MENTAL HEALTH WORKFORCE
PROFESSIONAL ENTRY

WORK INTEGRATED LEARNING SUPERVISION PROJECT

A Sydney Integrated Clinical Training Network Project

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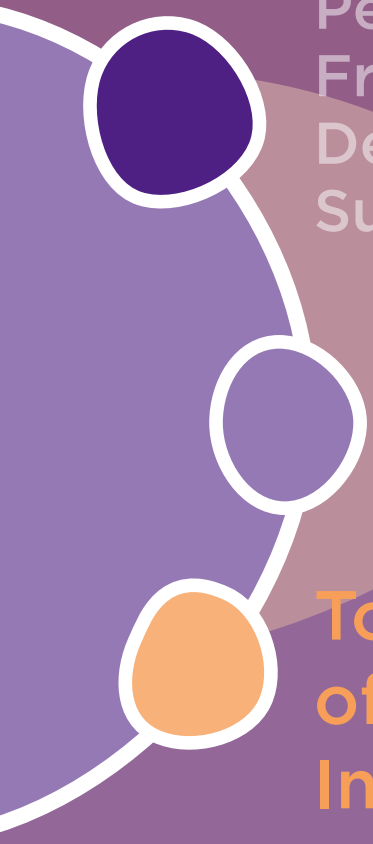

Peer Group Mentoring Framework for the Development of Student Supervisors

2015 Practice Placement Listing

Towards Development of a Community Sector Interprofessional Learning and Supervision Model FINAL REPORT

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The project partners are the Mental Health Coordinating Council, the Sydney Local Health District Centre for Education and Workforce Development and the University of Sydney.

Project Partners:

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This report is a partnership activity of the Mental Health Coordinating Council (MHCC), the NSW Health Education and Training Institute (HETI), the Sydney Local Health District, and the University of Sydney.

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EXECUTIVE SUMMARY

The community sector has great potential to enhance both the quantity and quality of student professional entry clinical/practice placements. Community sector practice placements help to develop the future health and community services workforce and to build skills in integrated and coordinated service delivery. The Mental Health Coordinating Council (MHCC) has been working with a range of partners over the past two years to explore and build the capacity of the community sector for student practice placements.

This Interprofessional Learning and Supervision Model (IPL&SM) Report consolidates experience and learning from three projects undertaken during 2013 and 2014:

Practice Placement Project (2013)

Practice Placement Project Enhancement (2014)

Work Integrated Learning Supervision Project (2014).

In this report the objectives, activities and outcomes of the two 2014 projects are discussed. Fifteen recommendations regarding directions for student practice placements and related workforce development within the NSW community managed mental health sector are presented. These recommendations are drawn from all three projects mentioned above, and also take into consideration the broader context for further activity.

IPL&SM Recommendations

Student Experience (practice placement range & responsiveness)

1. Adopt and further develop the IPL&SM structure.
2. Develop a set of capabilities that defines the successful completion of a practice placement.

Practice Placement Provision (host organisation and education provider capacity)

3. Determine the structure of the key driver.
4. Pilot a key driver in rural/regional areas, for a minimum of 12-months, which focuses on:

- Systemic support
- Engagement, partnership, and communication
- Placement coordination
- Gather and provide information
- Research

5. Incorporate a broader alliance of education and training providers into regional networks in order to prevent one form of practice placement potentially displacing another.
6. Build on MHCC's organisational capacity considerations to enable development and utilisation of practice placement KPIs linked to capacity for internal use by organisations.
7. Support an integrated approach to regional workforce development of CMOs.
8. Implement a train-the-trainer program for peer group mentoring leaders.

Policy and Planning (planning, funding and evaluation)

9. Apply a funding formula equivalent to that used for public and private health services for the provision of practice placements to CMOs.
10. Develop and trial a practice placement data collection process in the community managed sector.
11. Seek funding to develop and implement a research plan to rigorously evaluate the impact of the Peer Group Mentoring Framework on participants as well as the students they supervise.
12. Resource the key regional driver.

Research and Development (innovation and growth)

13. Undertake research and evaluation on how to best maximise recovery-oriented practice placement, practice supervision and interprofessional learning capacity-building activity within the community managed mental health sector, in consideration of the future health and community service workforce.
14. Establish the MHCC as the key contact for communication with, consultation on, and potentially trialling the involvement of CMOs in ClinConnect.
15. Pilot, evaluate the impact of, and disseminate findings of the Peer Group Mentoring Framework Trial, for a longer period (i.e. 12 months).

- The priorities for the community sector in taking this important work forward are:
- Adopt and further develop the IPL&SM structure
- Determine the structure of the key driver of community sector practice placements
- Trial and evaluate the Peer Group Mentoring Framework
- Build on MHCC's organisational capacity considerations to enable development and utilisation of practice placement KPIs linked to capacity for internal use by organisations
- Develop and trial practice placement data collection process in the community managed sector
- Research and evaluate how best to maximize recovery-oriented practice placement, practice supervision, and interprofessional learning capacity-building activity within the community managed mental health sector, with consideration to the future of the health and community service workforce.

MHCC's current focus on its practice placement capacity building project work aimed to articulate a community sector specific IPL&SM. This has been achieved through bringing the 2014 projects into greater alignment with one another. A potential framework for intersectoral practice placement capacity building, incorporating the public health, private for-profit, community managed not-for-profit, and higher education sectors is also proposed.

ABBREVIATIONS/ACRONYMS

CEWD	Centre for Employment and Workforce Development
CoP	Community of Practice
CMO	Community Managed Organisation
HEP	Higher Education Provider
HETI	NSW Health Education and Training Institute
HWA	Health Workforce Australia
ICTN	Interdisciplinary Clinical Training Network
IPL&SM	Interprofessional Learning and Supervision Model
KPI	Key Performance Indicator
LHD	Local Health District
MHCC	Mental Health Coordinating Council
NGO	Non-Government Organisation
PPP	Practice Placement Project 2013
PPPE	Practice Placement Project Enhancement 2014
USyd	University of Sydney
STAR	Supervision Training and Readiness
SVHS	Saint Vincent's Health Services
TELL	TELL (Teach Educate Learn Lead) Centre
TOTR	'Teaching on the Run' Training
WIL	Work Integrated Learning Supervision Project 2014

BACKGROUND

The Mental Health Coordinating Council (MHCC) is the peak body for non-government community managed organisations (NGOs/CMOs) operating in NSW. Our purpose is to build the capacity and ability of community sector organisations to support people on their journey of recovery from a mental health condition.

The MHCC Strategic Plan details the four key priorities MHCC will focus on in 2012-2015:

- Sector Development
- Policy Leadership, Influence & Reform
- Research & Development
- Organisational Development.

The community managed mental health sector is a changing and dynamic environment. Addressing the priority of sector development, MHCC works to build the capacity of the sector to meet current challenges and make the most of emerging opportunities. Health workforce development is a major challenge for NSW State and Australian Federal Governments, with large mental health workforce deficits projected for 2025[1] For example, deficits of at least 11,000 FTE nurses and 400 FTE doctors (i.e. psychiatrists) are projected if current approaches to mental health workforce development continue.

MHCC has been pursuing strong directions in community sector mental health workforce development since 2004, seeking to influence government directions and enhance community sector learning and development. To this end, MHCC become a registered training organisation (RTO) specializing in the delivery of community-based, recovery-oriented and trauma-informed mental health work accredited qualifications, and other professional development short courses.

It is important that people with mental health conditions are supported by skilled and caring health and community service workers, and that the community sector is included in state and national workforce development strategies and plans. This is because the community sector is a key player in the delivery of health and social care that is relevant to keeping people well and out of hospital. In an environment of large projected health workforce shortages, this also means that the community sector provides important work settings for the professional entry training of new workers, and the professional development of existing health clinicians/practitioners.

In light of the above, MHCC obtained funding in 2013 and 2014 for projects aimed at building the capacity of the NSW community sector to undertake professional entry clinical/practice placements. The projects also aimed to create directions for strengthening community sector clinical/practice supervision skills of supervisors of students and existing workers. This work has taken the form of three projects funded by Health Workforce Australia (HWA), now the Commonwealth Department of Health, through the NSW Health Education and Training Institute (HETI), and builds on work undertaken earlier by MHCC[2].

The three projects are:

- Practice Placement Project (2013)
- Practice Placement Project Enhancement (2014)
- Work Integrated Learning Supervision Project (2014).

This report, *Work Integrated Learning: Towards Development of a Community Sector Interprofessional Learning and Supervision Model (IPL&SM) brings together the three projects*, consolidating the experience and learning to date. The report makes recommendations regarding directions for student practice placements and related workforce development within the NSW community managed mental health sector.

1 Health Workforce Australia 2012, *Health Workforce 2025 – Doctors, Nurses and Midwives* (Volumes 1-3).

2 Mental Health Coordinating Council 2012, *Implementing Practice Supervision in Mental Health Community Managed Organisations in NSW.*

INTRODUCTION

The Australian government has identified the need for interprofessional training, education and practice that aims to achieve more integrated and collaborative care across a range of mental health work roles and work settings[3]. 'Collaborative practice' is one of the six key domains of the newly endorsed *National Mental Health Core Capabilities* and is fundamental to achieving Australia's mental health reforms.

The MHCC IPL&SM evolved from the Commonwealth Department of Health/HETI funded mental health practice placement projects and achieves the following:

demonstrates and fosters collaboration across the public health, community managed and higher education sectors

builds on the research and development directions to better understand the skills required for achieving coordinated and integrated services for people affected by mental health conditions.

The 2013 and 2014 Practice Placement Projects sought to build and enhance the capacity of the community sector to undertake professional entry health student practice placements, with particular focus on understanding the key drivers required to build community sector practice placement capacity, and the development of a proposed community sector interprofessional practice supervision model.[4] [5] [6] [7] [8] This work is essentially about expanding clinical/practice placement capacity in non-traditional settings, namely the community sector.

The Work Integrated Learning (WIL) Supervision Project sought to increase the capacity of the NSW community services and health industry to undertake professional entry health student practice placements, and ensure the quality of such placements. The WIL Supervision Project builds on and consolidates three Sydney Interdisciplinary Clinical Training Network (ICTN) projects conducted in 2013 that were evaluated as having a high impact in building supervision and training capacity.

3 Health Workforce Australia 2014, *National Mental Health Core Capabilities.*

4 Mental Health Coordinating Council 2014, *2015 Practice Placement Listing: Mental Health Workforce Professional Entry Practice Placements in the NSW Community Managed Mental Health Sector,* MHCC, Sydney.

5 Mental Health Coordinating Council 2013a, *Project Report: Mental Health Workforce Professional Entry Practice Placements in the NSW Community Managed Mental Health Sector – a NSW Pilot Study,* MHCC, Sydney.

6 Mental Health Coordinating Council 2013b, *Placement Guide: Mental Health Workforce Professional Entry Practice Placements in the NSW Community Managed Mental Health Sector – a Pilot Study,* MHCC, Sydney.

7 Mental Health Coordinating Council 2013c, *Placement Listing: Mental Health Workforce Professional Entry Practice Placements in the NSW Community Managed Mental Health Sector – a Pilot Study,* MHCC, Sydney.

8 Mental Health Coordinating Council 2013d, *Scoping Report: Mental Health Workforce Professional Entry Practice Placements in the NSW Community Managed Mental Health Sector – a Pilot Study,* MHCC, Sydney.

These projects are:

- Practice Placements in the Community Managed Mental Health Sector (MHCC)[9]
- Growing Clinical Supervision Capacity in Sydney ICTN through the implementation of 'Teaching on the Run' (Sydney Local Health District/LHD Centre for Employment and Workforce Development/CEWD)
- Supervision Training and Readiness (STAR) Program (St Vincent's Health Services/ SVHS).

The community sector Interprofessional Learning and Supervision Model (IPL&SM) first developed through the 2013 Practice Placement Project (PPP). It was progressed through the two projects completed during 2014, the WIL Supervision Project, and the Practice Placement Project Enhancement (PPPE).

The WIL Supervision Project was an initiative of the Sydney ICTN, and was undertaken as a partnership between the Sydney LHD CEWD, the University of Sydney (USyd) and MHCC. This project included:

- delivery of 'Teaching on the Run' Training (TOTR) for community sector workers and exploration of its community sector applicability
- development of a Peer Group Mentoring Framework through health and community services sector consultation, to assist in facilitating the transfer of practice supervision skills into the workplace[10]
- a Peer Group Mentorship Interprofessional Supervision Development Trial to further refine the Peer Group Mentoring Framework
- development of a IPL&SM guide/report (this document).

The Practice Placement Project Expansion (PPPE), an initiative of the NSW ICTN, undertaken by MHCC, sought to expand student placements in non-government community managed organisations (NGOs/ CMOs) delivering mental health and/or alcohol and other drug services across NSW. Activities of the PPPE included:

- developing relationships with twelve universities in NSW
- making practice placement and supervision material more accessible to CMOs[11]
- expanding the MHCC 2013 Practice Placement Listing (PPL)
- further exploring the role of 'key drivers' in expanding community sector practice placement capacity.

The 2013 Practice Placement Project (PPP) first introduced the concept of a Key Driver in expanding community sector practice placement capacity, in the context of making required recommendations about possible community sector inclusion in the NSW Health 'ClinConnect' student placement system.

9 Further information about the 2013 MHCC Practice Placement Project is available at: http://mhcc.org.au/sector-development/workforce-development/practice-placements.aspx

10 Nisbet, G, McAllister, L., and Heydon, M 2014, *A Peer Group Mentoring Framework for the Development of Student Supervisors.* MHCC, Sydney.

11 Via the MHCC Organisation Builder (MOB: http://mob.mhcc.org.au/) and adaptions to the MHCC website to capture the 2014 Commonwealth Department of Health/ HETI funded community sector projects.

MAIN PURPOSE OF THE INTERPROFESSIONAL LEARNING AND SUPERVISION MODEL (IPL&SM)

The main purpose of the IPL&SM is to increase the quantity and quality of interprofessional community sector practice placements across NSW. The achievements of the WIL and PPPE project objectives progressed this goal in 2014, as shown in Table 1.

Table 1. WIL and PPPE Project Objectives 2014

Objective	WIL	PPPE
1. Progress the establishment of higher education provider (HEP), health service and community sector relationships	√	√
2. Explore concepts of peer supervision, mentorship and coaching as these relate to workplace based supervision and professional development.	√	
3. Strengthen community sector capacity		
a. Extend application of TOTR supervision approaches to community sector settings	√	
b. Expand the MHCC 2013 Practice Placement Listing (PPL)		√
c. Make practice placement and supervision material more accessible to CMOs		√
d. Better understand the role of key regional drivers in increasing capacity		√

COLLABORATIVE APPROACH

The two 2014 IPL&SM projects were collaborative, with project partners taking on roles.

Table 2. WIL and PPPE Project Partners

Organisation/Role	WIL			PPPE
	Consortium Member/ Rep	Reference Group Member	Other	Steering Committee Member
CEWD (Sydney LHD) ■ Marie Heydon	√	√	Facilitator: Peer mentoring and TOTR; Author: Peer mentoring framework	
Consumer and Carer Rep. ■ Peter Heggie		√		
ICTN (NSW) ■ Carla Brogden				√
ICTN (Sydney) ■ Michael Hemingway		√		
RichmondPRA ■ Janet Ford		√		√
UnitingCare Mental Health Malcolm Choat		√		
USyd & Sydney ICTN ■ Professor Lindy McAllister	√	√	Author: Peer mentoring framework	√
USyd ■ Dr. Gillian Nisbet		√	Facilitator: Peer mentoring; Lead Author: Peer mentoring framework	√
MHCC ■ Tina Smith	√	√	Project Manager: WIL Project Manager: PPPE	√

WORK INTEGRATED LEARNING (WIL) AND PRACTICE PLACEMENT PROJECT ENHANCEMENT (PPPE) OBJECTIVES AND ACTIVITIES

WIL and PPPE used a range of activities to meet their objectives. These are summarized and brief comments made in Table 3, and detailed in Appendix 1.

