Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF KARYN COOK

I, Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, of Warrnambool Community Health, Koroit Street, Warrnambool, Victoria, say as follows:

BACKGROUND

Qualifications

1 I am a Registered Nurse and hold the qualification of a Bachelor of Psychiatric Nursing from the Royal Melbourne Institute of Technology. I also hold the following qualifications.

(a) Diploma of Applied Science in Psychiatric Nursing from the Phillip Institute of Technology.

(b) Graduate Diploma in Mental Health Sciences (Young People's Mental Health) from the University of Melbourne.

(c) Graduate Certificate in Dual Diagnosis (Mental Illness and Alcohol & Other Drugs) from the NSW Institute of Psychiatry.

(d) Diploma of Alcohol and Drug Works from North Melbourne Institute of Technology.

(e) Master of Advanced Nursing Practice (Mental Health) from the University of Melbourne.

2 In May 2013, I became a Member of the Australian College of Mental Health Nurses and became a Credentialed Mental Health Nurse concurrently.

3 I hold a Diploma in Business (Frontline Management) through Psychiatric Disability Services of Victoria. I am a graduate of the Australian Institute of Company Directors (**GAICD**) and the University of Adelaide's Executive Education Professional Management Program. I am currently studying a Master of Business Administration with the Australian Institute of Business.

Previous roles

4 My previous roles include the following.

(a) Nurse in Charge of the Wellington House Community Residential Withdrawal Unit and Assessment/Planning Outpatient Service at Box Hill Hospital (February 2005 to December 2006).

(b) Nurse Unit Manager of the Wellington House Community Residential Withdrawal Unit at Box Hill Hospital (January 2007 to November 2008). This role involved managing the day to day operations of a twelve bed residential acute withdrawal unit.

(c) Clinical Services Manager at Eastern Health Alcohol and Drug Services (November 2008 to January 2010).

(d) Senior Injury Management Advisor and Technical Services Manager at Territory Insurance Office in the NT (January 2010 to November 2010).

(e) Clinical Director (Alcohol and Drugs Diversion Programs) with the NT Department of the Attorney-General and Justice (November 2010 to July 2013). This role required operational and clinical leadership, senior clinical contribution to the development and implementation of programs, policies and procedures within the Department of the Attorney-General and Justice and engagement with a stakeholder network that included the Department of Health, AOD treatment agencies, courts, police, corrections and rehabilitation providers.

(f) Inaugural Manager of Darwin Alcohol Assessment and Treatment Services and Katherine Mandatory Alcohol and Rehabilitation Service Unit (**MARS**). This role involved clinical and operational leadership in the implementation and provision of evidence-based primary health care, chronic disease management and AOD treatment across two facilities containing 104 beds (July 2013 to March 2014).

(g) Inaugural Manager of Treatment Services at Turning Point under the purview of Eastern Health, which involved supporting the implementation of the Victorian AOD reforms (April 2014 to October 2014).

(h) Executive Manager, Mental Health and Wellbeing at Anglicare NT (September 2014 to October 2016). This role involved clinical, operational and strategic oversight of major mental health programs, including the headspace Early Psychosis Program and Suicide Postvention Programs. I carried the portfolio for Clinical and Client Practice Governance and Risk Management for Anglicare NT and had operational and financial oversight of program delivery under grant agreements with Commonwealth and state government agencies and not-for-profit organisations.

5 I have also held other professional appointments, including:

(a) from July 2016 to November 2017, I held the role of Board Director of the Mental Health Coalition; and

(b) in April 2016, I was appointed to the NT Health and Community Complaints Commission Review Committee by the NT Minister for Health; a role which I held until October 2019.

Current roles

6 I was appointed Executive Director of South West Healthcare (**SWH**) Mental Health Services (**SWH MHS**) in October 2016.

7 As Executive Director, I have direct operational responsibility for mental health services for the South West Region Area Mental Health Service (**AMHS**), which services an area of approximately 26,000 square kilometres and a population of approximately 110,000. The role involves direct responsibility for the strategic direction, coordination and management of SWH MHS which covers:

(a) primary and specialist services;

(b) Aged Persons services;

(c) Child and Adolescent Mental Health (**CAMHS**) services;

(d) four Adult Mental Health Services;

(e) a Mental Health Access Team based in Warrnambool; and

(f) a total of 30 beds, made up of 10 Adult and 5 Aged Acute beds; 5 Sub-Acute beds and 10 funded Prevention and Recovery Care (**PARC**) beds (there are an additional 3 beds and the option within the original PARC model of care for 2 day places at the PARC facility that have not been commissioned or funded to date).

8 There are no CAMHS beds available in the South West region. The AMHS caters for some community members who reside at least 5 hours from metropolitan Melbourne by car, or up to 10 hours by public transport, if available to them.

9 I also have organisational responsibility for consumer engagement and partnership in:

(a) AOD service delivery;

(b) suicide prevention and postvention programs;

(c) mental health services across the region (eg with partner AMHS); and

(d) promotion and engagement for access to services to the LGBTIQ community.

10 My role also involves chairing and executive sponsorship of a number of board committees, governance committees and strategic working parties in SWH. These relate to Alcohol and Other Drug Services and catchment planning, headspace consortiums, suicide prevention, mental health services and catchment planning and Emergency Services Liaison Committee.

11 In addition to my role at SWH MHS, I also hold the following professional appointments:

(a) Board Director of Heywood Rural Health, Victoria. I commenced in this role in July 2019 and will continue until July 2022;

(b) Independent Member of Warrnambool City Council's Audit and Risk Committee. I commenced in this role in November 2018; and

(c) Member of the Western Victoria Regional Training Hub Community Advisory Board at Deakin Clinical School. I commenced in this role in March 2018.

12 Attached to this statement and marked **KC-1** is a copy of my CV.

CHARACTERISTICS AND NEEDS OF PEOPLE EXPERIENCING A MENTAL HEALTH OR SUICIDAL CRISIS

13 There are many examples of situations where a person is likely to need crisis responses from mental health or other professionals. In general terms, persons with serious mental illnesses from time to time experience symptoms which require acute assessment and treatment to ensure the person is safe and is not a risk to themselves or others.

14 Persons with serious mental illnesses may require crisis response from time to time throughout their life, including when a person first experiences the onset of symptoms which eventually becomes a diagnosed serious mental illness or illnesses, and throughout the trajectory of their illness or illnesses.

15 Many people with serious mental illnesses may be stable in relation to their mental illness and managing within their lives as they choose, with or without ongoing pharmaceutical treatment for many years. However, at times, persons with serious mental illnesses may experience life stressors (or triggers) that add to the person's vulnerability to a relapse of symptoms or the experience of new or different symptoms related to their mental illness. This often leads to a crisis and the requirement of a crisis response from a specialist clinical AMHS.

16 For example, persons living with serious mental illnesses such as bipolar affective disorder, major depression or schizophrenia are often supported to be well in the community through long term pharmacological treatment. This may be with, or without, the addition of psychological therapies and psychosocial supports such as the persons' own support network (which may be family members, friends, or vocational activities). Persons living with these illnesses may experience a relapse of acute symptoms due to changes with one of the supportive processes keeping them stable and well in the community and/or the addition of significant stressors, such as housing insecurity, loss of a significant other, financial issues or non-adherence to medications (by choice, or due to other factors such as physical injuries or illnesses where ongoing mental health treatment may be disrupted). With a relapse of acute symptoms, the person may become unwell, confused, disorganised or at risk of harm to themselves and others, which can

lead to a crisis presentation directly or via family, other treatment providers or emergency services.

17 The crisis may present in the form of the person, as a result of the symptoms of their mental illness may be at risk of harm to themselves or to others, and may require compulsory assessment and possibly treatment in the community or at a designated mental health facility; whichever is deemed to be the least restrictive and safe option. The decision on the least restrictive option, will relate to a number of factors, including household and community supports available to the person in crisis, the presenting behaviours, actual communication from the person in crisis, symptoms of mental illness and identified risks, along with collateral information from family members, education providers or treating health professionals such as General Practitioners, counsellors or psychologists.

18 Attached to this statement and marked **KC-2**, is a confidential example of a situation requiring crisis responses from mental health or other professionals.

Common characteristics of people in crisis situations

19 People in crisis are often experiencing high levels of distress, exhibited in a variety of ways, that impact on their ability to regulate their own mood, thoughts and behaviours. A person in crisis may express a high level of emotion and be demonstrably upset, or be withdrawn and unable to express their needs to others. This may be further exacerbated by the use of alcohol or other drugs, often taken to help alleviate the crisis, but instead having the consequence of further exacerbating the crisis by impairing judgement, increasing impulsivity or worsening mental health symptoms such as psychosis. People in crisis can present with risks associated with decision making, related to their own safety or that of others, and may be prone to impulsive thoughts, decisions and actions. A person in crisis can broadly be described as being in distress.

Common characteristics or situations leading to a state of distress

20 All persons in crisis are unique and have a unique set of circumstances that leads to what might be termed as a crisis situation. There are numerous situations that can lead to a person experiencing a crisis and there will often be multiple factors. However, there are some common themes.

21 Crisis very often relates to a change in circumstances for the person, such as housing or food vulnerability, changes in relationships, death of a loved one, employment or business difficulties reducing access to income (such as loss of hours at work or impacts on farming income resulting from, for example, a reduction in milk price, bushfires, drought and other natural disasters or states of emergency).

22 At times, people can present in crisis related to change in medications, missed medications (including long acting injectable or regular oral medications) or due to other co-occurring illnesses and treatments that have affected their mental health treatment, such as recent surgery or life threatening illnesses where the medication to treat mental illness was unable to be continued for a period of time.

23 Crisis often relates to stressors linked with the social determinants of health (as described by the Australian Institute of Health and Welfare framework).[1] These include early life experiences, housing, socio-economic factors, access to healthcare, social exclusion/social disadvantage, employment/vocational, residential environment including access to public transport, services and recreation and support networks which are described as 'social capital'.

Common needs of people in crisis that may be met by other service providers

24 Following from the social determinants of health, common services required by consumers of mental health services often relate to housing, finances (including access to work and vocational education), primary health care (including general practitioners (**GPs**) primary mental health care and medicines), social connectedness, and access to public transport and services (for example, Centrelink, employment agencies, disability and allied healthcare providers).

25 A significant number of community mental health services are funded by the Commonwealth and/or State Government to provide mental health support outside of the Victorian state funded clinical mental health system, including crisis support to the Victorian or Australia-wide community via telephone, online, or in person (for example, Lifeline). These services fill some gaps, but anecdotally, we find that rural people do not necessarily know about these services, decide not to access them or prefer to access face to face services, where available. SWH MHS promotes access to community supports where appropriate and where they are available for rural people.

26 Often the needs of individuals who experience crises relate to ensuring they have regular reviews with their treating GP for both their mental health and physical health needs, and that they are connected with their usual support networks or linked in with other key agencies to address a specific need, such as housing, vocational, legal or psychosocial needs. Access to GP care is more challenging in rural areas (see paragraphs 40 to 42 below).

27 AMHS, particularly those in rural settings, away from main rural city centres provide linkages where possible to these other service providers. However, often the service

[1] https://www.aihw.gov.au/getmedia/11ada76c-0572-4d01-93f4-d96ac6008a95/ah16-4-1-social-determinants-health.pdf.aspx

provider is not located or available in the more rural settings and the burden will fall back to the AMHS clinicians, who may not have the skill set, or the time away from clinical work, to provide these kinds of services to meet all the needs of the consumer.

28 For example, supported housing options for persons with mental illnesses are only available in very limited numbers in Warrnambool, which may not be accessible or suitable for a person living in Heywood, Casterton, or beyond. The next closest options are Ballarat and Geelong, which might be 3-4 hours away from the persons' hometown, where their family and support networks are located. SWH MHS often finds itself spending significant time working with consumers who have housing insecurity, which impacts on their mental health recovery journey. Suitable supported housing options for Aboriginal people close to country, their family and community is almost impossible to find in the South West of Victoria.

29 SWH MHS are also accepting new referrals for persons with high mental health and psychosocial needs who have relocated to rural areas, often due to cheaper housing options. They often have minimal support networks, limited access to GPs and no public transport which often further isolates them. Limited or no access to these kinds of services creates vulnerabilities for the person, which can lead to the person experiencing crisis and these services may not be available to support them to recover in times of crisis.

Different characteristics, situations and needs for people in crisis in a regional and rural environment

30 Some of the characteristics, situations and needs requiring a crisis response from mental health services are different, or exacerbated, in a rural environment.

31 Isolation and disconnectedness is a major stressor for people in rural areas, contributing to their vulnerability to mental ill-health and poses many challenges for a person on their recovery journey.

32 For instance, lower population numbers mean people in smaller townships may have limited or nil psychosocial supports and access to extremely limited public transport and services infrastructure (e.g. trains, buses, and government offices such as Centrelink).

33 There are also geographical reasons causing isolation. Persons and their families living in rural areas include farms where neighbours and services may be many kilometres away, often adding to a sense of disconnectedness. Without regular access to a vehicle or the ability to take the time to drive hours to and from services, older persons, adults and young people in townships in rural Victoria can be isolated and not readily able to access supportive networks.

34 Social connectedness may come from sporting clubs; particularly football, netball and cricket clubs in the South West of Victoria. The local sporting clubs often have club rooms which serve as a venue for locals to meet up or attend social functions. Families and individuals who do not engage in sport or support sporting teams, may not have the same level of community connectedness as those that do. Other organisations such as rural schools, RSLs and Scouts can provide opportunities for people and/or their families to connect with their peers and neighbours within a rural context (for example, those from farms).

