Victorian Mental Health, Royal Commission

Bendigo Health

Submission

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100 Barnard Street, Bendigo VIC 3550
(Access via Mercy Street)
PO Box 126 Bendigo Victoria 3552
03 5454 6000
www.bendigohealth.org.au

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Executive Summary

It is widely acknowledged that the Victorian Mental Health System is in urgent need of review and reform in order to meet both current and increasing unmet demand, as well as preparation for future growth. In line with this, Bendigo Health (BH) welcomes the opportunity to provide solution based comment in relation to the key challenges being experienced by Designated Mental Health Services (DMHS) in providing specialised mental health treatment and support. In addition, as one of Victoria's Regional DMHS's, BH offers perspective on these challenges with consideration to service provision that meets the complex and unique needs of individuals living in remote and rural communities; a critical and too often overlooked component within the current mental health system. These challenges and recommendations are outlined across six core themes that provide a foundation for high quality mental health provision for Victorians:

- Workforce; considerate of current shortfalls and future needs related to capacity and capability of all fundamental mental health service disciplines and specialist workforces;
- Access and funding equity; to ensure timely access to appropriate services across all age demographics, geographical regions and service settings;
- Service provision; to ensure access to a broad and consistent range of general and specialist mental health services across all DMHS's;
- Therapeutic environment; through purpose built facilities across all service settings that promote therapeutic engagement and which support risk mitigation and cross service/sector integration in providing quality care
- Occupational health, safety and wellbeing; targeting and promoting safety and welling being for patients accessing and staff providing services; and
- Informatics and statutory reporting; through meaningful documentation requirements, data collection and DHHS set targets that monitor the quality of current service provision while also ensuring future development across Victoria is informed by population need and in step with growth.

It is anticipated that the recommendations of the Royal Commission into Victoria's Mental Health System will provide the broad and comprehensive systematic change that the mental health system requires.

Workforce

A training model that establishes and maintains a highly skilled, resilient and capable workforce within the speciality of Mental Health, that keeps pace with growth and is responsive to changes in patient and service level profile needs over time. This includes focus on pre and post graduate training for all disciplines specialising in mental health, as well as consideration to recruitment, retention and succession planning specific to each profession.

Context:

Victoria's clinical mental health workforce has over 5,000 workers comprised of five core disciplines: medical, nursing, social workers, occupational therapists and psychologists. In addition, there is a relatively small but growing lived experience (peer support and carer/consumer consultants) and dedicated Aboriginal workforce. Across these disciplines, workers are required to provide assessment, diagnosis, treatment, clinical case management and support to individuals of all age demographics across inpatient, residential and community settings. There are already significant workforce shortages across all disciplines, with the current workforce also ageing.

Challenges and Considerations:

It is already acknowledged that across the State, Victorian mental health services require additional community based resources and a significant increase in inpatient beds in order to meet current demand as well as future growth; the Access to Mental Health Services, Victorian Auditor-General's Office 2019 report indicates an 80 per cent increase over the next decade is required. This growth will require appropriately qualified staff to provide these services. Without adequate focus on both infrastructure and the workforce it will require, the system will continue to experience issues in relation to demand and access. Furthermore, the ability to provide consistent outcomes in relation to high quality, recovery focused patient care requires time and skill. Investment in relation to training prior to, as well as after entering the workforce, is crucial in ensuring the system has an appropriately skilled and supported clinical staffing profile to provide the treatment and care intended and essential to the health outcomes of Victorians.

In January 2017, Bendigo Health (BH) transitioned into a new purpose built hospital inclusive of Psychiatric inpatient services with an almost 100 per cent increase in mental health bed numbers; increasing from 42 to 80 beds across parent and infant, adult acute and extended care and aged acute settings. This required an additional 70 FTE across all disciplines at a time where there is a recognised national shortage of specialist mental health clinicians.

Recruitment required an approach necessitating a considerable investment in money and staff time to ensure the challenge of recruitment within a limited and competitive workforce market, in addition, the challenge of recruiting to a rural and regional service were overcome. Our approach included a recruitment campaign at a local, state, national and international level, staged opening of beds post-transition to the new facility, which continues, and a fine balance between skill and experience levels of applicants and the number of staff required without compromising safe and quality care provision. This needed to occur within an environment of high public and government expectation in relation to service provision and opening of all available beds as early as possible. The process demanded an increase in dedicated orientation, support and training to a high volume of new staff commencing with a variable skillset and level of experience.

BH has effectively managed, and continues to manage, these challenges to ensure quality care is provided, and that specialist services offered in our region continue to expand to meet the community's need (i.e. opening of the Dual Diagnosis Unit and Parent Infant Unit since Jan 2017). How these workforce challenges will be confronted and managed at a broader level needs to be addressed as a key adjunct in planning increase in services and bed numbers across Designated Mental Health Services (DDMHS). Strategies to understand and then address workforce profile, along with attraction and recruitment in relation to immediate gaps between demand and service capability across the state are needed to allow the system to transition from a state of reactive service provision with a workforce that is overstretched, to a system that is proactive and innovative in its approach. This needs to include consideration of the time clinicians and educators are required to provide practical support and mentoring to students and beginning practitioners.

In seeking to address the workforce supply issues, particularly in the rural and regional context, it is essential that innovative models that support advanced practice for nursing and allied health be supported to ameliorate the chronic shortage of Specialists available to rural and regional communities. In parallel, workforce strategies that focus on long term attraction, training and recruitment into the speciality of mental health services need to be developed with measurable targets set to assess progress and effectiveness at a state level. These strategies need to reflect and address the unique challenges of metropolitan as well as remote and rural services with an acknowledgment that a 'one size fits all approach' has not worked. In addition, contributing factors to the current workforce shortage need to be considered in informing strategies that aim to reverse the issue and develop a workforce market that will contribute to the proactive service expansion and increased capability of DMHS's in order to keep pace with population and demand growth in the future. This work needs to expand beyond the mental health system to be completed in partnership with tertiary education providers with the aim of ensuring the workforce market we 'grow' has a solid foundation in specialist mental health on which services and staff can then build.

