Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF SANDRA JOY KEPPICH-ARNOLD

I, Sandra Joy Keppich-Arnold, Director of Operations and Nursing, Mental and Addiction Health, of 55 Commercial Road Melbourne, in the State of Victoria, say as follows:

1 I am authorised by Alfred Health (the **Alfred**) to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

RELEVANT BACKGROUND AND QUALIFICATIONS

3 I have the following qualifications:

(a) Nurse Training, Lakeside Hospital/Box Hill Hospital (1972 to 1977);

(b) Graduate Diploma in Education (Health), Deakin University (1994); and

(c) Certificate in Health Systems Management, Melbourne University (2013).

4 I have over 35 years of clinical and leadership experience in public and private mental health services in Victoria.

5 I commenced employment at the Alfred in 2002, as Associate Director of the Aged Psychiatry Service at Caulfield Hospital. Since 2006, I have held the position of Director of Operations and Nursing, Mental and Addiction Health.

6 I hold the following academic positions:

(a) Adjunct Lecturer at Monash University; and

(b) Conjoint Associate Professor at Deakin University.

7 Since 2002, I have also provided consultancy services in specialist and primary mental health and aged care to various health service providers.

8 Prior to my roles at the Alfred, I was the Manager of Aged Psychiatry Services at Dandenong Hospital, from 1994 to 2002.

9 I am currently, or have previously been, a member of the following committee and panels:

(a) Chief Psychiatrist Quality Advisory Committee (2002 to 2017);

(b) Chief Psychiatrist Morbidity and Mortality Committee (2008 to 2017);

(c) Office of Chief Mental Health Nurse Reducing Restrictive Interventions Committee (2016 to present);

(d) Invited Expert of the National Mental Health Information Development Expert Advisory Panel (2002 to present);

(e) Department of Health and Human Services (**DHHS**) Clinical and Operation Reference Group - Clinical Mental Health Reform Project (2018 to present);

(f) DHHS Progress Measures Working Group (2018 to present); and

(g) Victorian Agency for Health Information (**VAHI**) Expert Advisory Group (2018 to present).

10 Attached to this statement and marked **SKA-1** is a copy of my curriculum vitae, which provides further details of my career to date.

Current role

11 I am operationally responsible for the public area mental health service in southeast metropolitan Melbourne, with a catchment population of about 400,000. We provide mental health and addiction services in hospitals, community residential units and clinics across 12 sites.

12 I have responsibility for leading the nursing and allied health workforce ensuring clinical capability and competence of the nursing program across community and inpatient settings.

13 Many initiatives have involved collaboration with providers of community and primary care, disability support, addiction, employment and housing services. Partners have included Wellways, MIND, Uniting Care Victoria, Sacred Heart Mission, Star (Community) Health, Salvation Army's Access Health, Launch Housing, Taskforce, Odyssey, First Step, Victorian Responsible Gambling Foundation and South-East Melbourne Primary Healthcare Network.

CHARACTERISTICS AND NEEDS OF PEOPLE EXPERIENCING MENTAL HEALTH CRISES

Crises response services needed to manage mental health needs

14 Crisis assessment is an important part of mental health services. There are numerous mental health services in Victoria, many of which do not serve the needs of the community well. The urgent need is for crisis assessment teams to be able to respond assertively to people with drug and alcohol problems and a co-existing mental illness is

a significant service gap across all areas. Many of these clients attend emergency departments but the absence of specialist and responsive outreach services to manage the complexity of a dual diagnosis means the emergency departments are often the only place available to the consumers for response.

15 Furthermore crisis assessment teams in a number of area mental health services have had the function of crisis response integrated into case management teams and this has resulted in a loss of service responsiveness as case managers attempt to juggle the competing needs of clients requiring continuing care, continuing care clients relapsing and requiring additional treatment and support and newly referred clients requiring brief and intensive interventions. The experience from the Alfred is that up to 60% of clients referred to the crisis team do not go onto require case management. For this reason we have continued to maintain a separate response to enable the team to offer timely and intensive short term treatment in partnership with primary care. Without dedicated and specialist teams this function is diminished and results in increasing numbers of people attending emergency departments to seek an emergency response.

16 Advice from clinicians is that the skills required in providing case management as versus intensive, crisis responsive care and treatment are “different” and that having specialist teams enables to staff capitalise on the work that they feel most suited to and competent in and that they derive the greatest satisfaction from. Training and competency frameworks differ across the different functions and teams within mental health settings and by amalgamating functions into single teams these differences fail to be recognised. It is important to understand that the skills and competency required to provide assertive and effective case management are often overlooked which is also to the detriment of the consumer outcomes.

17 Our experience is that consumers require a range of different responses to manage their mental health needs and with the loss of dedicated crises response teams, people with high prevalence disorders are unable to access adequate and timely treatment.

18 As a result, the Alfred provides a number of crisis response services, including the following:

(a) Crisis, Assessment and Treatment Teams (**CATT**);

(b) Emergency department crisis assessments;

(c) Ongoing case management with crises response to known clients by community teams;

(d) The Hospital Outreach Post-suicidal Engagement (**HOPE**) program;

(e) Aged mental health programs;

(f) Therapeutic interventions with specific response to identified groups for example, people with a borderline personality disorder; and

(g) Youth crises response.

19 I address each of these further below.

20 Traditionally, mental health services have focused on consumers with low prevalence disorders, such as psychosis, major depression and other disorders at the more severe end of the mental health spectrum, rather than on consumers with high prevalence disorders. However, an important component of any crisis team or crisis service is ensuring access for consumers with high prevalence disorders often complicated by misuse of alcohol and other drugs (**AOD**) is responded to with the same level of priority as people presenting with serious mental illness.

Crisis, Assessment and Treatment Teams

21 The Alfred's Crisis, Assessment and Treatment Teams (**CATT**) provide outreach assessment and treatment to consumers in the community who are in crisis or require more intensive support.

22 The CATT operates separately to case management services. At least 60% of consumers who access crisis assessment services through the CATT do not go on to access continuing case management services. Often consumers who access CATT have high prevalence disorders, such as anxiety disorders or depression, or are experiencing a situational or familial crisis complicated by misuse of alcohol and other drugs. These consumers can be supported by existing primary mental health services or private psychiatry services following a period of intensive community based treatment and interventions.

23 If the Alfred's CATT was embedded into case management services, these consumers would miss out on accessing services, particularly those who do not have the capacity to access private mental health services. The CATT differs from hospital substitution, in that the model generally requires the client to have a level of support to ensure the clients can be safely managed at home. Hospital substitution services routinely offer additional support to enable self-care and self-management; such as support with hygiene, meals and daily routines whilst the CATT team is more focussed on delivering pharmacological treatments and a range of evidence based individual and family therapies with oversight regarding medication adherence, risk management and response to treatments and therapies.

24 In providing outreach assessment, the CATT conduct risk assessment screenings for consumers who may be at risk of suicide, for example, to ensure there is nothing of

lethality in their home (such as ropes or weapons), and to discuss issues of risk with family members, including options for monitoring the consumer. Risk assessment also takes into account competency to accept and receive treatment, risks associated with relationships, reputation, finances and self-management.

Emergency departments

25 Another form of crisis response is emergency department crisis assessment, which is undertaken when consumers in crisis present to the emergency department.

26 Often consumers who present to an emergency department will also have high prevalence disorders. I discuss the role of emergency departments further at paragraph 51, below.