Table 3. Meeting WIL and PPPE objectives

Objective 1. Progress the establishment of HEP, health service and community sector relationships
Representatives from MHCC, HETI/ICTN, Sydney LHD/CEWD, University of Sydney, the community sector, and a consumer and carer representative formed the WIL Supervision Project Reference Group and PPPE Steering Committee. Relationships were established and strengthened as these representatives guided, contributed to, monitored, and jointly undertook the projects (e.g. USyd and CEWD[12]).
HEP, health service and community sector relationships were also established and strengthened through: delivery of the TOTR training Peer Group Mentoring Interprofessional Supervision Development Trial development of the 2015 Practice Placement Listing (PPL). Further support is recommended for relationship management continue.
Objective 2. Explore concepts of peer supervision, mentorship and coaching as these relate to workplace based supervision and professional development.
Literature review, consultation with community sector and Sydney LHD representatives, the Peer Group Mentoring Framework trial, and WIL Supervision Project Reference Group feedback, all informed the development of the Peer Group Mentoring Framework. USyd led the development of the Peer Group Mentoring Framework with strong support from CEWD. Further trialling and evaluation of the framework are recommended.
Objective 3. Strengthen community sector capacity a. Extend application of TOTR supervision approaches to community sector settings
15 participants received TOTR training Evaluation of the community sector delivery of TOTR indicated high ratings; further community sector contextualisations are recommended.
b. Expand the MHCC 2013 PPL
The '2015 PPL' includes an updated CMO section with 8 new CMOs, HEPs Requiring Practice Placements (33 HEP profiles included), the 2015 Placement Partner Contact List (60 primary contacts for HEPs, 30 primary contacts for CMOs), and presentation of CMO Programs and HEP Placement locations (by LHD/ICTN). Use of the 2015 PPL is likely to increase the quality and quantity of practice placements; maintenance of the PPL is recommended.

12 St. Vincent's Health Service (SVHS) was initially to be a Partner in the WIL Project, but was unable to be involved; USyd and CEWD jointly undertook the WIL Project.

c. Make practice placement and supervision material more accessible to CMOs
The *MHCC Organisation Builder (MOB) Policy Resource* material was updated to include content from the 2013 Practice Placement Guide, MHCC's 2012 *"Implementing Practice Supervision in Mental Health Community Managed Organisations in NSW"*, and the Peer Group Mentoring Framework. Adaptions were made to the MHCC website to capture the 2014 Commonwealth Department of Health/HETI funded community sector projects. IPL&SM material is integrated into the MHCC website.
d. Better understand the role of 'key regional drivers' in increasing capacity
2013 PPP evaluation, a literature scan, and learnings from implementation of PPPE 2014 informed the development of recommendations for the role of Key Driver(s). The function of the key driver (detailed in Appendix 2) was proposed; piloting of a key driver is recommended.

REFLECTING ON IMPLEMENTATION AND IMPACT

The WIL and PPPE are 'living' examples of interprofessional collaboration. Through planning, implementation and evaluation of these projects, the range of professionals involved enabled rich exploration of issues. Different perspectives could be voiced and held in a highly respectful, exploratory space in which achieving project outcomes remained the purpose.

Solution-focussed cooperation is essential to successful interprofessional collaboration. When it became clear Saint Vincent's Health Services (SVHS) could no longer partner in the project as initially planned in the WIL, a major adjustment to the WIL had to be made (the STAR program was not accessible). This impacted on all members of the Reference Group. Sydney ICTN, in its role as funder, communicated clearly with the Reference Group in order to negotiate changes to the agreed schedule of work. As a result USyd took a key role in the development of the Peer Group Mentoring Framework, with the other project partner CEWD. This is an example of solution-focused cooperation, in order to ensure that project outcomes were met.

Evaluation

The objectives of both the WIL and PPPE projects were met on time, often exceeding expectations. Appendix 3 shows excerpts from PPPE and WIL evaluation material.

Findings of particular note for the PPPE

The PPPE deliverable for the 2015 PPL was to increase the number of CMOs listed and include a Practice Placement Partner Contact List. The 2015 PPL includes these and additional features such as:

- *About Practice Placements in CMOs* drawn predominantly from the Practice Placement Guide 2013
- Summary of CMO Programs & Locations
- HEPs Requiring Practice Placements (33 HEP profiles included)
- ESSA endorsed fact sheet on supervision requirements
- Presentation of CMO Programs and HEP Placement locations (LHD/ICTN)

The PPPE 2014 Survey found that:

80% of HEP respondents became more willing to consider using CMOs for student placements as a result of perusing the draft 2015 PPL

Reported usage of the Practice Placement Guide is associated with reported improvement in practice placement quality in CMOs

As well as strengthening relationships with HEPs, MHCC developed a relationship with Exercise & Sports Science Australia (ESSA) resulting in clarification of supervision requirements during practice placements (the information is available in the 2015 PPL). Further work needs to be done to promote practice placement benefits and access to placement resources to CMOs.

Findings of particular note for the WIL

Participants rated the TOTR training highly, and participant's reported effectiveness, motivation and confidence to provide practice supervision increased.

The evaluation of the peer group mentoring trial found:

- strong endorsement by participants of the concept of peer group mentoring
- a current gap in support for student supervisors (the peer group mentoring framework, if adopted by organisations, would fill this gap)
- applicability of skills gained (via the peer group mentoring framework) to other aspects of practice
- peer mentoring may be a valid alternative to the traditional one-to-one mentoring
- a cross disciplinary peer group mentoring framework is likely to be a means for developing greater understanding between disciplines, fostering an interprofessional learning culture more generally in workplaces, and ultimately improving interprofessional practice
- participants indicated their willingness to take more students as a result of participating in the trial.

The potential to enhance professional entry clinical/practice placement/supervision capacity through this strategic approach to community sector placements is considerable through:

- facilitating strengthened interprofessional supervision capacity in the community sector
- increasing understanding and utilisation of group peer mentorship approaches in a range of community service and health settings
- enhancing the transfer of training to practice.

RECOMMENDATIONS FROM EARLIER PROJECTS

WIL Recommendations:

1. 1. Seek organisational support to run a longer pilot of the Peer Group Mentoring Framework (e.g. 1 year) within the public health and community managed sectors.
2. Implement a train-the-trainer program for peer mentoring group leaders.
3. Seek funding to develop and implement a research plan to rigorously evaluate the impact of the Framework on participants as well as students they supervise.
4. Disseminate findings of the trial nationally and internationally e.g. in an appropriate peer reviewed journal.
5. ontinue liaison with Sydney LHD, CEWD and the TELL Centre in regard to further community sector contextualisations for TOTR, and a related one-day course that targets supervisors of existing workers.

PPPE Recommendations:

1. Determine the structure of the key driver (e.g. overseeing body/network).
2. Pilot a 'key driver' in rural/regional areas for a minimum of 12-months, with a focus on:

a.) Engagement, partnership and communication

- Establish and maintain relationships, including the building of local alliances
- Coordinate discussion/engagement between CMOs & HEPs, i.e. be the 'first point of contact' for practice placement relationships between HEPs and CMOs to reduce the communication demands on each

b.) Gathering and providing information

- Maintain/update the Community Sector PPL, promote placement benefits/access to placement resources
- Provide information about community infrastructure in rural/regional areas

c.) Placement coordination

- Placement coordination, including the establishment of shared placements)

d) Systemic support for:

- Preparation of CMO supervisors/Placement Educators
- CMOs in determinants of interprofessional collaboration, with attention to:
    - clarity of vision
    - group culture, flattened hierarchy, effective leadership
    - clearly defined and understood roles and scope of practice
    - a person-centred approach to support; consumer education
    - communication strategies, shared time and space.
- Advocate for CMO funding, remuneration, and human resources when required.

e.) Research

- Conduct ongoing evaluation and support for research to develop an evidence base about the most effective ways to:
    - Increase the number and quality of practice placements
    - Support practice placements in rural and regional areas

2013 PPP Recommendations

1. Identify and resource a regional driver (e.g. MHCC), or workforce development champion, to maintain growth in capacity and quality. At a minimum, funding should cover the cost of:

- maintenance/updating of the sector Practice Placement Listing
- developmental material, e-forums and/or face-to-face forums throughout NSW that bring together HEPs and CMOs.

   Ideally, this funding would also cover the regional key driver to conduct ongoing evaluation and support for research to develop an evidence base about the most effective ways to increase the number and quality of practice placements.

2. Apply a funding formula equivalent to that used for public and private health services for the provision of practice placements to CMOs.

3. Conduct cost and benefit studies to elucidate the productivity components of practice placements in CMO and other placements alike.

4. Adopt the MHCC supervision structures (i.e. IPL&SM).

5. Provide support to an integrated approach to regional workforce development for community managed mental health service providers, including understanding the unique needs of non-metropolitan communities, and work with education and training providers to enable organisations undertaking practice placements to share developed materials to support their own longer term workforce and practice placement development.

6. Give in-principle support for the involvement of CMOs in ClinConnect subject to:

- ClinConnect functionality being able to accommodate the diverse requirements of CMOs
- CMOs being adequately resourced and supported to utilise ClinConnect.

   MHCC is the central point of contact for communication with, consultation on, and potentially trialling the involvement of CMOs in ClinConnect.

7. In consideration of the future of health and community service workforce, undertake research on how to best maximize recovery oriented practice placement.

8. In order to prevent one form of practice placement potentially displacing another, regional networks should incorporate a broader alliance of education and training providers in need of facilitating practice placements (i.e. university, vocational education and training/VET and other).

9. Training and education providers and professional bodies work more closely with practice placement providers to develop a set of capabilities that define the successful completion of a practice placement by a student, for adoption by community managed and other health and community services alike.

Table 4 presents recommendations from the 2013 PPP and 2014 WIL and PPPE projects, organised into categories.

Table 4. WIL, PPPE and PPP Recommendations

Recommendation	WIL	PPPE	PPP
A. Funding			
1. Apply a funding formula equivalent to that used for public and private health services for the provision of practice placements to CMOs. [13]			√
2. Seek funding to develop and implement a research plan to rigorously evaluate the impact of the Peer Group Mentoring Framework	√		
B. Regional Driver			
1. Identify and resource a regional driver			√
2. Determine the structure of the key driver (e.g. overseeing body/network)		√	
3. Execute a minimum 12-month rural/regional pilot of a Key Driver focusing on: engagement, partnership and communication gathering and providing information placement coordination systemic support research		√	
C. Alliances			
1. In order to prevent one form of practice placement potentially displacing another, regional networks should incorporate a broader alliance of education and training providers in need of facilitating practice placements (i.e. university, VET and other).			√
2. Training and education providers and professional bodies work more closely with practice placement providers to develop a set of capabilities that define the successful completion of a practice placement by a student, for adoption by community managed and other health and community services alike.			√
D. Workforce Development			
1. Provide support to an integrated approach to regional workforce development for community managed mental health service providers			√
2. Continue liaison with TELL in regard to further community sector contextualisations for TOTR	√		
3. Implement a Train-the-trainer program for peer mentoring group leaders	√		
E. Research and Evaluation			
1. Conduct cost and benefit studies to elucidate the productivity components of practice placements in CMO and other placements alike			√
2. Research and evaluation - how to maximise recovery oriented practice placement, practice supervision and interprofessional learning capacity-building activity within the community managed mental health sector			√
3. MHCC is the central point of contact for communication with, consultation on, and potentially trialling the involvement of CMOs in, ClinConnect			√

13 For background information about this recommendation, see Mental Health Coordinating Council (2013a, pp. 56-57 and 2013d, pp.34-38).

Recommendation	WIL	PPPE	PPP
4. Peer Group Mentoring Framework: Seek organisational support to run a longer pilot of the Peer Group Mentoring Framework (e.g.1 year) within the public health and community managed sectors Rigorously evaluate the impact of the Peer Group Mentoring Framework on participants as well as the students they supervise (subject to funding) Disseminate findings of the trial nationally and internationally, e.g. in an appropriate peer reviewed journal.	√		
F. Practice Placement Experience			
1. [MHCC] supervision structure (PPP 2013) be adopted			√

CONSIDERATION OF BROADER CONTEXT

Consideration of the broader context in which further development in CMO practice placements will occur will enhance opportunities for productive alliances with the public and private health sectors, and higher education providers.

Structural Context

The IPL&SM may involve many different professions and potentially a range of health and community service and education providers. In NSW, health services are provided by:

- Public health services e.g.:
  - Local Health Districts (LHDs)
  - Statutory health authorities
  - Affiliated Health Organisations (AHOs)
- Private for-profit providers
- Community managed organisations
- Primary healthcare providers

Reported Practice Placement Activity

Table 5 shows the percentage of total practice placement hours reported within the public, private and community managed sectors between 2012 and 2013.

Table 5. Clinical/practice placement hours reportedly undertaken in the public, private and non-government/community managed sectors [14]

Sector	Percentage of clinical/practice placement hours			
	2012		2013	
	NSW	Australia	NSW	Australia
Public	80%	74%	79%	73%
Private	18%	23%	17%	23%
NGO/CMO	2%	2%	4%	3%

14 Drawn from Sydney ICTN HWA Dataset 2012-2013 *Percentage of Private, NGO and Public clinical placement hours - NSW 2012-13*

Reported percentage of clinical/practice placement hours undertaken within the non-government community managed sector increased by approximately 50% nationally, and doubled in NSW between 2012 and 2013. Placement activity in this sector is likely to increase further in order to equip the future workforce for the continuing shift away from traditional hospital-based models, towards more community-based approaches for health care.

It has been proposed that a more detailed picture of current CMO and private placement activity is required, involving activities such as[15]:

- creation of a NGO data collection process (i.e. to establish a baseline and better track change over time to CMO private-for-profit work setting student practice placements)
- survey of current and projected student numbers undertaking health education courses to assist in identifying priority settings within the CMO/private sectors
- development of a model to ascertain best-practice clinical placement capacity that reflects difference across disciplines, settings and facilities, including consideration of the development of practice placement Key Performance Indicators (KPIs) linked to capacity for internal use by health and community services
- creation of targeted CMO and private placement initiatives based on existing data (e.g. aged care settings).

NSW Practice Placement Priority Areas

Eight practice placement priority areas have been determined following identification of barriers to the increase in quantity and quality of practice placements in NSW[16]:

- Workload
- Supervision skills
- Infrastructure
- Learning culture
- Staffing levels
- Course requirements
- Request management
- Geography

15 Sydney Interdisciplinary Clinical Training Network Data Subcommittee 2014, p.7.

16 Sydney Interdisciplinary Clinical Training Network Data Subcommittee 2014, p.6.

Potential Framework for Intersectoral Practice Placement Capacity

Further consideration of the broader context and the recommendations in Table 4 led to adaptation of MHCC's *Framework for Community Managed Mental Health Sector Capacity* (Appendix 5), in order to create a *Potential Framework for Intersectoral Practice Placement Capacity*, shown in Table 6.

