
# HACSU Submission

# Royal Commission into Victoria's Mental Health System

5 July 2019

# Contents

## About HACSU

The Health and Community Services Union (HACSU) is the specialist union for workers in the Victorian mental health, disability and alcohol and other drugs sectors.

We are committed to advancing and protecting the wages, conditions, rights and entitlements of our members through campaigning and workplace activism. We are equally committed to improving the services our members deliver to many of Victoria's most marginalised citizens.

With over 3,000 members working in Victoria's mental health system as nurses, allied health professionals, administrative staff and peer support workers, HACSU members are uniquely placed to provide the Commission with a detailed and granular view of the service system.

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## Overview

HACSU welcomes the opportunity to make a formal submission to the Royal Commission into Victoria's Mental Health System (the Commission). With over 3,000 members working in Victoria's public mental health system as nurses, allied health professionals, administrative staff and peer support workers, HACSU members are uniquely placed to provide the Commission with a detailed and granular view of the service system.

In preparing this submission, HACSU partnered with Per Capita (an independent think-tank) to undertake detailed research into the experiences of the Victorian mental health workforce and to identify the workforce's proposals for reform of the system. The research involved a 75-question survey undertaken in April 2019 augmented by five focus groups held throughout June 2019. There were 464 survey responses and 33 focus group participants. The vast majority of respondents (92.5%) were employed by a public, government, or government-owned entity. Just over half (51.9%) identified as nurses.

The research report—attached to this submission and referenced throughout—paints a compelling and grim picture of a fragmented and, oftentimes, violent service system that is manifestly failing the people it is designed to support:

- Almost half of all survey respondents (43.6%) reported feeling negative about their work.
- 1 in 5 workers (19.8%) reported they expected their feelings about their work to worsen over the coming 12 months.
- Half of all respondents (51.7%) said they weren't adequately supported to provide high quality mental health services to those in need.
- The overwhelming majority of respondents said they felt isolated in their job at least some of the time (71.6%)
- Nearly all respondents (87.5%) said their job in mental health put their health and safety at risk at least some of the time. Over a third (37.1%) said their job put their health and safety at risk most or all of the time.
- Over 70% of respondents believed that current level of community mental health services were inadequate.
- Over 80% believed that current level of hospital-based health services were inadequate.
- A clear majority of survey respondents (61.4%) felt that service and infrastructure planning within the system was badly underperforming.
- A similar proportion (56.4%) reported that pathways and interfaces between the mental health system and other services were badly underperforming.

Most concerning of all was that both survey respondents and focus group participants felt that the system was rapidly deteriorating:

> *"Over the last several years my personal enjoyment and fulfillment has gone downhill. I believe it is because the emotional and mental effort taken by my job. Many at my workplace say the same thing, nurses, any discipline. We all go home mentally exhausted. My 2 days off per week are spent in a state of exhaustion. I have a lot to be thankful for where I live, with my animals…but I no longer enjoy the things that used to keep me invigorated and able to enjoy my life. I have, over time lost my focus on what I need to do in my personal life. That is what working in adult public mental health has cost me. I am passionate about my job and it has*

*paid my mortgage almost and as a sole breadwinner but the personal cost has been enormous too." Survey respondent*

*"[The] system has become more rigid, less flexible and creative. Loss of staff camaraderie, staff feel more anxious and isolated in very stressful work…Continued inability to recognise the challenges and skills that support working and caring for clients, families and carers and supporting colleagues. A recent response to me when I found out a previous client (I worked with for about 18mths) had died by suicide, was 'don't worry, they were discharged more than 6 months ago, so there won't be an investigation.'" Survey respondent*

These findings and personal stories demonstrate that workers are trying to do the best they can within a funding and service delivery architecture that is clearly not fit for purpose and for which reform is well overdue. It is imperative that front-line workers in Victoria's mental health system must be front and centre of any attempt to review or reform Victoria's mental health system. These workers represent an invaluable resource to the Commission as it undertakes its inquiry and many of the survey respondents and focus group participants who contributed to this submission expressed a desire to directly share their experiences with the Commission. As one of our members so aptly put it when referring to their attendance at one of the June 2019 focus groups:

*"We stay in mental health and we come to these things because we're passionate about the work and we want to fix things." Melbourne focus group*

HACSU welcomes the opportunity to facilitate access to individual workers for the purposes of future public hearings and looks forward to working with Commission staff to enable this to occur. This submission is structured under six focus areas, which provide responses to most of the 11 questions posed by the Commission in its call for formal submissions. Furthermore, the full Per Capita research report "The Mental Health Workforce in Victoria" is provided as an appendix and should be read in conjunction with this submission.

# The Mental Health Workforce

## Overview

For almost two decades, successive governments—both Commonwealth and State—have been warned about the systemic risks facing the mental health system due to workforce shortages:

- In December 2003, a report prepared for the National Mental Health Working Group (NMHWG) and Australian Health Workforce Officials Committee (AHWOC) stated in no uncertain terms that "the mental health nursing workforce is experiencing a shortage of adequately qualified employees and the situation is becoming increasingly acute."[1]
- In May 2005, the Victorian Department of Human Services reported significant workforce supply issues for the mental health sector.[2]
- In September 2009, the Victorian Mental Health Workforce Strategy warned again of a "fundamental undersupply of mental health professionals."[3]

[1] Piazza, G., Rickwood, D., Morrsion, P. (2003) *Final Report into Mental Health Nursing Supply Recruitment and Retention* (prepared for the National Mental Health Working Group & Australian Health Workforce Officials Committee), p. 7.
[2] Department of Human Services (May 2005), Victoria's Direct Care Mental Health Workers: The Public Mental Health Workforce Study 2003-04 to 2011-12
[3] Department of Health (2009), *Shaping the Future: The Victorian Mental Health Workforce Strategy – Final Report.*

- In September 2014, a Victorian Department of Health report pointed to continued workforce supply issues and emphasised that "constraints are felt more strongly in rural and regional Victoria…and in areas of population growth."[4]
- In 2014, Health Workforce Australia predicted that by 2030, across Australia, there would be an 11,500 shortfall of mental health nurses, representing a 61% gap of workforce supply.[5]

The reason we reference these reports is to demonstrate that the sector (and Governments) have been aware of the longstanding issues facing the workforce. Now, in 2019, we are facing the same shortages and the same problems, compounded by decades of policy neglect.

On the matter of current workforce shortages, the Department of Health and Human Services (DHHS) 2018 mental health nursing workforce survey found six of twenty mental health services had a 10-20% vacancy rate (one service, Mildura Base Hospital, reported a 21-30% vacancy rate), with the average vacancy rate of 10% across Victoria.[6] This equates to over 460 vacant position. Based on the number of funded positions and the number of vacancies, in 2018 there were approximately 4,215 FTE nurses working in the Victorian public mental health system. While this represents an increase of 31% on June 2003 FTE numbers it is still below Victoria's population growth, which expanded by 34% in the same period.[7] With the number of mental health nurses on a per capita basis declining, and aggregate demand for services increasing, it is no wonder the workforce feels overstretched and unable to cope.

While much of the workforce data references mental health nurses—given they comprise the bulk of the clinical mental health workforce, this is not surprising—the shortage of allied health professionals and other support staff is just as acute. To HACSU's knowledge, there is no consolidated data on the number of allied health professional employed in Victoria's public mental health system, however, we believe it to be approximately 1,500 FTE. For context, there were 707 FTE allied health professionals employed in public mental health in June 2003.

As explained at the outset of this submission, HACSU partnered with Per Capita to undertake detailed research of the Victorian mental health workforce. The report (attached as Appendix 1) provides a comprehensive snapshot of the state of the mental health workforce predominantly employed in state-funded clinical mental health services. The full research report "The Mental Health Workforce in Victoria" should be read in conjunction with this submission and provides valuable data for the Commission in its inquiry. The remainder of this section details HACSU's recommendations to better attract and retain a skilled and supported mental health workforce.

## Building Workforce Skills and Supply

### Graduate Intake Reform in the Public Mental Health System

HACSU would submit that a major contributor to the high number of vacancies in the public mental health system is a constrained graduate intake program. This is particularly the case in allied health where there is no formal funded program, meaning there is no entry point for allied health graduates who comprise one-third of the Victorian public mental health

[4] Department of Health (2014), *Victoria's Specialist Mental Health Workforce Framework*, p. 17.
[5] Health Workforce Australia (2014) *Australia's Future Health Workforce – Nurses Detailed*.
[6] Department of Health and Human Services (2018) *Mental Health Nursing Workforce Survey 2018: Victorian Government Funded Mental Health Services.*
[7] Department of Human Services (May 2005), *Victoria's Direct Care Mental Health Workers: The Public Mental Health Workforce Study 2003-04 to 2011-12;* ABS (2019) *3101.0 - Australian Demographic Statistics, Dec 2018*, Estimated Resident Population, Persons, Victoria.

workforce. For context, each year, over 800 individuals apply for between 150 to 175 graduate nursing positions in the public mental health system. The graduate positions are all acute bed-based positions, with applicants required to complete two years of workplace training before becoming eligible to apply for a vacant position. Of the positions, 56 are funded directly by the Victorian Government, with the remaining funded by the various health services out of their existing budgets to grow workforce supply.

HACSU submits that easing the graduate intake bottleneck is a simple and cost-effective solution to the workforce crisis and would note this is a view shared by mental health services.[8] We believe that with an investment of $118.2 million over 5 years, the Victorian Government could create an additional 720 graduate places (running for two years each) for the strained service system, starting with 180 in the first year of operation.

To enable the service system to cope with the additional places there must be variations to the current graduate intake model. At present, graduate positions are exclusively for nurses in bed-based settings. HACSU proposes that the intake is expanded by an additional 180 places, comprised of 120 nurses and 60 allied health professionals. Additionally, all graduates should rotate across bed-based and community settings to ensure that the service system can deliver appropriate levels of clinical supervision. An added benefit of the rotation model is the possibility of improving graduate retention rates. Currently, graduates are compelled to work in bed-based services, which, by their nature, support consumers with the greatest acuity. By working in community settings, graduates will have the opportunity to witness the mental health recovery model in action, supporting consumers reintegrating into the community and providing hope that their intervention has a positive impact on people's lives.

To successfully transition this number of prospective students throughout the minimum three-year undergraduate university course, not only would these positions have to be fully funded, but serious consideration must be given to delivering additional financial support to ameliorate university tuition costs and providing support to existing clinicians who will be required to train and mentor graduates. With a total five-year base cost of $118.2 million (an average of $23.6 million per annum) this investment would increase total Victorian Government expenditure on mental health services by only 1.47% based on 2018/19 annual expenditure.[9]

The table below provides indicative base costings for the initiative. The figures are based on April 2018 rates of pay for a full-time Registered Psychiatric Nurses (RPN Grades 1 and 2) in the Mental Health EBA, with assumed 25% on-costs and indexation of 3.25% applied for each subsequent year.

| | Graduate Places | Post-Graduate Places | Cost |
|---|---|---|---|
| **Year 1** | 180 | - | $13,477,230 |
| **Year 2** | 180 | 180 (Year 1 Graduates) | $28,602,520 |
| **Year 3** | 180 | 180 (Year 2 Graduates) | $29,531,823 |
| **Year 4** | 180 | 180 (Year 3 Graduates) | $30,491,607 |
| **Year 5** | - | 180 (Year 4 Graduates) | $16,166,037 |
| | | | **$118,268,948** |

[8] In the 2018 DHHS Mental Health Nursing Workforce Survey all services reported the most effective recruitment pathway was the graduate program. Services also reported that additional resourcing of the graduate program would assist recruitment.

[9] Increase per annum of 1.47% based on total mental health expenditure identified in the 2018-19 Victorian State Budget of $1,605.7 million.

## Specialised Undergraduate Mental Health Nurse Education

The removal of specialist undergraduate mental nurse health training programs in Victoria from the early 1990s has been an abject policy failure, which ignored the reality that mental health is a specialised discipline. The result has been that fewer graduates opt to work in mental health services and those that do make the choice are underprepared. Whilst new nurses can (and do) develop mental health specific nursing skills post-graduation, on the job training must be provided by existing, senior staff who are already lacking the time to perform their core roles.

The failure of the current training regime was clearly highlighted by survey respondents. Nearly half of respondents (49.1%) disagreed that the current undergraduate and vocational nurse and allied health training programs were adequately preparing new mental health workers for entry into mental health. Furthermore, three out of every four survey respondents (76.3%) stated that it was "very important" for a worker in their particular role to hold a formal qualification specifically in mental health.

HACSU strongly recommends the reintroduction of a direct entry mental health undergraduate nursing degrees at Victorian universities. The direct entry model provides for more than one nursing undergraduate course, for example a psychiatric nursing course, a midwifery course, a general nursing course, etc. These different nursing courses have much in common and articulation arrangements can allow for credit transfer between direct entry courses. This would provide a streamlined, supported pathway into mental health services and has the potential to significantly boost both workforce supply and skill. It also has the possibility of reducing training costs in the longer-term, with the Victorian Government locked into an expensive training approach predicated on financially supporting postgraduate nursing education.

## Improving Entry Pathways into Mental Health

To meet the needs of a growing consumer-base and diversity, it is imperative to have a workforce that is reflective of the social, cultural and economic background of service users. Demand growth across nearly all of the social care sectors (family violence, disability, mental health, aged care, drug and alcohol, homelessness) also speaks to the need for a well-rounded workforce that can more easily transfer their diverse skills and expertise between adjacent sectors.

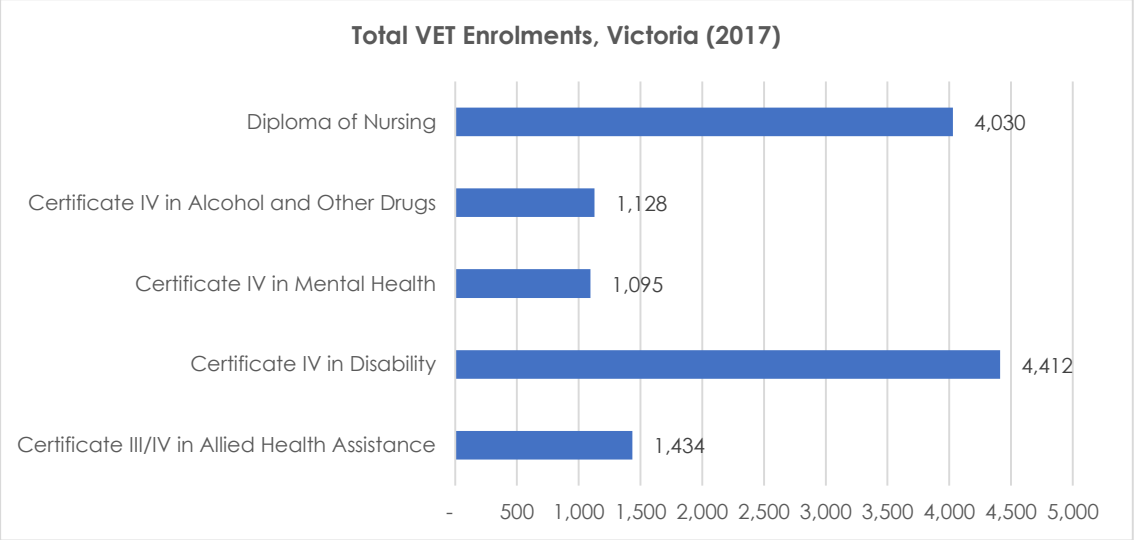
To achieve this HACSU recommends improving pathways into, and between, these sectors through vocational cross-training using the Victorian TAFE program. Currently, several free TAFE courses are available that have direct and indirect entry pathways into mental health including:

- Certificate III/IV in Allied Health Assistance
- Certificate IV in Mental Health
- Certificate IV in Alcohol and Other Drugs
- Certificate IV in Disability
- Diploma of Nursing

There were 12,099 collective enrolments in these qualifications in Victoria in 2017 (shown in the table below), which demonstrates a clear interest from prospective students in the social care sector.[10] However, VET completion rates remain low and there is a need for

[10] NCVER (2019), *Total VET Activity - Program Enrolments*. Customised data generated using VOCSTATS, filtered with Victoria as State/Territory of residence.

policymakers and industry to redouble efforts to support learners to complete qualifications and secure employment within their field of study.




HACSU recommends endorsement of these courses as entry pathways into mental health, by ensuring that appropriate mental health elective units from the CHC and HLT Training Packages are incorporated by Victorian TAFE's into their course offerings. The Victorian Government should also use its position on the Australian Industry and Skills Committee (AISC) to push for improvements to packaging rules and revised units of competency that reflect the growing importance of the social care workforce and the need for holistic mental health supports for consumers.

The benefit of reinforcing VET qualifications as an entry pathway into more advanced mental health roles is that these courses can equip graduates with base level training in mental health, enabling them to work in the sector earning a wage and developing on-the-job experience, which can support those who pursue further higher-education study in relevant nursing and allied health disciplines. This model could be supported through the introduction of a dedicated mental health cadetship, developed in partnership between Victorian health services and universities.

## Developing the Lived Experience, Administrative and Clerical Workforce

As a result of the grossly under-resourced workforce in mental health, clinicians across the sector are faced with unsustainable workloads. Consumers suffer as a result, failing to receive effective, recovery-oriented case management and poor continuity of care. To maintain wellbeing for those affected by mental illness, consumers require a range of non-clinical supports, including being connected to housing supports, alcohol and drug programs, financial literacy and support, education and training services, and, sometimes, criminal justice supports.

For unwell consumers, prioritising their post-discharge treatment becomes impossible without access to the necessities of everyday life: housing, energy, food, medical care and social connection. Staff working in mental health have a thorough awareness of these issues and often spend a great deal of their time managing complex consumers requiring a range of additional supports. However, too often, clinical staff are unable to provide adequate support and linkages to other services because of workload pressures. Safe discharge pathways and outpatient referrals, requiring limited clinical skills are absorbing clinicians' time and contributing to delayed access to mental health services.

HACSU represents members in all mental health fields. As such, we have a deep understanding of the entire workforce and understand that referral pathways can be more efficiently and effectively provided by Peer Support Workers and Psychiatric Service Officers. Similarly, pure administrative work can be completed by administrative and clerical staff. All services need an increased investment in these workers, something that has recently been acknowledged by the Victorian Government via the introduction of the Mental Health Workers Engagement Program. HACSU is recommending the expansion this program, as well as increasing numbers of the lived experience workforce, administrative staff and psychiatric services officers.

We would also note that there were only 57 Victorian enrolments in the *Certificate IV in Mental Health Peer Work - CHC43515* in 2017, barely changed from 56 enrolments the year prior.[11] HACSU recommend the *Certificate IV in Mental Health Peer Work - CHC43515* be added to the Victorian Government's list of free TAFE courses to boost the supply of Mental Health Peer Workers and that additional, tailored supports are provided to this learning cohort to assist them completing their training and entering the workforce.

## Ongoing Professional Development and Educators

HACSU members have consistently reported that workload and time pressures inhibit professional development for staff. In the Per Capita survey, 81% of respondents identified that the main barrier to participating in training and ongoing professional development was "lack of time". Addressing the workforce crisis is core to overcoming this barrier, but it also speaks to the need for localised training and professional development opportunities.

One tried and tested solution to local, place-based education is through discipline-specific educators. These individuals are vital to ensuring continuing professional development of clinicians and to achieving best practice service delivery. The relationship, support and development provided by discipline educators can also improve retention rates by reducing isolation reportedly felt by many clinicians.

HACSU members working as mental health nurses consistently report their positive experiences working with educators. Allied health members recently won the inclusion of three educators in the most recent round of enterprise bargaining for public mental health services, which commence later in 2019. However, expansion of these educator roles is urgently required to reach the entirety of the workforce. Currently there are approximately 97 FTE nurse educators in the public mental health system, producing an approximate ratio of 1 educator to 50 FTE nurses. HACSU recommends this ratio should be reduced to 1:30, representing an expansion of approximately 55-60 nurse educators. With regard to the allied health disciplines, once the three educators commence this will produce a ratio of approximately 1:500 FTE, which should be substantially reduced. There are no educators dedicated for the mental health peer workforce. HACSU recommends increasing the number of dedicated mental health educators for the nursing and allied health workforces and the introducing specific peer worker educators.

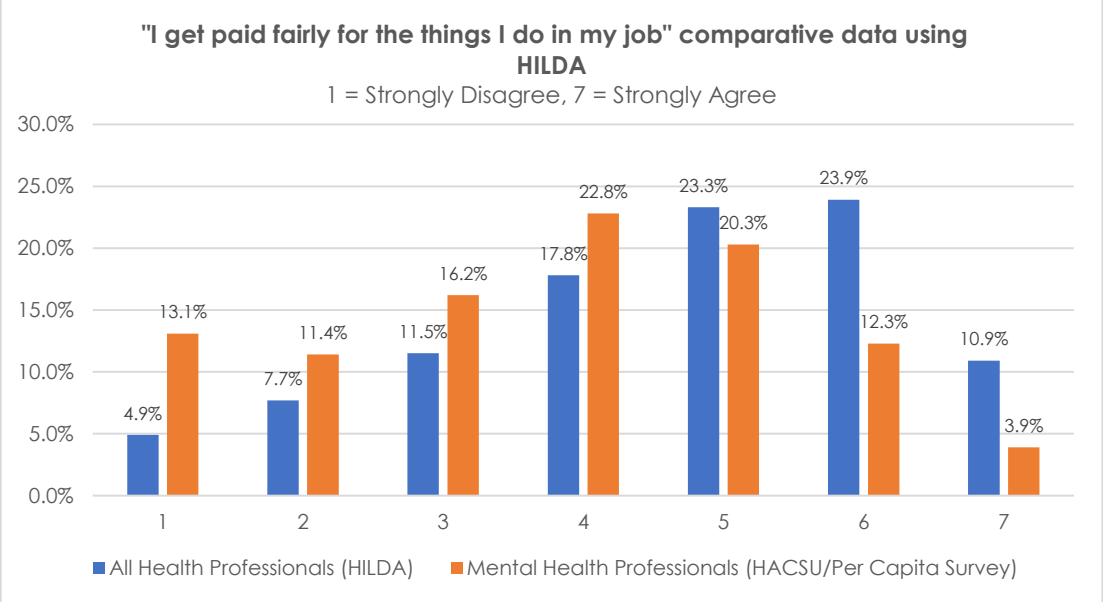
## Pay and Conditions

The primary reasons survey respondents nominated for working in mental health was that they found the work "personally rewarding" (54%) or that they "felt they were making a difference to the lives of people in need" (50%).[12] Whilst dissatisfaction with pay was not generally raised, the impact of wages and conditions on workforce attraction and retention cannot be overstated. In a 2013 study, researchers investigating the quality of frontline

[11] NCVER (2019), *Total VET Activity - Program Enrolments*. Customised data generated using VOCSTATS, filtered with Victoria as State/Territory of residence.
[12] Note, survey respondents could choose more than one response. See Appendix 1 for full responses.

healthcare jobs in the United States—including those in mental health—found that for the majority of workers, pay, precarious employment and unreasonable workloads outweighed the satisfaction they gained from the inherent nature of healthcare work itself. The researchers concluded that "these 'bad job' characteristics play a stronger role in whether workers will stay with their employers."[13] While this was study focused on workers in the United States, the same dynamics are playing out in the Australian context.

Mental health clinicians do important and complex work, often under high pressure and are frequently exposed to occupational violence. Despite this, they are not remunerated any differently to other practitioners in general health. While dissatisfaction with pay was not raised consistently in the workforce research HACSU undertook with Per Capita, the mental health workforce in general feels they are not paid fairly for their work relative to "Health Professionals" occupational data from the Household Income and Labour Dynamics in Australia (HILDA).




HACSU submits that any strategy designed to boost workforce supply in Victoria's mental health system must consider the role of pay and conditions, in addition to specific financial incentives designed to attract workers to the areas of greatest shortage: rural and regional Victoria.

## Improving Workforce Retention

### Addressing Workload

Chronic underinvestment and understaffing coupled with spiralling demand for services has seen an explosion in unsustainable workloads for the mental health workforce. This leaves clinicians without time for reflective practice and leaves workers often dealing with unsustainably high levels of patient acuity. The consequence has been increased burnout and is forcing skilled clinicians to exit the system.

> *"I feel exhausted and burnt out. The workload is much too big and too high risk, and we are so under resourced it just feels like you need to keep working all the time. Everyone is off sick and is unwell. It feels unhealthy to work here." Survey respondent*

[13] Morgan, D., Kalleberg (2013), *The quality of healthcare jobs*, p. 817.

*"There is more expectation to do more with less resources and a faster discharge cycle." Survey respondent*

While the chief method for addressing unsustainable workloads is to increase workforce supply, there are numerous inefficiencies within the system that could enhance the job quality of mental health practitioners, chiefly among these is a rationalisation of the paperwork mental health workers are compelled to complete.

In every focus group we conducted as part of this submission—and throughout the survey—mental health workers spoke about the sheer volume of paperwork they were forced to complete in the course of their work and that much of it was duplicated and not fit-for-purpose in a mental health service context.

*"The amount of extra forms that need to be completed has risen to a ridiculous level and many of the forms are taken directly from general /medical nursing and are ineffective and inaccurate within a psych unit." Survey respondent*

For context, clinicians working in the public mental health system are required to collect data and complete paperwork for a variety of actors throughout the mental health hierarchy, including the Office of the Chief Psychiatrist, the DHHS, Area Mental Health Services (AMHS), localised service data and with the consumer record data during clinical interactions.

*"We now have to enter two lots of stats every month with the new work management toll an added burden. Add this to CMI stats (which do not correctly reflect our workload), letters, reports, continuation notes and 9-12 page assessments and it becomes very overwhelming!" Survey respondent*

Not only was excessive paperwork reported as preventing clinicians from focusing on consumer care, but the sheer volume also made it more difficult for clinicians to easily review relevant history.

*"Nurses are being overburdened with paperwork that often does not actually correlate to better care. In fact, it often prevents staff from actively caring for their clients, as well as creating a paper-trail of irrelevant documentation." Survey respondent*

HACSU recommends that a state-wide review is undertaken for the purposes of rationalising and reducing the current levels of paperwork and data entry. This review should also consider reform and modernisation of out-dated state-wide data collection tools, in particular the Client Management Interface/Operational Data Source (CMI/ODS) no longer accurately longer reflects the complexity mental health consumers. Frontline workers and their representatives must be active participants in this review. It should be noted that duplicated and excessive paperwork has been a chronic problem and that since 2001, every successive public mental health enterprise agreement committing to a review, without action from the DHHS or health services.

### Improving Workforce Mobility Between Mental Health Settings

Another factor affecting turnover is the inability of clinicians to more easily rotate between different settings, particularly between bed-based and community settings. Nearly a third of survey respondents (29.6%) disagreed with the statement "There are possibilities to move around and do different kinds of work in my sector" with the majority of these negative responses originated from those employed in bed-based settings.

*"No career development for clinicians effectively keeping people locked into one role and pay scale for years and years." Survey respondent*

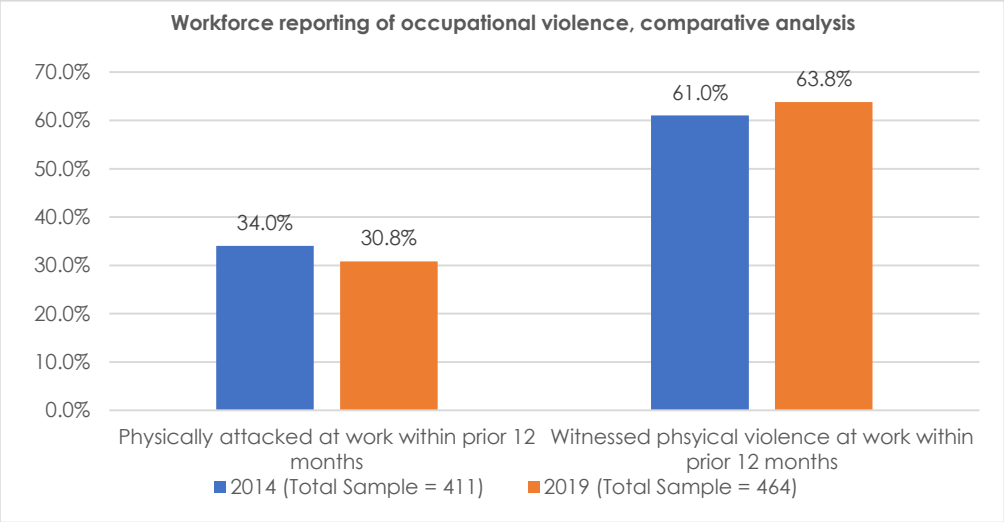
Locking clinicians within acute, in-patient settings is particularly problematic as these are the settings accessed by the most mentally unwell consumers, preventing exposure of these

clinicians to the positive work that they perform in integrating consumers back into the community. It is essential the mental health system provide pathways into settings where clinicians can see hope for the consumers they support and hopefully improve retention rates and reduce burnout. Consideration should also be given to implementing more flexible models of staff rotation, enabling a rapid movement of staff in bed-based settings into the community when they are at risk of burnout.

## Addressing Occupational Violence

Occupational violence has, unacceptably, become a standard feature of Victoria's public mental health system. Apart from the principle that in 21st century Australia no one should have to go to work fearing for their own safety, occupational violence is a major contributor to workers leaving the mental health system, and, far too often, requiring mental health services themselves after suffering repeated trauma.

In the HACSU/Per Capita survey a number of question were put to respondents regarding occupational violence, two of these questions were replicated from a 2014 HACSU/Melbourne University study to enable a comparison (presented below).[14] The 2019 data shows a marginal reduction in the prevalence of physical attacks in the workplace compared with 2014, however, with nearly a third of respondents (30.8%) to the 2019 survey reporting being physically attacked at work in the prior 12 months it is clear that mental health services are profoundly dangerous workplaces.[15] Additionally, a greater proportion of respondents in 2019 reported witnessing physical violence in their workplace within the prior 12-months compared with the 2014 sample. Whilst these questions limited the reporting of violence to incidents that had occurred within the prior 12-months, there is overwhelming evidence that the lifetime risk of assault for nurses working in acute mental health settings is approaching 100%.[16]




Some members reported that supply constraints were increasingly leading to consumers being admitted to clinical services who would otherwise be better suited in forensic settings.

[14] The samples for both surveys were remarkably similar in their composition of mental health worker employed in the public system and a majority of nurses.
[15] In the 2014 research, 99% of those who reported having been physically attacked in their workplace within the prior 12-months stated that a consumer was the source of the attack. This is similar to the 2019 data, where 93% reported a consumer was the source. It should also be noted that respondents also frequently reported consumer-on-consumer violence.
[16] Bowers, L., Stewart, D., Papadopoulos, C. et al. (2011). *Inpatient Violence and Aggression: A Literature Review*. London, UK: Institute of Psychiatry.

*"There is a huge change in the people being admitted. The numbers of people better suited to a forensic units, the levels of violence they bring, the drugs that are used that result increased levels of violence. Pressure to reduce the use of seclusion without an effective alternative. The risk of a permanently incapacitating injury to many nursing staff is real and high. These issues are constant, interfere with most nurses ability to feel safe at work and care for their patients and then go home uninjured." Survey respondent*

HACSU would submit that one of the contributing factors to occupational violence in the public mental health system is that there are no specific staffing profiles in adult acute units which include highly trained clinicians who can provide services to consumers with known or developing violent behaviours. There are also inadequate protocols and options for removing or isolating consumers with aggressive behaviours from acute units. Not surprisingly, this leads to the escalation of violence—with both consumers and staff suffering the fallout. Reducing occupational violence is in everyone's interest. A recent Australian study the found that the likelihood of the use of restrictive practices was very much related to mental health clinicians feeling unsafe at work.[17]

HACSU submits that in its deliberations on the workforce and restrictive practices the Commission must examine the epidemic of occupational violence and produce meaningful recommendations to address it. Some of the matters that should be considered are:

- The impact of smoking bans increasing agitation for some consumers in acute in-patient units.
- Reforming the built environment in which profoundly unwell consumers are treated.
- Increasing the variety of acute bed options to allow for separate intensive supports for high-risk consumers.
- Ensuring an adequate supply of specialist forensic services.
- Providing adequate support to clinicians injured at work (both physically and psychologically).

### Reforming a Bullying Culture

Troublingly, 1 in 10 respondents to the HACSU/Per Capita survey indicated they wouldn't be working in mental health in five years' time, with a further 28.3% unsure about remaining in the sector. Respondents intending on leaving the sector were asked to nominate the main reason for wanting to leave and, shockingly, the number one reason was that they had "experienced bullying or intimidation by colleagues and/or management" (27%). The proportion of all survey respondents who stated they had been subject to workplace bullying within the prior 12-months was almost half (48%).

*"Recent response to organisational bullying was to organise focus groups to discuss this with management and known bullies present running the groups, again another tick off process." Survey respondent*

Interpersonal conflict, workplace bullying, and intimidation are all symptomatic of a system under extreme pressure. While additional funding and more workers will alleviate this pressure, the long-term neglect of the Victorian mental health system by policymakers has resulted in a toxic workplace culture taking root. Reforming this culture will require more than simply dollars and bodies, it will require sustained and sophisticated strategies and is something the Commission must have front-of-mind when considering its recommendations.

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[17] Muir-Cochrane, E., O'Kane, D., Oster, C. (2018) *Fear and Blame in Mental Health Nurses' Accounts of Restrictive Practices: Implications for the Elimination of Seclusion and Restraint*, International Journal of Mental Health Nursing.

# Pathways and Interfaces Between Mental Health and Other Services

## Alcohol and Other Drugs

Alcohol and other drugs (AOD) dependency could be defined as a type of mental illness in its own right, yet AOD services are poorly linked with specialist mental health services. Currently, if a consumer requires integrated dual diagnosis treatment, their primary service team must negotiate treatment from a secondary service, AOD to mental health or vice versa.

