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ANMF (Vic Branch) Submission to the Royal Commission into Victoria's mental health system

Paul Gilbert
(Acting) Secretary
ANMF (Vic Branch)

4 July 2019

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Ms Penny Armytage
Chairperson
Royal Commission into Victoria's mental health system

Dear Ms Armytage

The Australian Nursing and Midwifery Federation (Vic Branch) welcomes the opportunity to make a submission to the Royal Commission into Victoria's mental health system.

We share the view of the Premier Daniel Andrews that Victoria is 'so far away from a system that the most vulnerable in our community need and they're right to demand that of us' (The Age, 24 October 2018).

Like the Premier, we believe that every person living with mental illness deserves high quality care, treatment and support when, where and for as long as they need it. We also know first-hand that such quality care, treatment and support requires a skilled mental health workforce.

Our submission draws on the direct experience of frontline Victorian nurses and midwives who have an in-depth understanding of the mental health care needs of people with lived experience and the challenges present in our mental health system.

It focuses on the many innovative and successful nurse-led interventions that have delivered best practice, person-centred, recovery-focussed care and makes recommendations to advance these life-changing programs.

I welcome the opportunity to discuss our submission further and invite you to contact me directly to arrange. I also urge your direct contact on all issues of relevance to our members that arise during your inquiry.

Yours sincerely

Paul Gilbert
(Acting) Branch Secretary

CONTENTS

LIST OF CASE STUDIES

We thank all our members who provided advice, information and input into our submission. We especially thank those who took the time to provide a case study.

We also thank the clients of Nurse P who have contributed with testimonials

To assist the Royal Commission, we have included the case studies listed below. These case studies represent the views of our members who work in a range of settings with people with lived experience, carers and families. In submitting a case study, these members wish the Royal Commission to understand the work they do and hear the concerns they voice on behalf of their clients and colleagues. In some instances, a case study may relate directly to a recommendation we have made; in others, the case study has been included to provide a context and amplify the voice of frontline nurses and midwives and the many people for whom they provide care. The case studies, and any examples they describe relating to individual clients, have been deidentified.

The ANMF (Vic Branch) members who have engaged with the organisation for the purpose of providing information to the Royal Commission through this Submission by providing case studies, have done so in the context of ss 39(4) and ss 40(1) of the Inquiries Act 2014 (Vic)."

DEFINITIONS

Carer means a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a relationship of care.

Family may refer to either family of origin and/or family of choice.

Forensic mental health services mean mental health services that provide assessment, treatment and care to people living with a mental illness who are in contact with the justice system, including the youth justice system. Forensic mental health services can be provided to people in both custodial and community settings and can be provided to people who have offended or are at-risk of offending.

Mental health workforce means those who deliver mental health assessment, treatment and care to people experiencing a mental illness. It includes, but is not limited to, general practitioners, psychologists, psychiatrists, counsellors, mental health nurses, midwives, general nurses, peer support workers, social workers and occupational therapists.

Mental illness means the experience of symptoms which impact thinking, perceptions, emotions, behaviour and relationships to others, or a combination of these.

Person-centred means treating a person receiving health care with dignity, respecting their preferences, needs and values and involving them in all decisions about their health treatment. The term recognises that a person's needs may be broader than their mental health treatment and care.

Other services mean the range of services supported by the Victorian Government that seek to address the wider determinants of mental health, such as housing, homelessness, disability, education, alcohol and other drug, family violence, health, justice and employment services. It also includes Commonwealth subsidised mental health services and funded and co-funded services, primary care type services and supports funded by the National Disability Insurance Scheme.

People with lived experience means people living with mental illness, their family members and carers.

NB: The ANMF (Vic Branch) recognises that people with lived experience of mental illness prefer different terms to describe themselves. Many people use the term 'consumer' for people accessing mental health services. This term is also used in the *Mental Health Act 2014* and in many policy documents and guidelines. Other people prefer the term 'client'. This is the term most often used throughout our submission to indicate people with lived experience who are engaged, or who seek to be engaged, with a health service. We also use other terms, including 'person', 'individual', 'consumer', 'people', 'people accessing mental health inpatient treatment' and 'people with lived experience' to reflect a 'people first' approach to language as much as possible. Where we have quoted directly from the work of others (e.g. case studies, reports or research papers), we have retained the terms used by the authors to ensure accuracy.

Psychiatric enrolled nurse is an industrial classification only and refers to an enrolled nurse in Division 2 of the Register of nurses of the Nursing and Midwifery Board of Australia by the Health Practitioner Regulation National Law Act 2009 (Vic)

Registered psychiatric nurse is an industrial classification only and refers to a registered nurse in Division 1 of the register of nurses of the Nursing and Midwifery Board of Australia by the Health Practitioner Regulation National Law Act 2009 (Vic)

Victoria's mental health system means any mental health services that are funded (wholly or in part) by the Victorian Government that support mental health and respond to mental illness. This includes clinical services delivered by area mental health services (AMHSs) and community-based services that focus on activities and programs that help people manage their own recovery and maximise their participation in community life. It also includes consumer-run services, forensic mental health services and specialist mental health services.

ACRONYMS

ACCOs Aboriginal community-controlled organisations

ACIS Acute community intervention service teams

ACNC Addictions clinical nurse consultant

ADHD Attention deficit hyperactivity disorder

AIHW Australian Institute for Health and Welfare

AHPRA Australian Health Practitioner Regulation agency

AMHS Area mental health service

AMSs Aboriginal medical services

ANUM Associate nurse unit manager

AOD Alcohol and other drugs

APMH Aged persons mental health

CALD Culturally and linguistically diverse

CATT Crisis assessment and treatment team

CCU Community care unit

CL Nurse Consultation liaison nurse

CMHT Community mental health teams

COAG Council of Australian Governments

DHHS Department of Health and Human Services

EBA Enterprise bargaining agreement

ED/s Emergency department/s

EFT Equivalent full-time

EN Enrolled nurse

EPC Early parenting centre

HITH Hospital-in-the-home

HOPS Homeless outreach psychiatric services

HOPE Hospital outreach post-suicidal engagement

HoNOS Health of the nation outcomes scales

KMS Koori maternity service

LOS Length of stay

MAC Ministerial advisory committee

MBU Mother baby unit – sometimes also known as parent infant units.

MCH Nurse Maternal and child health nurse

MDT Multi -disciplinary team

MHA Mental Health Act 2014

MHCC Mental Health Complaints Commissioner

MHCSS Mental health community support services

MHNIP Mental health nurse incentive program

MHNP Mental health nurse practitioner

MST Mobile support team

NMBA Nursing and Midwifery Board of Australia

NDIS National disability insurance scheme

NMHPV Nursing and midwifery health program Victoria

NP Nurse practitioner

OCMHN Office of the Chief Mental Health Nurse

OSQI Office of Safety and Quality Improvement

OVA Occupational violence and aggression

PANDA Perinatal Anxiety and Depression Australia

PAPU Psychiatric assessment and planning unit

PARC/YPARC (Youth) Prevention and recovery care

PBS Pharmaceutical benefits scheme

PECC Psychiatric emergency care centre

PEHP Perinatal emotional health program

PEN Psychiatric enrolled Nurse

PHN Primary health network

PROMPT Prehospital response of mental health and paramedic team

PSNP Primary school nursing program

PTSD Post traumatic stress disorder

RC Royal Commission

RPN Registered Psychiatric Nurse

SECU Secure extended care unit

SHARC Self-help addiction resource centre

SSNP Secondary school nursing program

VACCHO Victorian Aboriginal community-controlled health organisations

VAGO Victorian Auditor-General's office

INTRODUCTION

About the ANMF (Vic Branch)

The ANMF (Vic Branch) is the peak professional and industrial body for nurses and midwives in Victoria. We have more than 86 000 members working in Victorian health services, including in hospitals, mental health services, aged care facilities, community health services, maternal and child health services, schools, alcohol and other drug services (AOD), medical clinics, home visiting services and prisons.

Our strong and unified membership has enabled us to make a real difference to the quality of nursing care in Victoria and to the health and wellbeing of Victorians. For example, it was the drive and commitment of our members that saw Victoria introduce the world's first mandated nurse/midwife to patient ratios in 2001. The ratios, which have since been improved and expanded, have been so successful in increasing the capacity of health services to provide quality care for patients/clients that they have now been enshrined in legislation through the *Safe Patient Care Act 2015.*

We are strongly committed to a mental health system that allows all Victorians requiring mental health care to receive best practice, person-centred, recovery-focussed care through the health practitioner and facility that best addresses their needs. We know:

- Mental illness is now the single largest contributor to years lived in ill health and the third-largest contributor, after cancer and cardiovascular conditions, to reducing total years of healthy life for Australians.

- At any time, one in five people in Victoria experience some form of mental illness.

- Some people experience their illness once and fully recover; some experience multiple episodes of ill-health; some undertake a lifelong journey.

- Disadvantage and poor health are linked, and we support the use of the social determinants of health model, along with the provision of acute clinical mental health services and best practice, person-centred evidenced-based care, treatment and support.

- Some population groups and communities, including First Australians, experience disproportionately poorer mental health outcomes due to intergenerational trauma, systemic discrimination and barriers to accessing services.

- The stigma surrounding mental health remains a barrier to many people seeking help, with only 50 per cent of people experiencing mental illness in Victoria receiving treatment.

- The link between mental ill health and physical ill-health means many people suffer a shorter life expectancy due to missing out on treatable, timely, preventable health care interventions, including chronic disease management

- At the same time, mental health services are under increasing pressure from population growth, changing patterns of drug use and greater complexity of need, and demand continues to increase.

- These increasing numbers and complex care needs are challenging the Victorian mental health system, including nurses and midwives, with many people only receiving care when their mental health has reached crisis point.

We believe every person living with mental illness deserves high-quality care, treatment and support, when, where, and for as long as they need it. We agree that such care, treatment and support require a

skilled mental health workforce. We consider nurses and midwives, including mental health nurses, to be a critical component of this workforce.

Why nurses and midwives are integral to a best practice mental health system

Nurses and midwives comprise the majority of the health workforce; they are a highly-trained, capable and regulated workforce that has long been at the forefront of meeting the challenges of health care delivery and advancing solutions by implementing practice changes.

Nursing education provides a generalist foundation to prepare the profession for holistic health care delivery and a platform on which graduands and graduates can build post-registration specialisation.

The national registration and accreditation system provides effective regulation to ensure public safety through nurses meeting the required NMBA profession standards.

They work in the full range of clinical and service settings in metropolitan, regional, rural and remote areas, including public and private specialist mental health services, outpatient facilities, inpatient services, rehabilitation and sub-acute care, maternal and child health programs, specialist child and youth services, primary health services such as general practice clinics, district nursing and community health centres, supported accommodation facilities, hospital emergency departments (EDs), AOD services, dual diagnosis units, community mental health services, schools, prisons and the justice system, and homes.

Their practice includes health and wellbeing promotion, ill health prevention and intervention in partnership with the individual, risk management, early detection and intervention, health restoration, rehabilitation, and chronic disease management across all life stages and in crises and transition periods.

Through accredited undergraduate and postgraduate education, they have the expertise to provide holistic, person-centred care that addresses the person's physical, psychological, social and spiritual needs in the context of their lived experience and in partnership with carers.

Nurses and midwives have widespread engagement with the community across the lifespan and are well placed to provide universal mental health and physical health screening, intervention, referral and follow-up through a range of highly regarded nurse-led programs.

Investing in this workforce and these programs, as well as in a range of new initiatives outlined in our submission, would ensure the Victorian Government builds a mental health system where:

- people receive the care they need, when they first need it, for as long as they need it, where they can access it readily, wherever they live – right across their lifespan
- communities and people with additional needs, including people with dual diagnoses, people with physical comorbidities and people requiring AOD treatment and support can access services seamlessly.
- health professionals work to their full scope of practice, providing holistic, recovery-oriented practice in safe and well-resourced working environments

- midwife and nurse-led programs are optimised and community and primary programs strengthened as an effective and efficient way of providing early and expert treatment and support and smooth and timely movement between step-up and step-down programs and specialist care.

Our submission

To address the Royal Commission's key questions and terms of reference, we focus on:

- the critical contribution of nurses working to their scope of education and training and supporting mental health, care, across the breadth of service delivery, including inpatient services, residential, primary health, community and home-based services
- successful midwife and nurse-led programs and roles to show how the extensive and in-depth engagement nurses and midwives have with people with lived experience, families and carers can be optimised to deliver best practice outcomes
- case studies written by nurses and midwives that highlight their skills, concerns and potential solutions.

Mental health principles

We respect the Mental Health Principles in the *Mental Act 2014* and consider the recommendations we put forward in our submission uphold these important principles.

OUR PRIORITIES

RC Question 9: Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

To assist the Royal Commission, our submission includes many initiatives we think would help transform our mental health system. They can be summarised in the following top 10 priorities:

1.   Fix the funding shortfall

Everyone agrees the system is underfunded and stretched to the limit. It's time to take decisive action. We know about 3 per cent of the population experiences serious mental illness but our mental health system is funded for 1 per cent. We also know demand will grow. We recommend immediate and ongoing action to address this shortfall and match investment in public clinical mental health services to the proportion of the population with a severe mental illness. We also recommend revising funding and reporting for community mental health teams to reflect accurately all duties undertaken.

See chapters 1 and 7.

2.   Develop a detailed plan and workforce strategy

The Auditor General recommended the Victorian Government develop a new mental health plan that integrates service, capital and workforce planning. We agree. We recommend the plan also identify specific, evidence-based outcomes to be achieved; the best mix of services to achieve them (including the most practical service regions based on community needs); the organisations to be involved in achieving them; the specific investment and workforce measures to support each outcome; and the reporting and evaluation mechanisms built in to ensure best practice is maintained. See chapter 1.

3.   Continue to build and develop the nursing workforce

Nurses and midwives are integral to a skilled mental health workforce. They comprise the majority of the health workforce; they work in the full range of service settings; they are qualified to support mental and physical health, and their scope of practice ranges from health promotion to chronic and acute health management. We recommend specific measures to continue to build and develop this workforce, with special attention to regional and rural areas. The pipeline needs to start flowing now.

See chapter 6.

4.   Create safe workplaces

All employees have the right to perform their work in safe environments. Research points to an undersupply of mental health nurses, with attrition driven in large part by workplace stressors, including verbal and physical aggression. Addressing this issue is a pressing priority and needs to be carefully considered in system and service planning and design. We also recommend increased support for the implementation and enforcement of our 10-point plan to reduce occupational violence and aggression across the health system, including in Forensicare, with additional initiatives to encourage services to prioritise this issue. See chapters 4 and 6.

5.   Augment the acute system to meet current unmet need

Pressures on the acute system are well documented: Emergency department (ED) presentations have increased 9 per cent since 2015–16; acute hospital admissions have grown by 2.4 per cent per year; and length of stay (LOS) in hospital went from 14.7 days in 2009 to 9.6 days in 2017–18. It's a challenging churn for staff and means people experiencing mental illness are not getting the care they need, when they need it, for as long as they need it. We recommend an immediate investment in additional acute inpatient beds to establish a sustainable bed base. See chapters 1 and 3.

6.   Invest in community based clinical mental health services

It is essential our mental health system has a strong focus on prevention and early intervention, with universal routine screening for people at risk, and expert, tailored care available early in life, early in onset and early in episode through community and primary care settings. Nurses and midwives already have widespread engagement with community members through many successful nurse-led programs. The substitution of nurse roles threatens these programs. We recommend expanding and improving a range of these programs to facilitate access to discipline specific and interdisciplinary care, routine and opportunistic mental health risk screening, therapeutic solutions and referral across the lifespan as a very cost effective and efficient approach to prevention and early intervention. See chapter 2.

7.   Increase provisions for forensic health

The intense pressure on forensic mental health beds is well known; so is the solution. A 2014 Victorian Law Reform Commission report into the Crimes Act and a 2016 DHHS report into quality health care are just two recent reports calling for additional medium security beds. To meet the requirements of a growing prison population and ease the burden on general acute care, we recommend the government build three 20-bed medium security mental health units with dedicated staffing. See chapter 8.

8.   Improve health care journeys

The current system is fragmented and siloed, with links between services often unclear or broken for health professionals and the pathway through services invisible to community members. We need a system designed for people not providers, with clear, seamless, readily accessible pathways to tailored, holistic care. In chapter 4, we recommend investing in seven key initiatives for immediate impact:

- strengthening PARC/YPARC services by providing clinical nursing care 24/7, making them a genuine clinical step-up, step-down service
- reinstating and funding the acclaimed MHNIP program to augment primary care provided by GPs and psychologists
- introducing nurse navigators, so successful in Queensland, to improve health care journeys by creating a streamlined and simpler experience while making significant service efficiencies
- optimising nurse practitioners for expert, efficient and cost-effective mental health nursing care for clients with complex care needs especially in perinatal mental health, ED hubs, aged persons' mental health, AOD and CAHMS/CYMHS
- embedding trauma-informed care to increase safety for people with lived experience and clinicians
- reducing restrictive interventions to reduce trauma for people with lived experience and clinicians

- expanding hospital-in-the-home to mental health for increased access and improved outcomes.

9. Develop consistent, best-practice models of care

Suicide prevention; AOD and mental health; perinatal mental health; and mental health care for people with dual diagnosis or physical comorbidities all pose unique challenges, with many clients required to attend multiple services in different areas to receive all the treatment they need. We recommend a range of initiatives to facilitate a consistent, coordinated, whole-of-system approach that provides person-centred, integrated and interdisciplinary services by trained and equipped health professionals. See chapters 3 and 5.

10. Get governance right

When there are nursing vacancies and funding for these nursing positions continues to flow without accountabilities, services have little imperative to recruit to these vacancies. We frequently observe issues related to a lack of funding oversight and governance. We recommend accountability arrangements and oversights are put in place to ensure services employ the correct staffing profile and provide the services for which they are funded. See chapter 1.

1. FIXING FUNDAMENTALS FIRST

Improved system-level planning, investment and monitoring

In his 2019 report, *Access to Mental Health Services,* the Victorian Auditor General delivered the following assessment of mental health services in Victoria and the Department of Health and Human Services (DHHS) 10-year mental health plan:

> *'The lack of sufficient and appropriate system‑level planning, investment, and monitoring over many years means the mental health system in Victoria lags significantly behind other jurisdictions in the available funding and infrastructure, and the percentage of the population supported.*
>
> *While DHHS understands the extent of the problem well and has been informed by multiple external reviews, the 10‑year plan outlines few actions that demonstrate how DHHS will address the demand challenge that the 10‑year plan articulates:*
>
> - *there are no clear targets or measures to monitor progress in improving access*
>
> - *there are no forward plans for the capital infrastructure needed*
>
> - *the workforce strategy does not address the particular issues in regional and rural areas and fails to articulate specific targets*
>
> - *there is no work to address barriers to access created by geographic catchment areas.*
>
> *DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services; and in addressing historical inequities in funding allocations that do not align to current populations and demographics. This means many people wait too long or miss out altogether on services, and for those that do receive services, their clinical care can be compromised by the need to move them quickly through the system.*
>
> *Real progress is unlikely within the life of the plan unless DHHS accelerates and directs effort towards the fundamentals: funding, workforce and capital infrastructure. Until the system has the capacity to operate in more than just crisis mode, DHHS cannot expect to be able to make meaningful improvements to clinical care models or the mental health of the Victorian population.'*[1]

We concur with this assessment and share the Auditor General's concern about the profound repercussions this lack of system-level planning, investment and monitoring has for people living with mental illness and their families and carers.

It also has significant repercussions for our members, with nurses in the mental health system and general health system often bearing the brunt of this taut and fraught system. Nurses and midwives have felt the effects of reductions in clinical services, including the loss of mobile support and treatment teams, the cessation of clozapine nursing programs in some areas, a reduction in dedicated primary

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[1] Victorian Auditor-General's Office, *Access to mental health services: independent assurance report to Parliament*, 2019, p8.

mental health positions, the almost complete cessation of the CATT on-call service provision, the loss of public beds including numerous specialist aged persons mental health beds, and the sometimes sudden cessation of effective and valued nurse-led programs such as the Mental Health Nurse Incentive Program (MHNIP).

New service gaps created through 'recommissioning', including reductions in hospital and community health centre AOD services have created ambiguity regarding where people with amphetamine-type substance and related issues are to be cared for. By default, people with acute intoxication are being transferred to clinical mental health services and there is no clear mechanism to ensure mental health treatment environments can meet their medical and specific AOD needs.

These changes have contributed to the situation we now have, where people who are acutely unwell must reach crisis point before they can access either a bed within a mental health ward (for a very short stay) or emergency community care from clinical mental health services. As the Auditor General reports, 'increasing demand combined with current service shortfalls are placing the whole mental health service under substantial stress.' Citing figures from a 2017 external review of the mental health system commissioned by DHHS, he quantifies the increased demand as follows:

- emergency department (ED) presentations have increased 9 per cent from 2015–16

- acute hospital admissions have grown at an annual rate of 2.4 per cent

- length of stay (LOS) in hospital trends down from 14.7 days to 11.2 days from 2009 to 2017 (with LOS stay in 2017–18 at 9.6 days)

- unplanned readmission rates for adult mental health patients at 14.4 per cent in 2017–18

- community mental health contacts per 1 000 people declining at a rate of 2.5 per cent per annum over the last 10 years.[2]

As the Auditor General concludes, these demand pressures have lifted the thresholds for access to services so that acute mental health services only see the most unwell. This creates a serious flow on effect, with the number of people with lived experience accessing Victorian acute services through police, ambulance and self-presentations to hospital emergency departments increasing from 28 757 in 2004–05 to 54 114 in 2016–17.[3]

Nurses are at the front-line of managing this heightened demand. They deal with people when they walk in the door, as they wait for assessment and admission, and through their admission, assessment, treatment, discharge and follow-up care. They contend with families and carers struggling to understand why their loved one cannot access the care they need. They do their best to provide the high-quality, patient-centred care they are educated to provide, but are often unable to do so because the system itself does not have the capacity. They feel great distress when, based on service requirements, they must discharge an acutely unwell patient earlier than evidence or professional judgement recommends. They also find themselves on the receiving end of consumer, carer and community frustration and blame, and feel accountable for systemic and service flaws over which they have no control.

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[2] ibid., p45.

[3] ibid.

For example, statistics show people with mental ill- health are staying in EDs longer, and well over the national target of four hours. Between 2015 to 2017, the average wait time for a mental health patient in ED increased from 7.6 hours to 9.5 hours. And when wait times exceeded 24 hours, mental health patients made up 79 per cent of those occasions.[4] It is nurses who must most often account for, or are held responsible for, these delays and other service shortfalls. Consequently, the ANMF (Vic Branch) supports the following recommendations made by the Auditor General and considers implementing these recommendations fundamental to purposeful change.

That DHHS:

- complete a thorough system map that documents its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand

- use this map to inform a detailed, public, state-wide investment plan that integrates service, capital and workforce planning; setting out deliverables and time frames

- set relevant access measures with targets, which reflect the intended outcomes of the investment plan and routinely report on these internally and to the public

- undertake a price and funding review for mental health services, which includes assessing funding equity across area mental health services, and provide detailed advice to the Minister for Mental Health on the results and use this information to inform funding reforms

- resolve the known catchment area issues of misaligned boundaries that prevent people from accessing services

- re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability.

Transparent outcomes

These recommendations are consistent with recommendations the ANMF (Vic Branch) made in our submission to the 2015 consultation on Victoria's mental health strategy where we sought transparent outcomes, including outcomes in relation to reducing the physical health gap experienced by people with mental illness, improving the mental health of older people, particularly those in residential aged care, and reducing known neonatal and obstetric risks associated with mental illness.[5] We affirm this recommendation and the recommendations of the Auditor General here.

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[4] ibid., p46.

[5] Australian Nursing & Midwifery Federation, Victorian Branch, *Submission to the Department of Health and Human Services consultation on Victoria's next 10-year mental health strategy,* 2015.

RECOMMENDATION 1

The Auditor General recommended the Victorian Government develop a new mental health plan that integrates service, capital and workforce planning. We recommend the plan also identify specific, evidence-based outcomes to be achieved; the best mix of services to achieve them, including the most practical service regions based on community needs; the organisations to be involved in achieving them; the specific investment and workforce measures to support each outcome; and the reporting and evaluation mechanisms built in to ensure best practice is maintained.

Fair funding

Funding is out of step with demand as the following figures show:

- Victoria provides for 22 mental health beds per 100 000 people: NSW provides 36 beds per 100 000 people and the OECD average is 50 beds per 100 000 people.

- Victoria spent $206 per person on specialised mental health services in 2016-17 – the national average was $233 per person and Western Australia spent $305 per person.[6]

- Between 2011-12 and 2015-16, national recurrent expenditure per capita on specialised mental health services grew an average of 0.7 per cent annually but declined in Victoria by 0.3 per cent annually.

- DHHS pays 65 per cent of AMHS bed costs, compared with more than 80 per cent of costs for general health beds.

- DHHS provides mental health services to 1.2 per cent of the population, compared to the estimated 3.1 per cent of the Victorian population with a severe mental illness.[7]

- Funding for community mental health teams does not accurately reflect their full workload. Under the current model, funding is allocated by teams reporting only some elements of their work activities, not capturing all workload measures industrially defined in the current enterprise bargaining agreement.

The 2016 report of the review into hospital safety and quality assurance in Victoria asserts 'sustained growth in demand for mental health services in Victoria has not been matched with a commensurate increase in funding.' It describes 'ignored red flags in Victorian acute mental health provision' as follows:

…we should have strong and continuously improving systems in place to protect patients at elevated risk. But sustained growth in demand for mental health services in Victoria has not been matched with a commensurate increase in funding. Over the past 20 years, Victoria had the slowest growth in funding for mental health in the country, and went from being the state

[6] AIHW, Mental health services in Australia Web report, 2019.

[7] Victorian Auditor General's Office, *Access to mental health services: independent assurance report to Parliament*, 2019.

with the highest mental health spending per capita to the lowest. Hospitals have had to spread the same amount of resources more and more thinly.

One way this manifests is in the long waiting times that mental health patients routinely face in emergency departments before being admitted for treatment. … we have a very low bar for emergency wait times in mental health, with the state-wide target set at 80 per cent of admitted mental health patients waiting fewer than 8 hours in emergency beforehand. Nevertheless, we are consistently not meeting this target. Across Victoria about one in three mental health patients, on average, wait more than eight hours in a hospital emergency department before they are admitted for treatment.

