a program of work that can be undertaken by some – or all – of the department funded entities. It is envisaged that this approach will be supported in delivery by service agreement negotiations and variations led by the DHHS.

Among other functions, the connection and coordination role will see the CMHL reduce duplication of effort across training providers and mental health services, and improve access to the significant learning and development resources that already exist, while CMHL growth will support further innovation.

Opportunities are created when utilising the CMHL as the central access point for mental health learning and development to:

- Identify strategic learning and development needs and gaps
- Promote training and events through a consolidated statewide online portal
- Facilitate worker to worker, and organisation to organisation connections, and
- Improve access to evidence and other practice support tools and resources.[3]

The CMHL orients its work around four key functions:

- Engagement and Communication
- Alignment and Coordination

[3] (2017). Department of Health and Human Services, Call for funding submissions. https://www.tenders.vic.gov.au/tenders

- Evidence and Quality
- Innovation and Systems Change

CMHL values and design principles

The CMHL is founded on strong values that support collaboration across the sector. In initial DHHS engagement processes, stakeholders identified the importance of the CMHL to act with integrity; be transparent about what needs to change; and be authentic, with the work of the CMHL grounded in the realities of practice.

Design principles are a critical component of the overall operating model for the CMHL; they ensure that that the operating model supports the strategic priorities of the CMHL and that the organisation functions effectively. The key essence of these design principles is to guide the CMHL to: provide robust leadership, including consumer and carer leadership; develop a strong organisational lens that seeks to facilitate positive systems change; foster collaboration and respect; ensure that it is strategically responsive and sustainability; be informed by evidence and accessible to the workforce.

Figure 1: CMHL Governance and Leadership

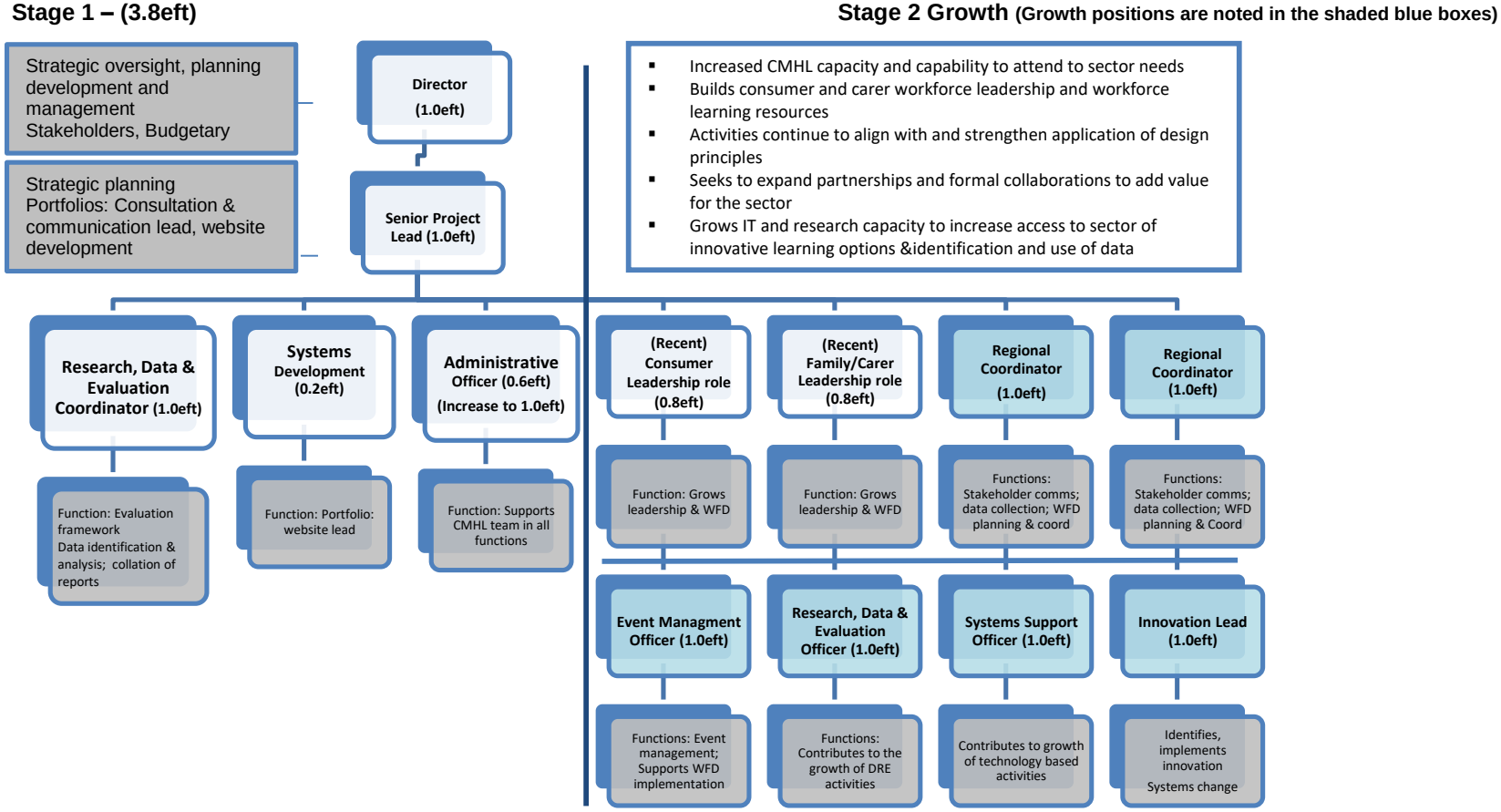
Since commencement the CMHL has operated under an establishment governance structure. This structure has included direct reporting to a DHHS Project Control Group (PCG), with advisory from an internal NorthWestern Mental Health partnership committee, and the DHHS Workforce Reference Group. An ongoing governance structure was endorsed by the PCG in January 2019 and will include:

- CMHL Governance Leadership Committee including three standing positions, and six positions filled by EOI, these include four lived experience workforce roles
- Advisory – DHHS Mental Health Workforce Reference group
- Advisory – Victorian regional learning and workforce development committees
- Advisory/action – Leadership Hubs: think tanks/working groups

CMHL workforce

Until late 2018, the CMHL was operating with three fulltime and two part time staff (0.2 & 0.6 EFT). More recently, the Consumer, and Family/carer workforce development coordinators, have transitioned from their previous location at the Centre for Psychiatric Nursing, University of Melbourne, to the CMHL; this increases total staffing to 5.4EFT. It is expected that growth, development, and sustainability of the CMHL over time will contribute significant value to the Victorian mental health learning and workforce development environment.

Figure 2: CMHL Organisational structure



What we know from the Victorian mental health workforce

How do we know what we know?

The CMHLs commenced its initial engagement and consultation phase in May 2018. To inform this process a comprehensive stakeholder analysis was conducted, followed by the development of a consultation strategy. Various types of consultations were facilitated between June 2018 and April 2019, these are described as:

Full consultations – Session duration of one to two hours (or greater) with a specific focus on, or variation of, CMHL consultation questions (See below)

Part consultations – Session duration of one hour or less

(Typically information exchange, CMHL promotion/updates where MHS or other organisations requested or provided CMHL attendance at established meetings i.e. executive, education, and discipline specific, or sought specific contact with the CMHL to explore possible collaborations)

Stakeholders were identified as primary or secondary based on their level of importance in informing CMHL establishment. Victorian mental health services (MHS) where classified as primary stakeholders, as were other key mental health workforce organisations/groups. As a result, rural and metropolitan MHS visits commenced as a matter of urgency, with engagement occurring concurrently with other key groups. Consultations included a mix of workforce groups including lived experience workers. Discipline specific consultations were also conducted to ascertain the perceived learning and workforce development needs of these as discrete groups.

Data collection

In total, 1735 contacts have occurred through the following consultations:

- 15 full consultations with Victorian mental health services
- Three part consultations with Victorian mental health services
- 23 specific lived experience workforce consultations (LEW were also well represented in full/part MHS consultations)
- Eight discipline specific consultations – (These consisted of some full and some part consultations)
- Four mental health educator forums
- Victorian mental health statewide training provider forums
- Survey consultation post scheduled events, as well as via online CMHL mailing list subscription
- 29 additional consultations (most full/some part) including;
    - Established meetings/events with mental health workforce groups: i.e. Chief Psychiatrist meetings, Senior Psychiatric Nurse meetings, Victorian Dual Diagnosis Initiative, Victorian mental health learning Clusters, Victorian Psychiatric Training Committee,

TANDEM, VMIAC, conferences and expo's, FaPMI, Victorian MH Interprofessional leadership Network, Centre for Excellence in Eating Disorders

- External organisations: i.e. Quit Victoria, Independent Mental Health Advocacy (IMHA), Phoenix Australia, Emerging Minds, Safer Care Victoria, Industrial bodies, Murdoch Children's Research Institute

Consultation questions

The questions asked and discussed during full consultations included:

- What is unique, special or different about your MHS/organisation?
- What are the core workforce learning & development priorities of your MHS/organisation? OR What is your organisation's perspective on the workforce development needs of the mental health workforce?
- What are the barriers and enablers to achieving your MHS's/organisation's vision for workforce development? OR What work does your organisation do in regards to mental health workforce development?
- What might a working relationship between your MHS/organisation and the Centre for Mental Health Learning look like? What are the most helpful functions, structures and processes that can facilitate this?