Ongoing case management

27 At times, consumers within case management teams require a crises response. At times this crises response can be provided through the existing team however in the event that the crises response required is deemed greater than what can be provided through the existing case management team the CATT team can augment the support. These consumers require very assertive follow up including, for example, up to twice daily visits to their home (to ensure they are taking prescribed medications and are eating and drinking), to conduct risk assessments and reviews, to work with family members, and to provide therapies within the home or preferred environment.

Hospital Outreach Post-suicidal Engagement (**HOPE**)

28 The HOPE program provides support and outreach to consumers following an attempted suicide or suicidal ideation, or those at risk of self-harm. Expert and evidenced based psychological therapies are provided in tandem with practical supports. These interventions are reported by recipients of the services as being helpful to recovery.

Aged mental health programs

29 Aged Mental Health programs provide a comprehensive range of services to older people who have grown old with mental illness, who have developed mental illness in old age, or who have a form of dementia with mood and/or behavioural issues that impact on their own quality of life or their carer's.

Therapeutic intervention

30 Another important aspect of crisis response is the provision of therapeutic intervention. This is an aspect of the mental health system which requires development.

31 At present, mental health services are primarily based on a medical model, and treatment has a strong biological approach, including medication management. Some mental health services undertake family therapy work, and provide a range of evidenced based psychological interventions. If mental health services are serious about providing proper mental health care, they need to embed into routine practice a range of evidenced based therapies to ensure consumers are provided with resources that build resilience and capacity to self-manage.

32 Therapeutic interventions can be delivered by a range of disciplines, in individual or group programs. The kinds of therapeutic interventions that support recovery will support the consumer in reducing symptoms (or the impact of symptoms) through structured psychological therapies, promote wellness through exercise, relaxation, mindfulness and other activities, encourage and enable community connection and social participation through group activities, and build skills and knowledge to promote independence. Therapeutic interventions for families and carers are also essential.

33 Investment is required to implement a large range of psychological therapies, particularly in adult services. This is a vital component of providing crisis response services to all consumers. Notably there are specific programs that are occurring in certain area mental health services. The Alfred has established specific programs to support consumers therapeutically when they have a borderline personality disorder, including programs to support establishing and building social relationships (such as rel8) and cognitive remediation. This is not routine but needs to be.

Common characteristics of people in crisis

34 A person in crisis is generally considered to be someone who is at risk of causing serious harm to themselves or to another person, or who is at risk of experiencing a serious deterioration in their mental or physical health.

35 The common characteristics of a person in crisis include someone who is displaying erratic and difficult behaviours; is not able to be negotiated with; is not coping and is not able to be contained in their current environment, whether that be at home, at work or in the community. Often these people find that the relationships or resources they would normally use for support are unavailable to them. Increasingly, people in crisis present intoxicated with alcohol or other drugs, and it is not uncommon for their behaviour to have triggered engagement of police or other emergency services. People with self-harming behaviours are also seen in crises, more often in the emergency department. As a result of significant and serious self-harm patients are admitted to trauma wards and there is a requirement for effective and expert consultation liaison services to provide advice and treatment. A diagnostic group of people with intellectual disability or an acquired brain injury presenting with psychological distress and/or behavioural

problems are a consumer group often requiring CATT involvement largely because of the absence of other appropriate services to respond to their needs.

36 The Alfred CATT attends and conducts assessments of people in the community who are in crisis, whether at their home, a GP surgery or a police station. If a person is in crisis in a public space, they will usually be brought by police into the emergency department at the Alfred for assessment. If they are in their own home, CATT will attend.

ROLE OF CRISIS OUTREACH TEAMS

The role of crisis outreach teams in future mental health systems

37 The Alfred still has a very strong commitment to providing a CATT and does not intend to dismantle that program.

38 The CATT plays an important role in providing emergency outreach and short-term treatment to consumers in the community. This model is highly effective in providing treatment to consumers, 50-60% of whom will not go on to have a long term mental health services involvement to assist them to get back on their feet.

39 A number of consumers of CATT's services already have private psychiatrists or psychologists, and require the assistance of CATT during situational or other crises. For those consumers, the CATT provides adjunct treatment. Without this support and treatment, these consumers might end up requiring ED or hospital admission. Family support inclusive of psycho-education, and to some extent capacity building to support family coping and understanding is also an important component of what is on offer. Treatment not only refers to the prescribing of medications but also to assisting consumers to develop coping strategies in response to their symptoms and/or distress.

40 The CATT model implemented at the Alfred was designed as a partnership model, reflecting the area in which the Alfred works, which has many private practitioners. The Alfred has strong relationships with private providers. If consumers in crisis are not linked with a private provider, CATT can arrange this if they require follow up treatment.

Comparison of current CATT services and CATT services described in the 1990s 'frameworks for service delivery'

41 The present CATT model is very different to that implemented in the 1990s. It is a superior model. The model established in the 1990s was developed following de-institutionalisation of the mental health system, where consumers with long term mental health problems such as schizophrenia, bipolar disorder and other forms of serious mental illness were moved out of institutional mental health services. At that

time, there was no alternative system to care for those consumers, and as a consequence CATT services focused on consumers with low prevalence disorders, first presentation / early psychosis treatment pathways.

42 Today, the Alfred's CATT operates in a different context. In particular, the CATT responds to and treats a greater number of consumers with high prevalence disorders. While previously the CATTs were comprised of only doctors and nurses, it is now an increasingly multidisciplinary team which includes social workers, occupational therapists and psychologists. All staff are competent in AOD issues, with a few holding post-graduate AOD qualifications. The Alfred continues to consider ways to refresh the CATT model. Specialist early intervention / early psychoses teams provide specific, evidence based treatment to young people with psychoses and who are experiencing mental illness for the first time.

43 One shortcoming of the current CATT model is a lack of continuity of care. Patients in crisis receiving services from CATT would be better served by being treated by the same clinician each day, rather than different clinicians. This difficulty arises as a result of rostering requirements which must be managed over 24 hours / 7 days a week.

Possible locations for crisis outreach function

44 The Alfred CATT is attached to The Alfred Hospital, and is integrated with the functions of bed management, emergency psychiatry (ED model), the Police and Ambulance and Community Engagement Response (PACER), and telephone triage. The CATT staff are rostered across all teams, which ensures that staff are exposed to a variety of work which minimises staff burnout. A shortcoming of this is the resulting lack of continuity of care.

45 There is no reason why a CATT would be better located in an ED. At present ED's are serviced by emergency psychiatry clinicians who can readily transfer care to CATT should community follow up be required. It is usual practice for telephone triage clinicians to discourage presentation to the ED where this is safe and practicable. Emergency Departments are not conducive to therapeutic engagement; they are time and space pressured, offer limited privacy, and often chaotic environments that can be more distressing for people in crisis. It is also of note that the relationship CATT have with the inpatient and community mental health teams is as important as the relationship experienced with the ED.

46 CATT is primarily a community program and many services take on the priority of the areas they are based within. Locating CATT services with emergency departments potentially would risk the community focus that is critical if the priority is to divert people from the emergency department. The experience that the Alfred had with the PACER

program demonstrates how the base for the program influences its responsiveness and the ultimate utilisation of what is on offer. At commencement of PACER, the decision was to base the mental health clinician with the CATT team rather than at the local police station, with the plan that police would pick up the clinician as required when calls were made for PACER response. This approach led to a low utilisation of the PACER clinician. A further decision to relocate the program to the local police has resulted in an increase referral pattern and reduction in call out to CATT or diversion to the emergency department.

