Chapter 8: Discussion and conclusions

Strengths and limitations of the evaluation

The current evaluation had a number of strengths, not the least of which was the fact that it was largely developed alongside the MHPN project, in collaboration with MHPN. It drew on information from a number of evaluation components; some relied on routinely-collected data and others were purpose-designed for the evaluation. This recourse to different data sources and methodologies allowed for the triangulation of findings, and engendered confidence in the conclusions that could be drawn from them.

Having said this, some of the data sources were more reliable than others. For example, some of the routinely-collected data relied on systems that 'went down' on occasion, resulting in periods where data were missing. Similarly, some of the purpose-designed surveys had sub-optimal response rates (e.g., the mental health professionals' 14-week follow-up survey). In some of these cases, certain biases may have been introduced (e.g., if those who chose to participate had particularly positive or negative views). In addition, some data were arguably collected too early, before an appropriate establishment period for the relevant activity had elapsed (e.g., the MHPN web portal survey).

Summarising MHPN's achievements against its stated objectives

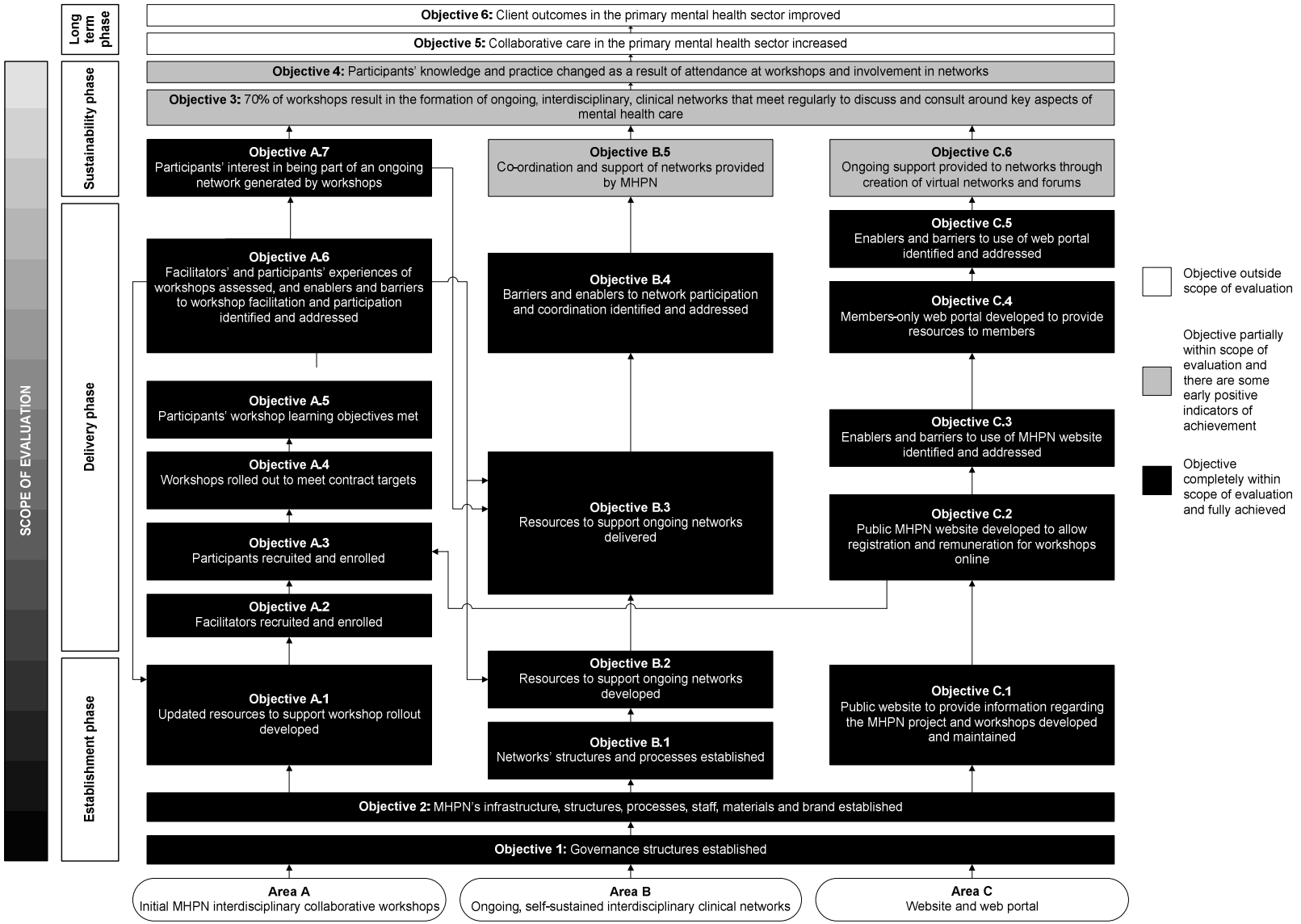
Figure 4 provides a summary of the extent to which MHPN has achieved the objectives outlined in its program logic. MHPN's lower-level objectives (relating to the establishment of structure and processes) have been completely achieved. It has established governance structures that are working well, has put in place appropriate infrastructure and personnel, and has developed a range of processes and physical resources to support its endeavours. It has also worked hard to market its activities to mental health professionals around Australia.