The data collected from consultations with the mental health workforce and related organisations have been collated and analysed. This information is included in the Centre for Mental Health Learning, Victoria – Response to the Royal Commission into Mental Health that follows, as it relates to:

> *Question 10 – 'What can be done to attract, retain and better support the mental health workforce, including peer support workers?'*

Centre for Mental Health Learning, Victoria – Response to Royal Commission questions

Q 10. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

The CMHL response to this question is organised according to four key themes.

- Key theme 1. Workforce capability and support
- Key theme 2. Sector connection/access to learning
- Key theme 3. Lived experience workforce development
- Key theme 4. Organisation/systems

Key theme 1: Workforce capability and support

Issue 1.1 – Inadequate knowledge and skills

During consultations, mental health service (MHS) staff described how the 'siloed nature' of skills and knowledge has negatively impacted on holistic care. For example, key concepts such as family sensitive practice, sexual safety, trauma informed care, cultural awareness, and LGBTIQ have over time, come to be seen as disconnected from foundational capabilities, often being taught separately as additional areas of interest, rather than being embedded as routine knowledge and practice. Deficits also exist in relation to sub-specialty knowledge and skills, i.e. Alcohol and other drugs (AoD), forensic, child and adolescent/youth mental health, and aged persons' mental health.

CMHL scoping data also conveyed the inconsistencies in foundational knowledge and skills of entry level recruits, and limited experience in the application of theory to practice. Where able, this requires MHS to expend significant energy and resources upfront in early career development to support and upskill new recruits, placing additional pressure on often understaffed education teams and/or supporting clinicians. These observations were not assigned to just one discipline, but rather were discussed in relation to all clinical disciplines, and the lived experience workforces (LEW). As part of this conversation, MHS staff also discussed the inconsistencies and lack of awareness more broadly, regarding what is defined and measured as core capabilities of the mental health workforce.

Recommendations

1. Develop a comprehensive Victorian Mental Health Workforce Capability Framework, where implementation in MHS is supported by the creation of planning, translation, education, monitoring, and evaluation tools

Issue 1.2 – Support and develop those that educate the mental health workforce

During consultations mental health educators expressed a number of challenges that limited the efficacy of their roles. This is of particular concern, as it is these people or teams, when working efficiently and effectively, that can have a significant influence on shaping and supporting the development and sustainability of a highly capable workforce.

Educators described situations where they:

- Are recruited to, but are not adequately prepared or trained to perform in these roles
- Have limited opportunities for professional development, mentoring, or coaching to support their practice
- Are derailed from education functions as organisational demands in other areas take precedence
- Experience cultures where learning and training is undervalued, not prioritised as essential, and/or not resourced sufficiently
- Experience their time/focus being directed towards supporting cumbersome mandatory training, with little time left available to develop translational, relevant learning opportunities for the workforce
- Have limited access to lived experience expertise to plan, design, deliver, and evaluate learning and development opportunities

Recommendations

2. CMHL develop and implement a program of work to support those with education functions in MHSs that includes:

- Upskilling opportunities
- Networking opportunities/Community of practice
- Online educator portal that houses best available learning and development evidence, practical learning and training templates, educator resources including interactive strategies for learning, training modules/and packages
- Access to a database of Victorian mental health educators with individual profiles, specialty areas, research expertise, resource sharing capacity

Issue 1.3 – Adhoc and inconsistent attention to clinical supervision

The lack of access to clinical supervision was noted in all MHS consultation data. This was a constant issue raised, in particular by mental health nurses, but also for allied health clinicians in rural areas in terms of access to discipline seniors. The lack of understanding about what supervision is or isn't, and the need for a common understanding between disciplines also emerged from discussions.

Of note was the reference to poorly defined models for supervision, the lack of availability to experienced supervisors, the varying value given to clinical supervision by staff and managers, the lack of minimum standards regarding acceptable training for supervisors, and the barriers experienced by clinicians in gaining protected time to participate in clinical supervision.