Recommendations:

1. **Review of undergraduate training to ensure clear career trajectory into mental health across all nursing levels and allied health disciplines with an increase in funded graduate positions.**

Introduction of a double degree in Nursing and Mental Health. This would be comparable with the qualification and recognition of Midwives. Re-instatement of endorsement as a mental health nurse on AHPRA registration to both acknowledge and re-establish Mental Health nursing as a speciality crucial to our healthcare system, while maintaining integral foundational links to general healthcare.

Revisiting the model for undergraduate education for nursing, specifically mental health nursing, inclusive of an international review of best practice is required. Consideration should be given to a blended approach incorporating both University and Hospital based learning to drive an increase in practice and experience while the academic component of their education progresses. For example, this could mean that after a set level of academic study and practical placement (one to two years into their degree) is successfully completed, students would be eligible to obtain a supported position within a DMHS. The remaining studies required to complete their qualification would then encompass part time study and part time paid and supported employment within a set scope of practice equivalent to their skill base.

Furthermore, the foundational skillset of mental health practice has evolved over time and is relevant to all mental health clinicians irrespective of discipline. Establishment of a clear core capability framework (with regulatory periods of review) to underscore course curriculum and establish a baseline standard for the mental health workforce is required. This framework should also recognise that the multidisciplinary team approach in community mental health services includes generalist clinical roles undertaken by nursing and allied health qualified staff alike and is different from inpatient and acute health roles and settings.

Reflecting the core capabilities, foundational training needs to include the provision of mental health treatment and support in the context of dual disability, dual diagnosis, family violence/forensic, and family based approaches for nursing and allied health disciplines specialising in Mental Health. Clinical placements throughout pre-graduate education need to be expanded to ensure an appropriate level of practical exposure to all areas and age demographics of mental health. Currently most undergraduate programs provide a total of one clinical mental health placement of two to three weeks' duration. Regulations regarding how tertiary education providers develop course content should also be reviewed to ensure pre-graduate training remains up to date with the needs and ever evolving requirements of mental health service provision in practice.

At a local level, BH in collaboration with La Trobe University have established a joint Masters in Mental Health program and have expanded our graduate positions with 10 self-funded, in addition to the one fully and three partly DHHS funded, positions. Additionally, BH support allied health staff and mixed stream graduates to attain specialist mental health training through this avenue. If, however, it remains the responsibility of services to develop local initiatives with tertiary education providers, specialised training will remain inconsistent across DMHS's and continue to occur after clinicians have entered the workforce and are already practicing. Funded graduate positions need to be increased so that services like BH can redirect the core clinical funding currently being used to supplement their graduate programs in order to address workforce need.

Any increase or change in placement times or models also need to be matched with resources within DMHS's to support these changes. Further to this, policy at a broad level needs to provide foundational support for placement models that allow and encourage students to return to the same service throughout their clinical placements. Exploration of a model like this works to improve both the learning experience of students while simultaneously adding to the current workforce.

2. Develop programs of post graduate training that support expanded Scope of Practice of both Nurses and Allied Health to enable increased autonomy of practice for clinicians in rural and regional communities

Programs such as the Masters in Mental Health could be extended to enable the scope of practice similar to the Nurse Practitioner qualification with defined formulary and prescribing authorities for clinicians practicing in rural and remote settings. Such models of expanded scope of practice should be further supported by Telehealth access to local Medical Specialists.

3. Review of structure and incentives to support post-graduate professional development and continued specialisation

Incentives for postgraduate qualifications in Mental Health, including scholarships and Commonwealth supported places for all disciplines, should be reviewed to identify capacity for future growth in line with service expansion and need. In addition, a framework should be developed for standardised and resourced clinical supervision and structured practical mentoring and role modelling for mental health clinicians with a focus on:

- general and specialist clinical service provision including focused evidence based psychological treatments that strengthen clinical care and service response
- development of qualities and skillsets in leadership, cultural change and resilience in developing a transformational workplace with strong succession planning

4. Formal and funded support structures for the Lived Experience and dedicated Aboriginal workforce

In developing a workforce profile that is robust and well-rounded in relation to the provision of mental health service provision, strategies that recognise, support and develop the Lived Experience and dedicated Aboriginal workforce in the same manner as it does clinical disciplines is required. This includes measurable targets to ensure they are an adequately represented component of the workforce for all DMHS's, as well as inclusion of these roles within a broader system capability framework as previously noted. It is also essential that in further developing the Lived Experience workforce, that these roles are developed as a complimentary workforce to, and not in replacement of, an appropriately qualified clinical mental health workforce.

Fully funded support and development structures should also be developed and implemented according to the specific needs of these cohorts to increase attraction and recruitment prospects and maximise retention by ensuring role requirements are consistent, clear and achievable. This includes extending funding beyond the positions themselves to include resourcing that enables the continued development and training, as well as appropriate supervision for individuals in these roles as they carry out their function within service provision and operational structures. It should also be recognised, that while the lived experience workforce is an integral component of the broader workforce profile and should be expanded and further integrated within DMHS's, this alone will not resolve current resource deficiencies being experienced in relation to clinical service provision. Strategies to enhance this workforce should be in parallel to focused efforts on enhancing and resourcing the clinical workforce appropriately. If this cannot occur, priority needs to be given to developing the clinical workforce to meet current shortfalls as well as future growth needs.

5. Development and resourcing for a family focused and capable MH workforce inclusive of further specialised family based interventional roles

Family based interventions have been shown to improve patient engagement in treatment, resulting in improved outcomes for both patient s as well as family/carers. Despite this, there remains little or no specific funding to DMHS's (or any other health and welfare sector) to support family based clinical interventions. In addressing this, all clinical programs require access to qualified specialists in family based interventions, in addition to a comprehensive roll out of complimentary training and practice support initiatives for all community based clinicians in relation to the family sensitive practice required to underpin the specialist interventions.

Access and Funding Equity

Establishment of a funding model that ensures allocation promoting access and equity across DMHS programs and settings that resources appropriately across all age demographics and service settings - inpatient, residential and community based.

Context:

Access to Mental Health services has recently been the subject of a thorough audit through the Victorian Auditor-Generals Office (VAGO). The report, Access to Mental Health Services, March 2019, details the broad and systematic factors impacting timely access when and where communities across Victoria need them. Included in the full report are findings and recommendations related to the issues identified throughout the audit. BH was an active participant in this Audit. The content and recommendations within the report are fully supported by BH and we encourage these to be included and further endorsed within the findings and recommendations of the broader Royal Commission. While we will aim to not repeat the content of the VAGO audit, there are some core considerations and recommendations to re-emphasise in relation to the impact that increasing demands combined with current service shortfalls have had in placing the entire mental health system under significant duress.