35 In rural areas, it can be quite challenging for people new to the area to integrate into the community, make friends and feel part of the community. In the South West of Victoria, there is a low percentage of refugees and migrants,[2] which can be a barrier for some immigrants to find support networks amongst other immigrants from the same country of origin; in addition to the usual challenges of 'breaking in' to a new community. Refugee and migrant services are limited in rural settings, particularly in the South West of Victoria. Services are often limited to the larger populated towns and regional cities; and may be difficult for a person living one, two or more hours away from the service to access.

36 There are also differences in the way in which ongoing care, and a consumer's needs, can be managed in rural areas. Access to community-based mental health services in most rural areas is extremely limited. Some larger centres in the south west of Victoria including Warrnambool, Hamilton and Portland have some community-based mental health services on offer (for example, Wellways), but many do not provide outreach (home visits) into rural areas. AMHS on the other hand will see people at home, including farms and residential care facilities. This can involve hours of travelling for clinicians, limiting clinician availability to others and often means that only a small percentage of people are seen. This time required for travel to consumers puts pressure on the clinicians to meet the needs of all of their consumers, including new referrals (which are often crisis presentations). The current activity based funding methodology does not adequately account for providing access to people isolated in rural areas, leading to a number of vulnerable persons in rural settings simply missing out on clinical mental health services and crisis responses.

37 Further, AMHS engaged in clinical care and ongoing case management or shared care with a GP work quite differently at times to their metropolitan counterparts. They will often provide the connectedness for mental health consumers who may not be able to access any other supports due to their geographic isolation. The further away from larger centres a consumer is, the less options they have for support in the community mental health and

[2] As at the 2016 census, 92.7% of the population was Australian-born in the 5 Local Government Areas (See https://www.abs.gov.au/websitedbs/D3310114.nsf/home/2016+Census+Victoria and https://www.vic.gov.au/sites/default/files/2019-08/6-Four-page-profiles-for-Major-Regional-LGAs-30May18.PDF and https://www.vic.gov.au/sites/default/files/2019-08/7-Two-page-profiles-for-rest-of-Regional-LGAs-30May18.PDF).

primary health sector. In short, it is more challenging for a rural person to have all their needs met in relation to the social determinants of health.

Barriers and enablers to referring consumers to non-mental health services

38 Consumers of an AMHS will often have unmet non-mental health needs. The way in which we link these consumers up with (or refer them to) other non-mental health services to ensure their needs are met differs depending on the service or need, and the persons' location. There are also barriers to doing so effectively.

39 Consumers of an AMHS will have a need for a GP as close to their home as possible. However, this is not always achievable, with a general shortage of GPs in rural and regional Australia, including the South West of Victoria.

40 Many GPs in rural areas are ready to retire, and they are already limited in number. A small town may have a GP visit once a fortnight or once a month, and there are a number of such towns throughout the SWH MHS catchment (for example, Derrinallum and Dartmoor) that have no GP services.

41 Further complications in accessing GPs include if bulk-billing isn't offered, and the high proportion of GPs in rural areas who may not have the capacity to take on new patients. Many GPs in rural settings are close to retiring. For persons who are new to rural areas, this is a major barrier to accessing necessary primary health care. Without regular access to appropriate primary healthcare, people often come to the attention of SWH MHS when they are in crisis as there has not been a mechanism to identify early warning signs of mental ill-health (such as high prevalence disorders or a relapse of a serious mental illness).

42 AMHS are often the facilitators of linking consumers in with primary care, alcohol and other drug services, and financial, legal and housing support. There are often long waiting lists for housing and food security services and other essential supports for individuals and/or their families. Often, persons who are on waiting lists for these services can present in crisis. Linkages to general counselling, specialist trauma counselling (e.g. CASA or Family Violence Services), and psychosocial disability providers can be time consuming and extremely difficult to source and arrange for consumers who do not live in, or near, one of the larger centres in the South West of Victoria. With a clinical mental health service undertaking significant 'gap filling' for non-clinical mental health services; this can be detrimental in the ability to provide services where the greatest need lies.

PROVIDING CRISIS RESPONSES TO PEOPLE EXPERIENCING MENTAL HEALTH OR SUICIDAL CRISES

Regional and rural environments

43 SWH MHS offers an integrated mental health service, meaning we do not have Crisis Assessment and Treatment Teams (**CATT**) or Mobile Support and Treatment Teams (**MSTT**). However, we attempt to offer that function if at all possible where there is a need for a consumer, as part of our integrated service delivery.

44 During business hours, stakeholders are encouraged to ring or attend one of the four community mental health services locations (Warrnambool, Camperdown, Hamilton and Portland). The clinicians at the mental health service will undertake screening if a person 'walks in' to one of our offices or an Emergency Department (**ED**) on the same site as our MHS offices or otherwise over the phone, via telehealth, from our MHS site. Clinicians from offices not co-located on the same site as an Urgent Care Centre (**UCC**) will attend if requested by the UCC to assess a person presenting with mental health concerns during business hours. The clinician may quickly move to an Initial Needs Assessment if indicated or support the person to access appropriate services, such as from a GP or a provider within the community.

45 SWH MHS has a 1800 number telephone line available 24 hours per day, 7 days per week, for mental health emergencies. Calls coming via the 1800 number during business hours are transferred to the correct team as per the above. Outside of normal business hours the Access Team will conduct a screening and, if applicable an assessment, via telehealth or over the phone.

46 If it is not appropriate or unlikely to be effective to conduct an assessment over the phone or telehealth, a person may be transported to a UCC, ED, or AMHS where a clinician may attend to carry out an assessment. Where it is not safe to transport the person to a UCC, ED or AMHS then, (depending on acuity), at least two clinicians (where assessed as safe to do so) may attend to undertake an assessment at a referral GP practice, police station or the consumer's home. Police and/or ambulance may be called to attend with the clinicians or it may form part of a Mental Health and Police (**MHaP**) response.

47 Persons in crisis may also present at an ED or UCC directly. If this occurs outside of business hours or the person is located too far away for the clinicians to travel to, the consumer may be able to participate in an assessment via telehealth (or telephone if telehealth is not available or appropriate).

48 This assessment undertaken by the clinician, includes a formulation of the presenting issues. An appropriate plan is then developed in conjunction with the on-call medical workforce and/or ED staff. A number of outcomes can occur after the assessment. The

clinician may recommend the person be transferred to the designated mental health facility, which for SWH MHS, is Warrnambool Base Hospital. This transport is usually via ambulance. It may result in an admission to an acute inpatient mental health bed or a plan to support the person in the community. For admission under the *Mental Health Act*, the person must, in the opinion of the mental health clinician, meet the criteria for compulsory treatment, which may include an inpatient admission for further assessment.

49 Outside of business hours, a crisis response in the rural context is often a joint response. By this, I mean that it is a response by both SWH and emergency services. Often the police are at the front line of crisis response, sometimes when the consumer themselves calls the police. Usually the police attend a callout to a consumer, undertake a risk assessment, and transport the consumer to an ED. Alternatively, sometimes the response is undertaken through the MHaP program, where a police officer and a senior mental health clinician are on shift together five nights a week and the senior mental health clinician on duty will attend the callout along with the police.

50 SWH MHS was the last AMHS in Victoria to receive funding for the MHaP, in late 2016.

51 Ambulance Victoria often responds as well, depending on the need and/or resourcing.

Barriers to regional and rural mental health services providing an effective, person-centred crisis response

52 There are no child or adolescent beds for mental health services in the region covered by SWH. While the Royal Children's Hospital (**RCH**) has allocated state-wide child and adolescent beds which SWH MHS CAMHS can access, these beds are not always available and are not prioritised to "those most at need". This system lends itself more to prioritisation of consumers well known to the RCH and less so to consumers from regional and rural areas who may be less known to services. Often the RCH CAMHS beds will be full, or they have some beds or rooms closed due to a recent incident. Sometimes we are forced to admit children to a non-mental health paediatric bed or adolescent consumers into adult mental health inpatient settings that are not appropriate for the consumer, and we have to put quality and safety controls in place. SWH MHS does not have staff specifically trained or with recent practice experience to work with children and adolescents in an inpatient setting.

53 Finding a bed for a consumer in crisis anywhere in the South West region of Victoria, whether they are a child, adolescent, or adult (if SWH MHS Adult beds are full), is incredibly difficult and time intensive. The managers and I can be making multiple calls to senior people within other health services trying to access a bed for 16 to 20 hours or over a number of days. We often have to cycle through calling the RCH, Austin Health, Eastern Health, Monash Health or Orygen, usually without success within a reasonable

timeframe. We are often informed that those services are either full, have impending/probable admissions or may not have staffing levels to accommodate new admissions. Generally, paediatric units in general hospitals will not take child or adolescent mental health consumers because their facilities are not purpose-built for mental health and their staff are not trained in assisting patients who are at risk of self-harm. Occasionally a child may have co-morbidities which require care in a paediatric unit, such as non-mental health surgical treatment, childhood illnesses or eating disorders. As a small service, SWH MHS are impossibly stretched to support non-mental health bed admissions or long ED stays with mental health staff providing 1:1 care, known as 'specialling'. Given we have only a small casual pool of mental health clinicians, if this kind of care is required, it involves overtime for CAMHS clinicians or senior staff, including myself from time to time.

54 The pressure on the system has stretched and broken down relationships between the health services. The mental health sector used to have quarterly forums that allowed clinicians and directors from different services to build relationships. This made it easier to call other services and ask for their last bed when in need. However, the DHHS Mental Health and Drugs Branch does not hold these forums anymore. There is a lack of a system-wide approach. A recent example is that SWH MHS was omitted from the State-wide bed flow weekly forum until COVID-19.

55 One of our biggest barriers is the size of our regional footprint. If there is a crisis on the border with South Australia, it takes a few hours to get there. We have only a handful of clinicians who can respond and when one attends an 'at distance' crisis response this significantly depletes our capacity to address any other cases that arise.

56 It is also more difficult for mental health services in rural areas to get access to ambulances. Even if we can find a bed for a consumer, we might not get an ambulance transfer for 24 hours. We therefore need resources to look after that consumer until the ambulance arrives. In the wait for an ambulance, the consumer often has to stay in the ED. While we provide training and information to assist the ED to retain and care for these consumers, the ED clinicians and staff are not specifically trained in mental health care. Sometimes a consumer may leave the hospital altogether during the wait for an ambulance as a result of long wait times for an ambulance. A long stay in ED for a mental health consumer is not appropriate, but is often the only option to maintain safety for the consumer. The ED at Warrnambool Base Hospital is old, very small and unable to meet demands of the community adequately when mental health consumers are in the ED for longer than necessary.

57 The long wait time for ambulances is largely because ambulances do not prioritise transfers of mental health consumers. The ambulance service may consider that consumers are safe in hospital, and will respond to other calls on the way to pick up the

consumer. Further, patient transfers take an ambulance out of operation, in the context of a limited number of ambulances and long distances they need to travel within our region to attend emergencies. A single ambulance will not transport the consumer from Warrnambool to the RCH. As a result, consumers are often subject to three or four transfers between different ambulances on the trip from Warrnambool to Melbourne. This is due to the 'requirement' to keep local ambulances in the designated catchment, but is extremely disruptive for the consumer, their carer and adds significant time to the long trip.

58 An additional issue relates to coordinating stakeholders and services required by consumers in crisis. SWH MHS is not funded to undertake this work, so when it is necessary to do so, this takes staff away from work which they are funded to complete. Given the size of the service and inability to maximise funding opportunities through a critical mass, there is not enough funding in the SWH MHS budget to employ allied health and programs staff for the acute inpatient unit, or project staff to undertake this work.

59 SWH MHS currently has a budget for the Full Time Equivalent (**FTE**) of 155 staff, including support staff. There are minimal administrative roles, and much of their time is taken up with data entry to CMI. Clinical teams cover large geographic areas and when vacancies are filled, they are often filled by very junior staff who may take months or years to develop the skills to provide acute clinical mental health services independently. Managers work directly with their staff on clinical work, and are not supernumerary. This means managers have little opportunity to provide support to senior management in implementing quality improvement activities, and new projects, programs and positions. For example, in the last two years at SWH MHS, programs such as Consultation and Liaison, MHaP, Way Back Support Services, Rough Sleeping Program, and the NDIS Interface have been undertaken by SWH MHS as best it can, without project implementation and management support. I, along with other senior managers, take on a considerable direct or indirect clinical role (secondary consultation and decision support) on an ongoing basis due to the flat structure and small size of SWH MHS.

Enablers to regional and rural mental health services providing an effective, person-centred crisis response

60 To enable regional and rural AMHS to provide an effective, person-centred crisis response, these services require:

(a) appropriate funding with a rural loading for beds and community based care (by removing population based funding models for rural services);

(b) appropriate resources such as ambulances and police readily available when needed to reduce the need to "compete" with other local demands on those services;

(c) where possible, co-located resources (for example, mental health co-location in EDs, with police and with ambulance services), supported by memorandums of understanding and the ability to be flexible in roles and positions (including increased service FTE);

(d) community health literacy and knowledge of services to potentially build resilient, social capital and avert crises before they occur.

AMHS working with emergency services to address consumers' distress

61 SWH MHS endeavour to work together with emergency services (such as police and ambulance) to address a consumer's distress. However, there are often barriers to working effectively in that way.

62 In more remote areas, police, ambulance and EDs or UCCs work closely together to manage crises through necessity and limited resources, although in many circumstances, our emergency services colleagues may not be highly skilled in de-escalation and safe management of consumers suffering a mental health crisis. We do not have mental health clinicians available to attend the more remote UCCs. If they have concerns about occupational violence and aggression by a mental health consumer, they may need to act quickly to sedate or physically restrain the consumer.