NB: Lived experience supervision was also noted as adhoc and limited; however, this is discussed in the 'Lived experience' section of this submission.

Recommendations

3. Establish a Victorian mental health interprofessional clinical supervision group that can inform the development of cross discipline clinical supervision definitions, principles, and standards

4. CMHL support the development of, and host, a Victorian mental health supervision database on the centralised CMHL website

Issue 1.4 – Inconsistent/limited understanding and application of trauma informed care (TIC)

The data from consultations highlighted a universal desire for MHS to become 'trauma informed'. Although some services/clinicians appear to have a more sophisticated understanding of what TIC means in practice, consistent or structured approaches to how TIC is implemented in MHS is more difficult to assess.

The Blue Knot Foundation describes trauma-informed services in the following way:

> [4]*….Becoming trauma-informed is about supporting people to feel safe enough in their interactions with services. To build trust, and help people overcome their fear and sense of betrayal.*
>
> *Becoming trauma-informed is not an end state, but a process. It requires a step-wise implementation and review over time. The journey to becoming a trauma-informed service has been conceptualised into 4 sages (Miesler and Myers, 2013):*
>
> 1. *Trauma aware: Staff understand trauma, its effects and survivor adaptations.*
> 2. *Trauma sensitive: The workplace can operationalise some concepts of a trauma-informed approach.*
> 3. *Trauma responsive: Individuals and the organisation recognise and respond to trauma enabling changes in behaviour and strengthening resilience and protective factors.*

[4] Blue Knot: Trauma-informed care and practice https://www.blueknot.org.au

4. *Trauma-informed: The culture of the whole system, including all work practices and settings reflects a trauma-informed approach.*

Trauma-informed care training for the workforce was also raised as an essential enabler; however there appears to be a lack of clarity or consensus regarding what is required and limited knowledge of, or attention to, the application of systemic strategies to implement TIC in practice. There are multiple TIC training providers with varying costs, some of which are prohibitive. What is apparent is that some MHS are utilising previously developed training packages, and/or modifying these or others to deliver training in services, without a connected systemic lens across all mental health services. It is also essential to note that training is also only one component of what needs to be a comprehensive systemic approach to TIC.

Recommendations

5. Establish a Victorian Trauma-informed care (TIC) advisory group, comprising representatives from learning and workforce development, training providers, MHS, lived experience, policy, research.

   That the purpose of this group is to identify and articulate current practices in Victorian mental health services, and to provide advice and guidance on the development of a coordinated multifaceted TIC program of work.

Key theme 2: Sector connections/access to learning

Issue 2.1 – Devolved workforce learning and development landscape

The lack of alignment and coordination within the Victorian mental health learning and workforce development system is well recognised. Prior to establishing the CMHL web portal, individuals needed significant time to search multiple provider websites to locate appropriate learning options and resources, with the quality of products hard to compare or assess.

CMHL MHS consultation data supports this by highlighting the lack of opportunities to connect and share (which could assist in reducing duplication and increasing efficiency), the difficulty in navigating if/what/where learning opportunities exist, and emphasising that learning opportunities are often metropolitan centric, with poorer access for rural and regional services.

Recommendations

6. Targeted focus on building CMHL website functionality to further facilitate access for all MHS staff to learning and workforce development, in particular to redress inequities between rural, regional, and metropolitan opportunities

7. In growing the CMHL website, expand functionality to include interactive learning options, online communities of practice, information and promotion of mental health as a career, and a centralised careers portal (recruitment and retention)

Issue 2.2 – Limited and/or ineffective use of technology to support learning

Technological challenges were a common theme during consultations. MHS Information Technology (IT) departments make different decisions, independent of each other, regarding what that particular health service deems as acceptable security measures. These decisions can be incompatible between MHS and interfere with staff being able to connect with people outside of their service. For example, the use of web based storage such as [redacted] or '[redacted]' or '[redacted] software, which support remote control, desktop sharing, online meetings, and file transfer between computers, can be assessed by services as high risk and as a result be limited or blocked.

Infrastructure, connection speeds, antivirus software, spam filters, and system requirements, also vary between MHS (and at times within MHS), hampering connections, and also restricting or limiting access to online learning.

A simple example used during consultations was the obstructions caused by different systems used for videoconferencing. While videoconferencing might work successfully within a service (because they are using the same system), it is not always successful when attempting to connect with colleagues at external MHS. Rural and regional participants also pointed out that videoconferencing (VC) is a mechanism that they use often, with typically effective systems, and knowledge and skills, within their MHS to support this. Rural and

regional MHS described struggling when attempting to connect with metropolitan MHS, who on the whole seem less experienced in this, and/or have limited access to VC or use older less effective systems. Metropolitan MHS may not understand the impact that this can have for rural and regional services, or the assumption may be that the connection difficulties lie with rural and regional systems.

