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Addendum:
Responding to the Royal Commission into Victoria's Mental Health System

The voice of Alfred Health's Mental Health workforce

July 2019

theAlfred
Caulfield HOSPITAL
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1. Background

Through its terms of reference, the Royal Commission recognised that engagement from the mental health workforce was vital in identifying opportunities to respond to current pressure points and improve Victoria's mental health system.

Working within this spirit, Alfred Health encouraged staff involvement, whether by attending the public consultations, making individual submissions; or contributing to the development of our health service's official response.

Though May and June we explored the views of our 480-strong mental health workforce. We held four workshops and published an online survey that probed six key themes:

1. **Better ideas for better outcomes** – service innovation, evidence-based care, genuine alternatives that involve families and carers
2. **Our partnerships in care** – mental health partner integration, including those in the tertiary, academic, forensic and community sectors
3. **Our people** – attracting, recruiting and retaining a trained and competent workforce
4. **Our physical environment** – infrastructure and buildings and the need to design facilities that are safe and therapeutic
5. **Compliance** – governance and oversight requirements
6. **Our data and research** – how to develop a culture of improvement and research in Victoria's Mental Health System

Over 130 staff participated directly.

The insights, challenges and potential solutions identified during this consultation are captured by theme in the following pages.

Not all the views discussed in this addendum are explored in our official submission. And not all views are held by the health service.

Importantly, these are the voices and opinions of our staff, coming directly from their own personal experiences.

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2. Themes: Better ideas for better outcomes

Exploring service innovation, evidence-based care, genuine alternatives that involve families and carers

The overarching concerns of participants centred on the rising demands for mental health services, the increasing complexity of patients' health problems, and drug and/or alcohol issues accompanying mental illness becoming more prevalent in our community.

There is a focus on making the patient 'fit' within the system, rather than delivering care that meets the patient's ongoing mental health needs.

"[We need to] move away from an acute/bed based model of care. Change the risk-averse mental health culture to one that promotes therapeutic risk taking."

"Focus on compassionate care and have clients lead the processes. At present service KPIs, structures and processes direct the interventions. These can stifle innovation, responsiveness and creativity."

"We focus too much on the behaviours that we see and blame an individual for these behaviours rather than consider the context the person exists in or is experiencing. People do not exist in isolation or as separate in their health, and yet as a tertiary hospital we separate the mental health from physical. Physical focused treatment streams feel unable to respond to mental distress and vice versa in mental health."

With a finite number of available beds, patients are being discharged early and this is reflected in re-admission rates. This approach is compounded by low awareness or understanding by patients, families, carers and the community of the mental health system and how to navigate available services.

"[We need] less focus on the emergency department times to get patients up to the wards and essentially 'pushing' discharges out of the door or making those patients sit in the corridor waiting for their medications, etc. In my experience it makes the patient feel lost and unimportant."

"[We must] provide consumers with what they identify as important to them and their loved ones. True multidisciplinary care which is not driven by a medical model."

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Adult Discovery Colleges and co-location of services

Alfred Health partners with headspace to deliver Discovery College, a youth-focused Recovery College born of our relationship with Headspace. Launched in May 2016, it is now based at four campuses (Bentleigh, Frankston, Narre Warren and Dandenong), with courses also offered in community-based venues across south-east Melbourne.

Over 150 students have participated in more than 30 separate courses. Participants include young people (aged 12–25), their friends and family members, and professionals working in numerous fields. Discovery College is a place where there is an educational approach to help people with mental health challenges. All courses are co-produced, co-delivered and co-received by people who are experts by experience and experts by profession in equal partnership.

There is nothing comparable in the adult mental health space, staff noted, that gives people a place to go to and integrates care over extended periods. Similarly, there is no service that improves people's literacy, skills, self-management capacity, and can support the search for meaningful daily contact.

There was a strong view expressed that this could be expanded for greater impact. Youth Discovery Colleges could be replicated into adult care spaces, drawing on experience with Headspace to expand into the adult space.

Not only is this an effective means of intervention it also is a proven way of embedding recovery values and attitudes throughout an organisation, they noted. In the United Kingdom, the Discovery College model for young people has been successfully expanded to the adult and aged sector of mental health.

They also felt headspace could be expanded into the older adult sphere. Alfred Health has been working with headspace since 2006. We have had positive developments, significant innovations in child and youth mental health and headspace that show the potential of what national brand identity and investment can achieve in the community. We could do more of this in the adult space. Alfred Health could become a centre of excellence in this regard, participants said.

It was noted that co-locating services should be explored. This may include vocational training, mental health services, and primary care solutions in one place. Participants also discussed whether to introduce enhanced emergency department services with a community hub alongside to deal with walk-ins.