> *"I see too many people settle their mental state but not their drug use, they get discharged, use, become psychotic and end up back in the system." Survey respondent*

Effective integrated treatment requires referral, regular confidential communication, the development of an integrated care/recovery plan, case conferencing and the capacity to respond quickly to any changes in the consumer's health e.g. relapse or stress. These activities take considerable resources that are rarely reflected in existing tenders and staffing profiles. Furthermore, the secondary service may be some distance from the primary; consumers may require transportation or escort and the service may use different clinical language from the primary service or have little understanding of the other service's treatment processes. The secondary service may also have no capacity or interest in integrated care and may see their work as specialist, separate or more important.

HACSU submits that better outcomes for consumers can be delivered if they could access a complex care coordinator within AOD residential services who understands the consumer's needs, the mental health service's processes and the sector. The role of this service would include completing comprehensive dual diagnosis assessments, developing cooperative relationships with relevant mental health services and mentoring colleagues as they learn to respond effectively to consumers with complex needs.

## Justice and Forensic Mental Health

In 2014, the Victorian Auditor-General reported that "indicators of under-capacity in prison facilities and compulsory mental health facilities outside prisons have been apparent for several years and have now become extreme."[18] However, in the five years since this report was tabled, there has been minimal expansion of forensic services within Victoria.

There is also poor discharge planning from Victorian correctional facilities. Frequently, consumers released after serving a custodial sentence are immediately placed on an assessment order and sent to the closet AMHS for treatment. The AMHS may only receive a few hours' notice that a bed is urgently required. There is an urgent need for better discharge planning between correctional facilities and AMHS.

Additionally, major investment is required to commission a new, purpose-built forensic facility, alongside funding to enable gender-specific rehabilitation streams within Thomas Embling Hospital.

## Homelessness

Both survey respondents and focus group participants identified the lack of appropriate and affordable housing for consumers as a major contributor of recurrent presentations at acute services.

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[18] Victorian Auditor-General (2014) *Mental Health Strategies for the Justice System*, p. xii

*"Constantly witnessing people being discharged from my mental health service within a prison into homelessness only to relapse and reoffend." Survey respondent*

Whilst a state-wide problem, it is more acute in regional and rural locations, some of which have no supportive housing infrastructure:

*"Shepparton has 20 beds. 15 Adult and 5 Aged care beds. This amount is excessively low for the area we service. The needs to be about 50 adult beds. And on discharge there is often nowhere for these people to go. Shepparton does not have one homeless shelter." Survey respondent*

HACSU submits that the Commission must make recommendations to increase the supply of safe, secure, affordable housing for consumers that require it.

### National Disability Insurance Scheme (NDIS)

The transition of a number of Commonwealth and State-funded mental health-specific programs such as the Mental Health Community Support Services program (MHCSS), the Personal Helpers and Mentors Service (PHaMs) and the Partners in Recovery program (PIR) into the National Disability Insurance Scheme (NDIS) has been disastrous for services, consumers and workers alike. In the HACSU/Per Capita survey, only 1 in 10 respondents (11.9%) agreed that the NDIS had been a positive development for Victoria's mental health service system.

*"Mental health was a last-minute add-on to NDIS. People currently serviced will not qualify for assistance and will put increasing pressure on emergency department and clinical services." Survey respondent*

One of the primary reasons for this is due to legislated requirement that a participant's disability be deemed "permanent" to access the NDIS. This requirement is completely incongruent with established principles regarding mental health recovery models and episodic nature of mental illness. Consumers who might have been eligible under the MHCSS program are now denied access to the NDIS, leaving them with no services at all until their illness escalates to the point they have to be admitted acute settings, and then the cycle begins anew.

*"I work in an acute psychiatric adult inpatient unit and there are serious concerns that many people who are admitted to our unit and require ongoing NDIS support will not meet the criteria for that support. The distress caused to individuals and their families over the issue of episodic mental illness or one off serious 'situational crisis' cannot be emphasised enough. The escalating suicide rate unfortunately is an example of the extremely high needs of people with a mental illness." Survey respondent*

*"[We] often have to discharge our young clients from the service without being able to offer another support service who can support with mentoring, psychosocial recovery aspects of their life. There are less options since NDIS was introduced and other services withdrawn" Survey respondent*

While HACSU is aware that some continuity of support arrangements have been introduced by the Victorian Government relating to the MHCSS program, and PHaMs from the Commonwealth, the fact remains that systemic flaws with NDIS's accessibility to people with mental illness is causing client and cost-shifts to Victoria's public mental health system. While the NDIS is a Commonwealth responsibility, Victoria is a shared stakeholder in the scheme and makes a significant financial contribution to scheme costs. For this reason, the Commission must examine the interface between mental health services and the NDIS in addition to establishing specific hearings for people with disability who also experience mental illness.

## Accessing and Navigating Mental Health Services

Accessing and navigating mental health services is a serious problem in Victoria's mental health system, frustrating and confusing for staff and consumers alike. A large proportion of the survey workforce (72.4%) did not believe that carers and family members of unwell consumers were adequately supported by the service system. This is a stunning indictment of a system that is meant to support vulnerable Victorians.

### Triage

The centralised triage model for most Area Mental Health Services (AMHS) is severely constrained, with call volumes increasing beyond the capacity of triage clinicians to respond to in a timely and appropriate fashion. Workers in triage also identified that the proliferation of different (and differently named) programs made it difficult triage clinicians to assist consumers to navigate the system.

> *"In triage you find services hiding around the corner….by chance, by word of mouth. It's not central. If someone were to say, what is the map of what [services are] out there? I don't think anyone would know." Melbourne focus group*

On the matter of differential names for the same program, just one example, the Crisis and Assessment Treatment Team (CATT) is named "Roster Function" at one AMHS, "Acute Response Team" at another and "Access Team" at yet another. This adds additionally complexity and confusion within an already overly complex system. A simple and low-cost solution would be for centralised and standardised naming of different services.

### Emergency Departments

Due to lack of acute inpatient beds, an all-too-common pathway into mental health services is via hospital emergency departments (ED). For most consumers, accessing services via the ED is a lengthy process. Most Victorian EDs have one or two mental health clinicians on per shift, however the rate of mental health presentations makes it nearly impossible for consumers to be seen within the four-hour National Emergency Access Target (NEAT). HACSU members report the pressures imposed by the NEAT causes conflict between staffing groups (mental health and general), which escalates at the 24-hour mark due to failures to meet KPIs.

> *"Over recent years the policy of centralised service access has contributed to overburdened hospital emergency departments and hampered access at earlier illness stages." Survey respondent*

Once within an ED, referrals for consumers can be a difficult process with multiple barriers preventing access necessary and timely services. These barriers include lack of available beds, difficulties contacting other services and pushback from health services not willing or able to accept the referral. Acute inpatient units that are co-located on the same campus as the ED face extreme pressure admit referrals from ED in order to meet the NEAT timeframes. We regularly hear reports from members that consumers with greater acuity who are referred via a community team are often pushed back in the queue to ensure NEAT KPIs are met, forcing community clinicians to sit and wait with a consumer in ED until they themselves are prioritised. This is a grossly inefficient and inequitable model.

> *"I am forced to work reactively with a large client list in a crisis-based model. Nil focus on preventative health. Client's being discharged unwell…resulting in massive care burden on family and risk for community clinicians. The system is ultimately lobbing sick people out into the community to create beds in wards." Survey respondent*

HACSU recommends that the Commission examine both internal and external referral pathways and the role of NEAT within emergency departments.

## The Need for Dedicated Emergency Mental Health Services Workers

The pressure felt by hospital emergency department staff has been equally shared by the frontline professionals who most often bring acutely unwell consumers to the ED: police and paramedics. HACSU has been advised via the Police Association that nearly 60% of police callouts relate to mental illness, yet there has not been a commensurate development of their skills in responding to consumers in crisis. Evidence shows that the Police, Ambulance and Clinical Early Response (PACER) model works. A Department of Health commissioned review of the program in 2012 found the program provided:

- More timely access to mental health assessment for the person in crisis.
- Better use of police first responder resources.
- Reduced referrals to emergency departments.
- Less frequent use of restrictive practices.[19]

However, PACER-like programs remain woefully underfunded. HACSU recommends the establishment of dedicated Emergency Service Response Teams, which embed mental health clinicians with police and ambulance staff to support the needs of the community 24-hours a day, 7-days a week.

## Governance, Accountability and Funding

It is imperative for the Commission to examine whether the Area Mental Health Services are still serving their original purpose as an effective demand-management system. AMHS boundaries have not responded to the significant growth of Victoria's population and must be redrawn. Furthermore, HACSU would submit that the segmentation of the mental health system into AMHS has introduced significant diseconomies of scale into the public mental health system. Various back-office services such as finance and human resources have been unnecessarily duplicated, diverting resources from under-resourced frontline clinical teams.

Mental health services also require their own funding allocation and governance structures, that are separate from overall health budgets. This would enable greater accountability and visibility of funding, ensuring that mental health budgets are not quietly absorbed by other service demands. Survey respondents were understandably keen for greater transparency in budgets:

> *"My understanding is that funding is provided to public organisation/service for executives to control. There seems to be no accountability in regards to how this is allocated, more transparency may help in understanding this complex area.*
> *"Maybe take focus of rushing people through services in order to meet KPIs to get more funding & give staff time to provide a holistic & caring response. This may also be beneficial to staff well being & retention, and prevent 'failed discharges'"*

In concluding this submission, HACSU would like to emphasise that without reformed governance, greater accountability and significant boosts to funding—the Victorian mental health system will continue to be one characterised by unmet demand, demoralised staff and poor outcomes for consumers. We sincerely hope this Royal Commission is the catalyst for real change.

[19] The Allen Consulting Group (2012) *Police, Ambulance and Clinical Early Response (PACER) Evaluation – Final Report* (prepared for the Department of Health, Victoria).

## Summary of Recommendations

The following provides a high-level summary of the recommendations contained in this submission, directed at both the Victorian Government and the Commission.

I. That the Commission work with HACSU to facilitate frontline mental health workers sharing their experiences directly in future public hearings.

II. That the Victorian Government expand and reform the public mental health graduate intake program.

III. That the Victorian Government reintroduce the mental health major in undergraduate nursing degrees at Victorian universities.

IV. That the Victorian Government pursue a range of initiatives to expand alternative entry pathways into mental health via:

   a. Requiring Victorian TAFEs to design relevant Free TAFE courses so that mental health units from the CHC and HLT Training Packages are included as elective units.

   b. Leveraging its position on the AISC to advocate for changes to national Training Package products to improve mental health units of competency, qualifications and packaging rules.

   c. Introducing a mental health cadetship model via partnerships with Victorian health services and universities.

   d. Adding the Certificate IV in Mental Health Peer Work to the list of Free TAFE courses.

V. That the Victorian Government significantly boost the numbers of peer workers and administrative and clerical staff.

VI. That the Victorian Government increase the number of dedicated nurse and allied health educators, alongside introducing dedicated lived-experience workforce educators.

VII. That the Royal Commission examine the role of pay and conditions in any considerations on workforce supply, including the role of financial incentives in attracting workers to low-supply areas (e.g. regional and rural).

VIII. That the Victorian Government urgently resource and establish a review into rationalising paperwork and data collection tools within the public mental health system.

IX. That the Royal Commission examine how best to support workforce mobility between different clinical settings within the public mental health system.

X. That the Royal Commission establish specific hearings on occupational violence and ensure that recommendations are made in both its interim and final report on ameliorating occupational violence.

XI. That the Royal Commission specifically examine the pervasive culture of bullying in the public mental health sector.

XII. That the Victorian Government establish complex care coordinator roles within alcohol and other drugs (AOD) services to build better linkages between mental health and AOD.

XIII. That the Victorian Government urgently begins work on developing a new purpose-built forensic mental health facility.

XIV. That the Royal Commission examine the supply of affordable and accessible housing and the interaction between housing undersupply and re-admission rates.

XV. That the Royal Commission specifically examine the rollout of the National Disability Insurance Scheme as it relates to the transition of funding from mental health specific programs.

XVI. That the Victorian Government enforce standardised naming for all mental health programs across the state and develop an updated service map.

XVII. That the Royal Commission examine the role of the National Emergency Access Target (NEAT) in emergency departments as it relates to mental health presentations.

XVIII. That the Victorian Government urgently resource dedicated emergency mental health services workers, modelled on the PACER program.

XIX. That the Royal Commission examine whether the Area Mental Health Service (AMHS) structure is fit-for-purpose in light of uneven population growth and issues relating to diseconomies of scale introduced by the AMHS system.

XX. That the Royal Commission audit the expenditure of health services to ensure that funds allocated for mental health and not being spent on adjacent general health services and that in future, mental health service budgets are quarantined from general health budgets.

XXI. That both the Royal Commission and Victorian Government accept and recognise that without a significant increase in funding the Victorian mental health system will continue to be one characterised by unmet demand, demoralised staff and poor outcomes for consumers.

# THE MENTAL HEALTH WORKFORCE IN VICTORIA

Abigail Lewis and Warwick Smith

June 2019

## About Per Capita

Per Capita is an independent progressive think tank, dedicated to fighting inequality in Australia. We work to build a new vision for Australia based on fairness, shared prosperity, community and social justice.

Our research is rigorous, evidence-based and long-term in its outlook. We consider the national challenges of the next decade rather than the next election cycle. We ask original questions and offer fresh solutions, drawing on new thinking in social science, economics and public policy.

Our audience is the interested public, not just experts and policy makers. We engage all Australians who want to see rigorous thinking and evidence-based analysis applied to the issues facing our future.

## About HACSU

The Health and Community Services Union (HACSU) is the specialist union for workers in the Victorian mental health, disability and alcohol and other drugs sectors.

We are committed to advancing and protecting the wages, conditions, rights and entitlements of our members through campaigning and workplace activism. We are equally committed to improving the services our members deliver to many of Victoria's most marginalised citizens.

With over 3,000 members working in Victoria's mental health system as nurses, allied health professionals, administrative staff and peer support workers, HACSU members are uniquely placed to provide the Commission with a detailed and granular view of the service system.

## Acknowledgements

Thanks to Emma Dawson for providing guidance and leadership throughout the project. Thanks to Myfan Jordan from Per Capita for providing feedback on the report and for facilitating the Melbourne focus groups, and to Mark Farthing from HACSU for note taking and assistance at two of the Melbourne focus groups, assistance with organising and recruiting for the focus groups, and promoting the survey to members.

The authors would particularly like to thank all of the mental health professionals who participated in the online survey and attended focus groups. Despite being in high pressure jobs and already feeling overworked, they contributed their time and energy to this process in the hope of improving mental health services in Victoria and improving working conditions for the mental health workforce.

All names used in this report are pseudonyms.

*"We stay in mental health and we come to these things because we're passionate about the work and we want to fix things." Geoff, Melbourne focus group*

## Executive Summary

*"If the Royal Commission is going to make meaningful change and improvement then it needs to have people who work at the coalface of mental health services involved in designing the new system." Carol, regional focus group*

The purpose of this research was to uncover and describe the state of mental health services in Victoria from the perspective of front-line staff who work with consumers, predominantly in the public system.

In April 2019 Per Capita and the Health and Community Services Union (HACSU) surveyed members of the mental health workforce in Victoria. The survey garnered a great deal of data, which is published in full in Appendix I. There were 464 survey responses. 65% of respondents had more than 10 years' experience working in the mental health sector; 40% had worked in the sector for more than 20 years. The vast majority – 92.5% - were employed by a public, government, or government-owned entity.

The survey was followed up with five focus groups in June 2019 that delved further into issues raised in the survey responses and also provided mental health professionals the opportunity to discuss and raise new topics.

The overall impression of the state of mental health services in Victoria was bleak. A picture emerged of a sector that is under-funded, understaffed, and under-resourced to the extent that it is unable to meet demand. While national per capita spending on specialised mental health services is growing by an average of 0.7% annually, Victoria's expenditure (already the lowest in Australia) is declining by 0.3% annually.[1] This is reflected in the survey's finding that 31% of the workforce believes increasing funding is the highest priority for the Victorian mental health sector.

Without sufficient funding, staff, or resources, services operate in crisis mode, risking the safety and security of both staff and consumers, and exacerbating a toxic culture of bullying and intimidation. Day to day, mental health professionals on the front line of service delivery feel overwhelmed, unsafe, and unable to provide adequate care. Two different professionals in different focus groups stated that they would hesitate to bring a family member into contact with the system even if they had a severe mental illness because they felt it might do them more harm than good. Some of these concerns about the system's ability to inflict potential harm related to the presence of consumers who would be more appropriately treated in forensic facilities but end up in emergency departments and acute wards because of lack of forensic capacity.

Under resourcing of preventative early treatment means that many mental health consumers first enter the health system through hospital emergency departments when their symptoms have become extreme. Government supported mental health plans that are authorised by GPs are inadequate in only offering ten appointments per year, and services that are available, particularly in regional areas, often require the payment of a gap fee that many cannot afford. A systemic review is needed of resource allocation overall as well as between the different levels of government, elements of the mental health system, and those systems that interact with the mental health system, including drug and alcohol treatment services.

[1] Victorian Auditor-General's Office, *Access to Mental Health Services* (March 2019), page 10

In addition to the quantitative survey data, the large number of free form survey questions and the focus groups provided rich qualitative and narrative information about the experience of working in Victoria's mental health sector. Some clear themes emerged of common experiences and shared priorities for reform:

*Workload*

Almost every participant felt that their workplace was understaffed and, as a result, the workload on the staff was too high. There was also significant criticism of unnecessary, repetitive, and unproductive paperwork, which many respondents felt was focused on protecting the organisation rather than on improving service delivery.

*Bullying and intimidation*

Workplace bullying by managers was a significant issue at many workplaces and was prominent in both the survey results and the focus group conversations. There was often a culture of blame in workplaces and a sense that upper layers of management didn't understand the work that was done with consumers.

*Risks to safety and security*

Almost a third of survey respondents (and almost half of the nurses who responded to our survey) have been physically attacked in the last twelve months. Management practices and resource constraints often exacerbated the risk with many focus group attendees telling us there was no suitable capacity for dealing with consumers posing a potential risk at their workplace.

*Siloed services*

There was frustration at the lack of integration and information sharing between various services, providers, and agencies. The lack of capacity for appropriate information sharing between different services leads to inefficiency and sometimes increases the trauma of consumers who have to continually repeat their stories to different providers and different parts of the service system. Better integration of drug and alcohol treatment was called for by many mental health professionals who found they were having to treat drug and alcohol addiction in their facilities before they could treat the mental illnesses.

*Lack of long-term care options*

A lack of affordable and appropriate housing plus a lack of medium to longer term support options combined to make homelessness a serious risk for many Victorians with mental illness. Many mental health professionals linked the lack of long-term care options to the deinstitutionalisation of acute mental health treatment, which they saw as a deeply flawed process that was driven primarily by cost cutting rather than care or concern for consumers. Some expressed a concern that there are substantial numbers of Victorians with a severe mental illness who cannot independently lead a healthy life in the community, some of whom pose potential risks to themselves or to others, and that the process of deinstitutionalisation failed to provide alternative, safe, secure, long-term housing for these consumers.

## The makeup of the mental health workforce in Victoria

The exact makeup of the mental health workforce in Victoria is surprisingly difficult to determine. Because the ABS do not collect fine enough scale data to identify all mental health professionals through the Australian and New Zealand Standard Classification of Occupations (ANZSCO) framework, exact numbers are hard to come by. Some indicative figures include:

- In May 2018 there were 4,683 publicly funded mental health nurses in Victoria.[2]
- In 2016, the Australian Institute of Health and Welfare (AIHW) data showed 5,306 FTE mental health nurses employed in Victoria.[3]
- There were 923 psychiatrists in Victoria at the time of the 2016 Census (909 FTE in 2016 according to the AIHW).
- There were 10,329 psychologists in Victoria in March 2019[4] (7,000 FTE in 2016 according to the AIHW[3]).

We do not have clear figures on the number of nurses in private practice nor the number of other allied health professionals and allied health assistants who work exclusively or primarily in mental health. We also do not have an accurate picture of the size of administrative and clerical workforce within the mental health sector or the lived experience workforce. There is also limited data available on the number of support workers providing supports to NDIS participants with psychosocial disability.

### Survey of the Victorian mental health workforce

The survey was promoted and advertised by HACSU, primarily through its membership. It was conducted online through the Typeform platform and consisted of seventy-five questions. The full list of questions and details of responses are included in Appendix I.

There were 464 respondents, which gives a margin of error for survey responses of 4%.

Of the 464 people we surveyed, 43.3% were psychiatric nurses (registered), 20% were mental health clinicians (not otherwise defined), 9.7% were social workers, 8.6% were psychiatric nurses (enrolled), 4.7% were administrative or clerical workers, 3.4% were occupational therapists, 2.2% were psychologists, and 1.5% were peer workers (carer). We also received a small number of responses from alcohol and other drugs workers, psychiatric services officers, consumer consultants, and peer workers (consumer). 6.9% selected the 'Other' option, indicating that their occupation was not listed on the survey.

More than half were employed on a permanent full-time basis, and a further third were employed on a permanent part-time basis. 5.2% were casual workers without paid leave entitlements, and 3.4% were on a fixed-term contract. The vast majority – 92.5% - were employed by a public, government, or government-owned entity. They worked in a wide variety of settings: 35% worked in a community team, 35% in an

[2] Department of Health and Human Services (2018) Mental Health Nursing Workforce Survey 2018: Victorian Government Funded Mental Health Services.

[3] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce/interactive-data

[4] Psychology Board of Australia. https://www.psychologyboard.gov.au/About/Statistics.aspx

acute inpatient unit, 16% in an emergency mental health service, and other responses from people working in continuing care units, forensic services, education, secure extended care units, prevention and recovery units, alcohol and other drugs, carer and consumer services, mother and baby inpatient units, psychiatric assessment and planning units, and mental health community support services.

Nearly half of the surveyed workforce had a postgraduate degree, and a further quarter had completed a bachelor's degree. 60% were qualified in a specifically mental health related field and a further 35% were qualified in a health or community services related field.

Nearly 60% of our respondents were aged 45-64, and 33% were 25-44. 70% were female. One respondent identified as Aboriginal. 88.6% were members of HACSU, 4.1% were members of another union, and 4.5% were not members of any union.

64.7% of the surveyed workforce reported having personal, lived experience of mental health conditions, either currently or previously dealing with a mental health condition themselves, caring for a person with a mental health condition, or having a close friend or family member with a mental health condition.

Responses were from across Victoria with 274 in Melbourne, 25 in Traralgon, 24 in Geelong, 24 in Ballarat, 24 in Bendigo, 19 in Shepparton, and the remainder spread throughout the state.

Some of our survey questions were replicated word for word from those asked in the Household Income and Labour Dynamics in Australia (HILDA) surveys in order to compare the responses to those of the general population and to all health professionals. HILDA surveys are conducted every year by the University of Melbourne's Melbourne Institute and include over 10,000 Australian households. These questions asked respondents to indicate their agreement with a statement on a scale of one to seven with one being strongly disagree and seven being strongly agree.

## The focus groups

Five focus groups were held; three in Melbourne, one in Ballarat and one in Geelong. The majority of attendees were nurses though we also had psychologists, social workers, and mental health clinicians represented.

| Location | Date | Number of attendees |
|---|---|---|
| Melbourne FG 1 | 13 June 2019 | 10 |
| Melbourne FG 2 | 14 June 2019 | 3 |
| Melbourne FG 3 | 20 June 2019 | 8 |
| Ballarat FG | 18 June 2019 | 4 |
| Geelong FG | 19 June 2019 | 8 |

Notes for focus group facilitators, including guiding questions, can be found in Appendix II.

# The experiences of the mental health workforce in Victoria

The following summaries and quotes are drawn from both survey and focus group data. Thematic analysis was conducted on the qualitative data from both focus groups and open survey questions in order to draw out the most prevalent and critical issues. These were then related, where possible, to the survey data and, in some instances, to data for all health professionals or from the entire Australian workforce from the Household Income and Labour Dynamics in Australia (HILDA) surveys.

> *"The reasons why I look at people and say "don't come into the job": number 1 is that the corporate model is built on micro-management and bullying and hasn't changed in 30 years." Megan, regional focus group*

## Positive experiences working in mental health

Every focus group began by asking people to talk about what they liked about the job. Additionally, where survey respondents identified that they felt positively about their jobs, we asked them to elaborate on why. Two clear themes emerged.

### *Supportive colleagues*

> *"I am surrounded by colleagues who are caring and who want to make a difference." Survey respondent*

Having supportive colleagues was the top nominated reason for employees to feel positively about their job. Of the 115 respondents who felt positively about their job, almost a quarter said their colleagues or team were the reason.

Respondents described their colleagues as supportive, compassionate, and caring people whom they respected and with whom they enjoyed working.

### *Rewarding work*

> *"I feel the care we deliver is excellent and see the difference that the team makes on vulnerable people every day." Survey respondent*

Of the 115 respondents who felt positively about their job, nearly 1 in 5 said it was because they found the job rewarding or because they felt that they were helping people.

Respondents in this category described their work as 'important', 'rewarding', 'purposeful', 'dynamic', and said they felt that they were making a difference in people's lives or contributing to society.

## Overworked, understaffed, and under-resourced

> *"I feel exhausted and burnt out. The work load is much too big and too high risk, and we are so under-resourced it just feels like you need to keep working all the time. Everyone is off sick and is unwell. It feels unhealthy to work here." Survey respondent*

# THE MENTAL HEALTH WORKFORCE IN VICTORIA

Research participants continually pointed to increasingly high workloads associated with increasing risk. These issues have been recognised by Victoria's Department of Health and Human Services (DHHS), which manages the public mental health system and by the Victorian Auditor-General, and according to participants have been reported by the workforce itself for many years.

Victoria's Department of Health and Human Services (DHHS), which manages the public mental health system, accepted in its 2015 document *Victoria's 10-year Mental Health Plan* that:

> "Increasing and sustained demand pressure on services has not been matched with increasing resources. Shifting population and growth has left some services under even greater pressure.
>
> The result is longer waiting times to access services and higher thresholds for entry. The increased pressure on services creates a risk that people may receive treatment that is less timely, less intensive and shorter in duration than they want or need."[5]

The Victorian Auditor-General's 2019 report *Access to Mental Health Services* found that:

> "DHHS has done too little to address the imbalance between demand for, and supply of, mental health services in Victoria…This means may people wait too long or miss out altogether on services. Real progress is unlikely…unless DHHS accelerates and directs efforts towards the fundamentals: funding, workforce and capital infrastructure."[6]

These findings were echoed loudly by the workforce. When asked what they felt was the highest priority for the Victorian mental health sector to address, 31% chose "Increased funding overall", and 19% chose "Increased staffing levels". When we add in those who chose "Increased funding of hospital services/beds" and "Increased funding for community services", 73% of the surveyed workforce felt that some form of increased funding is the highest priority for the Victorian mental health sector. Survey respondents and focus group participants expressed that they feel incredibly overworked and their workplaces are understaffed and under-resourced. Respondents referred to workloads having increased significantly over the last few years, and that expectations and demands have become unrealistic and overwhelming. One respondent said their client list had doubled, while another asserted that clinicians at their service were spending as little as 90 minutes per month with each consumer.

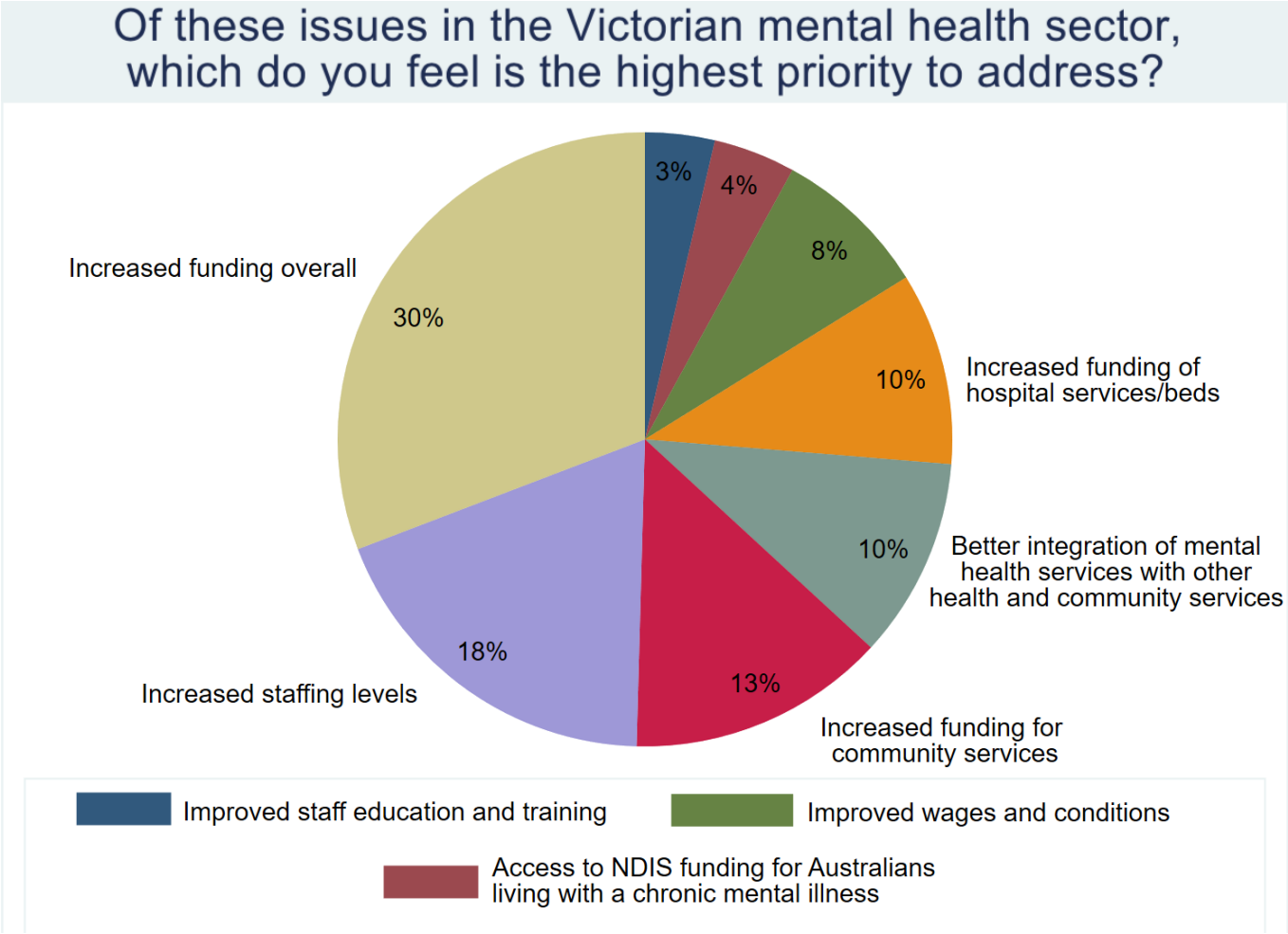
*"Caseloads and workloads are well known to be beyond the bounds of possibility for even the most dedicated and hardworking clinician." Survey respondent*

While expressing their understanding of the importance of good record keeping and paperwork, many focus group participants felt that the amount of paperwork represented an unnecessary workload burden that took them away from the more critical clinical work required to promote positive outcomes for consumers.

They were frustrated by having to duplicate paperwork every time a consumer moved from one service to another or having to duplicate information between different pieces of paperwork. There was also a sense

[5] State of Victoria, Department of Health and Human Services, *Victoria's 10-year Mental Health Plan* (November 2015), page 10

[6] Victorian Auditor-General's Office, *Access to Mental Health Services* (March 2019), page 8




that much of the paperwork they were required to do was more relevant to legal protection for the organisation and proof of manager competence, rather than about measuring and improving outcomes for consumers. Many mental health professionals said that they were doing a lot of unpaid overtime just to keep up with the paperwork, while others described the shortcuts they have to use or simply acknowledged that they didn't do it all.