COMMUNITY MODEL

Availability of services for people unable to attend clinic or centre based services

47 Outreach services are a critical component of mental health services. The ability to assess consumers in their home environment or elsewhere in the community is vital.

48 Around 50% of the activities undertaken by Alfred's mental health services are outreach services. This includes performing home assessments for consumers both in crisis and not, and seeing consumers in the community where they want to be seen, whether that is at home, in a park or in another public space.

49 We cannot expect to understand the context in which consumers are required to recover without this being part of the assessment. In my experience, a failure to do so often leads to a failure in treatment. Our ability to assess a consumer in a clinic environment is limited, they may present a different version of themselves in an office or clinic environment to when they are at home. We have a far better capacity to assess someone in their home environment. For example, we may see that a consumer lives in poor conditions, or does not have food in their fridge which allows us to understand their illness in context. It enables us to build a strong relationship with consumers and can be an important leverage in encouraging consumers to buy in to their treatment.

50 Outreach services should not be provided for all consumers, as it is important for people to take ownership and charge of their own health. However, it is absolutely critical that we provide an outreach response in some way, as it is an important component of the mental health services that we provide.

EMERGENCY DEPARTMENT RESPONSES

Resources available in Victorian emergency departments for people experiencing mental health crises

51 The resources in emergency departments are insufficient to respond to mental health crises.

52 The level of resources varies between hospitals across Victoria. It is my understanding that some hospitals have in their emergency department only the resources that are funded by the mental health branch of DHHS, It may have changed but in the past Monash Health, Austin Health and NorthWestern Mental Health stated that the Alfred Hospital was unique in that it provided additional support to manage the response to mental health above the funding levels. This is often in the form of a consultation liaison model, with a nurse based in the emergency department (or elsewhere in the hospital) to perform assessments as consumers present to emergency.

53 In 2013 the Alfred decided to fund additional resources to establish a Mental Health-Addiction Hub (**ED Hub**) and service stream in the emergency department at The Alfred Hospital. The model was developed out of the Alfred's awareness that the emergency department model did not provide a safe and calming environment for people in distress, and often allowed insufficient time for clinicians to engage people in brief therapeutic interventions that would support a more timely resolve to the crisis. The crisis hub model brings together mental health and emergency department resources, within a dedicated setting in the ED to provide more comprehensive observation and care. The ED Hub has led to a specialist environment for mental health assessment and treatment for people requiring brief interventions and support that might otherwise have required a short hospital admission. The Alfred does not have a Psychiatric Assessment and Planning Unit and this area provides an alternative but still less than ideal model for mental health short stay. Investment in post discharge support for AOD issues is still lacking.

54 The Alfred has two (core) mental health clinicians rostered in the emergency department over a 24 hour roster. The positions are further augmented by a (Monday – Friday) drug and alcohol nurse, a psychiatric registrar or nurse practitioner working morning and afternoon shifts to provide assessment and treatment within the emergency department and a rostered mental health nurse providing direct care and working within the ED Hub known as the West Wing.

55 To address the issue of wait times for mental health assessments and the risk that consumers presenting to the emergency department may leave and cause harm to themselves, the Alfred implemented a fast-tracking system.

56 As a result, every mental health presentation to the emergency department, whether by ambulance, police or self-presentation, is responded to and fast-tracked in the same manner as a major trauma. An emergency department consultant, triage nurse and security are paged to attend, and a mental health triage nurse conducts an assessment.

57 This initiative ensures that no consumers who present with a mental health concern, regardless of the nature of the mental illness or concern, will wait in the emergency department waiting room.

58 In circumstances where the person has been transported to the ED by police, an immediate response is provided that allows for immediate risk assessment and a determination of safe disposition of the person to an appropriate clinical area. This allows police officers to leave the emergency department without waiting. The team consists of an emergency physician, ED resource nurse, mental health clinician and security officer.

59 The triage initiative has been very successful in ensuring that mental health admissions are assessed without delay. It has also been favoured by police, to the extent that police officers will often travel to the Alfred rather than a closer hospital to ensure that consumers are assessed immediately and that officers are not required to wait in the emergency department as they would need to do at other hospitals.

60 This has put increased demand on the Alfred's emergency department. We are working closely with police through liaison meetings to ensure that police understand that if consumers are known to a mental health service in another area, they have a responsibility to take them to the emergency department in that area, rather than to the Alfred.

Potential investments or actions to improve ED responses

61 Despite the above initiatives, additional resources are still required in the emergency department to treat and contain mental health patients, and to ensure they do not deteriorate or require sedation or restraint.

62 Investment in more welcoming, private, less chaotic, yet safe environments would be of benefit with the inclusion of peer models would be advantageous.

Potential alternative services for people in crisis

63 In addition to the emergency department initiatives outlined above, the Alfred has a four-bed mental health short stay unit, ED Hub commonly referred to as the West Wing. Patients are admitted to the West Wing for up to 24 hours, allowing a more comprehensive assessment and commencement of treatment. It also enables family members of patients in crisis to be contacted, and for consumers to be linked to private providers.

64 The Alfred also has a Behaviour of Concern (**BOC**) room in its emergency department. The BOC room exists to ensure there is a dedicated space available for timely

assessment of people who are distressed or agitated. It offers a safer environment to general emergency department bays, and offers more privacy. The BOC room is intended for brief use when the person first presents to support rapid decision making about their care.

65 St Vincent's hospital in Melbourne has developed peer led interventions to support alternate options for people presenting in crises. I am not aware as to the impact they have had on ED presentations although the anecdotal feedback from consumers has been of a positive experience. UK mental health service models offer extensive post discharge support and specialist treatment for clients presenting to hospitals in crises with AOD problems. Residential programs for young people and their families experiencing eating disorders have been trialled with success in New South Wales. This program has been considered within the Alfred catchment but relies on significant investment to implement.

66 HOPE teams have been established to reduce the representation of people with suicidal ideation. These programs are subject to review at this point.

THE ROLE OF POLICE

67 Police assistance is absolutely critical to ensure the safety of workers and consumers in the mental health system.

68 Police officers provide backup and safe transport to crisis teams when they are required to attend uncertain, unstable or potentially volatile situations in the community, and to secure a safe environment for mental health clinicians. This includes not only where staff or consumers are at risk of harm from a consumer, but also involves providing safe passage to staff and consumers in potentially unsafe locations, for example where other residents may pose a threat to safety. Police also provide valuable assistance in conducting welfare checks if teams are concerned for the welfare of a consumer in the community.

69 In addition, police support or assistance is required in the following circumstances:

(a) to support staff members who have been assaulted by patients, including if they wish to lay charges;

(b) to support patients who experience sexual assault, recognising that wards are mixed gender and as a result, patients may be at risk of sexual assault; and

(c) on occasion, attending 'code black' calls in inpatient units, where patients are extremely aggressive.

70 While at times some police officers hold stigmatising views about people with mental illness, and their role and responsibility to respond to people with a mental illness, which can be problematic, other officers are assets, supporting engagement, and are very keen to assist mental health workers. Police assistance will continue to be required by our teams due to the violence that staff and consumers are exposed to, and is critical in an 'ideal' mental health system. They are also essential to ensuring people can be transferred to a safe environment at hospital as many people experiencing mental distress will not attend voluntarily. These situations can be extremely dangerous for consumers who may be scared and act impulsively, putting themselves at risk.