Table 6. Potential Framework for Intersectoral Practice Placement Capacity[17]

Student Experience (practice placement range & responsiveness)
■ Students are informed about practice placement experiences, and linked with relevant practice placement providers.
■ Accessible, relevant, well coordinated, practice placements, using evidence based teaching/ facilitation techniques, are available for students.
■ Practice placements are provided across the spectrum of vocations, education providers and settings, in urban, rural, and remote areas.
■ Practice placement quality indicators are utilised.
Practice Placement Provision (host organisation and education provider capacity)
■ Host organisations and education providers are strategically and operationally sound, well resourced, skilled, and engaging with each other in a streamlined regulatory environment.
■ Intersectoral partnerships are mobilised to provide accessible, relevant, well-coordinated practice placements.
■ A competent workforce that supports and provides practice placements is in place.
Policy and Planning (planning, funding and evaluation)
■ Transparent, consistent planning, funding and evaluation mechanisms for practice placements are in place in public, private and community managed sectors.
■ Policies and plans for intersectoral support of practice placements are developed.
■ Evaluation of the effectiveness, accessibility, and quality of practice placements leads to progressive change.
Research and Development (innovation and growth)
■ Transparent, consistent, intersectoral research mechanisms are in place.
■ New insights and innovative methods to increase quality and quantity of practice placements are researched.
■ Practice placement quality and quantity are monitored.

17 Adapted from *Framework for Community Managed Mental Health Sector Capacity*, MHCC, 2010

STRUCTURE OF THE IPL&SM

Within the context of the *Potential Framework for Intersectoral Practice Placement Capacity*, the structure of the IPL&SM emerges from the Peer Group Mentoring Framework[18] and the MHCC Practice Placement Project/s student placement model structure.

Peer Group Mentoring Framework

Box 1 shows key aspects of the Peer Group Mentoring Framework as outlined by Nisbet, McAllister and Heydon (2014), with a proposed outline of developmental stages shown in Figure 1.

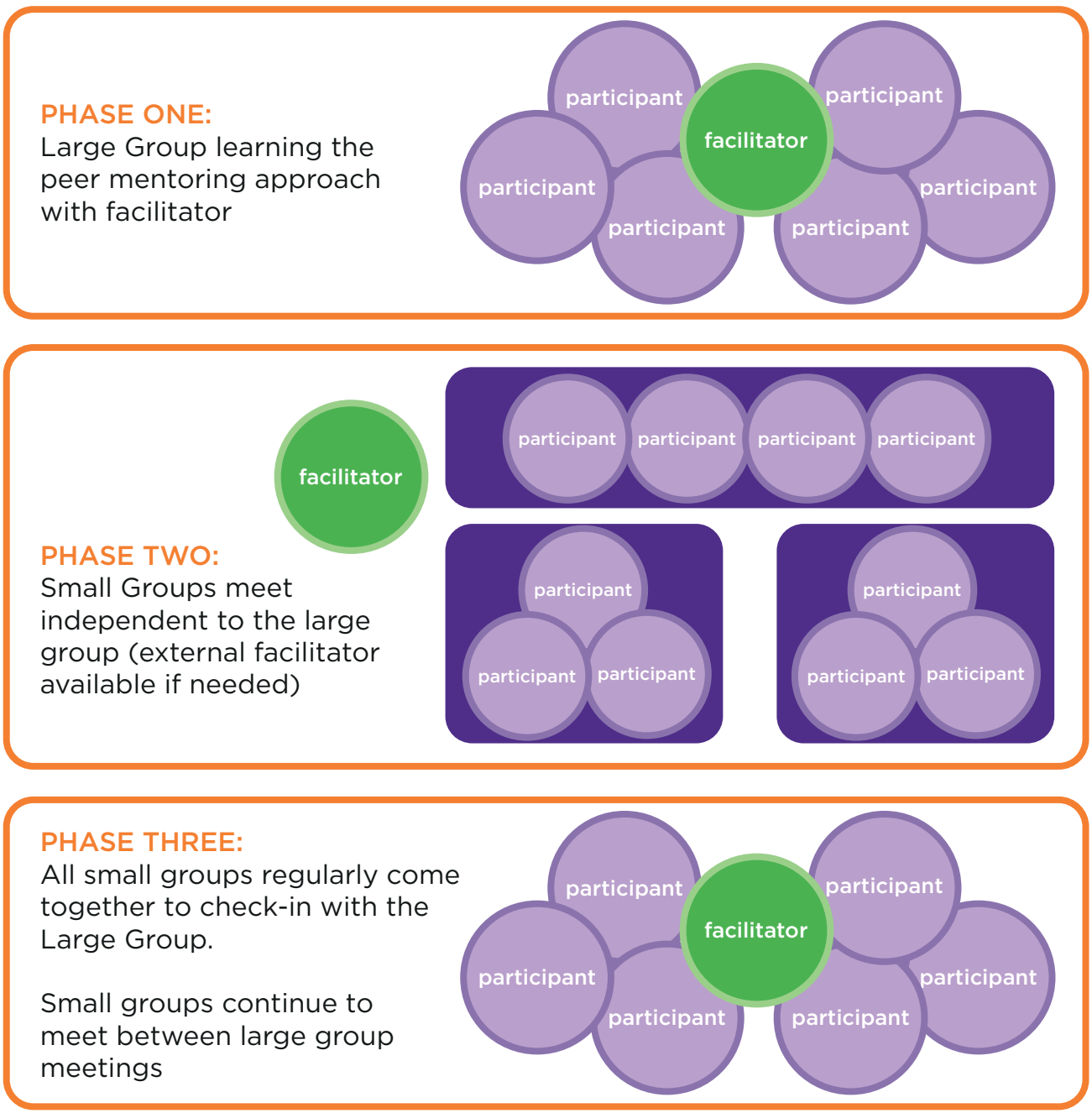
Box1. Key aspects of the Peer Group Mentoring Framework

1. Diversity in the range of professional backgrounds of participants, workplace experience and current place of work
2. Initial facilitator guidance to role model and help establish the peer group mentoring process
3. Skill development in both the process of peer group mentoring and student supervision
4. A scaffold approach to empower participants to take on the role of co-mentor within their mentoring group
5. A structured approach to encourage reflective practice – a range of reflective models are offered
6. A structure to enable evaluation of the mentoring process - what is working/ not working within the peer group mentoring program
7. Sustainability – this is dependent on perceived value to participants of the peer group mentoring program; perceived value to their organisation; and the support offered by organisations to allow participants to attend in work time.

From Nisbet, McAllister & Heydon 2014, p.35.

18 Nisbet, McAllister & Heydon 2014, *op. cit.*

Figure 1. Peer Group Mentoring Framework

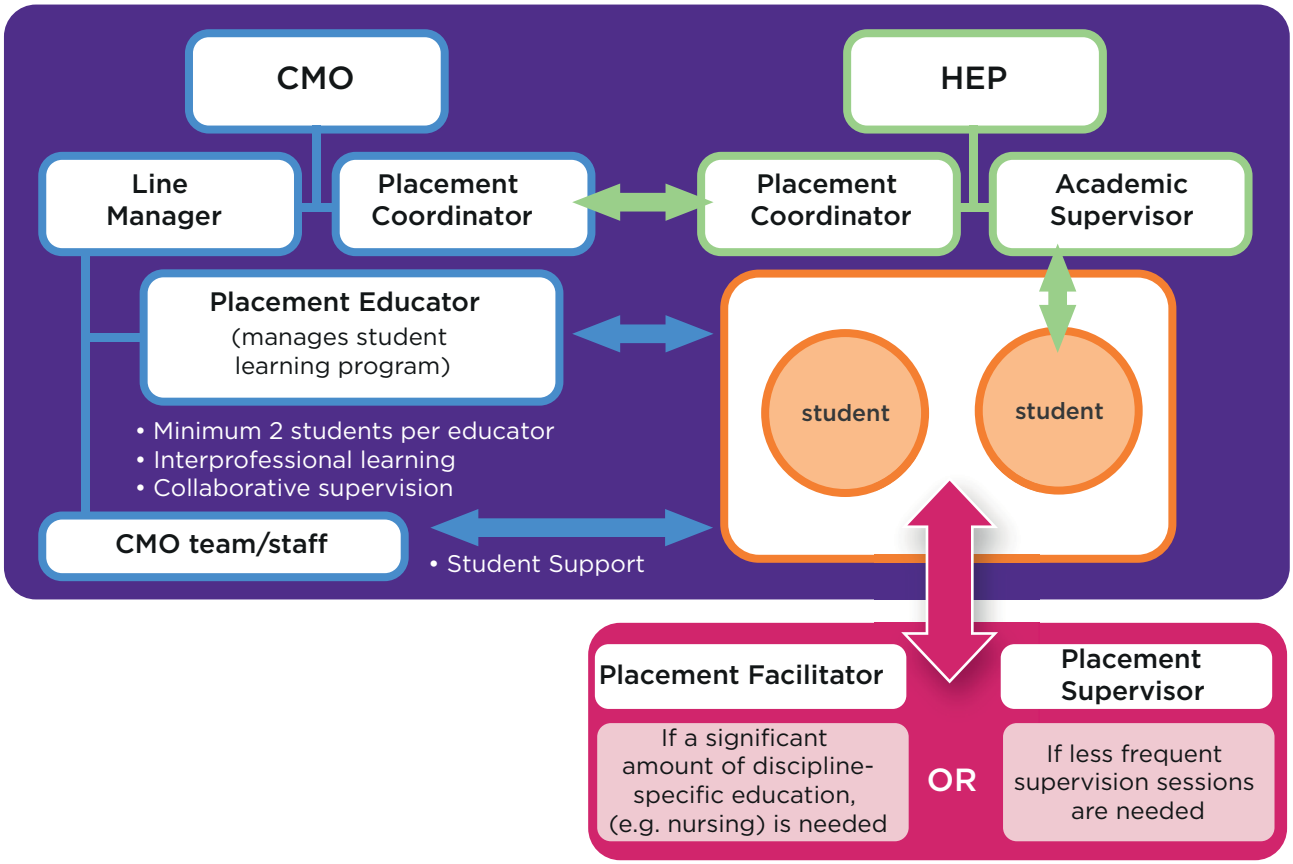


From Nisbet, McAllister & Heydon, 2014, p.36

CMO Practice Placement Structure

The CMO Practice Placement Structure shown in Figure 2 was developed in 2013 and refined in 2014.

Figure 2. CMO Practice Placement Structure



Features of Practice Placements in CMOs

- Interprofessional learning concepts can be integrated into all discipline specific placements.
- Service development tasks may be relevant to student learning outcomes.

Within the practice placement structure (Figure 2) it is envisaged that **where possible**:

- There is a minimum of two students per Placement Educator to maximise opportunities for peer assisted learning
- In cases where the CMO's Placement Educator is from a different profession to that of the student, students may be supervised by:
  - a Placement Facilitator funded by the HEP and
  - a Placement Educator funded by the CMO.
- Support for the Placement Educator may be provided via:
  - HEP briefings and HEP personnel
  - Practice Placement Guide
  - peer mentoring
  - regular CMO supervision (professional and line manager).

Profession of Placement Educator

When the CMO Practice Educator is from a different profession to that of the student, more opportunities for interprofessional learning are provided.

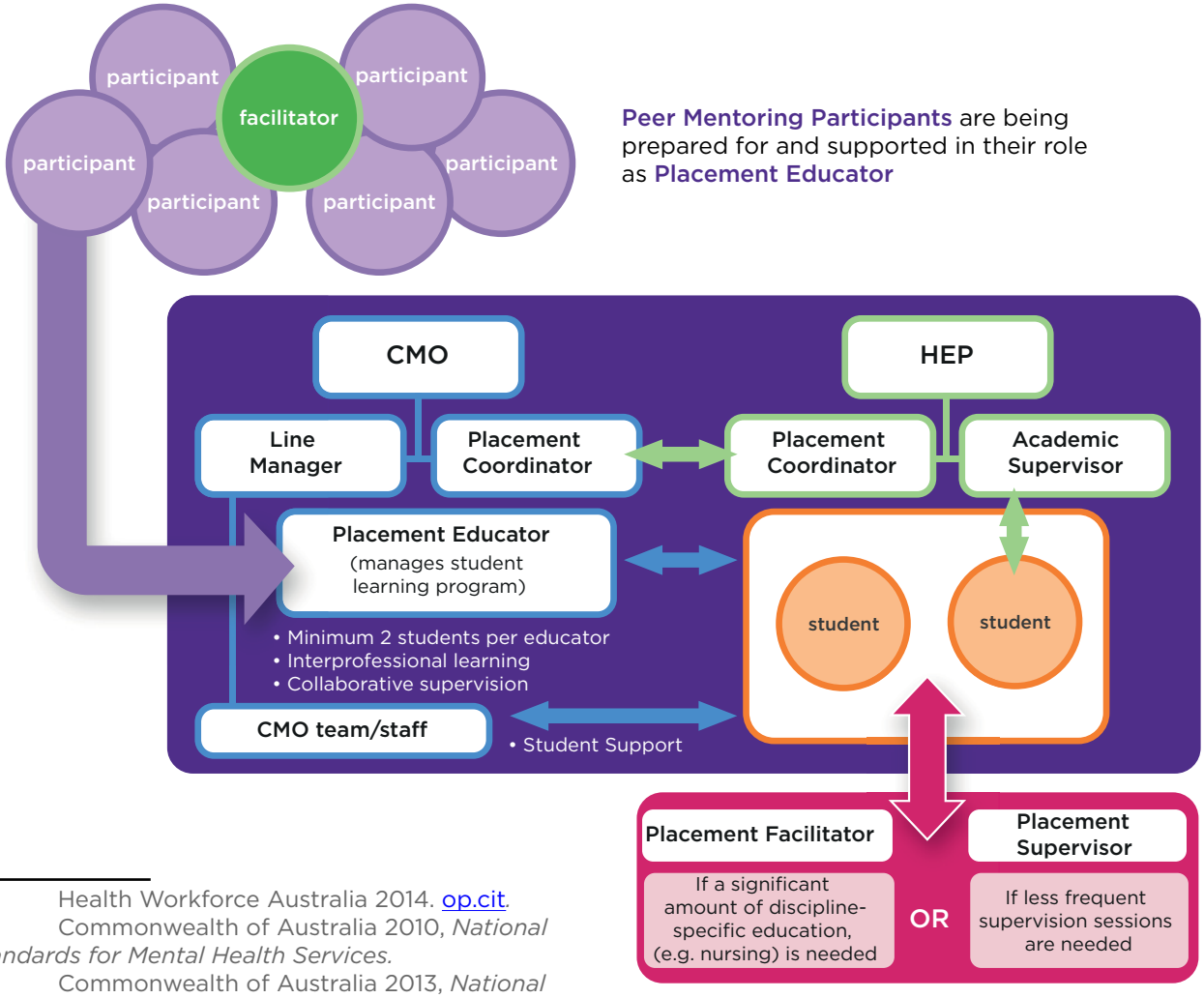
Recovery-oriented approach

It is seen as highly beneficial that students on practice placement in CMOs focus on a recovery-oriented approach to mental health support, which is in accordance with the *National Mental Health Core Capabilities 2014*[19], *National Standards for Mental Health Services 2010*[20], the *National Mental Health Practice Standards*[21], and the *Checklist for Mental Health in Pre-registration Curricula*[22].

Peer Mentoring Framework and the CMO Practice Placement Structure

The Peer Mentoring Framework and the CMO Practice Placement Structure combine to form the *Proposed Interprofessional Learning and Supervision Model*, as shown in Figure 3.