As Victoria's 10-year mental health plan notes:

> *… many people, including people with severe mental illness, do not access public mental health services ... 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.*

These problems have occurred in the context of broader national issues in mental health systems. As the recent review of mental health services in Australia conducted by the National Mental Health Commission concluded:

> *On the basis of our findings, it is clear the mental health system has fundamental structural shortcomings. This same conclusion has been reached by numerous other independent and governmental reviews. The overall impact of a poorly planned and badly integrated system is a massive drain on people's wellbeing and participation in the community – on jobs, on families, and on Australia's productivity and economic growth.*

> *Public mental health services in Victoria – which deal with the most seriously mentally ill – are in the same situation. Victorian public mental health inpatient services perform well on one key criterion: cost per patient treated. In 2013–14 the average cost per inpatient bed day in Victoria was about 80–83 per cent of the national average for all classes of patient except forensic mental health, where the bed day cost was around 73 per cent of the national average. Bed day costs were cheaper than every other state.*

> *However, performance on other measures was generally poor. In 2013-14 Victoria had:*

> - *the lowest proportion of the population receiving (public) clinical mental health services (1.1 per cent vs a national average of 1.8 per cent)*
> - *the lowest proportion of new clients to all clients, indicating failure or inability to discharge (36.8 per cent vs 41.7 per cent)*
> - *the highest proportion of patients readmitted within 28 days of discharge (14.7 per cent vs 14.3 per cent).*

Victoria's relative position has been stable for some years, yet the issues identified here have not been meaningfully addressed. Instead, hospital resources have been spread increasingly

thinly, with length of stay compressed and acuity thresholds raised to cope with demand. As a result, the average mental health patient is sicker both on admission and on discharge than they were five years ago. Occupational violence – a measure of stress on the system – is endemic but normalised to the extent that workers consider it 'part of the job'.

This poor access to care creates a problem for the individual who needs but can't get treatment, and a problem for the wider community in terms of potential safety issues.

The Victorian Government's strong commitment to mental health is an opportunity to turn this around…. Decisive action to address the worst inadequacies in care should now follow. The creation of an OSQI focussed on improving safety and quality presents an opportunity to strengthen mental health care. The department should consider the relationship between the office of the Chief Psychiatrist and the OSQI and undertake a review of the Office of the Chief Psychiatrist to ensure that there is good alignment of the safety and quality priorities of OSQI with mental health.

A strengthened focussed on improving care in mental health will be insufficient, however, when the overwhelming threat to safety and quality of care in mental health is the significant and rising pressure on services. This will need to be addressed through funding.

Victoria's acute hospitals are on average more efficient than hospitals in other states. As indicated above, the same is true for mental health services, but the difference between the national average and Victoria is greater (mental health services in Victoria costs about 80 per cent of the national average, whereas general health services in Victoria costs are about 90 per cent of the national average). The decline in quality indicators and strength of the evidence we heard about mental health services suggests that the drive for narrowly defined efficiency in mental health is now having an adverse impact on quality. [8]

The Review recommended DHHS ensure the Mental Health Annual Report includes indicators of access to and pressure on services (including Forensicare services), and safety and quality outcomes including adverse events, and is used as the basis of a broader discussion with the community on safety and quality in mental health services. We support this recommendation.

We also consider it essential that the Victorian Government:

- make a clear commitment that clinical mental health services will remain in the public hospital and health system and are not at risk of being compromised by service separation models of funding

- develop and implement a mental health funding model whereby services, no matter where they are accessed, can integrate and adjust, removing service fragmentation for consumers/clients

- match investment in public clinical mental health services to the proportion of the population with a severe mental illness – estimated to be 3.0 per cent

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[8] Victorian Government Department of Health & Human Services, *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: report of the review of hospital safety and quality assurance in Victoria*, 2016, pp133-138.

- work with the ANMF (Vic Branch) to revise the current funding model and reporting mechanisms for public sector community mental health teams (CMHT) to reflect accurately all work required of the role

- provide dedicated oversight of allocated funding to health services to ensure transparent accountability for the delivery of agreed services and workforce measures.

RECOMMENDATION 2

Make a clear commitment that clinical mental health services will remain in the public hospital and health system and are not at risk of being compromised by service separation models of funding.

RECOMMENDATION 3

Develop and implement a mental health funding model whereby services, no matter where they are accessed, can integrate and adjust, removing service fragmentation for consumers/clients.

RECOMMENDATION 4

Match investment in public clinical mental health services to the proportion of the population with a severe mental illness – estimated to be 3.0 per cent.

RECOMMENDATION 5

Work with the ANMF (Vic Branch) to revise the current funding model and reporting mechanisms for public sector community mental health teams (CMHT) to reflect accurately all work required of the role.

RECOMMENDATION 6

Provide dedicated oversight of allocated funding to health services to ensure transparent accountability for the delivery of agreed services and workforce measures.

A skilled nursing workforce

We also note the view of the Auditor General that while DHHS has completed and released its workforce strategy and secured funding through the 2018–19 budget for some new mental health workers, the workforce strategy does not include targets for the types or numbers of workers it aims to attract or retain and does not set action to address the significantly greater staffing challenges that regional and rural areas face.[9] As our submission details, nurse-led interventions deliver best practice, person-centred, recovery-focussed care and are integral to a quality mental health system. Investing in

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[9] Victorian Auditor General's Office, *Access to mental health services: independent assurance report to Parliament*, 2019, p9.

such programs and models of care is an impactful, cost effective and efficient approach to delivering system improvements.

This view accords with numerous reports, including the report of the Ministerial Advisory Committee on Mental Health, *Improving the physical health of people with severe mental illness: No mental health without physical health* (2012), the *Evaluation of the Mental Health Nurse Incentive Program Final Report* (2012), and the *Parliament of Victoria Family and Community Development Committee inquiry into perinatal services report* (2018) which highlight the impact nurses make in various roles across the system by delivering or supporting:

- preventative health promotion and support
- comprehensive health assessment with supported referral to appropriate services
- proactive early detection and treatment
- support to navigate pathways to affordable and responsive health care
- improved access to and continuity of care achieved through better availability and strengthened coordination and collaboration between specialist mental health, GP, allied and community health services.

The integral work of nurses in delivering best patient outcomes has been recognised and safeguarded in other key areas of the Victorian public health system through the Safe Patient Care Act 2015. The Act enshrines in legislation the nurse/midwife to patient ratios previously contained in the *Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012-2016* and subsequent improvements to ratios. In so doing, it values the role of nurses and midwives and ensures minimum safe nursing and midwifery staffing ratios that are fit-for-purpose and acknowledge increasing patient complexity, developing models of care and the growing demand for health services.

Significantly, the Act does not yet include ratios for public mental health. This adds to the perception that mental health nursing is not recognised as an important nursing specialty and people requiring mental health nursing care are not treated equitably to those in the general public hospital and public residential aged care sectors. In our 2016-20 Enterprise Bargaining Agreement, ANMF (Vic Branch) members achieved an historic 125.8 equivalent full time (EFT) increase in public mental health nurse numbers and an agreed nurse ratio for high dependency units, as well as agreed nurse staffing profiles for inpatient units on each shift that could be readily translated to ratios. In a 2018 pre-election commitment, the Andrews Government committed to enshrining the agreed nurse staffing arrangements for inpatient services across the state in the Safe Patient Care Act by 2021/2022. We welcome this commitment.

As elsewhere in the system, legislating these ratios will have a positive impact on nursing vacancies, improving recruitment and retention of the nursing workforce and relieving some demand pressures. Importantly, the ratios will also help to ameliorate the variation in service provision, enabling people with a mental illness to have access to the same level of nursing care regardless of where they live or the service into which they are admitted. Most importantly, it will give effect to the expressed core value that people with mental illness deserve the same level of care as people with other health care needs who access the health system.

It will however, require considered workforce development strategies, particularly for regional and rural areas, and we address this issue in detail in chapter 6. We also note that the agreed staffing levels do

not yet include Prevention and Recovery Centres (PARCs) and Transitional Support Units. We urge the Royal Commission to recommend the Victorian Government make this provision.

> **RECOMMENDATION 7**
>
> Recognise the importance of the nursing and midwifery workforce to high quality mental health care by investing in that workforce and legislating nurse to patient/client ratios in the Safe Patient Care Act for all inpatient mental health settings, including PARCS and Transitional Support Units.

2. PREVENTION AND EARLY INTERVENTION

RC Question 2: What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Prevention and early intervention across the lifespan

It is essential our mental health system has a strong focus on prevention and early intervention across the lifespan, with universal routine screening for people at risk, and expert, tailored care available early in life, early in onset and early in episode through community and primary care settings.

Nurses and midwives already have widespread engagement with community members through many successful midwife and nurse-led programs. We recommend expanding and improving a range of these programs to facilitate routine and opportunistic mental health risk screening, therapeutic solutions and referral across the lifespan as a very impactful, cost effective and efficient approach to prevention and early intervention.

RECOMMENDATION 8

Optimise existing midwife and nurse-led programs to provide universal mental health risk screening, early intervention, health promotion, therapeutic solutions, referral and follow-up across the lifespan.

RECOMMENDATION 9

Adopt universal mental health risk screening tools for scheduled and opportunistic use across midwife and nurse-led lifespan programs including pre and postnatal, school nursing programs, community outreach, GP clinics, EDs and aged care.

RECOMMENDATION 10

Provide additional funding to health services to increase consultation times to provide for scheduled mental health risk screening.

Pre-conception and perinatal mental health

The Parliament of Victoria's 2018 *Report on the Inquiry into Perinatal Services* emphasises the far-reaching impact of maternal mental illness during the perinatal period for the mother and child and makes significant recommendations for improvements.[10] In their submission to the inquiry, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists wrote:

> The importance of perinatal mental health and well-being cannot be underestimated in ensuring the future health of the next generation … The presence of maternal mental health conditions can also have an adverse impact on the growth and development of the foetus/infant, and the wellbeing of other family members. The psychological wellbeing of pregnant women and new mothers should therefore be considered as important as their physical health and considered as part of routine antenatal and postnatal care. [11]

Mental health problems during early years can also have enduring consequences if left unresolved, placing individuals at increased risk of difficulties in adult life and placing increased pressure on limited community service resources. Robust evidence indicates the onset of many adult psychological problems have their origins in childhood and adolescence, and families affected by parental mental illness are at particularly high risk. Suffering and negative outcomes can also cause intergenerational cycles which become larger problems to address.

Through existing programs, midwives and maternal and child health nurses (MCH nurses) are uniquely placed to identify women and families at risk of, or experiencing, mental illness and provide early intervention, referral and support. Midwives work with women and their families throughout the pregnancy journey; from planning and preparing to at least six weeks postpartum, either at a hospital, a clinic or in people's homes. They provide information and advice on how to stay healthy, labour and recovery and breastfeeding. They also provide emotional support throughout and referral to other services such as social work and counselling services as needed. They monitor the health of mothers and their baby during pregnancy and post-partum, conduct routine tests and screens, book other tests and scans and arrange follow-up care with maternal and child health nurses.

Similarly, MCH nurses are involved in the care of mothers, children and families from birth to school age. Victoria's MCH Service has three core components: the Universal MCH Service; the Enhanced MCH Service; and the MCH Line. The Universal service supports families and their children with an emphasis on parenting, early intervention and health promotion, developmental assessment, prevention of ill health, early detection and referral and social support. It provides a universal platform that can:

- help identify children and families who require further assessment, intervention, referral and/or support

- bring families together, foster social networks, support playgroups and strengthen local community connections

- deliver other services and supports, such as family support services and immunisation.

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[10] Parliament of Victoria, *Inquiry into perinatal services: final report*, 2018, pp107-156.

[11] RANZCOG 2016, cited in ibid., p122.

A key aspect of the Universal MCH Service is the provision, for every Victorian mother and child, to attend ten consultations from the child's birth until the child is at least three and a half years of age.

The Enhanced MCH Service responds assertively to the needs of children and families at risk of poor outcomes, especially where there are multiple risk factors, including mental health. We commend the significant additional funding provided by the state government in its recent budget which has resulted in a significant boost to services.

The MCH Line is a 24-hour telephone support, counselling, and referral service staffed by MCH nurses. It links parents to the universal MCH service, offers advice where appropriate on the phone, and provides direct referrals into the Enhanced MCH Service. In 2017 there were 99 000 calls to that service, and the 2017/18 Budget allocated funding for an additional 20 000 calls per year.

Through these services, women and families are already engaged with midwives and MCH nurses. Enhancing these services to strengthen their focus on mental health would be a very cost effective and efficient way to ensure early detection and initial management of mental health issues occurs for all women and their families, including those most at-risk.

Midwives and MCH nurses are uniquely positioned to equip new mothers and families with the skills and knowledge required to competently care for their babies or young children and therefore prevent – and make interventions – around the known risk factors contributing to vulnerability. This was recognised in the 2012 Report of the Protecting Victoria's Vulnerable Children Inquiry, which stated:

> *Victoria's antenatal and maternal and child health services are a cornerstone of its universal, early intervention and prevention program covering all children and are particularly important in the early care of vulnerable children. These services must be better resourced to meet the specific and demanding needs of Victoria's vulnerable children and their parents.*[12]

The MCH nursing service is also well-placed to collaborate with mental health nurses, midwives and other health professionals to support mothers, children and families in the community. Importantly, if antenatal clinics and MCH nursing services were appropriately resourced to also act as a referral point for perinatal mental health nurses, a fully integrated service would be available to women and their families. This would also remove the time and expense involved for women who would otherwise be required to access a separate service to obtain mental health advice or treatment – an absolute barrier to women accessing these services.

Given optimal maternal health and wellbeing is an enabler to optimal child health, wellbeing and development – and given the first 1 000 days of a child's life are pivotal to future health outcomes – the importance of supporting midwives and MCH nurses to make early identification, intervention and referral cannot be overstated.

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[12] Victorian Government Department of Premier and Cabinet, *Report of the protecting Victoria's vulnerable children inquiry*, 2012, pxxxiv.

RECOMMENDATION 11

Increase the capacity of maternal and child health (MCH) services to strengthen their focus on mental health by:

- enabling the Universal MCH Service to commence involvement during the antenatal period for enhanced mental health risk screening and early intervention

- maintaining funding commitments to the Enhanced MCH Service to meet the increasingly complex needs of families and children, including mental health needs.

- maintaining support to the MCH Line so it can keep pace with demand and provide a targeted and proactive MCH nurse led outreach service

- embedding the practice of referring clients to perinatal mental health nurses where screening requires and providing sufficient perinatal mental health nurses to meet demand.

Nurse E – Maternal and child health nurse

I have worked as a Maternal and Child Health (MCH) nurse for over thirty years. I am a Registered Nurse and Registered Midwife, with a Diploma in Community Health Nursing/Maternal and Child Health and a Bachelor of Education. As an MCH nurse, I work closely with families with children from birth to five years, providing home visits after the birth and key health and development reviews either in the family home or at the community MCH Centre. The early outreach visits to all Victorian families are critical in assessing the health and wellbeing of newborns, their birth mothers and the extended family and in establishing relationships that may last for 10 years as a family begins and sustains their early parenting experience. The visit involves early assessment of the physical, emotional, psychological and social health of the family and responding to emerging needs in a timely way.

A key early health assessment occurs when the baby is four weeks old. It focusses on maternal health, including a review of the birth experience, physical recovery, emotional wellbeing (including screening for post-natal depression) and a discussion about family functioning including family violence. It is an opportunity to explore the impact of birth on existing or emerging mental health issues and to make appropriate referrals with local service providers, including GPs, Community Mental Health Services (CMHS) and if needed, specific mother/baby support units.

The incidence of post-natal depression is thought to be as high as one in five women following birth (Perinatal Anxiety and Depression Australia/PANDA April 2019). Therefore, the mother, and partner if present, is invited to complete the Edinburgh Post Natal Depression Scale (EPNDS), a ten-question, self-rating scale designed to identify signs of anxiety and depression. Question 10 is about thoughts of self-harm, and answering this question is often the first time a parent will confirm they have thoughts of self-harm or of harming their infant.

In one such case, a mother who appeared to be managing confidently, presenting as organised and confident with a thriving baby, received a very high score. She had a professional background and a supportive partner and family but had not wanted to share her deeper thoughts about self-harm with them. She was experiencing an acute mental health crisis that needed an urgent response. With the mother's consent, her partner was contacted and immediately came from work to be with her for support. The local Crisis Assessment and Treatment Team (CATT) were contacted and, after a telephone consult, arranged to provide an outreach assessment at the family home. An appointment was made with her local GP. Her partner contacted her extended family and told them of the family's needs. The critical response from the CATT made an urgent outreach visit to assess the mother's mental health needs and a plan to continue home visits, especially in the evenings when the mother said her needs were greatest.

This support provided by mental health nurses was a critical bridge in holding the mother, infant and family safely while her mental health needs were assessed. It brought the partner and extended family into a more supportive role and strengthened the mother's links with her local GP, to implement a mental health plan and ongoing psychological counselling once the CATT had closed. A referral was also made to the Enhanced MCH nurse who was able to provide additional in-home support until the family were ready to transition back to the Universal MCH Service. The family continues to engage with MCH services. The mother's mental health has remained stable and she

feels well-supported by her partner and extended family. Both parents are better informed about the resources available in their local community.

Time is critical in mental health crises. The CATT concept is the linchpin in providing acute mental health care in the community, maintaining families in their homes, assessing and implementing care plans, liaising with other community health providers and referring into acute hospital-based programs as indicated. However, CATTs need more mental health nurses to be able to deliver responsive and sustained mental health care. Sustained in home mental health care is critical for families as an adjunct to the crisis response of the CATT. The former Mental Health Nurse Incentive Program (MHNIP) was an excellent example of community based, in-home mental health care and would complement an extension of the CATT response to families in crisis.

Perinatal mental health screening

Victoria's 10-year mental health plan states that women are at higher risk of particular mental illnesses and have increased risk to their mental health during pregnancy and following childbirth. The plan commits the Victorian Government to improving prevention, early intervention and treatment of vulnerable mothers from pregnancy through the post-partum and early infancy period. [13]

The *Australian Clinical Practice Guideline for Mental Health Care in the Perinatal Period* (2017) recommends that all pregnant women are assessed for psychosocial factors including previous or current mental illness as early as possible in pregnancy, after giving birth and in the post-natal period.[14]

We share concern about the incidence of mental illness including depression, anxiety, post-traumatic stress disorder, bipolar disorder, schizophrenia, borderline personality disorder and postnatal psychosis and the increasing number of maternal deaths from psychosocial causes. We also note the Maternal Health Study showed that the prevalence of maternal depression was higher when the first child was four years of age than at any point in the first 18 months postpartum and research from the Centre of Perinatal Excellence that estimates that if such mental health conditions are left untreated, the impact on individuals is long lasting and the cost to Victoria significant (around $116 million, not including higher risk refugee populations).[15,16]

The final report of the inquiry into perinatal services recommends that the Victorian Government create a Perinatal Mental Health Plan, as an adjunct of the 10-year Mental Health Plan, that articulates the following:

- universal mental health screening for women during the perinatal period
- universal screening for family violence
- ensuring health professionals have clear pathways for treatment of women and families
- training health professionals in mental health screening and bereavement care
- funding and expansion of a state-wide perinatal emotional health program (PEHP) program.[17]

We support this recommendation. However, we stress that most health service antenatal clinic templates provide insufficient time for midwives to provide all pregnancy care required, including mental health screening, and referral pathways are non-existent or unclear. This overall process needs to be remedied for effective routine screening to occur.

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[13] Victorian Government Department of Health and Human Services, *Victoria's 10-year Mental Health Plan,* Melbourne, 2015. p.18-22.

[14] Centre of Perinatal Excellence, *Mental health care in the perinatal period: Australian clinical practice guideline,* 2017.

[15] SJ Brown et al, Maternal health study p*olicy brief no.1: Maternal depression, 2014.*

[16] Price Waterhouse Coppers, *Valuing perinatal health: the consequences of not treating perinatal depression and anxiety*, 2014, cited in Parliament of Victoria, *Inquiry into perinatal services: final report*, 2018, p123.

[17] Parliament of Victoria, Family and Community Development Committee, *Inquiry into perinatal services Final report,* Melbourne 2018. p114.

RECOMMENDATION 12

Implement the recommendation in the final report of the inquiry into perinatal services that they create a Perinatal Mental Health Plan, as an adjunct of the 10-year Mental Health Plan, that articulates the following:

- universal mental health screening for women during the perinatal period
- universal screening for family violence
- ensuring health professionals have clear pathways for treatment of women and families
- training health professionals in mental health screening and bereavement care
- funding and expansion of a state-wide perinatal emotional heath program (PEHP) program.[18]

RECOMMENDATION 13

Provide funded access for women to midwife postnatal care, including mental health risk screening, via midwife home visits, early parenting centres and phone counselling as required for at least seven days.

National perinatal depression initiative

The National Perinatal Depression Initiative (NPDI) played a significant role in facilitating mental health screening. This Commonwealth-led national initiative, jointly funded by the state and federal governments between 2008-2013, aimed to improve the prevention and early detection of antenatal and postnatal depression and provide support and treatment for new and expectant mothers experiencing depression by providing:

- routine and universal screening for depression for women during the perinatal period using the Edinburgh Postnatal Depression Scale

- follow up treatment, support and care for women identified as at risk of, or experiencing, perinatal depression

- training and professional development to equip nurses to screen expectant and new mothers and make appropriate referrals and provide for research and data collection.

Through the program, Victoria initiated the Perinatal Emotional Health Programs (PEHP) discussed below. beyondblue also received $5 million to raise community awareness about perinatal depression and develop information and training materials for health professionals who screen and treat new and expectant mothers for perinatal depression. The Centre of Perinatal Excellence was subsequently established out of the success of the perinatal program at beyondblue.

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[18] NB: We consider the PEHP program to be a crucial program and address this separately in Recommendation 14.

Perinatal emotional health program

In 2010, the Victorian Government allocated funding for the Perinatal Emotional Health Program (PEHP) to regional Victorian area mental health services (AMHS) based on one EFT per 1 000 births.[19] This was the major treatment component of the Victorian NPDI program, providing early intervention for women at risk of, or experiencing, perinatal mental health problems.

Funding was allocated to regional Victorian AMHS based in Albury-Wodonga, Traralgon and Warrnambool. The program included free assessment, screening, referral, outreach or clinic-based appointments and education for families and healthcare workers about perinatal mental health.

The program was embraced by nurses, GPs and community members, with mothers highlighting the importance of this program during the community consultations for the Parliament of Victoria, Family and Community Development Committee Inquiry into Perinatal Services:

> *'When he was five months old, with the help of my husband and my mother, I accessed the wonderful services at the early motherhood service, where an incredible woman ensured that my mental health was put first. She developed a plan with my GP, who then diagnosed me with PTSD. With a lot of love, care and hard work, and a few meds along the way, I am proud to say that I am better. I am dealing with what happened to me and my son ▇▇▇ I am enjoying my kids, and I am grateful that ▇▇▇ is still here.'* – ▇▇▇▇▇▇▇

> *'In our newly formed mothers' group of 18 mums close to half of the women had made use of this service within the first two months of their babies' lives. We were shocked to hear that this service may not continue and collectively wrote a letter to our federal member, Cathy McGowan, at the time …*

> *Whilst I have never had to make use of the early motherhood service myself, it is something that could be a possibility. Many in this room would know that postnatal depression and other postnatal issues can strike anyone without warning following the birth of a baby. It could even potentially happen to me. I would describe myself as a generally happy and well person, but postnatal depression is something that is not predetermined, so it could happen to anyone in the community, and we do not know, so it is so important to have this service there.'* – ▇▇▇▇▇▇

> *'This seems to be a really important program. I have also had personal experience with this when my youngest daughter was five months old. I recognised that I was not coping. I was not being my normal self, and my behaviour had changed. I was extremely lucky to have already heard of this program when the nurse came and talked at an Australian Breastfeeding Association discussion meeting. Without that, I was not aware of the program. So I was in a position where I finally gathered the confidence to make a self-referral. The empathy that was provided by this nurse was incredible. The strategies that she provided got me back on the right track, and after a follow-up visit I was feeling better and better all the time.*

> *I think that this early intervention prevents the deterioration of many mothers' mental health. From an economic viewpoint, it prevents further strains on the healthcare system and more cost to the healthcare system, because mothers' mental health can be possibly improved with this early*

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[19] Parliament of Victoria, *Inquiry into perinatal services: final report*, 2018, p114.

intervention, instead of deteriorating to a point where it requires much more intensive strategies. The perinatal emotional health program is one that I think should be continued, if possible, with funding. These nurses and counsellors have a good understanding of the particular situations that mothers face with their families. – █████████

Northeast Border Mental Health Services' won several awards for their PEHP and became the template for the state-wide Victorian PEHP. In their submission to the Perinatal Inquiry, they advised that there were more than 2 500 births in their region, with almost 20 per cent of the mothers requiring perinatal mental health care.

Data from Sunshine Hospital showed the PEHP reduced length of stay within maternity services by 1.7 days, representing a saving of $2 635 per patient per stay or $806 310 per annum (based on 306 admissions in 2014).[21]

South West Healthcare also reported significant success, with the program receiving an average of over ten referrals a month (12 per cent of all births in the catchment's birthing hospitals). They told the inquiry the program was cost-effective, led to significant capacity building among staff and stakeholders, and was valued by consumers and stakeholders.[22]

Midwives and nurses welcomed the program because it filled a gaping hole in service provision for vulnerable women. Some midwives were provided with education and training to perform screening for depressive disorders and incorporated this screening into their routine antenatal care.

The Federal Government ceased funding the program in 2015. The loss of this funding stream has jeopardised the gains made and heralded a return to reduced rates of perinatal depression screening, with ill or at-risk women and children not receiving the early intervention treatment and support they need. It is ironic that as we increase risk assessment, we see a decrease in the options for referral and treatment. Midwives report that this is a very challenging ethical and clinical scenario which is regularly experienced in antenatal clinics.

The loss of funding has also affected the ongoing education for nurses and midwives and their capacity to continue to undertake this important screening. Given the success of the program in focusing on early intervention, the difficulty accessing other psychological care in regional areas, the sad reality that families without suitable mental health support are at greater risk of engagement with tertiary services such as EDs, family violence services and child protection, and the obvious cost benefits of providing an early community- based pathway to care and support, the ANMF (Vic Branch) is eager to see this funding reinstated, with the Victorian Government providing recurrent funding for state-wide PEHP programs with adequate EFT.[23]

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[20] ibid., p145.