The majority of MHPN's intermediate-level objectives (relating to the delivery of workshops and sustainability of networks) across its three main areas of activity have also been completely achieved. It successfully developed and ran an ambitious series of initial workshops which reached a significant number of mental health professionals from a range of disciplines who were working across the country in both urban and rural locations. The workshops were received positively by participants and generated considerable interest in the formation of ongoing, self-sustained, interdisciplinary clinical networks. MHPN established structures and processes to foster these networks, and developed and delivered resources to assist them in their establishment phase. MHPN also developed and maintained a public website to market and manage the workshops, and a members-only web portal to support within-network communication and collaboration. Across all of these areas of activity, MHPN worked hard to identify and address barriers and enablers to success.

Because MHPN was only moving into its sustainability phase at the time the evaluation ended, its remaining intermediate-level objectives were only partially within the scope of the evaluation. Nonetheless, there are early signs that MHPN is making inroads in terms of achieving these objectives. It has begun to provide co-ordination and support for emerging networks, including virtual support via MHPN Online. As yet, the networks are in their early developmental stages but there are indicators that a reasonable proportion of them will continue to evolve and grow. There are also indicators that participation in the workshops and membership of these emerging networks are leading to some improvements in mental health professionals' interdisciplinary knowledge and collaborative practice.

Assessment of the achievement of the highest level objectives in the hierarchy (relating to MHPN's purpose and overarching aims) was beyond the scope of the evaluation. It was not possible to assess whether collaborative care practices have changed in primary mental health care, nor whether client outcomes have improved. Such cultural and systemic change is difficult to measure, although there might be possibilities for doing so in future by using existing provider-based and client-based data collections as baseline information and repeating these data collections to examine change (e.g., a quantitative survey of providers' practices conducted as part of the environmental scan[1] that preceded the development of MHPN).

Figure 4: Achievement of objectives in the hierarchy



Understanding MHPN's achievements

MHPN's workshops were highly successful by any standard. MHPN ran almost 1,200 initial workshops, yielding 14,993 attendances by 11,930 unique individuals. This clearly represents a sizeable proportion of the mental health workforce, although the exact figure is difficult to quantify.[9] As intended, more than 30% of these workshops were conducted in rural areas. Although the average number of registrations at each workshop fell slightly short of the desired 20, there was a good mix of professionals at each group with 92% having representation from at least three types of mental health professionals. Forty two per cent of workshops met their target of four general practitioners in attendance. Workshop participants were positive about the delivery and content of the workshops and, more importantly, the workshops generated participants' interest in becoming part of interdisciplinary networks.