63 One way we are seeking to address this is through a telehealth consultation with a mental health clinician early in the consumer's presentation to the ED or UCC. The effect of this is that when a mental health consumer comes into an ED or UCC, we use telehealth, in partnership with the ED staff to observe and speak to the consumer. This allows an assessment by experienced mental health clinicians and allows collateral information to be gathered. Without telehealth, we would be deploying mental health clinicians on a four hour trip from Warrnambool – and the consumer may have been sedated in that time, meaning that the clinicians would be unable to make an assessment of the consumer upon their arrival.

64 Another way in which we work with police and ambulance services to try to address barriers to working effectively is through the Emergency Services Liaison Committee (**ESLC**). The ESLC includes representatives from police and ambulance services and our access (triage) teams, EDs and UCCs. There are 12 hospitals in the South West region covered by SWH. Two of these hospitals have EDs, and the rest have UCCs (with the small rural UCCs being nurse-led (some of whom are Rural and Isolated Practice Endorsed Nurses (**RIPEN**)).

65 The issues we discuss in the ESLC include occupational violence and aggression, and rapid sedation of consumers. The ambulance service has a zero tolerance policy for aggression, and due to gaps in transfer times, may need to resort to using sedation or

physical restraints to deal with aggressive consumers. Ambulance paramedics may need to heavily sedate aggressive consumers using Fentanyl which is indicated in the current Ambulance Victoria Clinical Practice Guidelines for use in Agitation.[3] This sometimes means upon arriving at a hospital UCC or ED, the consumer is too sedated for the mental health clinicians to assess.

66 Persons presenting with mental health crisis who are significantly sedated or intoxicated are unable to be assessed by mental health clinicians, often causing tension and frustration for ED or UCC staff, which at times, can impact upon professional relationships. The majority of complaints I receive from other health services relate to their belief or perception that mental health services have not been responsive enough to their needs. These kinds of issues are regularly discussed at the ESLC.

67 The ESLC is designed to enable all frontline emergency services an opportunity to share knowledge, and develop practices, policies or service level agreements as to how we will work together in relation to mental health emergency/crisis presentations. The ESLC can be a quality improvement enabler, have input into the development of new programs or systems (e.g. MHaP or telehealth for urgent mental health assessments in EDs and UCCs). At times, issues that have arisen in the preceding two months are raised for resolution, to discuss learnings and improvements for the benefit of all the ESLC stakeholders, the consumers and their families. The ESLC also allows important relationship building to occur, which is essential in rural settings. We often find that EDs and UCCs do not see mental health consumers as their patients, even whilst they are presenting or in the care of the ED or UCC, because they view MHS as having primary responsibility for the patient. SWH MHS finds that to be one of the largest barriers to collaborative care and relationship building.

Improving crisis responses in regional and rural environments in the future to ensure outcomes are increasingly person-centred

68 In order to improve crisis responses in rural environments in the future to ensure outcomes are increasingly person centred, there has to be a collaborative approach between AMHS, emergency services and EDs. Improving the service system is not simply about funding, although this is a significant factor. In the absence of appropriate funding that addresses rurality and equal access to services for persons in rural and remote settings, we need a model that expands upon the MHaP Response program across all rural areas. A potential model could include having teams of mental health clinicians based throughout the South West Victorian region that are emergency responders, dedicated to responding to mental health crises readily and effectively in partnership (where needed) with police and Ambulance Victoria. Governance and funding of such a

[3] https://www.ambulance.vic.gov.au/wp-content/uploads/2018/07/Clinical-Practice-Guidelines-2018-Edition-1.4.pdf

model would need to be carefully thought through, supported well during implementation and externally evaluated to ensure success and sustainability.

69 The opportunity presented by telehealth could be maximised in this model. Mental health clinicians cannot always respond to calls alongside police – it may be too dangerous, or there may not be enough clinicians on the ground. However, police could take an iPad or similar device to these callouts so that mental health clinicians can see the consumer and the environment in context and either assist the police with suggested measures on how to de-escalate the situation (particularly if the consumer's history is known to mental health services), or advise the police to transport the consumer for assessment and treatment to the most appropriate setting. This would be better than being on the phone, as the clinician could see all of the context.

70 Instituting collaborative response teams that respond to mental health crises within a 100 km radius of their base would deliver better outcomes and reduce the number of consumers presenting at EDs or UCCs in crisis.

Tailoring crisis responses for different cohorts

Children and youth

71 The core element of a crisis remains the same for adults, youth and children– that is, the consumer is unable to manage without some kind of assistance. However, a mental health crisis may manifest differently when dealing with a child. There may be indicators or manifestations similar to a crisis for an adult consumer; for example, self-harm and suicidal ideations. Alternatively, the younger consumer might exhibit behaviour that is distressing or harmful to others and more common in children, for example, hurting the family pet, acting aggressively towards family members causing parents to be concerned about their own safety or the safety of siblings.

72 Accordingly, the crisis response for a young consumer needs to be different than it would be for an adult, and within that sub-speciality there are further differences in treatment depending on the age of the young person. This can be due to the following.

(a) A young person's developmental stages.

(b) Emerging issues in the younger cohort can be the result of trauma (eg stemming from abuse in either the family setting or institutional abuse) or may be the manifestation or beginning of eating disorders. Although crises experienced by adult consumers may also stem from trauma, early intervention for babies, children and young people and families is vital. This can be done by focusing on positive attachment to parents, reducing family violence and ensuring a safe and nurturing environment in a person's early years. People with trauma experiences

in their early lives are more predisposed to developing mental ill-health or mental illnesses in teen or adult years.[4]

(c) The need for a family response. For consumers under 12 years of age, the crisis often manifests in the whole family unit – although this is not always the case. Crisis response for a young person needs to include a carer network, whether this be the consumer's parents or guardians.

(d) The need to avoid utilising the *Mental Health Act* or looking at inpatient admission unless absolutely necessary (particularly given SWH MHS does not have any paediatric mental health beds). Occasionally, inpatient admission of a consumer under 12 years of age is necessary, and in those circumstances, the consumer is accompanied by parents/family during their admission.

73 Clinicians need to be very accommodating around young consumers' development and be able to consider what is important to them. Not all clinicians have this expertise.

74 We have sub-specialties within the broader specialty of mental health in order to cater to children and young people. An example of this is our Child and Adolescent Mental Health Service (**CAMHS**). The metropolitan services tend to have a Children and Youth Mental Health Service (**CYMHS**). The CYMHS model was attempted in rural settings, but was not overly successful. The specialisation required to treat consumers from age zero to age 25 was not present in rural settings due to the small number of clinicians available. In contrast, the CAMHS team treats consumers from age zero to age 18. This leaves rural communities significantly disadvantaged compared to metropolitan communities.

75 The crisis response for children and youth also needs to consider the following issues:

(a) *Access to adolescent beds* – these beds are specifically designed and geared to deliver inpatient care to young people (adolescents) who have different needs and different treatment options to adults. Young people under 18, require a different model of care and generally higher level of supervision than adult inpatient consumers. Currently, there is no state-wide oversight into bed access, or a system for accessing out of area beds (ie, beds which are not located in the catchment of the AMHS). There are also geographical barriers of distance, transfers and lengthy ED wait times. At present, persons under 18 requiring a CAMHS bed need to travel at least 4 hours, often after a long wait for an

[4] Springer K. W., Sheridan J., Kuo D., Carnes M. (2003). The long-term health outcomes of childhood abuse: an overview and call to action. J. Gen. Intern. Med. 18, 864–870; Turner R. J., Lloyd D. A. (1995). Lifetime traumas and mental health: the significance of cumulative adversity. J. Health Soc. Behav. 36, 360–376; Taylor S. E. (2010). Mechanisms linking early life stress to adult health outcomes. Proc. Natl. Acad. Sci. U.S.A. 107, 8507–8512; Pine D. S., Cohen J. (2002). Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. Biol. Psychiatry 51, 519–531; Paolucci E. O., Genius M., Violato C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. J. Psychol. 135, 17–36; Mulvihill D. (2005). The health impact of childhood trauma: an interdisciplinary review, 1997-2003. Issues Compr. Pediatr. Nurs. 28, 115–136; Copeland WE, Wolke D, Shanahan L, Costello EJ (2015). Adult functional outcomes of common childhood psychiatric problems: a prospective, longitudinal study JAMA Psychiatry899-892:(9)72.

ambulance, to access the bed in Melbourne. The disconnect between SWH MHS and the Melbourne bed based service can also create issues around continuity of care and the ability for SWH MHS to meet consumer contact targets within a set period. In order to ensure that adolescents have access to specialised beds when required, increased bed access is required in regionals sites (e.g. Barwon), alongside state-wide leadership in developing a transparent system for navigating state-wide bed access. Such a system should be administered by a central authority that is able to make decisions across the different adolescent inpatient units that is based on bed availability and clinical need, rather than postcode.

(b) *Stakeholder teams* - when vulnerable young people are in crisis and there is no available guardian to provide a history, guardianship is unclear, or there are protective concerns, the current stakeholder systems are limited in responsiveness. For example, a scenario which occurs frequently within our service involves young people (around 16 years of age) presenting to the ED. Often, these consumers have no active parental support (for instance, if the consumer has been living transiently, or there is a history of involvement by the Child Protection Service (**CP**)). There is often a history of family violence in the family of origin or foster family. The young consumer may present with concerns around mental health issues and/or risk, but not acute risks requiring treatment in an inpatient setting. In these circumstances, where the parents are not actively engaged or cannot be reached, it can be very difficult to get consent to work with the young person and a community management plan in place. As a mental health service, we would like to closely partner with CP and youth homelessness services to develop an appropriate and well- formulated shared response. After hours, these scenarios typically result in the CAMHS/AMHS taking responsibility for accessing services on a consumer's behalf, in order to meet the young consumer's psychosocial needs. When doing so, we can experience reluctance or barriers to other agencies getting involved. This may mean that there is no safe, appropriate supervision for the young consumer in the community, and accordingly, this may lead to SWH MHS recommending the consumer be admitted to an inpatient facility in Melbourne to ensure they are safe. These inpatient admissions might otherwise not be indicated by the consumer's symptoms, placing further strain on limited inpatient resources. This creates delays in our ED awaiting a bed to become available and/or an ambulance that is available to transport the consumer. Greater crisis-based interfaces between senior representatives with decision making authority from CP, youth homelessness, youth AOD, education authorities and CAMHS would assist with developing, in a time critical way, shared knowledge of vulnerable young people, and collaborative approaches to interventions and supports in the crisis and

beyond. Currently, the systems are not as responsive in times of crisis as they could be, and each stakeholder can operate in isolation to the other - limiting the shared understanding of risks and needs for the young person and their family. Integration of services to support children and youth in meeting their psychosocial, physical, sexual, alcohol and other drug and mental health needs would be an ideal model to respond to the needs of children and young people intersecting with mental health services in all settings, but certainly in rural settings where access to services is currently very limited, or responsiveness of partnering agencies is delayed

(c) *History gathering* - similarly, each service develops its own history and profile on a young person and their family. This information is not always shared across key stakeholders for a range of reasons- time, consent, a service being unaware of risks/information another service holds, and information being assumed (for example, there was a family violence response from police reported, and an assumption is made that police have notified CP). A system that enables greater recording and sharing of critical risk information across services, and regular meetings between stakeholders to share information for local at risk young people that is supported by clear state wide policy and procedure is required, instead of the current person-based system which is not sustainable when staff turnover.

(d) *Guardianship/consent upon referral of a young person or child to the CAMHS service* - As a sector we require clear guidance on consent complexities, alongside avenues to escalate outside of CP if consent cannot be obtained (for example, an expert and specialised panel around the consent issues and steps to follow; such as a tribunal model). This would be distinct from the Victorian Civil and Administrative Tribunal (**VCAT**), where applications are made for specialised medical treatment or for a guardian if a person has a disability.

Indigenous people

76 At SWH MHS, we do not have a team with specific expertise in addressing the needs of Indigenous consumers because our service is not considered large enough to receive appropriate funding to support the South West community of strong and proud Aboriginal people with significant connection to the lands and waters of the South West dating back thousands of years. However, we are currently in the process of recruiting an employee who will work in the Aboriginal community development space and develop an interface between mental health services and Aboriginal health organisations, as we managed to obtain funding for one position this financial year.

77 There is a need to incorporate cultural safety into crisis responses for Aboriginal consumers. This can be difficult to achieve when the crisis is of such a nature that there needs to be a 'life and limb' response. For example, when a consumer needs to be

apprehended by police or restrained in a mental health facility because of the risk of harm to themselves or to others. However, once that imminent risk has been addressed, it is important to maintain cultural safety where possible. Examples of ways to achieve this include:

(a) ensuring that male consumers can speak to male clinicians or have female consumers cared for by female clinicians;

(b) access to Aboriginal Liaison Officers;

(c) ensuring that the consumer has access to their family and to any culturally significant objects and healing rituals; and

(d) liaising with the identified member of the family who has been designated to speak on the consumer's behalf.

78 We are working to improve our capacity to tailor services to Aboriginal consumers, but we have only received funding to recruit one employee to undertake this work.

Men

79 Men are over-represented in compulsory treatment scenarios. Internally generated SWH MHS data for 2018/2019 indicates 63% of compulsory treatment episodes related to male consumers possibly due to a reluctance to seek mental health care generally and not seeking mental health intervention early enough. Men are more often the perpetrators of family violence, and may have their own histories of trauma. Men are also typically more likely to:

(a) attempt to "self-medicate" with alcohol and other drugs, or engage in other risk taking behaviours which may render them more vulnerable to psychosis and other serious mental health issues;

(b) present in crisis via interaction with the criminal justice system following criminal activity, and be subject to mandatory engagement in the mental health system;

(c) be secluded once in inpatient mental health care due to poorer behavioural control; or

(d) be represented in statistics of death due to suicides.[5]

80 Possible enablers for reducing treatment compulsion, seclusion and interaction with the justice system for men are very difficult to pinpoint in the current clinical system.