Challenges and Considerations:

Increase in demand coupled with systematic shortfalls in relation to funding, infrastructure and workforce capabilities over decades of service provision have left DMHS's having to manage and prioritise a high throughput of acutely unwell individuals. The requirement to manage flow and bed availability in a system that has a demand that outweighs its capacity has resulted in:

- extended wait times in emergency departments (ED's), an environment acknowledged to be clinically inappropriate for the safe and effective treatment of mental health patients; across Victoria, mental health patients have been the most represented patient cohort when wait times in ED's have exceeded 24 hours
- the discharge of patients deemed to be the least unwell to 'create' capacity to admit those more acutely unwell; evident in the context of:
    - occupancy rates well and consistently above the national recommended levels of 80-85 per cent in order to support patient flow according to patient need and response to treatment
    - a constant decrease in the average length of stay for patients in mental health inpatient units
- the utilisation of other psychiatry units, as well as at times, general wards as an interim solution until an appropriate bed is available; i.e. the admission of an adult patient into an aged psychiatric bed

While these strategies assist in creating the throughput to meet demand at the time, the flow-on effects to patient care, family/carer burden and staff morale and resourcing (when staff specials are required to provide support to a mental health patient admitted in a general ward) are evident and more importantly, systemic causal factors remain. The adverse impact and burden of a work environment that persistently requires clinicians to implement treatment decisions based on demand rather than best practice is not to be underestimated.

Victorian mental health services have one of the lowest per capita bed bases across the nation. Block funding for mental health inpatient beds is currently allocated as a single price per bed without consideration to location (rural/regional incur higher operating costs that remain unfunded) or severity of illness. Unmet demand, population demographics/growth, the changing impact of the social determinants of health and community expectation are also not reflected within the funding allocation of DMHS's inpatient, residential or ambulatory services.

The current bed day based block funding for inpatient and residential beds creates a particular challenge for BH's smaller units (e.g. Mother Baby Unit 5 beds, Community Care Units 12 beds) as there is no economy of scale in units of this size. The funding received for these units does not cover the fixed operating costs they incur.

Further to this, a funding review in relation to Psychogeriatric Nursing Homes is required. The majority is through Commonwealth age care funding with a State supplement for psychogeriatric beds. Facilities for this patient cohort are often small residential aged care facilities designed in small hubs or house units. Lack of scale compounded with inappropriate design to cater for the varying resident cohorts within the one facility result in an environment that is not conducive to the care needs of its residents. Of the 40 beds within BH's Psychogeriatric nursing home, only 30 receive supplemental funding despite similarities in care level across all. In addition, staffing profiles for psychogeriatric nursing homes are in accordance with aged care ratios. Despite being located in a growing region and within an aging population, BH has not seen an increase in its psychogeriatric beds for over 20 years (since the initial establishment of the facility. Increased beds with funding to match service need in providing care to this patient cohort, inclusive of consideration to supported education of staff is required to meet current and future need.

Recommendations:

6. Findings and recommendations outlined in the recent VAGO report to be considered and enhanced within the recommendations and outcomes of the Royal Commission

This needs to include funding reforms that ensures allocation reflects the unique needs of each DMHS including population growth and geographical challenges. For rural and remote services this should include recognition that DMHS's are also in a position of providing essential support, practical and educational, to small rural hospitals within their catchment. BH has 23 sub-regional, small rural hospitals and health services within our catchment area. With the absence of funded and dedicated mental health beds or clinicians within these services, there is a heavy reliance on DMHS's. This includes the provision of phone consultations as well as practical assistance in relation to assessment and supported transfers to Bendigo Hospital, in lieu of discharge or the supported admission of patients within their own community. To assist in capacity building within the workforce of these hospitals, BH self-funds an education role dedicated to providing training, inclusive of industry updates.

DMHS's require care to ensure funding promotes program design that will allow services to provide effective treatment of all serious mental illness by both allowing and ensuring long term treatment and care planning that meets the individual needs of the patient. To achieve this, consideration of the setting and age demographic of the program needs to be clearly understood and reflected. For example, the complexity, intensity and systematic nature of CDMHS service provision in the community

is vastly different than that of adult, however this is not acknowledged within the current funding model.

A 'one size fit all' approach does not ensure equity and appropriate allocation in relation to funding. Rather, it often results in services being required to re-direct core and/or growth funding to address these shortfalls and gaps.

7. **Assess the efficacious management of mental health presentations to the ED to ensure models conducive to best practice are implemented, resourced and governed across all of Victoria's major ED's.**

As service demand increases so to do mental health and drug and alcohol presentations to ED's. Across DMHS's there have been various reviews, trials and approaches implemented in respect to the management and treatment of these presentations. Models proven to promote evidence based treatment and desired patient outcomes should be implemented as a standard requirement across all Victorian ED's in respect to:

- preventing unnecessary presentation to ED's; e.g. through PACER programs
- ensuring appropriate and timely assessment and treatment, including coordinated admission when clinically indicated, of mental health presentations; with respect to integration, role (ECAT) and level of resourcing for mental health nurses within ED's
- preventing avoidable admissions and bed block for patients who require a short stay admission for treatment and/or detox prior to assessment; e.g. through short stay dedicated detox and psychiatric care beds within ED's
- Develop alternative service response for people facing an acute reaction to social and relationship crisis ensuring the individual need is met in an appropriate environment. In doing so we will start to address the funnelling to ED for people who require crisis and short term psychological interventions. For example, an alternative drop-in space with an appropriately qualified mental health workforce located beside ED's or within specialist mental health or other community hubs
- explore models to embed mental health expertise into key service sectors including Child Protection, Alcohol and Drug as well as Housing services to both build capacity and provide timely service to the patient, thereby reducing avoidable deterioration requiring crisis presentation to ED's

Service Provision

Equity of access to specialist Statewide services (e.g. CDMHS inpatient beds, Neuropsychiatry and forensic mental health services), particularly as relevant to remote and rural DMHS. Service provision also includes consideration of:

- *barriers to discharge (e.g. homelessness) and the impact on access and service flow*
- *inpatient and residential bed numbers to meet both current and future demand/growth*
- *addressing current service gaps, including those resulting from the NDIS implementation and a lack of services designed to provide long term care in a supported facility, including recommissioning and restructuring of community mental health support and AOD services*

Context:

Victorians currently experience a fragmented service system that can hinder rather than streamline access to a full spectrum of mental health services. Demands on services continue to increase in terms of both the number of Victorians who require such services, as well as severity of illness. Coupled with current service shortfalls this increase in demand is placing considerable stress on DMHS's. Drivers for this increase stretch beyond population growth and include changes in the pattern of alcohol and other drug use, as well as an increase in the complexity of patient needs. In addition to this, individuals accessing mental health services are also often affected by trauma, socio-economic disadvantage, family violence, and disability with increasing rates of homelessness, all of which often occur from early childhood.