> *"I'd love to see management doing the paperwork because it's quite clear that anybody who's saying we should be doing it isn't doing it themselves." Brian, Melbourne focus group*

Concerns about ballooning demand and workload were exacerbated for respondents by the feeling that their service was understaffed. They described not only "chronic" staff shortages but also an exodus of senior and experienced staff, being replaced by staff with significantly less experience or staff who were not qualified specifically in mental health (see the section on 'Recognition of mental health as a specialist field of nursing' below). These concerns have not been addressed by DHHS's workforce strategy, which the Victorian Auditor General found:

> "does not include targets for the types or numbers of workers it aims to attract of retain and does not set action to address the significantly greater staffing challenges that regional and rural areas face."[7]

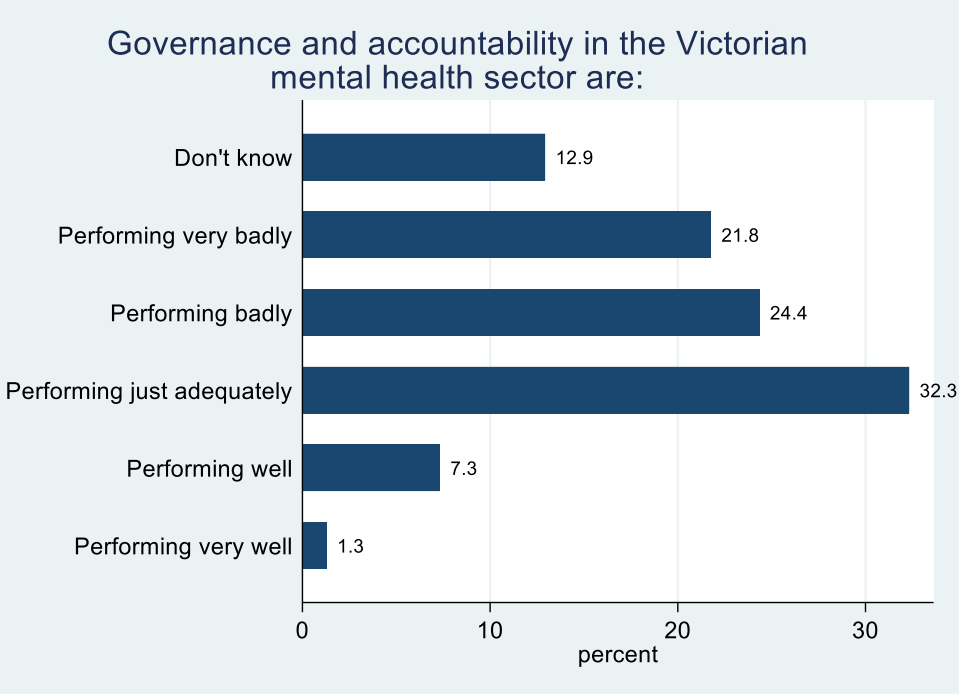
[7] Ibid, page 9

Work was described as "severely limited by a lack of resources" including facilities and infrastructure. These descriptions reflect the data that shows Victoria has one of the lowest numbers of mental health beds in the nation; a recent review commissioned by DHHS found that Victoria would need to grow its bed base by 80% to reach the service provision level of other Australian jurisdictions.[8] Currently, all major acute psychiatric units in Victoria regularly operate at above 95% capacity.[9]

Because of this, according to our survey, mental health professionals fear they will "miss something I am responsible for" and that "clients will suffer adversely as a consequence", or that they are not appropriately or sufficiently resourced to provide "adequate treatment" and care. One example of this is the common practice of early discharge, which is discussed in more detail below.

> *"I've had patients sitting out in police vans for three hours [because we didn't have the resources to admit them]. There's constant pressure from the police, from the medical staff in ED and from ED management. Yesterday I was on my own for four hours in ED."*
> *Laura, regional focus group*

## System governance and accountability




More than half of our survey respondents felt that governance and accountability in the Victorian mental health sector was performing "badly" or "very badly".

Elaborating further in the free-form answers or in conversations at the focus groups, a number of common experiences of poor governance and accountability emerged.

### *Focus on meeting KPIs over quality of care*

> *"I feel unfulfilled and believe the system is no longer providing the care to clients as it did in the past. It is driven by meeting KPIs not by quality of care." Survey respondent*

Firstly, there was a strong feeling from clinicians that the system was ruled by statistics and key performance indicators (KPIs) that reflected a service's performance as a 'business' rather than its delivery

[8] Ibid, page 12
[9] Ibid.

of care. Respondents reported that over the course of their career in the mental health sector they witnessed a trend away from governance and accountability based on quality of care and towards a focus on KPIs, business outcomes, and financial savings or profit.

> *"The service is being run like a business, only interested in numbers and not the real outcomes for consumers." Survey respondent*

Probably the most commonly mentioned example of a focus on KPIs detracting from quality of care was the measurement of "client throughput", i.e. how quickly consumers are moved through the system. A number of mental health professionals reported that in order to meet KPIs for throughput, services would often discharge consumers before they were ready. This evidence is reflected in the Victorian Auditor General's data: consumers were discharged on average after only 9.6 days in hospital in 2017-2018, down from 14.7 days in 2009, and 14.4% of patents are readmitted within 28 days of discharge.[10]

> *"Clients are discharged unwell…resulting in massive care burden on family and risk for community clinicians. The system is ultimately lobbing sick people out into the community to create beds in wards." Survey respondent*

### *Siloed services*

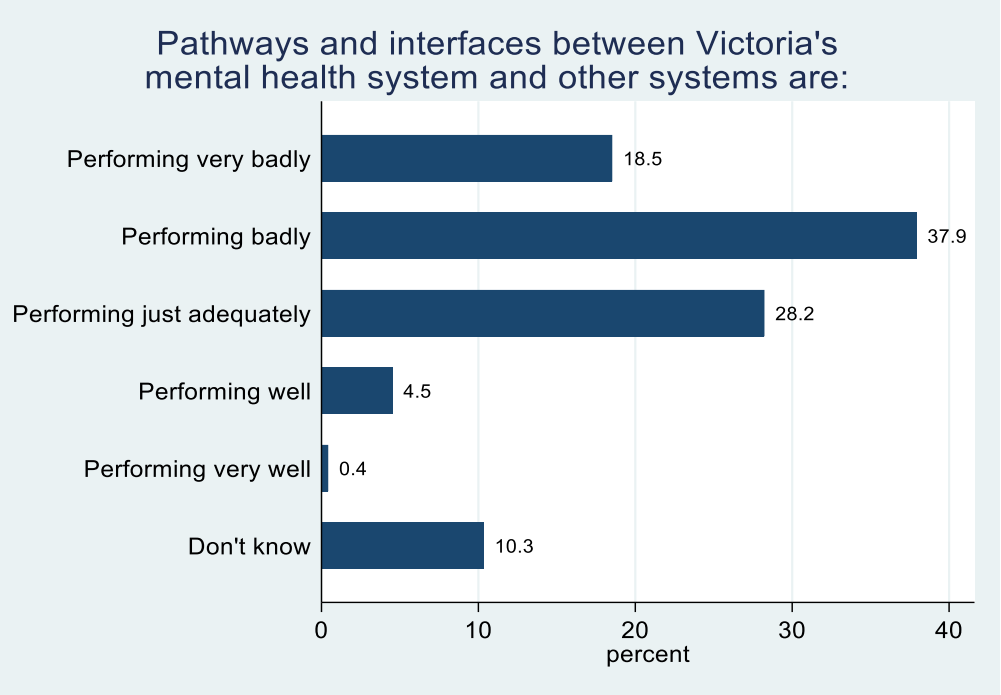
> *"In triage you find services hiding around the corner….by chance, by word of mouth. It's not central. If someone were to say, what is the map of what [services are] out there? I don't think anyone would know." Kyle, Melbourne focus group*

The Victorian Auditor General's first recommendation was for the DHHS to "complete a thorough system map".[11]

The need for better integrated services is also named as a priority in DHHS' *Victoria's 10-year Mental Health Plan*, which asserts that "services should have good linkage, communication flow, coordination and integration...people should be linked to the right services at the right time and their journey through these services should be safe, seamless and make sense".[12] It promises that "integrated service delivery will become the standard way that we operate" but acknowledges that at present, "people are expected to access separate services…without coordinated intervention to address all of their needs…people move from service to service and ultimately fall through the gaps."[13]

Nearly halfway into the 10-year plan, many of the surveyed mental health professionals say that Victoria's mental health system remains fractured. Services that should work together instead operate in silos with poor information sharing and virtually no collaboration. Services are so siloed that mental health professionals reported rarely knowing what services were available and appropriate for consumers in their area, and described referring consumers to those services as difficult, with no clear service pathway and badly-performing information sharing arrangements. Consumers are re-traumatised by having to share

[10] Ibid.
[11] Victorian Auditor-General's Office, *Access to Mental Health Services* (March 2019), page 14
[12] State of Victoria, Department of Health and Human Services, *Victoria's 10-year Mental Health Plan* (November 2015), page 20
[13] Ibid.




their stories over and over again with different services. Paperwork is duplicated or assumed to be unreliable because clinicians don't know which service has the most up to date information. Even the transition of consumers from youth to adult services was described as fraught with "push back".

Mental health professionals also described the mental health system as siloed from other closely adjacent systems like Alcohol and Other Drugs (AOD) services. Focus group participants felt that the various parts of AOD did not work well with each other, let alone with broader mental health services, and discussed how they spend a lot of their time initially with consumers first dealing with drug and alcohol issues before they could address underlying mental health concerns. There was a general sense of confusion around the extent to which AOD was part of the mental health service system and to what extent it was separate; mental health professionals reported that beds in mental health wards were being taken up by people who were "detoxing" and that separate, dedicated units were needed for people needing detox from alcohol or rehabilitation.

*"I see too many people settle their mental state but not their drug use, they get discharged, use, become psychotic and end up back in the system." Survey respondent*

Mental health services would also be much better delivered if there was structural integration between hospital emergency departments, acute wards, subacute care facilities, community services, law enforcement, forensic mental health services, and housing services. Poor pathways and interfaces between service systems all have flow-on effects that impact on the others and impede consumer recovery.

### *Managerial lack of accountability*

*"Increasingly stressful workplace due to unsupportive, unscrupulous, undermining, untrustworthy upper management practices." Survey respondent*

Finally, a strong feeling emerged that there was little to no accountability for middle and executive management. Survey respondents and focus group participants felt that their managers communicated with them poorly and failed to consult or inform the workforce properly on problems or decisions, resulting in confusion about governance and reporting. Many respondents reported unrealistic workload expectations from their managers, or experiences of micro-management. Managers were not held accountable for failing to follow up when staff were assaulted or subjected to violence in the workplace.

Managers were also accused of falsifying performance numbers and forcing staff to lie to stakeholders, with no accountability.

> *"We have no whistle-blower capacity to inform on a corrupted system…there needs to be ways to deal with managers who behave in abhorrent ways." Frank, regional focus group*

The process by which executives made funding decisions and allocated resources was described as lacking in accountability and transparency. Survey respondents mentioned incidents where significant funding avenues for areas in which they worked were cut off with no explanation and no one held accountable. HR practices like promotion and disciplinary action were also described as lacking transparency and good governance and were alleged to be based on "willingness to follow orders" rather than "experience and ability". Incidents or poor outcomes were said to be blamed on clinicians and other front-line staff, with executives and managers rarely held accountable.

Issues relating to management came up in every focus group with a common sentiment expressed that instead of facilitating patient care and service delivery, management made it harder for frontline staff to do their jobs. There was an almost universal belief that managers didn't understand the work that was being done with consumers.

> *"When you talk about people who are in middle management, some of them are nurses who've been out of touch with what's happening on the coalface. I'd like to see something in their job criteria that every so often they have to go down and work on the coalface so that they stay in touch. They make decisions that impact the work but don't understand the work." Mary, regional focus group*

## Bullying and harassment by managers

There was also a theme of bullying and harassment by management running through the survey responses. Numerous respondents reported ongoing bullying and harassment from both executive and middle managers, with colleagues who speak up targeted and forced to leave as a result.

> *"I have seen too many instances of bullying, harassment and racial discrimination in my workplace. It is entrenched from the very top of the organisation and this is a style that has flowed downwards for decades." Survey respondent*

48% - nearly half – of all respondents reported being bullied in the workplace by a colleague, manager, or other employee of their organisation within the last 12 months. When asked to comment further, respondents made it clear that the vast majority of bullying and harassment comes from executive and middle managers, with colleagues who speak up targeted and forced to leave as a result. Managers bullying staff was described variously as an "ongoing", "ingrained", "systemic", and "entrenched" organisational culture throughout the sector. Experiences of bullying and intimidation were the top reason selected for survey respondents being unsure they would still be working in the sector in five years' time.

Respondents alleged that the mental health sector is characterised by a "particular management style" that revolves around "promoting fear in staff". This was reported to include verbal abuse, unfair promotion processes, withholding of information, misuse of funding and resources, lying, breaching

employment contracts and agreements, and falsifying documents. Some respondents reported leaving previous jobs due to bullying, abuse, and harassment from their managers.

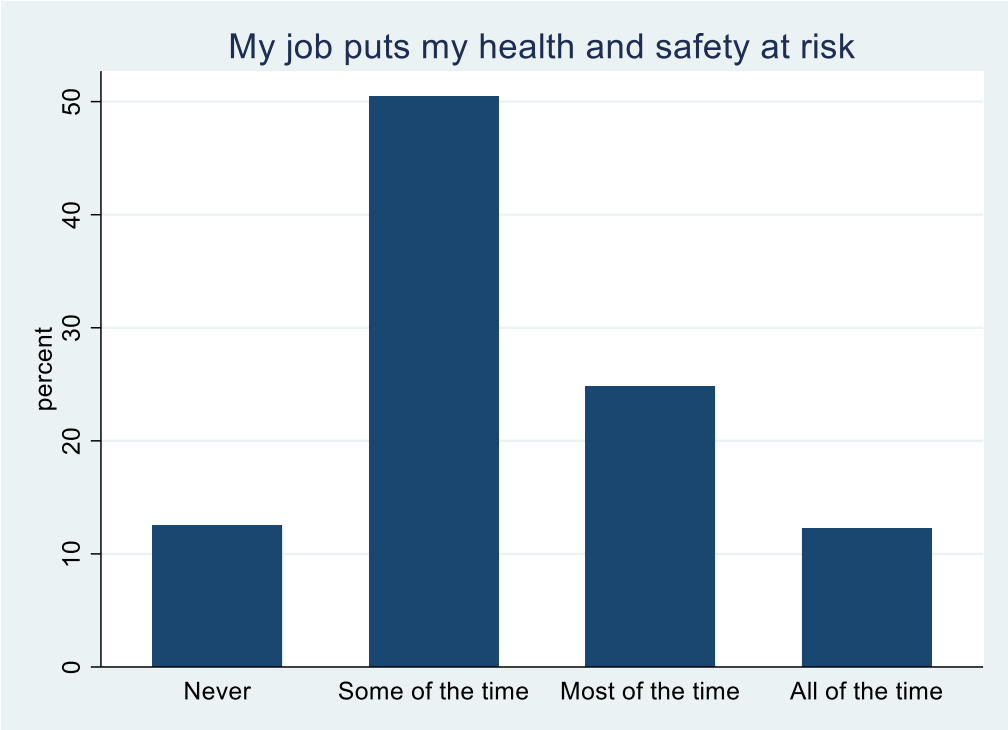
> *"It is a very sad state of affairs…violence is now ferociously horizontal. Bullying, harassment, intimidation and discrimination is still going on strongly and I know of a number of staff members who are currently depressed; some with thoughts of suicide. Nobody cares. The organisation is detached from its same employees who are putting in the hours." Survey respondent*

A second theme was the sense that victims who speak up face repercussions and that for this reason, staff who are bullied or harassed generally don't report the abuse. Where investigations did occur, they were described as inadequate and some respondents who had reported bullying said they were "pushed out" of their jobs as a result.

Another concerning trend was a number of reports of discrimination. Racial discrimination was described by one survey respondent as "rife" while other employees reported being discriminated against by their employer based on their age, their physical health difficulties, or their own mental health needs.

## Safety and security

> *"I feel unsafe in my work place due to the daily aggression we are required to deal with." Survey respondent*




31% of survey respondents reported that they were physically attacked in their workplace within the last 12 months, and that proportion grew to 44% for nurses. 99% of those attacked were attacked by a consumer, but some staff stated that they had been attacked multiple times by multiple different people in the workplace, including 6% who had been attacked by a consumer's relative, and 3% who had been attacked by their supervisor or manager. While that figure only represents four or five reports, any incidence of an employee being physically attacked by their supervisor is a sign of a system driven to crisis point. While 93% of incidents were reported to the respondent's employer, in 30% of cases no action was taken to investigate the causes of the incident. 64% of respondents had witnessed incidents of physical violence in their workplace in the last 12 months.

*"We had a patient take to six young ladies with a pool cue and it's not even being talked about." Mary, Geelong focus group*

Many respondents who had more years of experience in the sector reported that they had always experienced aggression and violence in the workplace, but that the number of serious assaults had increased recently to the extent that they felt unsafe in their workplace. The skills mental health professionals need to perform their work safely are very different from those of other health professionals and rely a great deal on experience with reading the environment and the consumers. Understaffing often forces mental health professionals into unsafe situations and many face choices between working safely and providing care to consumers.

*"Once I was asked to assess a dangerous patient by myself by my manager. We always have to have two people when dealing with this patient. I knew that if I asked somebody else to come with me then other areas would be understaffed. I didn't do it, I said to him "I'm sorry but I can't do that". He knew I shouldn't be doing it and he came with me. I'm lucky, I've been here a long time and I know what is safe and appropriate but just suppose it was a student or a junior nurse and they just do it because they've been told to by their manager and they get smashed up. That nurse would have been blamed for not following protocol. There's a culture of blaming the front-line staff when things go wrong." Jacques, Melbourne focus group*

The need for specific dedicated staff, space, and infrastructure to deal with high-risk consumers was repeatedly raised at focus groups with most saying that such capacity was inadequate or completely missing. High-risk consumers were often kept in insecure facilities with other consumers, putting both staff and consumers at risk. De-Escalation Engagement and Prevention (DEEP) training delivered to staff to assist them in preventing and managing clinical aggression was variously described as "ridiculously inadequate", and "shockingly inadequate".

There was a profound sense among both survey respondents and focus group participants that there were no mechanisms available to apply appropriate consequences to consumers who were violent towards staff and/or other consumers. Many reported that their employers failed to act on early warnings or reports of violence and that all risk was delegated to front line staff. Some felt that the Mental Health Act limited permitted responses to violence (for example by restricting police involvement) and this endangered them further.

*"It's being defended by the Mental Health Act. They then can't be prosecuted. Magistrates can't do anything; the police don't want to touch it because they know it will be thrown out." Frank, regional focus group*

In the short term, many of the survey respondents and focus group participants expressed a desire for more regular, trained security guards on the ward. They described feeling "much safer" when they knew there were security guards there, especially in rural and regional areas where police response might be delayed. However, there were also reports of security guards being assaulted to the point of "severe injury" or being "blamed" or "sacked" when they intervened to protect staff members from consumers.

*"We need specialised psychiatric security officers and they need to be skilled to manage the restraints." Clara, Melbourne focus group*

The violence associated with banning consumers from smoking was raised on several occasions with one acute ward nurse stating that the point when the smoking ban was enforced on her ward was when everything changed for the worse.

> *"Everything changed when they removed smoking from the facility. The Act removed a lot of their rights. Removing cigarettes increased aggression towards us." Katie, regional focus group.*

It was reported that many of the consumers are heavy smokers. When they come onto the ward they are not allowed to smoke for at least 24 hours. The result is that people who are experiencing an acute mental illness and have been admitted to hospital are also having to cope with withdrawal symptoms and loss of one of their coping mechanisms. This leads to increased conflict and violence.

Participants emphasised the fact that mental health consumers are fundamentally different from consumers in other wards and careful consideration should be given when applying blanket rules.

> *"It's patronising because people with a mental illness feel disempowered in the community – telling them they can't smoke adds to that. It's different from others at the hospital because they're being held against their will – even though they have not committed a crime." Craig, regional focus group*

There was a strong consensus across the survey and the focus groups that the mental health workforce has witnessed an exponential increase in the use of ice (crystal methamphetamine) and other methamphetamines among consumers.

> *"Ice…in triage it's a word that comes up every second or third call. A person's been using it and they're unwell, or someone's distressed because someone's been using it…they say there isn't an epidemic…they can call it whatever they like but only yesterday a 62-year-old was psychotic from using ice. I triaged a 70-year-old bloke who was psychotic because he was using ice." Kyle, Melbourne focus group*

Employees felt strongly that the "ice epidemic" strongly correlated with the increase in violence they were experiencing on the wards. They felt that there were not adequate resources, strategies, or services in place to deal with the aggression of ice and methamphetamine users.

> *"The escalation [of violence] is due to the prevalence of drugs especially of meth, and the lack of adequate services to manage…putting aggressive meth clients in with depressed and already traumatised clients is abuse." Survey respondent*

## The Mental Health Act

There was a substantial focus on the *Mental Health Act 2014 (the Act)* in several of our focus groups with many participants saying it made their work more difficult. One focus group participant raised the complexities around searching individuals upon admission and the pernicious effect of illicit drugs and other contraband entering services:

> *"Since the Act came in…we can't search people, or the conditions on searches are so stringent that we don't have the time and resources to do it, meaning drugs and dangerous objects enter the ward. All the risks are multiplied. We're running out of staff*

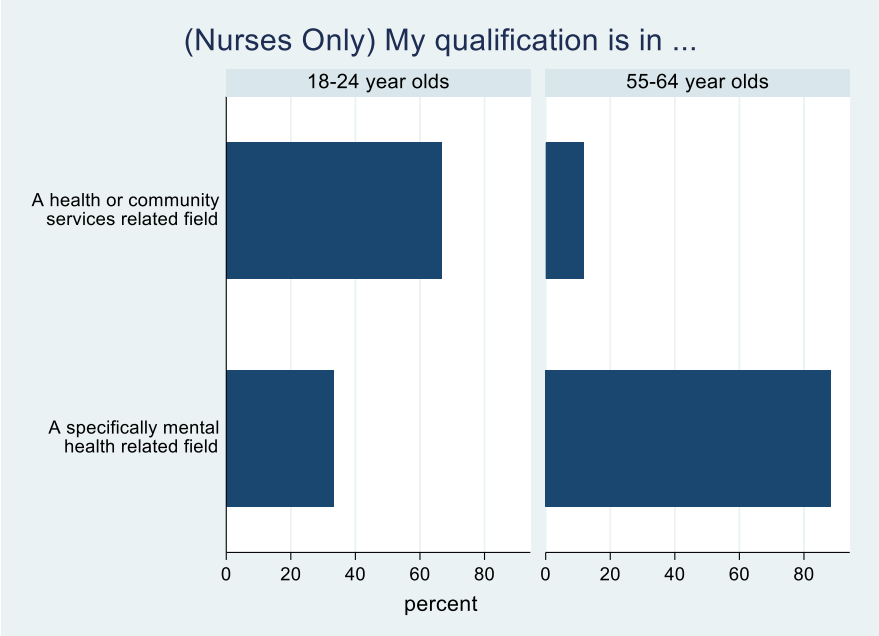
*as a result because nobody wants to work in those conditions." Frank, regional focus group*

Others noted that the *Act* is too limited in who it covers as it excludes those with an intellectual disability and its implementation often results in the exclusion of complex cases and dual diagnoses such as drug users with mental illness. This is part of a theme across the focus group and survey responses that the health system as it impacts mental health is siloed and fragmented and the result is people with complex needs not being properly treated.

Participants felt that the people in "positions of power" who were the writers and creators of the *Act* were alienated from the "mental health coalface" and did not have a good sense of how the *Act* would be implemented or how services should be run. The complaints commission established in the *Act* was seen as a toothless tiger, with focus group participants unable to recall a single positive outcome.

*"The Mental Health Complaints Commission really is an excess that's costing and is counter-productive. Every time I've interacted with that system it's resulted in an absolute non-event. Nothing happens except that staff get put through an enormous amount of stress." Craig, regional focus group*

## Recognition of mental health as a specialist field of nursing

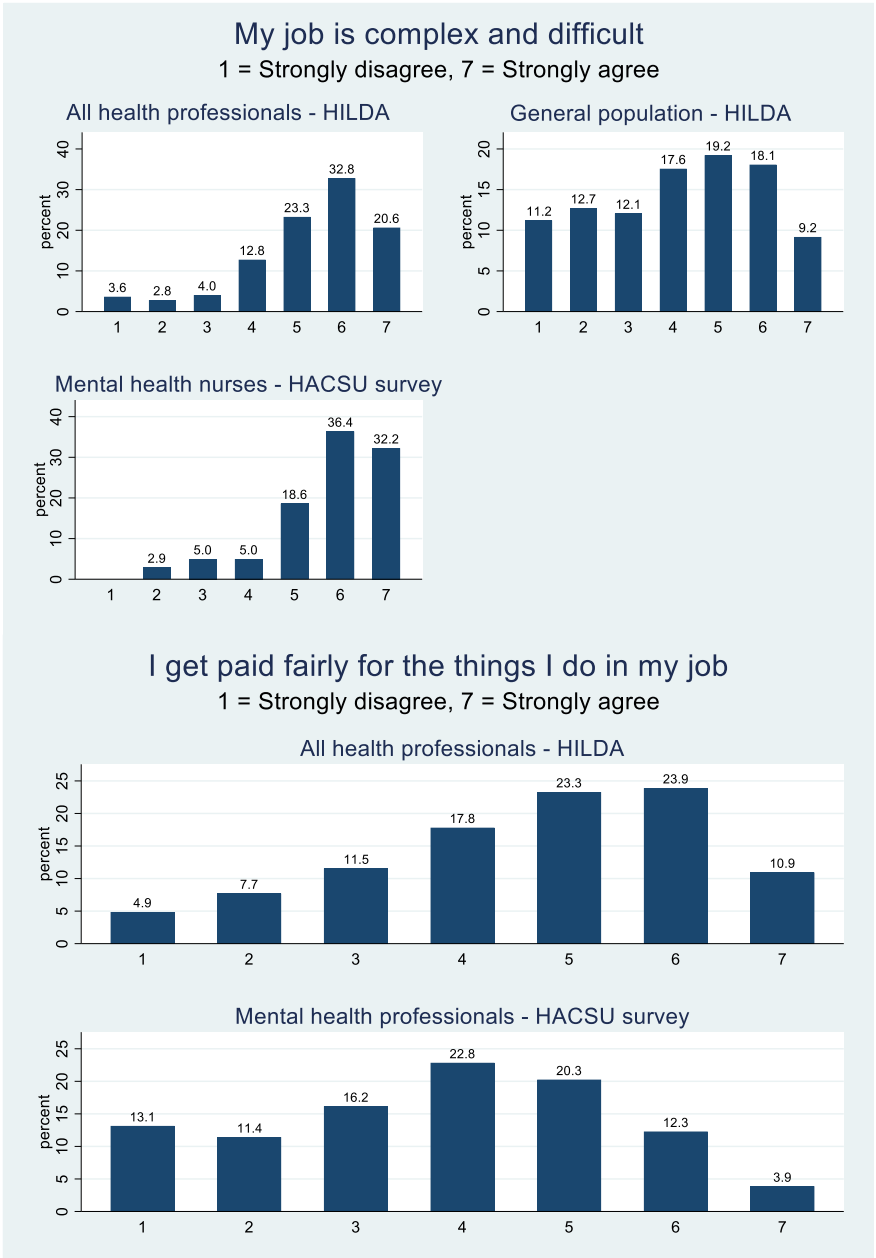



Many of the older nurses talked about being trained in a stream specifically for mental health work. This is no longer the case, with mental health training occurring 18 months into their degree and then not being revisited. In the past, nurses and clinicians would be required to spend time placed on a mental health ward as part of their training. This discrepancy between the qualifications held by younger and older nurses was very clear in the survey data. Two thirds of survey respondents also disagreed with the statement that the current undergraduate and VET nurse and allied health qualifications were adequately preparing new workers for entry into mental health.

Differences between mental health nursing and mainstream medical nursing were raised many times, particularly in relation to the skills required, the tools available, and the danger.

*"Mental health nursing is different because other nurses have tools at their disposal that they can use as a measurable way to assess what's happening with their patient. So, if you've got someone who's having a cardiac arrest, for instance, you can take their*

*bloods, put them on a heart monitor, do an ECG, you can put them on an oximeter. You actually see entirely what is happening with that patient and it's up there for you to see. With a mental health patient… the only thing you have to rely on when you're assessing a mental health patient is the skills of the clinician doing that assessment. It's the toolbox that clinician carries. If you don't have a clinician who is confident and knowledgeable and carries that toolbox, you're not going to get a good assessment. You're not going to get a good risk assessment, you're not going to get a good mental state assessment. Everything that we do is really complex. There is no test that will tell you psychologically, what is wrong with your patient. It's only the clinician's skills that will tell you that." Lucy, regional focus group*




Comparing our survey results to the same questions asked in the Household Income and Labour Dynamics in Australia (HILDA) surveys, we found significant differences between the answers given by mental health professionals and those given by the broader health workforce, particularly with respect to how complex and difficult the job was and how stressful it was.

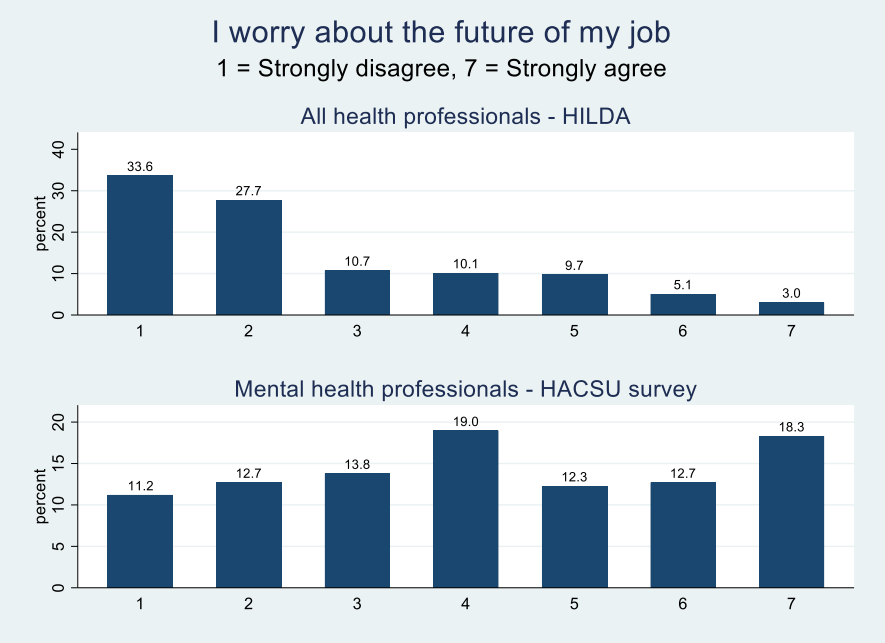
On a scale of 1 to 7, almost 70% of mental health professionals rated their job as 6 or 7 when it came to complexity and difficulty.

Mental health professionals were also less likely to feel that they were paid fairly for their work. Based on conversations in the focus groups, we believe this is due to the fact that their pay is the relatively similar to other nurses, but the complexity and risks are much higher.

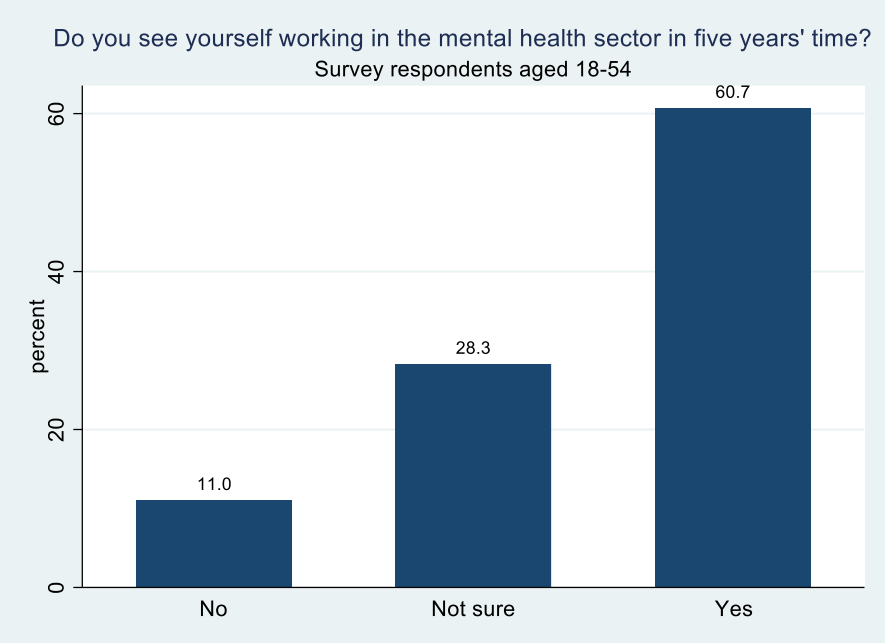
*"Across the disciplines mental health is by far the most complex field of allied health nursing, and yet not recognised." Craig, regional focus group*

## Future of the workforce

Many of the focus group respondents mentioned having trouble recruiting for empty positions and that short staffing wasn't entirely to do with insufficient resources but was also related to attracting staff. This was particularly apparent in Ballarat and Geelong. Focus group attendees saw more people leaving the mental health sector than entering and attributed this to the various factors listed above, including safety and security, workload, bullying, and unsupportive culture among management.




*"Can I find something good about my job at the moment? I'm not sure I can. I'm not sure that there's anything I want to go to work for anymore. But I used to like my job because you had time to see people get well, be part of that journey, whereas that's all gone now." Jane, regional focus group*




Only sixty percent of survey respondents between the ages of 18 and 54 were confident they would still be working in the mental health sector in five years' time.

*"Physical violence…was one of the reasons I left acute mental health work…I [also] quit mother and infant mental health work due to bullying in the workplace." Survey respondent*

## Long-term care and affordable/appropriate housing

A stark finding from the research was the lack of capacity within the mental health system to accommodate those individuals who cannot operate independently in society and have no family or friends who are willing and able to care for them. This is particularly an issue for individuals who, if unsupervised, represent a risk to themselves or to others. Participants felt that the deinstitutionalising of mental health services was primarily driven by cost-saving and that insufficient services were put in place to provide for the needs of these very high care individuals. The result is that many end up either homeless or in prison.

> *"There needs to be a universal approach to dealing with violence so that forensic clients become a part of the forensic system instead of being treated in the regular mental health system." Survey respondent*

Many focus group participants discussed the lack of long-term care options and lack of appropriate housing. Many consumers were missing out on care because they had no fixed address and/or no mobile phone. There's a cycle of crisis for many homeless people with mental health issues, particularly the violent ones. There is often no appropriate place for them in the system with the few forensic wards routinely overwhelmed. This means they return repeatedly to emergency departments and acute wards that are rarely appropriately equipped and resourced to deal with them. The safety of staff and other consumers is routinely compromised as a result.

> *"I feel safe working in a prison, I feel unsafe in an in-patient unit. I wouldn't go back" Adam, Melbourne focus group*

While none of the participants were advocating for a return to an institutional model of mental health care, there is clearly a need for expanded secure residential facilities, including forensic, as well as an increase in affordable and appropriate housing for people with enduring, severe mental illness.