"Set up wellness centres that treat biological, psychological and social aspects of wellbeing."

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Expand specialist teams

Staff discussed the idea of the early discharge model, as a step-down process. They noted that The Alfred has a number of teams which could have system-wide impact if adequately resourced. These include the Crisis Assessment and Treatment Team (CATT), the Hospital Outreach Post-suicidal Engagement (HOPE) team and the Mobile Support and Treatment Team (MSTT).

Alfred Health's MSTT and Homeless Outreach Psychiatry Program (HOPP) could be more effectively used as platforms for social integration, family support and relationship recovery, and the coordination of early intervention and prevention health services.

It was widely agreed that the CATT outreach program could be expanded and returned to its original function, including multidisciplinary teams in the community. We need a multidisciplinary team that can look after patients in the first two to four weeks after hospital, staff noted. Navigating the role of a service like CATT is critical in the aftercare period.

The original Police, Ambulance and Clinical Early Response (PACER) program allowed for joint crisis response from mental health clinicians and police attending people experiencing a behavioural issue in the community. Staff considered how to support this program to improve responses to people experiencing crisis in the community.

Alfred Health set up a HOPE suicide prevention team 18 months ago and this is already demonstrating good results as a post-suicidal assertive outreach program. Alfred Health was one of six services funded as a pilot and it is currently located at the St Kilda Road Clinic. It was agreed that this service should be expanded.

Drug and alcohol addiction

Psychological rehabilitation is very different to drug and alcohol addiction treatment, participants said. To accommodate dual diagnoses, we need better integration with services that already exist, as dual treatment options for addiction and mental health issues are currently limited.

"Drug and alcohol use and abuse requires a different facility that caters for withdrawal, education, rehabilitation."

Participants noted variation across the states. New South Wales has four times the number of detox beds than Victoria. Western Health has a ward specifically for the treatment of detoxing and drug and alcohol crisis care, alongside treatment for other mental health disorders. Queensland Health has done work on this and has integrated addiction and mental health services.

High-risk patients and behavioural management

There is a need for a state-wide intensive care model and purpose-built facility with a high level of security and state-of-the-art service options to cater for high risk vulnerable patients,

patients with intellectual disabilities, and civil forensic patients. The system needs many more gazetted beds.

There should be consideration of whether behavioural management hubs for low to moderate risk clients, who do not require complex medical interventions, have a role to play in providing patients with an alternative to emergency departments.

Participants stated it would help if a state-wide centre for excellence in ICU were created. This would focus on high risk or vulnerable forensic care and incorporate intellectual disability and behavioural management treatment capability, given the growth in personality disorders.

"I work in rehab and we continue to see a rise in patients we are treating that have mental health conditions. While we have the skills to rehab these patients physically and get them back to optimal recovery, we often lack the understanding of how to deal with the mental health aspect. This can often be frustrating from clinician and patient point of view.

"The roaming psych team can be of great help but they are only consulting and don't necessarily understand the full impact these conditions can have on staff that are not adequately trained for this sort of behaviour/condition management.

"And unfortunately the psych units are not equipped to take on patients that have physical issues so we have an inherent gap between how we treat physical and mental health and therefore how we treat the patient holistically and optimally (i.e. both mental and physical at the same time)."

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3. Themes: Our partnerships in care

Exploring mental health partner integration, including those in the tertiary, academic, forensic and community sectors

Staff agreed that on discharge, our patients continue to experience severe social disadvantage through poverty, social isolation, and limited access to appropriate housing, high unemployment, and exposure to violence and poor physical health outcomes.

Alfred Health's partners represent a broad range of healthcare, government, research, not-for-profit and community support organisations. Through these partners, Alfred Health seeks to extend the level of patient care from their acute stay through to their ongoing treatment in the community.

Many of our inpatients are of no fixed address and when they leave hospital, there is a need to create a sense of connection and help them navigate the system and attend the services available to them.

This service environment is fragmented, disparate, complex and offers varying degrees of service delivery, staff noted. It has a multitude of players that range from not-for-profits and NDIS-funded providers, through to private services and passionate individuals or organisations delivering programs that people do not know how to access. Or they experience delays accessing, or the programs are not of a scale to support community need.

The model we have does not translate well into supporting patients with social challenges like housing, family, vocational support, etc. Staff considered how the psycho-social support component was split off and allocated to the non-government organisation sector when mental health was de-institutionalised. The consequence of this is that the two elements now operate in isolation. Hospitals focus on those coming into acute care, the psycho-social focus is on those engaged with community programs – and there is no overlap whatsoever.