[21] FH Bilbao, *Implementing a perinatal emotional health program in a metropolitan Melbourne maternity hospital,* 2015.

[22] Op cit., pp146-147.

[23] Because of the success of the program in the Loddon Mallee region, when the PEHP was cut, the Bendigo Health maternity services program decided to help fund the PEHP from their own budget. This has resulted in a disadvantage to that hospitals ability to properly fund other clinical services. The total PEHP is 1:0 EFT and covers the whole Loddon Mallee region and is considered a vital but inadequately resourced service.

RECOMMENDATION 14

Provide recurrent funding for state-wide peri-natal emotional health programs (PEHP) with adequate EFT.

See recommendation 12.

Mother/parent baby units

Victoria has six public mother/parent baby units: Units at the Austin Hospital and the Monash Medical Centre have six mental health beds and cots; the Werribee Mercy Hospital unit has eight mental health beds and cots. In regional Victoria, Bendigo Heath and Latrobe Regional Health have 24 hour/seven days a week service with five beds and cots. The unit in Ballarat is a five-bed Monday to Friday service. Given demand is high, mental health needs don't cease at weekends, and women in regional and rural areas are recognised as a vulnerable group in relation to mental health, we consider all services should be increased to eight beds and eight cots and be operational 24 hours a day, seven days a week. The services would also be improved if they were able to include a maternal child health nurse (at least three days per week) as part of the staffing profile to support families in the care of their infant during their admissions.

RECOMMENDATION 15

Expand mother/parent baby units across the state to include eight beds and eight cots; enable them to operate 24 hours a day, seven days a week; and include a maternal child health nurse (at least three days per week) as part of the staffing profile to support families in the care of their infant during their admissions.

Early parenting centres

Early parenting centres (EPCs) play a crucial role by providing specialist advice and care to parents who experience more serious and persistent difficulties. They provide community programs, day-stays and longer residential programs to improve health, wellbeing and developmental outcomes for babies and toddlers.

Victoria currently has three publicly funded EPCs that offer programs for families with children from birth until they turn four: Tweddle Child and Family Health in Footscray, the O'Connell Family Centre (Mercy Health) in Canterbury and the Queen Elizabeth Centre in Nobel Park.

All have high occupancy rates and long waiting lists, with around six per cent of women in Victoria who have recently given birth being admitted to an EPC. Many facing long waiting lists. Given postpartum mental health is critical, more services are needed.

The Victorian Government announced $135 million in the 2019-20 Victorian Budget to build and operate EPCs in Frankston, Casey, Wyndham and Whittlesea – some of Australia's fasting growing communities. In regional Victoria, centres will be established in Ballarat, Bendigo and Geelong. The new centres will help more than 5 000 extra families every year and are a welcome addition. Tweddle Child and Family Health Service and the Queen Elizabeth Centre will receive a much-needed refurbishment and expansion to meet increasing demand. We welcome this announcement and are eager to see it come to fruition in a timely way.

Nurse H – Clinical nurse specialist, mother baby mental health unit

I have had the privilege of working with vulnerable families for over 20 years. A Registered Nurse Division 1, I have a Bachelor of Nursing and a Postgraduate Certificate in Health Science Psychiatric Nursing. I have also completed training in a range of international courses including: Circle of Security (relationship-based DVD course), Sollihull Approach and Sollihull Group training (resilience and parenting based framework) and Parent Child Mother Goose (interactive playgroup with storytelling).

I am employed as a Clinical Nurse Specialist (CNS) in a public mental health unit for mothers with serious mental illness and their infants under the age of one year. It is a 24-hour, seven- day-per-week inpatient facility offering care for women predominantly with psychotic disorders, mood disorders (including postnatal depression), anxiety disorders and personality disorders. There is a high co-morbidity of significant trauma history (usually childhood sexual assault and/or family violence), and their illness typically results in emotional and / or physical neglect of their infants and abnormal relational attachment patterns in infants.

The unit offers a multi-disciplinary team which includes a psychiatrist, a psychiatric registrar, a psychologist and a maternal and child health nurse in addition to mental health nurses. Access to relevant hospital resources such as paediatricians, paediatric physiotherapists, physicians, dieticians, interpreters, social workers and onsite legal services for patients experiencing family violence is available as needed.

As a CNS, I provide education, support and role modelling of sensitive, holistic, recovery-focused care to less experienced clinicians (including undergraduate and postgraduate nurses) and assist with the development of ward policies and procedures and models of care. I also have a role in ensuring adherence to the relevant policies and procedures, the Mental Health Act 2014, the Children, Youth and Families Act 2005/15 and the registration and practice requirements for AHPRA.

My working day normally consists of assessing the mental health and risk of mothers and infants throughout the shift, assessing the quality of the mother-infant relationship and relationships with significant others/carers and providing individual and group interventions to mitigate risk, facilitate recovery, wellness and resilience, and break what are often multigenerational patterns of dysfunctional parenting or relating and subsequent mental illness.

Most clients have experienced a re-living of past trauma with the birth of their infant, and a lot of my work includes providing education and support through this process. Often, I need to take over the care of an infant throughout the shift to reduce the risk of harm to the mother, infant or both. I spend significant time role-modelling normal healthy emotional and physical care of infants and provide emotional care for vulnerable babies when their mother/parents are unable to do so. I use supportive psychotherapy, mindfulness, sensory modulation, mothercraft strategies and medications throughout each shift, and encourage and empower patients to be as independent as they can.

Many of our patients have never experienced a major mental illness before and need assistance and support to gain relevant community supports. Part of my role is to work with clients to recommend and refer them to support services and help mothers and families identify which supports they would find most helpful. This is imperative to enable our clients to continue to recover in the community, in a supported and often closely monitored way, to reduce risk of relapse or harm and to ensure their infants receive 'good enough' parenting. Typically, 30 to 60 per cent of our families have DHHS Child Protection involvement, and many of them are linked in with community mental health teams. I liaise with these, and other support services and resources, throughout a patient's admission to ensure a smooth transition back to the community.

My role also includes supporting and assisting patients and carers with concerns or complaints relating to their care and advocating for their rights and optimal treatment within the hierarchy of health care. This can be very challenging.

Parenting resources and other aids such as mindfulness, progressive muscular relaxation, music and white noise are available on line, providing ready access for patients to use on the ward (with assistance, education and modelling) and ongoing access at home to facilitate recovery. Unfortunately, due to funding constraints, our hospital doesn't provide Wi-Fi access, so our patients and staff have to use their own data to access these.

Funding through Safewards has enabled the provision of many sensory modulation items to assist clients experiencing high distress or arousal, and I frequently educate and role model the use of these and assist clients to work out which ones are more appropriate to them. These items can at times be a viable alternative to medications to manage symptoms including distress and insomnia (especially the massage chair, weighted blankets and aromatherapy).

My nursing colleagues are also very committed and dedicated, and self-fund many of the more expensive training courses so they are equipped to offer an extensive range of modalities to patients.

Ongoing increases in documentation requirements, limitations of availability of Child Protection and other relevant supports, and a lack of Ward Clerk services after 2pm each day however, mean face-to-face work with patients is significantly reduced while we meet these responsibilities. Nurses also repeatedly interrupt patient care to open the front door for visitors and spend hours on the phone trying to make referrals to services that are overwhelmed or closed for new referrals. Additionally, DHHS Child Protection Services (CPS) will often now 'close' their case as soon as the infant arrives at our ward, rendering our staff with no option than to re-notify to CPS on discharge. This adds significantly to patient trauma, delays discharge, and interferes with the working therapeutic relationship developed with patients.

The vast increase in complexity of clients, the extensive trauma work and language needs for refugees, and the lack of education in basic infant care in new mothers, impacts greatly on our capacity to provide care but does not appear to be taken into account in staffing funding. Housing options are often limited, emergency finding for essentials is absent (or too arduous for our nurses to obtain on a ward with no dedicated social worker), and CPS often refuse to engage our women as their services are too overstretched.

One thing contributing significantly to the distress of mental health patients and nurses (across the board in all mental health care settings) is the varying approaches to clients and staff taken by consultant psychiatrists. Within the hierarchy of health care, they hold the position of most responsibility and most power and patients and nursing staff are very reluctant to put in a complaint about them. When encouraged to put in a 'feedback or complaints' form or to contact the Office of Public Advocate, patients and families are extremely reluctant to do so. When staff (in various settings) are encouraged to put in a formal complaint via the appropriate hospital mechanisms, or contact the Chief Psychiatrist, they too will almost exclusively not do so. If there has been a clear breach of policy, or the Mental Health Act, some nursing staff will definitely take it further, but many won't. Thankfully, patients (in my experience) will readily complain if they believe they have obtained inappropriate or unfair treatment from a nurse. This enables ongoing professional reflection and accountability and provides an ideal opportunity for patients to be supported with assertiveness, conflict management and repair of ruptured relationships in a meaningful and timely way.

Funding is an ongoing problem and dilemma in healthcare. It's expensive to care for our society's mentally ill and always will be. I have spent the last 20 years working in perinatal psychiatry because it gives me a great sense of achievement seeing people recover and knowing I'm contributing to the ongoing mental health of not only this next generation, but those to come.

School nursing programs

The Primary School Nursing Program (PSNP) is a free service offered to all children attending primary and English language centre schools in Victoria. Primary school nurses visit schools throughout the year to:

- provide children with the opportunity to have a health assessment
- provide children with information and advice about healthy behaviours
- link children and families to community-based health and wellbeing services.

The PSNP is designed to identify children with potential health-related learning difficulties and to respond to parent or carer concerns and observations about their child's health and wellbeing. Parents or carers complete the School Entrant Health Questionnaire (SEHQ) which is distributed during the first year of school. With their consent, follow-up health assessments are conducted by the school nurse as indicated. The program also provides formal and informal health education and health promotion to the school community.

The Secondary School Nursing Program (SSNP) aims to reduce risk to young people and promote better health in the wider community. Approximately two thirds of government secondary schools participate in the SSNP. The program is targeted to Victoria's most disadvantaged schools, and most nurses are allocated to two schools. The program aims to:

- play a key role in reducing risk-taking behaviours among young people, including AOD abuse and tobacco smoking and in reducing negative health outcomes around eating disorders, obesity, depression, suicide and injuries
- focus on prevention of ill health and problem behaviours by ensuring coordination between the school and community-based health and support services
- support the school community in addressing contemporary health and social issues facing young people and their families
- provide appropriate primary health care through professional clinical nursing, including assessment, care, referral and support
- establish collaborative working relationships between primary and secondary school nurses to assist young people in their transition to secondary school.

Again, these programs if enhanced are very well-placed to provide universal mental health care screening, referral and follow-up support. Nurses with mental health expertise have the appropriate skills to do so and can work in close liaison with other nurses in community-based mental health and services to make referrals and assertive follow-up that facilitates all at-risk children and young people who may be suffering in silence to receive expert and timely treatment. Strengthening these services to enable this to happen would be a very cost effective and efficient approach.

> **RECOMMENDATION 16**
>
> Extend and enhance the current primary school nursing program to include mental health nurses to conduct individual assessments on students and run mental health education, promotion and prevention programs for students, parents and school staff. We recommend 0.5 EFT per 500 students.

> **RECOMMENDATION 17**
> Extend and enhance the current secondary school nursing program to include mental health nurses to provide appropriate mental health intervention, professional clinical nursing, mental health assessments, physical care, holistic support and coordination between the school and community-based mental health and support services. We recommend 0.5 EFT per 500 students.

Child and adolescent mental health services

State-funded mental health services for young people aged 12-25 are currently provided by three service types: Child and adolescent mental health services (CAMHS), youth mental health services and adult mental health services. It is widely agreed that current barriers between CAMHS and adult mental health services fall at a critical developmental time and need to be addressed through a tailored response.[24] Differing ages and stages of the onset of mental health conditions and the differing prevalence of such conditions place different demands on each program. There are also differences in the models of care and service and in workforce provisions.

CAMHS and adult mental health services are working together to deliver a new response for children and young people aged 0 to 25 years – child and youth mental health services (CYMHS) – with the aim of providing seamless care across this age range.

Child and youth mental health services

Child and youth mental health services (CYMHS) are specialist services designed to provide direct mental health care for children and young people though:

- a single triage linked to assessment services

- mobile multidisciplinary teams providing intensive community-based crisis response and home treatment over extended hours

- mobile case management services for young people with complex needs who are difficult to engage in clinical-based care and/or are living in out-of-home care

- psychosocial case management and therapeutic individual and family services

- specialist disorder-specific services for young people with personality disorders, mood disorders and psychoses

- comorbidity clinics, particularly for young people with substance abuse and mental health problems

- peer-support programs for youth consumers and their families and carers

- comprehensive group-based personal, social and vocational recovery programs.

We strongly support this model and recommend it be extended to all areas to eliminate arbitrary age barriers and defined treatment periods.

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[24] Victorian Government, *Child and adolescent mental health services*, viewed 10 June 2019, <https://www2.health.vic.gov.au/mental-health/mental-health-services/area-based-services/services-for-children-and-adolescents/child-and-adolescent-mental-health-services>.

RECOMMENDATION 18

Encourage CAMHS and youth mental health services across the state to work together to deliver the CYMHS model to provide seamless care across this age range.

Nurse S – Nurse practitioner, youth early intervention team

I am a nurse practitioner (NP) employed in a regional youth early intervention team (YEIT), previously known as an early psychosis service (EPS). I have been working with youth for the past 12 years and have been a psychiatric nurse for 16 years. I regularly attend youth specific training around youth mental health to maintain a sound evidence base when treating young people.

Our current team is very small. Because input from an adult psychiatrist and a CAMHS psychiatrist is limited, the service identified the need for an NP. We cover quite a large rural and regional area – about 40,000 square kilometres, with an average driving distance to see consumers of 30-100kms both ways in a day. We provide an assertive outreach model of care. We do not expect the young person to attend a clinic if they are unable; our philosophy is to see the young person in their own environment to enhance recovery.

My work includes working at an advanced clinical level, case management and community work. It has expanded so I not only provide daily support, but I also make decisions regarding treatment – this could include prescribing and initiating medications, diagnostic tests and collaboration with youth services and the young person's family.

YEIT or EPS services were established in 2006 across the state of Victoria to meet the increased need to effectively address young people experiencing low prevalence disorders such as psychosis and bi-polar. The client group that are seen by our service are aged between 16-25. They are a diverse group of young people from differing socioeconomic backgrounds and ethnicities. The implementation of YEITs across the state is well established, but there has been no consistency in their implementation, with a number of differing age ranges. A number of EPSs are embedded in the adult mental health sector or as a part of CAMHS sector also known as CYMHS (child and youth mental health services). This has been a significant point of difference, as the services provided across the state are inconsistent, as what you may get in one area, might not be similar in another area of the state. This can cause much distress and uneasiness with young people and their families and impacts on them accessing appropriate and timely service. This is also evident in that young people in rural areas who require hospital admissions are required to attend metropolitan hospitals or admitted out of the state at the expense of the family, causing more unnecessary stress to all involved. This also impacts on clinicians involved as it is challenging trying to arrange a bed outside of the area you work in, especially when there are barriers and delays in accessing these services.

What has been evident over the past 12 years I have been working in youth is that the presentations of young people to tertiary level services have increased. We are seeing more young people present in crisis, suicidal and psychotic. However, the ability for services (CYMHS, CAMHS and Adult Mental Health) in a system that has not moved with the times is now struggling to support our youth in need. With an increase in the suicide rate, increased level of dysfunction in our communities amongst youth, increased substance use to cope, there has been no increased funding or development in services such as CYMHS or Youth Teams to address the short fall as stated in the VAGO report into child and youth services.

I was part of a communities of practice in 2010, with the redevelopment of CAHMS to CYMHS as part of a DHHS strategic plan moving forward to 2020. This did not eventuate, with more fragmenting of the youth system rather than enhancing it. What I have seen is the push for more Headspaces, which is good in hindsight as youth that can access them will attend a service like this, however the cohort of young that we are not seeing are those that present in crisis, attend EDs on multiple occasions for deliberate self-harm and suicidal behaviours and are living in quite rural, remote and

regional areas of our state. These are the youth that fall through the gaps. I have seen firsthand the impacts of services that cannot respond in a timely matter with devastating impacts, not only on the families but the community that young person was a part of.

This can also have an undesirable effect on workforce development; a number of senior clinicians with years of experience have left the mental health service due to fatigue and burnout. Child and Youth Services are much specialised area's and without the experience of senior clinicians, consumer care is also compromised.

Intensive outreach services

Intensive Mobile Youth Outreach Services (IMYOS) in CAMHS and Mobile Support and Treatment teams (MST) in Adult AMHS provide intensive outreach mental health case management and support to people who display substantial and prolonged psychological disturbance and have complex needs which may include challenging, at risk and suicidal behaviour.

They use an assertive outreach approach both in the home environment and community-based rehabilitation and operate extended hours seven days a week. They differ from continuing care services and crisis assessment services in the intensity and frequency of intervention offered and work more closely in partnership with Mental Health Community Support Services (MHCSS).

IMYOS and MSTs offer a flexible, responsive and intensive support service, working with individuals, their family and carers to help enhance their quality of life in the community and assist the individual to live to, and participate to, their full potential. We would like to see these teams introduced as standalone teams to prevent these consumers becoming lost to service.

> **RECOMMENDATION 19**
>
> Reintroduce and expand the MST and IMYOS intensive outreach services as stand-alone teams.

Clinical residential rehabilitation services

Community Care Units (CCUs) provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide a 'home like' environment where people can learn or re-learn skills necessary for successful community living. While many move through these units to other community residential options, others require this level of support and supervision for several years.

Significantly, these services often provide access to generic clinicians who undertake the case management of clients. Integrated holistic care is not supported by this approach. In fact, this approach undermines the potential many of these programs have and means clients do not benefit from discipline-specific care, and in particular, from nursing care by highly educated, skilled, experienced and regulated clinicians such as nurses who have the capacity to both assess and meet both mental health and physical health care needs.

The ANMF (Vic Branch) strongly endorses a community model of care that enables people with mental illness to access the spectrum of an integrated clinical nursing and allied health care at the one time, as is the case for people with physical ill health in the general health setting.

> **RECOMMENDATION 20**
>
> Retain the nurse-led model of care provided in CCUs but better integrate therapeutic environments to allow for ease of transition and promote well-being and recovery.

Nurse C: Associate charge nurse, community care unit

I hold a Bachelor of Nursing and a Graduate Certificate in Mental Health and have 30 years' nursing experience: 20 as a registered psychiatric nurse and 10 in general nursing including medical, surgical, orthopaedic, emergency, paediatrics, aged care and perioperative nursing. I also have extensive experience in other areas of health care and in other industries.

I am currently an Associate Charge Nurse (ANUM) in a Community Care Unit (CCU). CCUs aim to decrease or prevent relapse, readmission or use of hospital services by providing consumers with treatment and rehabilitation to help them develop the necessary skills for optimal independence and quality of life consistent with their level of functioning.

The CCU provides medium to long term accommodation averaging between six months to two years. It has a unique role in that it is not a Psychiatric Adult Rehabilitation Centre (PARC) and it is not a Supported Residential Service (SRS). In fact, there is confusion among some organisations and individuals about the true function of CCUs. Clients accept placement at a CCU on a voluntary basis, with the exception of those on Non-Custodial Service Orders (NSCO) and Community Treatment Orders (CTO) as per the Mental Health Act (MHA) which require the individual to continue prescribed treatment or on-going monitoring.

A CCU is a community bed-based facility with registered nurses providing 24-hour clinical and psychopharmacological support, as well as life skills and psychosocial therapy-based support. Care is provided by a multi-disciplinary team which includes a consultant psychiatrist, medical officer, social worker and occupational therapist as well as a nurse unit manager, graduate and post graduate nurses and allied health. They provide individualised assessment, care planning, treatment, monitoring, engagement, risk and mental state assessment and support in linkage with the community.

A CCU is unique in that it provides intensive and clinical based supports for clients who may have a high level of symptomology and risk factors. As such, it can be seen as a subacute community bed-based service providing monitoring, assessment and clinical team review along with risk prevention and interventional management plans that may include extra administration of medications, increased monitoring and in some cases re-admission to hospital.

All work is performed under the governance of policies and procedures, locally formed guidelines and core business outlines, legislated Acts and state and federal standards. CCUs use the recovery-based model of care, providing holistic and personalised care, promoting autonomy and self-determination, responsiveness to diversity, reflection and learning, a culture of hope, focus on strengths, reflection and learning, collaborative partnerships and meaningful engagement, and significantly family, friends, support people and significant others.

Outcomes are influences by a range of factors including socioeconomic issues, availability of housing or appropriate accommodation, level of involvement of family or significant others, effects of symptoms or condition of the individual, level of functioning of the individual, finance for programs and services of rehabilitation, access to other services, other services' willingness to engage with the client, understanding and skill level of clinicians, judicial or forensic issues, as well as facility based and organisational systems influences (failures).

Familial supports are provided to be inclusive of the client's needs and outcomes. Part of the systems in place provides for the family or significant others to be present at meetings, functions and reporting so that they have input and involvement in the continuum of care. Barriers that prevent this

relate to socioeconomic issues and willingness to engage. Provision to assist in this area comes in the form of financial assistance, however this can be a long process in applying for funding or insufficient for the duration of the client's time in care. Community visitors and peer support persons add to the voice and needs of clients and families in accessing support services.

Noticeably, families caring for a person with a mental illness are often aged. This puts a lot of pressure on these families. This may be in the form of financial, emotional or practical supports especially with appointments, accommodation and or transportation. When both the parent and the health recipient are on some form pension, this leads to underservicing for treatment and stress on the familial relationship. In some cases, the family are unable to return the individual to the family home in part due to these issues.

Constraints affecting the provision of this service type include:

- *Lack of understanding of the function of CCU by other organisations and other services, including that the CCU is an accommodation facility*

- *Lack of role definition or recognition of the role of CCU by other services*

- *Resistance from other services to take on certain clients (especially a client with intellectual impairment)*

- *Ineffectual communication from other service providers*

- *Lower priority level of funding given to CCUs*

- *The expectation to provide a higher percentage of under skilled clinicians for training in this area, which can affect the type of service given and demands of outcomes from the organisation and government departments*

- *Exposure of CCUs, as standalone facilities, to a range of issues that would not be found in a hospital setting or community service clinics, including a higher degree of risks, greying of role types and constraints in budgeting, as well as the ratio of inexperienced staff to experienced staff*

- *Lack of effective protective systems and heavy reliance on staff to be vigilant and responsive in assessments to divert catastrophes*

- *Lack of beds available for unwell clients in either EDs or inpatient psychiatric wards*

- *Shortage of appropriate accommodation for mental health care recipients both in the private and public sector*

- *Commonly advanced age of parents/carers, making it difficult for them to support the recipient of mental health care*

- *Limitations on National Disability Insurance Scheme (NDIS) funding for mental health recipients and need for careful and considered wording on funding applications to help success rate*

- *Capacity of clients with a mental illness to secure and maintain employment, with many having more difficulty finding and maintaining employment, needing extensive time off work, or being limited in the type of work they can undertake*

- *Lack of empathy in the Centrelink process that does not effectively take into account the extent of incapacity an individual may experience because of mental illness – this places additional stress and hardship on the person.*

Adult community mental health teams

We support moves to strengthen community-based mental health services to facilitate earlier interventions in primary care settings. This is in keeping with the growing body of research suggesting community mental health nurses have a major role in providing holistic mental and physical health management for people with lived experience accessing their services.

Recent research suggests a comprehensive approach to health screening in community mental health nursing settings is both practically feasible and could deliver significant health outcomes for people with severe mental illness. Multiple studies have also proposed that community mental health nurses have a high potential to provide holistic physical healthcare benefits to people with serious mental illness.[25,26] Mental health nurses are well positioned to offer individualised, person--centered health care and preventative health outcomes.

Adult Community Mental Health Teams (Previously known as Continuing Care Teams) provide non-urgent assessments, treatment, case management, while working to support the recovery of people with a mental illness in the community. The length of time case management services is provided to a person varies according to clinical need. Recovery care nurses may be involved with people for extended periods of time or may provide more episodic care. Recovery teams often include nurses who specialise in bilingual case management, dual diagnosis and homeless outreach. Recovery clinicians frequently liaise with, and refer to, generalist services including general practitioners for ongoing support and provision of services to people with a mental illness.

The potential of these services is reduced by generic case-management models. We recommend moving away from traditional generic case-management models and enabling health practitioners to work according to their unique discipline-specific skill sets.

> **RECOMMENDATION 21**
>
> Introduce a discipline-specific model of care in the community where nurses who are an AHPRA regulated workforce are qualified to lead all aspects of clinical care, allowing other disciplines to complement the care needs and provide expertise consistent with the inpatient service model.
>
> SEE RECOMMENDATION 5 on funding and reporting.

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[25] J Blythe et al, 'Role of the mental health nurse towards physical health care in serious mental illness: an integrative review of 10 years of UK literature' 2012
[26] T Bradshaw et al, 'Evolving role of mental health nurses in the physical health care of people with serious mental health illness', 2012.

Residential aged care facilities

People living in residential aged care facilities have complex care needs for a range of well documented reasons, including the following:

- Life expectancy is increasing, and people are staying in their own homes longer by using outreach services. This means people are older and frailer when they enter aged care.

- The prevalence of chronic conditions requiring more complex care increases markedly with age, so older residents have more complex care needs.

- To manage their complex care needs, most residents use multiple medicines (including high risks medicines such as anticoagulants, insulin, chemotherapy agents, narcotics and sedatives) with polypharmacy, the concurrent use of five or more medicines, the norm.

As with the general population, many experience mental health issues on top of their complex physical health care needs. This means they require mental health expert care, not routinely available in residential aged care facilities. It is therefore imperative to provide community mental health nurse programs for the aged, including making specific provisions for the assessment, care and treatment of people over 65 with mental health and AOD issues.

We consider this cohort would benefit greatly from strengthened Aged Persons Mental Health (APMH) teams with APMH nurse practitioners providing in-reach services to residential aged care services so older people with mental health conditions are identified and responded to appropriately. Nurse practitioners with specialist skills in this area would be very well placed to manage the mental health needs of clients while also taking into account their physical health and associated pharmacology.

RECOMMENDATION 22

Strengthen Aged Persons Mental Health (APMH) teams to include aged persons mental health nurse practitioners to provide in-reach services to residential aged care services so older people with mental health conditions are identified and responded to appropriately.