Challenges and Considerations:

Providing effective, holistic care to patients with the aim of supporting individuals to remain in their community, requires more than a focus on access to a full range of specialist mental health services. Effective collaboration across service providers and sector boundaries, including alcohol and drug, disability, justice, housing, employment, family violence and child protection services, are equally crucial. Adding to the challenge of service response and care coordination across multiple service partners, is the misalignment between the catchment areas of DMHS's with the boundaries of local government areas as well as other health and human service sectors across Victoria.

Whilst there are a reasonable range of statewide specialist services within the mental health system, many of these are based in Melbourne. As a result, these services, including Eating Disorder, Forensic, Borderline Personality Disorder, Neuropsychiatry and CDMHS inpatient beds, are often in high demand resulting in delayed access and a limited ability to provide early intervention.

For patients and their family/carers living in rural and remote areas of Victoria, access to Melbourne-based services incurs significant family dislocation, costs associated with travel, accommodation and lost income and removes the sufferer from the social and service supports within their local community. A review of these specialist statewide services in relation to service capacity versus demand and location to ensure timely and equitable access across all catchment areas must occur. Without early and appropriate intervention for these high risk and complex patient cohorts, delayed treatment and pressures faced by DMHS's and generalist health services, to support these patients in the absence of optimal expertise or an ideal environment will continue. Particular consideration to the financial,

accommodation and travel impacts of rural and regional populations in accessing state-wide, Melbourne-based services is necessary.

Example: Delays in accessing CDMHS inpatient beds will often result in extended stays for the patient in BH emergency department (ED) or admission to the Paediatric ward. Even with the support of CDMHS community staff as well as Psychiatry CL, the levels of distress that a delay to specialist service can cause to the patient, their family, and the staff awaiting access to this admission can be exponentially increased.

Despite a recognised increase in the requirement for dual diagnosis care, the Mental Health and Alcohol and Drug sectors continue to run in parallel. This often results in increased pressure on both service streams and suboptimal patient outcomes. As well as recognising the need for mental health clinicians to be dual diagnosis capable as part of their core skillset, an integrated approach across both sectors to provide a full range of focused dual diagnosis services is required. While Victoria has taken its first steps in opening 28 funded dual diagnosis residential rehabilitation beds, eight of which make up BHS's Dual Diagnosis Unit, broader integration at a sector level to ensure adequate and consistent governance and future service planning is required.

An increase in homelessness and a lack of safe, affordable and appropriate housing for people with a mental illness is having significant impacts on access. Delayed discharges from inpatient units results in disrupted recovery and bed block. In addressing this issue, three strategies need to be considered and appropriately resourced at a sector level:

- acknowledgement of individual patient context and choice supported in broad policy to enable appropriate clinical decisions and avoid management plans compromised by risk-aversion and fear of criticism
- establishment of long stay mental health facilities for the patient cohort that don't fit the need for a residential or ECU admission, but require ongoing care within the specialist clinical mental health system
- sector level partnership with housing services to prioritise the development of safe and affordable housing options, both individual and shared

General Practitioners (GP's) hold a pivotal role in the coordination of care for patients within their communities. Acknowledging the increased reliance on GP's within remote and rural regions to further assist in filling the gap that limited access to specialised services leaves, a review of the support and ongoing training for this workforce in relation to mental health is required. Further to this, GP's are often an essential element in both access to, and timely discharge from services e.g. Psychogeriatric Nursing Homes. Increasing support and education for GP's undertaking these roles will assist in addressing the reluctance that can currently be experienced in engaging a GP for these patients with resulting significant delays in discharge and appropriate placement.

In addition, the transition to NDIS has further increased gaps between clinical support and psychosocial rehabilitation, particularly for patients with complex chronic mental illness. A limited recognition and understanding of mental disability and the impact this can have in comparison to physical disability is reflected in the degree of difficulty this cohort of patients have in accessing the appropriate level of

support through this scheme. This is compounded further for patients living rural and remotely. Difficulty accessing support workers through NDIS with limited market forces and worker options, coupled with geographical distance and complex patient needs is significant. This is particularly true if there is a risk of variability in mental state requiring multiple support workers. The subsequent gap in required support leaves DMHS's to do the best they can with their already stretched resources to try and cater to and address these unmet needs

Recommendations:

8. Review and adjustment of current DMHS's catchment areas to better align with broader health and local government boundaries to assist the coordination of complex care across services and streamline navigation of service sectors for patients and their carer/family

A review and update of DMHS catchment areas is required with particular consideration given to ensuring the availability of a broad range of services across all age demographics and in accordance with the needs of the catchment profile. As the residence of an individual will dictate the services they have access to, matching service location and catchment need is crucial. That is, that the broad and consistent range of specialist services including Eating Disorders, Forensic, Borderline Personality Disorder, Neuropsychiatry and CDMHS inpatient beds, be provided in all regions. This would include considered alignment of the natural relationships between neighbouring communities.. It may also be timely to include a process that will allow for patient choice in relation to service access, rather than zoning of residence being the primary determinant.

To the extent that this is not possible, increased assistance is required to assist patients from rural and remote regions, as well as their family/carer to travel from their community and be appropriately accommodated within Melbourne where these essential services are located.