> *"We have a policy of not discharging people into homelessness, but we discharge them to places that will only let them stay short-term, so it's the same thing in the end." Clare, regional focus group*

## Poorly functioning NDIS

> *"NDIS is an ill-fitting system for community mental health, generating anxiety and distress for our clients and staff, and dismantling a formerly excellent community mental health service." Survey respondent*

Of the 464 respondents, just 12% felt that the NDIS had been a positive development for the mental health sector.

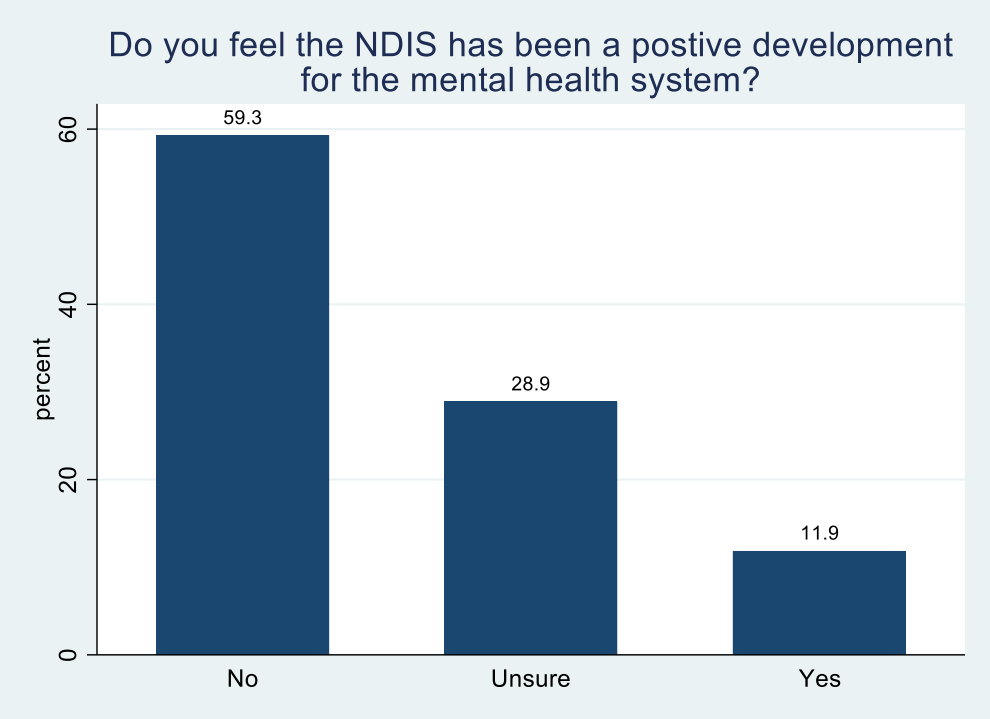
Issues with the NDIS mainly revolved around difficulty accessing it, because existing services had been absorbed by the NDIS, but tighter eligibility criteria meaning consumers that were previously eligible for support from those services no longer meeting NDIS criteria. This was particularly the case for consumers who had previously accessed the Mental Health Community Support Services (MHCSS) program.

> *"The reason they didn't spend all of the money allocated to the NDIS is because it's too hard to access the services, particularly for individuals with chronic mental illness.*

*Whether they get services is entirely dependent on whether or not they have effective and determined advocates acting on their behalf." Craig, regional focus group*

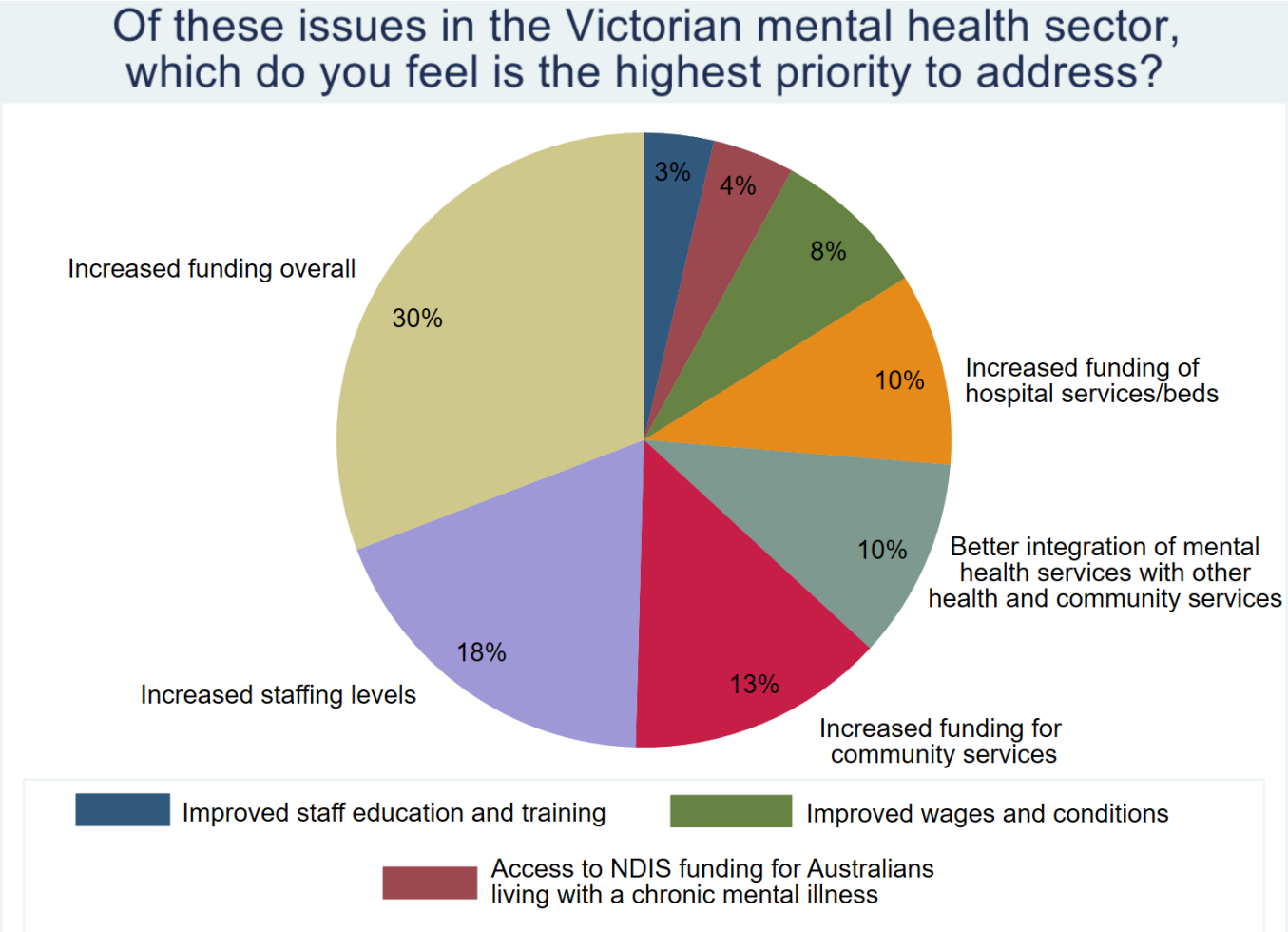
We heard multiple descriptions of consumers appearing at Administrative Appeals Tribunals regarding NDIS access and services and not even being asked a question or asked what services they want or need. The proceedings occurred as if they weren't even there.

*"The NDIS doesn't acknowledge that medication for many with a mental illness is a pharmacological equivalent of a prosthesis. The NDIS works quite well for…people with a relatively straightforward physical disability who are otherwise well. They can engage with the system and with providers but the system is fundamentally unequipped to deal with people with chronic mental illness." Katie, regional focus group*



## Priorities for reform

The below reform priorities are broad themes drawn from the survey responses and focus group conversations and do not represent a structured or thorough review of reform options for the mental health sector.




It's important to note that the options presented in the survey were developed prior to the focus groups and reflect preconceptions of what would be the highest priority issues. Open questions and focus group data are important complements for answering this question.

### Funding and resources

A complete review across the state is required of workload, service demand and outcomes. The perception of virtually every participant was that the system is strained to breaking point.

There should be space and time for collegiate feedback and support. Some participants mentioned past workplaces where time was made for staff meetings where cases were discussed with colleagues, risks and procedures were evaluated and where there was some control over how things were done that could help manage workload. None of the participants reported having anything like that in their workplace today.

## Safety and security

Employees expressed the need for specific infrastructure, training, and security staff to deal with potentially violent consumers. In many workplaces both staff and consumers were routinely placed in dangerous situations and many respondents and participants felt that there needed to be better accountability and consequences for violent behaviour.

Many survey respondents and focus group participants expressed their desire for dedicated security guards to improve safety on wards. While deeper structural reform of the system is needed in order to improve safety and security for both staff and consumers, such reform takes substantial time to implement and to improve safety. It is, therefore, very understandable that mental health professionals who currently feel unsafe at work advocate for security guards because this is something that could make their workplaces safer tomorrow.

An expansion of forensic facilities is a critical component of addressing safety concerns as lack of forensic capacity regularly results in consumers who are a known safety concern being treated in the regular mental health system.

## Standardise paperwork and record keeping across the state

Serious patient and staff risks are created by ineffective and duplicated paperwork that isn't configured in a way that allows for easy handover between organisations. Too much time is spent doing paperwork that doesn't benefit the services provided to consumers. There should be a state-wide review and standardisation of paperwork that focuses on effective service delivery, while maintaining consumer privacy and confidentiality.

## Workplace bullying and harassment

Structures are needed that allow for worker whistleblowing/feedback on management and culture. Processes need to be in place that ensure this input is taken seriously and that relevant authorities have the skills and capacity to react effectively.

In addition, organisations should consider flatter governance structures and an increase in local decision making to give workers greater control and decision-making power. Mental health professionals who are providing services to consumers should be involved in decisions that affect their work as they are often the best placed to understand the implications of these decisions on safety and service delivery.

## Education and training

The need for a return to specialist mental health nurse streaming in undergraduate training was very strongly expressed in several of the focus groups. However, it was also recognised that broader changes need to happen within the industry before students will join this stream.

A return to face to face training for mental health professionals. Online training was viewed as mostly useless and many were only able to do it on their own time. Focus group participants talked about the professional and personal value of face to face training both from the education itself and the opportunity to meet other mental health professionals and talk about the work. Even when resources were available for face to face training, many participants said that they were too understaffed to take the time away from work.

## Housing

Employees identified a strong need for more supported housing and accommodation options in the sector. Respondents and participants felt this lack was a huge gap in the system and that the lack of safe, affordable housing for discharged consumers perpetuated the cycle that saw them re-admitted to the ward within a short time frame. In addition, employees recommended options for long term supervised housing or forensic facilities for those consumers that could not be integrated into the community.

## Better integration of services

We repeatedly heard of services working in silos and "not talking to each other". There is no central or overarching framework of services and policies, and no clear clinical or service pathway. Mental health professionals felt that this detracts from patient care and is confusing for both consumers and professionals to navigate.

Consumers with multiple or very complex issues, including chronic physical illness, addiction, physical disability and intellectual disability, combined with mental illness are often poorly treated by the siloed system.

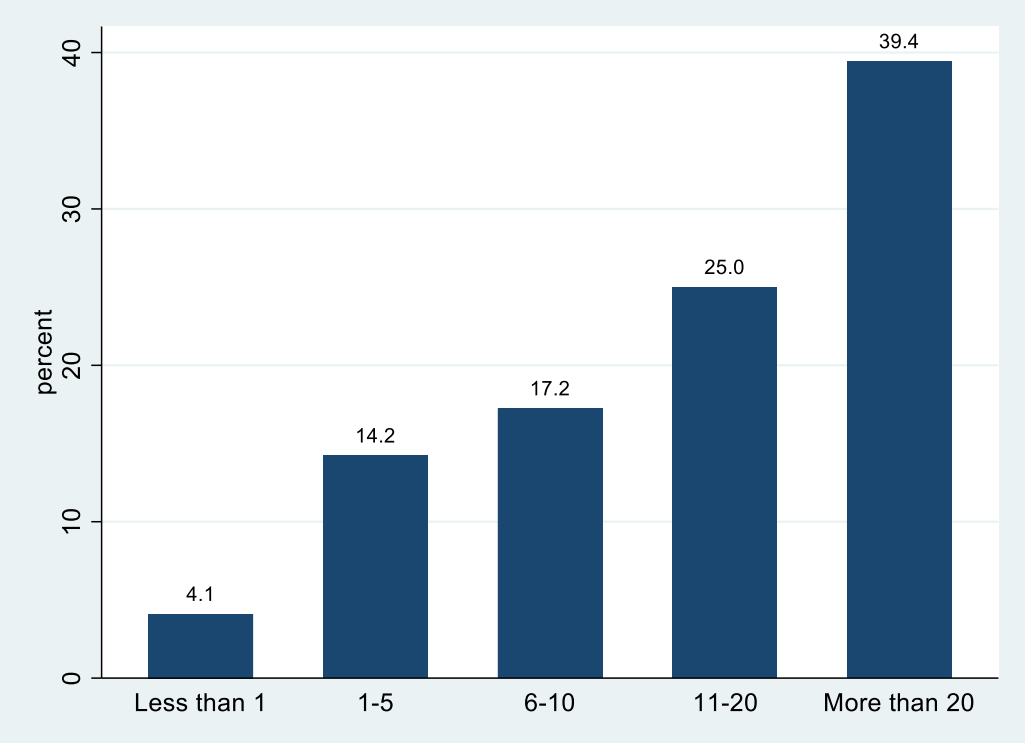
Many survey respondents noted an increase in the number of consumers admitted dealing with alcohol or drug addiction and recommended better integration of services as well as separate detox and rehab units where those issues could be specifically addressed without bringing the violence exhibited by such consumers into the mental health ward. It's clear that the siloed system results in many patients with both mental illnesses and addiction problems ending up being treated in one or the other service when they ultimately need both.

## Care over KPIs

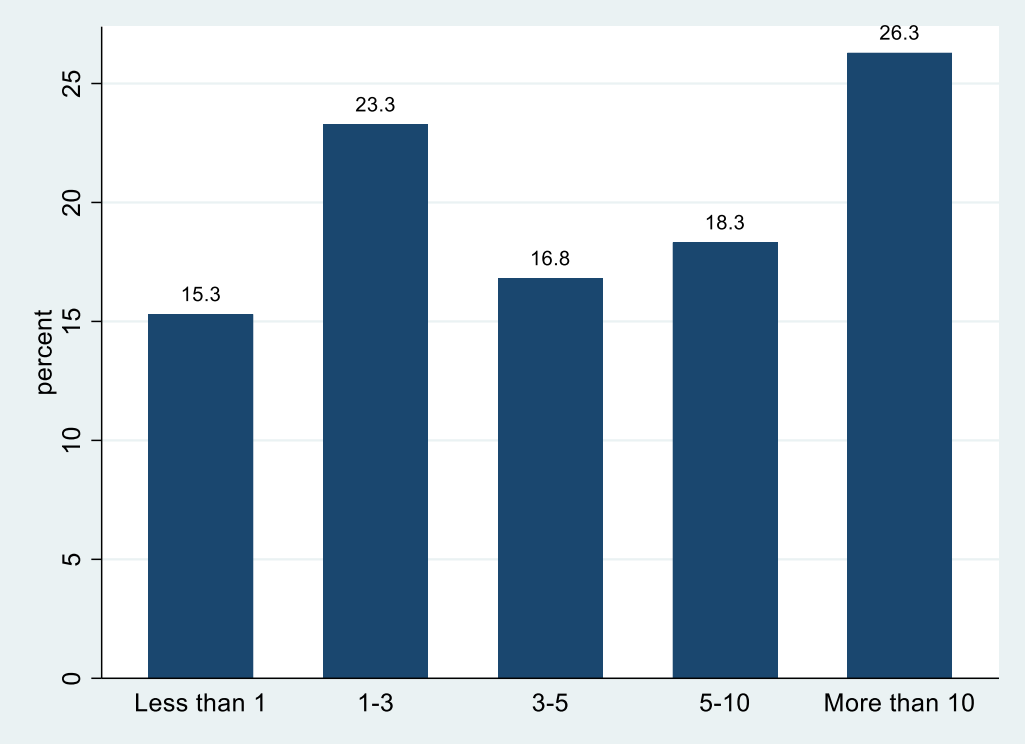
Many mental health professionals stressed that they wanted to see a return to a model based on patient care, rather than KPIs. Services should not be run under a business model – "ticking boxes to guarantee ongoing funds" – at the expense of patient service delivery. There was a strong feeling that stats like length of stay and bed turnover should not be more important than good patient care and recovery.

# Appendix I: Survey questions and results

*How long have you worked in the mental health sector? (years)*




*How long have you been in your current role? (years)*



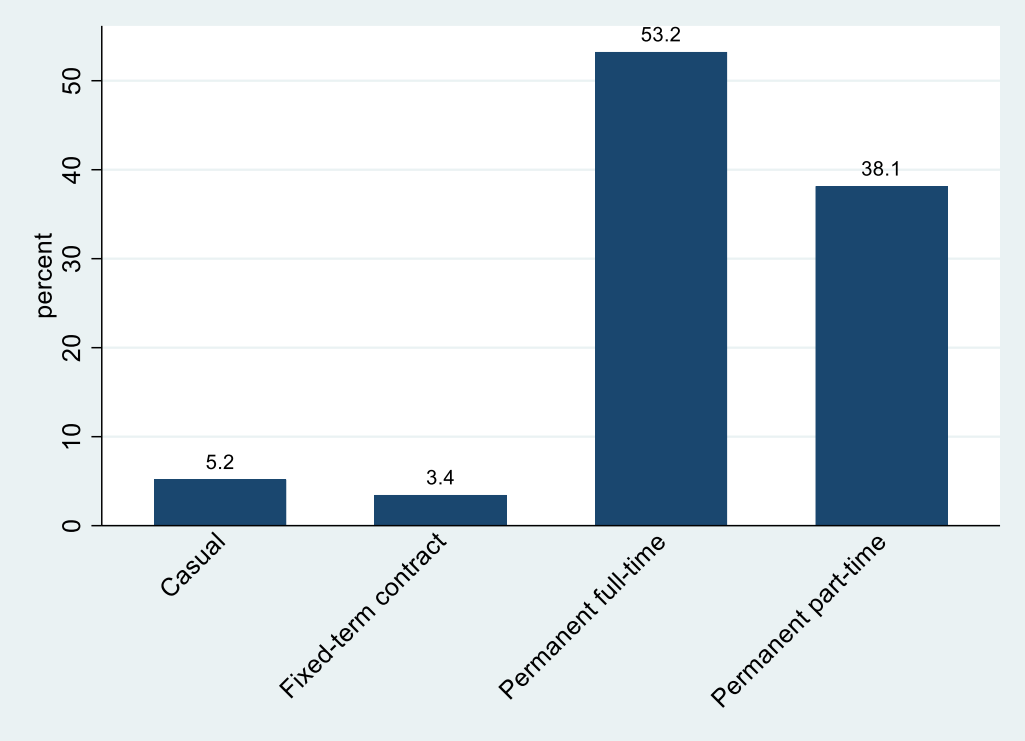
# THE MENTAL HEALTH WORKFORCE IN VICTORIA

*Which of the following categories best describes your role in the sector?*

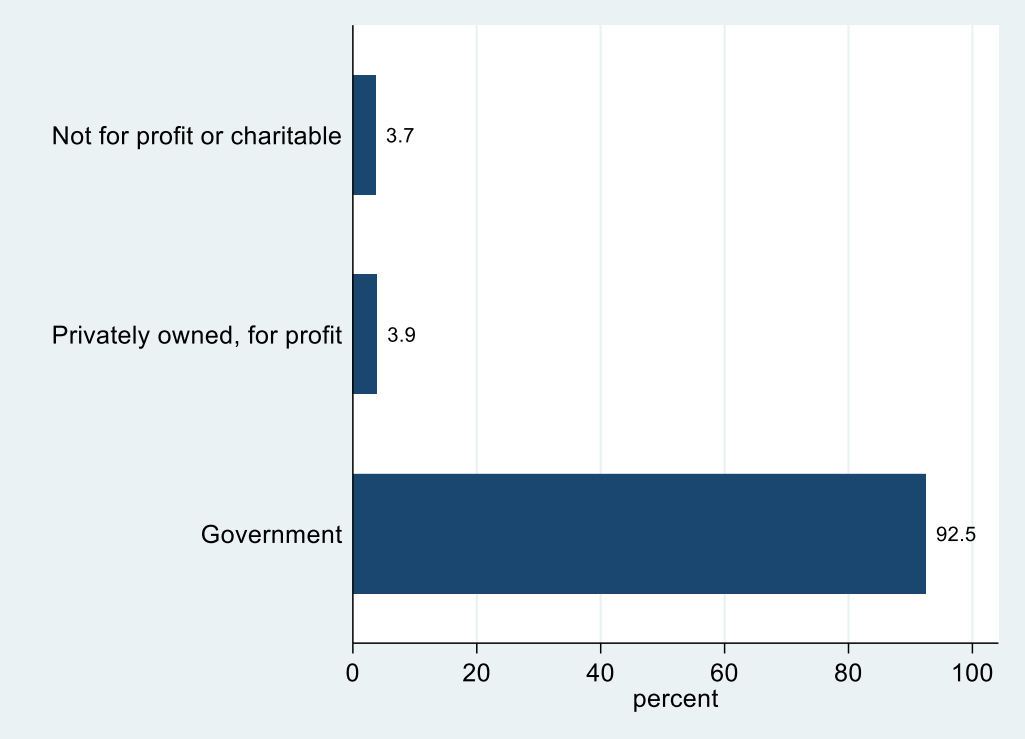
| Which of the following categories best describes your role in the sector? | Respondents |
|---|---|
| Administrative & clerical worker | 22 |
| Alcohol & other drugs worker | 4 |
| CMHS Manager | 1 |
| Consumer consultant | 3 |
| Domestic staff | 1 |
| Drug Court Clinical Advisor | 1 |
| Dual Diagnosis clinician | 1 |
| Fapmi Coordinator | 1 |
| Food service | 1 |
| Forensic Clinical Specialist | 1 |
| Manager | 1 |
| Mental health clinician (not otherwise defined) | 93 |
| Mental health promotion officer/clinician | 1 |
| Nurse Practitioner - Mental Healthcare | 1 |
| Occupational therapist | 16 |
| Patient Service Assistant | 1 |
| Peer worker (carer) | 7 |
| Peer worker (consumer) | 3 |
| Psychiatric nurse (enrolled) | 40 |
| Psychiatric nurse (registered) | 201 |
| Psychiatric services officer | 4 |
| Psychiatrist | 1 |
| Psychologist | 10 |
| Social worker | 45 |
| Specialist Family Violence Advisor Mental Health | 1 |
| Welfare worker | 1 |
| Manager | 1 |
| Senior credentialed psychiatric nurse in private practice | 1 |

# THE MENTAL HEALTH WORKFORCE IN VICTORIA

*Which best describes your form of employment?*




*Which best describes your main employer?*



*The patients/clients you most frequently work with are (select all that apply):*

| | |
|---|---|
| Elderly (aged 65+) | 388 |
| Adults | 96 |
| Adolescents (aged 12-18) | 95 |
| Children (2-12) | 35 |
| Newborns/infants | 20 |

*What setting/s do you work in?*

| Setting | Percent | Responses |
|---|---|---|
| Community Team | 34% | 162 |
| Acute Inpatient Unit | 34% | 161 |
| Emergency Mental Health Service (includes CATT, Triage, ECATT, PACER) | 15% | 73 |
| Continuing Care Unit (CCU) | 8% | 39 |
| Forensic Service | 8% | 39 |
| Education | 5% | 25 |
| Secure Extended Care Unit (SECU) | 5% | 25 |
| Prevention and Recovery Unit (PARC) | 4% | 21 |
| Alcohol and Other Drugs | 3% | 17 |
| Carer and Consumer Service | 3% | 17 |
| Mother and Baby Inpatient Unit | 1% | 8 |
| Psychiatric Assessment and Planning Unit (PAPU) | 1% | 7 |
| Mental Health Community Support Services (MHCSS) | 0% | 4 |
| Other | 8% | 39 |

*Please enter the postcode of your place of work:*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*What first attracted you to work in the mental health sector?*

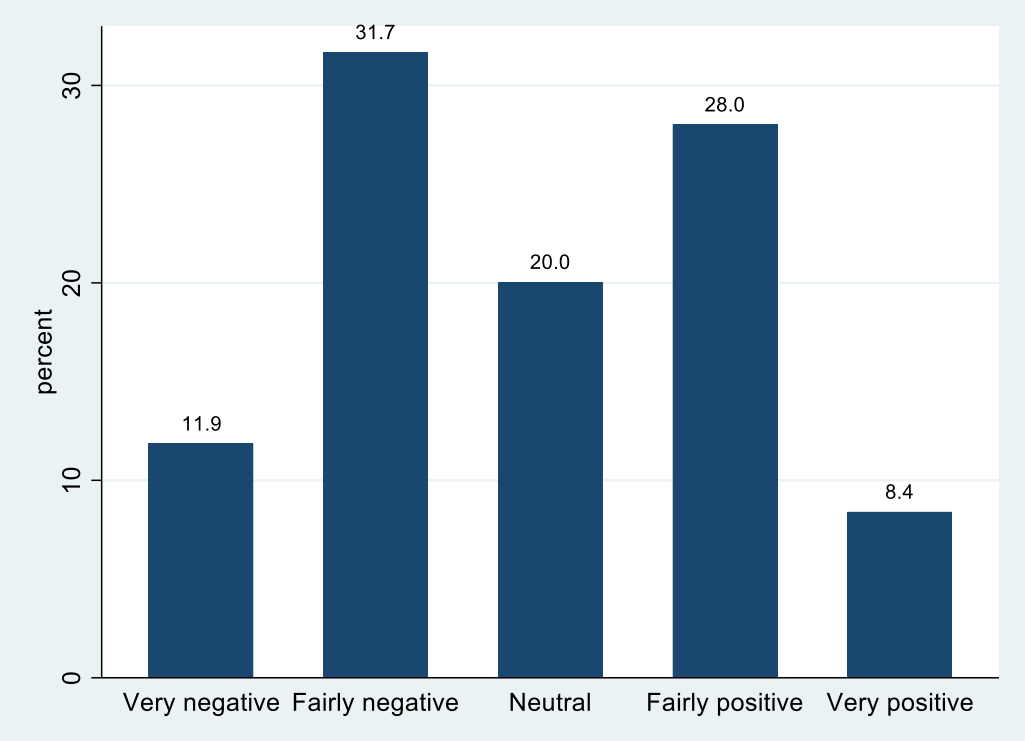
| | Percent | Responses |
|---|---|---|
| The opportunity to help people | 73% | 339 |
| Working conditions (e.g. flexibility, job security, location) | 29% | 135 |
| Career development opportunities | 24% | 113 |
| I have a family member with mental health issues | 14% | 65 |
| I have personal experience with mental health | 13% | 61 |
| The pay and/or benefits | 7% | 36 |
| It was the only job available to me | 3% | 14 |

| | | |
|---|---|---|
| Other | 8% | 37 |

*What are the main reasons you continue to work in the mental health sector?*

| | Percent | Responses |
|---|---|---|
| I find the work personally rewarding outside of pay and benefits | 54% | 254 |
| I feel I am making a difference to the lives of people in need | 50% | 236 |
| I enjoy working with my colleagues | 35% | 166 |
| Working conditions (e.g. flexibility, job security, location) | 30% | 139 |
| The pay and/or benefits | 15% | 71 |
| Career development opportunities | 11% | 51 |
| It is the only job available to me | 5% | 23 |
| I feel valued and supported by my employer | 4% | 21 |
| Other | 2% | 13 |

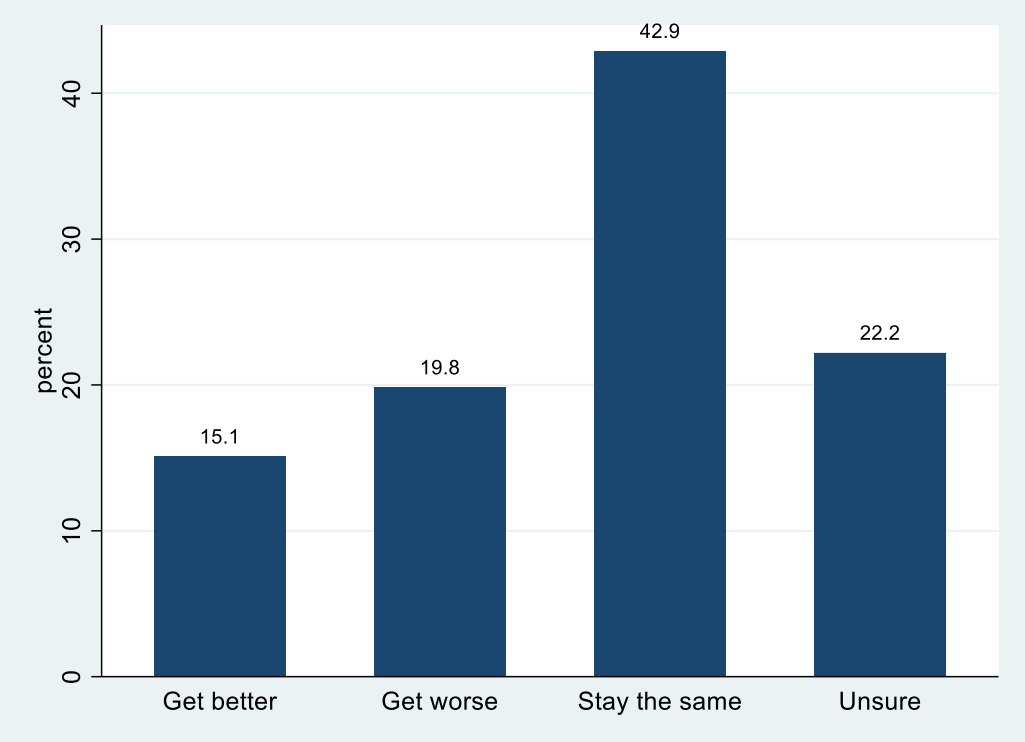
*Generally, how have you been feeling about your work over the last three months?*




*Why do you feel that way?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

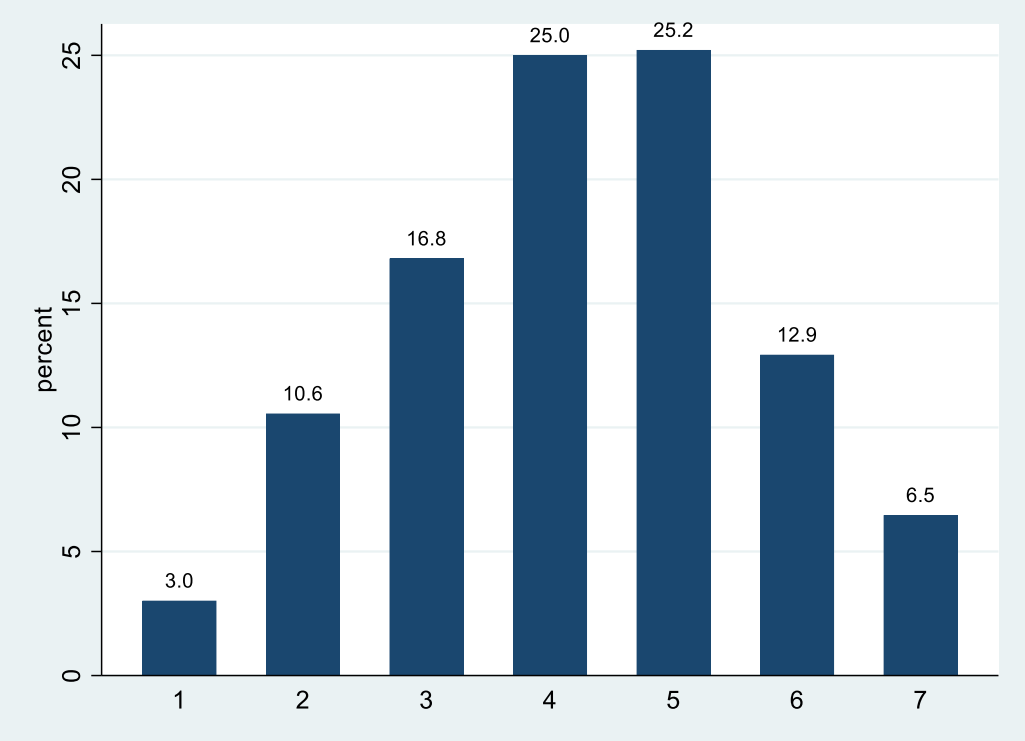
*Over the next 12 months, do you expect your feelings about your work will:*