The effect of these difficulties was associated with reduced access to colleagues external to the MHS, in particular by educators seeking to connect. The increased reliance on online learning also poses problems in this context. Individuals are supporting theirs, and others, professional development by sourcing learning opportunities external to their MHS, and are being encourage to join communities of practice, commonly hosted through online communication software. These types of tools are vital in supporting efficient and effective connections.

Web based software is easing some access issues (due to the hosting being managed on external servers), however the issues of individual MHS IT security filters, or policies regarding the use of these products, remain a barrier for some.

Recommendations

8. Targeted focus on building CMHL technology capacity to:

- Investigate and implement cohesive options between MHS that facilitate quality connections
- Provide stewardship to MHS regarding the importance and benefits of various online learning platforms
- Investigate online learning options that are evidence based, and easily accessible to the mental health workforce (i.e. web based simulation software)

Issue 2.3 – Victorian workforce learning and development planning

As noted previously in this submission, the Victorian mental health learning and workforce development landscape is a complex and devolved system. The Victorian Government invests approximately $26 million per annum in mental health and related learning and development across Victoria[5]. Some of this investment goes to funding approximately 21 mental health statewide training providers (SWTP), each operating independent of each other, delivering on separate service agreements, where duplication of effort and resources is inevitable. This funding also supports clinical academic positions in MHS, and funds graduate programs, and local MHS workforce development.

There is currently no clear collective understanding about how these organisations or individual positions make decisions about workforce development priorities, how and why they utilise allocated funds to invest in particular strategies or programs, if/how collectively these priorities and programs connect and align, and what outcomes are achieved as a

[5] (2017). Call for Submission papers – Background Information

result. The CMHL is now centrally positioned to work collaboratively with MHS and other mental health funded agencies, through which the collection and analysis of this type of data could be enabled. Critically, access to this type of centralised statewide data could then inform more collective strategic planning of Victorian mental health workforce development activities.

Recommendations

9. Build CMHL data and research capacity to:

- Conduct statewide scoping activities that collect and synthesise Victorian workforce development data
- Lead the creation of a Victorian mental health learning and workforce development strategic plan

Key theme 3: Lived experience workforce (LEW) development

Peer work is a collective term for a broad range of roles where either consumer or carer lived experience is an essential requirement, with other skills, experience and knowledge required depending on the role. In Victoria, peer work is often referred to as lived experience work because the phrase *peer work* can be confused with peer support work, rather than the broad range of roles that comprise consumer and carer work.

Some of the lived experience roles in Victoria include but are not limited to:

- Consumer Consultant, Carer Consultant
- Peer Support Worker, Family/Carer Peer Support Worker
- Consumer Educator, Family/Carer Educator
- Consumer Academic, Carer Academic
- Consumer Advocate, Carer Advocate
- Consumer Advisor, Carer Advisor
- Consumer Supervisor, Carer Supervisor
- Consumer Workforce Development Coordinator, Family Carer Workforce Development Coordinator
- Lived Experience Manager

A number of issues were identified through feedback from the LEW. The following is a summary of the issues and recommendations. More comprehensive objectives, actions and proposed timeframes to support mental health consumer and family carer lived experience workforces can be found in *The Strategy for the family carer mental health workforce in Victoria* and *The Strategy for the consumer mental health workforce in Victoria*. Both documents group objectives and actions under four main headings: Defining, Promoting, Supporting and Growing.

Issue 3.1 – Inconsistent role definition and poor role clarity

People with lived experience were first employed in Victorian Mental Health services in consumer or carer roles in the late 1990's. These roles were often isolated and evolved in unique ways that were dependant on: the management of the service, the needs of the consumers and/or carers in the service, and the individuals filling the roles. This has led to the roles being inconsistently defined across the system, and contributes to role confusion, role creep, and burnout.

Consumer and family carer workers in both consultant and peer support roles express pressure to respond to system demands and address service culture issues and discrimination at the expense of core work role responsibilities. With recent, rapid expansion of the peer support workforces, role confusion has increased and this emphasises the need to differentiate the work undertaken by consultants and peer support workers in particular. The National Mental Health Commission is leading the development of Peer Workforce Development Guidelines under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). These guidelines are due to be completed by 2021, in the meantime there are currently no agreed on principles or guidelines for either consumer or family carer work.