Nurse A – Registered nurse, aged care mental health

I am currently working as a senior clinician and have been in this role for five years, and at my workplace for 19 years.

I have worked in inpatient private psychiatric hospitals and metropolitan psychiatric hospitals in Melbourne. My initial training was in general nursing and I later specialised in mental health. I have 24 years' experience as a nurse.

My current role entails assisting our team clinical coordinator to facilitate best practice in the delivery of mental health, the planning and clinical operation of our team and representing our team at senior level meetings and external stakeholder meetings.

I also have a small case load of clients who I support through their journey of illness to recovery. This includes supporting individuals, carers and loved ones in their own home, working towards recovery and wellbeing according to each individual. For some clients this can be supporting them through their darkest times in suicide prevention.

Working with aged clients is very complex. Aged clients come with co-morbid complexity such as their physical health. Having experience as a general nurse is very beneficial in my role in mental health nursing. Physical illness can sometime present as mental illness, for example when clients present with a delirium.

I believe nurses are essential to best practice mental health care. Nurses provide all elements of care including assisting in metabolic monitoring to prevent comorbid illness associated with psychotropic medication; providing education and support to clients and families on medication, the importance of good dietary habits and sleep hygiene, as this also impacts on individual overall health.

Over time mental health has seen a shrinkage of fully qualified staff, with positions being made generic. The erosion of nurses from mental health is impacting on the support and care needs of individuals who have a mental Illness. Individuals with a mental illness are at higher risk of heart disease and diabetes. Without adequately trained nursing staff to support individuals with a mental illness the statistics will be worse in the years to follow.

Community nurses are under more pressure than ever. In the 19 years I have been on our team we have not received any additional clinician EFT. With the aging population, the baby boomers and increased awareness of mental illness, our demands from the community are greater than ever. Staff are feeling more stressed with workloads. There is no back fill available for clinicians on leave, and clinicians who are already under pressure are expected to absorb their workloads. This is also impacting on recruitment.

Mental health clinicians are very passionate about their chosen career. Working as a psychiatric- mental health nurse can be both extremely challenging yet rewarding. It is not an area of nursing which is glorified, and it is seldom recognised. Specialist nurses should remain in this complex area of health to ensure better outcomes for clients, family, cares and loved ones.

3.   SUICIDE PREVENTION

RC Question 3: What is already working well and what can be done better to prevent suicide?

A shared responsibility

Over 65 000 Australians make a suicide attempt each year, with suicide now the leading cause of death for Australians between 15 and 44 years of age. In 2017, more than 3 000 Australians died by suicide – about 75 per cent were men and 25 per cent were women – and the suicide rate among Aboriginal and Torres Strait Islander people was approximately twice that of non-Indigenous Australians.

Suicide prevention is the responsibility of all levels of government and government agencies. In 2017, the COAG Health Council endorsed the *Fifth National Mental Health and Suicide Prevention Plan* and associated implementation plan. This five-year plan seeks to establish a national, systems-based approach to suicide prevention that includes:

- a whole-system approach to suicide prevention, with government, business and the community working together and beyond a traditional health perspective
- a person-centred and integrated approach to service delivery
- integrated regional planning and service delivery and coordinated treatment and supports for people with severe and complex mental illness
- a trained and equipped workforce delivering quality suicide-prevention services
- high-quality services through standards and the regulatory framework.[27]

Early intervention and prevention model of care

The ANMF (Vic Branch) supports an early intervention and prevention model of care where people can access the care they need, by the right practitioner, when they need it, no matter where they live. We encourage the development of a state-wide consistent approach to suicide prevention that includes:

- increased service capacity in EDs
- preventative community-based services providing step-up and step-down care
- specialist services and risk management for people with AOD issues
- assertive outreach services
- immediate access to social supports in relation to debts, housing and employment.

We consider the services and programs outlined here could play an integral role in such an approach.

> **RECOMMENDATION 23**
>
> Develop and implement a state-wide consistent approach to suicide prevention that includes:
> - increased service capacity in EDs
> - preventative community-based services providing step-up and step-down care
> - specialist services and risk management for people with AOD issues
> - assertive outreach services
> - immediate access to social supports in relation to debts, housing and employment.

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[27] Australian Government Department of Health, *Fifth National Mental Health and Suicide Prevention Plan, 2017,* p25.

EDs pivotal to prevention

We are also eager to see a state-wide consistent approach to acute care, so that wherever a person accesses acute care, the same best practice care and treatment is available.

With accepted research showing a previous suicide attempt is the biggest predictor of completed suicide, EDs and ED health professionals are critical to suicide prevention. They should therefore be provided with contemporary education and training to improve their understandings and response to people who present post a suicide attempt.

EDs also require increased capacity so people presenting with suicide ideation or after a suicide attempt can:

- access clinical mental health services provided by a mental health nurse without delay, and preferably before they leave the ED

- remain in an acute ward until their thinking shifts toward living

- receive support from assertive discharge options and follow-up.

RECOMMENDATION 24

Develop a state-wide consistent approach to acute care that: increases skill capacity in EDs so people can access clinical mental health services provided by a mental health nurse without delay, and preferably before they leave the ED; enables people who are acutely suicidal to remain in an acute ward until their thinking shifts toward living; and provides assertive discharge options and follow-up.

RECOMMENDATION 25

Provide education and training for nurses and doctors within EDs to increase their awareness about the risks associated with a suicide attempt and the urgent need for clinical mental health services to be accessed without delay, preferably before the person leaves the ED.

ED mental health and AOD hubs

As part of the 2018-19 Victorian Budget, the Victorian Government funded ED Mental Health (MH) and AOD hubs in six EDs. The ED MH and AOD hubs are a specialised stream of ED care for people presenting with urgent high acuity mental health, AOD issues and/or physical health issues needing ED level assessment, diagnosis and treatment. They will provide access to a dedicated physical space that is more conducive to therapeutic interventions than a conventional ED.

The program aims to fast-track the most urgent presentations into specialist short-stay beds to provide improved timely assessment, treatment and assertive outreach support for individuals 16 years and older.

The program will:

- ensure people presenting with urgent mental health, AOD and physical health needs get the right support sooner

- reduce the trauma and distress experienced by people seeking care and staff associated with delays

- improve outcomes for people seeking care and reduce the likelihood of the person re-presenting to an ED

- improve collaboration across the medical, mental health and AOD streams of the ED

- establish improved referral and treatment pathways to services in the community

- avoid inappropriate inpatient admissions wherever possible and facilitate a safe and secure environment for everyone in the ED.

ED MH and AOD hubs, comprising four to six beds, will be established in EDs at Monash Medical Centre in Clayton, Frankston Hospital, Sunshine Hospital, Geelong Hospital, St Vincent's Hospital and the Royal Melbourne Hospital. People who present at ED in these hospitals will be assessed by ED triage for their physical, mental health and AOD needs and fast-tracked to the ED MH and AOD hub where appropriate.

Some people needing care will have a combination of physical, mental health and AOD treatment needs. It is widely recognised that the high stimulus environment of an ED is not always suitable for people presenting with high acuity mental health or AOD needs. In cases where people also require medical treatment, a senior ED clinician (doctor or nurse practitioner) will assess the person to determine if medical treatment would be best provided in the ED or could be provided in a sensory supported environment, such as the ED MH and AOD hub. Where medical treatment needs to be provided in the ED, this would ideally be provided as quickly as possible so as not to unnecessarily delay the person fast-tracking to the ED MH and AOD hub.

The ANMF (Vic Branch) supports this model of care, where nurses, nurse practitioners, allied health and specialist medical staff provide discipline specific care.

> **RECOMMENDATION 26**
>
> Expedite the implementation and evaluation of the six ED MH and AOD hubs and commit to expanding this program pending impactful evaluation.

> **RECOMMENDATION 27**
>
> Increase the capacity of hospitals to manage mental health crises by funding a consultation liaison nurse in every Level 1, 2, and 3 hospital (as defined in the Safe Patient Care Act).

> **RECOMMENDATION 28**
>
> Fund additional inpatient beds in regional Victoria and specialist mental health nurses to ensure people admitted with suicidal behaviours or ideation can receive specialist treatment and care until their thoughts have moved toward living.

Nurse F – ED mental health nurse

I am a registered nurse employed as a specialist mental health nurse (RN 4) in an overnight mental health triage and ED response service. I hold a Degree in Nursing and a Certificate in Psychiatric Nursing and have specialised in mental health nursing for 30 years. I have extensive experience in acute adult mental health nursing in community, ED and inpatient settings.

Mental health nurses have a unique skillset among mental health professions. We are expert generalists, able to consider the person's physical, psychological and social needs and trained to provide interventions to assist patients to meet these needs. Importantly our focus is on providing assistance that aids recovery (a return to the person's best functioning) rather than servicing disability. We are equipped to work in both inpatient and community settings.

In my current role I provide acute mental health assessments for patients across all age groups. I also provide a phone-based service (phone triage) to the community for the region's catchment area. This position is the 'gatekeeper' with respect to a clinical pathway for the patient. I make decisions about admissions and discharges (including use of restrictive powers under the Mental Health Act 2014) and provide advice or direct referrals to community resources (such as referral to a CATT or GP). ED medicine almost always defers to my advice. Frequently a medical assessment is not required.

Given the biopsychosocial nature of acute mental health presentations, assessments are usually complex and often involve AOD issues, homelessness, violence and family breakdown. Patients present alone, by ambulance, or by police, who frequently use their powers under the Mental Health Act to transport patients to ED for assessment. Young people often present with a parent.

On average an assessment takes two hours to complete and I would assess four to five clients a night. Often there are clients waiting to be seen when I arrive on shift or clients remaining to be seen when I finish my shift. It is rare to have no patients to see on a shift. Fifteen years ago, in a similar role overnight, I would have seen one or two clients a night – and none on one or two nights a week.

By way of example, my work over the past fortnight has included the following:

- *I held the hand of a psychotically disturbed young man for 20 minutes after he reached out for me while waiting for the effects of the oral (tablet) sedation he had been given to take effect. Holding his hand provided a therapeutic intervention that prevented an episode of restraint. I placed this man on an Inpatient Assessment Order and arranged an admission for him.*

- *I assessed an elderly woman after a senior ED doctor felt she was manic and needed a psychiatric admission. I concluded she probably had an organic mania due to the recent introduction of a physical medication and premorbid physical illness. The woman was consequently admitted to a medical ward.*

- *I intervened in a Code Grey (threat of violence) and assessed a man who was brought in by police, agitated and threatening violence, heavily intoxicated, handcuffed and threatening suicide. I was able to talk this man down, have the handcuffs removed and use oral sedation to help him sleep the effects of the intoxication off. This action prevented the use of restrictive intervention under Mental Health Act protocols. This man discharged himself from ED 12 hours later following a review by AOD services and after declining a mental health admission.*

- *I assessed a 13-year-old girl with acute behavioural disturbance at home (including minor self-harm and assault on her parents) requiring the intervention of police. This young girl settled with time in ED and a warm blanket tucked in tightly to provide therapeutic soothing. This action*

prevented an acute admission. I was able to discharge the patient with a commitment to the parents for follow-up from the young persons' mental health service (CYMHS).

Based on my experience, I consider the Victorian mental health system has the following gaps in service delivery for people who are acutely unwell:

- *A focus on good clinical outcomes has been lost with inadequate clinical care and a move to supportive and disability care by non-clinicians (support workers via NDIS). There is a disconnect between primary care (GP) and secondary care (Headspace and Primary Health Networks, private psychologists) and tertiary care (public mental health).*

- *Episodes of clinical care (public inpatient and community case management) are too short. More beds are needed, both acute and respite type (PARC) places so patients can have a longer period to recover. A severe side effect of the lack of beds is that wards are often chaotic and violent places for people who are disturbed, making it a difficult environment for patients and staff.*

- *Case management is now episodic, resulting in poorer outcomes for patients, frequent relapse and a paucity of case management support for those considered not at acute risk.*

- *There is a severe lack of mental health nurses and a state-wide focus on recruitment, training and retention is much needed.*

Ideas to help bridge these gaps include:

- *relaunching the Centre for Psychiatric Nursing (and add RPN4 clinicians to an advisory panel for it) and ensure there is real engagement between the various graduate and postgraduate education providers and professional development services in the state*

- *giving graduate nurses supernumerary placement in community settings so they can see work beyond the stress of inpatient settings*

- *conducting regular meaningful and mandatory off-site training and group supervision for all inpatient and community mental health nurses*

- *supporting GPs by placing senior mental health nurses in medical clinics, as was done under the MHNIP program, and supporting this program with regional management and clinical oversight and adequate psychiatrist input*

- *indenturing psychiatric registers so they are required to provide public mental health care as psychiatrists.*

Prevention strategies would be strengthened by a state government focus on health promotion in mental health that included:

- *health promotion around safe AOD use*

- *formal education for Year 11 and 12 students about mental health and AOD to destigmatise, educate and give hope – key messages: 'We are all the same...just different', 'Don't give up on yourself…your brain is still developing till you are 25…there is time for things to be better', 'All things pass...both good and bad things'*

- *free gym membership to 16-21-year-olds (and consider extending this to people who are unemployed and receiving disability support pensions) at not-for-profit, council and university gyms or swim centres – this would go a long way to promoting health and wellbeing by exposing people to an adaptive lifestyle and supporting those that lack community engagement*

- *massive investment in housing of all types.*

Crisis assessment and treatment teams (CATT)

CATT services operate within the Acute Community Intervention Services (ACIS) framework which also includes mental health telephone triage to determine the urgency and nature of response required, and dedicated face to face mental health assessments in the emergency department of major Victorian Hospitals. CATT takes this intervention further in the community by allowing short to medium term treatment in the community setting, often as an alternative to an acute inpatient admission.

CATT services work with consumers and their families, carers and significant others to provide responsive assessment and treatment in a least restrictive environment, in line with the principles of the Mental Health Act 2014 which also advocates for supported decision making and person-centred care. Nurses with mental health expertise have the capacity to provide comprehensive and holistic care and education to consumers, including about medication management and physical health needs.

Stand- alone CATT services are able to provide intensive treatment and early intervention, which can include daily, or more frequent, home visits. CATT services also have the capacity to provide intensive support post discharge from an inpatient unit, as part of an early discharge management plan, again to facilitate treatment in the least restrictive manner.

Unfortunately, many health services have moved to integrate their CATT services instead of retaining a dedicated service. Feedback from our members is this has reduced the ability to perform this acute intervention in a timely and responsive manner.

Reintroducing stand alone CATTs for each AMHS allows for dedicated teams to allow for the responsive: right time, right place mental healthcare to occur.

RECOMMENDATION 29

Reintroduce stand-alone CATTs for each AMHS and ensure they are led by nurses specialising in mental health.

Nurse K – Nurse practitioner, crisis assessment and treatment team

I commenced my nursing career in the mid 80's in a psychiatric institution. I completed a three-year, hospital-based training course in psychiatric nursing and went on to work in a number of institutions as a ward nurse and associate charge nurse. I hold a Postgraduate Diploma of Mental Health Nursing and a Master of Advanced Practice Nursing and am endorsed as a mental health nurse practitioner (NP). I am currently employed as an NP in the medical officer role on the CATT.

The CATT provides outreach assessment and treatment to people experiencing psychiatric crisis. People are referred via the mental health triage service. They may be at home or have been assessed in the ED or have been in an acute inpatient unit and need intensive support on return home. Involvement with CATT typically ranges from a day (for a one-off assessment) to a few weeks. People are then linked in with GPs, psychologists, and private psychiatrists, AOD services, or case managers from our mental health service. I regularly liaise with other clinicians from this mental health service as well as private practitioners.

My usual day on CATT involves review and assessment of clients either at their home or the mental health clinic, depending on their preference, level of risk and workload. When visiting at home, I team up with another clinician. I spend time engaging and developing rapport with people, as well as conducting mental state examinations and risk assessments. I see people aged between 16-64 years. The people I visit are in crisis. That presents in many forms. A person may be experiencing an acute psychosis as part of an established psychiatric condition such as schizophrenia or bipolar disorder; this may be their first presentation, or their presentation may be precipitated by illicit substance use. The people I see also experience varying mood disorders and frequently present with thoughts of suicide or may have recently attempted suicide. Another group of clients I see on a regular basis are those with personality disorders, often with a number of psychosocial stressors. As an NP, I prescribe medications, order diagnostic tests, diagnose conditions and provide medical certificates. There is no medical officer on the team. A psychiatrist is employed part-time and when they are absent, the clinical decision making is my responsibility.

My aim is to provide treatment and support to people to help them avoid hospital admission if possible, and promote recovery using strategies that are relevant to them. I like to present people with options for treatment, so they may choose medicines that are most suitable to them. I encourage non-pharmacological strategies too, such as psychological therapy, yoga, meditation, healthy eating, exercise, mindfulness techniques and engagement in positive activities. The CATT provides intensive, short-term support for people. There is a focus on linking clients in with other healthcare providers for ongoing follow-up when their acute episode resolves. Many people are lacking in funds as they are unable to work. There is a need for bulk billing private psychiatrists and psychologists with no gap fee that people can access for longer than six to ten sessions. It would also be beneficial if clients could access psychological therapy via the public mental health system. The majority of people I see have a history of some form of significant trauma. Lengthy periods of therapy are often required for people to have positive outcomes.

Another significant part of my role involves contact with family, carers, and support people involved with the client. Education regarding the client's condition, treatment, CATT support, and carer resources are provided. It is important to encourage people to debrief when needed, particularly if a family member does need to be admitted to hospital. We work together, in a collaborative manner, to decide the best course of action for each client, ensuring that people are well-supported when receiving treatment at home, and are aware of how to contact us between visits if the client's

condition changes. I see a variety of people from various cultures. Interpreters are frequently used to ensure that everyone has a good understanding of what is being discussed. Family or carer support is a significant part of home treatment for people and is often the only way that hospital admission can be avoided. Access to funds for short-term support would greatly help families and carers. People often take time off work to support their loved ones and do not always get paid for this, such as self-employed people and those with casual positions. The financial burden of caring for a loved one often causes additional stress for people.

Each client is discussed with the CATT on a daily basis. Twice per week there is a clinical review during which there is an in-depth discussion of each person, their progress and ongoing plan. The team is multidisciplinary, and a consultant psychiatrist oversees treatment. I have clinical supervision fortnightly with the consultant and we regularly discuss treatment options, particularly when switching medicines or if a client has problems with a particular treatment. I have managerial supervision every three months. I attend the mental health, AOD nurse practitioner collaborative meetings which are usually held every six weeks for peer support. I am also a member of the Australian College of Mental Health Nurses and the Australian College of Nurse Practitioners.

In addition to my clinical role with clients, I have leadership responsibilities within the organisation and am a member of several key clinical committees. I provide regular education sessions regarding medicines to nurses throughout the service and am a trainer for the suicide prevention training conducted throughout the year for all staff.

There are requirements of my work that are cumbersome and time consuming. The amount of paperwork required is one of these. The service uses an electronic system for documentation. There are regularly problems with internet connection, particularly during outreach visits. This results in information not being available or work being lost and needing to be repeated. There are many occasions in which written information is repeated. This tends to be for the purposes of evidence for accreditation or funding, rather than having any meaningful clinical purpose. Examples of this are forms that are completed for clinical review meetings. One afternoon and one morning per week is taken up by this for every team member. All information must be documented again and again, rather than initial information being gathered and then a note in the file including the client's progress and plan.

Availability of inpatient beds is another issue for CATT. Often a person will have to be admitted to an ED rather than a psychiatric unit. It is very difficult for people who are mentally unwell and distressed to remain in an ED where there is a lot of stimulus, and they are often confined to a cubicle rather than being able to walk around a ward. There is ongoing stigma associated with mental illness and with substance use. The clients I see speak about a reluctance to attend ED because of this. There is often a lot of pressure to move mental health clients out of ED even when they have presented for a medical issue rather than a mental health one.

When there are high numbers of people awaiting beds in ED, CATT is asked to accept people for early discharge management, often with minimal discharge planning. Clients are often still quite unwell or are still having medication changes, and this puts pressure on families and carers. A lack of discharge planning and communication with carers and families prior to leaving hospital, always increases the risk of relapse and readmission. This is very disruptive to the recovery process and can also pose risks to both the client and their family.

Staffing and filling of vacant positions is possibly the most concerning issue. There are numerous occasions when CATT is short staffed and there is no-one to work. Positions are advertised and

there are no applicants, or only unsuitable, inexperienced people applying. CATT is a specialised service and requires staff with extensive skills and expertise. Employing people without these skills has the potential to lower the standard of care, including poor assessment of both mental health and risk management. The staffing issue is service-wide, across all disciplines (including medical staff), but particularly applies to nurses, and poses numerous risks for clients and staff. There are many case manager positions that are vacant which impacts on CATT being able to access appropriate, timely follow-up for clients. Numerous vacancies also impact upon staff self-care and being able to access annual and long service leave. When a clinician goes on leave, there is no-one available to cover their case load. This leads to job dissatisfaction, burnout, and people leaving their positions.

Mental health nursing is a most rewarding career. There is nothing more satisfying than supporting a client who has been so unwell that they are unable to communicate effectively, or cannot function in their everyday lives, to be able to return to work or their role as a partner or parent etc and enjoy themselves doing whatever they choose to with their lives. I am hopeful that in the future some of the issues I have discussed will be improved to be able to provide further assistance and improve services for people when they are at their most vulnerable.

Hospital outreach post-suicidal engagement

Follow-up care post discharge from acute inpatient units or admissions to hospital can be challenging. Case management through community treatment programs is often overwhelmed by low prevalence disorders and CATTs can only offer short-term treatment for consumers assessed as moderate to high risk to self or of deterioration. The Hospital Outreach Post-suicidal Engagement (HOPE) initiative was designed to fill this gap and is an important part of the *Victorian Suicide Prevention Framework 2016-25.* Importantly, the program recognises that the biggest predictor for suicidal behaviour is a previous suicide attempt and provides practical support and follow-up for people leaving hospital after a suicide attempt. It provides assertive outreach workers also work with families, friends and carers so they can better support their loved one during this critical time.

In August 2018, the Victorian Government announced more than 500 people had been assessed and supported through the initiative which was operating at the Alfred Hospital, Peninsula Health, St Vincent's Hospital, Barwon Health in Geelong, Eastern Health in Maroondah and Albury Wodonga Health in Wangaratta. On the back of this success, they announced the program would be rolled out to six new hospital and health service sites: Casey Hospital, Latrobe Regional Hospital, Sunshine Hospital, Ballarat Health Service (including Horsham), Werribee Mercy Hospital and Bendigo Health Service (including Mildura).

We welcome this expansion because it is consistent with our view that people should be able to access the same suite of services wherever they live, and that anyone who has attempted suicide should be able to access such care. However, we consider HOPE services are most beneficial when they draw on the expertise of nurses specialising in mental health and when sufficient numbers of nurses are funded in the staffing profile to ensure no-one who has attempted suicide and been discharged misses out on this invaluable follow-up service.

> **RECOMMENDATION 30**
>
> Adopt successful post discharge support initiatives such as the HOPE program in all health services and expand to include sufficient mental health nurses in the staffing profile so anyone who has attempted suicide can access a nurse specialising in mental health and no-one falls through the gaps.

Nurse B – Registered psychiatric nurse, post discharge support

I am classified as a Registered Psychiatric Nurse Level 3 (RPN3) and have been at my workplace for almost 10 years. I hold a Bachelor of Nursing and a Postgraduate Diploma in Mental Health Nursing Science.

I work in a relatively new team providing additional post discharge supports to people with complex mental health needs, following an inpatient admission. Patients are voluntary patients under the Mental Health Act 2014 and are not being referred to another part of our service.

We use an integrated team approach that includes RPN3s, social workers, peer support workers with lived experience and a carer peer support worker. We report to a team leader and a consultant psychiatrist provides us with clinical governance.

At present, the three mental health clinicians work a seven-day rotating roster, with the aim of maintaining two clinicians per shift, from 8.00am to 4.30pm. This is extremely difficult to achieve: it affects our work-life balance and limits the service we can provide some days (i.e. no capacity to outreach due to staffing).

The objectives of this initiative are to:

- *minimise the risk of re-admission to an inpatient unit within 28 days*
- *reduce suicide rates post-discharge, with the first 28 days post a psychiatric inpatient admission being shown as a critical period for relapse*
- *achieve safe, coordinated and streamlined transition for consumers from an acute mental health inpatient setting to the community*
- *support people to establish/re-establish themselves in a community environment, including helping them access the range of community supports they need*
- *maximise recovery and resilience.*

We can have up to 30 clients 'on the books' at any time. Depending on the needs of our clients and the capacity of our team, we provide home visits as well as telephone calls. Clinicians make the first contact within three days post discharge and determine whether consumer peer support is needed and wanted by the consumer. Carer peer support is offered to those who have a Next of Kin (NOK) listed. We then continue to have contact with clients throughout the 28-day post-discharge period. If the client is being discharged out of area, we provide a one-off phone call.

The aim of our engagement is supportive contact. We build rapport, assess mental state and risk, assist with psycho-social stressors and work on recovery. We provide psychoeducation to clients and their families and attempt to link clients in with community services before disengaging. We also liaise with service providers and escalate mental health support e.g. to CATT or to case management, as required. This can be difficult at times as all branches of the service are struggling to meet the needs of the community.

It is a struggle to support clients and their families to access and navigate systems. Often there are barriers, especially around waiting times and costs. The wait to get in to see a private psychologist or psychiatrist can be lengthy. Even with bulk-billing, people worry about being able to pay the gap fee. We are not able to make direct referrals, so we have to direct people to their GPs. This works okay, depending on how well-versed the GP is in relation to mental health issues and the supports available. We find even if we call or fax instructions, clients still struggle to get their needs met.

Even if people can access these supports, the sessions provided are often not enough to enable proper support and recovery following an inpatient admission.

The lack of detox and drug rehabilitation options in our catchment area are also problematic. People will often detox on the inpatient unit, but wait for rehabilitation is lengthy, making sustained sobriety difficult.

Over recent years, there has also been a decrease in psychosocial supports for people. Having friends, routine, activity, occupation and a place to go often gives people meaning and purpose in life and is a motivator for recovery. Now we find an increase in social isolation, boredom and hopelessness as there are limited support options available for people.

Some consumers often state they would benefit from the support provided by our team for a longer period then the prescribed 28 days. These are the people who are not acutely unwell enough to need case management but would have more positive mental health if they could access services more frequently than monthly private appointments. Unfortunately, our program timeframe is strict, so this need is not met.