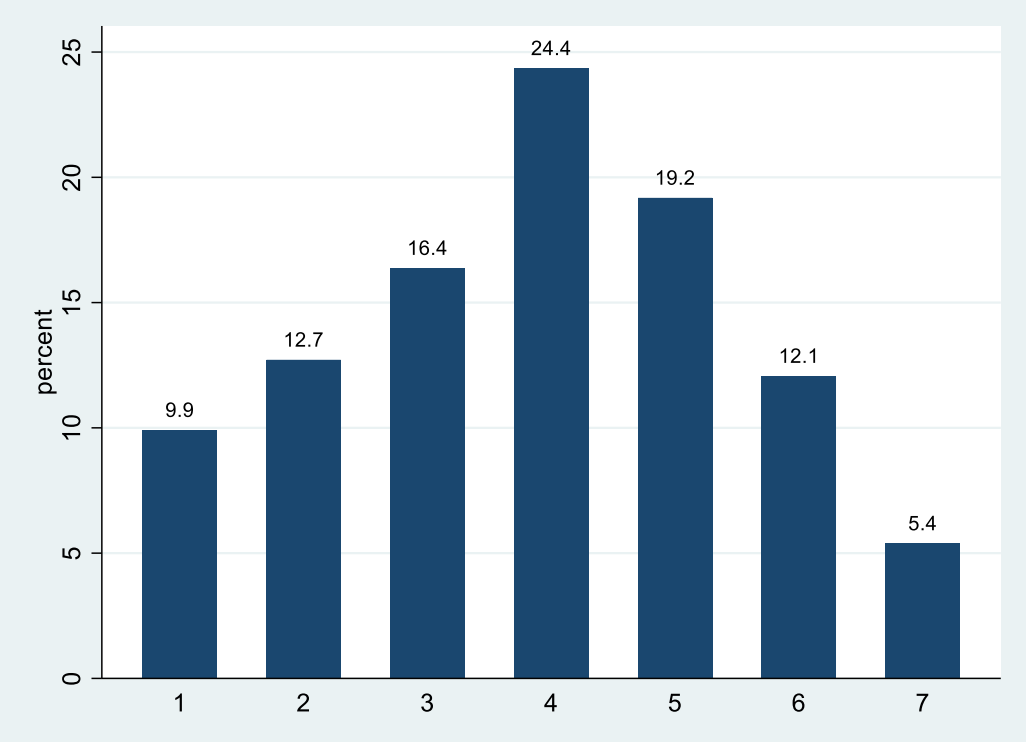

*Why do you expect they will _____?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*Society values the work I do*

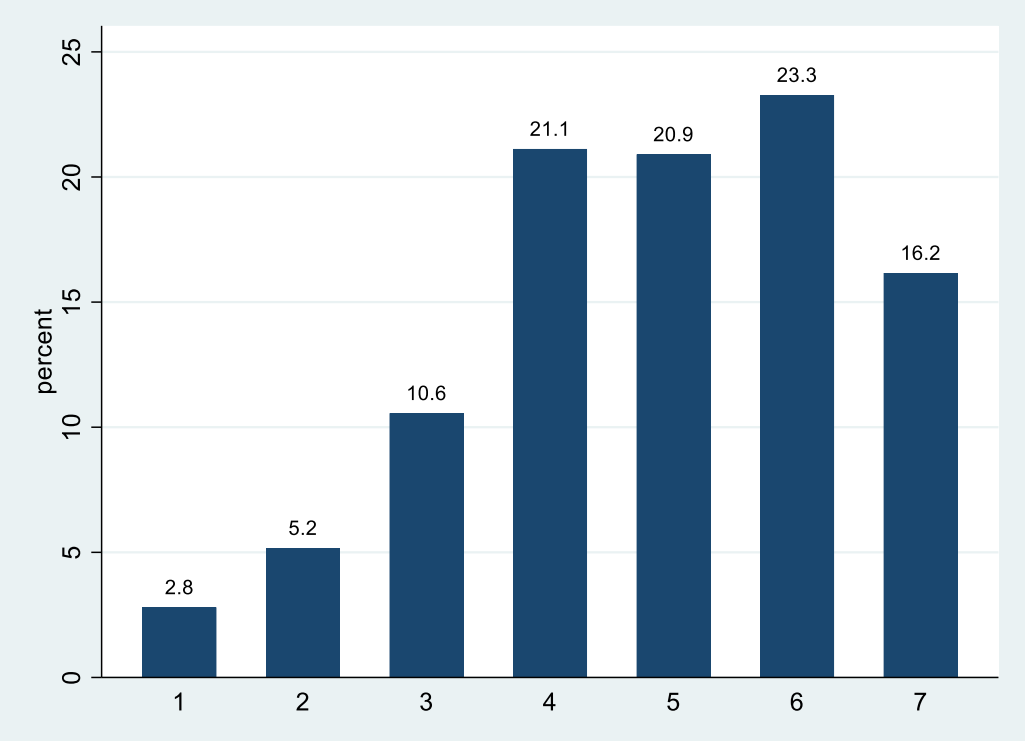


*My employer values the work I do*




| | Mean | Std. Err. | 95% Conf. interval | |
|---|---|---|---|---|
| Society values the work I do | 4.23 | 0.07 | 4.10 | 4.37 |
| My employer values the work I do | 3.88 | 0.08 | 3.73 | 4.03 |

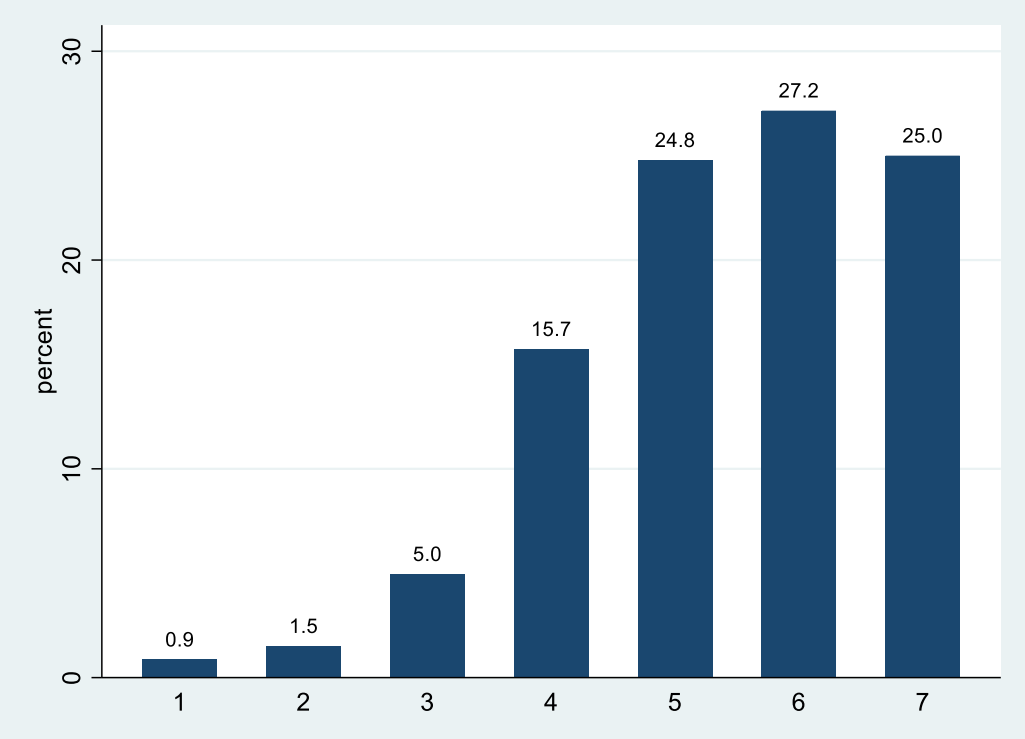
*My job is more stressful than I had imagined*



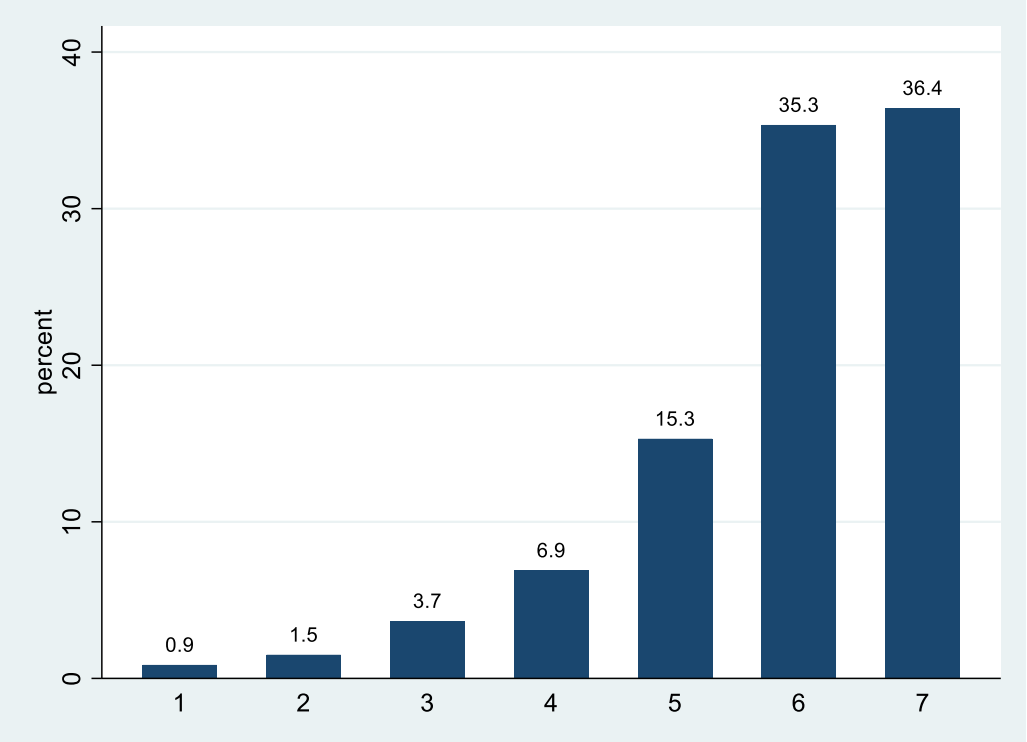

| | Mean | Std. Err. | 95% Conf. interval | |
|---|---|---|---|---|
| JobStressful | 4.87 | 0.07 | 4.72 | 5.01 |
| JobComplex | 5.73 | 0.06 | 5.61 | 5.85 |
| ReqNewSkills | 5.44 | 0.06 | 5.32 | 5.55 |

*My job is complex and difficult*

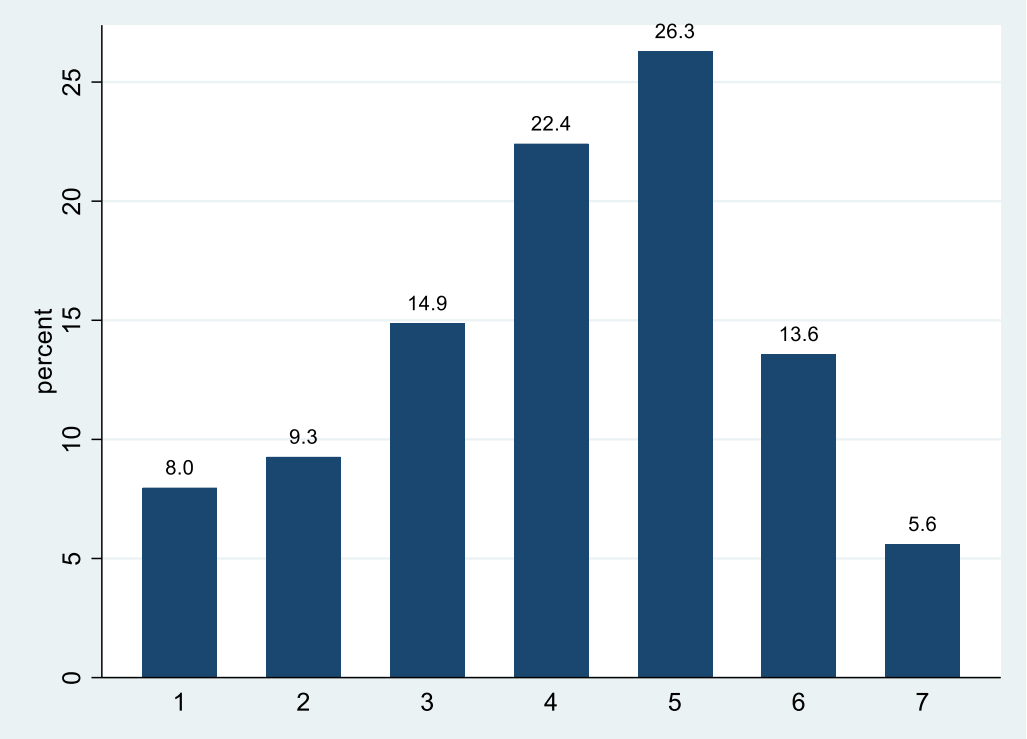

*My job often requires me to learn new skills*



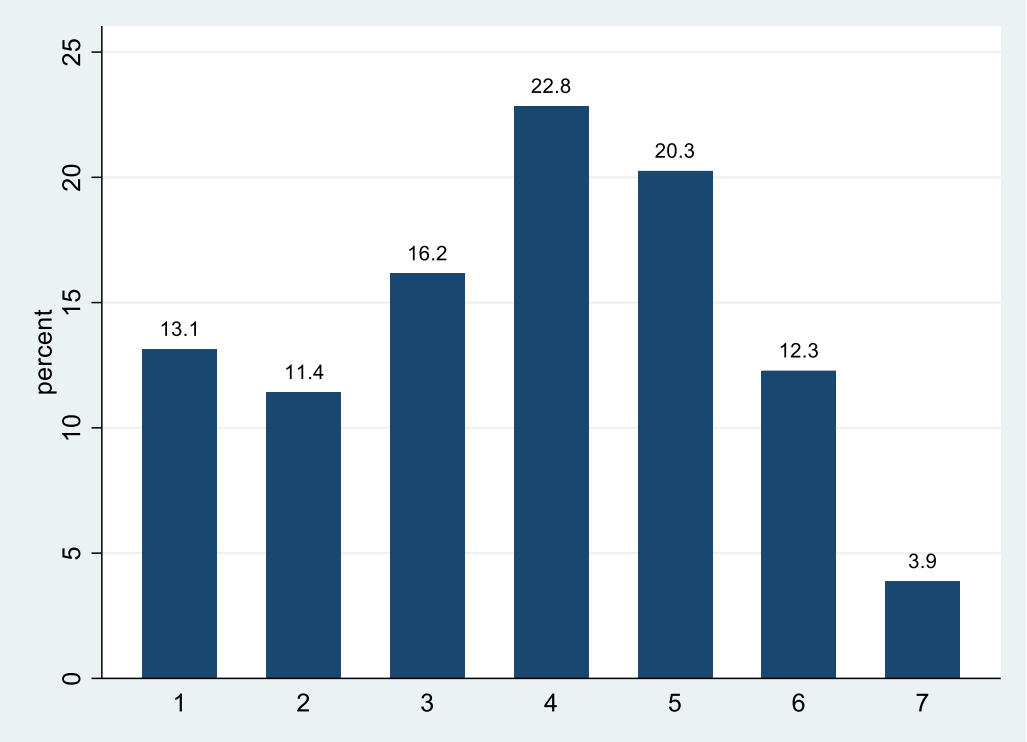
*I use my skills in my current job*



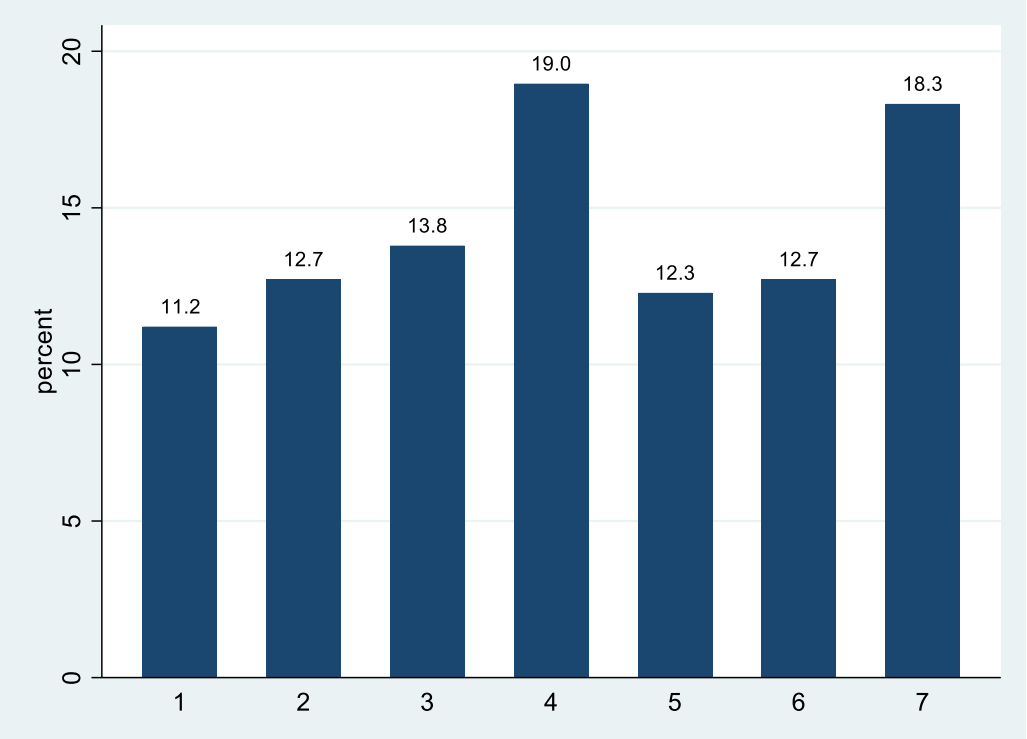

*I have freedom to decide how I do my own work*



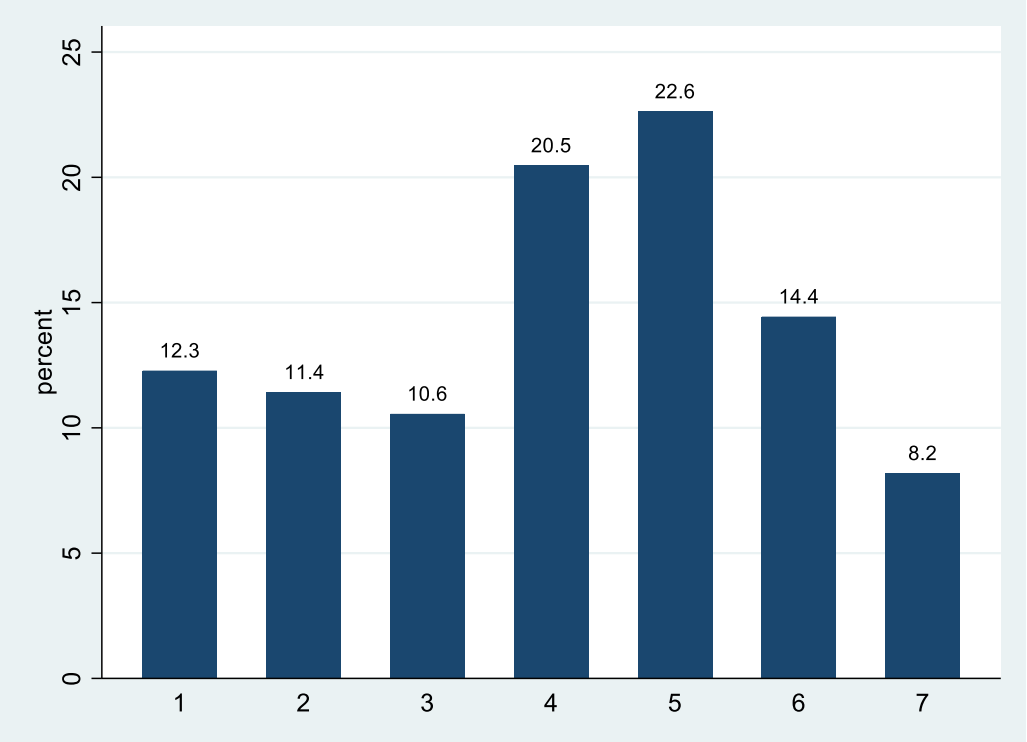
*I get paid fairly for the things I do in my job*



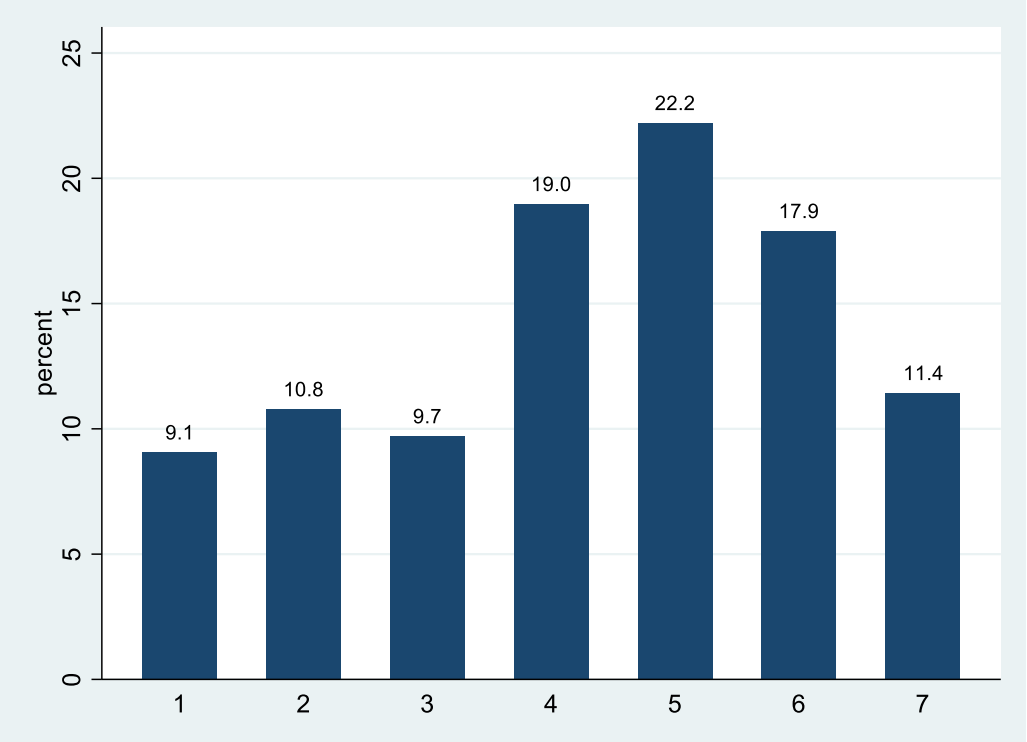

*I worry about the future of my job*



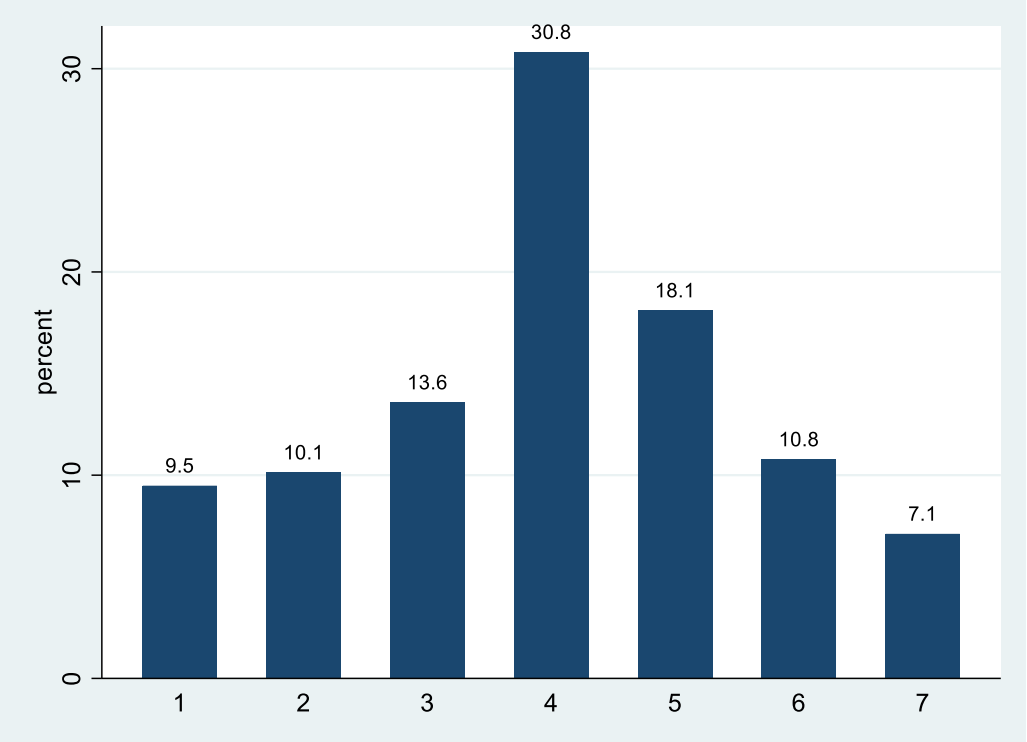
*There are possibilities for career progression in my sector*



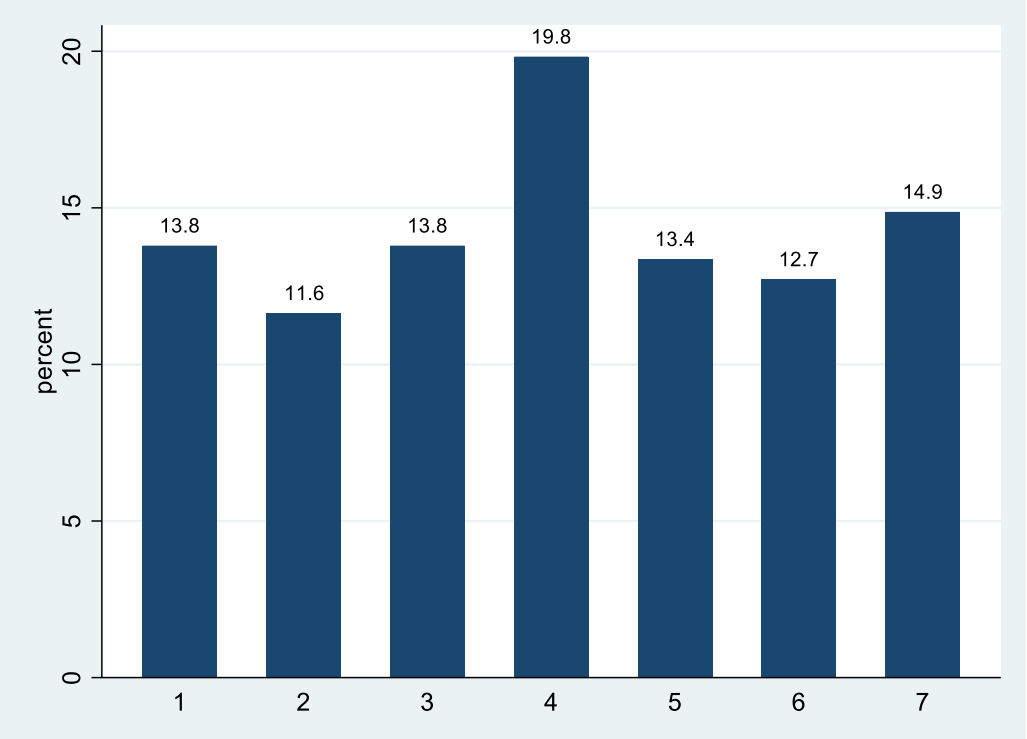

*There are possibilities to move around and do different kinds of work in my sector*



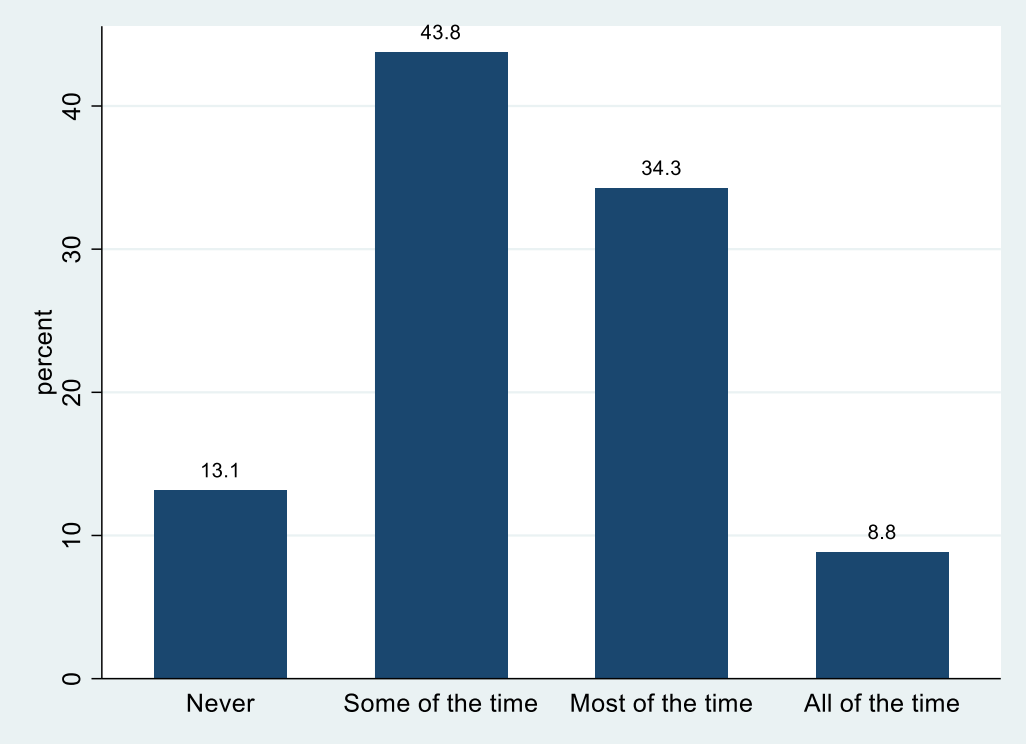
*I am reimbursed fairly for expenses incurred during my job*



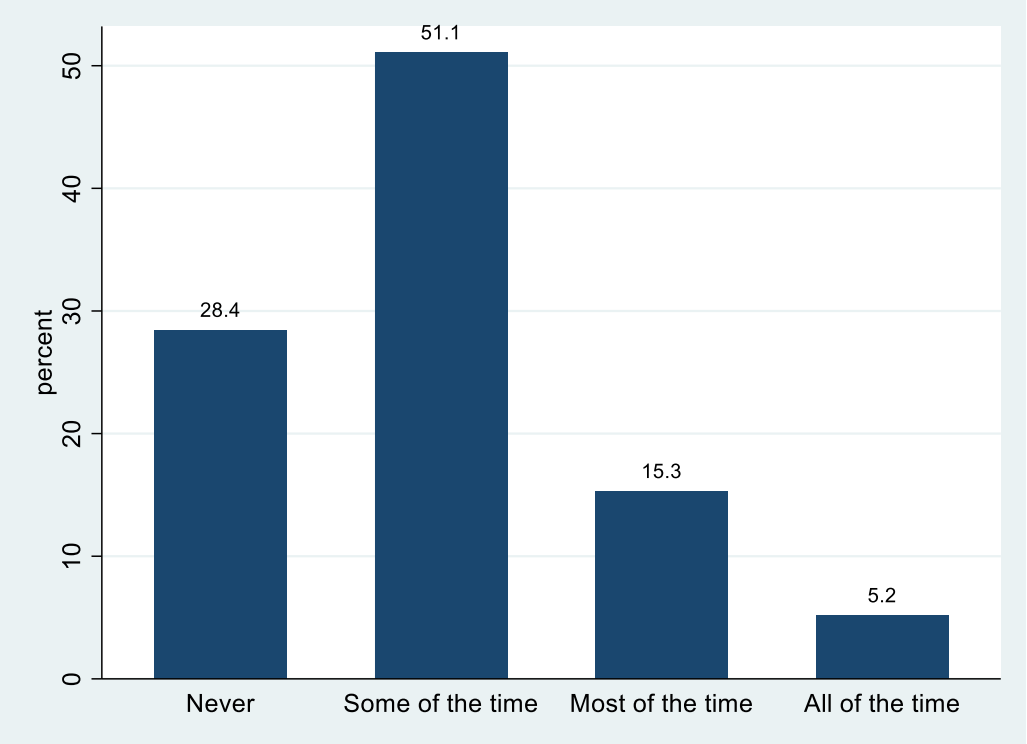

*I do more unpaid hours than I feel is reasonable in my job*



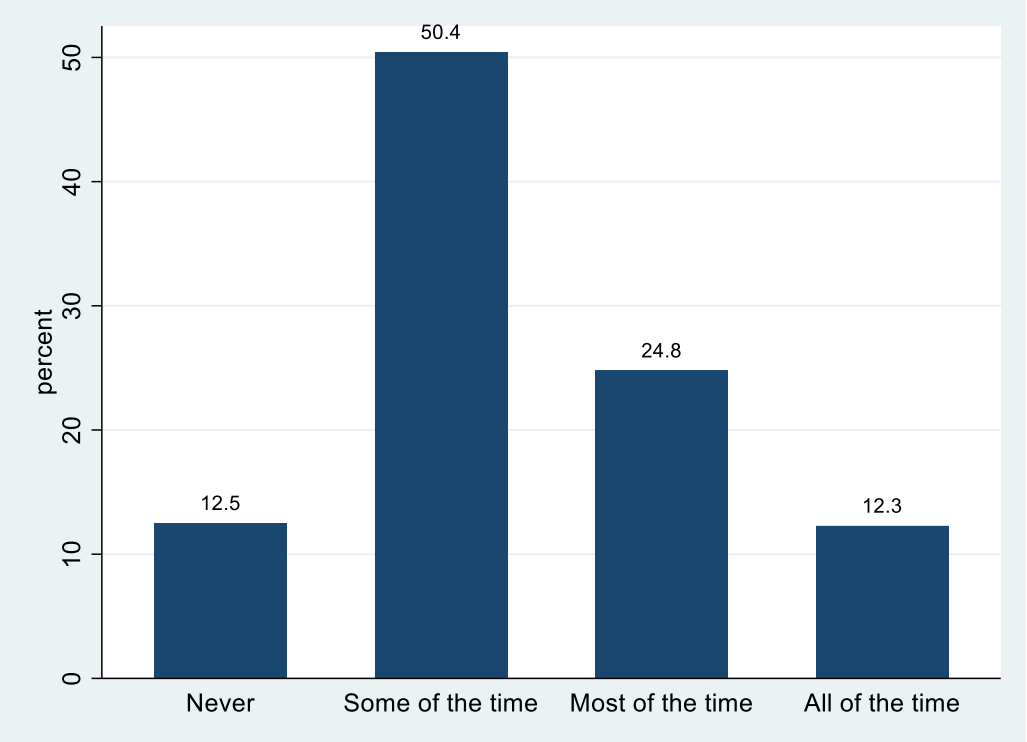
*I have enough supervision to do my job well*