Figure 3. Proposed Interprofessional Learning and Supervision Model IPL&SM Recommendations

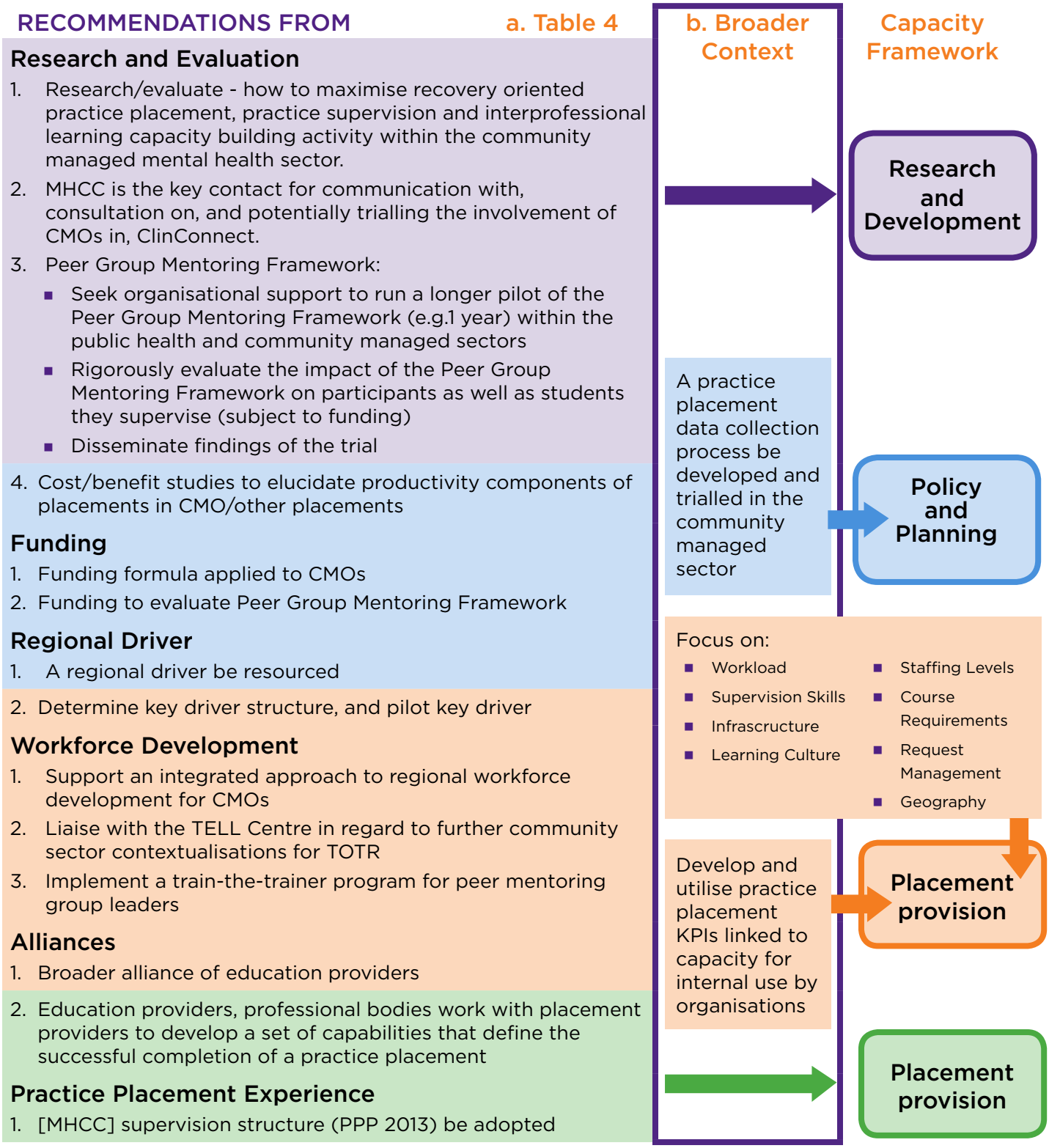


19 Health Workforce Australia 2014. op.cit.
20 Commonwealth of Australia 2010, *National Standards for Mental Health Services.*
21 Commonwealth of Australia 2013, *National Mental Health Workforce Practice Standards.*
22 Mental Health Nursing Education Taskforce Implementation Group 2012.

IPL&SM RECOMMENDATIONS

Figure 4 reframes and aligns recommendations (drawn from Table 4 and the broader context), with the **Potential Framework for Intersectoral Practice Placement Capacity** (Table 6).

Figure 4. Aligning recommendations with potential Capacity Framework



The *Potential Intersectoral Practice Placement Capacity Framework* provides a clear base from which further practice placement development can occur. Recommendations overlap with others. For example, allocating the function of practice placement data collection to the key driver may enable an associated process to be developed and trialed when the key driver is piloted in a regional/rural area.

Some recommendations have partly been fulfilled. For example:

- During the consideration of broader context, it was noted that there is a need for the development and utilisation of Practice Placement KPIs linked to capacity for internal use by organisations[23]. The MHCC Practice Placement Guide (2013) has already made some progress in this regard (see Appendix 5).
- A follow-up letter to the TELL Centre in regard to further community sector contextualisations for TOTR has been sent.[24]

Where practical, recommendations that overlap, are partly filled, or have been completed, are consolidated with others and/or removed.

Recommendations

A. Student Experience (practice placement range & responsiveness)

1. Adopt and further develop the Interprofessional Learning and Supervision Model structure.
2. Develop a set of capabilities that defines the successful completion of a practice placement.

B. Practice Placement Provision (host organisation and education provider capacity)

3. Determine the structure of the key driver.
4. Execute a minimum12-month pilot of a Key Driver focusing on:
   - **Systemic support**: preparation of CMO supervisors/Placement Educators; support for CMOs in determinants of interprofessional collaboration; workload, supervision skills, infrastructure, learning culture; advocate for CMO funding, remuneration, human resources when required
   - **Engagement, partnership and communication**: be the 'first point of contact' for practice placement relationships between HEPs and CMOs, and communication about course requirements
   - **Placement coordination**: including request management and shared placements
   - **Gathering and providing information**: including practice placement data collection, maintain/update the community sector PPL, promote placement benefits/access to placement resources, information about community infrastructure in rural/regional areas
   - **Research**: supporting practice placements in rural and regional areas.
5. Incorporate a broader alliance of education and training providers into regional networks, i.e. university, vocational education and training/VET and other, in order to prevent one form of practice placement potentially displacing another.
6. Build on MHCC's organisational capacity considerations[25] to enable development and utilisation of practice placement KPIs linked to capacity for internal use by organisations.
7. Support an integrated approach to regional workforce development for CMOs.
8. Implement a train-the-trainer program for peer mentoring group leaders.

C. Policy and Planning (planning, funding and evaluation)

9. Apply a funding formula equivalent to that used for public and private health services for the provision of practice placements should be applied to CMOs.

23 Sydney Interdisciplinary Clinical Training Network Data Subcommittee 2014, p.7.
24 Appendix 6.
25 Appendix 5.

10. Develop and trial a practice placement data collection process be developed and trialled in the community managed sector.
11. Seek funding to develop and implement a research plan to rigorously evaluate the impact of the Peer Mentoring Framework on participants as well as the students they supervise.
12. Resource the regional driver.

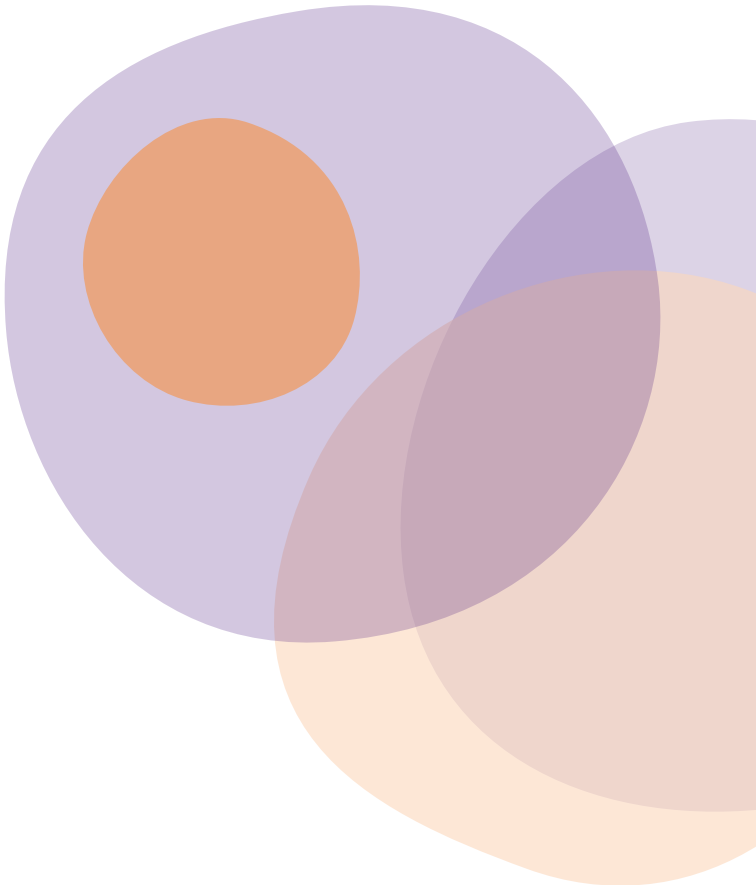
D. Research and Development (innovation and growth)

13. Undertake research and evaluation on how to best maximize recovery oriented practice placement, practice supervision, and interprofessional learning capacity-building activity within the community managed mental health sector, with consideration given to the future of the health and community service workforce
14. MHCC is the key contact for communication with, consultation on, and potentially trialling the involvement of CMOs in ClinConnect.
15. Peer Group Mentoring Framework will:

- Seek organisational support to run a longer pilot of the Peer Group Mentoring Framework (e.g. 1 year) within the public health and community managed sectors
- Rigorously evaluate the impact of the Peer Group Mentoring Framework on participants as well as students they supervise (subject to funding)
- Disseminate findings of the trial nationally and internationally e.g. in an appropriate peer reviewed journal.

The priorities for the community sector in taking this important work forward are to:

- Adopting and further developing the IPL&SM structure
- Determining the structure of the Key Driver of community sector practice placements
- Trialing and evaluating the Peer Group Mentoring Framework
- Build on MHCC's organisational capacity considerations to enable development and utilisation of practice placement KPIs linked to capacity for internal use by organisations.
- Developing and trialing a practice placement data collection process in the community managed sector.
- Researching and evaluating how to best maximise recovery oriented practice placement, practice supervision and interprofessional learning capacity-building activity within the community managed mental health sector, with consideration of the future health and community service workforce, i.e., projected deficits.



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26 Please note that additional references are provided in Attachment 2: The Role of Key Drivers.

APPENDICES

Appendix 1: Part 1 - Implementation of the WIL Supervision Project

Objective 1: Progress the establishment of higher education provider, health service and community sector relationships to increase clinical/practice placement capacity
1.1 Develop draft Terms of Reference (TOR) for Reference Group
1.2 EOI to identify community sector representatives to the Reference Group
1.3 Convene Reference Group to guide/advise on project
1.4 Development of Interprofessional Learning and Supervision Model (IPL&SM) Guide/Report and Reference Group endorsement

Objective 2: Extend application of TOTR supervision approaches to community sector settings
2.1 Obtain TELL Centre agreement to, and make, initial community sector contextualisations of TOTR (i.e. essential language changes)
2.2 EOI to identify TOTR training participants
2.3 Conduct community sector TOTR training
2.4 Use training and consultation experiences to inform recommendations for further contextualisation/customisation of TOTR
2.5 Seek authorisation and implement changes

Objective 3: Better understand the role of key regional drivers in increasing capacity for community sector training places_
3.1 Revisit PPP Scoping Paper literature scan relevant to community sector practice placements to identify any relevant current policy, research or activity
3.2 Conduct project evaluation
3.3 Table draft of Final Report for consideration of Steering Committee and update against advise
3.4 Progress development of final report
3.5 Produce a comprehensive final Project Report inclusive of consideration of interprofessional regional drivers of practice placements
3.6 Deliver final Project Report to HETI

Appendix 1: Part 2 - Implementation of PPPE

Objective 1: Progress the establishment of a higher education provider, health service and community sector relationships to increase clinical/practice placement capacity
1.1 Develop project proposal and plan
1.2 Execute the Performance and Funding Agreement with HETI
1.3 Identification of and contracting with Project Coordinator (consultant)
1.4 Re-establish relationships with the three Sydney universities that participated in the 2013 PPP and promote the availability of community sector practice placements partners and promote the availability of community sector practice placements
1.5 Establish relationships with the other nine NSW universities to identify practice placement

Objective 2: Strengthen community sector capacity to increase the quantity and quality of interprofessional community sector practice placements outside of Sydney
2.1 Clarify project evaluation approaches
2.2 Outreach to MHCC and other community sector organisations to identify those wanting to host student practice placements
2.3 Develop a comprehensive hardcopy and electronic practice placement partner contact list for all 12 NSW universities for the purpose of promoting practice placements in 2014 and beyond
2.4 Add to the 2013 PPP Placement Listing from the outcomes of process to identify additional community sector practice placements to develop Version 2 2014 Placement Listing
2.5 Enhance content of MHCC Organisation Builder (MOB) Policy Resource to include PPP Placement Guide content
2.6 Communicate with all university practice placement partners and community sector organisations included in the Placement Listing to promote 2015 student practice placements and the PPP Placement Guide that supports practice placements

Objective 3: Better understand the role of key regional drivers in increasing capacity for community sector training places
3.1 Revisit PPP Scoping Paper literature scan relevant to community sector practice placements to identify any relevant current policy, research or activity
3.2 Conduct project evaluation
3.3 Table draft of Final Report for consideration of Steering Committee and update against advise
3.4 Progress development of final report
3.5 Produce a comprehensive final Project Report inclusive of consideration of interprofessional regional drivers of practice placements
3.6 Deliver final Project Report to HETI

Appendix 2. Consideration of the Role of Key Driver

Consideration of the role of key driver is based on:

- 2013 PPP Evaluation
- Revisiting the literature
- Learnings from implementation of PPPE 2014.

One of the aims of PPPE 2014's consideration of the role of the key driver is to inform its structure. As such, there was no assumption during PPPE 2014 that a particular body was the key driver[27].

2013 PPP Evaluation

In its evaluation of the 2013 PPP the Workplace Research Centre at University of Sydney recommended that:

> *"A regional driver (e.g. MHCC), or workforce development champion, be recognised and resourced to maintain and expand on existing increases in capacity and quality. At a minimum, funding should cover the cost of:*
>
> - *maintenance/updating of the sector practice Placement Listing*
> - *developmental material, e-forums and/or face-to-face forums throughout NSW which bring together HEPs and CMOs.*
>
> *Ideally, this funding would also cover the regional driver to conduct ongoing evaluation and support for research to develop an evidence base about the most effective ways to increase the number and quality of practice placements"*[28].