We also can do very little for all the patients who are discharged as homeless. They are often put up in a hotel for a few days, then directed to crisis housing services. At times the accommodation options are very poor. We provide supportive phone calls but nothing in a practical sense, other than engaging in crisis planning. These calls can also only be made if people have phones, so they can be easily lost to follow-up if they do not have one.

Carer support is something that is emerging in terms of emotional and practical support. This is still limited but often very appreciated. There is minimal financial support available for carers and this stress can often be an additional burden to families who are already struggling to care for their loved ones. So much more could be done in this area.

Ultimately, the care we provide is as good as we can manage, within the constraints of our system. People still get missed. People still relapse. But there is now a group of people who are receiving a service who were previously overlooked. The feedback we have received is positive, and we would love to be able to do more and have better outcomes for consumers and their families.

Police, ambulance and clinical early response

The Police, Ambulance and Clinical Early Response (PACER) project built on similar successful initiatives overseas to trial a new model of early intervention with the aim of implementing more effective and efficient responses to mental health crises. It differs from usual service provision in that it is a mobile emergency mental health response acting as a secondary police response. It is informed by 'real time' police and mental health background information, assessing the person close to the time of crisis.

From the consumer's perspective, PACER offers early intervention in their mental health crisis and helps them avoid inappropriate delays and potential restrictions on their liberty. Where transport is required, ambulance services are used ahead of police. This is preferred by community members and is consistent with the least restrictive approach to management of the crisis.

An independent evaluation found PACER intervention provided more timely access to mental health assessment for the person in crisis, reducing the time to assessment from an average of around three hours to less than one hour. There were also fewer referrals to hospital EDs, reflecting the increased options and more tailored response available through the PACER earlier intervention. On average, the LoS in hospital EDs for patients referred by PACER was also reduced by around two hours.[28]

PACER currently provides a service for one shift a day, often 1400-2230hrs. The program would benefit for additional service provision to 24 hours per day to meet the coverage provided by the ACIS framework. Additionally, many regional health services do not have PACER programs implemented, despite the success of the program.

> **RECOMMENDATION 31**
>
> Roll out the successful PACER program to all AMHS and transition to coverage for 24 hours per day.

Prioritising suicide prevention in rural and remote areas

According to the AIHW, the incidence of suicide is 30 per cent higher in regional and rural areas and twice as high in remote areas, while mental health hospitalisations are higher by at least 10 per cent and intentional self-harm and AOD issues are higher by up to double when compared with major cities. The lack of available services results in many people not accessing prevention, primary health care and early intervention services. They present late, are diagnosed late and often are at a more advanced stage of illness, with corresponding physical comorbidities.[29]

The higher burden of mental illness for people who live in regional and rural Australia warrants a concerted effort by all COAG members. Achieving the objectives identified in the *Fifth national mental health and suicide prevention plan* will not be possible without significant investment in the rural and remote mental health workforce by the Victorian and Australian governments. We address this in chapter 7.

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[28] Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation*, 2012.

[29] Australian Institute for Health and Welfare, *Healthy communities: Hospitalisations for mental health conditions and self-harm in 2013–14*, 2016, cited in Queensland Nurses Union, *Submission to the Senate Community Affairs References Committee: inquiry into accessibility and quality of mental health services in rural and remote Australia,* 2018, p8.

4.   IMPROVED HEALTH CARE JOURNEYS

RC Question 4: What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link.

The current Victorian mental health system is fragmented and siloed, with links between services often unclear or broken for health professionals and the pathway through services invisible to community members. We need a system built for people not providers, with clear, seamless pathways to tailored, holistic care.

The initiatives we have outlined in chapters 2 and 3 and investment in an integrated nursing workforce providing universal assessment and screening, clinical nursing care and referral (see chapter 6) are essential to such a system. We also consider ready, impactful and cost-effective improvements that facilitate smooth and seamless client journeys through an integrated mental health system could be made by investing in the seven key initiatives outlined here:

1. Strengthening PARC/YPARC services by providing clinical nursing care 24/7, making them a genuine clinical step-up, step-down service

2. Reinstating and funding the acclaimed MHNIP program to augment primary care provided by GPs and psychologists

3. Introducing nurse navigators, so successful in Queensland, to improve health care journeys by creating a streamlined and simpler experience while making significant service efficiencies

4. Optimising nurse practitioners for expert, efficient and cost-effective mental health nursing care for clients with complex care needs, especially in perinatal mental health, ED hubs, aged persons' mental health, AOD and CYMHS

5. Embedding trauma-informed care to increase safety for people with lived experience and clinicians

6. Reducing restrictive interventions to reduce trauma for people with lived experience and clinicians

7. Expanding hospital-in-the-home to mental health for greater access and improved outcomes.

Strengthening PARC/YPARC services

Adult prevention and recovery care (PARC) services are short-term, supported residential treatment services located in the community. They have a recovery focus, providing:

- early intervention for consumers who are becoming unwell

- opportunity to strengthen and consolidate gains from the inpatient setting for consumers in the early stages of recovery from an acute psychiatric episode.

They are designed for people experiencing a significant mental health issue who do not need, or no longer require, a hospital admission. In the continuum of care, they sit between adult acute psychiatric inpatient units and a client's usual place of residence.

PARCs aim to help avert acute inpatient admissions and facilitate earlier discharge from inpatient units. They are not a substitute for an inpatient admission; they provide clinical treatment and short-term residential support to help a client post-admission, or to help a client avoid an admission, and are not currently available in all catchment areas.

Similarly, youth prevention and recovery care services (Youth PARC) are tailored to the needs of young people aged 16 to 25 years. They are short-term, sub-acute, intervention and recovery focused clinical treatment services based in residential settings. They aim to address the needs of young people with significant mental illness to enable earlier engagement and intervention in the context of their illness.

The ANMF (Vic Branch) strongly supports the PARC/YPARC model as a unique and valuable step-up, step-down service where acutely unwell young people and adults can receive treatment safely in a less restrictive environment.

However, we consider PARC services as they are currently configured fail to achieve their full potential. We are currently in discussions with DHHS about this. By adding 24-hour, seven-days -per-week clinical mental health nursing care, PARCs would have a real opportunity to deliver the breadth of mental health clinical care. Adopting a clinical model of care that provides for the holistic physical and mental health need of clients, with specialist mental health nurses rostered across all shifts, would be a much more effective use of current resources. It would enable the provision of short to mid-term care and go significantly further toward meeting community needs and relieving pressure on the acute system.

Under this model, PARCs would become a much needed clinical/nurse-led alternative between home treatment and acute inpatient admission. It would enhance existing options for early treatment and relapse prevention and offer a genuine post-discharge step-down option. This model would allow a planned, staged approach to mental health care, facilitating a true throughput and reducing bed blocking by providing a safe and recovery-centered step-down option where clients who are not yet ready, or not able, to access home treatment can continue to access clinical care. Adapted in this way, PARC clients would receive the benefit of a homely, community environment and the assurance of timely nursing assessment, care and treatment.

> **RECOMMENDATION 32**
> Invest in and prioritise the community-based response for people living with mental illness by funding PARC and YPARC services to employ specialist mental health nurses on every shift, providing 24-hour clinical mental health nursing care seven days per week.

Reinstating MHNIP nurses

Initiated in July 2007, the acclaimed Mental Health Nurse Incentive Program (MHNIP) provided payments to community based general practices, private psychiatric practices and Aboriginal medical services (AMSs) to employ mental health nurses to provide coordinated clinical care for people with severe mental illness. In this way, the program blended primary and secondary healthcare, with the aim of:

- ensuring people with severe and persistent mental illness received adequate case management, outreach support and coordinated care

- improving levels of care for people with severe mental illness

- reducing unnecessary hospital admissions/readmissions for people with severe mental illness

- helping people with severe mental illness keep well and connected with their community.

As the name suggests, mental health nursing is central to the program's service delivery. Working in collaboration with psychiatrists and GPs, they establish a therapeutic relationship with the client and provide no or low-cost services, usually in GP clinics or client' homes. This GP-led, one-stop-shop model of mental health nurses, psychologists and psychiatrists working together, sees mental health nurses providing co-ordinated care and interventions from the acute phase. Services include:

- reviewing and monitoring a client's mental state

- managing medication and improving links to other health professionals and clinical service providers

- providing information about physical health care

- working with family and carers to maximise medication compliance.

Nurses also:

- contribute to the planning, delivery and review of client care

- administer the HoNOS (Health of the Nation Outcomes Scales) for each client on entry and every 90 days to monitor changes in symptoms and functioning and when a client is exiting the program.

- maintain links with clients

- undertake case conference activities

- coordinate access to services outside the primary care clinical setting

- interact with medical and other health professionals to facilitate client care.

In this way, the program also relieves the workload pressure on GPs and psychiatrists, allowing them to spend more time on complex care.

Although MHNIP was a national program, almost 50 per cent of the sessions were conducted in Victoria. An independent evaluation of the program released in 2012 demonstrated the success of the program with the following key findings:

Appropriateness:

- MHNIP provides support to a sizeable group in the community – people with severe and persistent mental health illness who are primarily reliant for their treatment on GPs and psychiatrists in the private sector (around 0.6% of the adult population).

- The model of care received strong endorsement from clients, carers and medical practitioners using the program and from relevant peak bodies including the ANMF (Vic Branch).

Effectiveness:

- Clients receiving treatment and support under the program benefitted from improved levels of care due to greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans.

- For the sample group of clients, admissions for mental health decreased by more than 13 per cent for clients in the 12 months following their involvement in the program.

- For the same sample of clients, when they were admitted to hospital following their involvement in the program, there was an average reduction in their total number of admission days of 58 per cent, and the average length of stay (LOS) fell from 37.2 days to 17.7 days.

- Evidence also showed that clients supported by MHNIP had increased levels of employment, improved family and community connections, increased involvement in social and educational activities and reduced the number of emergency department presentations.

- MHNIP also had a positive impact on medical practitioner workloads by increasing their time to treat other clients and improve throughput.

Efficiency:

- A cost analysis of de-identified client data showed savings on hospital admissions attributable to MHNIP were on average around $2 600 per client per annum.

- The analysis also revealed many un-costed and intangible benefits associated with MHNIP, including the impacts of improved client outcomes, enhanced relationships with carers and family members and the effects on carer social security outlays.

- Some design features would benefit from re-examination, including the purchasing arrangements which offered limited capacity to manage demand and did not enable growth to be targeted in locations of greatest need.

Importantly, the model of care was strongly supported by GPs and psychiatrists who affirmed the difficulties they had in addressing the long-term treatment and support needs of people living in the community with severe and persistent mental illness because of:

- the high level of demand for their services generally, over and above the services sought by people with severe and persistent mental illness

- the complex nature of these clients

- the difficulty medical practitioners sometimes experienced in determining what types of treatment and support they are best placed to provide these clients.[30]

The program delivered real and valuable results for clients and the health system. An evaluation of GPs' and patients' opinions of MHNIP found very strong support for the program. Patients rated it as affordable, convenient, holistic and less stigmatising than accessing designated mental health services. GPs valued the collaborative working arrangements and the mental health nurses' ability to provide a wide range of interventions.[31]

GPs and psychiatrists particularly liked the flexible program guidelines for identifying in scope clients and the discretion available to nurses to see clients reasonably regularly, and for a flexible duration, depending on individual client need. They expressed a high level of respect for the treatment and support services mental health nurses provided to clients under the program and the positive impact this was having on patient outcomes. They considered nurses' skills, including taking comprehensive

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[30] Healthcare Management Advisors. *Evaluation of the Mental Health Nursing Incentive Program final report,* 2012.

[31] Primary Health Care Research & Information Service, *Improving the integration of mental health services in primary health care at the macro level,* 2015, p31.

mental and physical histories and providing holistic care, integral to the success of the program, as was their knowledge of local services.

As discussed in chapter 5, as well as it's positive impact on clients experiencing a mental illness, it was invaluable for patients with comorbidities. A report of the Ministerial Advisory Committee on mental health notes the program was identified by GPs and the clinical mental health service system as highly successful and 'offers significant potential to link clients of the specialist mental health service system to GP care.' The holistic approach to care delivered through this service model ensures patients can be managed systemically and in conjunction with the GP for any physical health concerns, with increased opportunities for intervention because the mental health nurse is co-located with the GP.[32]

Despite widespread support and very positive independent evaluations, the Australian Government's 2017-18 funding quarantine for the program formally ended in July 2018 when Primary Health Networks (PHNs) moved to the 'fully flexible' funding pool. PHNs abruptly informed specialist mental health nurses they would no longer be employed, leaving people residing within those PHN catchments, including many Victorian regional towns, without access to the essential mental health nursing care previously available under the MHNIP. At the time of this change, the ANMF (Vic Branch) understood the North Western Melbourne PHN was the only network within Victoria increasing its mental health nurses under the new 'flexible' funding model. The Western Victorian Primary Health Network reduced its mental health nurses from 10 to two in the Ballarat area, affecting approximately 250 clients. Each nurse had a minimum caseload of 25 clients, with some caring for up to 40 clients at any one time. The Murray PHN catchment lost ten mental health nurses in the Mildura, Swan Hill, Wangaratta, Wodonga, Benalla, Beechworth and Yarrawonga areas, affecting more than 200 clients.

The funding change effectively cut clients off from trusted professionals and asked them to start their treatment again elsewhere. As all health professionals know, trusted therapeutic relationships take years to build and are crucial to people managing their illness and staying out of hospital. As well as jeopardising real and significant client gains, mental health nurses considered the move undervalued their vital work and demonstrated yet again that the struggles of people with serious mental illness were invisible to decision-makers.

The Victorian Government has an opportunity to step in and allow this vital work to continue. It is a well-evaluated and highly regarded program. We consider the case for retaining this model of care is compelling and warrants prompt action. We encourage the Victorian Government to act quickly to retain the extraordinary expertise and capacity developed in the program and allow clients to resume the service they trusted and valued.

> **RECOMMENDATION 33**
> Reinstate and fund the acclaimed MHNIP program so clients can resume their therapeutic relationships with mental health nurses and receive the identified benefits to their physical and mental health, the program expertise is retained, and the cost and capacity benefits to the health system continue.

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[32] Ministerial Advisory Committee on Mental Health, *Improving the physical health of people with severe mental illness: No mental health without physical health,* 2012, ppi-iii.

> ### Nurse P – Mental health nurse incentive program
>
> *I was a MHNIP nurse until I lost my job in July 2018 when funding ceased. The Coalition Government's 'flexible funding' model has 'failed to understand and respect the mental health nurse role in the primary setting'.*
>
> *As a MHNIP nurse, I worked with mothers suffering post-natal depression and their families from 2010 to 2018. I worked remotely and saw mothers and their babies either face-to-face in their own homes or at an allocated office. The clients and their children also attended a fortnightly group program called 'Have a chat' that offered supportive social therapy. The clients had unlimited phone contact with me when they needed, outside of their scheduled session times.*
>
> *The geographic area I worked in was vast and remote, with a client base of 30-35. The role consisted of employing a number of therapies including CBT, Counselling, Family therapy and Parenting Therapy.*
>
> *Between 70-90 per cent of referrals into the Enhanced MCH program have a mental health issue. The demographic represents a low socioeconomic status, isolation and complex family issues, combined with a multitude of mental and physical health issues, attachment issues, relationship issues and pre-existing problems. This all impacts on the mother/child relationship, their health and their wellbeing.*
>
> *The MHNIP Program offered coordinated physical, mental and social care, with positive evaluation and proven effectiveness. During my time in this role, I am pleased to say I had not one incident of self-harm or suicidal behaviour from the time of the nurse-client engagement, even though some clients presented with a recent history of these complex behaviours. This certainly demonstrates one vital example of the effectiveness of the program.*
>
> *I was very passionate about this role and felt privileged to be able to offer women hope and practical advice and support when they felt so isolated and alone. Having to leave this position with no choice, has devastated the clients and myself. Women with mental health issues will fall through the gap without the therapeutic relationship with their mental health nurse. When a client has postnatal depression affecting themselves, their infant, their mother and child bond and their family, losing the MHNIP Program support is a very significant loss.*

Quotes from clients of Nurse P

> ### Client 1
>
> *I am writing to express my disappointment with the decision made to cease the funding for services provided by Nurse P*
>
> *I am one of the many mothers who has struggled with perinatal mental health issues, including severe depression and anxiety. Following the birth of my second child I suffered postnatal depression and anxiety, which was managed quite conservatively with medication and regular GP attendance.*
>
> *However following the birth of my 3rd child, my severe depression and anxiety led to an extensive stay in a psychiatric mother-baby unit. Over the past 6 years I have undergone multiple medication regimes, electroconvulsive therapy, attended countless hours of psychotherapy, with psychiatrists, clinical psychologists and counsellors. The toll this experience has taken on myself and my family cannot be underestimated.*

Whilst I hope I am resilient enough to navigate the day-to day stressors without long-term professional support; for me, ongoing recovery requires the kind of support which can only be fostered through a deep therapeutic relationship. My relationship with Nurse P has proven to be this and is a valuable and instrumental part of maintaining mental wellness and continuing to recover.

I can only ask you to consider the repercussions for the many women and families like mine, when our support structure is thrown into chaos. The stress induced after learning that my therapeutic relationship would be cut short, due to funding decisions; contributed to an exacerbation of my anxiety and led me to take sick leave from my job as a midwife. The support structure, which many of the mothers of this community have come to rely upon assists us to continue to be contributing members of society and continue to fill the many roles and obligations we have.

Client 2

I have been a client of Nurse P since my third child was but a few months old. She has provided support and advice to myself and my family during this time for without, I don't know how I would have coped at all.

After my third daughter was born, I struggled with post-natal depression, agoraphobic tendencies and very low self-esteem as well as other issues.

During this professional relationship, Nurse P has been able to support me as a parent through so many events and referred me to other services to gain additional support for finances and health among other things, including encouraging me to attend maternal and child health appointments and using services available. When I have been unable to go to appointments or suffered crisis situations, Nurse P was also able to provide support to me through phone contact. It is almost inexcusable to prevent her from supporting families when they are requiring her exceptional method of enhanced assistance.

Client 3

I am writing to you to express my disappointment at hearing of the ending of the Program.

This program has helped me extensively over the last 2 years and I can honestly say that without Nurse P I would not be here today. She has been a huge support to both myself and my family through my battle with depression and anxiety. Since meeting Nurse P I've gone from being in a dark abyss of feeling like ending my life was the only solution to end the pain, to a happy, confident person who is looking forward to the future with my beautiful family.

I have seen many specialists, psychiatrists, etc. over the years but this has been the one program that has essentially saved me.

It breaks my heart and terrifies me that I will have to continue my journey to recovery without Nurse P and this program. Since seeing Nurse P I've had the confidence of knowing that when I am ready to have another baby she would be there alongside me, ensuring I get the support I need to prevent having a repeat of the terrible time I had with my mental health after the birth of my daughter. Sadly, that confidence has now been taken away from me and it hurts me deeply to know that there are women in our area who will suffer like I did and not have this valuable program available to them.

My family are eternally grateful that Nurse P came into our lives and essentially put our family back together again. She has let my husband have his wife back and my daughter have her mother. She has let me see light at the end of a long dark tunnel and given me a bright future that I thought would never exist. I know this letter will not be able to reinstate the program, but I hope you can see what an important program is being taken away from the community.

Client 4

I have been seeing Nurse P for the past 3 years. In that time, she has been a huge help and   support to me. I could not have got through many of the challenge's life has thrown at me without her support and care. She has not only helped link me in with other support services and looked at different avenues for treatments that no one else had thought of but also helped me with my 3 children's many ongoing health issues. She has helped me and my family tremendously. I am truly devastated as I'm sure many of her other mums are to hear that she can no longer help me and that there is 'apparently' no longer a need for the mental health nurses which i can most definitely assure you is incorrect. I along with the other families that have Nurse P supporting them will suffer enormously from this decision.

Introducing nurse navigators

Many inquiries into Victoria's health system have shown clients are frustrated with a system set up to treat individual illnesses and conditions, rather than provide holistic care. Fragmentation starts with the funding model which influences the transactional, siloed way heath care is delivered.

Best practice contemporary models of care rely on an integrated interdisciplinary team providing holistic care. However, even when such a model of care is available, it can be difficult to navigate for people with complex and chronic physical and mental health care needs.

The Nurse Navigator program, initiated by Queensland Health, shows great promise for helping people with lived experiences and their families and carers navigate, and get the most out of, Victoria's mental health system.[33] While new to Australia, similar roles have been around for many years overseas where they are sometimes referred to as patient navigators and to varying degrees already exist within some larger emergency departments.

The model
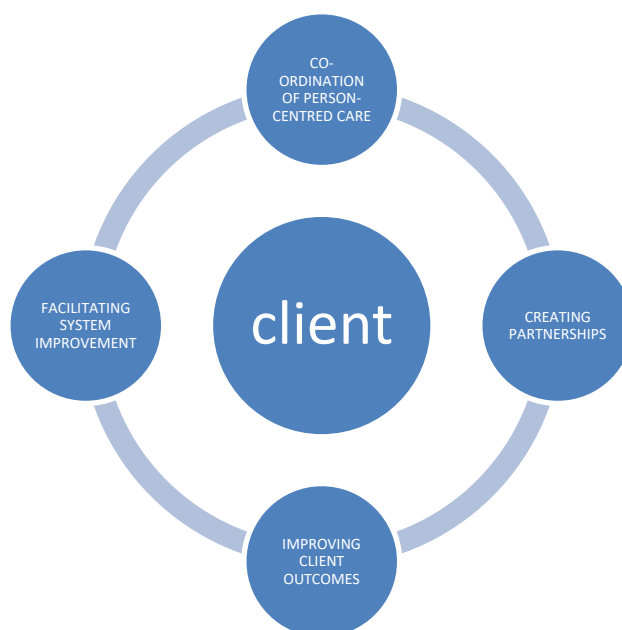
As the name suggests, the general role of the nurse navigator is to help clients navigate the intricacies of the health system and the services they need. The nurse navigator knows the system very well and uses this knowledge to work with the clients and their carers/family to coordinate the client's care across their journey. Working with people with complex care needs, they help them navigate from their referring GP or other primary care provider, through hospital specialist teams, community services and back home again. They improve client outcomes by:

- creating a partnership with the client

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[33] In 2015, the Queensland Government allocated $105 million over four years to create 400 nurse navigator positions. O'Donnell, C *Nurse navigators*, PowerPoint presentation, 2015.

- providing a central point of communication and coordination for the client and their families and carers

- using and supporting evidence-based, client-centred care pathways that are responsive to the client's changing needs

- coordinating timely access to appropriate health and social services

- improving the integration of services and reducing fragmentation, duplication, delays and barriers

- establishing consistent and effective lines of communication across primary and tertiary care providers using innovative communication pathways when needed

- building client and carer heath literacy so they can make informed decisions about the client's health care options, including advanced care planning

- engaging the client in developing health care goals that promote self-management and helping them to identify general, specialist and multidisciplinary treatment that is timely, seamless, culturally appropriate and tailored to their needs.

In Queensland, nurse navigators work across a broad spectrum of care: paediatrics, aged care, midwifery, disability, diabetes, telehealth, offender health, stroke, critical care outreach and complex chronic disease. They work with some of the most vulnerable communities to ensure they receive holistic nurse-led care and support in a timely and efficient manner. By providing an end-to-end care coordination service, they help clients better understand their health conditions and enable them to self-manage or actively participate in decisions about their own health care.

Recent research concludes 'the role of nurse navigator has enormous potential for assisting the rapidly growing population with complex and chronic conditions as well as others who are under-served or experiencing disconnected patterns of care'.[34]

Early evaluation of nurse navigators in the Gold Coast Integrated Care program after one year found nurse navigators 'effective in enhancing access to care for people with chronic disease by bridging the gap between primary and secondary care.' Importantly, the evaluation also found patients, GPs and practice nurses all reported high levels of satisfaction with nurse navigators.[35] The Queensland Government has now committed to funding the program on a recurrent ongoing basis. When announcing this funding, Queensland Health Minister Steven Miles said:

> 'We created the nurse navigator position in 2015 – the first of its kind in Australia – and at the 2017 election we committed to employ 400 Nurse Navigators across Queensland. The position has been such a success and helped so many people, we're now making these positions a permanent part of our healthcare delivery. The highly experienced nurse navigators play an integral role in a patient's health care journey, ensuring they are seen by the right person, at the right time and in the right place. Not only do they help patients navigate the system, but they also educate them about self-managing their conditions and improving their way of life.'[36]

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[34] A McMurray et al, 'The nurse navigator: an evolving model of care', 2017.

[35] A McMurray et al, The primary health care nurse of the future: Preliminary evaluation of the Nurse Navigator role in integrated care, 2018.

[36] S Miles, Media statement: *400 Nurse Navigators here to stay in Queensland*, 4 June 2019.

Speaking at the same time, a Queensland nurse navigator explained her role as follows:

'Over the past three years I have had the pleasure of following the health journey of some of the most inspiring individuals I have ever met. I have been welcomed into homes, into medical specialists' appointments and into families, armed with advice, plans and a listening ear. At the end of the journey I take a moment to look back and with great joy see how far these complex patients and their families have come with the help of navigation.'[37]

While formal evaluation is not yet complete, preliminary data and self-reports from clients show the program is delivering excellent results, including the following:

Marker	Percentage change
Percentage change in ED presentations	– 30.77 per cent
Percentage change in LoS	– 23.86 per cent
Percentage change in 28-day representations to ED	– 26.38 per cent
Percentage change in 28-day readmission to ED	– 44.20 per cent
Percentage change in admissions via ED	– 38.86 per cent
Percentage change in 5-day readmissions to ED	– 65 per cent.[38]

One very satisfied client explained the impact of the program as follows:

'The nurse navigator service is the best thing to happen to me. They explain everything to me and talked to all the doctors in the hospital and my doctor. When I was readmitted, they led a meeting with other health care professionals and a plan was agreed to. I have not been back to the emergency department since.[39]

With an emphasis on improving health care journeys by creating a streamlined and simpler experience, the ANMF (Vic Branch) considers these highly skilled roles would readily translate to the Victorian mental health system where they would help to improve and saves lives while saving the health system significant costs. Nurse navigators would work with clients with complex care needs, including complex mental health issues, dual diagnoses, physical comorbidities or concurrent AOD issues and be invaluable in:

- monitoring health needs

- educating and helping clients better understand their health conditions

- enabling clients to self-manage or participate in decisions about their health care

- helping clients identify actions to take to manage their health

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[37] ibid.