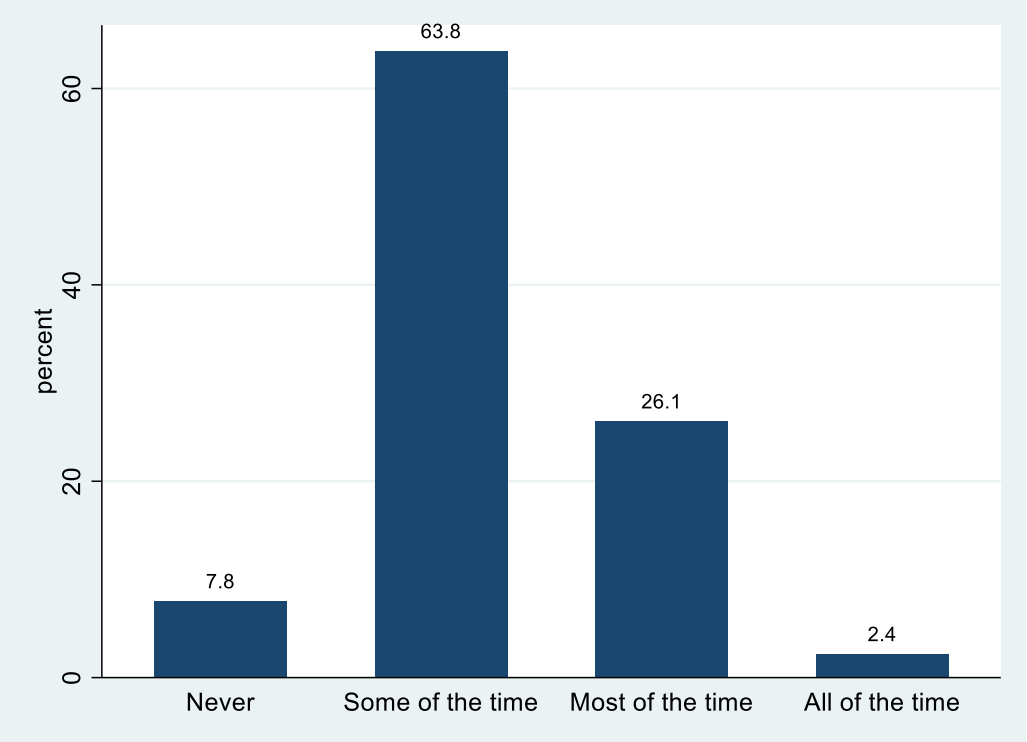

*I feel isolated in my job*



*My job puts my health and safety at risk*



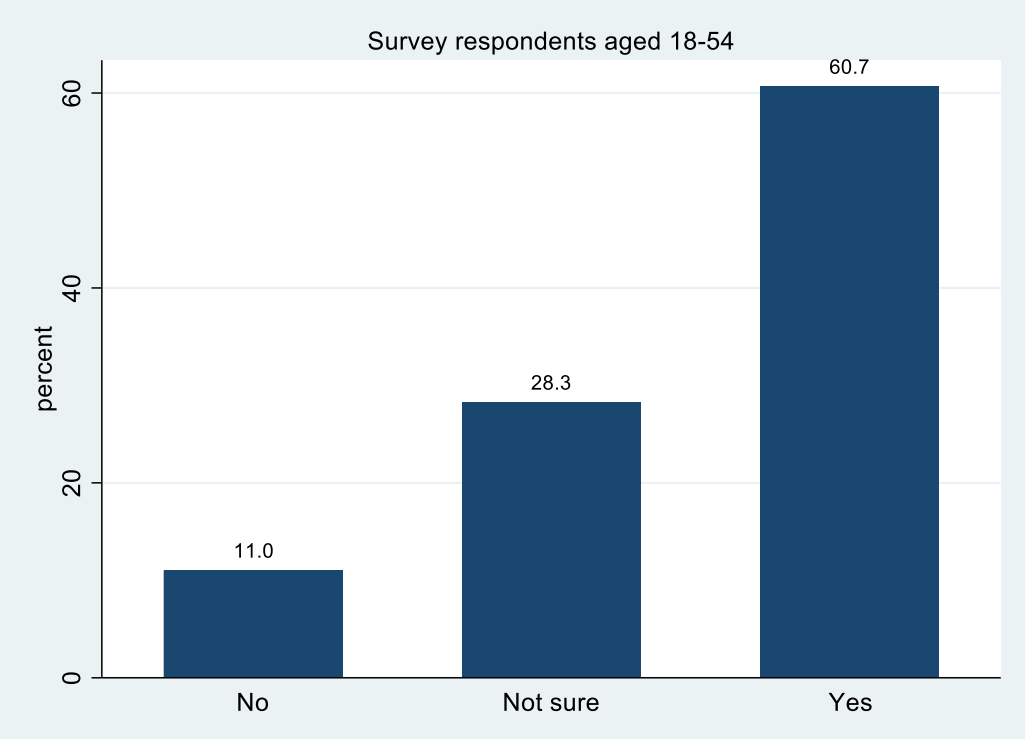

*I have the time to focus on the things that matter most in my work*



*Are there any other issues relating to your thoughts, feelings or forecasts about your work that have not already been covered? This might include issues that you feel affect your ability to perform, or enjoy, your role or reduces your capacity to effectively meet consumer needs.*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*Do you see yourself working in the mental health sector in five years' time?*




*Which of the following reasons best describes why you won't be/are not sure you will be working in the mental health sector in five years' time?*

| | | |
|---|---|---|
| I have experienced bullying or intimidation by colleagues and/or management | 27% | 63 |
| I won't be formally working (e.g. retired, maternity/paternity leave, studying) | 27% | 62 |
| I do not feel safe at work | 22% | 50 |
| I find the work too stressful | 21% | 49 |
| I can get better conditions doing work in another sector | 19% | 44 |
| I have limited career development opportunities | 14% | 32 |
| I want a career change | 12% | 29 |
| I can get better pay doing work in another sector | 9% | 22 |
| I don't receive enough training opportunities | 6% | 14 |
| The work is too difficult | 5% | 12 |
| I don't like the unsociable hours | 4% | 10 |
| Because of reduced or changed work hours | 3% | 8 |
| Other | 11% | 25 |

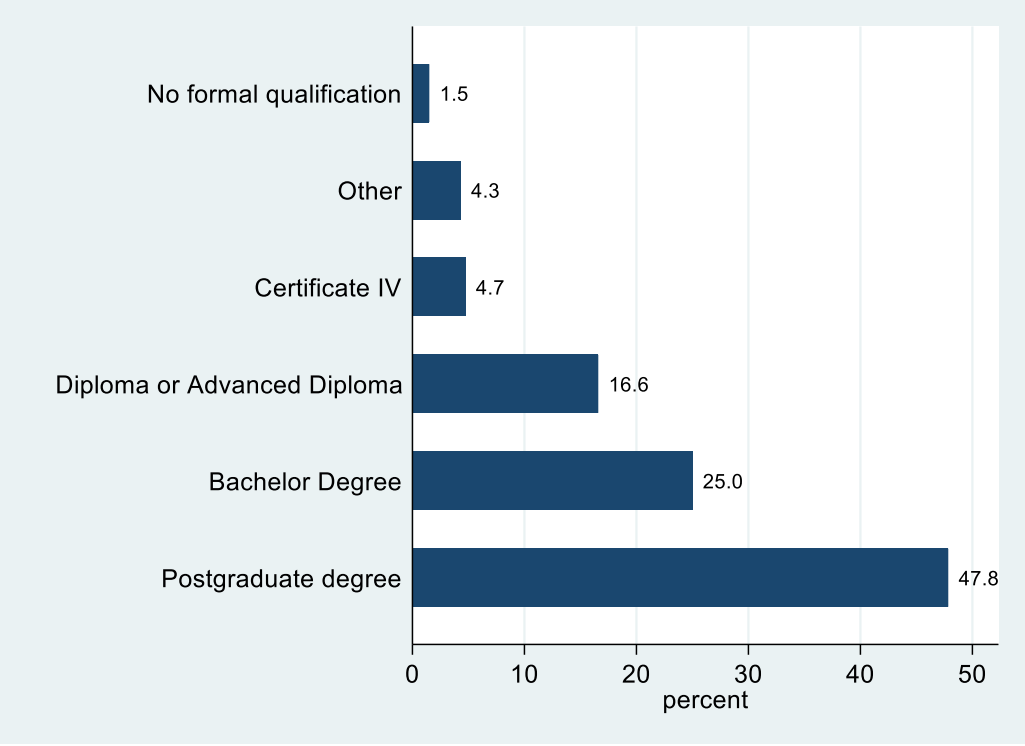
*Where do you feel you might be working instead?*

| | Freq. | Percent |
|---|---|---|
| Aged care | 2 | 0.88 |
| Disability care | 4 | 1.76 |
| Education | 7 | 3.08 |
| Family violence | 4 | 1.76 |
| General health | 10 | 4.41 |
| In another health or community services role | 34 | 14.98 |
| In another industry or occupation | 53 | 23.35 |
| Unsure | 113 | 49.78 |

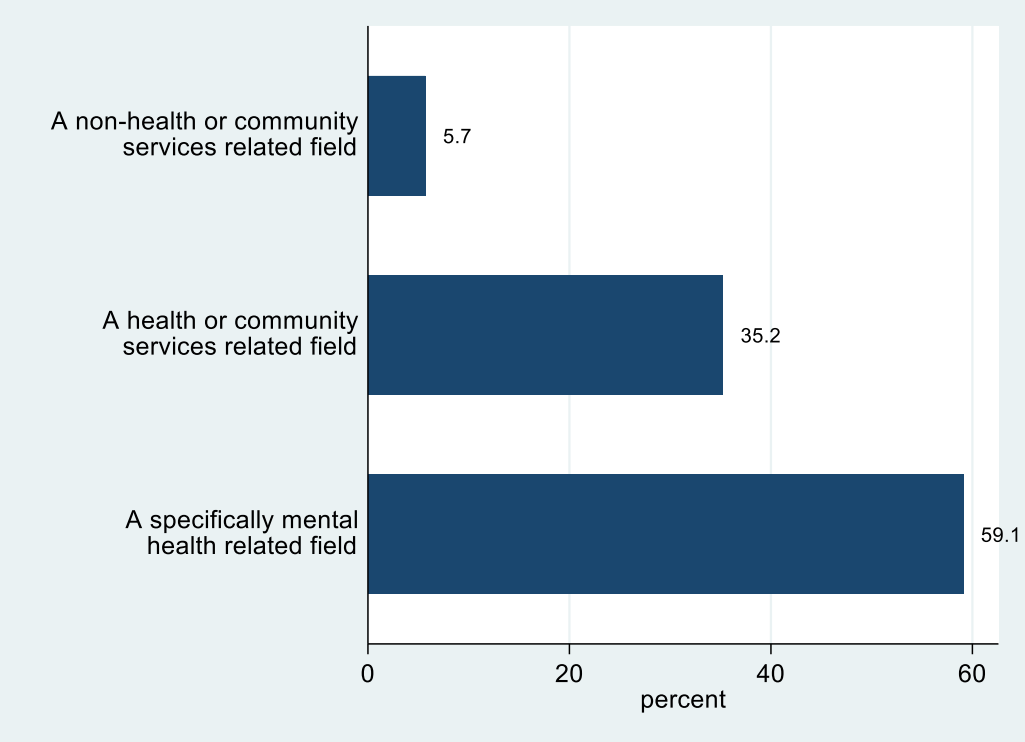
*Please specify*

This was an open question and the varying responses were collected and analysed in the main body of this report.

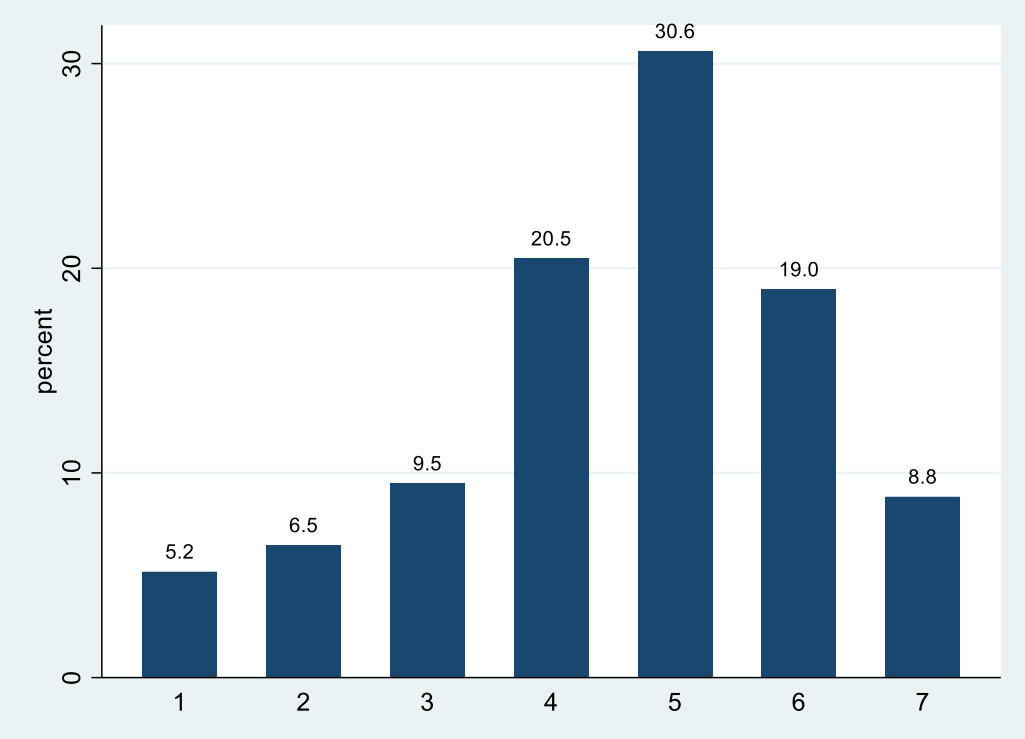
*What is the highest post-school qualification you have completed?*



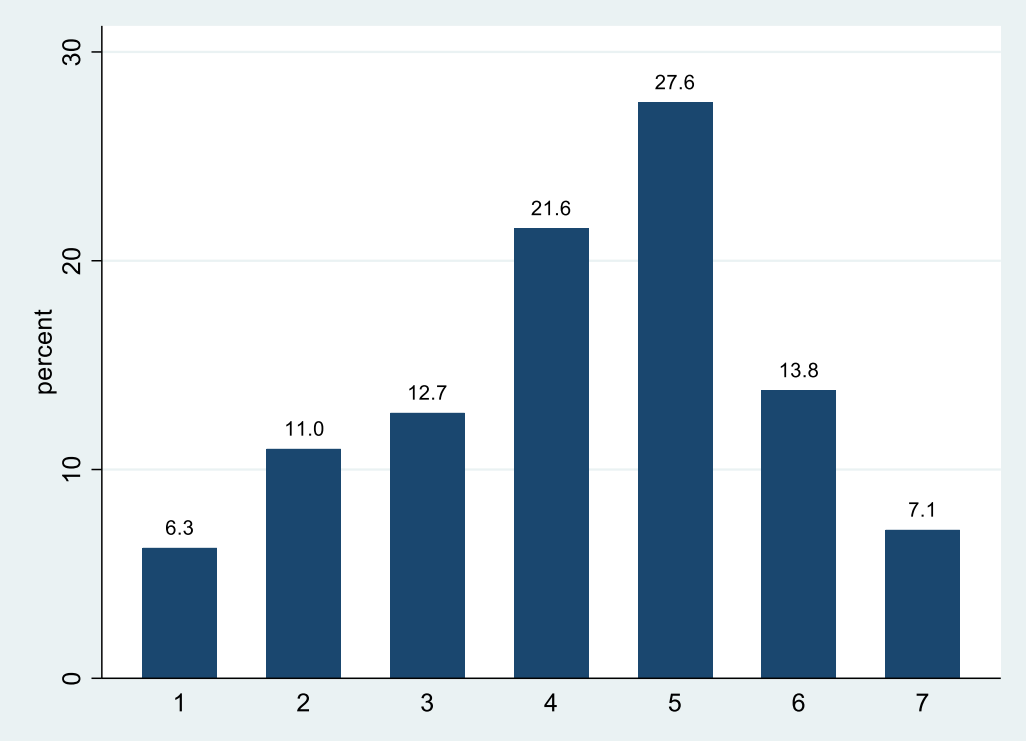
*My qualification is in:*



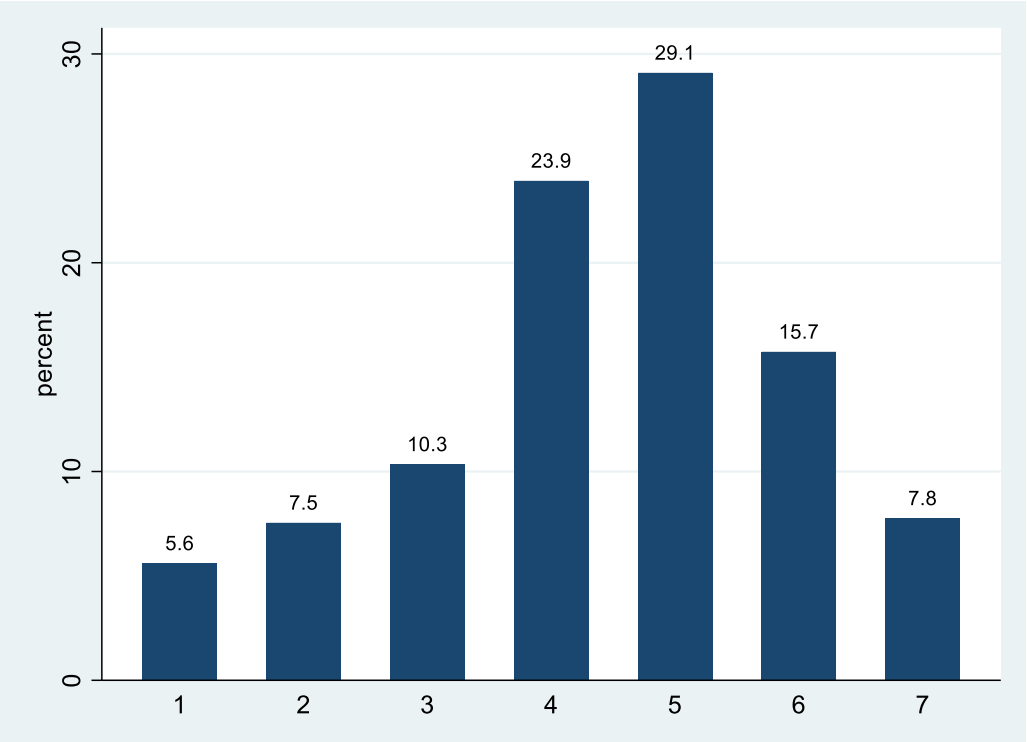

*I have access to the training I need to do my current job safely*



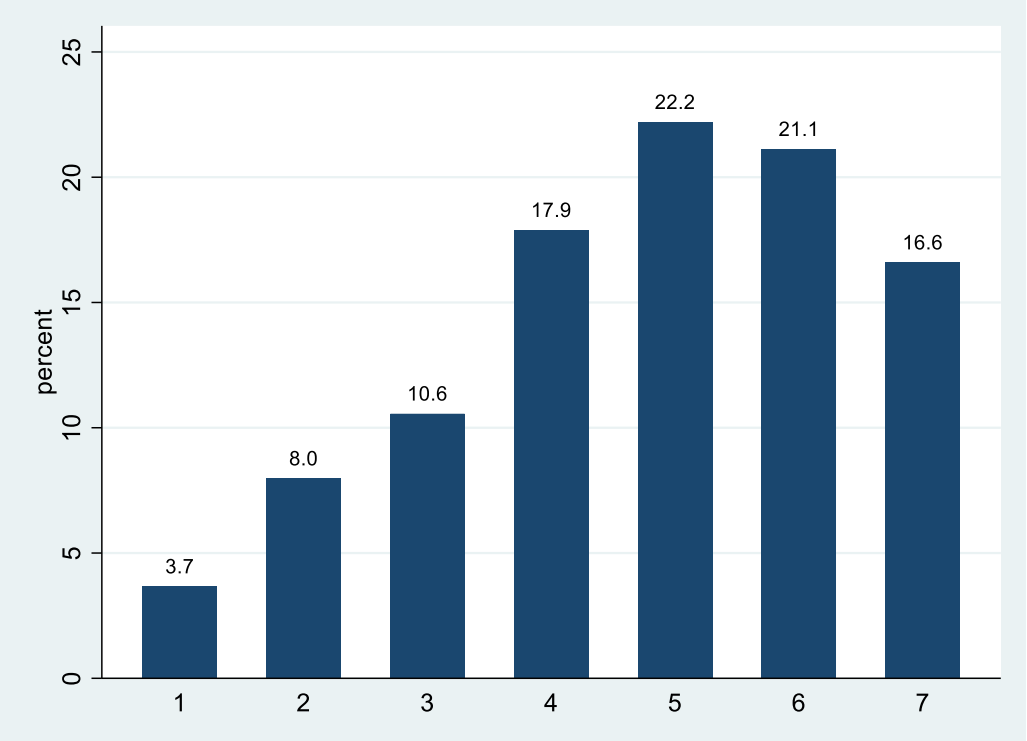
*I have access to the training I need to grow/progress in my career*
1 = Strongly disagree; 7 = strongly agree




*I have access to the training I need to best support my clients*
1 = Strongly disagree; 7 = strongly agree



*There are barriers that prevent me from participating in training as much as I would like to*
1 = Strongly disagree; 7 = strongly agree

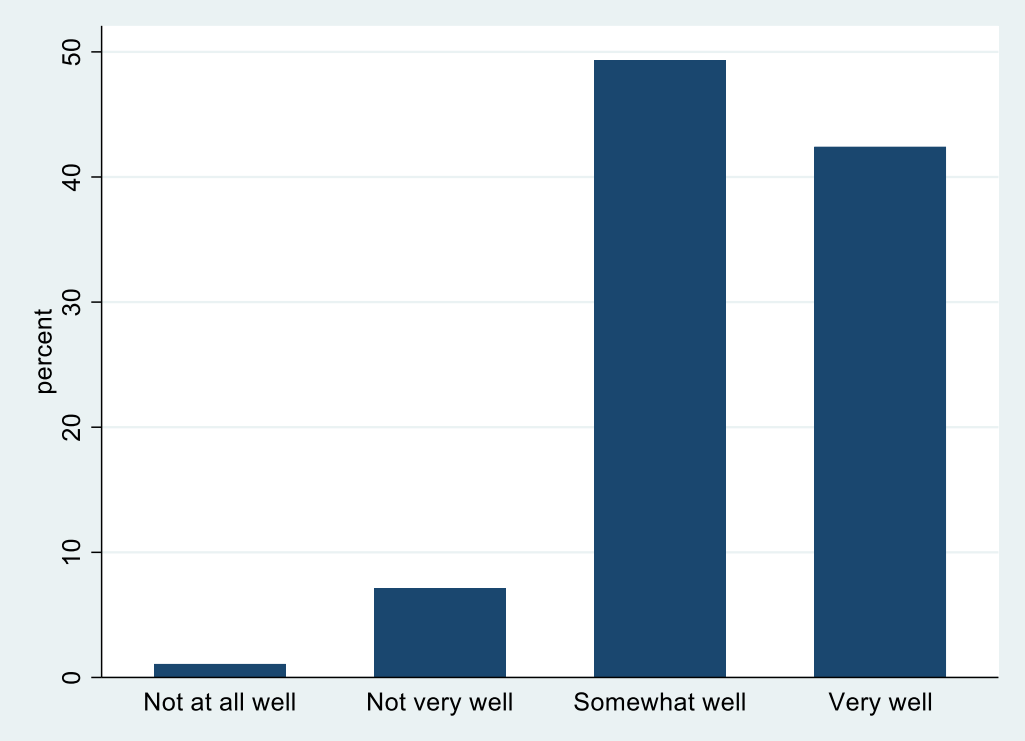



*What are the main barriers that currently prevent you from participating in training as much as you would like to?*

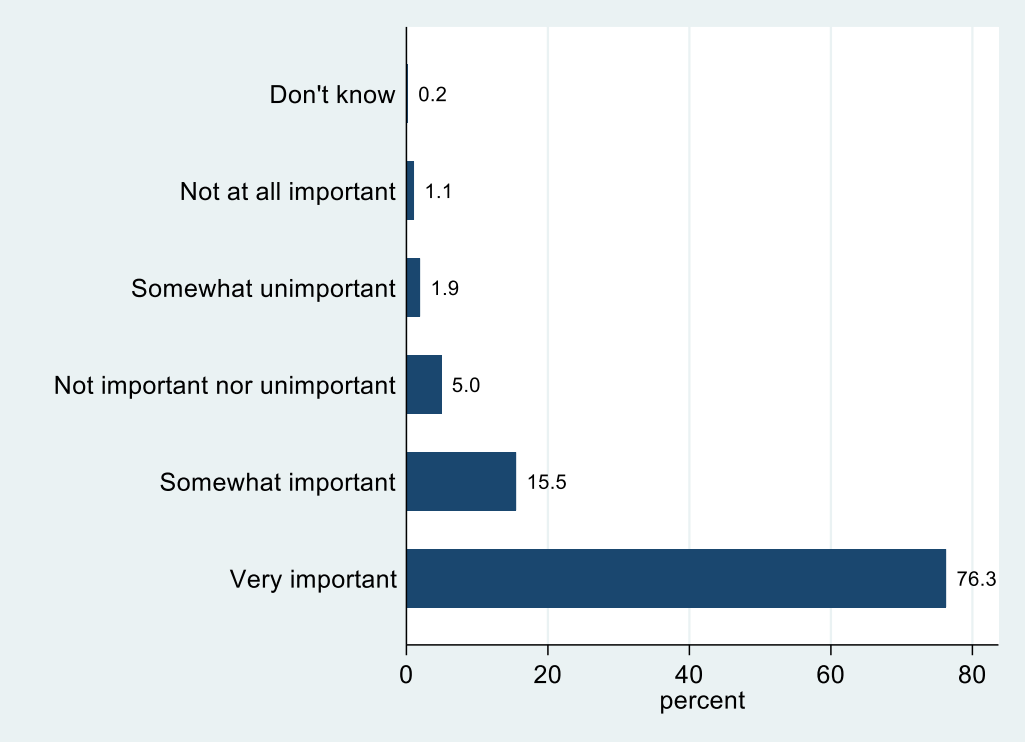
| | | |
|---|---|---|
| Lack of time to participate in training | 81% | 332 |
| The expense of training | 46% | 189 |
| Lack of funding to my employer for training | 31% | 127 |
| The location of training | 27% | 112 |
| Lack of support from my employer for training | 23% | 95 |
| The timing of training | 19% | 78 |
| The training I would like isn't available | 17% | 73 |
| The training available isn't appropriate | 12% | 51 |
| Other | 5% | 21 |

*What training are you most interested in accessing?*
This was an open question and the varying responses were collected and analysed in the main body of this report.

*How well does your qualification/s equip you with the skills you need for your role?*




*How important do you think it is that a worker in your particular role has a formal qualification specifically in mental health?*



*Is there anything else you would like to say about the quality and fitness for purpose of mental health qualifications and training?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*Of these issues in the Victorian mental health sector, which do you feel is the HIGHEST priority to address?*

| | Percent | Frequency |
|---|---|---|
| Increased funding overall | 30% | 143 |
| Increased staffing levels | 18% | 87 |
| Increased funding for community services | 13% | 63 |
| Better integration of mental health services with other health and community services | 10% | 49 |
| Increased funding of hospital services/beds | 10% | 47 |
| Improved wages and conditions | 8% | 38 |
| Access to NDIS funding for Australians living with chronic mental illness | 4% | 20 |
| Improved staff education and training | 3% | 17 |

*Do you have any other suggestions around priority areas for Victorian mental health services?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*What is the most important thing that would improve mental health services in Victoria?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

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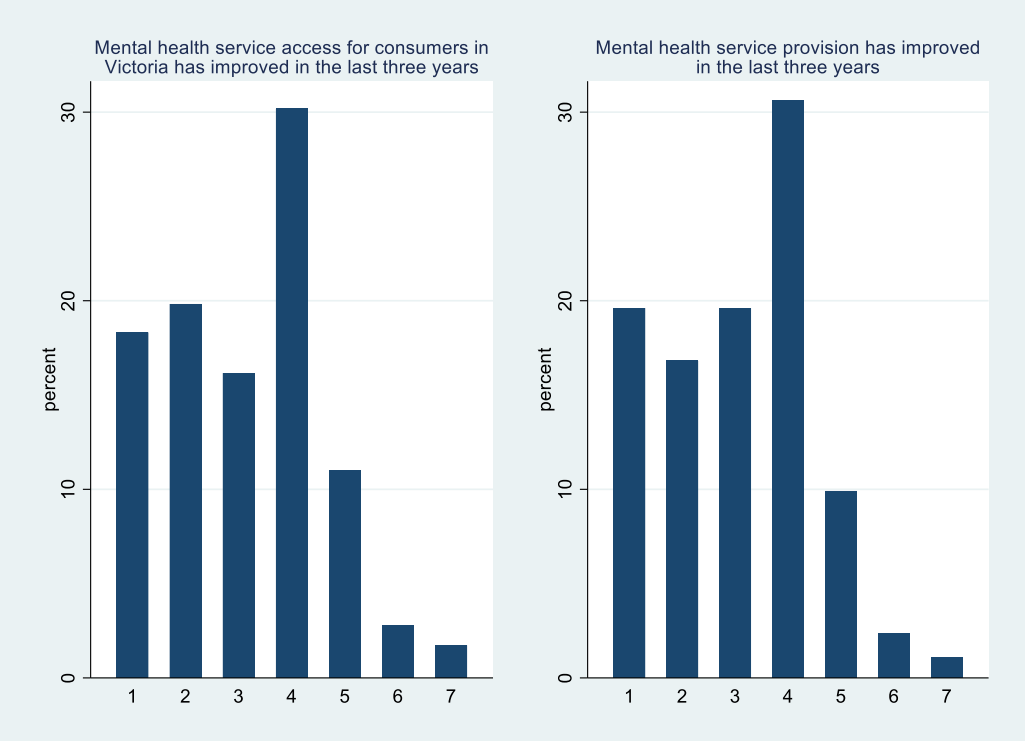
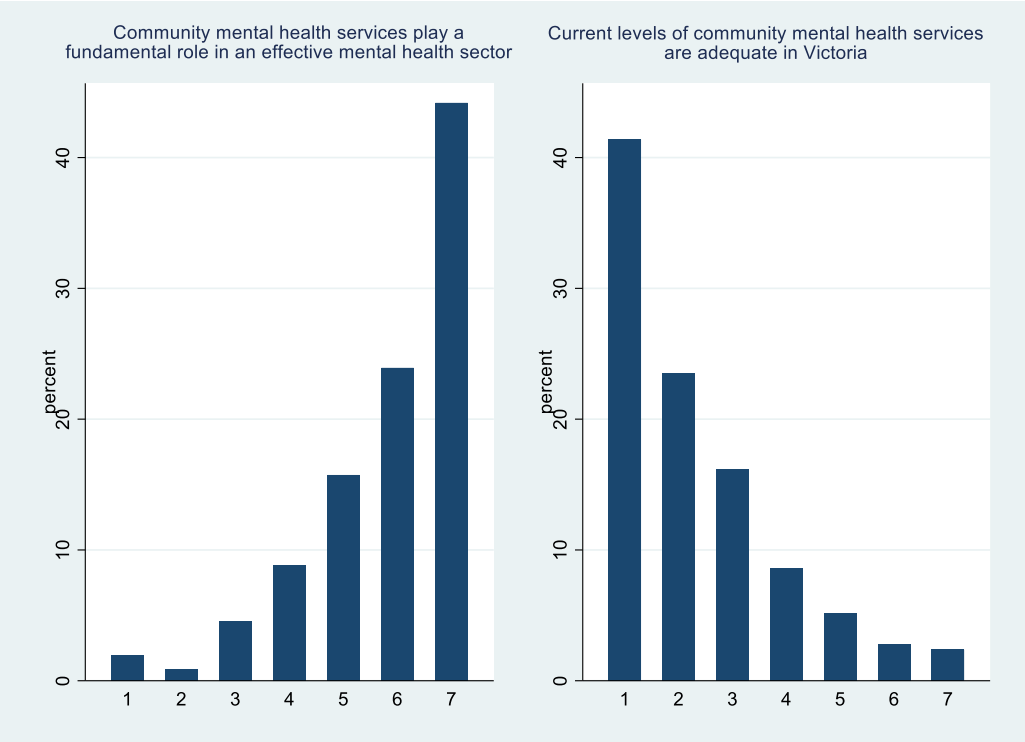
*Mental health service access for consumers in Victoria has improved in the last three years / Mental health service provision has improved in the last three years*

1 = Strongly disagree; 7 = strongly agree




*Community mental health services play a fundamental role in an effective mental health sector / Current levels of community mental health services are adequate in Victoria*