THE ROLE OF AMBULANCE SERVICES

71 People experiencing a mental health crisis should always be transported to hospital by ambulance. While that is the ideal situation, this is not possible given the limited resources available.

72 A common situation faced by the CATT, case management and homeless outreach teams (HOPS) is waiting too long for an ambulance. This issue arises almost weekly for mental health services at the Alfred, and clinicians often decide to transport consumers to hospital in their own vehicle. This can be dangerous for both clinicians and consumers – clinicians are at risk of being assaulted by consumers who cannot be restrained, and consumers can be a risk to themselves. Clinicians balance this risk against the risk that a consumer may abscond while waiting for an ambulance.

73 At times, if teams cannot get an ambulance in time, they will call police for assistance. Whether the police are able to respond often depends on the resources available to them at the time and the priority they place on assistance to the team. There is little transparency as to the resources available and any competing demands. It is not uncommon for ambulance services to attend and assess that the person cannot safely be transported by ambulance, and then make their own request for police attendance which is an inefficient use of resources, and extends the duration that the person is at risk in the community setting.

COLLABORATION BETWEEN POLICE AND EMERGENCY SERVICES

Strengths and weaknesses of the collaborative models

74 The Alfred was one of the early health services to trial the PACER program. The PACER team responds to mental health crises in the community, together with a member of the police.

75 At the Alfred, one senior mental health clinician from the CATT is rostered to work in the PACER program which operates for one shift from 2.00 pm to 10.30 pm each day.

Initially, the PACER and CATTs were co-located as the team were concerned it would lead to periods of "down time" and that if the clinician was based within the hospital team they would be able to assist with triage calls, emergency department response or CATT response. The reality was that this rarely happened and the police experienced delays in having to collect the PACER clinician from the Alfred so that they could attend the call. After review, the decision to co-locate the PACER clinician at the police station was made and the program has been far more successful.

76 A challenge experienced following the implementation of the PACER program was that the CATT staff saw the work done by PACER teams as being focused more on psychosocial and AOD issues rather than 'pure' mental health. Over time the team have seen the benefit of responding to a broader range of mental health issues rather than a more defined criteria of mental illness.

77 The work undertaken by PACER often involves family violence situations and/or consumers with AOD misuse issues. PACER teams operate primarily in the afternoons and at night, which is the time family violence tends to be more prevalent, and when alcohol is being consumed.

78 The program has been successful in that it has lowered the bar in terms of the community being able to access mental health responses. It has also enhanced the understanding of mental health for many members of the police force. PACER-type programs have a role in the mental health system of the future. Initially, our view was that if all mental health services had a CATT, they would not need a PACER. However in our experience, police may not always wait for mental health services to attend a situation (in the same way that our teams cannot always wait for police or ambulances to attend). It is also valuable to have police and mental health clinicians working collaboratively to enhance the understanding of mental ill health within the police force.

79 The PACER program has played an important role in helping to reduce the stigma associated with mental health for police officers, providing officers with a lens through which to view situations that they may have ordinarily had.

Critical components for successful collaboration

80 Being able to design the model with police, and working in a collaborative framework, was critical. PACER is not uniform across Victoria, which is unlike the system design for mental health services across the rest of Australia, where such programs are more defined. In Victoria, each mental health catchment area designs and develops the program according to local requirements.

81 There are benefits to this, as what works in one area might not work in another, however there are also weaknesses, such as community expectations may not be met

in one area because program design and delivery has locally evolved and has considered different responses within the design. Responding to service planning within unique catchments is best undertaken with co-design methodology.

Examples of collaborative models from other jurisdictions

82 South Australia have implemented a model similar to PACER but with ambulance officers rather than police whereby Mental Health Clinicians and ambulance workers provide a single response. This model is being trialled in the Geelong area. The RAMP panels to discuss and respond to victims of family violence are another example of collaboration between Victoria Police and mental health services.

ROLE OF MENTAL HEALTH TELEPHONE TRIAGE SERVICES

Strengths and limitations of current telephone helpline services

83 Mental health telephone triage services involve more than just triage. Helpline staff are required to determine consumers' need for treatment, and it is difficult to have a "one-size-fits-all" approach.

84 A limitation of current helpline services is the variability in responses between catchment areas, with varying thresholds for admission in different catchments. This means that callers in some locations may be assessed and receive treatment, while those in other locations may not, leading those consumers to miss out. Some consumers will design their responses to reflect what will enable them to receive treatment.

85 There is also a variability between triage workers within the same service, as the decisions involved are subjective based on the information being given by the caller. The Alfred works to reduce the variability of the service by undertaking a clinical review of every telephone triage call received. This involves an experienced or senior clinician with the power to overturn decisions made by triage workers reviewing each case. While this is a time intensive process, it provides accountability for decisions made by triage workers.

Role of telephone helpline services in future mental health systems

86 Mental health triage services, when resourced adequately, allow callers to talk through their own mental health concerns, or concerns they have about someone else. These interactions are not only valuable in detecting the presence of mental illness and need for assessment, but also to provide general mental health or wellbeing advice and linkages to allied services such as AOD treatment services, disability, or family support services. Mental health triage is a vital support to GPs, and private practitioners and it should continue to serve these functions.

87 The Alfred has conducted research into triage and worked on developing modules for triage training, which include competency framework. To enable telephone helpline services to perform their role well, decision support tools must be developed to assist triage workers in assessing situations against particular criteria and identifying whether a situation needs to be escalated.

88 Decision support tools would be of particular benefit to unskilled or junior workers. At present, there are inadequate systems in place to assist such triage workers to identify when a situation needs to be escalated for a patient in crisis.

89 Further work needs to be done to identify when a consumer or caller is experiencing a deteriorating mental state, and what to do when that occurs. By thinking laterally, mental health services can learn from and adopt systems from other health services and apply them to mental health.

Other innovative approaches to triage

90 Mental health or illness is a subjective 'human' condition and as such, decision support tools and clinical screening tools and questions are better placed to assist in the decision making than digital algorithms

91 The Alfred does not use FaceTime or other audio-visual means for telephone triage as a secure and encrypted platform is required. Endorsed Telehealth platforms and innovations are being considered more closely as a result of COVID-19, as teams will not otherwise be able to conduct assessments for patients who are self-isolating or in quarantine.

92 Chatbots used in other service industries that are used to answer queries when a person is online could offer some benefit in reaching out to people when they are browsing mental health service internet pages, however much of mental health triage work is undertaken by the clinician's impression of the person in conversation and by unspoken things that they notice. Triage could not be safely or robustly conducted via Chatbot, however helpful prompting, and supportive encouragement to reach out could be of benefit to those reluctant to do so. These could also be helpful in directing the person to the right service to make their enquiry. Mental health triage wait times can be long, and it is frustrating for people to wait on hold and then be told they are better served by another area mental health service, program, or provider.

93 The Alfred's Child and Youth Mental Health Service (**CYMHS**) utilises digital means to communicate with consumers more than other services, as the use of such systems are often activated by the consumer, for example if they call in using FaceTime. The CYMHS also utilises options such as text messaging and email to send links to services and programs such as anxiety management or psychological therapy to consumers.

94 The development of digital platforms and other innovations for telephone triage, and for the mental health system more broadly, is important for the system of the future. However, the potential consequences of clinicians giving advice over unsecured lines and/or how such platforms can be secured will need to be carefully considered.