In addition, family carer workers experience further challenges in role clarity related to working with families and carers in a system oriented around the consumer. Services are focussed on consumer needs, and family/carer workforce expressed that support for families/carer seems to be a 'tack on' or after thought rather than part of core business.

One example of the impact of the mismatch between family/carer support and consumer-centred practice is a lack of clarity and consistency across services with regard to documenting the work of family carer peer support. Some services direct family/carer workers to document carer contacts in the consumer file, however family/carer peer support workers and consultants express concern that this compromises the family/carer's privacy and may pose a risk to their relationship with the consumer. In instances where family violence is a concern this poses additional concerns. Some family/carer workers keep a separate carer file however policies, guidelines, procedures and training are needed to support effective carer peer support documentation in a clinical setting.

Unlike consumer peer support work, which has been studied extensively and has a body of evidence demonstrating benefits for consumers, organisations and peer support workers, family carer lived experience work (which is often not seen as 'core business') does not have the same literature base to inform the work or provide an argument for growing the workforce.

Issue 3.2 – Lived experience work is poorly resourced

Despite a large body of evidence demonstrating that consumer peer support work benefits consumers, organisations and the peer support workers themselves (http://peerworkhub.com.au/the-case-for-peer-work/) and consistent messages that peer support work is valued by consumer and carers, the workforce remains proportionally small in number and EFT. LEW feedback highlighted the proportionally small size and fractional nature of both consumer, and family carer workforces. A survey undertaken by DHHS in 2017 identified 341 lived experience workforce positions in Victoria, (238 consumer and 104 family carer) totalling 187 EFT. The majority of the lived experience workforce roles were employed 3 days or less per week (84 consumer; 72 family carer).

Feedback from LEW highlighted this issue in relation to the increasing demands on both workforces, where individuals are constantly feeling pressured to prioritise other system demands rather than core work role responsibilities. LEW also report that workload demand impacts on ability to access training and development activities.

LEW also report poorly resourced working conditions, including lack of space to have confidential conversations with consumers or families, and lack of access to standard office equipment, such as telephones, computers and stationery. Almost exclusively, at each MHS site consultation the feedback included an appeal for the increase of LEW, as well as career progression pathways, and the urgent need for workforce development opportunities.

Issue 3.3 - Appropriate training is not easily accessible for LEW

Lack of access to specific training designed by and for lived experience workforce compounds challenges of poorly or inconsistently defined roles. Consumer and Carer Consultants in particular describe working for years without access to training that supports them to understand and be effective in their role.

Intentional Peer Support Training (IPS) was supported through DHHS to organisations employing Peer Support Workers in the Expanded Post Discharge Initiative, however not all services made this training available to peer support workers and some workers were in the role for months or years before having access to training. There is no designated ongoing funding for this training.

The cost of IPS training and Certificate IV in Mental Health Peer Work is a significant barrier for lived experience workers who are low-paid. The Cert IV in particular requires a considerable time investment and this is challenging for workers who may work in several part time roles in order to receive a living wage.

LEW report that support for LE learning and development needs (e.g. paid study leave, payment of course fees, approval to take time off to attend training) varies from service to service and is often dependant on the value that managers place on LEW, on training and on the interpretation of the EBA. IPS training is written by and for consumer peer support workers, and Carer Peer Support Workers felt the IPS training didn't necessarily speak to their work, and they needed to extrapolate to make it relevant.

Until the launch of the CMHL website learning hub, there was no centralised way for LEW or their managers to find training designed by and for the LEW. The CMHL learning hub and resource hub have made it possible to filter training by workforce discipline and search by key words. However there are currently very few learning and development training or resources designed and developed for lived experience workforce, there are no specialised training about Consumer or Family/Carer Consultant work nor is there any training for family/carer peer support workers or in lived experience leadership. CMHL has two dedicated lived experience workforce development roles, however designing and delivering training is currently beyond the capacity of these two roles.

Issue 3.4 – Lack of discipline specific supervision, support and career development pathways

From LEW feedback, MHS still remain unprepared to adequately support, develop, and sustain the LEW. The clinical culture continues to pervade as the dominant priority, creating barriers to genuine change.