Forensic partnerships

Staff were concerned that the current system of forensic mental health care provides a centralised specialist forensic mental health service with limited capacity and with an orientation to serving the justice and corrections systems.

Adult mental health hubs are a great model and public mental health services should be funded to manage them, they said. The issue of governance is critical. headspace has struggled for this reason – it's set up well but other outreach agencies aren't set up/integrated so well and that creates complexity and barriers. Partnerships should be fuelled by investment.

Staff noted the need to work more closely with Youth Justice in forensic partnerships. They have been historically isolated from mental health services. There is a resistance and lack of understanding about mental health issues for young people and they are not provided with appropriate care.

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> *"DHHS, DOJ, Department of Education and so on need to stop working in silos. Change needs to occur from top down as this would improve partnerships and collaboration on the ground as well. Private needs to work closer with public, and federal and state funded [services] need to connect. It is all too messy at present."*

There is a need for greater information sharing between hospitals, general practitioners, police, Ambulance Victoria and justice partners to close the gaps. A better model could be developed with Victoria Police as well, to extend PACER. There is a need to expand and invest in this program, some participants said.

Thomas Embling Hospital and Ravenhall Correctional Centre, and similar facilities, contribute to a disconnection between mental health and drug and alcohol addiction treatment and incarceration, which is to the detriment of patients. Staff said more gazetted beds are required to ensure continuity of treatment when patients are transferred between these locations.

Primary partnerships

Participants were clear that hub-based models with Alfred Health at the centre, that encompass services such as vocational learning and housing, are key to enhancing the system. They create multiple reasons for clients to engage and visit the hubs, and can help maintain and build connections after being discharged from hospital.

They considered how to restructure relationships to provide opportunities for catchment-based, non-clinical mental health services, to participate in activities driven by Alfred Health e.g. educational and co-design forums.

One strong requirement would be better partnerships to provide better support for younger patients transitioning to the adult mental health service as there are different systems for different age groups.

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4. Themes: Our people

Exploring how attracting, recruiting and retaining a trained and competent workforce.

There is a general consensus across the sector that Victoria's mental health system is under significant strain. The demand for mental health services has grown exponentially in the past ten years. At the same time, staff noted that significant structural and environmental factors affected the ability to access a workforce that is trained to deliver the evidence-based therapies and effective models of care.

Staff believed the areas for greatest for improvement are the attraction of suitably qualified graduates and the retention of senior staff who see limited options and opportunities for leadership development. This is further exacerbated by a prevailing negative perception of the mental health services as a place to work, a generally poor working environment, and the real and growing threat to the physical and psychological welfare of staff.

Training and qualifications

The mental health system is increasingly seeing new graduates and candidates for junior positions presenting with limited skills and experience that is specific to the sector, participants stated. This is due to the underlying standard of the under-graduate degree curriculum. Mental health units are often electives or specialist subjects so there is no requirement to get even a basic grounding in the area.

"[More] Mental health nurse specific training, not just a few sessions during undergrad. Allowing student nurses to develop autonomy and decision making skills."

"Undergraduate training needs to be more tailored to mental health. I am a mental health nurse, and I only received one subject in mental health before I worked in it. That is atrocious. There is a negative stigma for our young workforce to work in mental health. More undergraduate training is required in order to lessen this stigma. More placements within the mental health system. More education around how tertiary care can actually enable poor mental health."

This results in new staff who are not 'job ready', and this is likely to increase as the demand for services grows in the coming years. Considerable time and effort is required to support and supervise these new staff, often by clinicians who do not have the required experience or skill set. Mentoring and transition programs were seen as positive support structures.

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> *"Often education sessions fill up fast or staff are not able to attend because there is not enough staff on the ward to leave. A longer orientation period that is actually adhered to [is essential]. I was meant to have a two-day orientation day but as we were short staffed I had the first few hours of a morning and then left to take a full load."*

An increase in part-time or casual workers, including short term contracts, provides benefits to staff and hospitals in terms of flexibility, but has also created a lack of continuity of care and a disincentive to invest in people.

Career development and progression

While there is an opportunity for professional development in the mental health space, the sector does not offer clear or obvious career paths to people entering the field. It was noted that historically, leadership positions have been confined to people with medical and nursing backgrounds, further diverting those with the most experience and skill away from direct care. With direct care not viewed or remunerated as a rewarding career path, the result is a junior, unskilled, and disempowered frontline workforce.

> *"A Discovery College model at The Alfred would attract progressive, informed, collaborative staff rather than those with just academic excellence. We want staff with people skills who genuinely want to work collaboratively with consumers and carers."*

Unlike other areas of the health sector, for clinicians in mental health there are limited avenues to pursue career development through research and publication.