[5]See https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3; https://www.beyondblue.org.au/media/statistics; https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books; http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas

Identifying young men who are vulnerable to a mental ill health trajectory (due to their own early childhood experiences and economic or social circumstances) early in their childhood and adolescence, and responding assertively to engage them in understanding and managing emotions and building resilience to life's challenges, may be effective in addressing the mental health challenges men and boys may face. This may rest more with universal providers, such as schools and non-government providers. Community based resilience building programs may also assist with early intervention. Men's behaviour change programs are only available in Warrnambool in the South West catchment, and are therefore difficult to access from other parts of the region. SWH MHS often pay for, and facilitate men accessing these programs, but there are many geographical and funding barriers to overcome in doing so.

81 In relation to seclusion, staff skilled in de-escalation and diversion working directly with male consumers in inpatient or ED settings may reduce the likelihood that seclusion is required.

Current examples of best practice crisis response in a regional and rural environment

82 I am not aware of a particular model or example that is held up as best practice crisis response in regional and rural environments in Australia. SWH would welcome a focus on action research and service development, specifically targeted at rural mental health service delivery and crisis responses (which include frontline emergency services and public clinical mental health services). Action research is research initiated to solve an immediate problem or a reflective process of progressive problem solving led by individuals working with others in teams or as part of a "community of practice" to improve the way they address issues and solve problems. SWH would be very open to participating and collaborating with other rural mental health services in Victoria and across Australia in partnership with universities, Mental Health Reform Victoria and consumer and carer peak bodies to identify models of care for crisis response and clinical mental health services in rural settings.

Crisis response innovations in Australia or overseas

83 I am aware of innovative crisis response models that have been developed in Canada that are designed around providing comprehensive services into rural areas, mostly in order to provide services to indigenous people, or those living very remotely. It is largely a telehealth model, called E-Mental Health, commissioned by the Canadian Mental Health Commission.[6]

[6] https://www.mentalhealthcommission.ca/sites/default/files/MHCC_E-Mental_Health-Briefing_Document_ENG_0.pdf

SUICIDE PREVENTION

Improving responses to people who are at risk of suicide, and their families and carers

84 Improving responses to people at risk of suicide, and their families and carers needs a system-wide approach, including education and health prevention promotion covering:

(a) identification if a person in the community may be at risk of suicide or self-harm;

(b) suicide prevention literacy amongst non-mental health providers such as GPs and within the community, including schools, sporting clubs and the like.

85 Certainly AMHS play a key role in responding to and assessing persons who are actively expressing suicidal ideation to their families, other health or community services providers, however the suicide prevention/mental health promotion work is not funded to be undertaken by AMHS. At SWH MHS, we have very limited capacity to undertake the enormous task within the catchment that would be required. Largely this work is funded within the south west of Victoria via the Western Victoria Primary Health Network (**WVPHN**). The roll out of the Place Based Suicide Prevention trials through the WVPHN has been slow. I have participated in the Leadership Group to identify local needs and programs to respond where my time has allowed. I am unable to delegate due to other senior managers being very stretched.

Improving follow up post a suicide attempt

86 There are effective postvention programs in place at metropolitan and larger regional AMHS which are not available in smaller regional and rural areas. These mainly include HOPE and Beyond Blue Way Back. Having these programs implemented effectively across all AMHS in Victoria would improve follow up for consumers after a suicide attempt. If consumers are followed up after a suicide attempt, the risk of another attempt is significantly diminished.

87 SWH MHS was supposed to receive funding for two postvention programs: the Beyond Blue Way Back support service and the HOPE program (funding for which was recommended in the Royal Commission's Interim Report). SWH MHS has not yet received funding for either of these programs, meaning that they have not yet been implemented. Whilst finalising this statement, the service agreements for the Beyond Blue Way Back service were received by SWH MHS, but we have not yet received the funding and are still in the process of engaging with the WVPHN.

88 The funding that we receive for the Beyond Blue Way Back service will cover one senior clinician. We understand the funded clinician will work with EDs/UCCs and with the SWH MHS Access Team and provide immediate responses to mental health crises, as well as acting as the clinical lead and supervisor for other agencies that follow up consumers who

have attempted suicide. The bulk of the funding will go to a mental health community support service.

89 We have never received sufficient funding or resources for the actual implementation of postvention programs. For example, while we will receive funding for the Beyond Blue Way Back service itself, we will also need a clinical staff member to manage the implementation of the program which diverts them from their clinical duties. The impact of this is exacerbated in a small region with significantly limited resources and no project or admin/management resources with capacity for redeployment. This results in overloading already full managerial roles. Further, when we are able to create a new senior position for new programs these roles tend to be taken up by a staff member from our limited pool of mental health clinicians – leaving a gap in the current service for which it is hard to recruit a replacement.

Barriers to better responsiveness

90 The ability for a MHS to respond to consumers who are at risk of suicide is limited by several factors.

91 Firstly, consumers who are at risk of suicide may not be referred to, or otherwise come to the attention of AMHS. We are not necessarily made aware of people who are at risk of suicide amongst members of the community, unless they are a pre-existing consumer with SWH MHS. Consumers may use community or 'at distance' services like Lifeline, Beyond Blue or Headspace but this does not always lead to a referral to the local tertiary AMHS, as the service may be able to work with the person to develop a safety plan and ensure the person has the supports they need to address their risk of suicide. SWH MHS has no control over whether referrals are made to us, however we do receive referrals from a number of community services and other health professionals where they are concerned about a person's level of risk related to suicidal ideation, plan or intent of self-harm or suicide. We work hard to develop relationships with community mental health or crisis services.

92 Secondly, members of the community do not necessarily have the inclination or opportunity to indicate to clinicians that they may be at risk of suicide. Funding for mental health promotion and action does not sit with clinical mental health services in south west Victoria, rather, with the community health sector. Such programs are delivered by promotions workers with limited understanding of mental health vulnerabilities and interventions, who may avoid direct enquiries about suicidality due to fear of the response that may be elicited. The funding is often generic with limited expectations or deliverables.

93 We still find that in rural settings, help-seeking in relation to mental health is not common given people often do not know what is available and how to access services. Often

people in rural communities may not know that they themselves can access public clinical mental health and community mental health services within their region. Anecdotally, we find that rural communities tolerate a high level of observed psychological distress or unusual behaviours which may indicate mental ill-health without intervening, making a referral or reporting this to mental health services or police. I have observed this on many occasions since my commencement at SWH MHS, where we see a person unknown to us from a small rural area or farm, who is very unwell and in crisis and who could have benefited from assessment and treatment far earlier.

94 A number of rural communities have undertaken initiatives to normalise talking about mental health and to promote early intervention and help seeking. By way of example:

(a) In the south west of Victoria, a foundation called 'Let's Talk', was founded by bereaved parents of a young person who died by completed suicide and a local mental health clinician and advocate. The foundation raises funds to enable community education and awareness raising amongst the rural community, sporting clubs and the like, to promote help seeking when a person is experiencing suicidal thoughts or developing plans.[7]

(b) Other community groups such as football clubs are undertaking Mental Health First Aid Training[8] to promote help seeking and to educate leaders and members on how to manage challenging conversations around mental health and suicide, the questions to ask and how to make a supportive referral to assist the person in accessing support via their GP or the AMHS.

95 Local AMHS have also undertaken efforts to promote services across a very large geographic footprint. For example, SWH MHS has a Primary Mental Health Team co-located with many general practices in the South West region, to promote mental health care and facilitate referral to public clinical mental health services if required. SWH MHS is not funded for Primary Mental Health services, however, we have not rolled back this work in alignment with funding and policy changes, due to community demand and the importance of providing services to a broader community in the absence of appropriate levels of community-based primary private mental health services. Despite the efforts of SWH MHS, there still remains a significant deficit in knowledge about mental health prevention and treatment services within rural communities.

96 Thirdly, members of the community have a limited understanding of what a clinical mental health service is or the services that are within its scope. As a result, there is confusion as to where to refer consumers or where consumers can seek help themselves. Families or community organisations becoming concerned about a person's mental health do not

[7] https://letstalkaustralia.org/location/warrnambool/

[8] https://mhfa.com.au/courses/public

necessarily have knowledge about where to refer that person for help (including to an AMHS). People often access support through local and non-government organisations such as the Black Dog Institute, which may or may not be appropriate for that particular consumer's needs and may or may not lead to referral to an AMHS. We find many health professionals and members of our community believe SWH MHS provide general counselling services for high prevalence disorders. When a referral is redirected, this can create a reputational risk for SWH MHS. The Stepped Care Model is not well understood by health practitioners and the general community.

97 Finally, the size of the SWH catchment and the fact that we are not able to be everywhere at once is a barrier to responsiveness. We are not always able to dispatch a clinician or an ambulance to consumers, and where there are limited resources, consumers who do not meet the criteria under the *Mental Health Act* may not be prioritised over a consumer with higher acuity or risk within the community.

Better supporting the capability and confidence of these workforces to work with people in a suicidal crisis

98 The capability and confidence of mental health crisis services, emergency services (police and ambulance) and EDs to work with people in a suicidal crisis could be better supported in a number of ways.

99 Firstly, the mental health capability of EDs and UCCs would be improved by embedding telehealth services in all health services - including smaller rural hospitals. Mental health clinicians are not needed frequently enough in small rural hospitals to warrant full-time placements, so we need to be able to assist these smaller hospitals remotely. For example, last year a smaller sub-regional health service in the South West catchment had approximately 48 mental health presentations at their UCC, so it would not be feasible to have a full time clinician at that site. Embedded contemporaneous support is required for those occasions when a consumer presents with a mental health crisis. Currently, responsivity on site at some of the smaller hospitals and UCCs relies on the availability of a medical officer or GP to complete the paperwork for admission under the *Mental Health Act*. If this condition cannot be met, the consumer has to be transported to the next largest UCC or ED where there is a registered medical practitioner available, and in the most likely scenario, the person is transported to Warrnambool Base Hospital as an efficiency measure. This is not an ideal solution for the consumer or their family, and impacts on SWH's resources. This is a unique situation to rural settings. Repatriation back to the person's home is very difficult and can cost SWH MHS significantly if the person is not admitted.

100 Secondly, every mental health clinician needs dual diagnosis training and experience. This also applies to clinicians in EDs in larger centres like Hamilton, Portland and

Warrnambool. Approximately 83% of mental health consumers have comorbidities, including substance abuse. In my experience, substance misuse can often lead to impaired judgment, impulsivity, or exacerbation of the worries a person has, in turn often leading to the person presenting in crisis, including at times involving suicidal thoughts, the development of suicidal plans or attempts. Alcohol and other drug (**AOD**) services expertise needs to be built into mental health service expertise, and vice versa. The Victorian Dual Diagnosis Initiative, which was implemented 10 to 15 years ago, did good work in this area through its knowledge and assessment sharing initiatives, but has been less active in recent years as the program was wound back significantly over the last decade to an advisory function. Generally, my experience is AOD services are not funded well to provide appropriate reach across a large geographic rural area, leaving all crisis and acute work to be managed by the AMHS.

101 Thirdly, all EDs should have a Safe Assessment Room (**SAR**) and Psychiatric Assessment and Planning Unit (**PAPU**). These rooms and units are dedicated safe spaces in which clinicians can assess and provide care to consumers at risk of suicide. Warrnambool Base Hospital is the only ED in the south west of Victoria which has a SAR. The implementation around the use of the SAR was challenging as a new model of care for our ED colleagues, as mental health access team staff are not rostered to work in the ED and are not part of the ED staffing profile. The access team clinicians are not all mental health nurses.

102 In regional and rural hospitals the physical space can be a significant limitation. For example, it we want to have mental health clinicians available within an ED, there may be no dedicated space for them. Often only one clinician can sit in these small EDs at a time, because there is so little physical space. Rooms can also be difficult to use flexibly for mental health consumers due to the type of furniture and equipment that are required to be in them, and the types of risks that presents for mental health consumers, for example, use as weapons or ligature risks.

103 The acute mental health adult inpatient unit at Warrnambool Hospital was commissioned 28 years ago, and since then has had no major structural changes to ensure the unit maintains contemporary building standards for mental health inpatient facilities. The unit has only had cosmetic changes in the last five years. Other changes have occurred as a result of specific funding, such as the creation of a women's only outdoor area. This area is rarely used. Female consumers have reported feeling uncomfortable using it as it is open and visible to others, including male consumers in the acute inpatient unit.

104 The current Acute Inpatient Unit is nominally funded for 5 Aged beds. However, the unit is not fit for purpose, meaning only consumers who are over 65 that are able to ambulate and self-care can be cared for in the current unit, which is highly challenging when an older person is in crisis related to their mental health. In the South West region of Victoria,

there is a funding supplement provided by the Mental Health and Drugs Branch (**MHDB**) of DHHS to two Residential Aged Care Facilities to provide care for psychiatric aged care services. All stakeholders are dissatisfied with this model and continue to seek leadership and clarity on the guidelines and performance outcomes. This funding model has been in place for at least two decades, however it is unclear what the reasoning was for providing that funding and what the intended outcome, model of care or relationship with the AMHS, was supposed to be.

105 Two new mental health specific facilities have been included in the Warrnambool Base Hospital master plan – a new mental health acute inpatient unit and a PAPU adjacent to the ED. There was also separate planning work undertaken with the endorsement of Department of Health and Human Services (**DHHS**) for a project to consider redevelopment of the existing acute inpatient unit to increase acute bed numbers from 15 to 20-21, with the introduction of a vulnerable persons wing; bringing the unit in line with contemporary standards and ensuring it is as safe and recovery-orientated as possible.