95 Telehealth services have been adopted during COVID 19 and with resourcing can offer an important adjunct to triage through offering brief intervention at the point of contact and offer limited follow up for people requiring anxiety management. “In-person” responses remain the best approach for assertive treatment and for deteriorating patients, but the use of telehealth as an adjunct is useful.

96 However, telehealth systems may be the most effective way to assess remote or rural consumers who are in crisis or deteriorating, and to provide intervention and support. The Alfred has provided support to other rural mental health services through telehealth, and will continue to do so, however this is generally not in crisis situations.

ALCOHOL AND OTHER DRUGS

Best practice service response

97 A best practice service offers the skills, knowledge, capability, and environment necessary to address a person’s mental illness and alcohol or other drug issues simultaneously. It would not require repeated re-assessment of a person’s AOD issues at each transition in care because the AOD support could integrate with each element. A best practice service would offer individual and group therapies that range from harm prevention and education, to motivational interviewing, and manualised group programs to support the person through stages of change. A best practice service would ensure these interventions are available as standard. A best practice service model would ensure environments are available to support detox when a person has a co-occurring mental illness, and transition to a rehabilitation service with robust mental health staffing and support. A best practice service would invest in lived experience support workers for both consumers and families and carers.

Best practice service response for young people and adults

98 Best practice service responses for young people must be family inclusive and ensure the family system is considered. Whilst this is also an important component of adult mental health services the emphasis is different as many consumers of adult mental health services do not live with family members and the *Mental Health Act (2014)* (Vic) places emphasis on consent in regards to sharing of information. This balance can be difficult in adults when consent is not given by the consumers to speak with family members.

99 Services at their best are co-designed and co-delivered. The Child and Youth mental health services within the Alfred have achieved this to a greater extent than adult mental health services have. This is an important element for all services to embrace but to date CYMHS have been more successful in this engagement.

Defining 'integrated care'

100 Integrated care means that a person's co-occurring needs can be addressed simultaneously, and that each element would not be interrupted by the change of activity of care focus of the other. For example, should a person's mental health deteriorate this should not mean that their AOD treatment stops, or has to change. It should continue in a form that adapts. Integrated care also means that clinicians in both specialty have sufficient skill, knowledge, and capability to work in a way that acknowledges the other.

Structures specific for people living with both mental illness and problematic alcohol and other drug use

101 Mental health and alcohol and other drug services are currently not funded or governed by a shared body and as such consumers experience care as being in two very different streams. Consumers often experience barriers to AOD treatment because of their mental illness. In a redesigned future system this would not be the case. Detoxification facilities for example would have adequate mental health clinical expertise embedded to support people with both mental illness and AOD issues to access and remain in treatment. This would also be true of rehabilitation. Consumers would also experience less frustration with accessing prescription opioid replacement therapies which is not a usual practice of most psychiatrists.

WORKFORCE

Significant issues facing the mental health workforce

102 Adequate tertiary training and preparedness of graduates for practice is a critical issue. Mental health services assume a significant responsibility for the training of health service mental health professionals. Continued supply is also a significant issue as public mental health is not largely considered a prestigious career, and people can earn more money in less challenging environments.

Occupational violence is also a significant issue. Challenges to achieving collaborative, cross-disciplinary professional practice

103 Disciplines are keen to protect their skill base and their points of difference between different craft groups. The capacity to understand what is core to mental health skill sets and what is expert ensures discipline recognition is maintained and valued. It doesn't

mean that nurses cannot lead specific therapeutic programs or interventions, or that occupational therapists cannot be rostered into direct care roles in mental health units. What is important is that different disciplines apply their own lens to the activity and this is shaped by their training, knowledge and experience. The challenge is to ensure that the outcomes are identified and articulated to ensure benefit to consumers.

104 Across different settings the value of disciplines varies and skill sets are valued differently. Undergraduate and post graduate training prepares craft groups differently for specific areas. For instance nurses wishing to work within speciality areas providing evidenced based interventions will require different preparation and training to achieve knowledge and capability to other allied health and psychology staff groups that are generally better prepared during undergraduate training in regards to mental health.

105 There is also a financial challenge in that different disciplines have different rates of pay. This can become an industrial issue if staff are paid to undertake a generic or undifferentiated role but are paid at either a substantially lower or higher pay grade than their colleagues undertaking the same tasks.

Access to specialist addiction expertise

106 Understanding problematic alcohol and other drug use is a core competency requirement for staff working within mental health services. Staff need to be able to screen and respond to management of AOD issues across all adult mental health settings. Within services there is value of having advanced practice staff to complement staff working with core competencies.

107 All members of the Alfred CATT have the core competencies of AOD, suicide prevention, family violence and core mental health issues, and have all completed advanced suicide prevention training.

108 AOD competency and motivational interviewing is standard to core skills for all clinical staff at the Alfred, regardless of their role or area of speciality, complete the basic core competencies within a reasonable period of time after starting at the Alfred. The workforce team provide reports to managers on completion rates for core skills undertaken.

Workforce organisation for holistic support for consumers with co-occurring conditions

109 With the expansion of demand for mental health services over the past few years, the Alfred has been required to consider how to build capability for its workforce. We are currently preparing curriculum to support nurses and allied staff in the CATT. We have developed a comprehensive workforce model to support post graduate learning for staff transitioning to specialist areas. These areas include the Adult Community Case

Management team, the Homeless team, the Mobile Support and Treatment Team, the Child and Youth Mental Health Service and the Mobile Aged Psychiatry Program and this program has now been extended to include the CATT.

110 The CATT has also lost experience and capability in this expansion, as a result of senior and experienced clinicians moving to senior positions in community teams or specialist positions in other teams (where shift work is not required). This capability needs to be rebuilt. Through establishing post graduate training in the CATT team learning and development is supported for novice staff to develop skills and capability. CATT work is complex and risk assessment in community settings is nuanced, therapeutic skills and providing evidence based therapies is not part of any mandatory curriculum. The expectation of staff developing skills in mental health settings has been about having experience. Through provision of peer mentoring, practice development and training models the approach to skills development is much more intentional and it is this approach that will ensure capability is built and enable staff to be able to practice as a novice and with the support of active supervision and learning achieve not only competency but also expert capability.

Necessary structures

111 Workforce development teams that provide structured learning and development opportunities for staff is an important component of maximising the capacity and capability of professional groups. Ensuring staff have protected time for supervision and mentoring is critical. Competency frameworks that support staff learning and development through observation, supervised practise leading to independent practice have been helpful and necessary to develop skills and build capability. Establishing discovery colleges as learning and training hubs is an opportunity to develop the tradition of co-facilitated learning for staff, consumers and carers. A recent trial at the Alfred provided the inpatient staff to undertake a training session on psychiatric medications with consumers, carers and staff instigated through the discovery college. The session was planned and co-facilitated by a consumer peer worker and psychiatrist. The evaluation of the content, engagement and collaborative learning by all participants (consumers, staff and carers) was extremely positive.

RESTRICTIVE PRACTICES

Psychological and physical impacts of restrictive practices on consumers

112 Restrictive practices can involve seclusion or physical or mechanical restraints.

113 These interventions can be distressing and traumatising for patients, particularly for patients who have had traumatic experiences in their past, where restrictive practices can replicate that trauma.