Through the workshops, MHPN has made inroads into establishing local networks of mental health professionals who can meet to share experiences, exchange interdisciplinary perspectives, learn from each other and develop potential collaborative working relationships. Four fifths of the workshops have resulted in the formation of ongoing, interdisciplinary networks of local providers, and MHPN is now supporting these networks in a range of innovative ways to encourage them to reach their full potential. MHPN has achieved its ambitious target of 70% of its workshops resulting in the formation of ongoing, interdisciplinary, clinical networks, and has done so in a relatively short space of time.

It is worth considering why the workshops and the networks that have emerged from them have been so well-received. One of the reasons probably relates to MHPN's systematic approach. MHPN's graded, flexible and supportive approach that involved conducting the three inter-locking areas of activity (running workshops, fostering networks and providing online support) over four distinct phases (establishment, delivery, sustainability, long-term) has worked well. Identifying barriers and enablers and modifying elements of the project accordingly was also a strength.

Another key reason may relate more to the 'climate' within which MHPN was introduced. MHPN's efforts began at a time when there was an increasing recognition of the potential benefits (both for providers and consumers) of interdisciplinary collaboration but there were few formal avenues through which such collaboration was being encouraged. Mental health professionals were keen for better collaboration with their peers. With the introduction of Better Access, new players (e.g., psychologists, social workers and occupational therapists) were emerging in far greater numbers in the primary mental health sector. For these providers to offer optimal care to their clients, they needed to have good working relationships with others from whom they might receive referrals and/or with whom they might provide shared care. At a more basic level, they needed to 'come to grips' with how these other professionals operated. The same imperative existed for

[9] This difficulty arises because the appropriate denominator is hard to calculate. The Costing Information Analysis Section of the Department of Health and Ageing provided the CHPPE evaluation team with denominator data on providers who were registered to provide relevant services in the twelve months prior to the end of data collection (e.g., psychologists who were registered to provide Better Access services; mental health nurses who had registered for the Mental Health Nurse Incentive Program (MHNIP)). However, these figures represented an underestimate because MHPN encouraged attendance at workshops by those who were not registered to provide these services in order to encourage collaboration more broadly. This created the potential for individuals to be represented in the numerator (because they had attended a MHPN workshop) but not in the denominator (because they were not registered to provide relevant services). For this reason, the proportions of each provider group who attended MHPN workshops are not presented here.

medical providers (e.g., general practitioners and psychiatrists) although arguably Better Access had less of an impact for them because their provision of mental health care services already attracted a Medicare rebate.

Where to from here?

Despite its achievements, MHPN has, as yet, really only had the opportunity to 'scratch the surface' in terms of promoting interdisciplinary collaboration. It has achieved its project deliverables within the relatively short allotted timeframe; however, because of the complexities of creating ongoing interdisciplinary networks, a longer period is necessary to allow these networks to develop and flourish. Networks are complex, evolving entities and are not yet fully understood. Many have not yet met, and it is likely that their membership may be quite fluid until their purpose and approach are more clearly defined. There are many workshop attendees who have yet to be convinced about the benefits of networking; they are not actively opposed to it but have, so far, not found a network to which they feel that they belong. Even those networks that have met have not generally yet had time to establish themselves as fully functional entities. MHPN's role in supporting these networks at the various stages in their evolution over the coming twelve months and beyond is likely to be crucial to their success. In addition, it will be important for MHPN to monitor workshops from which no networks have emerged to date, in order to ascertain their potential.

In performing these support activities, MHPN will need to set priorities, recognising that these priorities may change as more becomes known about the way networks operate and the relationships on which they are based. For example, MHPN should consider how to prioritise the three scenarios outlined above: the situation in which networks are 'up and running' and holding meetings; the situation in which networks are in a fledgling state and have not yet become sufficiently organised or mobilised sufficient interest to meet; and the situation in which a workshop group has not spawned any network activity. Early on, equal attention might be given to all three scenarios, on the basis that it is likely that weaker networks can be strengthened and additional networks can be formed, but that this shouldn't occur at the expense of networks that have already begun to flourish. As time passes, however, it might be sensible to invest most heavily in networks that are demonstrating effectiveness, on the grounds that there is likely to be a point at which only diminishing returns will be realised.