106 However, to date an opportunity to submit an application via the Rural Health Infrastructure Fund (part of the Victorian Health and Human Services Building Authority) or via the MHDB of DHHS has not arisen, despite regular discussions with the MHDB and the Victorian Health and Human Services Building Authority. Capital funding, in my experience, is prioritised to larger health services.

107 SWH MHS have limited options to be considered for funding what we believe to be urgent redevelopment of inpatient services on the Warrnambool Base Hospital campus, which would allow us to change the model of inpatient care to a recovery orientated consumer-centred approach.

ROLE OF MENTAL HEALTH TELEPHONE TRIAGE SERVICES

Strengths and limitations

108 The SWH MHS 24/7 mental health crisis line (the 1800 number referred to above) is the triage service for our AMHS – it is not a helpline service. The triage service requires highly skilled clinicians and we generally have our most experienced clinicians on the phone conducting triage.

109 One strength of this aspect of our service is our ability to conduct telehealth screening wherever possible. A telehealth connection strengthens the clinician's ability to remotely conduct a comprehensive assessment. There are multiple factors to a mental health assessment – for example, how a person is dressed, their physical appearance, behaviours (tremors, irritation), and their facial expressions – things that cannot be observed over the phone. Telehealth allows clinicians to make those observations and take them into account in making an assessment.

110 Sometimes a telehealth connection is not available and it is too difficult to screen the consumer over the phone. If the consumer has presented at a small rural service or are with their family, we can enhance screening or conduct an assessment using collateral information provided by doctors, nurses or family members. Otherwise, we have to err on the side of caution and arrange to bring the consumer into Warrnambool Base Hospital for assessment, often via ambulance. If the consumer arrives at Warrnambool Base Hospital, is assessed and does not meet the criteria for admission, they then need to be repatriated – meaning that they need to return home again, which may amount to a six hour round trip for family or payment of a taxi.

111 When this happens, the request to have the consumer attend for an assessment can raise expectations of the consumer or their family members that they will be admitted or treated at the mental health unit. If the consumer then does not meet the criteria for admission this can create confusion or disappointment. If the consumer needs crisis intervention services in the future, they or their support people may not contact us due to their past experience. Turning consumers away after bringing them in for an assessment damages the reputation of an AMHS and dissuades people from presenting to us. However, the admission criteria must be adhered to, as we only have 15 acute adult inpatient beds in the SWH MHS catchment. Our occupancy is usually high.

112 We are also unable to provide a 24/7 face to face crisis response across the entire catchment. If we screen a consumer over the phone or make an assessment via a telehealth connection that they meet the admission criteria, they may need some form of physical assistance to get to the acute unit. In those situations, we may need to make a triple-zero call so that police or an ambulance can respond. Even then, a response may take hours because there may only be one emergency vehicle in the consumer's local government area.

The role of 24/7 mental health triage phone lines in the mental health system of the future

113 In order for 24/7 mental health triage phone lines to play a role in the mental health system of the future, there are changes which should be made to enable this service to be most effective.

114 Firstly, providing greater access to telehealth would alleviate many of the limitations associated with the triage service.

115 Secondly, I suggest upskilling all non-mental health clinicians that work in EDs and UCCs with the capability to undertake mental health assessments in conjunction with a secondary consult. We need to implement a shared decision-making framework that allows clinicians to liaise with mental health specialists so that every ED and UCC is equipped to care for and triage mental health consumers. It must be acknowledged that

these suggestions place additional expectations on ED staff who are already dealing with significant numbers of patients. However, if this was possible, hospitals' capacity frameworks could be expanded to acknowledge the ability to jointly assess for mental illness/mental health crisis.

116 We should develop a model for capacity building mental health clinicians in EDs and UCCs that is consistent across Victoria, similar to the state-wide model for stroke treatment. We could enhance emergency and urgent care clinicians' capacity in the area of mental health triage by training them in the model approach and providing resources such as specialists' contact numbers. It should be acknowledged that this is a substitute for an optimal model of care that would allow for mental health clinicians to be embedded in an ED team twenty-four hours per day. SWH MHS would not be able to staff that type of model without significant funding boosts and delivery upon the Victorian Mental Health Workforce Plan.

Challenges particular to regional and rural environments

117 The effectiveness of these mental health triage services depends on the clinician providing the service. Triage is complex work and requires highly experienced clinicians. In a rural area like ours, our workforce typically consists of either very experienced clinicians with 30 to 40 years of experience (and who are close to retirement), or clinicians who are new to the field with limited experience. Undertaking mental health screening, triage and assessment via the phone requires clinicians to have a high level of experience in order to do so effectively. In order to improve the consistency of the quality of our triage service we need greater numbers of experienced clinicians. Training can take years and recruitment is extremely difficult in rural areas.

118 While we are trying to attract experienced skilled workers, there is currently a workforce shortage – especially in rural areas. Workers willing to live outside the metropolitan area will generally elect to go somewhere like Ballarat, which has a shorter commute to Melbourne. As a result, we primarily attract clinicians with less mental health clinical experience such as social work or OT graduates, junior nurses and provisional psychologists, who require high levels of training, supervision and support.

119 I address the particular challenges of recruiting and retaining mental health nurses in paragraphs 150 to 155 below.

INTERSECT BETWEEN PHYSICAL ILLNESS AND MENTAL ILLNESS

Understanding and addressing the physical health needs of registered mental health clients in inpatient and community settings

120 Understanding and addressing the physical health needs of registered mental health clients in inpatient and community settings is important, though there are barriers to doing so in rural areas.

121 There are fewer health services in rural areas. The further people live from major town centres like Warrnambool, the more difficult it is to get a GP. See above paragraphs 40 to 42 above for further detail.

122 Many rural mental health consumers, or those who might become mental health consumers, do not have equal access to care for their primary health needs. This is often due to social disadvantage. Many people moved to the region to work in farming or because housing is cheaper. However, they then lack connections with their new local community and become isolated.

123 Further, because SWH MHS are focussed on addressing acute care in a mental health crisis, stabilising the consumer and relieving their crisis then moving them into a more appropriate setting or into community care, we have limited capacity and resources or otherwise to address a consumers' physical health needs during crises. For example, we cannot provide consistent metabolic monitoring with our current resources. This can create further disadvantage and poorer health outcomes for mental health consumers.

124 The principles of tying together physical and mental health are important. For example, some of our patients with psychosocial disabilities who take psychotropic medications have trouble with weight gain and physical fitness, which then puts them at risk of co-morbidities such as type II diabetes, high blood pressure and coronary disease. We have a part to play in supporting consumers' physical health as well as their mental health, but we can only stretch our resources and our funding so far. Sharing care with GPs is our preferred model.

125 SWH has commenced implementation of the Equally Well program, a framework for Victorian mental health services to reduce the gap in life expectancy that exists between those living with a mental illness and the general population. The framework is based on a consensus statement issued by the National Mental Health Commission in 2017 entitled "Improving the Physical Health and Wellbeing of people living with a mental illness in Australia". The consensus statement calls for better collaboration and coordination between governments, professional bodies, social and community services and other leaders in mental health to make the physical health of people living with mental illness a national priority. Whilst some training and resources have been provided by DHHS to

support the implementation of the framework, SWH MHS has not received funding for the project resources or administration, and therefore the implementation lacks structure and ongoing evaluation. It is difficult for rural AMHS to roll out programs with existing resources.

Ensuring that the mental health needs of patients with a physical illness are met

126 It is equally important to ensure that the mental health needs of patients with a physical illness are met. One of the enablers to doing so is the new National Safety and Quality Health Service Standards (**NSQHS Standards**). The NSQHS Standards require all health professionals caring for people, to consider their needs as a whole person. The previously separate standards for mental health care have now been incorporated into the new version of the NSQHS Standards. The standard around deteriorating patients in the NSQHS Standards now considers deterioration in both mental health and physical health thresholds, with a view to early intervention and prevention of emotional crisis and relapse. This has been especially important with the treatment and management of acute confusion states such as those which can be seem with dementia, depression and delirium where aetiology may be unclear but disorganisation, agitation and risk of harm are prominent, requiring intervention.

127 The barriers to ensuring that the mental health needs of patients with a physical illness are met include the capacity and confidence of the workforce. By this I mean that general nurses who do not have particular expertise around mental health may not confidently manage or recognise mental health symptoms in a patient with a physical illness. Similarly, staff treating the physical health needs of patients with pre-existing mental health conditions may make an automatic referral to mental health services, without there being a particular mental ill health concern. This is a phenomenon known as diagnostic overshadowing, and we often see this in ED settings.

128 For example, the patient may have a broken limb and a pre-existing diagnosis of depression and the treating team may refer that patient to mental health services despite their condition being well controlled and easily managed in a general ward. The treating team may not feel confident enough to have a conversation with the consumer around what their needs are and to then be guided by the consumer about their own mental health condition. In rural areas, where there may be a workforce with many years of experience, staff may carry through outdated views about whether, as a physical health practitioner, they ought to be involved in treating mental health conditions. In bigger metropolitan services, generally speaking they may have a higher volume of newer staff with contemporary views and, therefore, may not experience as much resistance to and lack of confidence in addressing mental health needs in a physical health environment.

The role of Consultant-Liaison Psychiatry in inpatient and community settings

129 A Consultant-Liaison Psychiatrist (**CL Psychiatrist**) is a psychiatrist who provides secondary consultations, or 'in-reach' into non-mental health inpatient areas. This means that the CL Psychiatrist consults with a patient's primary treating practitioner who is treating their physical health needs, rather than being the primary provider of treatment to the patient. A patient admitted to hospital for their physical health needs may be an existing consumer of the mental health services requiring some additional support, or may not have an existing mental health condition, but have significant symptomatology or behavioural concerns requiring psychiatric assessment or treatment.

130 For example, a patient might be admitted under the care of a cardiac specialist in the general hospital, but have an existing mental health condition (such as schizophrenia). That patient may need an adjustment made to their psychiatric medication because their usual medication might not be as effective as it ordinarily is given the patient is outside their usual environment. The role of a CL Psychiatrist is to review and provide support to the primary treating team and prescribe psychiatric medications, if necessary.

131 CL Psychiatrists are not based in mental health services, and will not have any particular patients admitted to the hospital under their care. CL Psychiatrists also cover presentations to the ED. This may involve differentiating whether a consumer's presentation might be due to a mental health condition, AOD intoxication or withdrawal, or a combination. Effective Consultation Liaison Psychiatry is enabled by:

(a) the CL Psychiatrist being considered as a part of the broader health service medical workforce; and

(b) the CL practitioner also having a role to undertake capacity building activities within the broader health system such as imparting a baseline understanding of, and exposure to, a range of mental health conditions, and the application of the *Mental Health Act* including in the context of restrictive interventions.

132 Barriers to effective CL Psychiatry in a rural setting include the following

(a) Funding. At SWH, we have a small nurse led CL program, as the funding provided is not sufficient to cover a Psychiatrist in addition to the nurse for the program. The current part time FTE allocation is funded through another revenue stream. The CL model and team must meet the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) guidelines to be accredited as being able to meet all required training requirements in CL, in order to offer a compulsory rotation for psychiatry trainees. Given the part time nature of the medical workforce in the SWH CL program (due to the inability to fund a consultant

psychiatrist to oversee the program and any trainee), this is not possible. We are unable to offer this rotation to our trainees currently.

(b) There is variability in the capability of the staff working in the general hospital in understanding the role that CL Psychiatry has and the scope of the role. We often experience pressure for a psychiatrist to become the primary treating practitioner.

(c) Geographical reach. As outlined in paragraph (a) above, CL at SWH MHS is a mental health program, not a psychiatry program, as we are unable to pay for a psychiatrist due to funding. At SWH, Mental Health CL only extends to Warrnambool, one of 12 hospitals in the SWH catchment. Everything is centric to the main hospital and CL Psychiatry is not provided in community settings (ie it is for inpatients). Depending on capacity, Mental Health CL might be able to provide services to Camperdown Hospital but these services would be provided over the phone. This has occurred in the past 2 years on a few occasions for residential aged care consumers. SWH psychiatrists often attend general hospitals when they are in regional locations, however this takes time away from the available community clinic time, which is always in high demand. This is not a true CL Psychiatry model, given the psychiatrist is visiting a person in a community setting and may not have hospital visiting rights. It is largely an in person secondary consultation.

HOUSING AND HOMELESSNESS

Housing needs for people experiencing a mental health or suicidal crisis

133 In the South West region, housing is very often a need for consumers experiencing a mental health or suicidal crisis. Up to 20% of our consumers are homeless or at risk of homelessness at any given time.

134 SWH MHS participates in the Rough Sleeping Partnership Initiative along with Brophy Family and Youth Services (Lead Agency), Gunditjmara Aboriginal Health Services, and Western Regional Alcohol and Drug Services. SWH MHS work within the partnership to identify mental health consumers who are currently impacted by rough sleeping in order to actively engage them with accommodation support services and to facilitate expedited access to mental health treatment if required. The Initiative is part of Victoria's Homelessness and Rough Sleeping Action Plan released in 2018,[9] which aims to intervene early to prevent homelessness, provide stable accommodation as quickly as possible, support people to maintain stable accommodation, and facilitate an effective and responsive homelessness and support service system.