114 When referring to restrictive practices, I am referring only to seclusion and physical or mechanical restraints, and not to chemical restraints. It is difficult to define the concept of chemical restraint, as medications that have a restraint effect are primarily administered for the treatment of a patient. In managing patients experiencing severe psychotic distress or drug withdrawal, for example, those patients may be administered medication that may have the effect of calming or sedating them. There is a duality of purpose, as while the effect of the medication may sedate the patient, it is administered for treatment purposes.

Psychological and physical impact of restrictive practices on mental health service workers

115 Restrictive practices can also be traumatising to mental health workers, particularly on the first few occasions that workers are exposed to them. Clinicians may become desensitised to restrictive practices over time.

Challenges in reducing restrictive interventions

116 Reducing restrictive interventions is complex and is complicated by factors including:

a) the rates of illicit substance use on inpatient units and levels of aggression;

b) the physical nature of the inpatient units. Patients are often required to share bedrooms and bathrooms resulting in a loss of privacy that can increase patient distress. Inpatient units are also crowded with little access to break out space for consumers;

c) workforces on the inpatient unit are generally the most junior with graduate and post graduate nurses making up to 30% of the staffing profile;

d) managing competing demands. The time to undertake routine tasks including medication administration is a task that takes considerably longer than expected. A time and motion study reflected that to provide medication in a therapeutic way took 7 minutes to prepare and administer for each patient. This is largely under recognised in the organisation of wards and frequently nurses are interrupted in undertaking these core but routine tasks; and

e) Allied health staff programs operate Monday to Friday with little emphasis on activities beyond these days.

117 The Alfred has succeeded in reducing seclusion rates to a current rate of 5 episodes per 1000 bed days, through a range of interventions.

118 Initially, some medical staff were sceptical of such interventions, fearing that they would experience more aggression and assaults from consumers. Many nurses were of the view that they would be holding the risk for longer, or that their authority and autonomy had been taken away. The interventions implemented at the Alfred (discussed below), involved clinicians responding to situations to discuss options with nurses and attempt de-escalation techniques, rather than using restrictive intervention.

119 This was initially perceived as showing the nurses a lack of respect. De-escalation techniques also require much more engagement with the patients, and can be exhausting for nursing staff.

Alternative strategies

120 Seclusion rates at the Alfred have significantly reduced over the last 4 years. The Alfred went from having what was among the highest seclusion rates in the State in 2006 to the fourth lowest seclusion rate in Victoria in the first two quarters of the 2019 financial year.

121 This was a long journey. A lot of work was done to challenge the culture among staff and start a dialogue that high rates of restrictive intervention were not acceptable.

122 In support of the work that has been undertaken research was undertaken relating to the process of implementing change and the experience for nurses in working through the changes.

123 Diagnostic criteria was identified to determine when restrictive intervention might be required, and when it was not acceptable. This includes people with a diagnosis of borderline personality disorder.

124 The Alfred also implemented Psychiatric Response to Behaviours of Concern (**PsyBOC**) calls around three years ago, which are the mental health service equivalent to Medical Emergency Team (**MET**) calls for patients who medically deteriorate.

125 A PsyBOC call is made when a patient experiences a deteriorating mental state, and a doctor, nurse manager or associate charge nurse and allied health worker respond. The team has a 'time out' with the nurse to discuss the situation and strategies for de-escalation and attempt to negotiate with the patient to de-escalate the situation. After hours the response team includes the Associate Charge Nurse from the other ward and the on call registrar. The Senior Nurse on Call is available for a telephone consultation.

126 A patient's mental state may deteriorate for a number of reasons. While some patients display aggressive and unacceptable behaviours that cannot be de-escalated, most patients exhibiting serious behaviours are in crisis. They may be delirious, psychotic, or

depressed, or may have a need which has not been met. In those situations, it is important for the team to assess and understand the situation rather than to adopt a zero tolerance approach.

127 PsyBOC responders use a range of strategies to problem solve and de-escalate behaviours. This might include providing weighted blankets, arranging a phone call to family members, providing distractions to address boredom, or bringing a cup of tea or an ice-cream. Most situations are able to be de-escalated and do not result in restrictive intervention.

128 The system has been tweaked over time, including by creating clear criteria about when a PsyBOC call is to be made. These criteria include when patients:

(a) are drug and/or alcohol affected;

(b) return after having absconded;

(c) have been brought across to the inpatient unit from the ED in mechanical restraints;

(d) are sexually vulnerable;

(e) have a deteriorating mental state; and/or

(f) are receiving "bad news".

129 As a result of the introduction of PsyBOC calls, seclusion rates have significantly reduced.

130 Both the implementation of PsyBOC and the experience of staff have been evaluated and published.[1]

131 In addition to PsyBOC calls, all incidences of seclusion are also reviewed by the leadership team including the operations manager, peer worker and Consultant Psychiatrist.

132 When considering seclusion rates, both the number of episodes and the hours of seclusion are important. While the Department of Health monitors episodes, it does not measure hours of seclusion. The Alfred monitors both episodes per 1000 bed days and hours per thousand bed days. It is important to measure both as the number of

[1] Robin Digby, Hannah Bushell and Tracey K. Bucknall, 'Implementing a Psychiatric Behaviours of Concern emergency team in an acute inpatient psychiatry unit: Staff perspectives', *International Journal of Mental Health Nursing* (2020) (doi: 10.1111/inm.12723).
Fiona Whitecross, Stuart Lee, Hannah Bushell, Matthew Kang, Caitlin Berry, Yitzchak Hollander, Gamze Sonmez and Ilan Rauchberger, 'Implementing a psychiatric behaviours of concern team can reduce restrictive intervention use and improve safety in inpatient psychiatry', https://doi.org/10.1177/1039856220917072

episodes may be lower where a patient is secluded for a longer period of time, rather than being secluded on more occasions but for shorter periods of time.

133 Research is also currently being undertaken at the Alfred to identify the criteria that evidences a deteriorating mental state. This is to recognise that patients across the hospital experience mental health crises, whether in an inpatient unit, or, for example, a surgical unit or the ED. On any given day, approximately 30 to 40 patients at the Alfred will be seen by a consultation liaison psychiatry service throughout the hospital where behaviours have escalated or concerns about a patients mental health have been identified.

QUALITY AND SAFETY

Improving the safety and wellbeing of staff and service users

134 The safety and wellbeing of staff in the mental health sector is a major issue. In my view, to address this, a number of changes are required.

135 Firstly, purpose-built streamed services in units are essential to minimise the occurrence of harmful incidents. We currently have generic mixed gender wards, where patients of differing levels of behaviour are together. Patients experiencing depression are in the same ward as forensic patients and patients with long histories of psychosis. To ensure the safety of both staff and patients, purpose built streamed services which respond to different needs are required.

136 In the past, prior to de-institutionalisation, mental health facilities had separate units for patient cohorts such as forensic patients, those with AOD issues, and patients entering the system for the first time. While the days of institutionalisation should not be returned to, a strength of that system was that it was recognised the differences in patient cohorts.

137 Purpose-built streamed services can provide hope to patients, and can aid in delivering effective treatment. This would enable deliberate and useful treatment to be provided to groups of particular patient cohorts. It is an important factor in ensuring the safety of staff and patients.

138 Developing good criteria around escalation and support for mental health staff in such situations is supportive. Criteria for escalation requires agreed circumstances for escalation and an understanding of the continuum of aggression including verbal and non-verbal aggression and aggression towards objects , others or self. Establishing fixed criteria builds surety that in certain circumstances escalation of the current or deteriorating circumstances advice will be sought. These circumstances can include

but are not limited to attempts to abscond, sexual disinhibition, refusal of medication, being substance affected and making verbal threats.