[38] **J** Whitehead et al. 2019. Navigator workshop: Health services chief executives forum, unpublished. Available through QNU.

[39] ibid.

- helping clients navigate the system's intricacies and obtain effective and holistic care when needed, and as early as possible in life, in illness and in episode.

They would also be of great assistance to people from CALD communities who can have a higher burden of mental health because of social isolation and who often struggle to navigate our complex health system with the added addition of language and cultural barriers. Given Victoria has the highest proportion of patients readmitted within 28 days of discharge (14.7 per cent), nurse navigators have the potential to make substantial costs savings.[40] By facilitating best practice client-centred care and better integrating services around client needs, nurse navigators would also support the sustainability of the health system and ensure substantial cost savings by reducing readmission, duplication and delay.[41]

RECOMMENDATION 34

Introduce the highly successful nurse navigator role in Victoria, commencing with mental health clients, including CALD clients – this would improve the sustainability of the mental health system by ensuring people living with mental health issues access the care they need, by the right practitioner, when they need it.

RN nurse navigator – Queensland

'A nurse navigator is a 'puzzle master'. The patient is at the centre, and all the puzzle pieces sit outside and they're all fragmented, and then the nurse navigator comes in and picks up those pieces and puts then all together to make one big puzzle. We provide care co-ordination across the patient journey. We facilitate the delivery of their care, and we try to keep all the services working together and talking to each other so that the patient has one person they can go to – the nurse navigator, a one-stop shop. We bring services to patients, rather than the patient coming to hospital, and we provide them education to improve their health literacy. Patients come to Eds and acute wards when things aren't going well, but we can get the services to the patients before things begin to happen. The benefits of having nurse navigators are twofold: it creates a far more streamlined and simpler experience for the patients and it is better for the health system operationally as it improves relationships between the community and health services and results in fewer admissions.'[42]

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[40] Victorian Government Department of Health and Human Services, *Targeting zero Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care, Report of the review of hospital safety and quality assurance in Victoria,* 2016, pp133-138.

[41] A McMurray et al, 'The nurse navigator: an evolving model of care', 2017, p210.

[42] QNU, 'Navigating patients through a complex health system: Nurse Navigators explained', *Inscope* article, undated.

Optimising nurse practitioners

Nurse practitioners are clinical and professional leaders; most of their work involves direct service delivery where they can put their advanced education, clinical expertise and skills to best use. They work within a model of nursing practice that meets a particular service need. Their practice is supported by evidence-based policies and guidelines agreed by their employer. Each nurse practitioner model is different because each service, client group and employer is different.

As the following case studies show, nurse practitioners are already playing an integral role in Victoria's mental health system, providing expert, innovative and impactful models of care. Supporting additional nurse practitioner positions across perinatal mental health, ED hubs, aged persons' mental health, AOD, CAMHS and youth services, and in regional and rural community health centres would help meet demand for efficient and effective mental health treatment and care while providing a much-needed career pathway for nurses who are candidates for endorsement as a nurse practitioner.

RECOMMENDATION 35

Invest in the strategic use of nurse practitioners to augment the nursing workforce by funding nurse practitioner positions across perinatal mental health, ED hubs, aged persons' mental health, CYMHS, AOD and mental health and in regional and rural community health centres to help meet demand for efficient and effective mental health care and provide a much-needed career pathway for nurses who are candidates for endorsement as a nurse practitioner.

Nurse L – Nurse practitioner, mental health

As a Nurse Practitioner (NP), I autonomously and collaboratively provide assessment and management of patients using advanced and extended nursing knowledge and skills. This includes, but is not limited to, diagnosing health disorders, prescribing treatment, ordering and interpreting diagnostic investigations, and the direct referral of patients to other health care professionals.

I provide leadership, education and on-going research around implementation of evidence-based practice. Grounded in nursing's professional values, knowledge, theories and practice, I provide innovative and flexible health care delivery to patients with mental and behavioural disorders. My role is assessed and my scope of practice reviewed annually. To keep up-to-date, I maintain memberships with professional colleges and bodies such as: Australian College of Nursing; Australian College of Mental Health Nurses; Australian College of Nurse Practitioners; ICN Nurse Practitioner/Advanced Practice Nursing Network; Drug and Alcohol Nurses Australia; International Transactional Analysis Association; and the Australian Nursing and Midwifery Federation (Victorian Branch). I also ensure I receive regular professional, peer group and clinical supervision.

My day-to-day duties include:

- *checking referrals and state-based computer systems for screening registration of patients (participating in rotational duty system also)*
- *meeting with a multidisciplinary team to discuss referrals and agree actions*
- *providing assessment of new referral or clinical review of other patients – this involves documenting clinical duties in clinical records and capturing workload for state-based and organisational systems (all separate and some duplication)*
- *ringing patients who do not attend/assertive outreach*
- *liaising with carers and family members*
- *writing reports and communicating with other health care professionals*
- *completing review of patients for other health care professionals regarding issues that are outside their scope of practice/competence*
- *attending meetings (team, professional development, governance, research, DHHS and clinical review)*
- *completing research regarding area of practice*
- *writing journal articles, policy or clinical practice documents*
- *providing supervision for other health professionals*
- *reading to keep up to date on policy, procedures and clinical guidelines*
- *completing professional development (attending lectures, training, workshops, webinars, reading and/or symposiums).*

As a NP, I engage with patients, their carers/family and the wider public by both self-referral and referral via other health care professionals (in primary, secondary and tertiary care settings). Referrals can also be received via first responders and court-based services and can involve joint face-to-face assessments. Engagement or contact is: by telephone (triage and initial engagement); e-mail and SMS/text-message; face-to-face; in family sessions; in group sessions; in initial assessment in inpatient settings; in community rehabilitation or recovery centres; and in health promotion and literacy development or education sessions.

These contacts can be for single sessions or on-going sessions that provide in-depth therapeutic intervention. My focus is on providing care in a collaborative recovery format; working with GPs and emergency services to facilitate early assessment and treatment in the community setting. This is with the intent of enabling the patient to have care coordinated via their primary care-based provider, preventing the need for hospital level assessment and care.

I am involved in risk screening for suicide and planning of care using frameworks such as the Collaborative Assessment and Management of Suicidality (CAMS), a flexible approach that can be used across theoretical orientations and disciplines for a wide range of suicidal patients across treatment settings and different treatment modalities.

I work with patients to ensure they have had all presenting symptoms assessed and investigated via initial screening of the patient and referral on to the appropriate health and social care professional or setting. This involves discussion and health literacy development with the patient and carers or family members. I may also attend appointments with the patient and provide treatment collaboratively with other professionals.

In relation to carers and families, I am limited by funding to providing support to individuals who attend at the same time as the patient. My support is primarily in the form of advocacy for meeting needs, by accessing independently run services that have waiting-lists. This feels like I am more of a sign-posting service, only able to provide support to the carer or family member through the care that is being provided to the patient.

I work collaboratively with medical and allied health and social care professionals. I work with health care systems that have peer reviewed policy, procedures, and guidelines. I work using nationally agreed treatment guidelines, developed by federal departments and independent groups of health professionals.

Medicare funding is at low levels and this limits access to services and the professional group that can provide the service. The short-term nature of contracts also means the provision of long-term care cannot be guaranteed and continuity of care is compromised.

My role as a NP is also constrained by funding, both federal Medicare and state-based; federal and state legislation limiting the use of skills and competence to practice, despite other legislation authorising these activities; the public's limited understanding of the services a NP can provide; and agreement of other professionals to develop advanced practice roles.

Nurse I – Nurse practitioner, brief interventions

I am a general and mental health nurse with over 35 years' experience in mental health. I hold a Master of Nursing and Graduate Diploma in Social Science (Family Therapy).

I currently work as a Nurse Practitioner Mental Health (NPMH) in a metropolitan health network in a small team created to address a gap in service. Essentially, people are referred who are not complex enough to meet ongoing case management within the public mental health system.

I provide a two to three-month episode of care (approximately six face-to-face sessions) for people experiencing mental health complaints and who need extra intensive support and coordination with various relevant GPs, community and other health services to assist with their recovery.

People referred may have experienced various mental health issues including self-harm and suicidal behaviours and may need support in finding ongoing help for the mental health difficulties they are experiencing. Families, carers and friends are actively engaged in this process.

The team work in a collaborative recovery-model with a solution-focused therapy approach that gives clients agency in their care. We work to identify what services might be able to help people beyond our episode of care and provide linkage to that service.

The process includes:

- *assessing physical health*

- *prescribing and monitoring of medication*

- *requesting pathology and tests*

- *providing positive future-focussed therapy, known as solution focussed therapy with a recovery focus*

- *liaising and linkage with GPs, psychologists, other non-government organisations, housing, Department of Human Services, hospitals, child and youth services, interpreters, primary health care networks, domestic violence services, National Disability Scheme providers, AOD services, National Disability Insurance Agency, forensic and legal services. Often discussions occur with people's workplaces, schools and tertiary education providers.*

I have a focus on families and carers as being essential to the recovery of the people we see. I often ring them and invite them to come to sessions unless explicitly requested not to by the client. It is rare for anyone not to want or allow any contact with some of their supports.

The team often needs to accept people with a high level of acuity and complexity. This is because we are seen as an option to take on people when the continuing care teams have a waiting list. The wards need to discharge people and we feel pressured to accept people who are outside our remit of six sessions. Often the problems are difficulties in stabilising mental state, housing, financial stress, Centrelink and Department of Human Services issues, and are all long term. I spend a large amount of time on the phone liaising and information sharing.

In more recent times people are pushed back to the GP and psychologist. The now defunct Mental Health Nurse Program (MHNIP) was providing free ongoing regular supports and liaison for up to two years for many of these people. Now the default is a psychologist – via a mental health care plan – who often charges a Medicare gap (unaffordable to many) and only provides six to ten sessions. Clients I see cannot afford the payment gap and have issues that cannot be fixed in six face-to-face sessions alone. Psychologists often will not follow-up with phone calls or liaise with families, carers, housing, workplace, Department of Human Services, EDVOS, AOD or Centrelink on behalf of or with

their client. I have noted a distinct paucity of communication if psychologist or counsellors are involved. Previously the mental health nurse (MHNIP) would contact me as would other non-government case managers

Although I do not directly work with people who are on community treatment orders, in my view there has been an increase in long term clients, who are struggling to make recovery, taken off orders that enforce treatment. Once people start to relapse due to their refusal to have ongoing treatment, it takes time and resources to help them return to recovery. Helping someone recover from their relapse is a distressing time for them and can often require the intervention of various services, e.g. police, CATT, hospital ward, family members, government housing staff, people in the community and of course the case managers in public mental health. Unfortunately, the result of this relapse is the client needing to commence another episode of public mental health care, often resulting in the client going back on a treatment order.

Also, I have noted that psychologists and GPs are not able to meet the needs of many people with a psychiatric diagnosis. Consequently, people are referred to the ED or mental health triage because psychologists and GPs are unwilling to sit with mild to moderate risks that mental health nurse incentive program (MHNIP) nurses would have managed in the community and not refer clients into tertiary services. This includes the risks of self-harm and suicide. So the mental health service has to address these people in EDs more frequently. The ED and ward reach capacity quickly, with these clients then admitted and then discharged to our team or a continuing care team. They cycle is relentless and increasing in intensity.

I believe it was a mistake federally to cease the funding of the MHNIP and would encourage its reintroduction in some form. Like all services, it had some issues that needed addressing (such as the nurse needing to be credentialed, a private process that has no relationship to APHRA, the national registration body) but overall it was effective a meeting people's needs at a primary (GP) level.

The PHNS, Headspace, NDS providers, and CYMHS are not providing adequate mental health support to help clients recover to live a rich and meaningful life. Often these services are disability rather than recovery focused. Complex clients are consigned to the waiting list of underfunded, under resourced continuing care teams in public mental health.

Within the public mental health system there are significant constraints that affect my ability to perform my role. The burden of slow, unwieldly IT, having to negotiate multiple platforms for one client. Bureaucracy is still ridiculous, with huge amounts of paperwork and with a view that if you didn't write it down you didn't think about or do a particular action. The concept of charting by exception is an anathema in public health.

Funding that imposes six session targets is a frustration, as is the overall decrease in expertise of staff and a downgrading of their level of seniority by natural attrition over time. There is also a lack of clinically focussed supportive managers and a general lack of recognition of the clinician's level of expertise resulting in micromanaging.

Nurse O – Nurse practitioner, alcohol and other drugs

Drugs and alcohol play a major role in mental illness by contributing to mental illness, influencing the path of mental illness, or resulting from mental illness. Irrespective of how alcohol and drug use effects individuals, it is apparent that the number of people with a mental illness who are treated at our hospital (ED, inpatient or through our community mental health program) has increased, both in numbers and severity. For example, the number of people admitted to our inpatient mental health unit with a drug induced psychosis has increased.

For evidence of the interplay between mental health and drug use, I refer to the 2014 report of the Parliamentary Committee of Law, Reform, Drugs, Crime and Prevention into the use of methamphetamines.[43] While this report concentrated on the use of methamphetamines and the particular problems it presents, the Committee pointed to the social impact of use of this drug while acknowledging that:

> *research shows that the use of methamphetamine, both in Victoria and nationally, is considerably lower than the harmful use of alcohol and much lower than tobacco and cannabis. It is also lower than the use of ecstasy and misuse of pharmaceutical drugs.[44]*

It is important that the Royal Commission hears from different perspectives and develops recommendations to deal with mental illness which focuses on how mental health of Victorians can be improved. While recognising that drug and alcohol use, by themselves, do not constitute mental illness under the Mental Health Act,[45] their impact on people with a mental illness or their contribution to a person becoming mentally ill cannot be underestimated.

From my perspective, coming from an alcohol and drug background, the most important contribution which can be made is a coordinated, seamless approach to assist people with harmful drug and alcohol usage. This requires providing pathways that are easily used by those affected, are evidence-based and perceive those seeking treatment as individuals, not as receiving 'products' through disjointed 'treatment streams' where the emphasis is on a funding a segment of the person's journey.[46]

Experience and qualifications

I am an endorsed Nurse Practitioner (NP) currently employed as an AOD NP in a regional hospital. I have extensive knowledge and expertise gained from over 30 years' in a range of nursing settings, My qualifications include: Bachelor of Nursing; Master of Nurse Practitioner and Master of Nursing; Post Graduate Diploma in Mental Health; Diploma in AOD; and Cert IV in Education and Training.

My role

A large part of my role involves direct patient contact – identification, management and treatment of patients in the whole hospital who are alcohol or drug dependent. The other part of my role involves

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[43] Parliament of Victoria, Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the supply and use of methamphetamines, particularly ilce', in Victoria — Final Report,* 2014.

[44] ibid., px.

[45] Mental Health Act 2014, s.4:

mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

    (2) A person is not to be considered to have mental illness by reason only of any one or more of the following—

       (I)   that the person uses drugs or consumes alcohol;

[46] See for example, Victorian Government Department of Health & Human Services, *Funding of alcohol and other drug services,* viewed 18 June 2019, <https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/funding-of-aod-services>.

workforce capacity building, education, policy and planning, clinical role modelling/mentoring regarding alcohol and drug approaches to treatment.

My daily work involves assessment of patients in the ED, assessing and supporting patients on the ward (both acute medical and inpatient mental health), sometimes with specialist psychiatric addiction support. There is no addiction medicine unit at the hospital. I review every inpatient, usually daily, who is receiving pharmacotherapy as an inpatient. Our region has limited access to pharmacotherapy providers and this impacts on the availability of community services to provide our patients with methadone or suboxone that can be commenced in hospital. This can impact on patient ongoing care needs. Given the increasing rise of misuse of prescription opiates, this has the potential to become a major issue.

Every day, I interact with patients, family members, nurses, psychiatrists, doctors, managers, administrators, junior and undergraduate doctors and a range of other professionals within the industry. I also liaise and collaborate with and participate in a number of mental health or drug and alcohol consortia and partnerships in the region. I participate in MHAPR (mental health & police response) – which entails accompanying police to incidents involving individuals with mental health or drug and alcohol involvement or where family violence is involved. I also liaise with numerous external agencies to offer the optimal support and follow-up for patients.

As a senior member of the nursing staff, I have leadership responsibilities including consulting with staff and organisational wide planning, development and formulating strategic vision.

Keeping people out of hospital

I, and many of my colleagues, realise the importance of keeping people out of hospital. Unfortunately, the current funding system does not provide sufficient community supports, nor does the public hospital funding (based on bodies in beds) provide the answer. We have tried to find ways to keep these individuals out of hospital while obtaining necessary medical treatment and minimising (but not necessarily eliminating) the risks of continued alcohol and/or drug consumption. This cannot currently be accommodated in the public hospital system, nor can it be supported in the community with the current funding structure and community attitudes (including the views of health professionals). This is an area where cost-effective, patient centred care offers viable alternatives and we hope to develop a functional model. Unfortunately, it will only be supported if it can be shown to save costs in the long term.

A normal day at work

On a normal day at work I would be attending a busy ED to assess and manage patients who have come in due to mental health and alcohol/drug concerns. The following is one example:

███████ is a young woman presenting due to recent suicidal ideations around ongoing issues with benzodiazepine dependency. She has a long history of benzodiazepine dependency but no previous history with a mental health service. She said she has had intermittent thoughts of suicide since her mother died when she was nine years old but has never acted on these thoughts. She said she gets frightened if she goes without benzodiazepine and would be better off dead but had no active plan. Nil suicidal ideations and nil depressive symptoms were evident during assessment.

She is compliant with her antidepressant medication but states they don't help her sleep like they used to. She has recently moved home and was feeling unsettled, with financial pressures causing her to feel hopeless and helpless at times. She said she was motivated to change.

I identified chronic risk but no acute risk, protective factors identified with good supports and took the

following actions, agreed to by the client:

- *engaged hospital Aboriginal liaison worker for cultural sensitivity and local knowledge*
- *discharged home with AOD support worker and GP follow-up appointment at local Aboriginal co-op (made within 48 hours)*
- *organised strict daily pick up of benzodiazepine from pharmacist to prevent misuse*
- *made appointment with community liaison psychiatrist for medication review in two weeks*
- *gave a script 4 x 15mg Oxazepam tablets to take home to prevent benzodiazepine withdrawal until review by GP*
- *made appointment with community health AOD nurse to assist with benzodiazepine reduction and withdrawal and attend with her at GP (often a two week + delay)*
- *gave her the mental health triage numbers and direct line AOD numbers*
- *provided psycho education on benzodiazepine dependency and withdrawal dangers and risks.*

This case study shows the extent of collaboration that is needed and the importance of building a solid foundation of goodwill and trust between external agencies. The difficulties faced are finding a GP who understands addiction and the time taken in the ED to organise this patient's ongoing AOD care needs. Arguably, if the client had comprehensive short-term case management with a mental health AOD team then much of the work could be done in the community, but because Penny doesn't have a mental health diagnosis, she doesn't fit anywhere. The assessment and the follow up are time intensive, yet essential, if there is to be continuity of care, involvement, motivation and engagement of the client and better health outcomes.

Challenges: different buckets

The frustration I face daily is the difficulty accessing appropriate care for patients with an alcohol and/or drug problem. The interventions which I can provide are limited because of the split in funding. If I 'followed the funds', patients seen here would be detrimentally affected. I am unable to provide the services or 'products' required as much of this funding is held by the provider of this product in the catchment area. The best I can do, as shown in the case study, is to coordinate care through the patient's GP or suggest specific interventions from support services, not necessarily treatment services.

In my experience, the current DHHS funding does not consider urgent and acute interventions. It seems everything needs to be planned, which in the AOD world and the ED world is an anomaly. My role can see me actively engage someone who is ready to change but I am unable to access AOD services immediately given the current intake and assessment processes and department rules of engagement for AOD service providers.

Reading the DHHS document, Funding of alcohol and other drug services highlights the fragmented nature of AOD services with its mixed funding model – activity based and block grant, residential and non-residential. As it states:

> *Product prices are calculated based on a cost-modelling exercise that involves determining the likely inputs that contribute to delivering alcohol and other drug services, including the clinical and non-clinical resources, indirect costs and overheads and combining these with costs data, to derive a 'modelled cost' for each alcohol and other drug treatment product.* [47]

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[47] ibid.

Following recent 'reforms' to the assessment and intake process, collaboration between hospitals and AOD service providers has been curtailed with no clear pathways identified to promote immediate access to AOD services. In our region there are only four detox beds. For a patient to access a detox inpatient bed or a specialised withdrawal nurse in the community, that patient will need to go through the approved catchment service provider's pathway. This may be totally separate from the recommended course of action and ignores the thorough assessment made by NP trained in AOD treatment. The approved service provider then replicates the process already undertaken (for which they are paid a 'product price') which can take many weeks. In the meantime, there may be a lack of continuity of care and support which is crucial in dealing with patients with alcohol/drug concerns. Not only is immediacy of care important from the point of view of motivation, but collaboration and information sharing are crucial to continuity of support and care.

It is not uncommon for a follow-up request for information by me as to the progress of a referred client, in order to provide advice for further treatment, to be met with a blanket response that 'Victorian and Commonwealth privacy laws prevent sharing of information'. This is despite an MoU between the service provider and the hospital and the catchment funded service provider to share information, the actual or implied consent of the patient and the existence of laws (e.g. the Health Services Act) which facilitate sharing for further treatment. Everyone is expected to sit in their silo.

Prior to these 'reforms', as an AOD practitioner in a public hospital, I had direct access to the local community health provider which was the AOD fund-holder. This provided direct and timely access to a withdrawal nurse who could access bed-based services and other support services as required.

This no longer happens; hospitals are no longer a part of the system; seeking services directly is 'jumping the queue'. AOD services in each region (different providers resulting from tenders) now have a central intake point (separately funded) which duplicates the work I do. This means clients have to re-tell their story (something the reforms were expected to fix); access is not dependant on acuity but on where the person is in the queue. AOD services are staffed by non-clinical clerical staff charged with allocating persons with AOD to services without the necessary clinical skills and knowledge. In the end, of course, it is the client who misses out and falls between the gaps, either through non-delivery of services in a timely manner or a failure to provide the right services.

Ongoing and serious attempts to collaborate with other organisations in the AOD sphere, have not resulted in any changes to access or treatment. Every aspect is determined by the funding model pursued by DHHS.

If I could I would….

1. *Mental Health services need to be properly funded for AOD interventions with appropriate numbers of trained staff for both inpatient care and follow up through community mental health services. There is a lack of focus on AOD and career pathways for nurses. In the AOD workforce strategy an increase is mentioned in AOD nurse numbers but currently they have nowhere to work. If we had AOD nurses on mental health inpatient units and community MH teams it would arguably have better patient outcomes.*

2. *Currently, I am the only specific AOD funded clinician in the hospital. The acute inpatient mental health units and general hospital wards would benefit from access to more specialised AOD nurses. Having access to more specialised staff would assist with medical management and treatment and reduce occupational violence risks associated with pts drug intoxication and withdrawal.*

3. *Mental health acute community intervention service teams (ACIS) are currently funded to support patients post discharge from MH inpatient units. Access to a specific AOD clinician within the ACIS team to follow up AOD issues would be beneficial. This would assist in withdrawal management and community linkage of dual diagnosis patients.*

4. *Attention to co-locating AOD services with community mental health or making AOD part of mental health would lead to less fragmentation and delays. Consideration could be given to co-location of AOD and mental health services to allow seamless service delivery and prevent current silos and lack of continuity of care*

5. *There should be more emphasis on encouraging participation from family members for an AOD patient. The importance of family support is often underestimated, leaving the individual unsupported.*

6. *Funding should be targeted to individual recovery. The emphasis must be on the individual and the language for recovery should be focused, not using language suggesting they are merely a 'product recipient' receiving a 'product package'. Although this is a minor point, it reflects the current fragmented system where the emphasis is on receiving the payment for an AOD product and resources which reinforces a silo approach.*

Summary

The AOD system is fragmented and arranged to reflect funding, not the needs of persons with mental illness who have an AOD problem. There needs to be an emphasis on providing quality care from trained AOD professionals who have access to a wide range of interventions (including intensive inpatient and detox services) and supports. While community supports may take different forms and involve different agencies, the whole process needs to be determined on the basis of patient needs and be delivered via a professional, planned response.

As an advocate for my patients, I hope my suggestions may in some way be beneficial in highlighting the current siloed model of care that exists for clients presenting to public hospitals who require alcohol and other drug AND mental health care services.

Nurse M – Nurse practitioner, alcohol and other drugs, mother baby inpatient unit

I am a Nurse Practitioner (NP) in a mother and baby inpatient alcohol and drug withdrawal facility. I hold a Bachelor of Nursing, a Graduate Diploma in Addiction Studies and a Master of Public Health (Addiction) and am endorsed in primary care and mental health. I have extensive clinical experience managing both the medical and behavioural aspects of inpatient withdrawal facilities. My endorsement as a NP evolved from the lack of on-site medical services available to our community residential inpatient facility.

We admit approximately four people each business day to undergo withdrawal from combinations of alcohol, tobacco, cannabis, methamphetamines, prescriptions pills, heroin, benzodiazepines and GHB. Our data last year indicated that around 85 per cent of program participants were diagnosed with anxiety and depression; a smaller percentage had PTSD, ADHD and low prevalence disorders. Approximately 30 per cent of program participants had experienced either a suicide attempt or suicidal thoughts and plans. During withdrawal from their substances, suicidal thoughts can emerge but are largely able to be managed in our environment as these thoughts are fleeting and associated with resurfacing emotions, triggering events and other factors. Overall, the vast majority of people will have a history of significant childhood trauma. Childhood sexual abuse is the most common trauma, followed by family violence. I have noticed that more of our program participants have lost a parent to suicide when they were young. Other traumas include recent traumas relating to family violence and recent sexual assaults. As we now run a mother and baby withdrawal service, we have seen an increase in women who were themselves removed from their parents as children. Issues with poor education, chronic unemployment and early school leaving are common. In general, most participants are due to commence counselling or rehabilitation programs. A fair number travel extended distances to access our service. Many of our residents will go on to residential rehabilitation programs or our six-week day rehabilitation programs.