[9] https://fac.dhhs.vic.gov.au/news/victorias-homelessness-and-rough-sleeping-action-plan

Challenges in relation to homelessness and housing needs in rural and regional areas

135 Unlike the metropolitan areas, regional areas have very limited access to public housing. People with major mental illnesses or other conditions that might cause different behaviours may also be subject to discrimination when applying for housing. Landlords and those managing public housing put quite stringent guidelines on who they will accept and who they won't. Many mental health consumers end up couch surfing or rotating through the criminal justice system, because their behaviours may be more visible in regional or rural areas (for example, if they are on the streets or engaging in theft, they tend to be noticed). As a consequence, people with mental health concerns may experience:

(a) discrimination and disadvantage;

(b) increased length of stay in inpatient units or a complex discharge process;

(c) discharge to environments that are not safe (such as to family violence situations); and

(d) increased risk of not following-up with clinical mental health services if they have relocated out of the area.

Area Mental Health Services and housing and homelessness providers working together to support consumers' mental health needs

136 SWH MHS has implemented the Early Intervention Psychosocial Support Response (**EIPSR**) program, which fills the gap for those not getting access to the National Disability Insurance Scheme (**NDIS**). Although aimed at wider support than housing, the EIPSR model could be utilised effectively in the areas of housing, food security and social security.

137 EIPSR is a support model for individuals receiving adult mental health services who do not qualify for the NDIS or have experienced a delay or difficulty in accessing the NDIS. The initiative means individuals requiring mental health support can be supported over a short- or medium-term basis, with a focus on their ability to improve psychosocial functioning (such as by developing connections within the community, developing skills for practical daily living and management of mental health, and transitioning to the NDIS).

138 EIPSR is a partnership between SWH MHS and Mental Health Community Support Services (**MHCSS**) where there is a collaborative approach to planning interventions and shared responsibility for delivering psychosocial care and support to consumers already engaged with mental health services. We received funding for this program, but we had to implement and commission the MHCSS ourselves.

139 A part of the non-government sector, MHCSS are distinct from clinical services, and play a role in supporting people with a severe mental illness and psychiatric disability throughout the recovery journey. MHCSS support people with psychiatric disability to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment.

140 It was not ideal that we had to do the commissioning for this program, which was extremely time-intensive. Clinical services should not be commissioning. We should be using our resources to do consumer-facing work. Unlike metropolitan services, rural services do not have project or administrative resources that can be deployed for commissioning work. There are limited economies of scale. We are under-resourced for this administrative burden. As there was no choice in providers, with just the one agency operating in that capacity in south west Victoria, SWH MHS had no special knowledge that made us better suited to do the commissioning than it being commissioned centrally by DHHS.

141 If the EIPSR model is utilised effectively in the areas of housing, food security and social security, the model would need to be a joint venture. Without such an arrangement, mental health consumers tend to be pushed to the bottom of other services' priority lists. Health services could set up the structures and governance of the scheme, and DHHS could provide the commissioning. The advantage of such a model is that various services would be motivated by their connection in the joint venture and would ideally work together to achieve outcomes and monitor KPIs, which are linked to funding.

WORKFORCE CONSIDERATIONS

Current workforce shortages impacting on the capacity of the mental health system to meet the needs of consumers

142 Difficulties in recruiting to rural areas often mean services experience staff shortages in a range of specialty teams and programs.

143 Recruitment to these positions can often take months, hence clinicians within the service are often managing increased workloads and demands. The impact of multiple and competing demands leaves clinicians unable to provide the intense, comprehensive care and support to consumers and families that they would provide if there were adequate resources.

144 To ensure that demands are met, and that the required staffing ratios are met, staff often work additional hours to provide coverage and support to consumers and their families.

145 In rural areas there is also a significant shortage of appropriately skilled private practitioners. This can lead to increased demand on the public mental health system

when consumers and their families are unable to access private intervention in a timely manner, and also leads to further deterioration and distress being experienced by the consumer.

Contemporary workforce

(a) Size and composition of the workforce, and distribution of professional skills and expertise

146 Workforce is one of the pillars of Victoria's 10 Year Mental Health Plan.[10] Victoria also has a Mental Health Workforce Strategy which acknowledges the challenges and issues and discusses options and actions to address them.[11] To date, there has been little progression with the Workforce Strategy, in my view. SWH MHS has undertaken a small project within our inpatient services to address the impending retirement of a number of experienced mental health nursing staff and to develop strategies and systems to support the sustainability of the workforce for inpatient services. Although many inroads were achieved, recruiting to funded positions offered by the Office of the Chief Mental Health Nurse (**OCMHN**) has proven nearly impossible in the current climate. The Australian Nursing and Midwifery Federation and Health and Community Services Union have also contributed to delays in recruitment by insisting on change impact statements for new positions and getting involved in the detail of position descriptions. COVID-19 has brought up a range of challenging priorities for health services, which has further impacted on timing for recruitment.

147 An increase in demand upon the mental health system means that there will need to be a focus on recruitment and retention to promote a specialist workforce into the future. Over the past decade, there has been a reduction in the number of people pursuing a career in the health sector including mental health nursing, psychiatrists and allied health. This is widely discussed and written about at both the Commonwealth and State/Territory level. This impacts significantly upon the ability to recruit a multi-disciplinary team (including mental health nurses, psychologists, social workers, and occupational therapists), particularly in rural areas. SWH MHS has a long history of recruiting graduate psychologists to supplement the mental health workforce and grow our own. However, psychologists are expensive practitioners once they become fully registered and have more than four years of service and it is difficult to meet this cost due to budgetary constraints (it is approximately a $11,000 difference per year). Further, utilising psychologists as generalist mental health clinicians can be deskilling and lead to attrition for those wanting to obtain endorsement, or maintain therapeutic assessment and treatment skills.

[10] https://www.dhhs.vic.gov.au/publications/victorias-10-year-mental-health-plan
[11] https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy

148 SWH MHS could benefit from a funded project specifically for rural areas to explore the development of a public/private partnership model where psychologists and other credentialed[12] mental health clinicians could train and work in public mental health services and also rotate to primary care/private clinical models. This would ensure these clinicians received experience in supporting consumers who are largely in the high prevalence category or those with low prevalence disorders that could benefit from specific psychological therapies. Mental health clinicians often do not get this experience in rural services, as AMHS are too busy responding to acute and crisis needs of consumers and their families.

149 Changes in course content for many undergraduate courses leave individuals who are wanting to pursue a career in the specialised area of mental health often needing to pursue further post graduate studies and training to ensure they have the knowledge and skill base required to work in the area. Typically, this training is provided in metropolitan areas.

150 For the discipline of nursing, I note that universities stopped offering undergraduate training in mental health nursing as part of a nursing degree approximately fifteen years ago. Many of the remaining hospital or undergraduate trained mental health nurses are aging out of the workforce. By this I mean that, the existing mental health nurses who trained several decades ago, are only now beginning to retire, creating vacancies in times when we are now unable to fill them with mental health trained nursing graduates. We now have to train junior general nurses in mental health nursing. This takes about two years, after which they often leave to work in community settings with less acute consumers. Many mental health clinicians also go into private practice as the remuneration is better, and the acuity of the consumers is usually lower than in an AMHS.

151 These problems exist throughout Victoria, but are heightened in rural areas. The reason the lack of graduate mental health nurses is heightened in rural areas is because, for example, we only have a small nursing school based in Warrnambool and undergraduate nursing students get only one short mental health placement, which is often taken at a residential aged care facility. Given we are the only AMHS, we can only take a small number of nursing students at a time. The chance of those students choosing to specialise in mental health nursing directly out of university is low. Many nurses are not interested in mental health, or wish to consolidate their general nursing skills first. Further, becoming a mental health nurse requires post graduate study and an appetite for further study. Financial constraints may also be a barrier.

152 Melbourne, and larger cities close to Melbourne, have large numbers of nursing students and graduates, which increases the chances of attracting appropriate numbers of nurses

[12] By an external body, such as the Australian College of Mental Health Nurses or the Australian Association of Social Workers in order to be eligible for Medicare and other Commonwealth funded programs.

into mental health services in order to develop a sustainable mental health nursing workforce. The South West of Victoria is often too far for graduate nurses to consider moving to, or is simply not of interest when there are numerous offers in Melbourne or large regional cities near Melbourne, where most of the new graduates live.

153 Additionally, unlike metropolitan services, we do not have access to agency mental health nurses, because people are not going to drive four hours to Warrnambool for a shift. The casual bank of nurses is small and we are rarely able to add to it, as the majority of mental health nurses or mental health clinicians trained to work in a clinical AMHS are already employed with SWH MHS. At least twenty percent of our clinical staff are above 60 years of age, including those in the casual bank (semi-retired), and it is difficult to replenish being so far away from Melbourne and larger centres such as Geelong, Ballarat or Bendigo.

154 Working in acute mental health triage is extremely demanding (because consumers may become aggressive, or because staff may feel responsible if a consumer completes a suicide or harms themselves or others), which may be a contributor to the high turnover in staff.

155 The sector has received little government assistance in facing these workforce challenges. While Victoria's 10-year Mental Health Plan included a workforce strategy, very little has been done in this space. The Victorian government should bring back undergraduate mental health nursing. Whilst it is important to also grow other disciplines to work in mental health as they are important for providing a multi-disciplinary approach; mental health nurses are extremely versatile clinicians. They can work in both clinical inpatient and community settings and have experience with administering medications. We are also able to capacity build mental health nurses and train them into nurse practitioners. It is comparatively difficult to attract and train general nursing graduates in mental health nursing.

(b) Organising workforces to provide multidisciplinary and consumer-focused professional practice across community-based services

156 Emphasis on providing a multi-disciplinary team has been well recognised as an effective means of ensuing holistic treatment and should always be the preferred approach when possible. This also includes the involvement of the lived experience workforce (**LEW**). A holistic approach that includes the coordination of all aspects of consumer care (mental health, physical health and psychosocial factors) including support to families and carers should be adopted in the future.

(c) Assisting professionals to collectively work at their 'optimal scope of practice'

157 In order to assist mental health professionals in working at their 'optimal scope of practice', so that consumers receive the expertise they need in a multidisciplinary context, the following is required.

(a) Access to ongoing mental health specialist professional development opportunities, to enable ongoing development of specialist clinical skills. These should be easily accessible to rural clinicians. The majority of education and professional development opportunities are in Melbourne or larger regional cities, requiring a significant commitment from the health service and the clinician or LEW to participate. This has implications for service delivery locally, as time away from the office may include up to two travel days either side of the training opportunity.

(b) Access to regular clinical supervision for all clinicians working within mental health settings. Clinical supervision needs to enhance the development of specialist clinical skills whilst also promoting reflective practice and the emotional wellbeing of the practitioner. Clinical supervision needs to be embedded within the services, and time protected against multiple and competing demands. This is particularly challenging to achieve with a smaller rural AMHS where clinicians are integrated into teams, often with vacancies that mean clinicians are constantly pulled in to acute or crisis work and supervision and other important developmental and governance related supervision falls away. When I worked in a Metropolitan health service, we were able to develop a supervision roster across multiple services and disciplines to enable the servicing of clinical supervision effectively. That is not possible in a rural setting. We continue to search for ways to improve access to and regularity of clinical supervision for all clinical staff. Guidelines are provided by peak bodies and DHHS, however there is lack of understanding that it is difficult to achieve without additional resources which cannot be achieved within the funding provided to us. Funding is often provided to us on a fractional basis (population based), resulting in a very stretched workforce with unachievable objectives, including responsibility for administering the program. Frontline consumer and carer facing services must be prioritised, leaving senior directors and managers working very long hours to meet administrative and reporting demands involved in clinical supervision.

(c) Mentoring of newer clinicians, in order to promote best practice from the commencement of a clinician's career. This can be challenging when there are few experienced and skilled clinicians to share around an inexperienced workforce, which is now the reality for SWH MHS.

(d) Ensuring the workforce is well-resourced by providing a structure to promote the recruitment and retention of a specialist, sustainable workforce.

(d) New roles and functions

158 The workforce could be further developed by promotion of, and increased exposure to, the mental health field during undergraduate studies (for example, by establishing cadetships or 'internships' to promote the development of skills required to work within the mental health setting). There would need to be additional resources assigned to mental health services to support models like this. Additionally, to promote recruitment to rural areas, the development and provision of relocation packages or rural allowances in salary might be an incentive to skilled mental health practitioners to relocate to these areas.

159 Workforce models should include structured approaches to providing mentoring and development of the junior workforce. This process should be inbuilt at each level to ensure the development of a specialist, sustainable workforce (including graduate nurses, Associate Nurse Unit Managers (**ANUM**), Nurse Unit Managers (**NUM**)). This would be enhanced by ongoing professional development and clinical supervision that is inbuilt into this system. These suggested enablers are more difficult to implement as the pool of available staff to undertake this work is limited and attracting and retaining suitably skilled clinical staff and mental health nurses is very challenging in rural settings. When new programs or frameworks are recommended, they need to be adequately resourced and supported in terms of project implementation and administration to ensure successful implementation and attainment of the desired outcomes.

160 Funded multi-disciplinary programs, which are funded at rates to support medical appointments to enhance dual diagnosis, are needed. Currently we have funding for up to three positions across the entire mental health service (depending on classification), which does not allow for the work to be undertaken across the service equitably. Funded primary mental health services in rural areas are essential to fill some of the service gaps. There are not enough psychological, counselling and primary mental health services within the primary care sector to meet the south west community's demand for consumer facing work. Only with a funded project would SWH MHS be able to have the resources to facilitate exploration and implementation of a primary mental healthcare/private/public partnership model.

Improving the safety and wellbeing of staff and consumers

161 Medical workforce shortages in rural health services mean we are forced to rely on locums. It can often take a week to get locums oriented to health and safety provisions at the site, trained in how to use electronic health records-keeping systems and oriented to policies, processes and performance targets. This adds to delay in ensuring consumers

can access timely psychiatric review. The temporary nature of the locum workforce may also require consumers to share the same stories multiple times and, therefore, become frustrated or disengage from services entirely. This approach also naturally leads to a short term treatment focus and variability in approaches between doctors, leading to frequent changes to treatment approach for the consumer and vulnerability to relapse in the longer term. It is very expensive and not sustainable to have a locum workforce on a regular basis, because it requires closer supervision by senior doctors in our service, and mentoring by senior mental health clinicians.