1 = Strongly disagree; 7 = strongly agree



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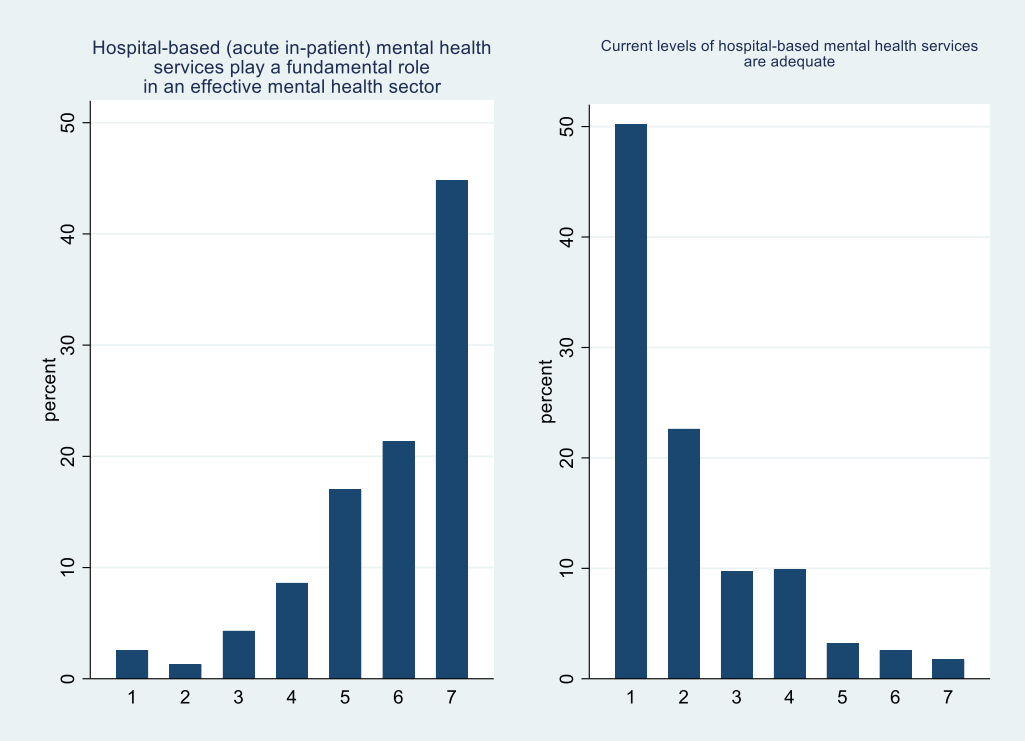
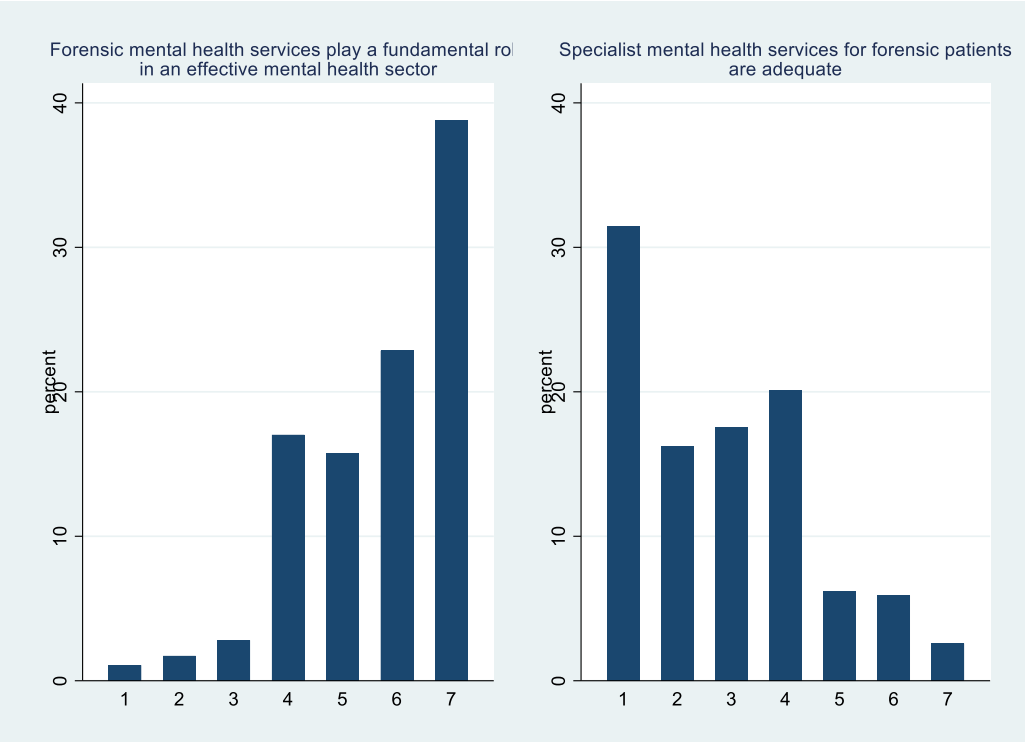
*Hospital-based (acute in-patient) mental health services play a fundamental role in an effective mental health sector / Current levels of hospital-based mental health services are adequate*

1 = Strongly disagree; 7 = strongly agree




*Forensic mental health services play a fundamental role in an effective mental health sector / Specialist mental health services for forensic patients are adequate*

1 = Strongly disagree; 7 = strongly agree



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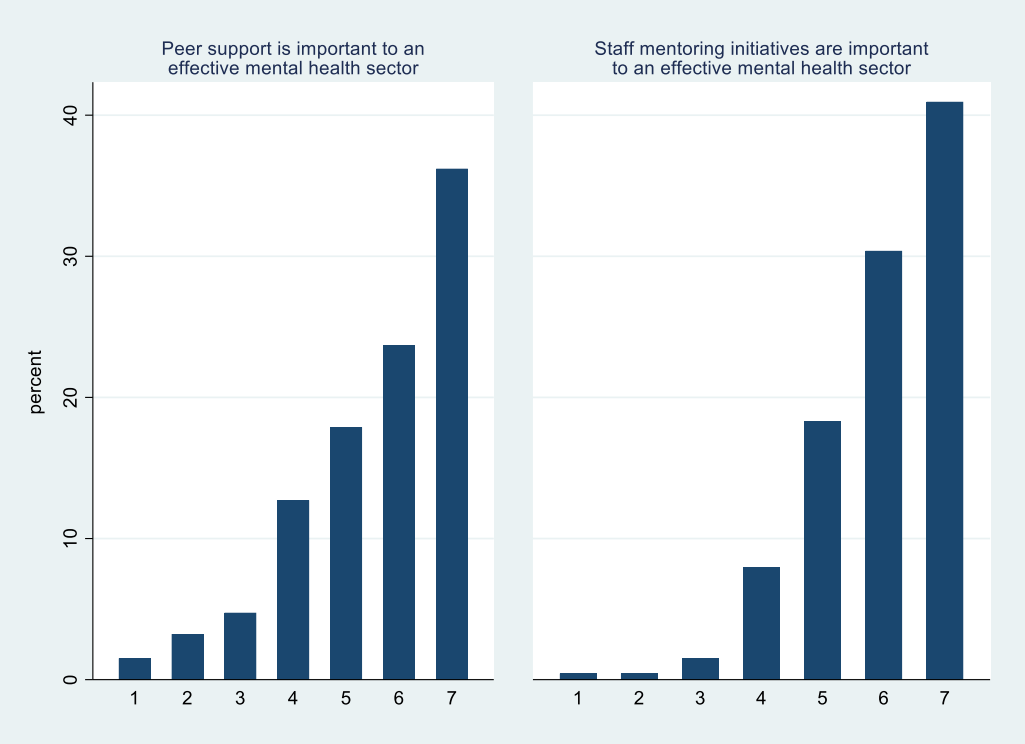
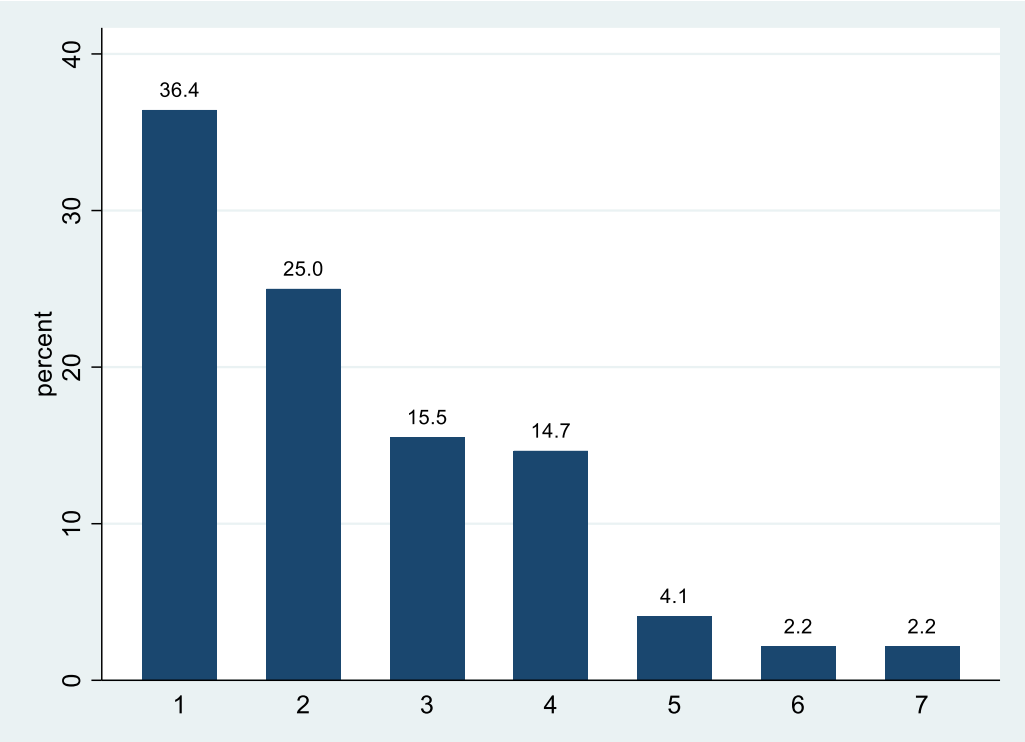
*Peer support is important to an effective mental health sector / Staff mentoring initiatives are important to an effective mental health sector*

1 = Strongly disagree; 7 = strongly agree

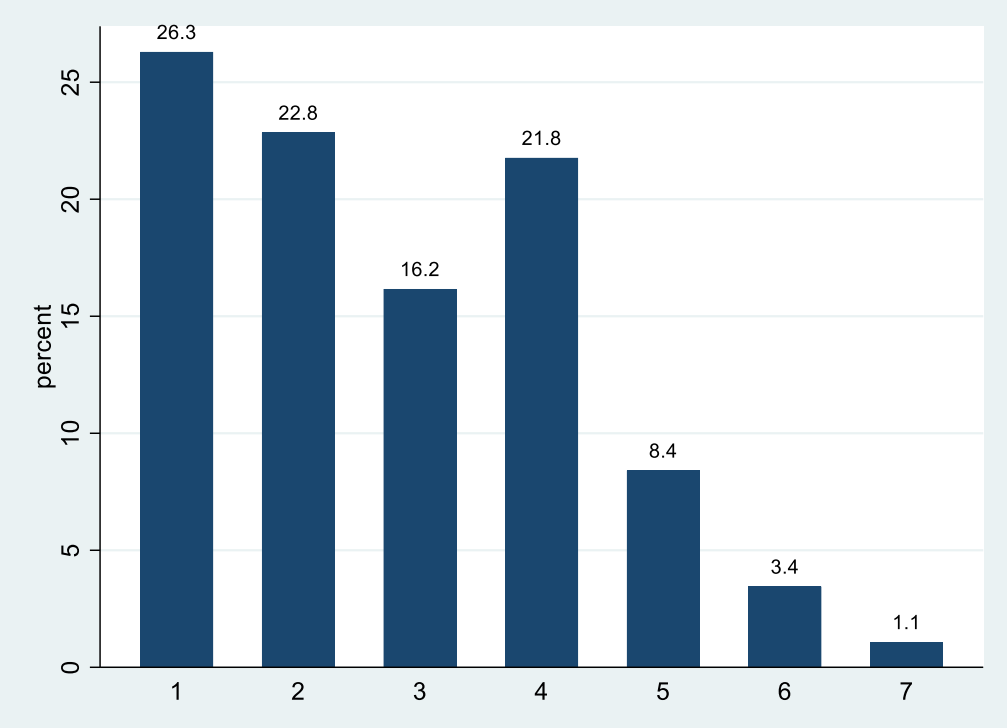



*Preventative services around mental health are adequate*

1 = Strongly disagree; 7 = strongly agree

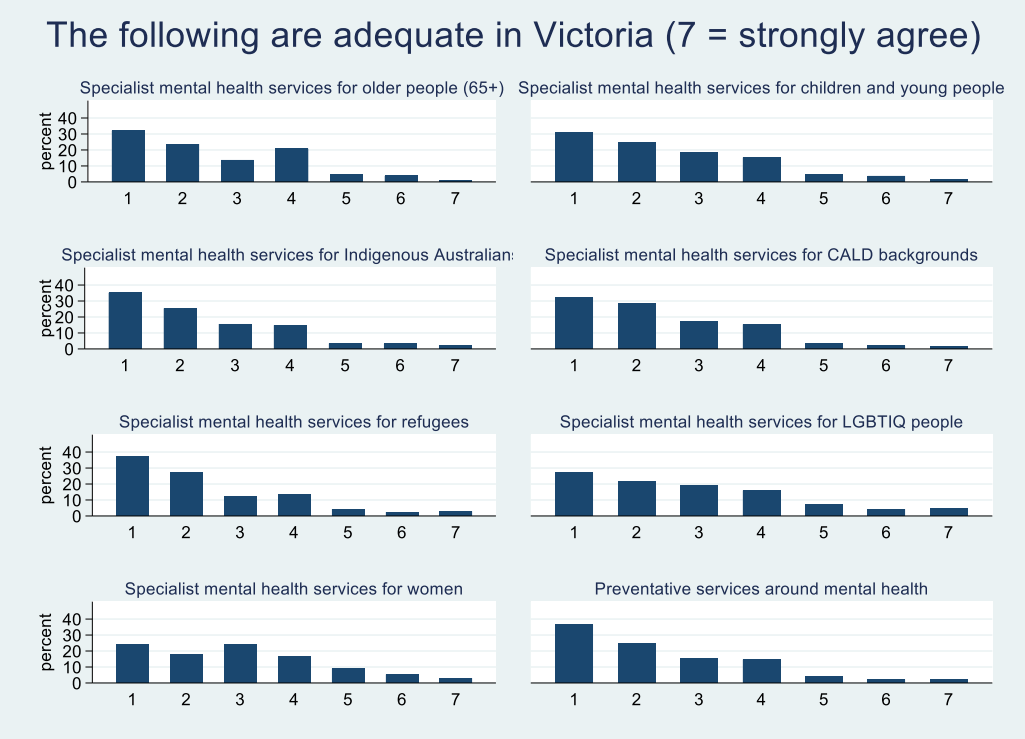


*The current undergraduate and vocational nurse and allied health training programs are adequately preparing new mental health professionals for entry into mental health*
1 = Strongly disagree; 7 = strongly agree



# THE MENTAL HEALTH WORKFORCE IN VICTORIA

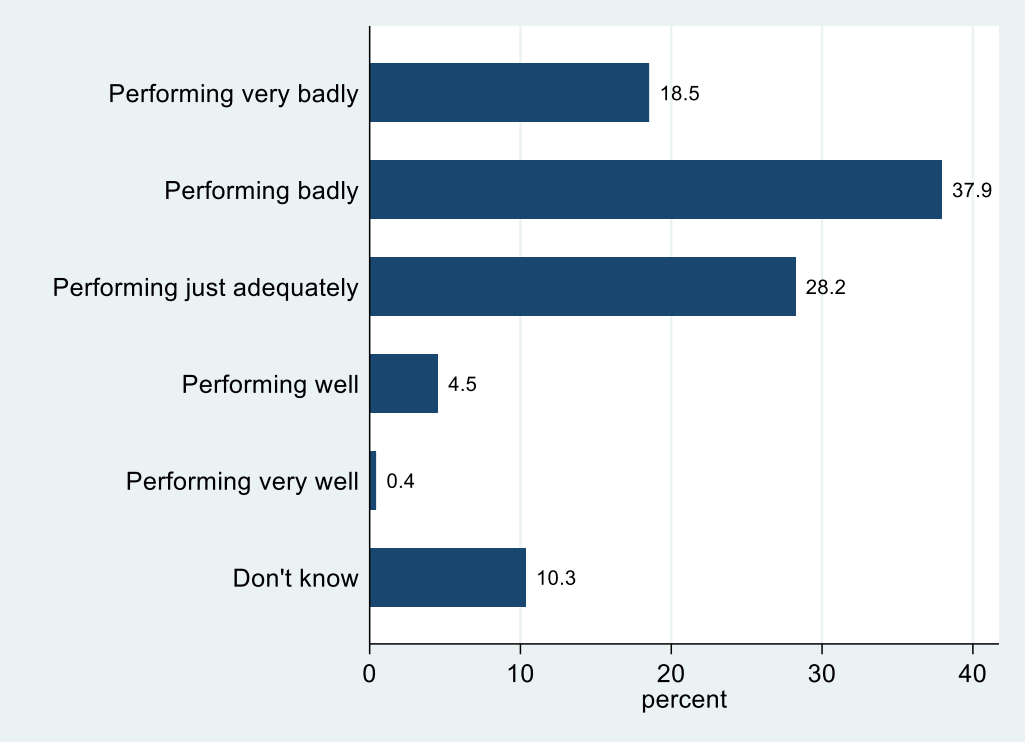
*Specialist mental health services for older people (65+) in Victoria are adequate / Specialist mental health services for children and young people (under 25) in Victoria are adequate / Specialist mental health services for Indigenous Australians in Victoria are adequate / Specialist mental health services for Victorians from culturally and linguistically diverse backgrounds are adequate / Specialist mental health services for refugees in Victoria are adequate / Specialist mental health services for LGBTIQ people are adequate / Specialist mental health services for women are adequate*



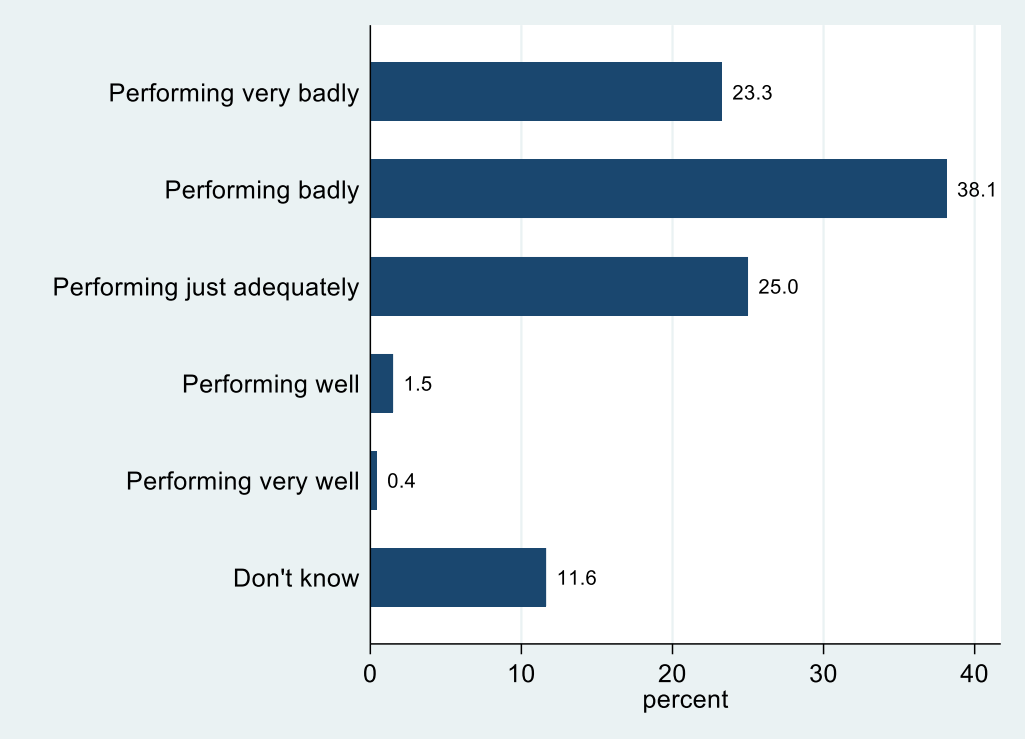

*Please indicate whether you would value further training in relation to the mental health needs of (select all that apply):*

| | | |
|---|---|---|
| Forensic patients (consumers currently serving a sentence at a mental health facility) | 56% | 264 |
| People with a refugee/asylum seeker background | 50% | 235 |
| Indigenous Australians | 49% | 229 |
| People from culturally and linguistically diverse backgrounds | 48% | 227 |
| Children and young people | 39% | 185 |
| LGBTIQ people | 39% | 181 |
| Older people | 34% | 158 |
| Women | 31% | 146 |

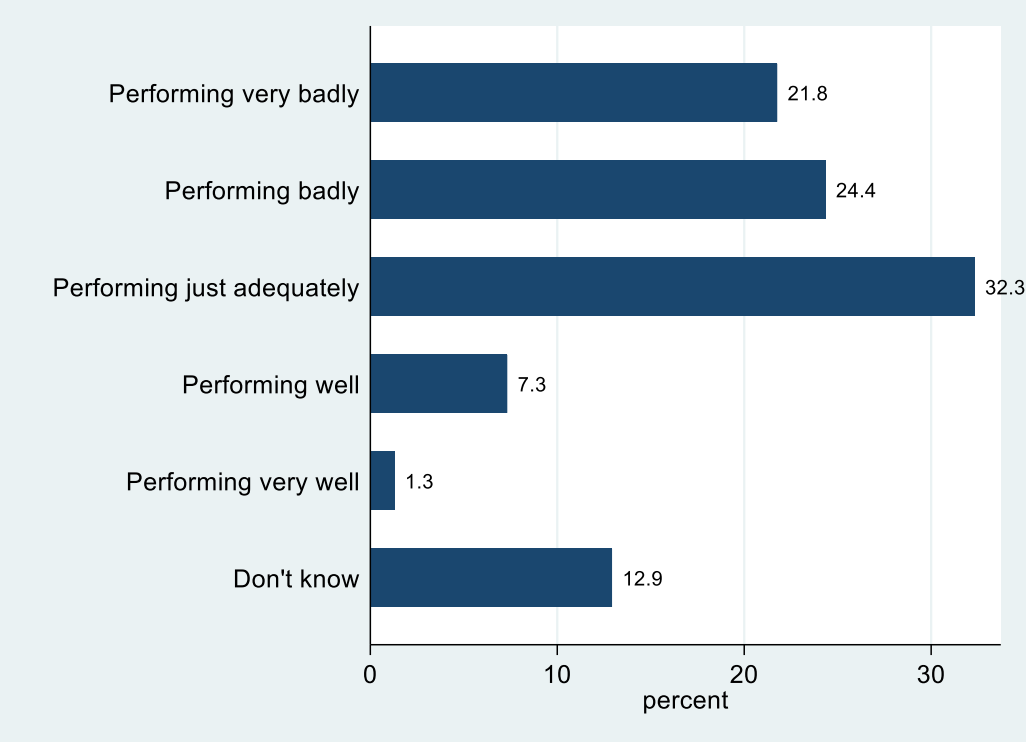
*Pathways and interfaces between Victoria's mental health system and other systems*



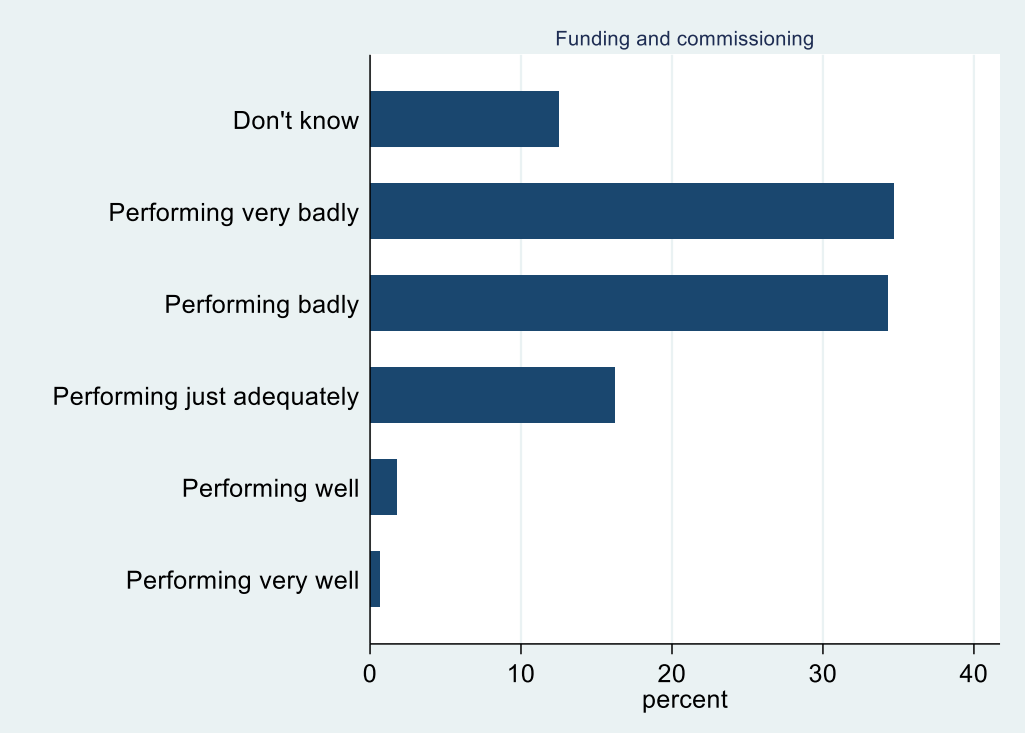

*Service and infrastructure planning*



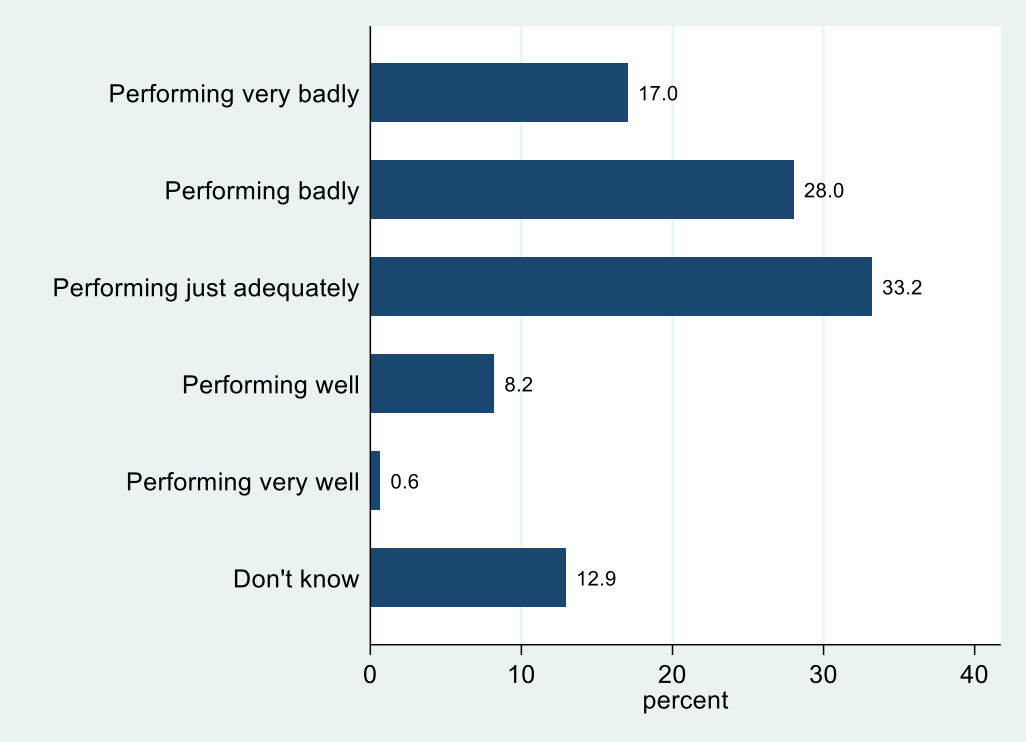
*Governance and accountability*



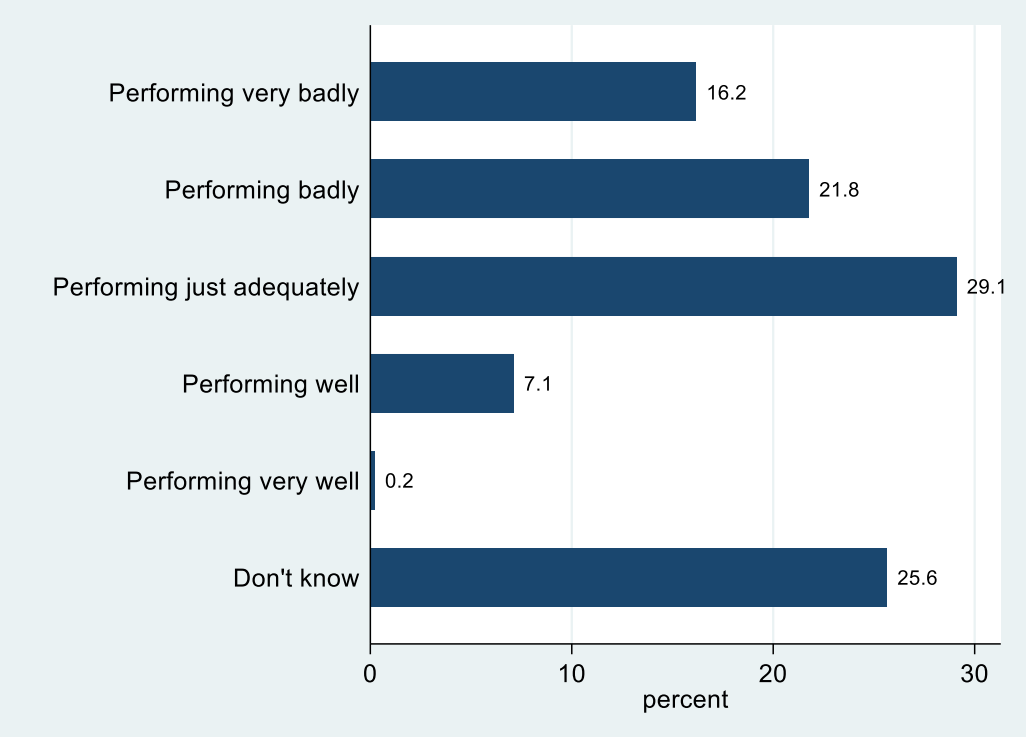

*Funding and commissioning*



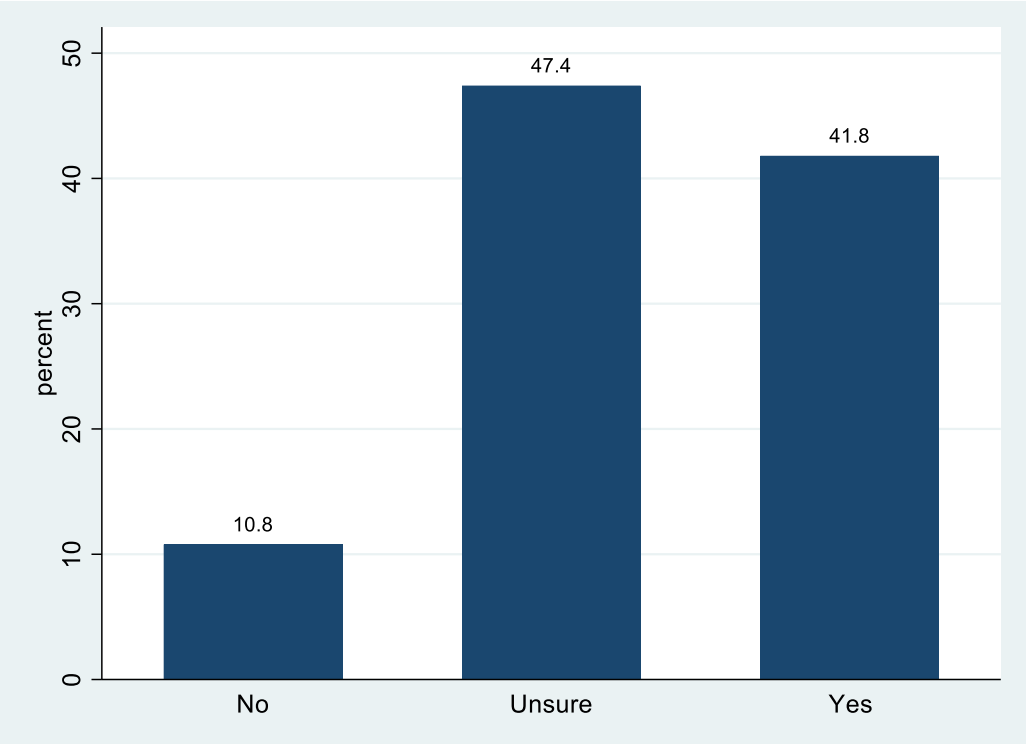
*Information sharing arrangements*




*Data collection and search strategies to advance continuity of care and monitor the impact of any reforms*