139 Thirdly, designing and developing the workforce is critical. This includes:

(a) Developing a 24/7 workforce, which would allow psychologists, clinicians and social workers to be more available and present, and ensure that nurses are not left at the forefront on their own. Currently, in the inpatient psychiatry unit doctors and allied health staff are not present from 5 pm for routine work. After hours and on call arrangements are in place for psychiatrists and registrars to manage urgent issues relating to treatment requirements but beyond this there is no opportunity for other therapeutic inputs supporting family, recovery and discharge planning.

(b) Funding occupational therapists in inpatient units, in particular high dependency units would be beneficial. This would enable them to deliver tailored interventions to individual patients and to conduct more sensory work, which can make a significant difference to recovery. Patients often complain of boredom which can be a driver for escalating behaviours of concern. Occupational therapists also develop and deliver group programs with a focus on recovery and diversion/ recreation/ occupation which can be vital in reducing distress, supporting recovery, responding to boredom. All these outcomes lead to a safer environment.

(c) Ensuring access to quality training and adopting and funding standardised approaches to training. Presently, there is significant variability across the State in aggression management training, with each health service designing their own program, and a lack of consistency in the way that training is designed or delivered. Standardised approaches would be beneficial, together with funding. The Alfred has implemented annual aggression management training across its entire workforce, which has been a costly exercise that is an unfunded activity.

The use of quality and safety data and information/feedback

140 The Alfred has a comprehensive data set that is closely monitored to determine the sorts of risks that need to be considered regularly. Activity data is provided in a weekly dashboard. Seclusion rates are updated daily on the Alfred Health dashboard and are available to the community to review. We are working to enable mechanical restraint data to have the same visibility. Daily reports are generated that identify the number of code grey incidents, the number of *Mental Health Act 2014* (Vic) section 10 presentations to the emergency department. Occupational health and safety information

is considered regularly. Quality reports are generated on a monthly basis and variations are reviewed.

Improving the quality and safety of mental health services

141 It is important to consider the roles of the Office of the Chief Psychiatrist, Safer Care Victoria and the Mental Health Complaints Commission as we move forward. Within these bodies there is duplication and it is not unusual for all three to be engaged in response to an issue that has been raised. Having to respond to different bodies over similar issues can create unnecessary overload in ensuring timely responses.

GOVERNANCE

Accountability mechanisms

142 The statement of priorities, an existing accountability mechanism, has been an important mechanism to achieve improvements in seclusion reduction. It is with this in mind that accountabilities can be selected and considered to ensure sector engagement.

COVID-19

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

143 As a consequence of COVID-19, the speed at which mental health services have responded and adopted telehealth and digital platforms has been remarkable. The program has adopted a number of activities that will likely extend beyond the COVID-19 pandemic.

144 The use of telehealth at triage has been especially useful and will be maintained as an option, as will responsive and supportive telephone counselling with follow-up to callers experiencing anxiety. The capacity of triage workers to have video chat calls to clients calling in aids the assessment and engagement with the caller. Until COVID-19, callers would be provided with advice and support in a one off intake call if they were not deemed as requiring follow up. However through this period triage workers have continued to provide telephone counselling and anxiety management to a numbers of callers that has been of enormous benefit and value.

145 It is of interest that some of our hard to engage consumers who were unreliable in community follow up are able to be engaged through telehealth appointments. This is something we will continue to monitor in the post COVID-19 period but it is potentially an option that we will maintain in a future state. Certainly, going forward we will offer clients alternatives to face to face consultations as a form of contact with clinicians.

146 The peer work force has emerged as a valued member of the team. Clients have valued their roles and inputs during this period and greater priority on peer workforces will be considered in future service planning.

147 Demand for consultation liaison psychiatry has grown through this period with an increase to the Alfred Hospital of people presenting as a result of significant self-harm and people with eating disorders. At this point work is underway to enable the system to develop clinical pathways for eating disorders patients in medical units specifically. Opportunity to use digital physical health monitoring in community settings is of further potential

148 Workforce models have meant that we have had to develop better mental health literacy for medical colleagues as they have had to deliver a range of services at home or in quarantine hotels where previously they would have called up a range of consultation liaison clinicians to provide opinion and advice. In response a psychological first aid on line training and webinar series has been established through the mental health workforce team and rolled out with acceptance from medical colleagues. This will be continued and embedded into workforce training.

149 Family meetings in inpatient units have relied on families attending a specified times and often at great disruption the family routine. Inevitably they have had to take significant time off work or out of usual routines to travel to the hospital and now as a consequence of telehealth and digital platforms family meetings are still scheduled within business hours but not to the level of disruption as previously as all participants can now phone in and through the use of either zoom or micro-soft teams family meetings are occurring. Family feedback is very positive.

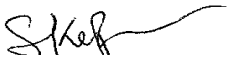
150 Group programs across community, in residential rehabilitation and in inpatient units are critical to supporting client's recovery. Through the use of digital platforms groups are now occurring and can be recorded for client engagement at suitable times. The programs have all invested in smart televisions which allows groups to be streamed from one environment into many and this can broaden the opportunity for group activities and engagement. We are continuing to explore and expand this opportunity.

151 Developing training packages for staff to understand the principles and practice implications for telehealth has been important. In taking telehealth forward and into the future we need to be sure staff are skilled and capable in telehealth and that our clients are orientated to different platforms, have access to technology and have the option of making a choice. It is clear that telehealth and digital platforms do not appeal to everyone, but for some consumers they appear to be preferred.

152 A final action that is emerging is the partnership and priority for housing of vulnerable people that many agencies are undertaking. As a consequence of COVID-19 a number of housing initiative with mental health support have started to emerge. The Alfred purchased accommodation for a small number of vulnerable clients in the event they would require somewhere to live and this has been embraced by some clients. Going forward it would be exciting to consider housing as a crucial component of a client's mental health.

Longer term opportunities for new approaches to service delivery

153 We have currently submitted an ethics approval to research the value and benefit of a number of the changes to enable thoughtful adoption of the strategies employed through this time. It is inevitable we will maintain a number of practices into the future for efficiency and because it is effective, because clients and their families experience a better service and because clinicians are confident in the modality. The balance of all these factors is what is critical and what needs to be understood before universal and deliberate adoption of the changes.

sign here ► 

print name Sandra Keppich-Arnold

date 18 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SKA-1

This is the attachment marked 'SKA-1' referred to in the witness statement of Sandra Joy Keppich-Arnold dated 18th May 2020.

A. PROF SANDRA KEPPICH-ARNOLD
Director of Operation and Nursing
Mental & Addiction Health, Alfred Health
Melbourne, Victoria, Australia

CONTACT DETAILS

ADDRESS/ ALFRED MENTAL & ADDICTION HEALTH, ALFRED HEALTH, PO BOX 315, PRAHRAN, VICTORIA, AUSTRALIA, 3183

PHONE (W)/ +61390763718

FAX (W)/ +61390762341

PHONE (M)/+61419770040

EMAIL/ s.keppich-arnold@alfred.org.au

CAREER STATEMENT

I am an operations director and mental health nurse with over 35 years' clinical & leadership experience in public & private mental health services. I presently hold appointments as Director of Operations and Nursing for the Mental & Addiction Health at Alfred Health and Conjoint Associate Professor at Deakin University.