162 In addition to what I have already set out at paragraphs 150 to 155 about the shortage of mental health nurses, it is also incredibly difficult to recruit Fellows of the RANZCP, and the junior medical workforce, to rural areas.

163 One way to address this would be to recruit staff internationally. However, it is increasingly challenging for international medical graduates, or psychiatrists in other countries, to obtain limited registration in Australia and get on the comparability pathways with the RANZCP. The red tape is unbelievable, which takes months to work through.

164 In my view, there should be a way, led by the Australian Government, to 'fast track' or streamline registration for international medical staff for rural health services. SWH MHS does not have the capacity to fly overseas and recruit medical or mental health clinical staff from, for example, the United Kingdom, as other larger metropolitan health services do. The Australian Government could incentivise these workers to work in rural areas (not regional areas), and place conditions on their visa to require them to stay for at least 2 years. Perhaps a central department could be established which could work with the Medical Board of Australia, the AMA and the RANZCP to establish programs for placements, and rural services would then only have to ask for a certain number of placements. This may also reduce locum costs, and the other quality and safety issues each year that can arise with use of locums.

165 At times RANZCP funded positions for psychiatry trainees can sit temporarily vacant because we are unable to always fill the placement with exactly what was prescribed by the RANZCP. An example is an addiction psychiatry training post that remains unfilled, as we recently lost a qualified supervisor to a large neighbouring health service which provided that person with more opportunities and scope of work. As a smaller AMHS, it is hard to compete with larger health services with a greater breadth of opportunities and variety for energetic young consultant psychiatrists.

QUALITY AND SAFETY

Reporting to the Office of the Chief Psychiatrist (OCP)

166 There are extensive reporting requirements to the Office of the Chief Psychiatrist (**OCP**). The regulatory oversight of restrictive interventions by the OCP is appropriate to ensure adherence to the strict guidelines, practice directions and the *Mental Health Act*. However, any additional reporting obligations place significant administrative burdens on senior managers and directors and our small administrative teams.

Reporting to the Mental Health Complaints Commissioner (MHCC)

167 The MHCC require biannual complaints/feedback reports produced from the Victorian Health Information Management System, known as Riskman. Other reports are produced on incidents to Community Visitors upon request, usually at least on a monthly basis, and this may be without notice.

168 The MHCC officers can also tend to insert themselves into situations in the middle of those situations occurring, which I do not think is constructive in terms of assisting in resolving the complaint. For a small AMHS this can be disruptive and an additional administrative burden which has the potential to take our attention away from dealing with the matter in real time. For example, we might be changing a consumer's medication or we might have assessed a consumer as meeting the criteria under the *Mental Health Act* for an inpatient treatment order and the consumer may complain directly to the MHCC. The MHCC often require us to provide a written response immediately, which at times diverts attention from resolving the consumer's or families' concerns. It would be more useful if the MHCC could inform SWH MHS of the complaint, ask us to confirm we are addressing the complaint directly with the consumer contemporaneously, and request a summary of the circumstances in the next 2 weeks.

Reporting to the Department of Health and Human Services (DHHS)

169 In reporting to the MHDB of DHHS, we have twice yearly program meetings. In recent years, this has included a visit to our services in Warrnambool. This often involves new staff, as DHHS staff tend to change roles frequently, resulting in a loss of knowledge and experience. When we have new staff visiting, they usually travel down the day prior and stay overnight for one or two nights (the same is not able to be done by us as a health service as we cannot afford the time away from the service due to our very lean leadership structure, high workload and the associated costs of accommodation and lost time).– When we travel to DHHS in Melbourne for meetings or forums, it is a full day round trip via car or train, which involves a 15 hour turnaround. During the visits, we usually offer tours of our facilities in Warrnambool and on one occasion in the three and half years I have been in my role, the Assistant Director (now the Director of the MHDB), visited all of

SWH MHS sites over two days, including all three rural mental health services in Portland, Hamilton and Camperdown.

170 Mental health also features as an agenda item in the quarterly performance meeting with the Rural and Regional Branch of DHHS. The meetings provide oversight discussions directly with DHHS and the opportunity to relationship build and demonstrate our services, including challenges around quality and safety.

Using the data internally at SWH MHS

171 SWH MHS receives aggregated data reports from the DHHS MHDB based on information entered in the Client Management Interface (**CMI**). This data focuses on inpatient and community services, and follows the program streams (Adult, CAMHS and Aged).

172 The DHHS MHDB data is reported internally to board level, and is used to inform quality improvement to some extent. However there are limitations to this data, which also make it difficult for SWH MHS to use the data to inform where we focus our strategic planning and service delivery. These limitations include that:

(a) some data is difficult to interpret, as there is no formula to identify small case numbers and percentages are used;

(b) the data is limited by what is measurable via CMI, and we therefore have no process to easily gather information on other important measures like consumers' agreement with or satisfaction with their treatment plans;

(c) the information received is limited to high level data and doesn't measure the more intangible elements of mental health care, such as consumer engagement or imply an improvement pathway (for example, there may be a number of strategies required to resolve some of the identified issues, to the point where it's difficult to know what's working);

(d) the data is usually limited by the measures used to collect it, such as the BASIS-32 to measure consumer engagement, where the tool itself is problematic and not well accepted by the consumer group. The focus on "compliance" rather than improvement limits how dynamic the service can be in responding to the needs of consumers; and

(e) SWH MHS do not have the funding to employ positions such as analysts and project teams to address some of the deficits raised by the data.

173 The data we receive serves the important purpose of highlighting emerging risks and issues which can be used to inform the SWH risk register and the monitoring of those risks.

174 Further, although data sources are readily available (including Mastercare electronic health record and associated data warehouse, along with State-wide data), there is limited expertise and time within SWH MHS to develop and generate internal reports, and use this data to drive decision making.

Feedback received by SWH MHS in relation to the data

175 Breaches of targets or thresholds set out in the data are usually followed up by a request for an explanation from Senior Program Advisors at the DHHS MHDB. We are usually expected to provide a written response and outline improvement strategies.

176 Aside from acknowledgement of receipt, there is generally little feedback provided on the information given to the DHHS MHDB in this response.

177 Data and results are discussed at the twice yearly Program Meeting with the DHHS MHDB, usually by exception, where targets have not been met.

Gaps, duplication or overlaps in roles, responsibilities and functions of regulatory and oversight bodies

178 There is a lot of duplication in the reporting which is required to regulatory and oversight bodies. This can be frustrating, and should be streamlined.

179 For example, if there has been a sentinel event, we are required to:

(a) complete a *Mental Health Act* Notice of Death MH 125 and submit it to the OCP within three days of becoming aware of the death;

(b) notify the DHHS MHDB and the Regional DHHS Director, usually via email, which usually includes a telephone call;

(c) register our interest with the Coroner's Court of Victoria, and provide clinical notes and relevant documents as required directly to the Coroners Court (or via police, who are charged with putting together the brief of evidence for the Coroners Court of Victoria);

(d) provide a notification summary or a copy of the MH 125 notice to the Victorian Managed Insurance Authority (**VMIA**);

(e) notify Safer Care Victoria via the Sentinel Events Program. Although this is required, the OCP guidelines do not currently reflect this, as the guidelines have not been updated since responsibility for sentinel events moved to Safer Care Victoria; and

(f) commence participation in a sentinel event program with Safer Care Victoria and/or internally commissioned root cause analysis or in-depth review.

180 We also have to liaise with the Chief Psychiatrist and the coroner's office in relation to deaths which may not necessarily be a suicide, but may otherwise meet the criteria for reporting because they are unexpected, unnatural or violent.

181 All of the above bodies request the same information, so we end up duplicating it and producing it to each. Often, the bodies listed above will require further information, written reports and other details and it can be challenging to respond and track actions following sentinel events. As a small AMHS, we do not have staff that can be delegated these tasks. Instead, it sits with my office. Significant internal reporting is required concurrently to ensure governance and oversight of incidents and quality improvement actions.

Strengthening existing regulatory or oversight mechanisms to improve the quality and safety of mental health services

182 There are several ways in which existing oversight mechanisms can be strengthened in order to improve the quality and safety of mental health services.

183 Firstly, services need to be well resourced for strategies to engage with consumers and families to seek feedback at the individual level, and this data should be reportable and benchmarked between agencies. For example, there is no current mechanism to report compliance with requirements for consumer involvement in the development of treatment plans. Expansion of the peer workforce would be one way to achieve this outcome. The National Safety and Quality Health Service (**NSQHS**) Standards recognise the fundamental principle that caring for a person's mental and physical health are integrated processes. While different members of the workforce have different roles, it is everyone's responsibility to collaborate to deliver person-centred care that meets all of the person's health needs. The newly adopted 'version 2' of the NSQHS Standards focuses more on acute services and tangible and measurable aspects of a person's care. There are many intangible elements to mental health care that cannot be measured easily beyond the individual level.

184 Secondly, the annual YES survey could be modified. Co-designed and completed by consumers and carers, the YES survey is benchmarked between organisations and supports continuous quality and safety improvement. The YES survey could be further strengthened by remaining open for the entire year, rather than the annual 3 month interval, and reported on and benchmarked periodically (for example quarterly). This would enable services to be more responsive to the feedback and embed the consumer voice into all quality and safety systems.

185 Thirdly, reports and recommendations from various regulatory agencies should be made available to services in a timely way in order for them to be able to respond dynamically continuously improve. For example, SWH participated in the OCP electroconvulsive

therapy (**ECT**) audit in October 2019, however we are yet to receive a report or recommendations as an outcome of this process. The provision of timely feedback will strengthen the ability of services to plan actions and monitor changes, over time.

RESTRICTIVE INTERVENTIONS

Approaches to reducing the use of restrictive interventions

186 In SWH MHS, everyone has the skill set to work at reducing the use of restrictive interventions such as trauma informed practice, de-escalation techniques, and strategies to establish mutual respect and recognition.

187 Safewards is a major tool used by AMHS in this regard. The Safewards model and associated interventions is directed at recovery-oriented practice, and has been highly effective in reducing conflict and containment, and increasing a sense of safety and mutual support for staff and patients. SWH MHS was the last AMHS to have Safewards rolled out to us from the OCMHN.

188 As SWH MHS is a small service with a number of vacancies across key senior nursing positions, the implementation of Safewards at SWH has not been as successful as hoped. Accordingly, training has been fairly basic so far, and we are still trying to embed Safewards into our way of working. However, with a renewed focus in 2020, we are optimistic the principles of Safewards will be further embedded.

189 At SWH MHS, we have a Reducing Restrictive Interventions Working Party that reports to the Mental Health Services Committee (formerly known as the Mental Health Services Clinical Quality and Risk Committee), which in turn reports to the SWH Clinical Governance Committee and then up to the Quality Care and Clinical Risk Board Committee. SWH MHS works hard to reduce restrictive interventions within the bed-based mental health service, and also works with ED staff to support them to minimise restrictive interventions. This includes sharing the Safewards training and education on the *Mental Health Act* with ED staff.

190 SWH would significantly benefit from a PAPU to support the specialist work that needs to be undertaken with consumers who present in crisis related to mental health and/or AOD misuse. A PAPU was proposed as part of master planning for SWH Warrnambool Base Hospital. A PAPU adjacent to the SWH ED would allow specifically trained mental health clinical staff to manage consumers with behavioural needs, including agitation and aggression using the Safewards principles, which are not commonly used in EDs.

Barriers to reducing the use of restrictive interventions

191 For SWH MHS, the use of restrictive interventions is generally low, and is reducing. Where SWH MHS has exceeded the threshold target, it has generally related to a

consumer with significant aggression that has required multiple restrictive interventions, with attempts at ceasing being unsuccessful.

192 A challenge is that there is variability in how restraint and seclusion is used across emergency services and the various non-mental health units across hospitals within our catchment to keep staff and consumers safe. We work with our colleagues in ED at SWH to assist them in understanding that the whole of Warrnambool Base Hospital is a designated mental health service facility and reinforce the regulatory requirements. This has proven to be a successful education piece for us at SWH. For example, to ensure ED staff appreciate that if they contain someone in a safe assessment room that would fall within the meaning of seclusion under the *Mental Health Act*, and therefore would require relevant authorisation, observations and adherence to reporting requirements.

193 At SWH MHS, we do occasionally share training (for example, the Safewards modules) with our emergency services colleagues. They are increasingly showing interest in the use of de-escalation techniques so that they do not have to resort to using restrictive interventions for mental health consumers (including the use of handcuffs, pepper spray or tasers by police).

194 In my view, there needs to be really strict guidelines for any emergency services that are implementing restrictive interventions and DHHS or Safer Care Victoria should lead this, with support from local AMHS as necessary.

PHYSICAL INFRASTRUCTURE

Healing, restorative, respectful and safe

195 At SWH MHS, we have a Prevention and Recovery Care (**PARC**) centre which meets the expectations of consumers that treatment and care is provided in physical environments that are healing, restorative, respectful and safe. The PARC meets these expectations through both considered and contemporary design features such as anti-ligature fixtures in the private spaces. The PARC has open areas and multiple break out spaces, access to outdoor and restorative spaces that are both calming and sensory stimulating, and operates under a model of care that supports agency and the learning of new skills to mitigate the risk of future crisis. The PARC is designed to be a home-like environment, and is intended to feel welcoming. The welcoming, calm environment inside and outside in the garden demonstrates to consumers (known as guests) that they are valued and enables a recovery oriented model of care in partnership with the guest to occur. This is in direct contrast to the current two inpatient units on the Warrnambool Base Hospital Campus.