Additional references to the key driver in that document include:

> *"...increased understanding of the role of key regional drivers in increasing capacity for training places - especially in rural and regional areas where infrastructure issues may be fundamentally different to metropolitan areas"*[29].
>
> *"...build local alliances, drive change..."* [30]

The 2013 PPP material indicates that the **role** of the key driver is to support increases in CMO practice placement capacity and quality. **Actions** which may assist the key driver to support increases in CMO placement capacity and quality include:

- maintain/update the sector Practice Placement Listing
- build local alliances via developmental material, e-forums and/or face-to-face forums throughout NSW which bring together HEPs and CMOs
- understand Practice Placement differences in rural and regional areas where infrastructure issues may be fundamentally different to metropolitan areas.
- conduct ongoing evaluation and support for research to develop an evidence base about the most effective ways to increase the number and quality of practice placements.

Revisiting the Literature

In order to further consider the role of the key driver (Objective 3 of this project), PPPE 2014 revisited and further scanned literature in regard to practice placement challenges in rural/regional areas, and interprofessional practice placements.

Practice placement challenges in rural/regional areas

It has been proposed that the following challenges need to be addressed in regard to effective and efficient placements in rural and remote settings[31]:

27 NOTE: Although the 2013 PPP evaluation identifies MHCC/workforce development champion as the key driver, it was thought a freer consideration of the key driver's role would occur if that assumption was suspended, then the identified functions used to inform the structure.

28 Mental Health Coordinating Council 2013a, p.10

29 Mental Health Coordinating Council 2013a, p.9

30 Mental Health Coordinating Council 2013a, p.54

31 Adapted from HWA 2013,p. 6-9 and Killam

Environment/infrastructure

- CMO Infrastructure: Insufficient space for placement students, lack of computers, and limited internet communications/access.
- Community Infrastructure: Lack of suitable student residential accommodation and travel options.

Supervisors

- Lack of qualified professionals (potentially addressed by ensuring professionals are trained as supervisors/preceptors/educators).
- Itinerant nature of many rural health professionals.
- Higher prevalence of relatively junior health professionals working in rural areas, who may not have the experience to supervise.
- Perceived lack of professional recognition of the additional supervision and teaching workload.
- Lack of financial compensation for additional supervision and teaching workload.

Students

- Lack of understanding by students of the placement and its challenges and benefits

Education Providers

- under-appreciation of the value of non-traditional clinical placements in the aged care and mental health sectors
- accreditation bodies stipulate duration and location of placements as well as the experience and qualifications of supervisors. Distant supervision (using tele-link or other communication technology) and cross discipline supervision may not meet the requirements of the accrediting body
- inability of universities, TAFE institutes and accreditation authorities to coordinate interprofessional placements or accept assessment of the students by another. discipline.

& Carter, 2010.

Supporting practice placements in rural/regional areas

Factors which will support practice placements in rural/regional areas were drawn from the literature scan[32] (with strong emphasis on those proposed by HWA 2013):

Environment/infrastructure

Ensuring the following infrastructure support is available for students on placement:

- CMO infrastructure: sufficient space (e.g. study/work areas, breakout rooms), and internet communications/access
- Community infrastructure: residential accommodation, and transport (and/or financial support to subsidise accommodation & travel costs)

Supervisors

- providing adequately prepared CMO supervisors
- supporting distant supervision (using tele-link or other communication technology) and enabling cross discipline supervision, where permitted by the professional body.

Students

- enabling orientation in the lead-up to placement
- being clear about the different roles students have on rural practice placements
- students going with a particular goal or project in mind
- students keeping a reflective journal (with a focus on professional practice)
- providing opportunities for regular briefing and debriefing during the placement
- building in mechanisms for students to deal with situations of concern or conflict
- providing opportunities for students to learn about policies in rural health as well as how to advocate for change.

32 Gocan, Laplante, & Woodend 2014, pp.8-9, Gum et al 2013, p1-2, HWA (2013), Killam & Carter 2010, Lapkin et al 2013, p.90, Levett Jones et al 2012, p.935-936, Liman et al 2007, pp.15-16

Education Providers

- integrating experiences from rural and interprofessional practice placements into the general curriculum (drive from within the curriculum).

Coordination/Partnerships

- establishing and maintaining partnerships between education providers and rural CMOs providing mental health services
- maintaining clear and regular communication between HEPs and CMOs prior to, during and after placement
- establishing shared placement opportunities (e.g. coordinated between Local Health Districts (LHDs), Aboriginal Medical Services, CMOs & Medicare Locals).[33]

Interprofessional practice placements in CMOs

Interprofessional practice placements may be more likely to occur in a system in which professionals are prepared for collaborative practices and in organisations in which there is a culture of interprofessional collaboration.

Interprofessional Collaboration

Gocan et al (2014) reviewed the literature and found the following determinants influence the success of interprofessional collaboration within Ontario's Family Health Teams:

- Healthcare system determinants
  - Adequate funding, remuneration, and human resources
  - Degree of professional preparation for collaborative practice
- Local context determinants

degree of electronic medical record integration

  - formation of community alliances or program facilitation partnerships.
- Team determinants
  - clarity of vision
  - group culture, flattened hierarchy, and effective leadership
  - clearly defined and understood roles and scope of practice
  - patient-centred approach to care and patient education regarding their role
  - communication strategies, shared time and space.

According to Lapkin et al, traditional, discipline-specific education does not adequately "*equip graduates with the necessary knowledge, skills and attitudes for effective interprofessional collaboration and for working as part of a complex health care team*" [34].

IPE is built on the premise that "*when health professional students learn together they will be better prepared for interprofessional collaboration and teamwork, ultimately leading to improved health outcomes*"[35]. Further, Gum et al[36] propose that interprofessional learning can be enhanced in a rural community context and note that:

> *"Student learning experiences can be enhanced through engagement and integration in a rural community context. Interprofessional learning in a rural community placement can increase students' understanding of professionalism, teamwork and collegiality, which are all important components of collaborative practice. Reflective journaling is a useful method for evaluating the student experience"* (Gum et al 2013, pp.1-2).

33 From discussion with ICTN Coordinators at meeting 24/07/14 and follow-up discussion with the Coordinator NSW West Interdisciplinary Clinical Training Network (ICTN)

34 Lapkin et al 2013, p.90

35 Barr et al 2005 in Levett Jones et al 2012, p.936

36 Gum et al 2013, pp.1-2

Levett Jones et al state that "*IPE opportunities should be provided in 'real' healthcare contexts during the experiential learning that occurs when students undertake clinical [practice] placements*"[37].This assertion, along with the finding in the MHCC Final Report (2013) that CMOs "*provide students with more opportunities for interprofessional learning*"[38], and Gum et al's statement that interprofessional *"learning experiences can be enhanced through engagement and integration in a rural community context"* [39]; this lead to the proposition that practice placements in rural/regional CMOs will be likely to provide enriched interprofessional learning experiences.

Challenges for arranging interprofessional practice placements

- The following challenges are associated with interprofessional practice placements[40]:
- complexity of student scheduling across disciplines
- Placement Educators may not:
- meet the supervisor requirements of accreditation bodies
- have sufficient professional preparation for collaborative practice
- varied academic support for interprofessional practice placements, including the degree to which:
- necessary academic/ logistical program changes accommodate interprofessional practice placements
- students are already prepared for interprofessional teamwork e.g. students enrolled in one program may be more familiar with the interprofessional model than students taught from more traditional perspectives of health care and education.
- expanded role required of placement coordinators e.g. student scheduling, screening, and matching to communities.

Supporting interprofessional practice placements

A literature scan provided the following suggestions for supporting interprofessional practice placements[41]:

provide coordination (Liman et al (2007) found that when Placement Educators play a broader coordination role it is likely to result in an unsustainably high demand on their workload)

improve communication with Placement Educators to ensure they are aware of the potential positive outcomes of interprofessional practice placements

secure appropriate shared accommodation

integrate experiences from interprofessional practice placements into the general curriculum (drive from within the curriculum)

promote a culture of interprofessional collaboration at organisational and systemic levels.

Supporting rural and interprofessional practice placements

Factors which support practice placements in rural / regional areas and the above supports for interprofessional practice placements are combined and shown in Table 2.

37 Levett Jones et al 2012, p.935
38 MHCC *Final Report*, 2013, p.14
39 Gum et al 2013, pp.1-2
40 Gocan, Laplante, & Woodend 2014; HWA 2013, p.6-9; Killam & Carter, 2010; Levett Jones et al 2012, p.935 Liman et al 2007, pp.15-16

41 Gocan, Laplante, & Woodend 2014; Liman et al 2007, pp.15-16

Table 2. Rural/Regional and Interprofessional Practice Placement Supports

Rural/Regional and Interprofessional Practice Placement Supports

System/Environment
■ Support systemic determinants of interprofessional collaboration.
  • provide adequate funding, remuneration, and human resources.
  • promote a high degree of professional preparation for collaborative practice
■ Support determinants of interprofessional collaboration in CMOs
  • clarity of vision
  • group culture, flattened hierarchy, and effective leadership
  • clearly defined and understood roles and scope of practice
  • a person-centred approach to support; consumer education
  • communication strategies, shared time and space.
■ Ensure the following infrastructure support is available for students on placement:
  • **CMO infrastructure:** sufficient space (e.g. study/work areas, breakout rooms), internet communications/access, electronic personal record integration
  • **community infrastructure:** shared residential accommodation, transport (and/or financial support to subsidise accommodation & travel costs)

Supervisors ■ Provide adequately prepared CMO supervisors. ■ Ensure a high degree of professional preparation for collaborative practice. ■ Support distant supervision (using tele-link or other communication technology) and enable cross discipline supervision, where permitted by the professional body.
Students ■ Enable orientation in the lead-up to placement ■ Be clear about the different roles students have on rural practice placements ■ Students should go with a particular goal or project in mind ■ Students should keep a reflective journal (with a focus on professional practice) ■ Provide opportunities for regular briefing and debriefing during the placement ■ Build in mechanisms for students to deal with situations of concern or conflict ■ Provide opportunities for students to learn about policies in rural health as well as how to advocate for change.
Education Providers ■ Integrate experiences from rural and interprofessional practice placements into the general curriculum (drive from within the curriculum).

Rural/Regional and Interprofessional Practice Placement Supports

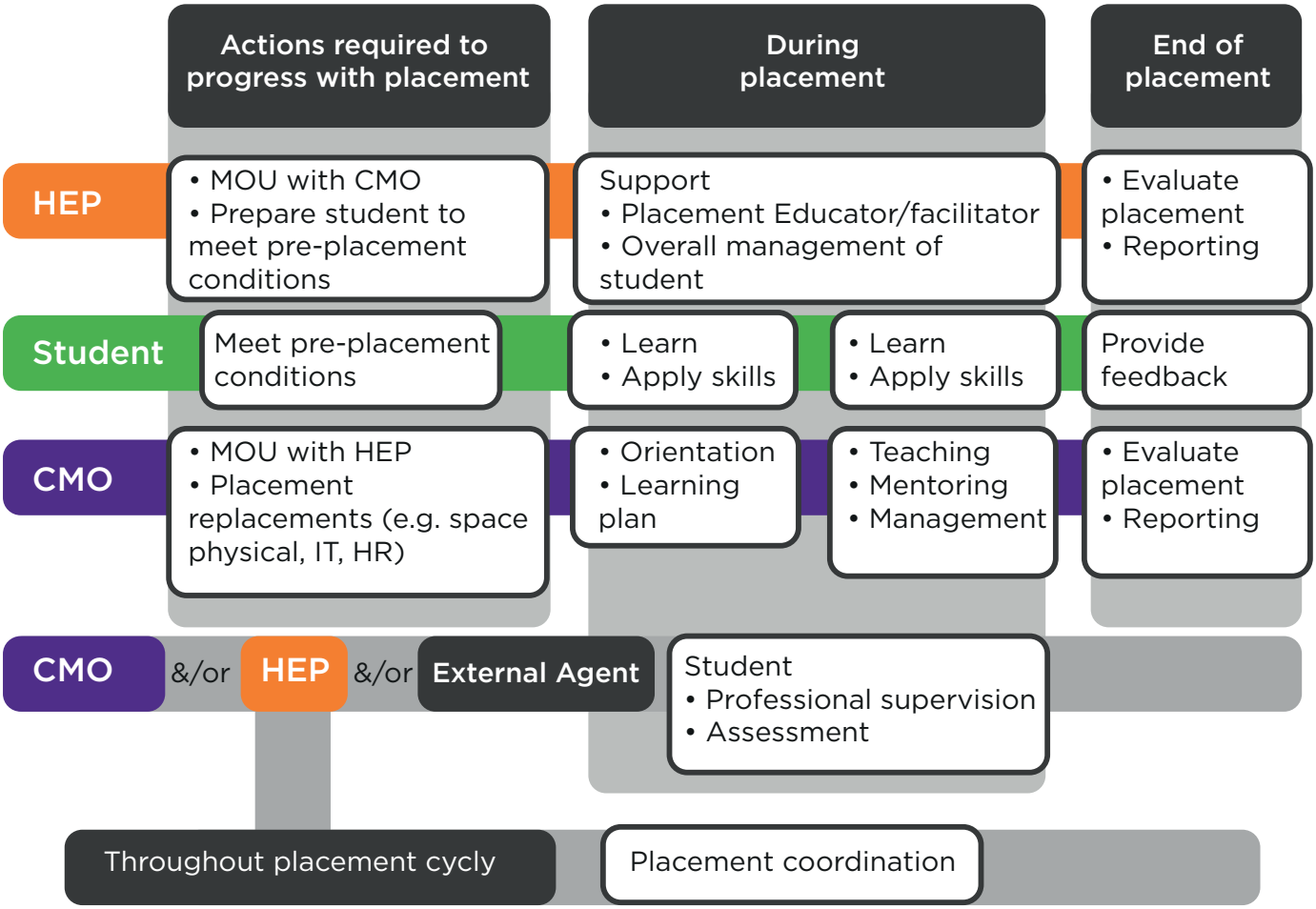
Coordination/Partnerships

- Establish and maintain community alliances and partnerships between education providers and rural CMOs
- Maintain clear and regular communication between HEPs and CMOs prior to, during and after placement
- Establish shared practice placement opportunities (e.g. coordinated between Local Health Districts (LHDs), Aboriginal Medical Services, CMOs & Medicare Locals).

Who is responsible for providing particular supports for rural practice placements?

An observation from the literature scan reveals that while solutions and essential elements are proposed, little consideration is given in regard to who is responsible for ensuring that these supports are in place. Figure 2 presents the PPP2013 scoping paper's consideration of CMO, HEP, and student responsibilities in regard to practice placements[42].

Figure 2. HEP, Student and CMO responsibilities throughout practice placement process [43]



42 MHCC 2013a
43 Adapted from MHCC 2013a

Table 3. Potential Functional Accountabilities for Student Practice Placements[44]

	Accountable party			
Function	**Student**	**CMO**	**HEP**	**External**[45] (if needed)
Placement coordination		√	√	√
Prepare student to meet pre-placement conditions			√	
Meet pre-placement conditions	√			
Prepare workplace		√		
Workplace orientation		√		
Manage student		√	√	
Develop learning plan	√	√	√	√ *e.g. external professional supervisor*[46]
Teach and facilitate learning		√	√ *e.g. facilitator supplied by HEP for nursing*	√ *e.g. external professional supervisor*
Learn professional skills and apply them to the workplace	√			
Professional supervision of student		√	√ *e.g. facilitator supplied by HEP for nursing*	√ *e.g. external professional supervisor*
Assess student	√	√	√ *e.g. facilitator supplied by HEP for nursing*	√ *e.g. external professional supervisor*

The accountabilities in Table 3, along with the supports proposed for rural/regional placements (i.e. those in Table 2), provide a basis for further discussion of accountabilities associated with supports for rural/regional practice placements in CMOs providing mental health programs.