9. Recognition of rural and remote challenges DMHS's face in providing quality patient care in isolated communities with the development of strategies to address these within broader reforms

This includes innovative strategies to leverage emerging technologies and further embed telehealth within standard service provision to optimise resource efforts and bridge the gap that distance from services can create. Using telehealth to enhance patient choice on venue and provide assessment of patients in the community of which they reside as well as to communicate between specialist areas and hospital or outreach staff increases access, minimises delay in treatment and strengthens patient and family partnerships with service providers by bringing mental health care to them. Broad investment into utilising technology (including telehealth) in the provision of high quality timely and responsive mental health care is needed to ensure it is introduced and utilised to maximise benefits and reduce risk. Investment in effectively implementing technology-based strategies like telehealth cannot be funded by DMHS's within existing revenue and will require additional governmental support both financially and within policy to guide its application in practice.

10. Ensure resource levels and associated funding are determined and allocated to provide service provision for all serious mental illness beyond crisis treatment and interim resolution, to achieve long term recovery and wellbeing of patients

Resource levels, and associated funding models, should ensure that services have a skilled workforce to provide long term treatment and care for all people with serious mental illness across all service settings. Resourcing the inpatient setting to improve patient flow at the expense of building our

community resources will not work in providing effective service provision. As long as there remains unmet demand and underfunded community based clinical services, patients will continue to deteriorate, increasing pressure on inpatient units to continually prioritise one acutely unwell patient over another. Conversely, if bed numbers do not increase to meet current and future demand, length of stay and thus inpatient treatment will continue to be compromised and expectations on community services to increase their level of support to compensate for early discharge will remain. For an effective and responsive mental health service, sufficient capacity across both inpatient and community services is essential.

Therapeutic Environment

Ensuring treatment is provided in facilities that promote therapeutic engagement, support risk mitigation and ensure the provision of quality care as it pertains to:

- *purpose built facilities with attention to age and gender separation as well as optimal size*
- *co-location of services; mental health, integration within general hospitals as well as with key external partners (i.e. housing, employment and AOD agencies)*
- *the impact of the Public Private Partnership (PPP) model on clinical care and service delivery*

Context:

Focusing effort on changing structures to enable and build the skillset of the mental health workforce as well as the appropriate level of resourcing and infrastructure will provide DMHS's with the space and time to rebuild and embed therapeutic programs back into service provision at the level required for effective long-term treatment and recovery. These programs include reintroduction of psychosocial rehabilitation, work rehabilitation, counselling and psychotherapy as well as social therapy programs throughout service provision. Underpinning this work is the requirement to ensure the physical environment and facilities of mental health services, as well as its workforce, as already noted, are appropriate and conducive to therapeutic engagement, recovery and safety. For example, in line with the growing evidence base around the importance of physical activity, purpose built facilities and staffing profiles should include the provision of gymnasium spaces in inpatient precincts supported by the addition of exercise physiologists within the mental health multidisciplinary team.

Challenges and Considerations:

In January 2017, BH transitioned into purpose built psychiatric inpatient units, co-located with one another but also integrated within the Bendigo Hospital. While not the only service to have done so, it does allow for a perspective in relation to both strengths and challenges for consideration in the design of future mental health environments across the system.

Co-location of psychiatric inpatient units results by default in the co-location of staff across all disciplines. This is beneficial, not only for patient care but also in ensuring safety for patients and staff with easier access to enhanced clinical response for emergencies (particularly medical) as well as extra support if incidents of aggression occur. When supported, co-location of services can increase the opportunities for patients receiving inpatient treatment to strengthen their support network within the consumer community through coordinated programs and activities across units. It also helps to prevent programs from functioning within silos and promotes collaboration and support to the benefit of patient care and staff morale. Integration within a general hospital allows for an increase in timely response and strengthened pathways between general acute and mental health services.

As well as impacting individual patient outcomes, BH has recognised the initial impact this has had in tackling stigma commonly associated with mental health patients, staff and services within the hospital environment. Independent research undertaken by RMIT University (soon to be analysed and published) has verified this outcome being reported by patients, families and staff.

A purpose built environment at a time where technological advancements within health care (provision and physical environments) is increasing, allowed for the leverage of technology throughout all stages

of development. This has allowed for increased flexibility within the structure of the environment to create a unit layout in relation to gender separation that can be configured in response to changes in clinical need and unit profile. Increased infrastructure in relation to telehealth capability and access to computers to cater for the transition to digital patient records and increased use of digital documentation was also considered and catered for within the design of the environment. Achievements that add value to service provision and patient safety and that are more difficult to achieve within repurposed facilities.

Increasing in use within health care is the use of Public Private Partnerships (PPP) in the provision of healthcare.

Environments in which mental health services are provided across all service settings, repurposed or purpose-built, need to support the model of care for mental health service provision and be conducive to recovery in safe and welcoming settings. Services co-located within general hospitals by default become more medicalised environments, so throughout all stages of development careful planning was undertaken to ensure a more home-like environment. This included thought to the placement of psychiatric units within the hospital building (i.e. to allow for open air courtyard access and as much natural light as possible).

In addition to the environment, care to ensure that all partners involved in service delivery have an understanding of the model of care within mental health settings, particularly where these differ from general healthcare with which they may be more familiar, and how their contribution to the environment in fulfilling their role impacts on care outcomes and patient recovery is essential. This is particularly important within a PPP where services outside of the clinical realm are provided by external contractors and are guided by contractual agreements.

Recommendations:

11. **Comparison of purpose built facilities, including those co-located within acute hospital environments to identify the successes and challenges experienced by DMHS's throughout the design and use of these environments, as experienced within Bendigo Health, be conducted at a state level and utilised to inform future infrastructure development across the system**

In particular, this should include consideration to location and optimal size of facilities/units, particularly inpatient and residential. With the requirement for a statewide increase in bed numbers in order to close the gap between demand and current service capacity, as well as a well-planned and long term approach to ensuring service capacity continues to grow in step with future demand, thought to how these beds will be integrated into services is timely. Evidence to inform the decision to increase the bed size of established units versus the establishment of additional units to accommodate future growth will be pivotal in optimising the impact of additional beds on communities accessing them and services governing them.