LEW express challenges accessing effective line management supervision from managers who understand:

- The pressure to 'become clinicalised' (also known as 'peer drift') which inhibits authentic LEW.
- working in environments which may trigger past negative or traumatic experiences of mental health treatment and services, for example witnessing restraint, forced medication and seclusion as well hearing language that is illustrative of negative staff attitudes toward consumers and families
- the need to 'pick your battles' and the burden of guilt when choosing to not respond to every example of poor practice

LEW report discipline specific supervision remains difficult to access with insufficient skilled consumer or family/carer perspective supervisors and limited training specific to this type of supervision. Additionally services have restrictive supervision policies which don't allow for the unique requirements of LEW, further limiting the ability to obtain supervision, where it is

accessible, due to cost, time released from duties, and/or misaligned values and understanding of the discipline between the employing organisation and the supervisor.

Attitudes and structures that embed LEW into all levels of the organisations remain inconsistent, with outcomes often dependent on the influence of local leadership; this is despite national and state policy frameworks that prioritise consumer and family/carer participation and co-productive ways of working.

Other disciplines in mental health have professional bodies that:

- Support ongoing professional development
- Develop a Code of Conduct or Code of Ethics to guide behaviour
- Highlight examples of good practice
- Provide networks for to meet and discuss their field of expertise
- Publish newsletters, journals or magazines
- Enable fairer access to the profession, so that the workforce is representative of people from all backgrounds
- Provide career support and opportunities for students, graduates and people already working
- Set minimum standards or competencies or qualifications

There is no professional body for LEW and there is little incentive for MHS to provide training, support and develop the LEW disciplines because the workforce is unregulated, and as a result are not compelled to complete specific professional development points/activities for registration purposes. The National Mental Health Commission funded a feasibility study into the establishment of a member based organisation for the peer workforce in Australia which was submitted in Jan 2019. Although the feasibility report has not been made public, the literature review has, and this identifies current practice in relation to the peer workforce in Australia and internationally, and makes recommendations to best support the LEW. The report can be accessed here https://www.mentalhealthcommission.gov.au/our-work/mental-health-peer-work-development-and-promotion.aspx.

At this time, CMHL capacity to address the multiple lived experience development priorities is limited. The depth and breadth of work required to attend to desired system improvement, facilitate policy reform agenda, align and coordinate existing strategies, undertake the work required to meet specific LEW training needs, and provide broad LEW leadership and strategic input, is immense.

Recommendations

10. Strengthen and expand CMHL lived experience workforce development capacity to support the:

- Implementation of a consistent, statewide program of workforce learning and development for the LEW that:

  - Develops LEW leadership, role definition, work readiness, supervision, and adequate skills and knowledge to effectively and safely perform their roles
  - Strengthens the organisational readiness of MHS to embed LEW with equity and respect, as with other disciplines
- Implementation of specific lived experience ‘Engagement & communications’ roles
- Implementation of specific lived experience ‘Strategy & systems’ roles

Key theme 4: Organisation/systems

Issue 4.1 – Organisational cultures regarding learning and workforce development

The data from consultations exposed numerous complexities regarding organisational/systems issues. A synthesis of these comments highlighted that the culture of an organisation, and the factors that lead to either positive cultures that are supporting and embracing of learning, or negative cultures that stifle learning, have a major impact on work environments and workforce satisfaction. Key concepts related to this included 'the value placed on learning', 'knowledge translation', and 'leadership'.

Participants expressed that negative/limiting individual and/or organisational cultures continue to exist, where 'learning is devalued, derailed, or is alternatively viewed as dispensable. Educators are managing high demand and competing priorities, especially in smaller MHS, where there may only be one or two educators managing the total load of workforce development.

Recommendations

11. Through CMHL Innovation and Systems Change functions – lead a collaborative program of work that engages MHS in 'workforce development as valuable and transformational'

Issue 4.2 - Mandatory training

Different organisational cultures regarding workforce development may also explain the diversity of approaches to mandatory training between services. Some consultation participants described excessive mandatory training requirements, leaving little or no time for other ways of learning and working or for exploring more pertinent learning opportunities at their MHS. There is significant variation between services in what training is mandatory, for whom, how much time it takes and how frequently it should be completed. Working collaboratively with MHS to collect data and understand motivations for local training requirements may inform greater awareness and more acute critical thinking in this area.

Recommendations

12. Build CMHL capacity for statewide workforce development data collection and analysis to increase awareness/consensus of mandatory training requirements between MHS, with a possible result of identifying guidelines or proposals around quantity and content of mandatory training.