44 MHCC 2013a, p.82

45 Examples of "external party": external professional supervisor (see note below), Key Driver, professional body, funder.

46 "External professional supervisor" refers to a professional supervisor not employed by the CMO, but is contracted specifically to provide practice placement supervision (eg, Social Work).

Table 4. Potential Functional Accountabilities for Rural/Interprofessional Practice Placements in CMOs[47]

		Potential Accountable party			
Function	*FUNCTION with emphasis on rural/ interprofessional support*	**Student**	**CMO**	**HEP**	**External** (if needed)
Placement coordination	▪ All main coordination activities		√	√	√
	▪ Establish shared practice placement opportunities			√	√
Student to meet pre-placement conditions		√		√	
Prepare workplace	▪ sufficient space for student (e.g. study/work areas, breakout rooms) ▪ internet communications/access		√		
	▪ preparation of CMO supervisors		√	√	√
Workplace orientation	▪ enable orientation in the lead-up to placement		√		
Manage student	▪ briefing/ debriefing; manage concerns, conflict		√	√	
Develop learning plan	▪ particular goal or project ▪ reflective journal	√	√	√	√ [7]
Teach, facilitate learning and assess	▪ provide opportunities for students to learn about policies in rural health/how to advocate for change	√	√	√ [8]	√ [9]
Professional supervision of student	▪ professional supervision		√	√	√ [10]
	▪ support **distant supervision** (using tele-link or other communication technology) and **enable cross discipline supervision**, where permitted by the professional body			√	
New Functions	*FUNCTION with emphasis on rural/ interprofessional support*	**Student**	**CMO**	**HEP**	**External** (if needed)
Systemic support	▪ Adequate funding, remuneration, and human resources		√		√
	▪ Promote a high degree of professional preparation for collaborative practice		√	√	√
	▪ Support CMOs in determinants of interprofessional collaboration		√	√	√
Curriculum development	▪ Integrate experiences from rural and interprofessional practice placements into the general curriculum			√	
New Functions	*FUNCTION with emphasis on rural/ interprofessional support*	**Student**	**CMO**	**HEP**	**External** (if needed)

47 MHCC 2013a, p.82
48 e.g. facilitator supplied by HEP for nursing; external professional supervisor.
49 e.g. facilitator supplied by HEP for nursing.
50 e.g. external professional supervisor.
51 e.g. facilitator supplied by HEP for nursing; external professional supervisor.

Establish and maintain relationships	Maintain clear, regular communication between HEPs and CMOs prior to, during and after placements		√	√	√
Information about community infrastructure	Suitable student residential accommodation, transport (and/ or financial support to subsidise accommodation & travel costs)				√

The functions shown in Table 4 that may be allocated to the key driver are shown below.

Recommended functions for key driver from revisiting the literature:

- placement coordination
  - all main activities
  - establish shared placements
- preparation of CMO supervisors
- systemic support
  - adequate funding, remuneration, human resources
  - professional preparation for collaborative practice
  - for CMOs in determinants of interprofessional collaboration
    - clarity of vision
    - group culture, flattened hierarchy, and effective leadership
    - clearly defined and understood roles and scope of practice
    - a person-centred approach to support; consumer education
    - c communication strategies, shared time and space
- establish and maintain relationships
- provide information about community infrastructure.

PPPE 2014 Project Learnings and the Role of Key Driver

Complexity of HEP-CMO Communications

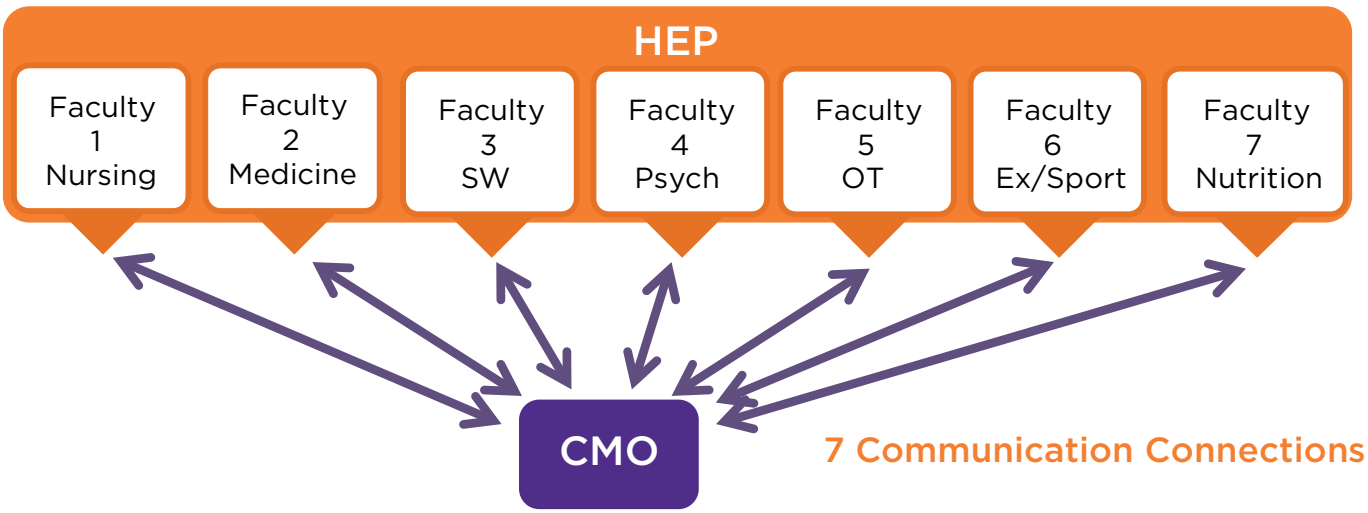
Actions for CMO/HEP pre-placement engagement and discussion

Prior to carrying out practice placements, CMOs and HEPs will be involved in pre-placement engagement and discussion activities such as:

- finding out about the other's needs and offerings
- ascertaining and establishing points of contact
- discussions to determine suitability of students for placement.
- deciding whether or not to proceed with placements
- ensuring placement agreement and insurances are in place
- clarifying placement expectations
- ensuring student information is provided to CMO
- deciding whether or not the student is accepted by the CMO for placement.

Figure 2 shows that when there is one HEP (with the 7 target disciplines) and one CMO (with one placement contact) there are seven communication connections.

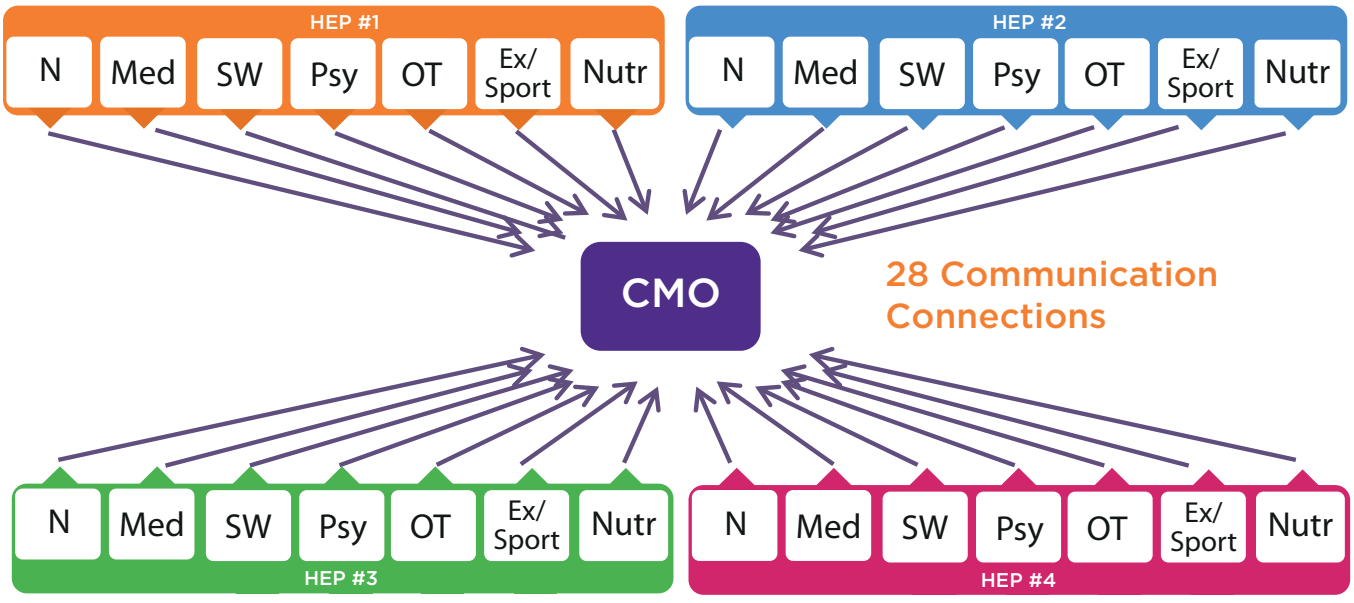
Figure 2. Faculty representatives from one HEP in direct communication with one CMO



As the number of CMOs and HEPs in direct contact increases, the communication demands on HEPs and CMOs also increase, as shown in Figures 2 and 3.

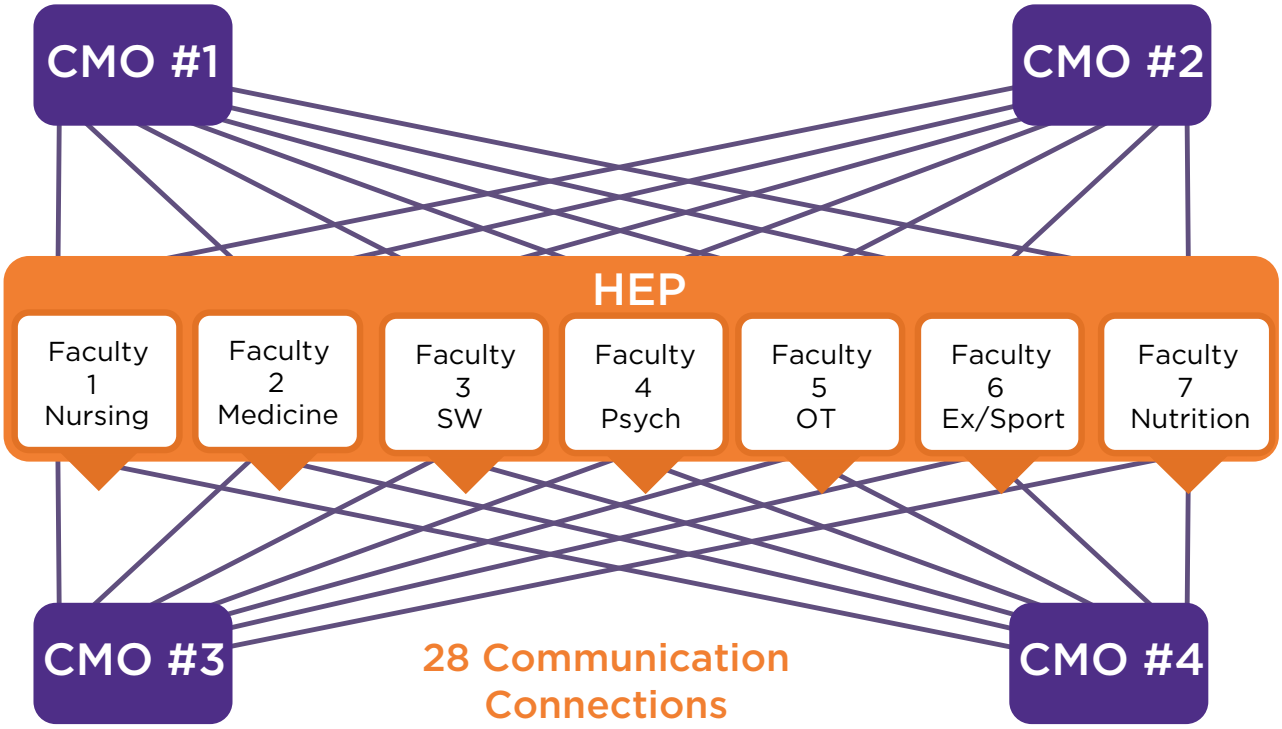
Figure 3 shows the number of connections a CMO may experience if it is approached by the target disciplines of four HEPs.

Figure 3. Four HEPs directly approach one CMO



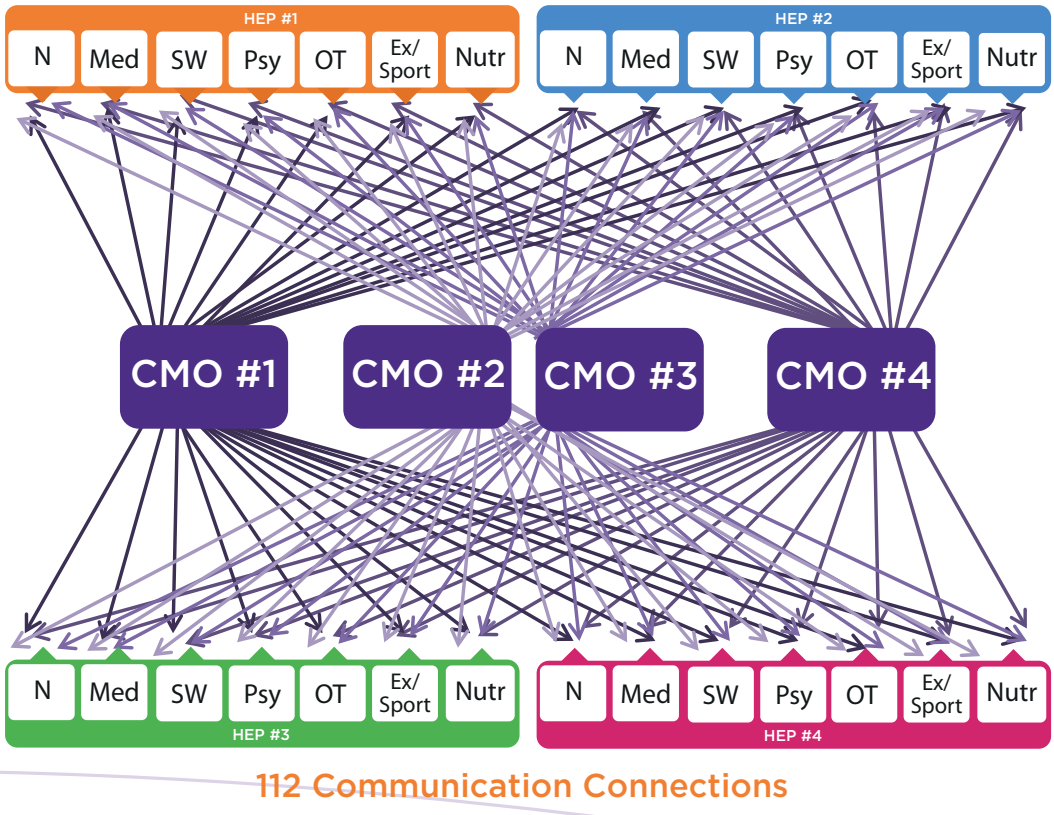
If there were several CMOs in the same geographical area as the HEP seeking students for placement, the communication demand on HEP could increase markedly as shown in Figure 4.

Figure 4. Four CMOs directly approach one HEP. 28 Communication Connections



Where four CMOs and 4 HEPs are in direct contact, there may be 112 connections occurring, as shown in Figure 5.