Some of the barriers to networking identified in the current evaluation can be regarded as start-up issues that are likely to reduce over time; others are more likely to be longer term impediments. The latter will need to be approached in innovative ways if they are to be overcome. For example, the time required to participate in networking activities is clearly an impediment for many. This is likely to remain an issue, given that MHPN's target group primarily comprises mental health professionals who are operating on a fee-for-service basis and for whom attendance at network meetings may involve forfeiting income. In addition to encouraging mental health professionals to understand that the benefits of networking may outweigh any perceived costs, MHPN will need to consider ways to help offset these costs. It would not be realistic to recommend that MHPN should be funded to recompense mental health professionals for their time spent on networking activities, but there might be other forms of incentives that could be considered. One option might be for MHPN to provide networks with some level of financial support (over and above the existing $500 payment) that is tied to their bringing in expert speakers. Another option might be continuing professional development points. MHPN is well-placed to pursue this, given its relationship with the major professional bodies that represent the key disciplinary groups targeted by MHPN; the recent move to national registration for these groups also presents opportunities in this regard (e.g., by mandating that mental health professionals accrue a certain number of professional development points within a given time period).

Some of the issues faced by MHPN in assisting networks to take root and grow are within its control and others are beyond its influence. For example, MHPN can do a lot with respect to helping networks clarify their own

goals and working with them to develop a program of meetings that are likely to meet these goals. However, MHPN will have less control over some of the more nuanced factors that promote or inhibit network activity, such as whether there are pre-existing tensions within or between disciplinary groups in a local area, whether or not the initial workshop members 'get on', and whether there is someone who has the respect of workshop members and is keen to take on the role of network co-ordinator. Having said this, MHPN may still be able to use clever approaches to overcome some of these barriers. For example, the fact that so many of the existing networks have developed from a combination of workshop groups suggests that members engage in some 'shuffling around' before settling on a group with whom they want to form an ongoing relationship. There may be ways that MHPN can assist individuals to make contact with those from other workshop groups in order to facilitate networking. MHPN Online may be particularly helpful here.

In order for MHPN to address many of these issues, the overall purpose of MHPN as it continues its sustainability phase will need to be further clarified. In part, this will involve explicating the way in which networking is expected to improve collaborative care and consumer outcomes. It will also involve determining whether the desired impact is for MHPN to produce self-sustaining networks, or whether there is an ongoing expectation that MHPN will need to continue to be involved in facilitating the networking process for it to flourish. Clarifying these issues will provide a conceptual framework within which MHPN Network Sustainability Project Officers and Senior Project Officers can provide visionary leadership and practical advice to network co-ordinators and members.

There is a good case for the continuation of MHPN. The emerging networks are not yet sustainable and further support from MHPN is necessary for them to 'stand on their own two feet'. The current lack of certainty about MHPN's future may be hindering its momentum and hampering its ability to plan for the future. This in turn may be creating a sense of uncertainty among network members, and jeopardising the development of a shared vision. MHPN should concentrate its immediate efforts on consolidating existing membership of existing networks, but ultimately it might expand its activities to creating bigger and more numerous networks, possibly with a broader mix of private and public mental health professionals. It should explore different models, systems and processes of networking that may work best in particular circumstances. It should also continue to develop and implement MHPN Online as a tool to keep mental health professionals engaged. Paid network/and or regional co-ordinators will also be necessary if the emerging networks are to avoid floundering.

Recommendations

- Ongoing support should be provided for MHPN in order to capitalise on its early successes in creating ongoing, interdisciplinary, clinical networks that meet regularly to discuss and consult around key aspects of mental health care.

- Careful consideration should be given to the definition and purpose of networks, in order to promote a shared understanding with respect to their ongoing directions. This will involve articulating their role in improving collaborative care and consumer outcomes, and determining whether there is an expectation that networks will ultimately become self-sustaining or will continue to require support from MHPN in the longer term.