Negative perceptions and the reality of working in mental health

The mental health sector suffers generally from negative perceptions about what it is like to work in the area. This extends back to undergraduate training for students and makes it difficult to recruit capable people with the right skill set and capabilities.

Generally, career advancement across disciplines is difficult. When combined with the lack of obvious career development, there is an incentive for staff to leave the sector to pursue opportunities in more high profile services.

This negative perception of the sector is reinforced by generally poor infrastructure and physical working environments. There is also growing concern for the physical and psychological wellbeing of staff. A number of internal and external forces have created a working environment that can be confronting and physically dangerous for staff and patients, participants said.

The lack of dedicated facilities that recognise the different stages and manifestations of mental health disorders has hindered effective intervention. It has also made it difficult to provide adequate care and consistent treatment for people with a range of mental health issues.

> *"Our current IPU is a traumatic, unsafe, disrespectful environment that our consumers, carers and clinicians are fearful of."*

All this has culminated in the welfare of staff at mental health service facilities increasingly being compromised or put at risk.

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5. Themes: Our physical environment

Exploring infrastructure and buildings and the need to design facilities that are safe and therapeutic.

There was universal accord from participants that Alfred Health's mental health facilities are not fit-for-purpose, on virtually every measure. They reflect outdated or ill-conceived design approaches that do not enhance patient outcomes, and staff safety and wellbeing.

Staff strongly agreed these are not pleasant places for carers, visitors, family and friends. Importantly, they are not designed with patient or occupational safety in mind, especially when dealing with patients who exhibit violent behaviour. They are inadequate, dangerous, and not focused on promoting wellness.

"The environment on the wards is inhumane. There is no sunlight in one of the High Dependency Units. It is contained, people are frightened. It's small, it's dirty. It's a fact that people live up to their environments. When the environment is poor, people behave poorly. Provide them with a nicer environment, and individuals will live up to their environment. They will feel respected, and in turn respect it."

Staff are embarrassed by these conditions, and noted that the reaction of many families can often be one of horror, promoting an immediate desire to get their loved ones out of the environment as quickly as possible.

"Run down facilities devalue clients and staff."

The physical environment of mental health service facilities is recognised as a significant factor in the success of treatment. Currently, the focus is on harm prevention and security rather than creating a welcoming space for patients, families and carers.

The inpatient units provide limited outdoor space, inadequate protection for women, inadequate capacity to stream patients who do not present a risk to others, and limited space for family connection, therapy, and even clinical interviewing.

"We need single rooms with en-suite bathrooms, sensory adjustable environments, safe spaces for women, family rooms and outdoor environments with space to move."

"Create warm therapeutic spaces for allied health staff to see clients rather than having to see clients in medical rooms."

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Most in-bed facilitates have shared rooms and limited bathrooms, with one inpatient unit having eight toilets for 27 patients.

"There are very few single rooms so it is hard to isolate patients if needed. Many of the buildings are old, often needing repairs while still trying to work around these repairs. Patients often complain it is not a nice environment to recuperate in, it is too cold in winter and too hot in summer."

"Provide a respectful environment to patients. Provide them with privacy, their own bathrooms."

These facilitates are cold, hard and colourless with limited privacy, soundproofing, comfortable furnishings and little or no flexible spaces.

"There is not enough space to safely have tables, chairs, frames and other equipment needed. There is especially not enough space to safely resuscitate a patient in an emergency."

Staff agreed that changes need to be made to the design approach and philosophy of mental health facilities. They agreed that assistance and partnerships to achieve this should be sought outside the mental health sector. Working with architects, urban designers and behavioural experts, the Government could establish an agreed set of design guidelines to inform all future design, fit-out and construction of mental health service facilities.

This could include elements such as sensory adjustable environments where all aspects of the facility – light, noise, space and temperature – can be adjusted to suit the purpose.

"Individual patient rooms are needed to help prevent conflict. We need more communal areas in low dependency to allow different environments – noisy, quite, bright, dark, visitors etc."

Participants noted that Peninsula Health's facility at Frankston mirrors a display home model with homely spaces working together. It could also include access to courtyards and outdoor spaces, like those adopted at St George's Hospital aged care facility, as well as therapeutic rooms, break out zones and designated staff areas.

Technology solutions should be explored to improve the physical environment and patient safety and comfort. For example, advances in facial recognition technology and other artificial intelligence could mean patients movements around the facility could be governed by automated recognition and entry, greatly improving the safety and security of patients and staff.