Example: In transitioning to the new hospital environment, BH's 24 bed adult acute mental health unit (originally designed as a 20 bed unit) increased in size to 35 beds. While the physical environment and workforce increased to match, this increase in patients and staff resulted in unexpected impacts relating to the physical footprint, therapeutic milieu, ambience and thus clinical management at a shift level of the unit. BH met these challenges with:

- *the implementation of a new clinical management role within the unit: the role sits between the Nurse Unit Manager (NUM) and the Associate Nurse Unit Manager's (ANUM's) adding an additional layer of clinical support and guidance to the units operation at a practical level*
- *changes within the model of care to better support the smooth provision of care in line with growth e.g. implementation of team based nursing within the unit*
- *increase in the Program and Practice Development education for ANUM's and inpatient staff*
- *creative problem solving in collaboration with consumers; for example, negotiating across the PPP to enable consumer art work on glassed surfaces to make the area more homelike whilst also providing engaging activities*

In terms of future growth in relation to adult acute inpatient beds in the future (average occupancy for the last twelve months for the unit despite the increase in bed numbers in January 2017 is 92.8 per cent) under the governance of BHMHS, consideration to how these are added to the current service structure will be important.

While the aim of future development should be purpose built mental health facilities, there should also be an acknowledgment that this will require long term planning and investment to be realised. In parallel to planning for future growth in terms of infrastructure, investment in ensuring currently utilised and suboptimal environments across the state are reviewed to ensure safe provision and recovery focused care can be provided is also required.

12. Development of purpose built Mental Health clinical community hubs for community mental health teams to be co-located with key external providers to foster and strengthen collaborative partnerships that support comprehensive care across services in the community settings

As patient needs become more complex and require the co-ordination of care across service streams, dual diagnosis, housing, employment, justice, child protection, Aboriginal community supports and family violence services for example, strong partnerships at a service level are essential to patient outcomes. Developing purpose built community hubs to include co-location with these services will serve to foster strong pathways between these partners and strengthened collaboration between staff at the coalface of patient care. An integrated approach supported by physical co-location will also assist service providers to help patients and their family/carers to navigate a complex system to receive the care and support they require across services in a manner is not overly burdensome or unnecessarily challenging. Links at the leadership level of these sectors will be pivotal in supporting the practical output of this integration at a governance and policy level.

Occupational Health, Safety and Wellbeing

Ensuring training, supervision and ongoing support processes that promote safety and wellbeing for staff and patients alike are funded and appropriately resourced. Also, that such models recognise the trauma impact on staff, not only of high impact isolated events, but in relation to long term exposure to incidents of violence (verbal and physical), self-harm and suicide (attempted and completed).

Context:

Occupational violence is a complex issue that has far reaching negative effects physically, emotionally and psychologically on people with direct experience as well as those who witness workplace aggression. In addition to the personal impact, workplace violence carries both a clinical and financial cost. While financial costs incurred result from sick leave, work cover claims and at times the repair of the physical environment, adverse clinical impacts on the delivery of quality care and on patients who are also often witness to such incidents is far more costly and requires urgent attention for the wellbeing of patients and staff.

Poor staff morale resulting from increased occupational aggression, re-direction of staff resources in attending to critical incidents of violence and the loss of experienced staff due to injury and psychological trauma or burnout, have a direct impact on patient care. In addition, attraction and recruitment to the specialty of mental health as well as retention of skilled and knowledgeable staff is also compromised in the context of increased occupational aggression.

Challenges and Considerations:

The causal factors of violence within the healthcare setting are multiple. Fear and uncertainty, distress, symptoms of medical and mental illness resulting in confusion, hyperactivity and impulsivity, the effects of drugs and alcohol, the provision of treatment against an individual's will, personal history of trauma, as well as the reaction of family and friends to treatment decisions, are all potential catalysts to unpredictable and aggressive behaviours. The potential influence from broader community exposure to and challenges with violence compounds the complexity in effectively addressing the issue.

Strategies to address occupational violence and create a culture of safety that protects the rights of all who utilise and work within mental health services, requires a sustainable, comprehensive and integrated approach that provide:

- support for staff, both proactively and following a workplace incident
- a clinical response to both threatened or actual violence
- clinical support of patients who have been involved in or witness to episodes of aggression
- a suite of evidence based interventions as part of core clinical practice that reduce incidents of conflict
- appropriate facilities that are designed to promote safety and engagement

When determining the level of resource and funding to be applied to DMHS's to implement and sustain strategies developed to address occupational aggression, including a framework and suite of models appropriate for each clinical setting, consideration needs to reflect individual service capabilities and challenges in relation to catchment area.

Example: BH have 23 sub-regional, small rural hospitals and health services within our catchment area. In managing mental health presentations through their Urgent Care Centre's (or equivalent) and while treating the physical needs of those suffering a mental health condition within their communities, small rural hospitals are required to provide mental health support to patients without being adequately resourced and trained to do so. With no designated mental health beds or clinicians, local GP's often provide primary support for mental health care in these circumstances. While BH employs an educator dedicated to providing education to small rural hospitals and their staff to expand the skillset, knowledge and capability of these services, inclusive of coordinated aggression management, this is currently self-funded and functioning at capacity.

Recommendations:

13. Implementation of a standardised and evidence based training model for the clinical response to and management of workplace violence and aggression across all DMHS's

Conduct an international research, review and identification of an evidence based, best practice framework for the management of occupational violence with an appropriately coordinated and resourced roll out to all DMHS's at a state level. Currently it is up to each DMHS's to resource and implement an approach to workforce aggression within their service resulting in potential for statewide inconsistency and lack of clarity in best practice for an issue with far reaching and at times, fatal consequences. Government funding to support the implementation of an endorse framework to address occupational violence must reflect the needs of each DMHS's to ensure effective resourcing at a local level to achieve an effective roll out of the model across their catchment but that the model is sustainable.

14. Mandatory and funded Clinical Supervision for mental health nursing staff

Acknowledging that a Victorian framework for clinical supervision for the mental health nursing workforce has recently been developed, emphasising the value of structured and supported reflective practice, clinical supervision for nursing staff (accounting for two thirds of the mental health workforce) remains voluntary with minimal and varied uptake. This is despite the known benefits for professional practice and fact that clinical supervision is a mandatory requirement within the medical, occupational therapy and social work fields. With recognition that long term exposure to workplace aggression has a resounding impact on mental health clinicians and can result in burnout and trauma, mandatory and resourced implementation of clinical supervision for all mental health clinicians is essential in developing a resilient and self-reflective workforce that is proactively responsive to the emotional and psychological impact of workplace conflict.