Issue 4.3 – Knowing what works: Knowledge translation and evaluation

There also appears to be no consistent or formal framework for understanding the efficacy of training provided in and across MHS, or statewide training providers, nor robust collective data that tells us what strategies have been most effective to-date for translating knowledge into practice in Victorian MHS (i.e. one-off face-to-face training, experiential practice development, online learning). With significant government investment in Victorian mental

health workforce development, the evaluation of translation to practice and implementation of a framework must be a priority to guide meaningful investment.

Recommendations

13. Develop a Victorian Mental Health Knowledge Translation Framework, supporting MHS and others to translate knowledge to practice through access to common toolkits, facilitated practice development, innovation, and evaluation strategies

Issue 4.4 – Leadership

The influence and impact of effective leadership can also not be underestimated. Consultation data revealed gaps in leadership capability, as well as a strong desire to improve how leadership is collectively understood and applied in practice. Suggestions included that 'effective leadership' needs to be more clearly defined and then embedded in organisational policies and procedures starting at recruitment, with accountability measures in place so that all staff understand what is expected.

Recommendations

14. Conduct an analysis of current MHS leadership activities, including associated policies, available trainings, procedures, and documentation

15. Invest in established mental health leadership initiatives (i.e. The Victorian Mental Health Interprofessional Leadership Network) to strengthen MHS leadership at all levels and across all workforce groups

Appendix 1: Recommendations in full

1. Develop a comprehensive Victorian Mental Health Workforce Capability Framework, where implementation in MHS is supported by the creation of planning, translation, education, monitoring, and evaluation tools

2. CMHL develop and implement a program of work to support those with education functions in MHSs that includes:

    - Upskilling opportunities
    - Networking opportunities/Community of practice
    - Online educator portal that houses best available learning and development evidence, practical learning and training templates, educator resources including interactive strategies for learning, training modules/and packages
    - Access to a database of Victorian mental health educators with individual profiles, specialty areas, research expertise, resource sharing capacity

3. Establish a Victorian mental health interprofessional clinical supervision group that can inform the development of cross discipline clinical supervision definitions, principles, and standards

4. CMHL support the development of, and host, a Victorian mental health supervision database on the centralised CMHL website

5. Establish a Victorian Trauma-informed care (TIC) advisory group, comprising representatives from learning and workforce development, training providers, MHS, lived experience, policy, research.

    That the purpose of this group is to identify and articulate current practices in Victorian mental health services, and to provide advice and guidance on the development of a coordinated multifaceted TIC program of work.

6. Targeted focus on building CMHL website functionality to further facilitate access for all MHS staff to learning and workforce development, in particular to redress inequities between rural, regional, and metropolitan opportunities

7. In growing the CMHL website, expand functionality to include interactive learning options, online communities of practice, information and promotion of mental health as a career, and a centralised careers portal (recruitment and retention)

8. Targeted focus on building CMHL technology capacity to:

    - Investigate and implement cohesive options between MHS that facilitate quality connections
    - Provide stewardship to MHS regarding the importance and benefits of various online learning platforms
    - Investigate online learning options that are evidence based, and easily accessible to the mental health workforce (i.e. web based simulation software)

9. Build CMHL data and research capacity to:

    - Conduct statewide scoping activities that collect and synthesise Victorian workforce development data
    - Lead the creation of a Victorian mental health learning and workforce development strategic plan

10. Strengthen and expand CMHL lived experience workforce development capacity to support the:

    - Implementation of a consistent, statewide program of workforce learning and development for the LEW that:
    - Development of LEW leadership, role definition, work readiness, supervision, and adequate skills and knowledge to effectively and safely perform their roles
    - Strengthens the organisational readiness of MHS to embed LEW with equity and respect, as with other disciplines
    - Implementation of specific lived experience ‘Engagement & communications’ roles
    - Implementation of specific lived experience ‘Strategy & systems’ roles

11. Through CMHL Innovation and Systems Change functions – lead a collaborative program of work that engages MHS in ‘workforce development as valuable and transformational’

12. Build CMHL capacity for statewide workforce development data collection and analysis to increase awareness/consensus of mandatory training requirements between MHS, with a possible result of identifying guidelines or proposals around quantity and content of mandatory training.

13. Develop a Victorian Mental Health Knowledge Translation Framework, supporting MHS and others to translate knowledge to practice through access to common toolkits, facilitated practice development, innovation, and evaluation strategies

14. Conduct an analysis of current MHS leadership activities, including associated policies, available trainings, procedures, and documentation

15. Invest in established mental health leadership initiatives (i.e. The Victorian Mental Health Interprofessional Leadership Network) to strengthen MHS leadership at all levels and across all workforce groups