196 However, the rest of the physical infrastructure at SWH MHS does not meet these expectations and is average at best. Camperdown Mental Health Service, Portland

Mental Health Service and Hamilton Community Mental Health Service, and the two inpatient units (both in Warrnambool) are all substandard. The buildings are largely in the original built condition or have been re-purposed to become community mental health facilities. The Warrnambool Community Mental Health Service is overcrowded and the physical environment is unable to accommodate the number of staff needed on duty.

197 The building environment or infrastructure can contribute to safety issues. For example, we have had a number of assaults occur in the Camperdown Mental Health Service, and we are therefore working towards getting some minor capital work done there which includes improved visibility of reception and waiting areas, addition of dual entries and exits into consulting spaces and retrofitting of CCTV and other technology. Older buildings are also more likely to have issues that mean they do not meet contemporary building guidelines for mental health services, placing consumers and staff at increased risk.

198 There are lots of challenges in updating infrastructure. For example, the Hamilton Mental Health Service is on a Western District Health Service (**WDHS**) site (at Hamilton Base Hospital). Rural health services only have an opportunity to put in two bids for funding through the Rural Health Infrastructure Fund each year – which includes bids for updating essential theatre and critical care equipment. It is challenging for rural health services to prioritise only two submissions, when lifesaving equipment must be prioritised. WDHS are very supportive of SWH MHS pursuing funding for a new or redeveloped community mental health service site and if successful, there would need to be a partnership arrangement to ensure the Hamilton SWH MHS site fitted in with any capital planning at WDHS, if SWH MHS remained on the WDHS campus.

199 A solution would be to create a specific rural mental health infrastructure funding pool for major AMHS renewal that was not competing with all other health service needs.

200 Recently, SWH MHS was successful in gaining some funding from the Regional Health Infrastructure Fund to design and build a new Portland Mental Health Service. When this work is finished in September 2020, the building will meet contemporary requirements. Once Portland Mental Health Services have a new facility that is co-located with Portland District Health, it will demonstrate the stark difference with the Camperdown and Hamilton Community Mental Health Services.

DIGITAL TECHNOLOGY AND INNOVATION

Opportunities for digital infrastructure and capability to enable information sharing, collaboration, care coordination and seamless transitions between services both within the same health service and other services

201 There are many opportunities for digital infrastructure to assist in enabling information sharing, collaboration, care coordination and seamless transitions between services both within the same health service and other services, including:

(a) Improving the robustness of the Community Management Interface (**CMI**) and Operational Data Store (**ODS**), including the ability to interface to it by HL7[13] or other appropriate interface for collecting and sharing health services data.

(b) State-wide funding of electronic health records to standardise data collection and entry, minimise duplication, and enable secure messaging and information sharing;

(c) Developing a secure portal between police, ambulance, CP and Family Violence Services to support the electronic sharing of information that is more efficient than the current paper-based Family Violence Information Sharing Scheme (**FVISS**) and Child Information Sharing Scheme (**CIS**);

(d) Increasing funding for device access, especially for consumer connectivity in inpatient units;

(e) Reviewing the current Regional Alliance Models of IT services to ensure equal access, partnership and consultation for all contributing services, and divisions within services.

Opportunities for digital infrastructure and capability to enable data analytics, research and innovation

202 There are also opportunities for digital infrastructure and capability to enable data analytics, research and innovation, including:

(a) Making data warehouse capability available to AMHS, to enable services to access their own data, monitor performance easily, and slice it to suit their own strategic planning. Accessing reports has been somewhat challenging over the years, due to the different platforms the reports are placed upon for an AMHS to access. They are not provided directly to the key management personnel and the data is not able to manipulated to assist us to understand it and support managers

[13] "*Founded in 1987, Health Level Seven International (HL7) is a not-for-profit, ANSI-accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services.*" See http://www.hl7.org/index.cfm sourced 12 May 2020.

to monitor it closely and report against anomalies. Recent cyber security events involving SWH have impeded our access to various platforms due to firewalls and other controls.

(b) Resourcing analytics personnel, establishing links to University Departments, and funding post-graduate opportunities such as part-funded PhD and Masters opportunities to enable services to retain exceptional staff for longer. Additional resources should be made available for rural services to support the recruitment and retention of such staff given the inability to leverage economies of scale and increased costs associated with travel to support these aspirations.

COVID-19

Observations of the emerging changes in mental health service delivery as a consequence of COVID-19

203 During the COVID-19 pandemic, funding to non-AMHS in Victoria and across Australia was boosted significantly to support people who are experiencing distress as a result of the pandemic response and state of emergency. SWH MHS did not receive any additional funding to support a rise in persons experiencing high prevalence disorders or symptoms when other services, including the GPs, were not accessible or harder to access due to physical distancing requirements.

204 SWH provided additional website advice and linkages during COVID-19, developed videos and frequent advice from the CEO and other key personnel relating to wellbeing, and developed a wellbeing single session model support telephone line for persons not eligible for services provided by an AMHS. A single session mode of support or therapy model is a specific form of therapy conducted by mental health clinicians and other counselling professionals to address a persons' presenting concerns, within one session. There is shared understanding that the when the session takes place, it is likely to be the only one. On occasion, a follow up session or call is made to 'check in' with the person to see if they were able to follow up on strategies developed during the single or first session.[14] This was in partnership with SWH MHS and SWH Primary and Community Services who have qualified clinicians to provide over the phone single session work and onward referrals to supports in the community, via telephone, or online. None of the initiatives have been funded by DHHS to date.

Longer term opportunities for new approaches to service delivery, for the benefit of consumers and carers (flowing from the emerging changes as a result of COVID-19)

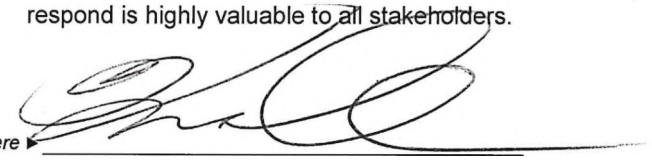
205 SWH MHS has been able to broaden the reach and uptake of telehealth using the Health Direct platform during the COVID-19 pandemic; which given our resources are stretched

[14] https://www.interventionjournal.com/sites/default/files/A_primer_on_single_session_therapy_and_its.3_0.pdf.

as outlined above, is certainly a positive. We do believe that where possible, face to face interaction remains the best form of engagement with consumers and their carers and allows us to undertake a comprehensive assessment, taking in to account behaviours and responses (for example, twitching, tremors, hand wringing or leg tapping) which may not be seen via the video conferencing of telehealth.

206 Regular 'welfare' checks on consumers to ensure access to food, medicines, GPs and screening for COVID-19 symptoms has been a very important wellbeing and consumer engagement piece and I would like to see that continue. As staff are not travelling long distances to visit consumers as often throughout our large geographic footprint, there is more time to make calls to more consumers each day.

207 The lived experience workforce always adds so much value to informing our everyday practice, however during a 'crisis' such as the COVID-19 pandemic, their ability to relate to what consumers and carers are or may be experiencing and relay how we need to respond is highly valuable to all stakeholders.

sign here 

print name Karyn Michelle Cook

date 21 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT KC-1

This is the attachment marked 'KC-1' referred to in the witness statement of Karyn Cook dated 21 May 2020.

RESUME

Personal Details

Name: Karyn Cook
Executive Director, Mental Health Services
South West Healthcare

Career Snapshot

Heywood Rural Health, Victoria – Board Director	**July, 2019 – July, 2022**
Audit & Risk Committee - Independent Member – Warrnambool City Council	**November, 2018 – Current**
NT Health & Community Complaints Commission Review Committee Member	**April, 2016 – October 2019**
Appointed by the NT Minister for Health	
Board Director, Mental Health Coalition - NT	**July, 2016 – Nov, 2017**
Executive Director, Mental Health Services – South West Healthcare (SWH)	**October 2016 – Current**
Executive Manager, Mental Health and Wellbeing - Anglicare NT	**Sept 2014 – October, 2016**
Manager, Treatment Services Turning Point Eastern Health	
(to support Victorian AOD Reforms)	**April 2014-October, 2014**
Darwin & Katherine Alcohol Assessment & Treatment Services	**Jul 2013 – Mar 2014**
Clinical Director (AOD) - Department of the Attorney-General & Justice, NT	**Nov 2010 – Jul 2013**
Technical Services Manager/ Injury Mgr. Advisor Territory Insurance office (TIO)	**Aug 2010 – Nov 2010**
Clinical Manager - Eastern Health Alcohol and Drug Services (EHADS)	**Nov 2008 – Jan 2010**
Nurse Unit Mgr. & AUM Community Residential Withdrawal Unit (EHADS)	**Feb 2005 – Nov 2008**

Professional Development

- **Safer Care Victoria Executive Leadership Gateway incl. LSI 360 Survey & Coaching Comm. Aug 2019**
- **Rural and Remote Mental Health Symposium Adelaide – October, 2019**
- **8th Public Sector Women in Leadership Summit – Canberra – November, 2019**
- **Masters of Business Administration (MBA) – current with Australian Institute of Business comm. Aug 2018**
- **Delivering leadership for managers & leaders of South West Healthcare – Growing Great Teams module**
- **Partnering with Consumers – Safer Care Victoria August 2019**
- **HOW2 – Rainbow Tick Implementation Training – Rainbow Victoria commenced August 2019 – Dec 19**
- **Safer Care Victoria – Sentinel Events and Root Cause Analysis 1 Day Workshop August 2019 & 2017**
- **Mindframe Media Training – July, 2019**
- **Office of the Chief Psychiatrist - Safety and Quality in Mental Health Forum, November, 2017,18,19**
- **Probity & Open Disclosure Training, VMIA April 2019**
- **NSQHS Standards (Version 2): Planning for Success, March 2019**
- **NSQHS Standards (version 2): Executives and Board Directors Workshop – March 2019**
- **Neuroplasticity in the context of trauma. Dr Hayley Peckham May, 2019**
- **Partnering in Healthcare (with consumers and carers) – Health Issues Centre July, 2019**

- **1st & 2nd Annual NDIS & Mental Health Conference, Sydney, 2017 & Melbourne 2018**
- **Safer Care Victoria – Sentinel Events Program and Root Cause Analysis Master Class 2019**
- **National Mental Health Services Planning Framework Training Stages 1, 2 & 3 – obtained licence 2018**
- **Mental Health Complaints Commission Forum** – Complaints and Avoidable Harms: Ensuring sexual safety in acute mental health inpatient units, 2018
- **Office of the Chief Psychiatrist - Safety and Quality in Mental Health Forum, November, 2017**
- **ADF Transition Seminar – Canberra 2017**
- SafeWards Victoria 2nd Annual Forum September, 2017 & 3rd Annual Forum September, 2018
- **Regional Clinical Governance Development Forums sponsored by DHHS – 2017**
- **Financial Management for Directors and Officers – AICD – 2016**
- **Graduate – AICD Company Directors Course (GAICD) – 2015**
- **Motivational Interviewing Advanced Skills - 2014**
- **Forward Management Program – Eastern Health** (Karyn featured in 2008/09 Annual Report) – **2008**

University Education

- **Master of Business Administration – Australian Institute of Business Commenced August 2018 – Current**
- **Professional Management Program (1 Year with Subject Credit for 1st Year MBA) – The University of Adelaide, March 2014 (*High Distinction & Award for best Strategic Management Project*)**
- **Masters of Advanced Nursing Practice (Mental Health) NP Stream – University of Melbourne, 2009**
  Included Population Health, Research & Adult Education subjects
- **Graduate Diploma in Mental Health Sciences – The University of Melbourne, 2004**
- **Graduate Cert Dual Diagnosis – Mental Illness and Alcohol & Other Drugs – NSW Inst of Psychiatry, 2004**
- **Bachelor of Psychiatric Nursing – RMIT, 1993**
- **Diploma of Applied Science (Psychiatric Nursing) – Phillip Institute of Technology, 1991**

  (In partnership with Muriel Yarrington School of Psychiatric Nursing)
- **Diploma of Business (Frontline Management) – VICSERV, 2006**
- **Diploma of Alcohol & Drug Works – NMIT, 2007**
- **Certificate IV in Training and Assessment (Bridging Course) for TAA40104, Victoria University, 2010**

Previous Employment History Summary

- Casual Contract Psychiatric Nurse, ECT Recovery and Triage – PCC Nursing Agency 2005-2007
- Clinical Nurse Educator – RMIT University 2005 – 2007 & Victoria University (via PCC Agency)
- Clinical Nurse Specialist – Discharge Care Coordinator – Top End Mental Health Service 2003-2004
- Client Services Manager – Goulburn Access to Employment Enterprises Inc. 2000 – 2002
- **Prevention Program Officer – Victoria/Tasmania – Melbourne Office Comcare Australia 2000**
- Rehabilitation Case Manager – ACT Department of Justice and Community Safety (seconded) 1999
- **Rehabilitation Advisor ACT Government & Stress Claims – Comcare Australia 1998 - 1999**
- **Rehabilitation/Job Placement Consultant – IRS Total Injury Management – 1996-1998**
- Statutory Claims officer/Rehabilitation Coordinator – Territory Insurance (TIO) 1994-1996
- **Registered Nurse – Gribbles Pathology (Puckapunyal, Seymour, Nagambie, Kilmore, Eildon & Yea Districts)**
- Registered Psychiatric Nurse in Victoria and Northern Territory, including Early Psychosis Services 1991-1995
- Enrolled Nurse (RN Nursing Student)/Registered Nurse – The Melbourne Clinic – Casual – 1990-1995
- **Part time: Retail Assistant, Childcare, Senior Financial Clerk, Forestry Firefighter & Cleaner – 1982-1992**