15. Continued Statewide support and implementation of Safewards as core clinical practice within mental health settings

As a model of evidence based reduction in restrictive practice and conflict, improved therapeutic relationships and development of a culture of safety and respect, Safewards training and resources have been provided to all DMHS's through the DHHS . Focus now needs to shift to sustainability of Safewards with interventions embedded within the model of care for service provision. Linking additional funding to service proposals for continued expansion of Safewards at a local level would further incentivise DMHS's to prioritise continued implementation and improvement in this area leading to a proactive and standard approach to the prevention of workplace violence at the point of care.

BH is currently piloting the Safewards program within our Emergency Department (ED) and we remain optimistic that this will benefit all people presenting to the ED and provide consistency of experience to those mental health service users entering care via the ED.

Informatics and Statutory Reporting

To ensure documentation and reporting requirements work to achieve the intended outcomes and are not applied in a manner that unnecessarily diverts time and resource from patient engagement. This includes consideration of system integration to streamline data collection and reduce 'double handling' of clinical information at a service and state level, as well as ensuring reportable data is accessible in a manner that is meaningful and timely in interrogating and informing service provision.

Context:

Victorian DMHS's are mandated to utilise the Client Management Interface (CMI) and Operational Data Store (ODS) system to record demographic and clinical patient-level information, as well as to manage data items from CMI for state reporting purposes.

Challenges and Considerations:

While use of the system is mandated, the system lacks functionality and usability is poor. In addition, ability to access live data from the system at a service level is limited. As a result, DMHS's are utilising bespoke systems in addition to CMI/ODS to allow for local analysis and interrogation of data to both monitor performance and inform service provision, duplicating both data collection and resource effort as system integration with CMI/ODS is not supported.

The increased use of technology in healthcare, including the digital transformation of paper patient records within electronic systems provides an opportunity for services to review and streamline clinical documentation. In doing so we have an opportunity to create efficiencies in processes and reduce duplication of information as much as possible, redirecting effort back into patient engagement and care without compromising clinical documentation requirements. In addition, statewide databases require dedicated funding and mandated ongoing review to ensure these systems remain up to date not only with legislative requirements but technological advancements to ensure these systems are easy to navigate and time spent using them is effective. Further, in order to support services and their workforce in maximising the safe use of technology, consideration to the training and roll out of technology based advancements to ensure it adequately caters to the varied literacy levels of staff in relation to technology is essential.

In line with this, BH has recently undertaken a project to transition from a paper based clinical record to a bespoke digital platform across our catchment area (covering 37,036 km2). In delivering a platform designed to capture an accurate and comprehensive clinical account of a person's engagement with the service from point of entry right through to discharge, flow of clinical information across service settings and regional teams has been strengthened, with essential information now available at the point of care in real time. In addition, interoperability with broader organisational systems supports the safe sharing of critical information without compromising data integrity. This includes demographic level information between the organisations Patient Admiration System (PAS), patient alerts and allergy information as well as episodic information in relation to medical presentations or admissions. For example, the platform receives a flag to alert of a medical presentation to the organisations Emergency Department for a patient being actively supported by Mental Health Services in the community.

As a result of this project, BH's experience in relation to digital transformation of the mental health clinical record is that it is crucial that MH services have a purpose-built rather than off-the-shelf or generic electronic record; that it must function across inpatient and community settings, resulting in an integrated file; and that there must be bi-directional accessibility between the acute hospital and MH electronic records. Further, bespoke programs have the capacity to deliver enhanced performance at considerably reduced cost compared to the large, commercially available, and whole of hospital type products.

Recommendations:

16. Review and update of the CMI/ODS system to ensure usability and timely access to reportable data

Effort and resource needs to be applied to update the usability and functionality of the CMI/ODS system with consideration to usability, quality and reliability. A focus on three main elements is needed in the update of the system.

- system interoperability that allows for DMHS's to upload local data collected within local bespoke databases to minimise double handling and wasted resource by having to replicate data entry across multiple clinical systems
- DHHS support for services to locally extract KPI and contact data sets from local systems for submission to DHHS in meeting reporting requirements (as per current ability with the triage minimum data set) while again reducing dual entry and ineffective use of resourcing. This will require the development of technical specifications for provision to DMHS's across all reporting requirements to ensure services continue to report appropriately
- real time reporting of all mandatory data sets to allow services to proactively monitor performance and interrogate service data in reviewing and informing service provision at a local level without having to wait for quarterly KPI reports with considerable lag time. Data extraction for up to date, proactive reporting and performance monitoring is currently difficult if at all possible and without access to review detailed reportable data, services will continue to have limited ability to efficiently identify and systematically implement strategies to drive change and achieve DHHS set targets proactively

17. Statewide measures and service targets need to be reviewed to ensure reporting requirements accurately capture meaningful and longitudinal data that creates accountability and monitors performance of DMHS's while also promoting and informing safe, quality and effective service provision at a local and state level

Current KPI and reporting requirements remain unchanged and while they provide commentary against DMHS service performance, as they are, they do not create a comprehensive or accurate picture. Current measures collected and reported at a state level do not capture and reflect unmet demand or wait times for treatment beyond those within major Victorian ED's. In addition, small rural hospitals who provide care for rural communities and operate Urgent Care Centres (or equivalent) are not currently required to capture and report on mental health presentations at any level leaving mental health within these settings 'invisible' within the broader system.

Data collected and reported at a state level needs to provide a complete picture of mental health service provision against need in order to understand current effectiveness and meaningfully direct future efforts in relation to the changing needs of Victorians at the service level and at a state level. Accountability at the state level to utilise data reported to identify and then respond to broad systemic