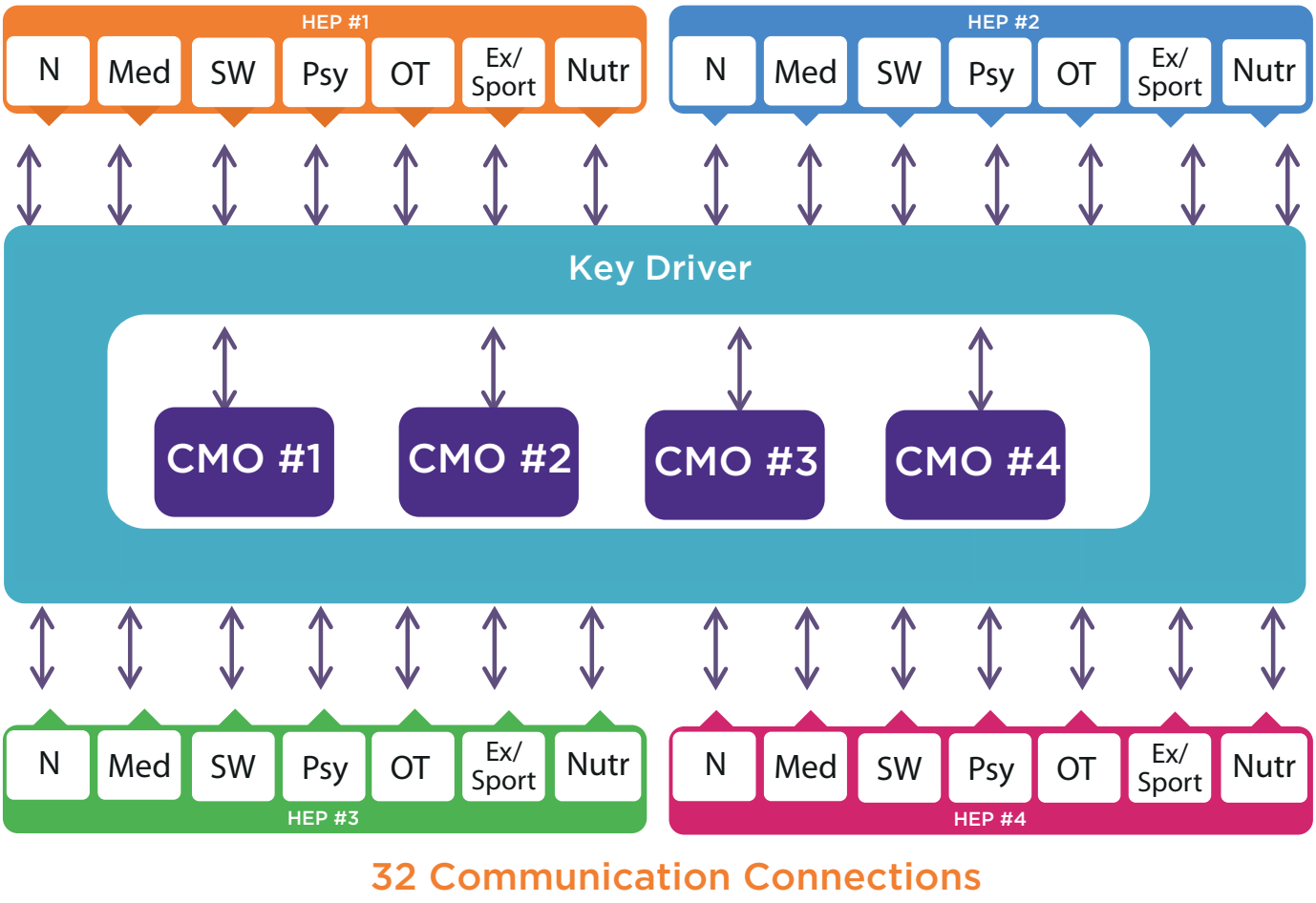
Figure 5. Four CMOs and four HEPs communicate with each other



In this case, introduction of a key driver would reduce communication demands on CMOs and HEPs by decreasing the number of connections from 112 to 32, as shown in Figure 6.

Alternatively, having one central point of communication at each HEP, who liaises with the CMO on behalf of all disciplines at that HEP, would reduce the complexity of communication between CMOs and HEPs. However, since that point of contact would need to be highly familiar with the requirements of each discipline, the complexity of communication within each HEP may markedly increase (as shown in Figure 7) [52].

Figure 6. HEP Faculty Representatives and CMOs. 32 Communication Connections



52 During implementation of PPPE 2014, the Project Coordinator was frequently directed by HEP placement (administrative) coordinators to communicate directly with other coordinators who have deeper knowledge of discipline placement requirements, supporting the notion that HEP internal communication demands may markedly increase if there is one central point of communication at each HEP.

Figure 7. Representatives from four HEPs in direct communication with four CMOs

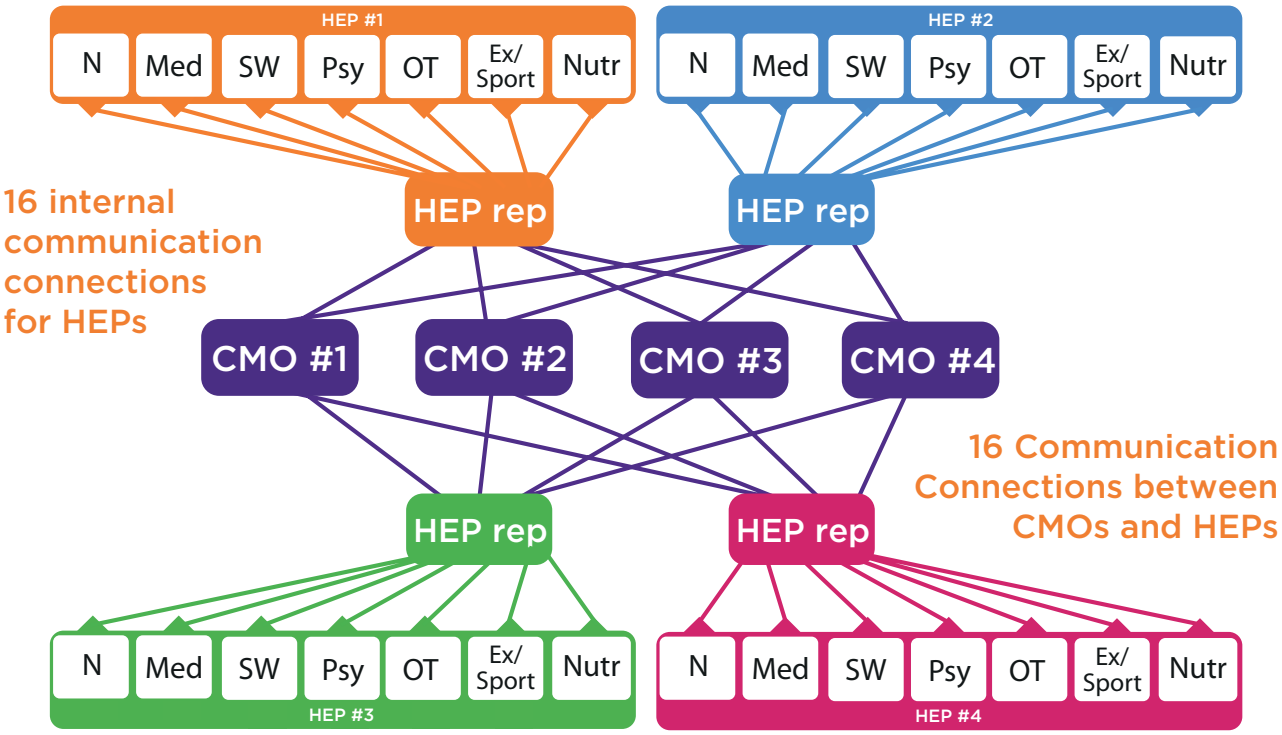


Table 5 shows the impact on the number of communication connections with a Key Driver, and with a HEP representative.

Table 5. Communication Connections between HEPs and CMOs with and without a Key Driver

CMOs	CMO contacts	HEPs	HEP contacts	Total	# connections with Key Driver (KD)			Diff	# connections with HEP Rep			Diff
				Tot C	**KD to HEP**	**KD to CMO**	**Tot KD**	**Tot KD-C**	**HR to CMO**	**HR internal**	**Tot HR**	**Tot HR- C**
1	1	1	7	7	7	1	8	1	1	7	8	1
1	1	2	14	14	14	1	15	1	2	28	30	16
1	1	3	21	21	21	1	22	1	3	63	66	45
1	1	4	28	28	28	1	29	1	4	112	116	88
2	2	1	7	14	7	2	9	-5	2	7	9	-5
2	2	2	14	28	14	2	16	-12	4	28	32	4
2	2	3	21	42	21	2	23	-19	6	63	69	27
2	2	4	28	56	28	2	30	-26	8	112	120	64
3	3	1	7	21	7	3	10	-11	3	7	10	-11
3	3	2	14	42	14	3	17	-25	6	28	34	-8
3	3	3	21	63	21	3	24	-39	9	63	72	9
3	3	4	28	84	28	3	31	-53	12	112	124	40
4	4	1	7	28	7	4	11	-17	4	7	11	-17

				Tot C	KD to HEP	KD to CMO	Tot KD	Tot KD-C	HR to CMO	HR internal	Tot HR	Tot HR- C
4	4	2	14	56	14	4	18	-38	8	28	36	-20
4	4	3	21	84	21	4	25	-59	12	63	75	-9
4	4	4	28	112	28	4	32	-80	16	112	128	16

Considering the potential complexity of communication connections (with more than one CMO and more than one HEP interacting directly), an important action for the Key Driver may be to coordinate discussion/ engagement between CMOs and HEPs.

Recommended function for key driver from PPPE Learning:

- Coordinate discussion/engagement between CMOs and HEPs

Maintaining/updating the sector Practice Placement Listing (PPL)

The Practice Placement Listing has been welcomed as a clear source of information about CMOs in NSW that are interested in hosting practice placements for students.

The 2013 Practice Placement Listing received positive feedback from HEPs in 2014, and praised as a useful and needed initiative.

- *"What a fantastic initiative!"*
- *"The CMO Practice Placement Listing looks great"*
- *"This looks quite interesting for OT."*
- *"Sounds exciting in terms of future prospects for placement and experiences for students".*
- *"This is a great initiative to link mental health services providers in to a quality placement framework"*

CMO Information

The 2013 Practice Placement Listing contained twenty-one organisations and twenty-one primary contacts. In June 2014 these twenty-one organisations were approached to ensure the primary contact details for the PPL were current. Through this process, it was found that:

- ten of the initial primary contacts had changed
- one organisation had changed its name.

HEP Information

Through the 2013 Practice Placement Project MHCC developed relationships with twenty-two contacts from sixteen faculties in three universities within the seven targeted disciplines[53]. In June 2014 these twenty-two contacts were approached to ensure their details were current, and to ascertain interest in completing a HEP Profile for the 2014 PPL. Through this process, it was found that:

- over the course of one year, around half of the contacts in CMOs and HEPs had changed
- ten of the initial twenty-two HEP contacts had changed
- one faculty was not interested in discussing or exploring practice placements in CMOs for its students.

Time-investment to update Placement Listing

If the Key Regional Driver updated the Placement Listing annually, it is likely to:

- save time for HEPs and CMOs in tracking down relevant personnel
- prevent the disincentive associated with '*it's too difficult to make contact*' from emerging, making it more likely that HEPs and CMOs can easily connect and work with each other to arrange student placements.

53 The targeted disciplines include: Medicine, Nursing, Psychology, Social Work, Occupational Therapy, Nutrition/Dietetics, and Exercise/Sports Physiology

Reconsideration of ClinConnect:

It could be argued that ClinConnect could take on the role of updating the Practice Placement Listing contact information. However, it has not yet been ascertained whether or not ClinConnect can easily interface with/support CMOs.

Recommendation from PPP 2013 Final Report:

> *" In-principle support is given for the involvement of CMOs in ClinConnect, subject to:*
>
> *a. ClinConnect functionality being able to accommodate the diverse requirements of CMOs*
>
> *b. CMOs being adequately resourced and supported to utilise ClinConnect."*

At this stage we do not know if ClinConnect functionality is able to accommodate the diverse requirements of CMOs, or what resources and supports are required for CMOs to utilise ClinConnect.

The above factors have not yet been thoroughly explored. Unless it is ascertained that ClinConnect can easily interface with/ support CMOs, maintaining/updating of the sector Practice Placement Listing (PPL) should sit with the key driver.

Recommended function for key driver from PPPE Learning:

- Maintain/update the sector Practice Placement Listing (PPL)

Recommended Functions of the key driver

The recommended functions of the key driver, drawn from the PPP 2013 Evaluation, a revisit of the literature, and PPPE 2014 learnings include:

engagement, partnership and communication

  - establish and maintain relationships (including the building of local alliances)
  - coordinate discussion/engagement between CMOs & HEPs (be the 'first point of contact' for practice placement relationships between HEPs and CMOs to reduce the communication demands on each).
- gathering and providing information
  - maintain/update the Community Sector PPL
  - information about community infrastructure in rural/regional areas
- placement coordination
  - placement coordination, including the establishment of shared placements
- systemic support for:
  - preparation of CMO supervisors/ Placement Educators
  - CMOs in determinants of interprofessional collaboration:
    - clarity of vision
    - group culture, flattened hierarchy, effective leadership
    - clearly defined and understood roles and scope of practice
    - person-centred approach to support; consumer education
    - communication strategies, shared time and space
    - advocate for CMO funding, remuneration, human resources when required
    - research
- Conduct ongoing evaluation and provide support for research to develop an evidence base about the most effective ways to:
  - increase the number and quality of practice placements
  - support practice placements in rural and regional areas.

Structure of the Key Driver

a. Potential Structure for Key Driver Functions

In order to ensure that all of the above functions are carried out, the potential structure for key driver functions requires consideration.

Although the 2013 PPP Final Report recommended that the regional driver be MHCC or a workforce development champion, the breadth of functions may require a network and/or positions within rural/regional ICTNs/LHDs, HEPs or CMOs/MHCC. An overseeing body would be required to ensure that functions are resourced, allocated for implementation, and that implementation is monitored.

Table 7 shows potential implementers for particular functions. It should be noted that this is a basis for further discussion rather than a definitive recommendation.

Table 7. Potential implementers for Key Driver functions

Key Driver Function	Potential implementers *(one to be selected to lead each function)*
Engagement, Partnership, Communication	
Establish and maintain relationships (including the building of local alliances)	CMOs (local network &/or via MHCC) HEPs ICTNs/LHDs
Coordinate discussion/engagement between CMOs & HEPs (be the 'first point of contact' for practice placement relationships between HEPs and CMOs to reduce the communication demands on each)	CMOs (local network &/or via MHCC) HEPs (one central point of contact in each HEP)
Gather and Provide information	
Maintain/update the Community Sector PPL, promote placement benefits/access to placement resources	CMOs (local network &/or via MHCC)
Provide information about community infrastructure in rural/ regional areas	
Placement Coordination	
Placement coordination, including the establishment of shared placements	CMOs (local network &/or via MHCC) HEPs ICTNs/LHDs
Systemic Support	
Preparation of CMO supervisors/Placement Educators CMOs in determinants of interprofessional collaboration ■ Clarity of vision ■ Group culture, flattened hierarchy, effective leadership ■ Clearly defined and understood roles and scope of practice ■ Person-centred approach to support; consumer education ■ Communication strategies, shared time and space	CMOs (local network &/or via MHCC), HEPs, ICTNs/LHDs CMOs (local network &/or via MHCC)
Advocate for CMO funding, remuneration, human resources when required	MHCC

Key Driver Function	Potential implementers *(one to be selected to lead each function)*
Research	
Conduct ongoing evaluation and support for research to develop an evidence base about the most effective ways to: ■ Increase the number and quality of practice placements ■ Support practice placements in rural and regional areas	HEPs CMOs (research network)

Recommendations - Key Driver

1. The key driver functions will include:

- engagement, partnership, communication
- gathering and providing information
- placement coordination
- systemic support
- research

2. Structure and funding for implementation of key driver functions will be determined and piloted in rural/regional locations.