Overall, our program participants have limited contact with the community funded AMHS due to experiencing situational crisis or chronic anxiety and depression. Where we have a person begin to experience suicidal ideation, it is rare for us to seek support from CATTs as it is rare for them to visit. Most support is provided by telephone. It is more common for us to use ED psychiatric triage if the person's mental health is beginning to deteriorate and they are prepared to go in an ambulance. On occasions, we request welfare checks for people who exit our facility when we have concerns about them. We admit people to our facility who are linked with AMHS to undergo withdrawal from poly substance use, including tobacco.

Our focus is on keeping people out of hospital, suicide prevention, recovery and wellness. In general, almost none of our program participants will require acute mental health services at the time of their admission, but several will have been referred by CATT to us and were supported by mental health services in the weeks preceding admission. Suicide prevention and suicide risk assessments are conducted on all program participants during admission and on exit.

We consistently work with people who have ongoing suicidal thoughts and on occasions risk rises during withdrawal, but the risk rarely becomes imminent. Many program participants become suicidal during intoxication but as they are not intoxicated in our program the imminent risks are minimal. Our role is to support people to increase their emotional capability and personal strengths. Many people assume we focus on physical symptoms alone, but emotional support and behavioural management are also key tasks undertaken.

The AOD field can be challenging to access because many people seek EDs in crisis but do not follow through referral options to our facility. Or, if we assist the ED and admit a person in rapid circumstances, it is rare that the person remains longer than a day or two, usually because of complications at home. This appears to be a complicated pathway to access services. In this way, people who are in crisis with both AOD and imminent mental health concerns are seen through the mental health services. Appropriately, people are only detained for a few days as the imminent suicide risk resolves.

In this way, families are left frustrated without the capacity for services to keep their family member. We refer a lot of people to Family Drug Help Line to seek support as the journey to access treatment voluntarily can be extended.

The Severe Substance Use Dependent Persons Act is rarely used in Victoria and the ability to use it is very limited although there are gazetted beds. Saying that, I would urge caution for Victoria to expand this Act as none of the inpatient facilities have the capacity to detain people. I imagine other services sectors may call for involuntary admissions for AOD issues and families may seek or recommend laws to enforce treatment. However, the AOD residential model is not designed, nor should it undergo redesign, to receive AOD drug dependent persons, despite families' distress. An increase in care and recovery and peer workers may be better suited to building relationships and encouraging people to access treatment. I urge caution about involuntary treatment solutions.

Overall, the beds in adult withdrawal services do not run to capacity because people do not arrive for admission and early exit is the norm for about 30 per cent of program participants – people leave after 24, 48 or 72 hours for a range of reasons.

The AOD withdrawal sector, due to limited medical officer support and minimal staffing on weekends, does not admit on Saturdays and Sundays or public holidays. For a long time, there has been reluctance to review this model. Many of the withdrawal services do not employ RNs overnight or weekends. We have remained a welfare-based model despite the increasing poly drug dependence, comorbid medical and mental health conditions of the people who access our services. The changing role of Division 2 nurses gives the state government an opportunity to review the model and consider increasing opportunities for services to increase their capacity and admit persons over the weekend. This may make better use of AOD withdrawal beds and decrease people seeking ED care. I acknowledge that this may be resource intensive.

Due to a lack of medical services at our facilities, EDs are used as after-hours medical services. Saying that, the ED can see people quickly and exit them back to the facility quickly if it is for a medical condition only. We would still consider ED psychiatric triage useful as well, rather than increasing psychiatric support to AOD units after hours. Perhaps, if there were ways to provide sobering up beds in withdrawal facilities, this may be more useful, or step-down beds from EDs. The only obstacle to this is the number of staff in our facilities after hours and access to medical care.

Overall, most of our AOD people are not well linked with GPs so early intervention into their mental health, anxiety and depression is delayed or emerges from behind their substance use. In my opinion, public health messages that address the link between stress, substance use, anxiety and depression and encourage people to seek assistance or online counselling and reduce substance abuse help to encourage people to act early. I have found the advertisements on family peace to be very useful to give positive messages about parenting and the impact of substance use on parenting.

In general, many of the people who arrive at our services have lost the capacity for self-recovery at that time. I support the introduction of programs that teach small steps to finding internal solutions.

Larger public health messages enhancing self-recovery should also be promoted. Opportunities to look at the link between cannabis and mental health, methamphetamine, alcohol and prescription pills, especially the link between taking substances to 'help cope' but in doing so, making it worse in the long run, may be useful for us to promote so members of the community can self-identify when substance use and mental health are impacted. In primary schools, all the programs about emotional resilience are useful for this younger generation.

Embedding trauma-informed care

The ANMF (Vic Branch) recognises efforts to reduce occupational violence and aggression (OVA) are strengthened by embedding trauma-informed care in all practice, but particularly in mental health services. Trauma-informed care:

- recognises the high prevalence of experiences of trauma such as assault and abuse among people accessing mental health services and takes steps to avoid practices or discussions that may trigger memories of such trauma

- is based on the recognition that many behaviours and responses – once seen as 'symptoms' – are in fact adaptive behaviours that can be positively integrated into people's care

- acknowledges people's lived experiences are the bedrock for therapeutic decision making and promotes people's choice and empowerment as vital to their treatment

- values the consumer in all aspects of their care; uses neutral and supportive language that does not judge or 'label' people; and seeks to engage people on their terms – for example, requesting their permission before contacting their family.

Trauma-informed care systems usually follow guiding principles, including:

- a focus on building therapeutic relationships that are empowering and support individual strengths and learning

- the preparation of comprehensive treatment plans based on professional assessments of a person's trauma history

- close collaboration with external agencies and expert consultants who can provide specialised advice and trauma care

- careful consideration of the potential for re-traumatisation through inappropriate work practices and/or any continuing trauma in the person's personal life

- embedding of trauma-informed care approaches in policies and workplace practices across the service

- staff education and training on the prevalence and impacts of trauma and the widespread occurrence of violence and victimisation among people accessing mental health services

- an assumption that everyone accessing the service has potentially experienced trauma, and the need to adopt trauma-informed approaches in all aspects of the service's treatment and care.

While DHHS provided training in trauma-informed care some years ago, it is not embedded into workplace policies and practices, and consequently workplace culture, across the service. This view is echoed in the report of the Mental Health Complaints Commissioner into sexual safety, which recommends that the Victorian Government:

- implement trauma-informed care as a primary prevention strategy in recognition of the prevalence of trauma among people accessing acute mental health inpatient services and the re-traumatising impacts of sexual safety breaches

- develop tiered approaches to implementing trauma-informed care to ensure mental health service staff with the appropriate skills and capabilities lead responses to sexual safety breaches and ensure pathways to trauma-specific care are clear and available.[48]

NB. We note the Mental Health Complaints Commissioner's report into sexual safety also makes the following relevant recommendation in relation to sexual safety and trauma-informed care:

> A trauma-informed approach to ensuring sexual safety in acute inpatient mental health services requires policy settings and mental health services to recognise and respond to the prevalence and impacts of trauma in people accessing mental health inpatient treatment – at all levels and in all aspects of service delivery. While there is a stated commitment from the department and mental health services to implement trauma-informed care, embedding such approaches into service delivery still requires significant practice changes to ensure that people experience trauma-informed, sexually safe services.[49]

The report recommends:

- developing plans for minimum infrastructure requirements to support sexual safety in mixed-gender environments and piloting and evaluating single-gender units

We support this recommendation.

We also consider it is essential the Victorian Government renew efforts to embed trauma-informed care across services, equipping services to adapt a whole-of-organisation approach that embeds trauma-informed care into workplace policy, practice and culture.

RECOMMENDATION 36

Implement the recommendations of the Mental Health Complaints Commissioner to:

- implement trauma-informed care as a primary prevention strategy in recognition of the prevalence of trauma among people accessing acute mental health inpatient services and the re-traumatising impacts of sexual safety breaches

- develop tiered approaches to implementing trauma-informed care to ensure mental health service staff with the appropriate skills and capabilities lead responses to sexual safety breaches and ensure pathways to trauma-specific care are clear and available

- develop plans for minimum infrastructure requirements to support sexual safety in mixed-gender environments and piloting and evaluating single-gender units.

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[48] Mental Health Complaints Commissioner, *The right to be safe: Ensuring sexual safety in acute mental health inpatient units sexual safety project report,* 2018, p7.

[49] ibid., p49.

> **RECOMMENDATION 37**
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> Renew efforts to embed trauma-informed care across services, equipping services to adapt a whole-of-organisation approach that embeds trauma-Informed care into workplace policy, practice and culture. This would include:
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> - acknowledging the significant existing clinical mental health workforce who have experienced workplace trauma and its associated impacts and providing urgent supportive strategies that enable people to process their workplace experiences of trauma
> - delivering mental health trauma training across all EDs.

Reducing restrictive interventions

Restrictive interventions are coercive interventions that cause consumers, carers and clinicians to feel a range of negative emotions. While restrictive interventions may only be authorised for consumers considered to be an imminent and serious risk to themselves or another person, these practices can have an impact on the therapeutic relationship, cause serious physical harm (and in some cases death), be experienced as a traumatic event, and may trigger and exacerbate previous experiences of trauma. In Australia, the Australian Government's National Mental Health Working Group (2005) identified reducing the use of restrictive interventions as one of four safety priorities in mental health services.

In Victoria, there has been an ongoing commitment to reducing the use of restrictive interventions with the implementation of the *Creating Safety: Addressing Restraint and Seclusion Practices* project in 2006. Most recently, the *Reducing Restrictive Interventions* project (2015) supported inpatient services and EDs throughout Victoria to reduce and, where possible, eliminate restrictive interventions.

The Mental Health Act 2014 strengthens state government policy and initiatives to reduce the use of restrictive interventions by regulating the practice of restrictive interventions and increasing oversight and accountability. Part 6 makes the following provisions:

- the use of restrictive interventions to be authorised by an 'authorised psychiatrist', or a 'delegate' determined by the authorised psychiatrist by written instruction
- where an authorised psychiatrist or delegate is not immediately available, a registered medical practitioner or the senior registered nurse on duty may authorise a restrictive intervention – this covers the use of a restrictive intervention in an ED or a general area of the hospital where mental health services are being carried out
- a registered nurse may approve the use of physical restraint if it is necessary as a matter of urgency to prevent imminent and serious harm to the person or another person and an authorised psychiatrist, a registered medical practitioner or the senior registered nurse on duty is not immediately available to authorise the use.

Reducing restrictive interventions is not a one-off measure. It requires ongoing attention and vigilance, including:

- regular training and refresher training for all direct care staff (registered nurses and registered medical practitioners) – this must occur with new staff at orientation and all staff through regular and frequent fresher training

- clear, concise and consistent approach to responding to potential or actual threats of aggression or violence. This must include nurse-led Code Grey policies and procedure, and teams that prioritise the safety of consumers and staff in de-escalating and responding to such situations in a clinically appropriate manner

- collaborative nursing care planning that considers individual consumer needs, preferences and experiences, and carer views of what interventions are most effective and should be in place for each consumer (this includes input from the consumer consultant or peer worker where the consumer wants this to occur)

- close communication with consumers about the reason for any restrictive interventions

- collaborative reviews after each restrictive intervention, with input from the consumer, carers and relevant parties

- debriefing and support for consumers, carers and relevant parties.

The training required is significant as it must focus on early intervention and prevention and develop:

- a good understanding of Part 6 of the *Mental Health Act 2014* governing the use of restrictive interventions and DHHS guidelines

- an understanding of the need to consider the use of restrictive interventions within a framework that promotes recovery-oriented practice and trauma-informed care

- a knowledge of trauma-informed care principles and practices

- sound knowledge of the service's policy and approved approach to restrictive interventions

- an awareness of consumer experiences of compulsory treatment and restrictive interventions

- an understanding of the causes of aggressive or threatening behaviour

- an awareness of the impact of staff behaviours and attitudes on consumers

- proficiency in de-escalation, the use of sensory modulation and other approved techniques; observation and monitoring; recognising signs of physical distress during the use of restrictive interventions; responding to escalating emergency responses and basic life support skills (CPR)

- a knowledge of how medication can be used to prevent and support a person who is acutely agitated.

This work represents a significant undertaking and requires dedicated attention from a designated member of staff who has direct responsibility for ensuring these measures are in place and practised. We consider this role is best fulfilled by a registered nurse given their in-depth and ongoing involvement in clinical care, their relationships with consumers and carers and their legislated responsibilities in relation to restrictive practices.

> **RECOMMENDATION 38**
>
> Fund a dedicated nursing role to build and monitor reducing restrictive intervention compliance by
>
> - providing regular training and refresher training for all direct care staff and security personnel
> - leading/coordinating collaborative nursing care planning
> - leading/coordinating communication with consumers about the reason for any restrictive interventions
> - leading/coordinating collaborative reviews after each restrictive intervention
> - leading/coordinating debriefing and support for consumers, carers and relevant parties.

Expanding hospital-in-the-home

One strategy which bridges the gap between hospital and community care and helps to avoid unnecessary hospitalisations is 'hospital-in-the-home' (HITH). HITH services have been funded in Victoria since 1994 and are consistently affirmed as being safe and appropriate. They are generally staffed by a multidisciplinary mix of nursing, medical and allied health staff who provide care in the home that people would otherwise receive in hospital as an admitted patient. People who receive HITH care are classified as admitted patients and their care is funded through a health service's case mix revenue. Many HITH people are elderly and chronically ill, but there is a significant cohort of people who have an acute event and require short-term, intensive medical treatments, including paediatric and neonatal treatment.[50]

As the Mental Health Nurse Incentive Program (MHNIP) discussed in chapter 4 and the example from South Australia below show, this type of service translates very well to mental health.

> In South Australia, an innovative HITH initiative, the Mental Health Hospital @ Home (MHH@H) service, was established at Flinders Medical Centre to provide an alternative to inpatient treatment for people in crisis. This model takes into account the local context and is informed by evidence that outcomes improve when patients are treated at home. This service operates across several domains, including health/medical, carer support, and social services (e.g. AOD, Centrelink). One of the core strategies relates to referral pathways. The primary aim of the model was to reduce pressure on the emergency department. However, once MHH@H was operating, it became apparent that it was also freeing up inpatient beds, allowing quicker admission of patients for whom inpatient treatment was necessary. Despite initial resistance on the part of staff, particularly psychiatrists who doubted the effectiveness of home-based treatment, once the programme was implemented, approval was high. This demonstrates the importance of inter-professional education, in which health care providers learn of the roles and responsibilities of other providers, and discuss methods of working in a complementary fashion.[51]

> **RECOMMENDATION 39**
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> Expand the successful hospital-in-the-home program to mental health.

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[50] Victorian Government Department of Health & Human Services, *Hospital in the Home Guidelines*, 2011.

[51] Primary Health Care Research & Information Service, *Improving the integration of mental health services in primary health care at the macro level,* 2015, pp30-31.

5.   ADDITIONAL MEASURES FOR UNIQUE COMMUNITIES

RC Question 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Communities experiencing poorer mental health outcomes include Aboriginal people, people from CALD communities, people experiencing homelessness, women in vulnerable or high-risk living circumstances, people with AOD issues, people with dual diagnosis or physical comorbidities, and people in regional, rural and remote communities. All pose unique challenges for the health system, with many clients required to attend multiple services in different areas to receive all the treatment they need.

We respect the principle, 'nothing about us without us', and support communities identifying solutions that are culturally relevant and responsive to their unique needs. Consequently, rather than making specific recommendations for some communities, we highlight a range of initiatives to facilitate a consistent, coordinated, whole-of-system approach that provides person-centred and integrated services by trained and equipped health professionals.

First Australians

Optimising culturally appropriate maternal and child health services

Consistent with our views in Chapter 2 in relation to the importance of enhancing early prevention strategies by optimising existing midwife and maternal and child health programs, we note the Victorian Parliamentary Inquiry into Perinatal Services report states the following:

> *Ms Miller from the Wathaurong Aboriginal Co-operative told the Committee that while the perinatal period can be a time of increased social and emotional difficulties, mood disorders, increased anxiety, and mental health issues for Aboriginal and Torres Strait Islander women, it is also a time in which Aboriginal and Torres Strait Islander women are more likely to access health services:*

> *Our clients have complex family issues, with [domestic violence, alcohol and other drug use], child protection involvement, housing uncertainty, and involvement in the justice system, all of which have an adverse impact on the social and emotional wellbeing of our families.*

> *Pregnancy, however, is a great opportunity for families to receive assistance when they access the health service.*

> *However, Ms Miller noted that accessing support services is not always easy with many mainstream services lacking cultural responsiveness, clients facing long waiting lists, and a lack of availability of female counsellors, which often meant that 'emotional and social support falls to the Midwife and Aboriginal health worker further increasing workloads'.*

> *In 2014, the Centre for Perinatal Excellence (COPE) released a report into Aboriginal and Torres Strait Islander perinatal mental health which stated that there are 'extensive' mental health problems in Aboriginal and Torres Strait Islander communities, more than in the broader population, with high rates of depression, anxiety, trauma, grief, self-harm, suicide and domestic violence. COPE notes that, despite this, Aboriginal and Torres Strait Islander people are less likely to engage with mental health services 'due in large part to the potential for culturally inappropriate*

services that fail to embrace Aboriginal concepts of health and wellbeing'. Regarding mental health screening and the barriers to accessing mental health services, the report stated:

When investigating the potential barriers and enablers to screening and assessment, interestingly the most frequently identified issues were fear, trust and stigma. In turn, these barriers are perceived by health professionals to be impacting on disclosure and ultimately the effectiveness of screening and assessment practices. These issues, together with the perceived unavailability of culturally appropriate referral services were also perceived by almost all health professionals to be preventing post-screening referrals being acted upon by women. This is being further impeded by current poor communication between services – another major barrier to effective referral practices. Further, in some cases more logistical issues such as transport were also commonly identified barriers to screening and referral practice.

Given the increased risk of mental health issues for Aboriginal and Torres Strait Islander women during the perinatal period, the Committee recommends that the Victorian Government ensure that all mental health workers providing perinatal care are trained in cultural awareness and engagement with Aboriginal and Torres Strait Islander communities.[52]

The ANMF (Vic Branch) supports this recommendation while noting many hospitals and service providers already provide some training in this area. We consider all treatment for mental and physical illness should be integrated and respectful of cultural identity and welcome all efforts to build cultural awareness and cultural safety among mental health practitioners, including midwives and nurses.

However, we stress the pressing need for culturally sensitive midwife and nurse-led services providing expert clinical trauma-informed integrated care and welcome opportunities to contribute to such service development. As the Inquiry heard in relation to pregnancies among Aboriginal women, 'the fact that they are Aboriginal automatically classes their pregnancy as high risk', with Aboriginal women more likely to be younger and more likely to have diabetes before pregnancy than non-Aboriginal women. Late presentations and poor attendance for perinatal care increase their risk.

The Committee also heard that Aboriginal and Torres Strait Islander children are 8.3 times more likely to be the subject of a child protection substantiation, and that previous contact with child protection can make all mothers, including Aboriginal and Torres Strait Islander mothers, reluctant to connect with services:

Particularly for mums who have experienced significant contact with child protection services, they are wary. When we talk about retraumatising and we talk about their own family histories a lot of the time, being able to trust services like ours is really challenging, particularly when you are responding to a referral someone else has made.[53]

This makes efforts to develop expert, culturally sensitive services providing trauma-informed care critical.

Koori Maternity Service

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[52] Parliament of Victoria, *Inquiry into perinatal services: final report*, 2018, p312.

[53] ibid., p295.

The Koori Maternity Service (KMS) program provides access to holistic, culturally appropriate care for Aboriginal women and their families during pregnancy. This state-wide program is delivered by midwives, Aboriginal health workers and Aboriginal hospital liaison officers who work in a complementary team of two or more health professionals. Each Koori Maternity Service tailor their model of care to the local community.

The program operates in 14 sites: eleven are in Aboriginal Community Controlled Organisations (ACCOs) and three are in public hospitals. The program aims to:

- increase access to, and participation in, antenatal services and postnatal support

- facilitate relationships between women and birthing hospitals

- optimise the health and wellbeing of women and their babies.

- identify and manage maternal and foetal risk factors, particularly early in pregnancy

- reduce perinatal morbidity and mortality, including incidence of preterm birth and low birth weight.

The Victoria Parliamentary Inquiry into Perinatal Services recommended the Victorian Government identify areas not currently serviced by KMS programs with a view to expanding programs and funding, in collaboration with Aboriginal community-controlled organisations and other mainstream services. We support this recommendation.

> **RECOMMENDATION 40**
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> Consistent with our views in Chapter 2, we encourage the Victorian Government and VACCHO to recognise the importance of including culturally appropriate perinatal mental health screening for Indigenous Women as a key service and take steps to ensure it is funded and built in to the service provision.

Enhanced discharge planning and collaborative frameworks

We note that the Aboriginal Families Study Policy Brief No 5 highlights the important role of primary health care services in safeguarding mothers' health and recovery in the postnatal period. It emphasises enhanced discharge planning and collaborative frameworks to ensure maternal health in pregnancy is communicated to services providing postnatal care and strategies to ensure seamless transition between antenatal and postnatal care, among other things.[54]

People from CALD communities

The Victorian Parliamentary Inquiry into Perinatal Services heard evidence that women from culturally and linguistically diverse (CALD) and refugee communities face disadvantages and barriers in accessing perinatal services. They often experience social isolation and may not have their families or support networks around them. This contributes to CALD women being particularly vulnerable to developing mental health conditions during the perinatal period. This is compounded if they have difficulty communicating and navigating health and social services and struggle to receive the support and services they need. The Committee also heard health professionals and services were often

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[54] SJ Brown et al, *Aboriginal families study policy brief no. 5: safeguarding the health of mothers and babies*, Murdoch Children's Research Institute, Melbourne 2016, p4.

inexperienced in working with families from CALD backgrounds and the complexities of working with interpreters.[55]

The report cites a Multicultural Centre for Women's Health Sexual and Reproductive Health: Data Report which found interactions with healthcare professionals were critical to migrant and refugee women's access to healthcare. The report identified the following enablers to accessing healthcare in Australia:

- the provision of interpreters and bilingual health professionals

- multilingual resources, including information on how to reach healthcare facilities

- appointment reminding services

- home visits

- provision of female health professionals

- health professionals using their time to listen to concerns, answer questions and explain treatment options.[56]

We recognise these special circumstances and enablers, and consider the nurse navigator role, described in chapter 4, would be of enormous benefit to this client group. Working with interpreters as needed, nurse navigators would be able to monitor health needs; educate and help clients better understand their health conditions; enable clients to self-manage or participate in decisions about their health care; help clients identify actions to take to manage their health; and help them navigate the system's intricacies so they can obtain effective and holistic care when needed, and as early as possible in life, in illness and in episode.

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[55] Parliament of Victoria, *Inquiry into perinatal services: final report*, 2018, p321.

[56] ibid., p327.

> **SEE RECOMMENDATION 34**
>
> Introduce the highly successful nurse navigator role in Victoria commencing with mental health clients, including CALD clients – this would improve the sustainability of the mental health system by ensuring people living with mental health issues access the care they need, by the right practitioner, when they need it.

People experiencing homelessness

Many people experiencing homelessness have ongoing mental health and AOD issues, along with a range of other comorbidities, making it imperative this client group receive holistic and integrated care. They need a teamwork approach to treatment for their physical health, AOD use and mental health issues. However, key barriers to this exist including:

-   insufficient inpatient beds to treat clients that are acutely mentally unwell

-   stretched outreach services unable to offer complete care and follow-up when clients are discharged

-   a shortage of trained mental health staff to provide mental health care, support and referral

-   a lack of primary health care services staffed by multi-disciplinary professionals equipped to provide holistic care

-   a reactive rather than proactive approach from mental health services.

As the Homeless outreach psychiatric services HOPS program shows, nurse-led homeless persons programs employing mental health nurses working alongside AOD nurses, community nurses and HIV nurses can make a real difference. All nurses would be trained in trauma-informed care and have expert knowledge of and links with support services available to ensure clients' needs can be met in a timely and integrated way.

Homeless outreach psychiatric services

Homeless outreach psychiatric services (HOPS) provide a range of specialist psychiatric treatment, interventions, assertive outreach and intensive support for adult clients aged 18-64 years who are experiencing mental illness and homelessness or are at risk of homelessness and do not engage readily with mental health services.

HOPS work in partnership with homelessness services and use assertive outreach to locate and engage with their clients. They aim to work with clients and service providers to create a pathway out of homelessness by providing early and appropriate treatment and support. HOPS link clients into the mental health service system, access to long-term housing and outreach support, and improve the coordination and working relationships between mental health and homelessness services.

HOPS also provide assessment and secondary consultation to homelessness services and other mental health workers. A typical HOPS team includes a consultant psychiatrist, psychiatric registrar, occupational therapist, social worker and psychiatric nurses who provide: psychiatric assessment and

treatment; clinical case management; family and carer support and specialist allied health interventions. It's a very valuable service and worth extending to all catchment areas.

RECOMMENDATION 41

Support nurse-led homeless persons programs to employ mental health nurses to work alongside AOD nurses, community nurses and HIV nurses, all of whom are trained in trauma-informed care and have good knowledge of the services available to ensure their clients' needs can be addressed.

RECOMMENDATION 42

'Fast track' people with these complex needs to appropriate public housing and require ongoing engagement with the nursing service.

RECOMMENDATION 43

Recognise the strong association between homelessness and family violence and ensure victims of domestic violence (and their children) can access safe refuges and be protected to make transitions to affordable housing.

RECOMMENDATION 44

Encourage public sector governance of homeless services to reduce expenditure on overheads and allow funds to go to direct service provision.

RECOMMENDATION 45

Ensure people with a dual disability admitted to Transitional Support Units (TSUs) receive regular and ongoing care from nurses.

Women in vulnerable or high-risk living situations

The Healthy Mothers Healthy Families Research Group, Murdoch Children's Research Institute Policy Brief summarises findings from an Australian longitudinal study of over 1 500 first time mothers and their firstborn children. It states one in five mothers experienced emotional and/or physical abuse by an intimate partner in the year after having a baby. This translates to 14 000 Victorian families a year affected by family violence during a child's first year of life.[57] The same study found that almost one in three women reported depressive symptoms between pregnancy and four years postpartum. This makes a compelling case for health services to complement the current focus on high quality clinical

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[57] SJ Brown et al, *Maternal health study policy brief no 2: health consequences of family violence,* 2015.

care with equivalent attention to social factors such as family violence that also place the health of the mother and child at risk.[58]

Many vulnerable women are not visited at home for postnatal care because of overriding safety concerns for midwives and other staff. For example, women who have been assessed as having a history of AOD or an abusive partner or family member/s, will be asked to return to hospital for a check-up. These women are arguably more in need of a home visiting service than many others as they are often unable to leave home.