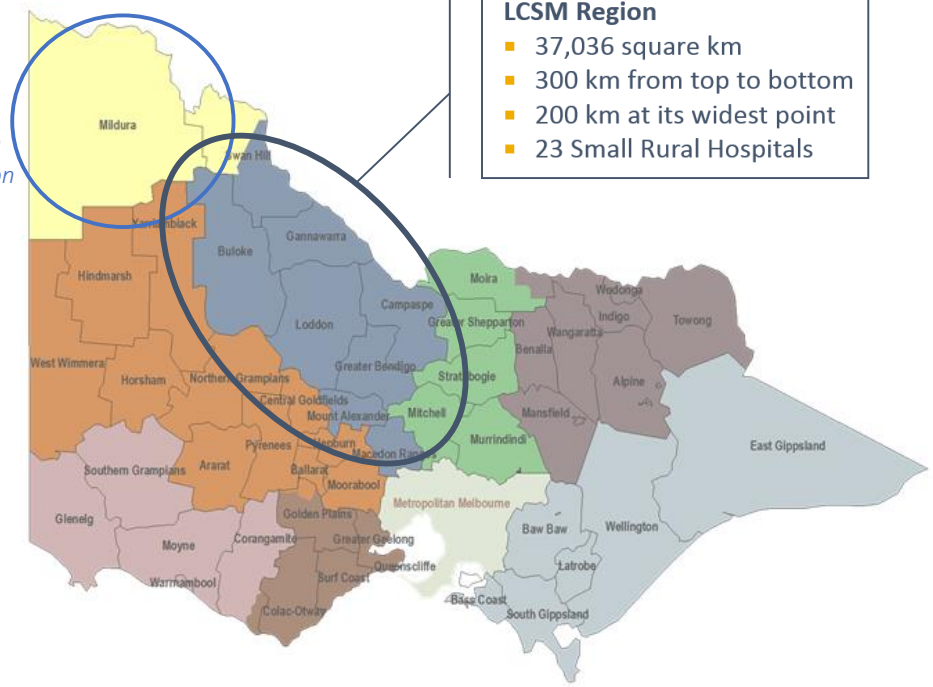
service gaps (i.e. unmet demand and access issues) is essential to ensure the broader Victorian mental health system does not become stagnant once again in the future.

APPENDIX 1

Bendigo Health Mental Health services (BHMHS) – Service Profile

Bendigo Health Mental Health Services provides mental health services across the Loddon Campaspe Southern Mallee (LCSM) region.

After hours Regional Triage also cover the Northern Mallee region



LCSM Region

- 37,036 square km
- 300 km from top to bottom
- 200 km at its widest point
- 23 Small Rural Hospitals

LCSM region **Small Rural Hospitals** (*23*)

2017/18 Service Data

- Triage phone screenings: 10,364 (avg. 28 per day)
- Total ECAT Assessments: 1,725
- Psych ED admits: 727
- Total admissions: 1,400 (Inpatient)
  722 (Residential)
- Current active cases: 1116

Based across 11 regional sites - Greater Bendigo region, Echuca, Swan Hill, Castlemaine, Maryborough and Kyneton - services are provided across three service settings; Inpatient, Residential al and Community.

LGA Profile

Population – 282,388

Diversity, Disadvantage and social engagement

The percentage of:

- people of **Aboriginal and Torres Strait Islander origin** is above the state measure
- **humanitarian new settler arrivals** is among the highest in the state
- people who **feel valued by society** is among the lowest in the state
- people **with food insecurity** is among the highest in the state
- **children with emotional or behavioural problems at school** entry is higher than the state measure

The rate of **child protection investigations** completed per 1,000 eligible population is well above average, but the rate of substantiations is only slightly above

Registered MH patients per 1,000 population 2nd highest in state

Intentional injuries treated in hospital per 1,000 population 3rd highest in the state.

LGBTI population data not collected on entry statistically – will be highlighted in treatment plan/notes.

Inpatient Services

Parent Infant Unit (PIU)

- 5 beds
- Average Occupancy 65.1%

Adult Acute Unit (AAU), ages 18-64

- 35 beds, including 5 ICA beds (with capacity to swing to nine)
- Average Occupancy 92.8%

Extended Care Unit (ECU), ages 18-64

- Current beds: 15
- Future beds: 20
- Average Occupancy 94.8%

Older Persons Unit (OPU), ages 65+

- 20 beds, including 4 HDU beds
- Average Occupancy 92.8%

Residential Services

Continuing Care Units (CCU), ages 18-64

- 12 beds
- Average Occupancy 73.7%

Adult Prevention and Recovery Care (PARC), ages 16-64

- 10 beds
- Average Occupancy 81.7%

Youth Prevention and Recovery Care (YPARC), ages 16-24

- 10 beds
- Average Occupancy 78.9%

Dual Diagnosis Unit (DDU), ages 18-64

- 8 beds
- Average Occupancy 64.7%

Community Services

Child and Adolescent Mental Health Services (CAMHS), ages 0-17

- Based in Bendigo with clinicians also based in Swan Hill, Echuca, Castlemaine and Kyneton

Youth Community Mental Health Team (YCMHT), ages 18-24

- Based in Bendigo with clinicians also based in Swan Hill, Echuca and Castlemaine

Adult Community Mental Health Team, ages 25-64

- With teams based in:
  - Bendigo
  - Echuca
  - Swan Hill
  - Castlemaine
  - Maryborough
  - Kyneton

Older Persons Community Mental Health Team (OPCMHT), ages 65+

- Based in Bendigo with clinicians also based in Swan Hill, Echuca, Castlemaine, Maryborough and Kyneton

Short Term Treatment Team (STTT)

- Provides short term follow up and assessment across the Greater Bendigo region all ages

Primary Mental Health Team (PMHT)

- Provides advice and consultation to external health providers i.e. GP's
- Offers assessments for individuals with non-urgent and low risk mental health issues

Perinatal and Emotional Health Program (PEHP)

- Provides early intervention for women and families experiencing emotional difficulties during pregnancy and up to one year of birth

Specialty Services

- Kids with Confidence
- Families where Parent/s have a mental illness (FaPMI)
- Mental Health Carer Support Program
- 8 Olinda Street: Community Library and Support and Education Centre
- Mental Health Spiritual Care Practitioner
- Women's Mental Health Program
- Consumer Consultant
- Family and Carer Project Worker
- Post Discharge Peer Support Workers
- Improved Housing Initiative
- Access employment worker
- Annual Review Clinic
- Autism Disorders Assessment Clinic (ADAS)
- CAMHS & Schools: Early Action Program (CASEA)
- Consultation Liaison Psychiatry
- Headspace FTE contribution
- Tobacco Treatment Specialist Nurse
- Dual Diagnosis Coordinator
- Forensic Clinical Specialist
- MHARS Clinicians
- Reducing Restrictive Interventions Coordinator/s
- Small Rural Hospital Educator
- Hospital Outreach Post-suicidal Engagement (HOPE) initiative