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Links

Creating an Interprofessional Learning Environment Through Communities of Practice

http://cihc.wikispaces.com/Creating+An+Interprofessional+Learning+Environment+Through+Communities+of+Practice

Appendix 3. Excerpts from WIL and PPPE Evaluation Material

Appendix 3: Part 1. Excerpt from PPPE Evaluation Material

The PPPE 2014 evaluation indicates that the non-government community managed sector is continuing to develop its capacity to provide high quality practice placements. Evaluation activities included:

- review of Deliverables
- schedule of progress (KPIs)
- survey questions developed by the PPPE steering committee (10 CMO respondents and 25 HEP respondents)
- MHCC PPP website use

PPPE 2014 Objectives

Objective 1: Progress the establishment of higher education provider, health service and community sector relationships to increase clinical/practice placement capacity.

Objective 1 was met, with higher education provider and community sector relationships progressing well in order to increase clinical/practice placement capacity.

Supporting evidence:

- PPPE 2014 Steering Committee included higher education provider and community sector representatives
- 2015 PPL includes contributions from HEPs and CMOs, enabling each to understand each other's needs more easily
- PPPE 2014 Survey found that 80% of HEP respondents have become more willing to consider using CMOs for student placements as a result of perusing the draft 2015 PPL
- All HEP respondents rated the quality of CMO placements as being satisfactory *or better*
- 25% of CMO respondents indicated that their relationships with HEPs had improved over the previous 18 months.

Relationships are developing well. However, further support is required for relationship management to continue.

Objective 2: Strengthen community sector capacity to increase the quantity and quality of interprofessional community sector practice placements outside of Sydney.

Objective 2 was met, with community sector capacity further developed to increase the quantity and quality of interprofessional community sector practice placements outside of Sydney.

Supporting evidence:

- The PPPE 2014 Survey found that reported usage of the *Practice Placement Guide* is associated with improvement in practice placement quality in CMOs
- In regard to the 2015 Practice Placement Listing (PPL):
  - The eight new CMOs included in the 2015 PPL add significantly to the quantity of practice placements available (twenty-eight additional relevant programs in areas such as Albury, Bondi, Campsie, Central Coast, Deniliquin, Finley, Griffith, Hunter Region, Leeton, Newcastle, Orange, Redfern and Rozelle).
  - Profiles provide the opportunity for host organisations to state what types of professional and interprofessional experiences can be offered to students, and what types of activities are required by higher education providers. The presentation of succinct information by HEPs and CMOs supports preparation for placement by both parties, as well as students, ultimately contributing to better quality practice placements.
- Material from PPP 2013 and the MHCC Supervision material have been integrated into the MHCC Organisation Builder (MOB)
- There was some increase PPP in webpage views as a result of promotion, but further work needs to be done to achieve a sustained increase.
- Community sector capacity to host practice placements outside of Sydney has increased.

The next steps are to:

- focus more on interprofessional placements, as indicated by the PPPE 2014 Survey findings (there has been little discussion between CMOs and HEPs about interprofessional practice placements).
  - further promote to CMOs:
  - the benefits of hosting practice placements
- how to access and utilise practice placement resources as indicated by the webpage statistics.

Objective 3: Better understand the role of key regional drivers in increasing capacity for community sector practice placement places.

The role of key regional drivers in increasing capacity for community sector practice placement places is understood much better following consideration of information drawn from the PPP 2013 Evaluation, the literature scan, and PPPE 2014 learnings. The recommended functions of the key regional driver include:

- Engagement, partnership and communication
- Gathering and providing information
- Placement coordination
- Systemic support
- Research.

The breadth of functions may require a network and/or positions within rural/regional ICTNs/LHDs, HEPs or CMOs/MHCC. An overseeing body would be required to ensure:

- functions are resourced
- functions are allocated for implementation
- implementation is monitored.

The next steps are to determine the structure of, and to pilot the key driver in rural/regional areas for a minimum of 12-months.

Appendix 3: Part 2. WIL Evaluation Material

Analysis of community sector Teaching-On-The-Run training

- There were a total of fifteen community sector training participants
- All participants completed all six learning components of the TOTR course
- Fourteen learners rated their overall reaction to the course as 'excellent' and one rated it as 'good'
- Thirteen participants rated the presentation of the course as 'excellent' and two rated it as 'good'
- Thirteen participants rated the extent to which workshop provided useful information as 'excellent' and two rated it as 'good'
- Fourteen participants rated the extent to which course materials were useful as 'excellent' and one rated it as 'good'
- Eight participants rated the extent to which engaging with the TELL Centre Community of Practice (CoP) was useful to learning as 'excellent' and four rated it as 'good'
- The average amount of time required to complete pre-work was estimated to be 115 minutes (range is 40 to 180 minutes)
  - Ten participants said this was a reasonable amount of time for pre-preparation
  - Four participants said this was too little time for pre-preparation.
- All participants said that the workshop duration was reasonable
- Participants' average ratings before and after the workshop indicate that effectiveness, motivation and confidence to provide practice supervision increased.

Online surveys and focused discussions for the Peer Group Mentoring Framework

The findings from this evaluation of a peer group mentoring trial indicate strong endorsement by participants of the concept of peer group mentoring. Furthermore, the trial highlights a current gap in support for student supervisors and suggests that the Peer Group Mentoring Framework, if adopted by organisations, would fill this gap. Findings from the focussed discussion highlight the applicability of skills gained to other aspects of practice.

Participants particularly valued the small group mentoring sessions where they had the opportunity to experience the mentoring process and interact with their co-mentors. This is consistent with literature findings that suggest peer mentoring as a valid alternative to the traditional one-to-one mentoring (see Framework literature review for details).

Interprofessional learning was clearly evident from the trial. We suggest that implementing a cross-disciplinary peer group mentoring framework is an ideal means for developing greater understanding between disciplines, fostering an interprofessional learning culture more generally in workplaces, and ultimately improving interprofessional practice. Bringing together participants from different *sectors* (in this case, non-government community managed organisations and health sectors) further enhances the interprofessional benefits.

This trial suggests that peer group mentoring is a viable option for increasing both the capacity and quality of student supervision. Participants identified a number of areas where their supervision skills had been improved and where they were able to implement some of the strategies discussed within the peer group mentoring sessions, resulting in a perceived improved learning experience for the student and supervisor. Participants indicated their willingness to take more students as a result of participating in the trial.

The positive findings around quality of student supervision were impressive, given the short timeframe of this trial. Also impressive were the types of changes participants had implemented, or intended to implement. We anticipate that these would continue to develop with a longer program. However, it

must be recognised that the groups were at an early stage of group development for this trial. The robustness and sustainability of the model should be tested over a longer timeframe when the group development process can be fully realised.

Whilst participant numbers for this trial were small, this evaluation has highlighted areas where the framework could be improved to make its implementation more worthwhile to participants. Most of these suggestions have been incorporated into the final framework, for example running the first two large group sessions over one day.

In conclusion, this trial supports the literature that peer group mentoring is a viable means by which to develop the knowledge and skills of our student supervisors. Implementation of the Peer Group Mentoring Framework within organisations will assist in filling the current gap in this area of support for student supervisors.

Recommendations

1. Seek organisational support to run a longer pilot of the Peer Group Mentoring Framework (e.g. one year) within the public health and community managed sectors.
2. Implement a train-the-trainer program for peer mentoring group leaders.
3. Seek funding to develop and implement a research plan to rigorously evaluate the impact of the Framework on participants as well as students they supervise.
4. Disseminate findings of the trial nationally and internationally e.g. in an appropriate peer reviewed journal.

Appendix 4. MHCC's Framework for Community Managed Mental Health Sector Capacity

Elements of community managed mental health sector capacity

Consumer Experience (program range & responsiveness)

- People are informed, educated and empowered about mental health issues, and linked with needed personal mental health supports
- Accessible, relevant, well-coordinated, recovery oriented mental health programs, using evidence based supports, are available for people with mental health concerns
- Programs are provided across the spectrum of age groups, in urban, rural and remote areas, using culturally and linguistically competent and disability friendly responses
- Recovery oriented indicators of wellbeing are used to enable consumers to monitor outcomes.

Service Provision (organisational capacity)

- CMOs are strategically and operationally sound, well resourced, skilled and engaging with each other in a streamlined regulatory environment
- Community partnerships are mobilised to: identify mental health problems, develop solutions to increase wellbeing, and provide accessible, relevant, well-coordinated mental health supports
- A competent mental health support workforce is in place.

Policy and Planning (planning, funding and evaluation)

- Transparent and consistent sector planning, funding and evaluation mechanisms are in place
- Policies and plans that support individual and community mental health efforts are developed
- Evaluation of the effectiveness, accessibility, and quality of personal and population-based community managed mental health programs leads to progressive change in the sector.

Research and Development (innovation and growth)

- Transparent, consistent, sector research mechanisms are in place.
- Mental health problems and mental health stressors in the community are investigated.
- New insights and innovative methods to increase wellbeing and prevent mental health problems are researched.
- Wellbeing of the population is monitored, and community mental health problems are identified.

Appendix 5. Community Sector Practice Placement Capacity Considerations[54]

a. Consumer Experience (program range & responsiveness)	Comment	
Will practice placements contribute to (and not detract from) accessible, relevant, well-coordinated, Recovery-Oriented mental health programs?	Yes/No	

b. Service Provision (organisational capacity)		
Organisational and financial skills		Comment
■ Is the budget well-managed?	Yes/No	
■ Are contractual agreements fulfilled?	Yes/No	
■ Have insurance liabilities been considered and covered?	Yes/No	
■ Are partnerships established and mobilised for practice placements?	Yes/No	
Systems and infrastructure		Comment
■ Are policies and procedures in place for partnering, professional development and practice placements?	Yes/No	
Physical and financial assets		Comment
■ Is there enough physical space (e.g. a desk); is a computer/ phone (if needed) available?	Yes/No	
■ Are funds available for expenditure associated with practice placements?	Yes/No	
Human Resources		Comment
■ Are staff who will be supervising practice placements: • skilled and qualified? • experienced? • well-supported? • allocated time for work and students?	 Yes/No Yes/No Yes/No Yes/No	

c. Policy & Planning (planning, funding and evaluation)	Comment	
■ To support practice placements, are there: • transparent funding mechanisms? • intersectoral policies and plans?	 Yes/No Yes/No	
• *Are practice placements evaluated:* *at individual and at broader levels?* • against how they contribute to organisational goals and outcomes?	 Yes/No Yes/No	

d. Research & Development (innovation & growth)	Comment	
■ Are transparent, consistent, cross-sector research and development mechanisms in place for practice placements?	Yes/No	
■ Does research occur into new insights and innovative methods in order to increase quality and quantity of practice placements?	Yes/No	

54 MHCC Practice Placement Guide 2013, p.26

Appendix 6. Letter to the Teach, Educate, Learn, Lead (TELL) Centre

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mental health coordinating council
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28/11/2014

Faculty of Medicine, Dentistry and Health Sciences
The University of Western Australia (M500)
35 Stirling Highway
Crawley, Perth
Western Australia 6009
Email: mailto:enquiries-fmdhs@uwa.edu.au

Re: NSW Community Sector Trial of Teaching on the Run Training

To whom it may concern,

The Mental Health Coordinating Council (MHCC) is the peak body representing community sector organisations in NSW that provide services to people affected by mental health conditions. During 2014, we were funded by the NSW Health, Health Education and Training Institute (HETI), Sydney Interdisciplinary Clinical Training Network (ICTN) to undertake a community sector trial of Teaching on the Run. This activity was part of a larger project: *Work Integrated Learning (WIL) - Towards Development of a Community Sector Interprofessional Learning and Supervision Model Supervision Project* (AKA WIL Supervision Project).

This is one of three projects that HETI has funded MHCC to undertake during 2013 and 2014. The projects are about increasing the NSW community services and health industry professional entry student clinical/practice placements; with a particular emphasis on exploring and building community sector capacity building opportunities. The projects have been funded as the community sector is increasingly recognised for its important contributions to the development of the health workforce.

For this project our partners were the Centre for Education and Workforce Development (part of Sydney Local Health District) and the University of Sydney (Work Integrated Learning, Faculty of Health Sciences). MHCC is writing today to provide you with some feedback on the community sector trial as this was an agreed action of our project Reference Group.

Firstly, the community sector trial was not large, however, the opportunity to strengthen their student supervision skills was greatly valued by participants. You will have earlier this year received the standard pre and post-training evaluation spreadsheet data and this is repeated here as Attachment 1. This includes some additional items that were relevant to the 'fit' of the Teaching on the Run (ToTR) training product to community sector mental health settings. Overall, 10 of the 12 TOTR participants rated the community sector 'fit' of TOTR as 'Very Good' to 'Excellent. Importantly, participants experienced an increase in their confidence to teach and supervise effectively.

MHCC wishes to thank you for providing our partner SLHD/CEWD with permissions earlier this year to make some basic contextualisations to the course handouts and PowerPoints for use with the community sector trial. These were quite minimal and included, for example, changing the work 'clinical' to 'practice' and 'patient' to 'person' or 'client', etc.. Participant feedback, including that of

community sector representatives to our project Reference Group, is that further contextualisations of the resource would even further improve community sector 'fit' if the product were to be further promoted to community sector organisations in the future. The most common feedback provided to us was for further refinements to the language used across the training resources to be more person-focused and non-clinical, or medical model, in its orientation. Participants and community sector Reference Group members also wanted to see video and vignettes (ie, 'case' studies) that are based on the actual experiences of community sector workers with regard to practice/service delivery orientation. Other feedback was for TOTR facilitators delivering the course to community sector participants to be from the community sector.

The nature of these contextualisations would be to ensure a social model of health and community care (ie, as opposed to a medical model). This was felt to be important given what we now about the social determinants of health and increasing policy directions to provide preventative and community-based care. We would be more than happy to discuss this feedback further with you should an opportunity arise.

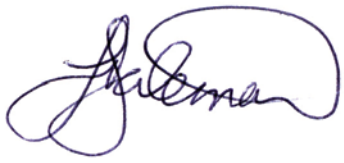
Some community sector participants also provided feedback that the skills they had learned had been transferable to their supervision of existing staff. During the course of the project we became aware that the TELL Centre has developed a new one day 'clinical supervision' course that targets supervisors of existing staff. The NSW community managed mental health sector has expressed a high level of interest to trial that product in 2015. A product that focuses on enhancing supervisory practice within community sector organisations would also help to build skills transferable to student placements.

We thank you for the opportunity to trial TOTR in the community sector and to provide feedback about the trial. Should you wish to discuss this feedback please contact:

Tina Smith, MHCC (Chair, WIL Supervision Project Reference Group): tina@mhcc.org.au

Again, we greatly appreciate the support of both yourselves and the SLHD/CEWD in facilitating the community sector trial of ToTR in NSW.

Regards,



Jenna Bateman,

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