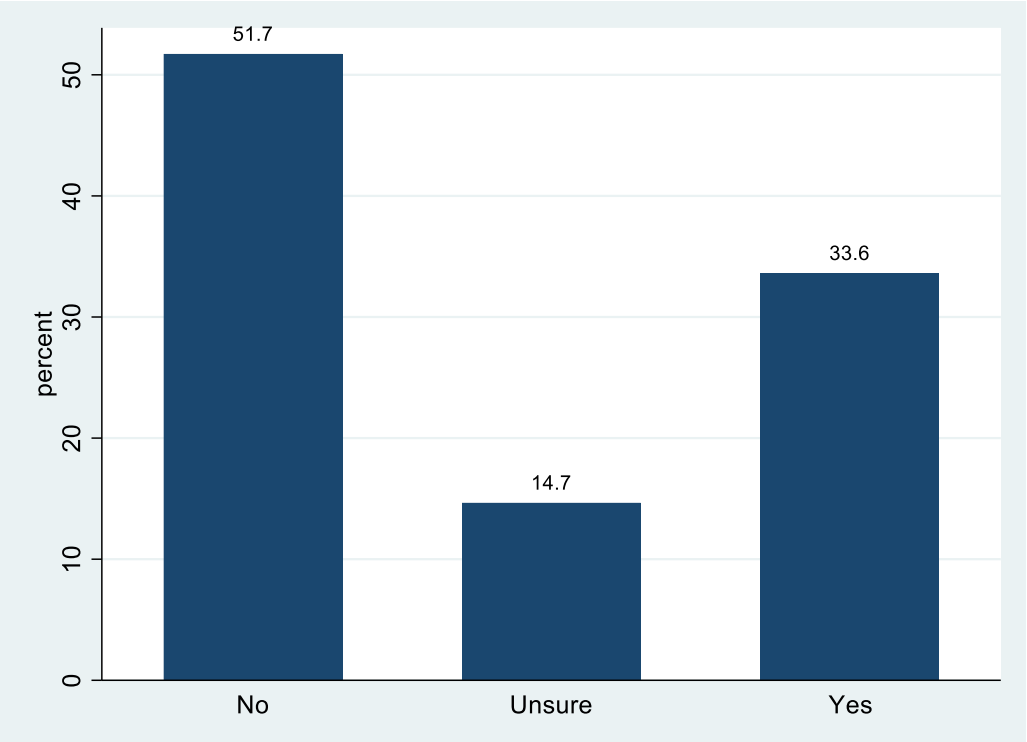
*Could existing funds be reallocated within the sector to promote better mental health outcomes?*



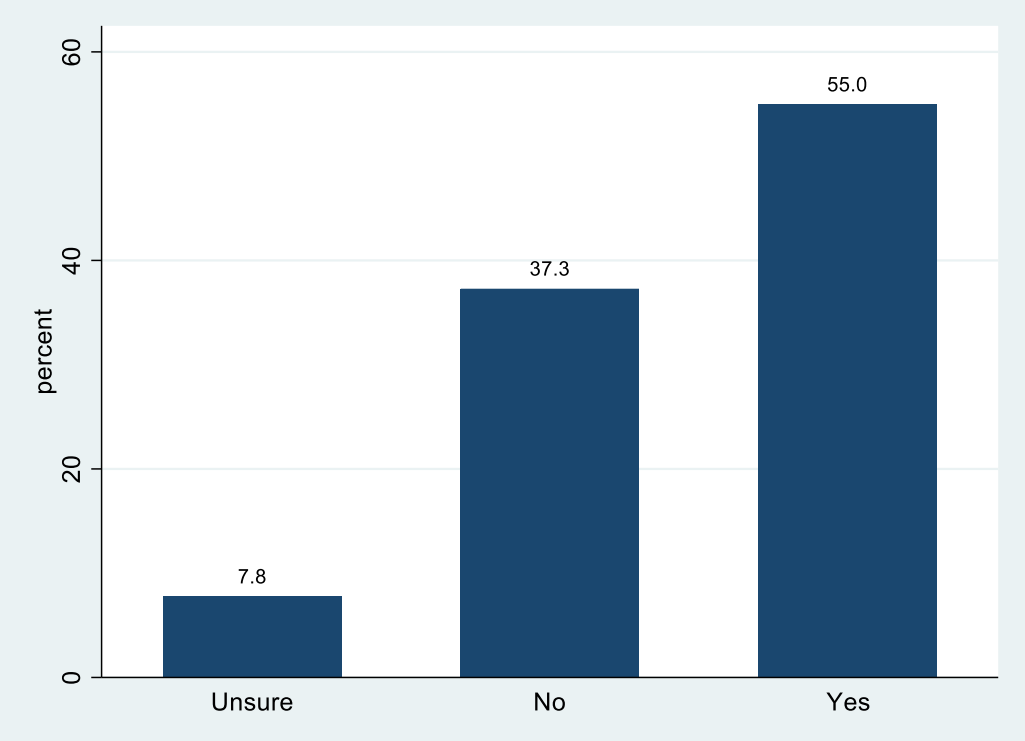

*Are you able to indicate where funds could be reallocated from and to?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

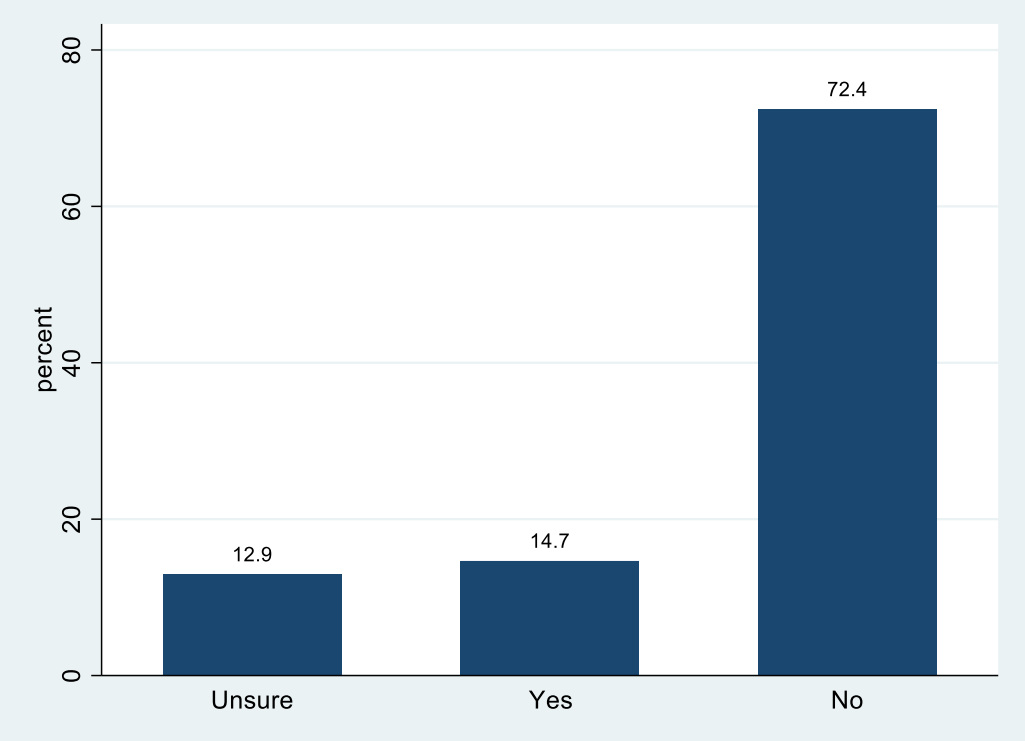
*Are you adequately supported in your current role to provide high quality mental health services to those in need?*



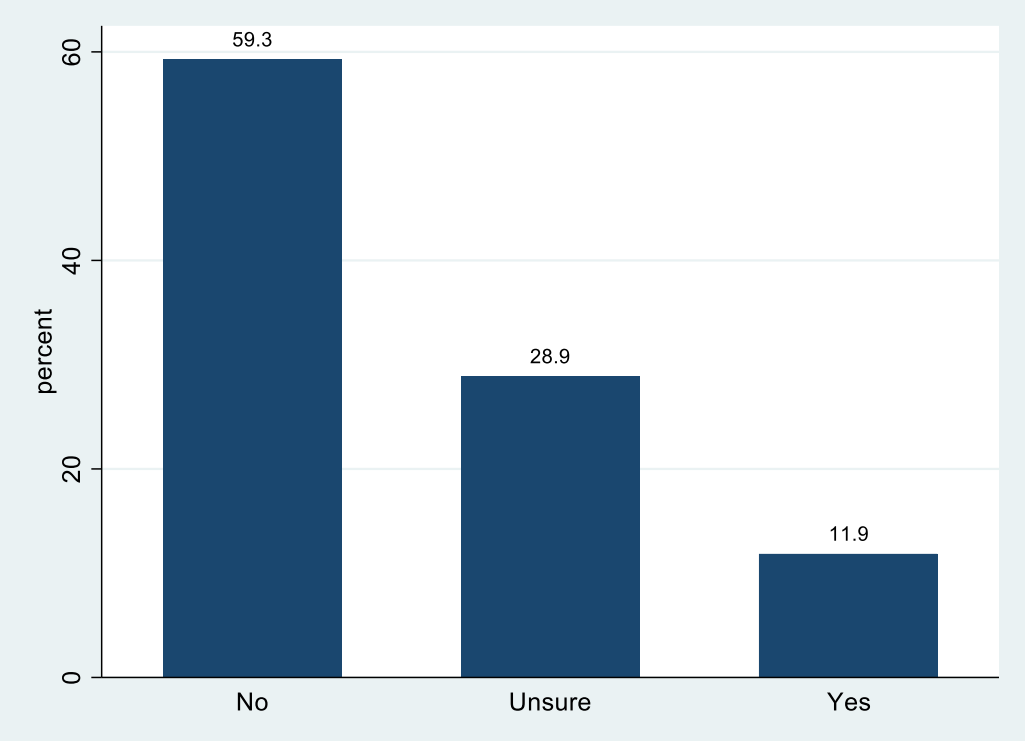
*Are you adequately supported in your current role to liaise with carers and family members of people experiencing mental health problems?*



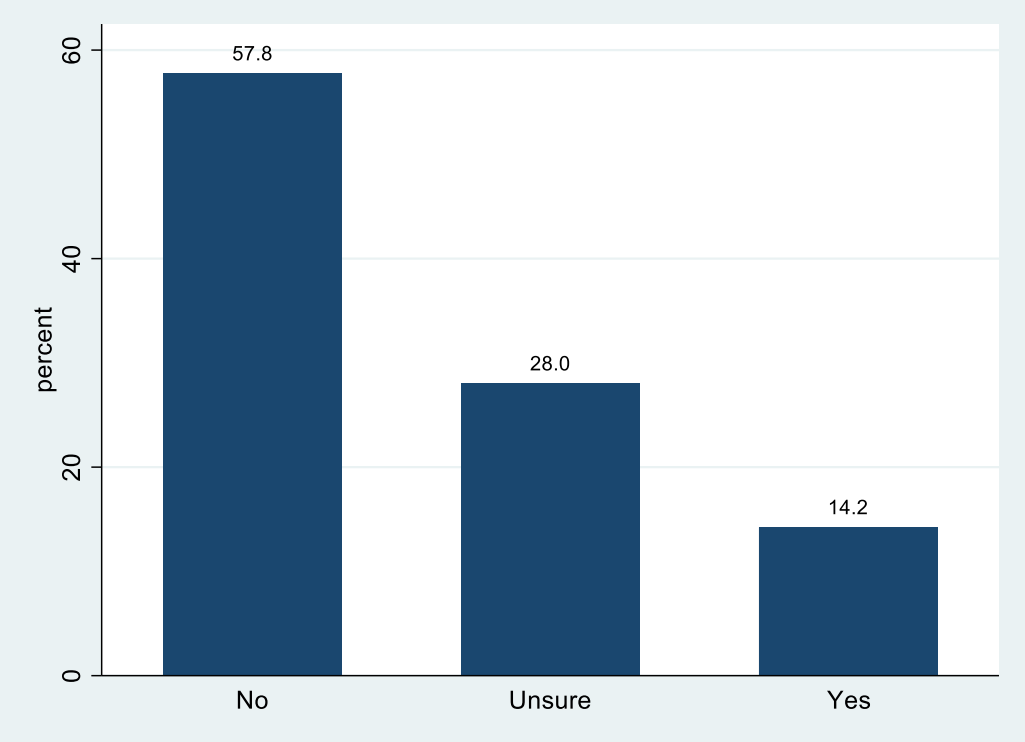

*Do you think carers and family members of people experiencing mental illness are adequately supported by the service system?*



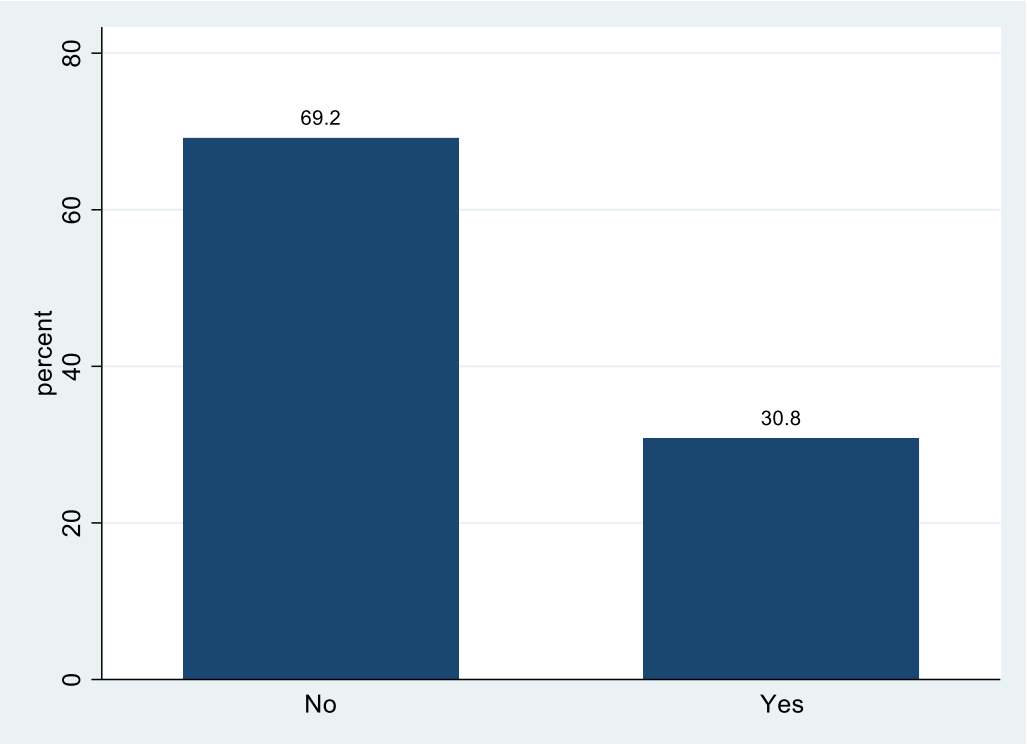
*Do you feel the NDIS has been a positive development for the mental health service system?*




*Do you feel the NDIS has been a positive development for people living with mental illness?*



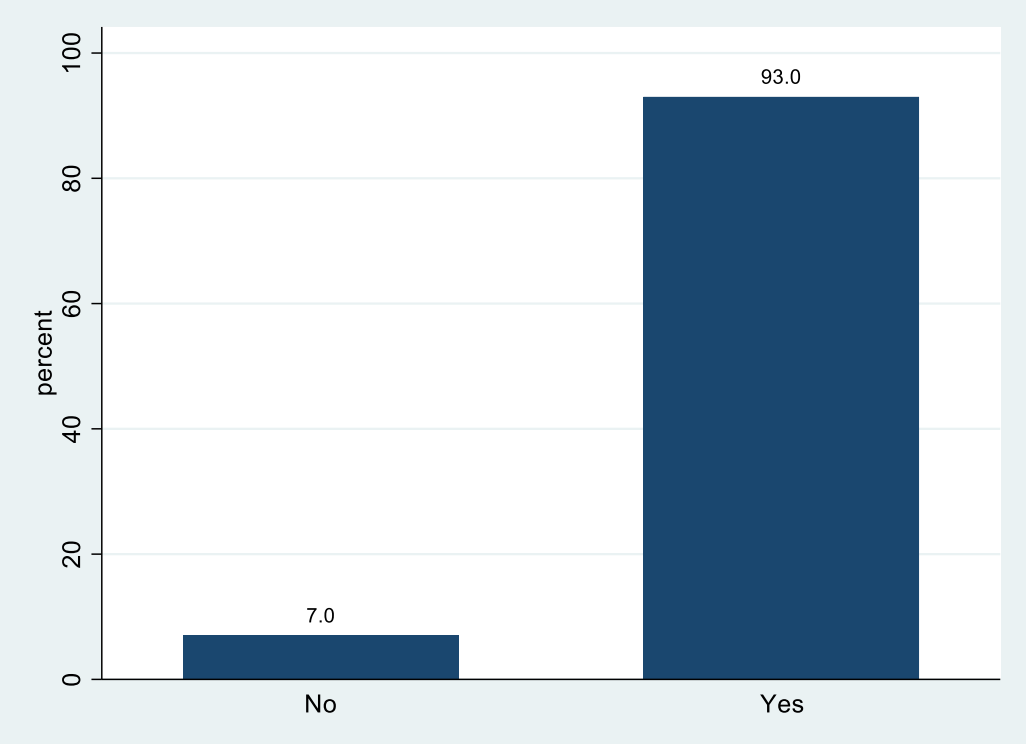
*In the last 12 months, have you been physically attacked in your workplace?*



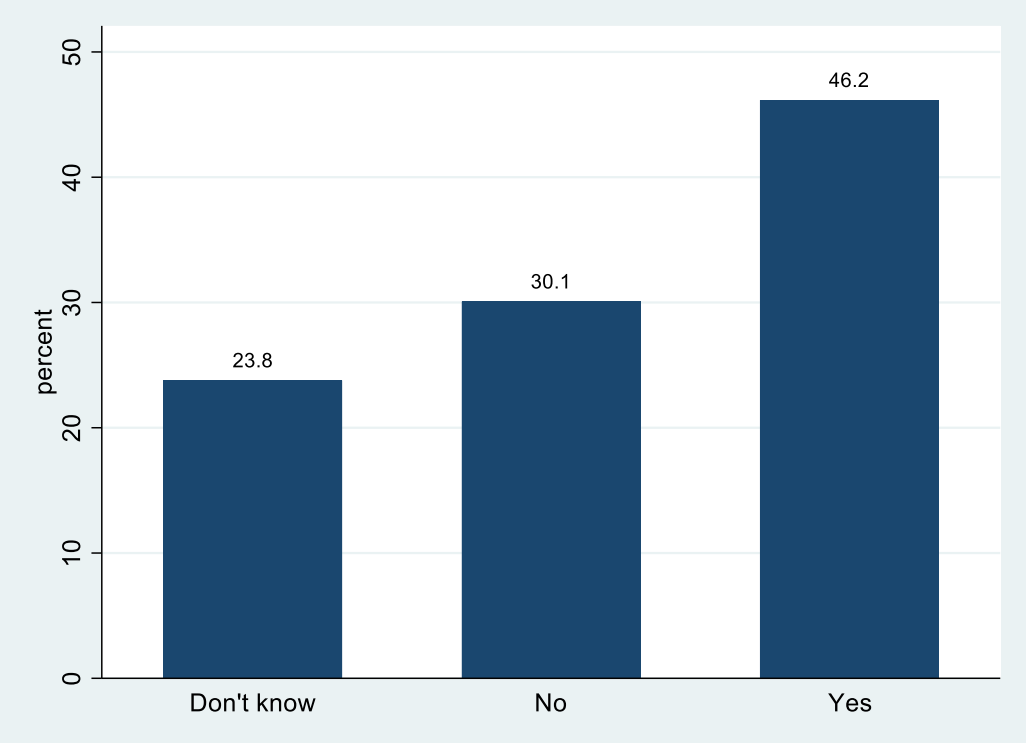

*Who attacked you?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

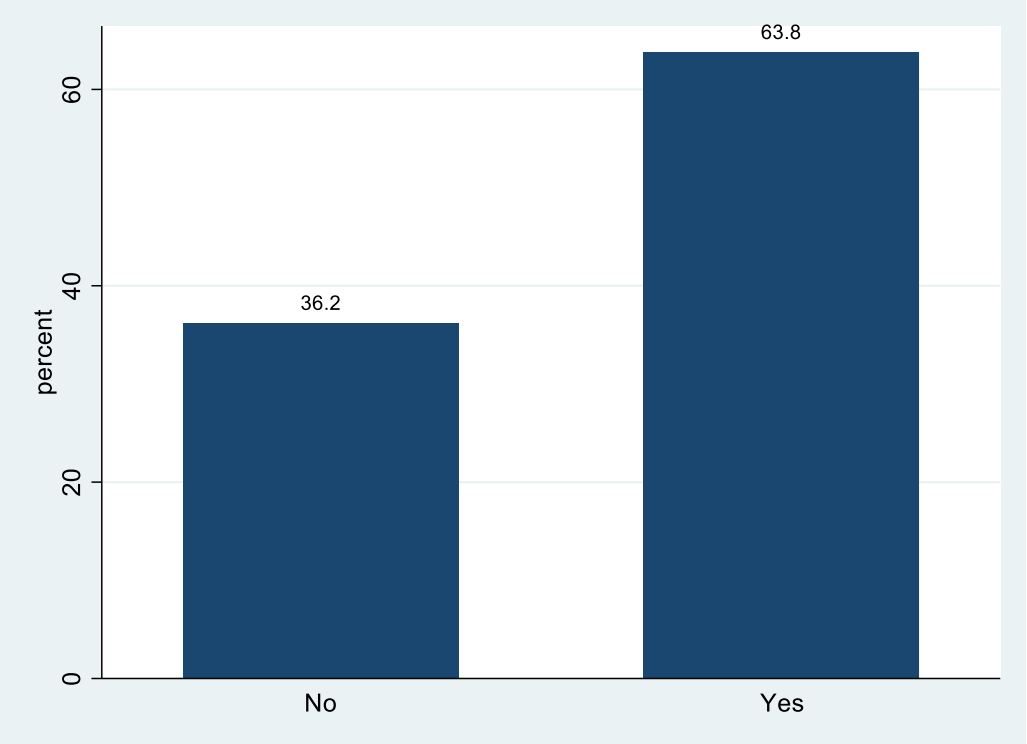
*Did you report the incident to your employer?*



*Was any action taken to investigate the causes of the incident?*

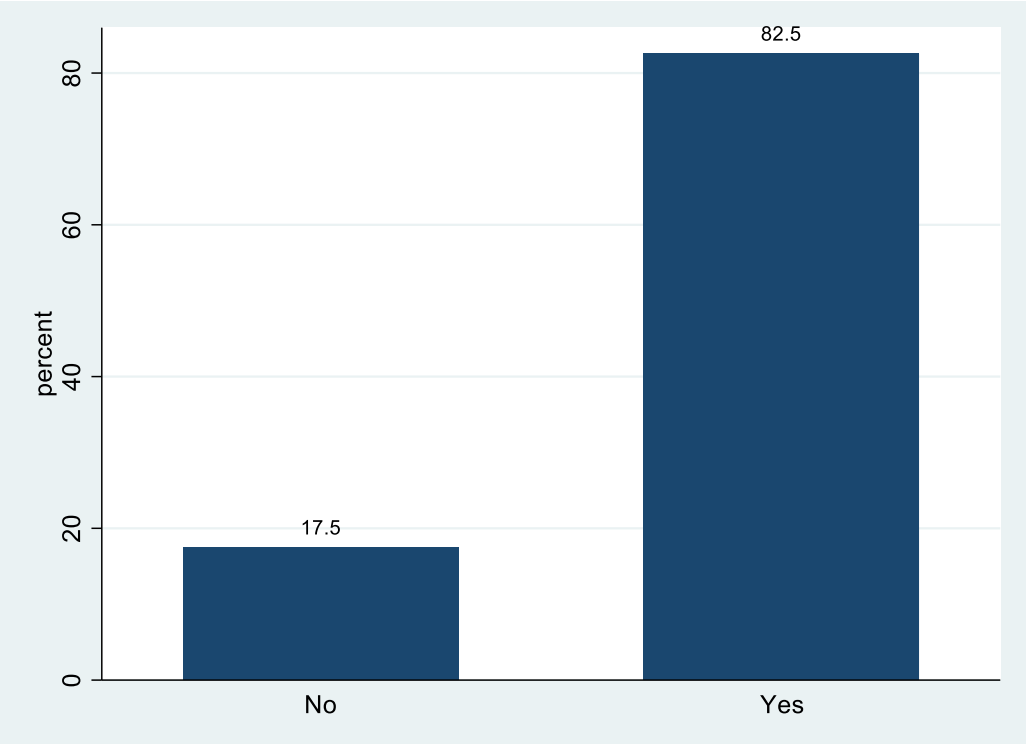



*In the last 12 months, have you witnessed incidents of physical violence in your workplace?*

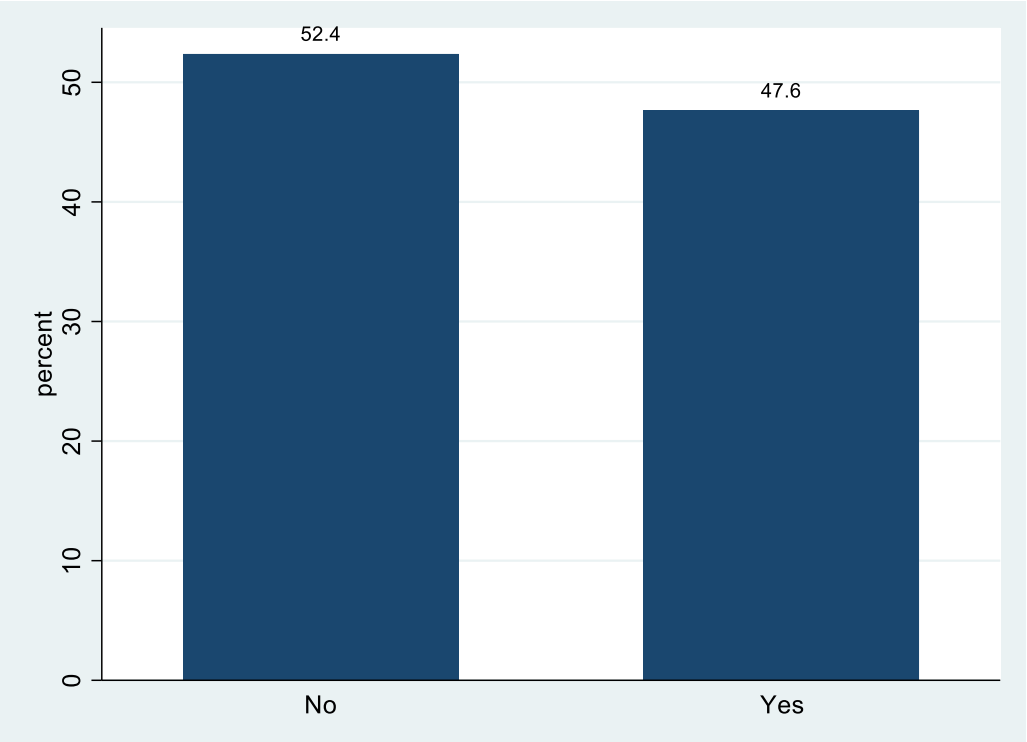


*Do you have any other comments on the prevalence of physical violence in VIC's mental health sector?*
This was an open question and the varying responses were collected and analysed in the main body of this report.

*In the last 12 months, have you been verbally abused in your workplace?*



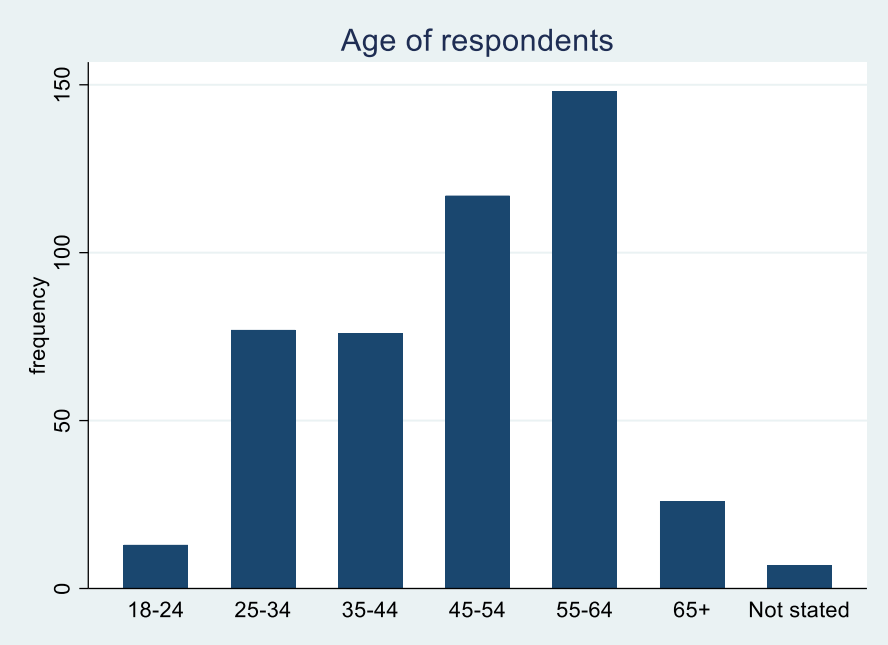

*In the last 12 months, have you been bullied in the workplace by a colleague, manager, or any other employee of your organisation?*



*Do you have any other comments on the prevalence of verbal abuse and/or bullying in Victoria's mental health sector?*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*Into which age category do you fit?*



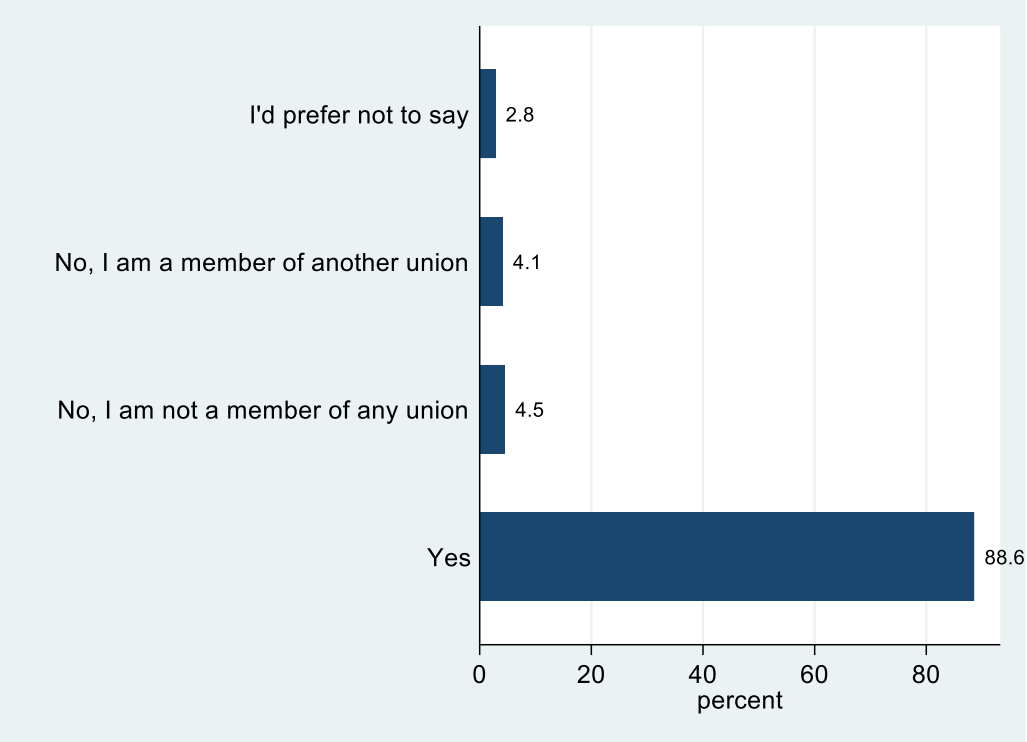

*What gender do you identify with?*

| | |
|---|---|
| Female | 322 |
| Male | 122 |
| Non-binary/other | 3 |
| Prefer not to say | 17 |

*Are you of Aboriginal or Torres Strait Islander origin?*

One respondent out of 464 identified as Aboriginal or Torres Strait Islander.

*Are you a member of the Health and Community Services Union (HACSU)?*




*Do you personally have lived experience of mental health conditions?*

| | Percent | Respondents |
|---|---|---|
| Yes, I have a family member with a mental health condition | 40% | 186 |
| No, I have no personal lived experience of mental health conditions | 28% | 132 |
| Yes, I have a close friend with a mental health condition | 20% | 94 |
| Yes, I have previously had a mental health condition | 19% | 92 |
| Yes, I currently have a mental health condition | 11% | 54 |
| Prefer not to say | 6% | 32 |
| Yes, I am the carer of a person with a mental health condition outside my paid job | 6% | 32 |

*If you have any feedback about the survey, please write it here:*

This was an open question and the varying responses were collected and analysed in the main body of this report.

*If you have any other comments about your experience in the mental health sector in general, please write them here:*

This was an open question and the varying responses were collected and analysed in the main body of this report.

## Appendix II: Focus group questions/themes – notes for focus group facilitators

Begin with a few very open questions that allow people to get the burning items off their chests and also to speak about issues they're most comfortable talking about.

Ask the first few questions and then see where the conversation takes us. The focus groups will be relatively free-flowing conversations that allow the most important issues to percolate to the surface. It's not intended that the facilitator proceed through the list of questions but merely use the questions as a checklist and as a prompt when the conversation needs to move on so that towards the end of the session we can make sure we haven't left out any important topics.

1. Please introduce yourself and tell us a little about your role.
2. What's the best thing about your job or your workplace?
3. What are the main challenges you face in your job?
4. Are these challenges being actively managed or addressed?
5. What single thing would most improve your work situation?
6. Do you feel adequately trained for the work that you do and are others around you adequately trained?
7. Do you have access to training for professional development?
8. How is your workload? Is it manageable or does it cause you stress?
9. Do you feel safe at work?
10. Are there things that could be done to make you safer?
11. What's the culture like in your workplace? (this question is about bullying, solidarity, support etc.)
12. Do you feel that your views are taken into account regarding the quality of services or the employment environment?