- MHPN should continue to provide clear vision and practical support to networks at all stages of their development, but ultimately it will have to prioritise where it invests its largest efforts. At some point, it is likely that the greatest returns will accrue from focussing attention on networks that are 'up and running' and holding regular meetings.

- MHPN should make a concerted effort to reduce identified impediments to networking, particularly those which are likely to remain problematic in the long term (e.g., lack of time on the part of busy mental health professionals). Some of these will need to be addressed by innovative approaches which might include providing funding for expert speakers who might act as drawcards, and offering continuing professional development points. Different strategies may be required for different professional groups.

- MHPN should assist networks to identify co-ordinators with leadership potential, and should encourage workshop facilitators to take on the role. It should continue to provide support to network co-ordinators, which might include reimbursement for their time, administrative support, and skills development. It might also include communication about the various models of co-ordination that are being employed by different networks, including joint co-ordination and rotating rosters. In addition, it might include opportunities for network co-ordinators to come together to plan regional strategies for network activities.

- MHPN should continue to communicate regularly with existing and potential networks, delivering consistent messages about networking. This communication should not be prescriptive, and should recognise that individual networks will require the flexibility to tailor their activities to the expressed needs of their constituent members. At the same time, however, MHPN should offer insights from its growing body of knowledge on networking.

- MHPN should continue to foster communication between mental health professionals, including not only those who have already joined a network but also those who have not yet found a network to which they wish to belong. MHPN Online should be the cornerstone of these communication activities, but other forms of communication may also be required.

- Emphasis should be given to the ongoing evaluation of networks once the definitional issues surrounding networks are further refined. The evaluation approach should draw a range of data sources, and should aim to not only quantify the number of networks and the number of network members, but also to characterise the quality of the networking experience for participants and to consider the impacts of networking on collaboration and consumer outcomes. Consideration should be given to whether there are ways of maximising the comprehensiveness of data from sources like the network master list dataset and the network attendance dataset (e.g., by maximising their utility as tracking tools for individual networks). Consideration should also be given to what additional data sources would be of value in monitoring the progress of networks. It is likely that additional one-off surveys and focus groups will be important to examine the experiences of networking from the perspective of key stakeholders.

Conclusions

MHPN has successfully undertaken an ambitious project designed to promote interdisciplinary networking. Few comparable initiatives have been conducted in mental health; most international efforts designed to promote good collaboration and communication between different groups of primary mental health care providers have been much smaller in scale.[16]

MHPN's efforts have resulted in the early emergence of a substantial number of local networks, and there are signs that mental health professionals' behaviour is changing, but further support will be needed for these networks to reach their full potential. Several factors may assist these emerging networks to fulfill their potential in terms of improving collaborative care and consumer outcomes. MHPN will need to be clear about

the purpose of these networks, and communicate this vision to mental health professionals in general and network members in particular. MHPN will also need to provide guidance about what a sustainable network might look like, bearing in mind that different networking models may be appropriate in different locations or for different mixes of professional groups. In addition, MHPN will need to be clear about the level of support it can and should offer. The initial workshops acted as a catalyst to the formation of networks, and resources like the web portal are proving invaluable. MHPN will definitely need to continue to provide leadership and input, but a careful balance will need to be struck if the emerging networks are to become self-sustaining.

MHPN is a lynchpin of the Better Access initiative. As noted in Chapter 1, the Better Access initiative aims to improve outcomes for people with mental disorders by encouraging an interdisciplinary approach to their mental health care. The Medicare item numbers go some way to doing this by increasing the range of mental health care professionals that consumers can readily access, but, arguably, without MHPN, these providers would be operating in relative isolation. Through MHPN, substantial numbers of mental health professionals have been exposed to each other. At the most basic level, this has meant that professionals from one discipline have met professionals from another discipline. At a more complex level, this has meant that these mental health professionals have been exposed to others' treatment perspectives, skills and ways of operating. This exposure has increased mental health professionals' understanding of each other, and increased their likelihood of providing collaborative care and achieving positive outcomes for consumers.