I have been motivated to lead and provide the kinds of mental health services that are welcoming; treat people with dignity; provide safe & effective care with a safe and competent workforce, promote clinical & social recovery; engage families & friends; and are valued by the local community.

SKILLS

Clinical adult & old age psychiatry; clinical governance; mental health services research & evaluation; mental health policy; change management; participatory healthcare; health & community leadership; consultancy.

CURRENT EMPLOYMENT

ALFRED HEALTH / DIRECTOR OF OPERATIONS AND NURSING, MENTAL & ADDICTION HEALTH| 2006 - PRESENT

I am operationally responsible for a public area mental health service in southeast metropolitan Melbourne, with a catchment population of about 400,000. We provide mental health & addiction services in hospitals, community residential units and clinics across 12 sites. Our service supports service evaluation through collaboration with academic partners. Our budgeted revenue is over $A80 million per annum and we employ over 650 full time equivalent staff.

I have the responsibility for leading the nursing and allied health workforce ensuring clinical capability and competence of the nursing program across community and inpatient settings.

Since 2006, our team has successfully implemented a number of initiatives, including:

- A state-wide psychiatric intensive care hospital unit (PICU);
- A state-wide problem gambling specialist community mental health service;
- An intensive adult community rehabilitation & complex care service, known as New Horizons;
- A restructure of the adult community program stream, including the establishment of a service (known as the Navigations service) combining intake, primary mental health consultation & short-term treatment and transition to primary care.
- An adult sub-acute service in the community, the South Yarra Prevention & Recovery Care or PARC Unit);
- A clinical alcohol & drug service, including a pharmacotherapy clinic (Southcity Clinic) and a hospital addiction liaison service at The Alfred;
- A youth primary mental health clinic known as headspace primary (combining general practice, addiction, employment and mental health services);
- A regional headspace youth early psychosis program (the Southern Melbourne hYEPP), which has integrated Early Psychosis Youth Centre (EPYC) and Open Dialogue models of care;
- A Mental Health & Intellectual Disability service for youth (MHIDI-Y);
- A Forensic Youth community mental health consultation service.
- Expanded Consultation and Liaison services across the Alfred to enable a seven day a week service.
- Leading management of behaviours of concern across the health service with specific programs to provide early intervention as a result of mental state and behavioural deterioration. These interventions are identified within the health setting as The West Wing within the emergency department, PSY-BOC within the mental health unit and DiVERT program within the medical and surgical units.
- Establishing peer programs across inpatient and community settings
- Establishing a suicide prevention strategy with activities in schools, developing protocols with ambulance and police and establish a post discharge from ED treatment and support program (HOPE)
- Responsive services to family violence

Many initiatives have involved collaboration with providers of community & primary care, disability support, addiction, employment and housing services. Partners have included Wellways, MIND, Uniting Care Victoria, Sacred Heart Mission, Star (Community) Health, Salvation Army's Access Health, Launch Housing, Taskforce, Odyssey, First Step, Victorian Responsible Gambling Foundation and South-East Melbourne Primary Healthcare Network.

As the Director of Operations and Nursing we have been successful in a number of activities including:

- Reduction of seclusion rates through a range of interventions to achieve a current seclusion rate of 5 episodes per 1000 bed days.
- Established graduate and post graduate nursing and allied health programs with 90% retention of staff
- Implemented practice development programs to building capacity and cability of nursing across settings
- Reviewed nursing and allied health models of care in community residential rehabilitation and implemented nursing and occupational therapist rosters to achieve better patient outcomes and establish a structured and measurable rehabilitation program
- Embedded mandatory and competency based training into staff learning requirements

- Developed a toolkit for transition to community nursing available on the Mental Health Branch (DHHS Victoria) website
- Improved recruitment and retention of nursing staff achieving vacancy rates to the program at less than 2%
- Established nurse practitioner roles across the program in areas of aged mental health, physical health, dual diagnosis, drug and alcohol within hospital settings, crises intervention within community setting and the emergency department.
- Established safewards programs within the Adult and Aged inpatient units.

DEAKIN UNIVERSITY / CONJOINT ASSOCIATE PROFESSOR| 2017 – PRESENT

ADJUNCT LECTURER MONASH UNIVERSITY 2016 – PRESENT

I am an active contributor to undergraduate and postgraduate teaching and nursing programs at Alfred Health. I support an active workforce development team with co-design approaches to learning and development through practice development, and a discovery college at Headspace YEPP and commenced "taster" sessions for Discovery courses within the adult mental health program I co-lead a service evaluation stream of research and our team has published articles in peer-reviewed mental health journals and other mediums, undertaken service consultations and delivered oral presentations at national and international conferences and clinical service forums. I collaborate within the academic streams of Deakin University to support research.

CLINICAL AND LEADERSHIP CONSULTANCY SERVICES IN SPECIALIST & PRIMARY MENTAL HEALTH & AGED CARE | 2002- *PRESENT*

Clients have included SA Health, North Western Mental Health, Latrobe Valley Health, Bendigo Health, Eastern Health and Ballarat Health.

DHHS – Mental Health Branch –

- Review of High Dependency Units – Victoria
- Protocol for Intensive Care Nursing in Mental Health
- Sexual Safety in Mental Health Services in Victoria

Member of the Chief Psychiatrist Quality Advisory Committee 2002 – 2017
Member of Chief Psychiatrist Morbidity and Mortality Committee 2008 – 2017
Member of Office of Chief Mental Health Nurse Reducing Restrictive Interventions Committee – 2016 –Present
Invited Expert – National Mental Health Information Development Expert Advisory Panel 2002 – Present
Member of DHHS Clinical and Operation Reference Group – Clinical Mental Health Reform Project 2018 – Present
Member of DHHS Progress Measures Working Group – 2018 – Present
Member of VAHI Expert Advisory Group – 2018 – Present

PAST EMPLOYMENT

- ALFRED HEALTH (CAULFIELD HOSPITAL) | ASSOCIATE DIRECTOR, AGED PSYCHIATRY SERVICE| 2002 - 2006

- MANAGER, AGED PSYCHIATRY SERVICES, DANDENONG HOSPITAL/ 1994 - 2002
- MONASH UNIVERSITY | LECTURER| 1998- 2000

ACADEMIC QUALIFICATIONS & KEY CONTINUING PROFESSIONAL DEVELOPMENT

- DEAKIN UNIVERSITY, GRADUATE DIPLOMA, EDUCATION (HEALTH) 1994
- MELBOURNE UNIVERSITY, CERTIFICATE IN HEALTH SYSTEMS MANAGEMENT 2013
- NURSE TRAINING (LAKESIDE HOSPITAL 1975/ BOX HILL HOSPITAL 1977

KEY CONTINUING PROFESSIONAL DEVELOPMENT

- TEAM COACHING INTERNATIONAL 2013
- CREDENTIALED MENTAL HEALTH NURSE

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4. Eloisa Evangelista, Stuart Lee, Angela Gallagher, Violeta Peterson, Jo James, Narelle Warren, Kathryn Henderson, **Sandra Keppich-Arnold**, Luke Cornelius, Elizabeth Deveny: *Crisis averted: How consumers experienced a police and clinical early response (PACER) unit responding to a mental health crisis*. International journal of mental health nursing 03/2016; DOI:10.1111/inm.12218
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