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6. Themes: Compliance

Exploring governance and oversight requirements

In considering the compliance theme, workshop and survey participants indicated acceptance of the need to monitor the impact of care. However, it was also felt that there was a risk-averse culture that resulted in an approach that is not recovery-focused.

> *"You can't provide recovery-focused care in the current environment. The current environment only increases chemical and physical restraint."*

Comments indicated that the burden of compliance and governance continues to rise and has become increasingly complex for staff to understand. Compliance requires resources and training for the patient-facing workforce. It places a large workload on clinicians and others, and the required paperwork detracts from engaging with patients.

For example, the compliance requirement for authorising leave for a patient takes the carer away from having more practical conversations about how the patient will manage their needs while on leave.

> *"Everything that takes us away from face-to-face contact with the patient, reduces the quality of care we might deliver."*

Staff said that the Victorian system is trapped in part in a culture in which compliance, or risk aversion and the burden of it, impacts on the system and care and outweighs what is best for the patient.

> *"It helps to keep everyone safe but it hinders rapport and patient relationships."*

The current compliance regime does not measure the right things to drive better outcomes, staff said. While the volume of data collected continues to grow, there seems little benefit in this data to the patient. Indeed, it is unclear to staff whether the system is tracking and measuring the right things – those elements of care that deliver better outcomes.

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The Mental Health Act 2014

In 2014, the Victorian Government rewrote the State's Mental Health Act with the express aim of maximising choice and enabling patients to make, or participate, in decisions. Participants believe the Act's aims are worthy.

> *"The Mental Health Act has enabled consumers, families and carers to have a stronger voice and introduced more safeguards under compulsory treatments."*

While the Mental Health Act permits the compulsory treatment of people, this can only occur after the Victorian Mental Health Tribunal has carefully considered a person's ability to make a decision. It was felt there is a growing unease at the burden it places on senior doctors and others. For example, the number of cases being presented to the Tribunal is burdensome on clinicians, and so often junior staff attend the Tribunal.

With two or three Tribunals to present in a week, staff noted this can eat into clinical time or time that could be spent with a patient. It also means that often the clinician with most exposure to the patient is not present at the Tribunal. This can lead to decisions being made without the most experienced person's input, raising questions about whether the patient's best interests are being served. It is not a recovery-focused structure.

Having a legislative framework that supports people getting care when they need it is imperative. There is broad support for the Act's intention to support decision making.

Staff said that a co-design process should assess what compliance data is required to monitor and evaluate whether patients are receiving timely, safe, effective and dignified care. This should involve patients who can assess what appropriate and quality outcomes should look like. The process should champion outcome-based regulation and compliance.

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7. Themes: Our data and research

Exploring how to develop a culture of improvement and research in Victoria's Mental Health System

Participants indicated that research is often funded with little consideration about whether it will impact on clinical care or service provision.

"Staff need to be more involved in research. I am the only research nurse working in Alfred Psychiatry that has had hands-on experience. That is atrocious. Why is that? My job was created on an ad-hoc basis. We need more teams of research, in order to then implement research results."

While Alfred Health has an academic/research centre in partnership with Monash University, the Victorian mental health system lacks a coordinated approach to research that has practice-based benefits.

"The current geographical layout separates researchers, educators, workforce etc. so there is poor communication between each of these areas. These teams need to work together, not separately."

The complexity of the system and of patient presentations requires greater agility in how research and data inform effective, evidence-based care.

"My current role is a result of supporting research by funding a new service. This is a great example of building services based on best evidence."

However, participants stated the current system is not geared for constant learning, improvement and change so that it can meet the needs of service users and communities. The system finds difficulty in drawing on publicly funded researchers, quality improvement specialists, clinicians and people with lived experience to be part of the research process.

It was felt that in Victoria, there is limited public investment in research and training and there is no coordination of outputs, priorities and desired research.

By way of example, in the UK, there are clear guidelines around mental health and there is a multidisciplinary approach to the profession that can draw on the same evidence-based research. Staff considered that the UK government took an approach to change the system and ensure all professions within mental health were unified and operated from the same evidence-based framework.

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Research in Victoria (and Australia more broadly) is fragmented across time and disciplines. This makes a holistic and connected approach to evidence-based care difficult. Big Data has been a buzzword for some time now. The use of massive amounts of information from diverse sources led to hopes of ground-breaking findings and changes. This has yet to materialise.

Staff said we need more effort to bring together the fragmented research undertaken today and to disseminate knowledge across the system so that evidence-based care is enhanced. This should include greater connections between different areas of research including social, clinical and biological research.

Centres of excellence would support this aim.

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