It is essential the Victorian mental health system find flexible solutions for these women. This may mean providing a longer length of stay in hospital, assistance with transport to return to hospital, increased resources to allow midwives and others to undertake risk assessments and mitigate risk to safely visit the woman's home and community options where postnatal advice and assistance can be accessed.

From a workforce perspective, it is essential that qualified and experienced nurses and midwives with appropriate vehicle and equipment infrastructure are available to deliver essential postnatal care to these women in a way that is safe and helpful to the women and safe for the workforce.

> **RECOMMENDATION 46**
>
> Review existing screening for family violence within clinical mental health services and provide clear guidance and professional development about the best approach to screening and providing safe responses and support, including new solutions to ensure women living in vulnerable or high-risk circumstances receive home nursing care safely and nurses are safe when they provide it.

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[58] SJ Brown et al, *Maternal health study policy brief no 1: maternal depression*, 2014.

Nurse G – Community health nurse, outreach

I have been a nurse for 40 years and have been working in my current role as a community health nurse for 14 years. I work in an outreach position where I care for some of the most marginalised and vulnerable people in society.

My target client group include people who are homeless or at risk of homelessness, people with substance use issues, sex workers and people with mental health issues. A significant number of my clients have a combination of the above issues. They live in a range of places, from sleeping rough in parks and doorways, living in rooming houses, crisis accommodation and public housing.

My role is to support this complex client group to attend to their physical and mental health needs. This includes engaging with clients, assessing their needs, providing care and referring clients to relevant health services.

A case study

▮▮▮▮ is a 41-year-old woman who currently lives in community housing. She is a street sex worker and poly drug user with a long history of mental health issues. She was first diagnosed when she was 12 years old and has been diagnosed with schizophrenia and PTSD. She has attempted suicide several times and has ongoing issues with pain from injuries sustained in one suicide attempt. She has no contact with her family, including with her teenage son.

She has been a client of the heath service for almost 15 years. I have been working intensively with her for the past four years. My program has given me the time to engage with ▮▮▮▮ and build a strong rapport with her. This had resulted in ▮▮▮▮ developing trust in the Homeless Persons Program (HPP) nurses and has meant we have been able to help her achieve good outcomes. We provide support with medication management, taking her to medical appointments (both GP and hospital) and referring her to housing, legal and community services as requested. We also advocate on her behalf with the services.

▮▮▮▮ has had frequent admissions to inpatient psych units at several hospitals. Before her last admission earlier this year, she had not had an inpatient admission for 16 months – an excellent outcome for her. This was achieved through ongoing support from HPP nurses who regularly met with ▮▮▮▮

We spent time with ▮▮▮▮ allowing her time to vent feelings, frustrations and voice any concerns we took her concerns seriously and assisted her where possible to find solutions for these issues We monitored her medication management and helped her to take her medications as prescribed. We referred ▮▮▮▮ to health services and provided transport and advocacy when needed so she could attend to her physical health needs. We worked closely with her case worker from the mental health outreach service. This provided ▮▮▮▮ with coordinated support from workers who were working together to provide holistic care.

This worked extremely well when ▮▮▮▮ needed her recent admission to hospital. Working with the mental health team, we were able to admit ▮▮▮▮ to the psych unit with minimal trauma. Although very mentally unwell, she trusted me to drive her to the hospital and this made police involvement unnecessary. I was able to stay with her during the admission process and, despite her being distressed, security and restraints were not needed. This resulted in a shorter stay in hospital.

Despite having many complex issues, with adequate support ▮▮▮▮ is able to live her life more positively. She needs ongoing support to keep out of hospital and regular contact to assess her mental and physical health. There are still issues concerning her housing as she lives in a community rooming house where most residents are male. This causes her to feel unsafe and anxious.

Working with our client group and trying to assist them improve their health, I see the following barriers that prevent them from achieving better outcomes:

- *Inadequate funding for health services – this includes both inpatient and outreach services. There are not enough beds to treat clients that are acutely mentally unwell. The community outreach services are stretched and can't provide the complete care and follow-up needed when clients are discharged.*

- *A shortage of trained mental health staff to cope with the numbers of people suffering from mental health issues.*

- *A lack of primary health care services that are staffed by multi-disciplinary professionals who are focused on providing holistic care for all health needs. Clients need a teamwork approach to treatment for their physical health, drug use, as well as their mental health issues. It is often these complex clients, who have multiple issues, who fall through the gaps as services are not flexible or able to provide long-term support.*

- *Limited number of community services providing socialisation opportunities – isolation and feeling uncared for can exacerbate mental health problems.*

- *Limited funding for legal services to assist mentally unwell clients to deal with legal issues – the legal services that are available have huge workloads.*

- *Inadequate safe and secure housing – mental health issues are exacerbated by living rough or living in unsafe, substandard housing.*

- *Lack of support for families and carers who find it hard to navigate the system.*

- *A reactive rather than proactive approach from mental health services.*

Too many times I have seen a client's mental health deteriorate but have been unable to access the help they need because they are deemed to be not unwell enough. It is terrible knowing that the 'train wreck' is going to happen and not being able to prevent it from happening. More funding needs to be made available for prevention as well as treatment.

People with mental health and AOD health issues

Service issues

It is imperative the Royal Commission recognise and consider the relationship between mental health services, the AOD sector and addiction medicine services and recommend solutions that facilitate clear and timely pathways.

AOD use can contribute to mental illness, influence the path of mental illness or result from mental illness. This close association has impacts for clients and services. Many clients are required to attend multiple services in different areas to receive treatment for both their mental health and substance use disorders. They need specific help and support to do so. However, people with concurrent mental health and substance use concerns often struggle to find appropriate treatment and are bounced between the AOD sector and mental health, with no one sector truly equipped to work effectively with this unique group.

The AOD sector itself is difficult to navigate, and many working in it struggle to understand what services are available and how to access those services. Clients with co-occurring mental health problems have even less chance of successfully navigating the AOD system and are often re-directed to local mental health services.

Motivation is essential to treatment and recovery and is soon lost when a client is faced with wait lists for community residential detoxification units or is left to navigate a fragmented and complex system of services. While acute settings can offer a unique and timely setting, very few hospitals are equipped to do so.

Clients may require access to inpatient care, detoxification, residential rehabilitation and specialist counselling. Victoria currently has only one residential rehabilitation service equipped to manage people with co-occurring mental health and substance use disorders – Westside Lodge which opened in 2018 and operates a unique model of care compared to standard residential rehabilitation programs.

The lack of appropriate specialist treatment services for concurrent mental health and substance use disorders, including detoxification beds, residential rehabilitation beds, specialist outpatient services and targeted peer support groups as well as the lack of detoxification beds within hospitals to support complex withdrawal management frequently means clients can end up going nowhere.

As one of our case studies explains:

> 'Clients attempt to engage with the AOD sector, however, may be considered too complicated so they are referred to mental health services who then advise the client to address their substance use disorder before attempting to address their mental health. The cycle continues, and clients fail to engage in treatment. Subsequently, they re-present to hospital feeling lost as to where to turn for help.' (Nurse Q, p90.)

Other barriers to effective and timely treatment include:

- the lack of specialist AOD and mental health nursing positions in hospitals to support more appropriate treatment and management of substance use disorders

- the lack of staff comprehensively educated in both mental health and substance use treatments

- the lack of training programs to maintain skills in the treatment of concurrent mental health and substance use disorders

- the lack of resources to support the treatment of clients with substance use disorders who are admitted to hospital for other medical/surgical reasons

- the lack of specific support for people over 65 with mental health changes and concurrent substance use disorders.

Workforce issues

While the AOD sector is well supported by peer support workers and other support staff who provide invaluable support to clients, there are not enough qualified staff to provide much needed clinical care and treatment. This means many clients fall through the gaps, ending up in the hospital system as the public AOD sector is not equipped to manage the complexity of these clients.

For standard residential programs to be able to accept clients with major mental health changes, their model of care needs to change. Most are staffed with peer support staff and provide limited access to clinical specialists; they need additional beds and appropriately qualified nursing staff to manage clients with complex mental health and substance use disorders.

Ongoing, rolling training programs on how best to treat and work with clients with major mental health changes and substance use problems targeted at mental health units are also needed, as their treatment needs can be quite different to standardised AOD treatment.

Support for nurse-led programs such as those in our AOD case studies (see also chapter 4) would ensure more clients benefit from specialist nursing care and treatment; effective client advocacy to ensure adequate access to appropriate treatment; and help accessing and navigating the service system.

The ANMF (Vic Branch) also supports harm minimisation strategies delivered through qualified specialist nurses, including the provision of methadone and buprenorphine, the roll out of long acting buprenorphine, supervised medical injecting, needle syringe and mobile needle syringe programs and pill testing. For many AOD and mental health clients, harm minimisation treatments are the only treatment they will receive, and expanding these services will promote greater engagement, save lives and potentially reduce the impact this cohort has on mainstream services.

Development opportunities

Nurses and midwives across the state have demonstrated how keen they are to upskill to participate in AOD programs. Initiatives under the Andrews Government 2017 Drug Rehabilitation Plan were readily embraced:

- Methamphetamine training provided by the ANMF (Vic Branch) and Turning Point: Face-to-face training for frontline nurses and midwives in delivering effective services to people affected by methamphetamine use. More than 1900 nurses and midwives have attended training.

- Customised training in alcohol and other drugs for nurses and midwives provided by the ANMF (Vic Branch) and Turning Point: Two-day workshops designed for nurses and midwives not currently working in the sector and one-day workshops for those already in the sector were delivered around the state. Nurses enthusiastically embraced these opportunities, with workshops quickly reaching capacity, sometimes within 24 hours of promoting. Over 610 nurses and midwives have attended this training.

- Twenty AOD nursing scholarships to facilitate completion of the Graduate Certificate in Addictive Behaviours were offered: Almost 100 applications were received.

- Two half-day open days held in October 2018 attracted over 560 nurse and midwife registrations. A further regional AOD information seminar in Traralgon in June 2019 attracted over 50 registrants.

RECOMMENDATION 47

Build capacity of health services with appropriate specialist treatment services, e.g. detox beds and residential rehab services staffed by AOD nurses – the general hospital bed environment is not appropriate for detox.

RECOMMENDATION 48

Consider better overall integration of AOD services in the health system, including co-locating AOD services with community mental health to reduce fragmentation and delays and facilitate more seamless service delivery and continuity of care.

RECOMMENDATION 49

Introduce incentives to encourage medical and nursing staff to complete additional postgraduate education and/or ongoing professional development in mental health and AOD to maintain best practice treatment.

RECOMMENDATION 50

Introduce mechanisms to encourage, where possible, participation from family members to support their loved one as they go through treatment.

RECOMMENDATION 51

Fund additional specific provisions for the assessment, care and treatment of people over 65 with mental health and AOD issues.

SEE ALSO RECOMMENDATION 34

Introduce nurse navigators to enhance recovery by helping clients navigate and optimise the supports and treatments available in a timely way.

SEE ALSO RECOMMENDATION 27

Increase the capacity of hospitals to manage mental health crises by funding a consultation liaison nurse in every Level 1, 2, and 3 hospital (as defined in the Safe Patient Care Act).

Nurse Q – Addictions clinical nurse consultant, acute care

I have worked in mental health nursing for over 10 years in a range of settings including: acute psychiatric inpatient unit; community care units; community treatment and continuing care; homeless outreach; mobile support; emergency psychiatry; dual diagnosis; drug and alcohol nursing: emergency department; addiction medicine

I am currently employed in a consultation liaison team as the specialist addictions clinical nurse consultant (ACNC). I provide direct clinical care to inpatients at my base hospital and telephone consultation for two other hospitals. I have an addiction psychiatrist and addiction medicine physician who I work with clinically and who provide me with supervision.

My role is to provide specialist nursing care and treatment to current inpatients with substance use disorders. This includes patients in the psychiatric adult inpatient unit. My team comprises an addiction medicine physician, an addiction psychiatrist, a psychiatric registrar, a general medicine registrar and myself. We also have a specialist nurse located in the ED.

As an ACNC I play a vital role in the overall coordination of the Addiction Services (ASs), as well as providing specialist nursing support to this highly complex and often ostracised client group. This nursing role differs significantly from that of my medical colleagues through my focus on harm minimisation, my understanding of the extended AOD sector and my established knowledge of pharmacological interventions for substance use disorders. The registrars on rotation with the addictions service are focused on learning and training. Frequently, they have no prior knowledge or training in AOD and limited understanding of the required management strategies.

I engage clients therapeutically and support more rapid access to ongoing treatment providers. This is largely supported by the networks I have maintained across the AOD sector. On any given day our team will review the treatment and management of between 10-20 clients across the hospital with a focus on withdrawal management; managing difficult behaviours associated with substance use disorders; implementing pharmacological interventions such as opioid agonist treatment (e.g. methadone); managing complex opioid dependence with concurrent acute/chronic pain and supporting clients to link with ongoing service providers in the community (e.g. AOD counselling, ongoing pharmacotherapy providers or step down to residential detoxification).

The following scenarios represent common examples of the types of referrals that the addictions team may receive:

- *Client X has been admitted under the infectious diseases team with infective endocarditis on the background of injecting heroin use. The infectious diseases team requests support and advice regarding the commencement of methadone or Suboxone.*

- *Client Y has been admitted under the general medicine unit with pancreatitis. The client has a long history of alcohol use and has been drinking up to four litres of wine per day. The general medicine team requests support and treatment recommendations regarding withdrawal and anti-craving therapy.*

- *Client Z has been admitted to the acute inpatient unit (psychiatry). They have a long history of schizophrenia which has more recently been complicated by crystal-methamphetamine use leading to multiple admissions. The client is now requesting support to access ongoing*

treatment. The psychiatry team requests support with access to services and to monitor withdrawal.

A large proportion of my work is associated with client advocacy and ensuring adequate access to appropriate treatment. This may be in the inpatient or community setting. The addictions service provides support to a range of the outpatient services with navigating the AOD sector, as well as, the provision of telephone consultation/collaboration regarding complex client presentations.

Client and family needs

Clients primarily require treatment and support within the hospital environment to remain abstinent for the course of their admission. This can be quite difficult because of the interplay between the client's physical health (and reason for admission), concurrent medications and the severity of withdrawal syndrome. Stigma and a lack of understanding of how to manage withdrawal appropriately by other health care providers can further complicate matters, with clients often going without adequate pain relief, or enough medication, to manage their withdrawal. This can lead to quite significant adverse events such as seizures in the context of poorly managed alcohol related withdrawal.

Within the acute mental health inpatient environment, severe withdrawal can be overlooked and confused with acute mental health changes (e.g. delirium tremens associated with a complicated alcohol withdrawal syndrome may be mistaken for psychosis). Similarly, there is often an expectation that the inpatient environment is equipped to manage a range of AOD withdrawal states when priority should be given to medical treatment in the first instance.

Unfortunately, very few major hospitals have inpatient detoxification units. The addictions service is a consultation team and does not have any admitting rights. Therefore, the decision to admit a client for the purposes of detoxification relies on admitting officers of other teams (e.g. general medicine). Addictions are then called to provide consultation regarding treatment throughout the admission. This frequently delays treatment as most consultation and liaison ASs operate 9.00am to 5.00pm, Monday-Friday. This means too often clients spend extended periods of time in hospital without sufficient pharmacological treatment for their withdrawal. The establishment of addictions specific inpatient beds within all hospitals would dramatically improve treatment outcomes through the provision of timely and targeted interventions.

Clients and families often present to EDs seeking help for their substance use disorders as a last resort. They are faced with wait lists in the community for residential detoxification units and staggered intake processes which can become frustrating and repetitive.

The hospital environment can provide a unique setting to engage clients around their substance use disorders, however, as it stands, there are simply not enough resources to respond to every client that presents requesting immediate help. Hospital wards and the psychiatric inpatient environment are not usually able to provide inpatient detoxification and many clients and their families struggle to understand this. There is limited access to support groups, one-to-one therapeutic interventions and aftercare due to the focus on medical management of withdrawal. One of the main limitations is that the ward environment does not reflect the same milieu required for appropriate therapeutic interventions generally provided in residential detoxification units.

As a result, many clients are re-directed back to community treatment programs and their short period of motivation, crucial in effective substance use treatment, is lost. Families are often frustrated by the lack of ability of hospitals to respond to their loved ones and become confused when attempting to navigate the AOD sector. Many clients refuse to allow health care providers to speak with their families which can further complicate these types of presentations.

I am frequently involved in discussing with family the limitations of the hospital system to respond adequately to clients with substance use disorders and provide assistance to families accessing community-based treatment. Where possible, I will complete direct referrals to service providers in the community to encourage the client's up-take of treatment and link family members to relevant support programs.

Family/carer support

One of the major difficulties we face in consultation addictions is an inability to speak with families. This can be due to relationships breaking down because of substance use or clients refusing to provide consent to speak with family members. There is a clear need for family and peer supports within the hospital environment to bridge some of these gaps. Families and friends often struggle to understand why treatment is not 'enforced' and why clients are able to discharge despite the risk of relapse.

SHARC (Self Help Addiction Resource Centre) has implemented an outstanding support program for family members of people with substance use disorders. However, this program is not always accessible across Victoria. While SHARC has invited partners in the sector to implement the program locally to meet the need of specific communities, consideration should be given to encouraging this collaboration further, in particular within adult inpatient psychiatric units.

Reducing hospital admissions

The addictions service at my hospital is one arm of the psychiatric consultation and liaison (CL) service. This has created a close working relationship and an integrated approach to client treatment. The relationship between suicide risk and substance use disorders is well established and our combined treatment approach is critical when working with clients with concurrent mental health changes and substance use disorders.

Many clients are admitted to hospital after attempting suicide while substance affected or intoxicated. A unique feature of our AS is our capacity to manage a range of mental health changes. Our team includes an addiction psychiatrist, psychiatry registrar and I am a registered psychiatric nurse. Our co-location and joint governance with CL Psychiatry allow for rapid referrals and joint consultations when clients have complicated concurrent disorders. When required, CL Psychiatry will jointly review clients with the AS to ensure adequate treatment is in place during the hospital admission and during the post discharge period to reduce the risk of representation and further suicide attempts.

Many other hospitals do not have a combined team, and this can create a fragmented approach to care. Likewise, there are very few community treatment programs that are truly equipped with both specialist mental health and ASs. Many clients are required to attend multiple services, in different areas, to ensure treatment occurs for both their mental health and substance use disorders. This significantly impacts on continuation of treatment and leads to increased rates of drop out.

The ongoing siloing of community-based mental health and the AOD sector creates one of the major barriers to service provision. Clients attempt to engage with the AOD sector, however, may be

considered too complicated so they are referred to mental health services who then advise the client to address their substance use disorder before attempting to address their mental health. The cycle continues, and clients fail to engage in treatment. Subsequently, they re-present to hospital feeling lost as to where to turn for help.

Service navigation

The AOD sector can be notoriously difficult for clients and families to navigate. This is further complicated when a client has concurrent mental health changes or chronic physical health problems. This is concerning given the well-recognised correlation between substance use disorders and a range of other health changes.

While changes are being made to intake processes to improve access to the AOD sector, there appears to be little consideration for the difficulties that clients with comorbidities face. DirectLine, and the development of central intake points, has greatly assisted with promoting initial contact; however, assessment processes can be cumbersome and time consuming and this contributes to poor engagement.

Currently, people with significant mental health changes have only two options in Victoria for residential rehabilitation: Westside Lodge and Wellington House (Turning Point). Implementing these programs has been a step in the right direction, but there are already lengthy waiting lists to access these services.

I spend a large proportion of my time helping clients navigate community-based treatment options and supporting them to complete referrals. This can be very time-consuming process with a range of AOD services requesting extensive documentation before appointments for follow-up can be made. Unfortunately, not all members of the AS have the resources or time to complete the level of documentation required.

Gaps

Clients with major mental health changes and substance use disorders are frequently lost to follow-up because of difficult intake processes in the AOD sector and the ongoing 'silo' approach to mental health and substance use treatment. The lack of appropriate detoxification and residential rehabilitation services for this client population results in further failures to engage in treatment and early drop out.

Incentives to encourage medical and nursing staff to complete further training regarding concurrent mental health and substance use disorders are clearly needed. Unfortunately, the level of stigma that comes with substance use disorders often discourages health care providers from working in this speciality area.

Primary gaps:

- *Lack of appropriate specialist treatment services for concurrent mental health and substance use disorders, including detoxification beds, residential rehabilitation beds, specialist outpatient services and targeted peer support groups.*

- *Lack of detoxification beds within the hospital environment to support complex withdrawal management.*

- *Lengthy intake processes for standard AOD treatment which can discourage engagement.*

- *Lack of specialist nursing positions within hospitals to support more appropriate treatment and management of substance use disorders.*

- *Lack of treatment services for clients with prescription medication use disorders. SafeScript is a well-overdue and well-received initiative but risks many clients having treatment abruptly ceased without adequate treatment providers in place to take over care / manage withdrawal.*

- *Lack of staff trained comprehensively in both mental health and substance use treatments. Many staff have attended one-off training programs but have not continued with education to maintain their skills.*

- *Lack of training programs to maintain skills in the treatment of concurrent mental health and substance use disorders.*

- *Lack of resources to support the treatment of clients with substance use disorders who are admitted to hospital for other medical/surgical reasons.*

Under resourcing sees addictions nurses stretched across multiple sites and required to engage in leadership, administration and planning while still providing direct clinical care. Balancing non-clinical work with increasing clinical need can be arduous and this is not always understood by management. My role is constantly restricted by a lack of resources and lack of consideration of the benefits that enhanced addictions treatment can have on mental health outcomes, inclusive of discharge planning and community engagement.

Addiction nurses are critical to ensuring timely and effective treatment and community follow-up plans. Integrated treatment by combined mental health and addictions services enhances treatment and follow-up and combined teams are likely to reduce the rate of representation to hospital and length of stay for those admitted, particularly to psychiatric inpatient units. Given the increasing number of clients turning to the hospital system for treatment, addiction nurses are needed in all level one and two hospitals.

The new Department of Health initiative establishing mental health and AOD hubs from the ED is a perfect example of how these collaborative programs can be developed to reduce the burden on the hospital system. Clients with concurrent mental health changes and substance use disorders struggle to engage in mainstream health care systems. Subsequently, assertive outreach programs that engage clients while they are in hospital are critical to maintaining engagement in treatment and encouraging follow-up in the community.

The Wellington House Addiction Medicine Unit is another example of a service that should be expanded. Clients should be able to access appropriate addiction medicine regardless of the hospital to which they present. Unfortunately, as previously discussed, there are very few services in the state equipped to manage clients with complex mental health changes, physical health problems and concurrent substance use disorders. The Wellington House model of care should be explored and considered as part of broader discussions when looking at enhanced treatment options for detoxification. While there is absolutely a place for standardised residential detoxification units, consideration should be given to a range of different treatment models to truly meet the needs of this complex client population.

The aging population

People over the age of 65 with mental health changes and concurrent substance use disorders need access to specialist treatment. This is one of the largest gaps in mental health and across the AOD

sector. Australia has an ageing population which is well recognised. The Royal Commission into aged care is likely to reveal gaps in the provision of appropriate treatment for a range of substance use disorders in the elderly, especially prescription medication problems and alcohol use disorders.

Currently, people over the age of 65 may be overlooked and not considered eligible for AOD treatment. This is generally because of a lack of understanding regarding addictions and a lack of access to services that specialise in working with the elderly.

The lack of access to appropriate AOD treatment can greatly increase the risk of mortality and morbidity in an already very vulnerable population. For example, age related disorders and neurodegeneration greatly impacts on how a range of pharmacological and non-pharmacological treatments will be received. The ageing process can alter the pharmacokinetics of many medicines and cognitive changes can impact on the client's ability to understand standardised AOD counselling.

The aged mental health system is under increasing pressure to work with clients who have chronic health conditions because of substance misuse, for example, Korsakoff dementia associated with alcohol dependence. Aged mental health services do not have access to specialist aged AOD treatment services. This means many clients in the aged sector do not access the treatment they require, and substance use disorders are overlooked again. This becomes problematic when clients are admitted to hospital and staff do not understand the potential risks of ceasing a range of prescription medications without considering withdrawal syndromes. The risk of significant adverse events associated with withdrawal is much greater in the elderly and requires careful planning with consideration for how medications will be processed differently.

Given the substantial risks associated with this population, specialist aged substance use disorder services are much needed. At present, there is only one specialist aged AOD service in the state; the Older Wiser Lifestyle Program through Peninsula Health. All other clients are directed to the adult system which is not equipped to manage this client population effectively.

Regional and rural communities

While the prevalence of mental illness in regional and rural Australia is similar to that in major cities, mental health professionals are in much shorter supply. The AIHW asserts almost 90 per cent of psychiatrists and 75 per cent of psychologists are employed in major cities, with only three psychiatrists and 30 psychologists per 100 000 people employed in remote and very remote areas. [59]

The GP is often the only source of continuing care for people who have experienced a mental illness in rural and remote locations, but waiting lists are long, bulk billing is limited, and the focus is on crisis care rather than continuing care and relapse prevention. Mental health nurses, nurse practitioners and nurse navigators (see chapter 4) are well placed to provide much needed services, but governments need to do more to educate, recruit, develop and retain these critical clinicians.

Nurse practitioners establish collaborations with other health-care providers, in particular medical practitioners and can fulfil consumer demand for primary prevention counselling, improve access to mental health services and early intervention and provide mental health services that better reflect national priorities.[60]

As outlined in chapter 4, nurse navigators are also well placed to facilitate the client journey through an increasingly complex health system and can reduce fragmentation, duplication and barriers and educate, empower and coordinate client care. Underpinned by clearly articulated clinical pathways between hospitals and mental health services, mental health nurse navigators can find practical solutions for people who present to hospital with highly complex mental health conditions,

Increasing the number of mental health nurses, nurse practitioners and nurse navigators and enabling them to work to their full scope of practice, including prescribing and ordering diagnostic tests to their scope of practice, would play an important role in addressing the needs of regional and rural communities. To give full effect to this however, it would also require the Victorian Government, to pursue through COAG, an appropriate funding mechanism that enables clients of nurse practitioners to access appropriate Medicare rebates for approved diagnostic and pathology services ordered by their nurse practitioner in accordance with that nurse practitioner's scope of practice.

> **RECOMMENDATION 52**
>
> Pursue through COAG, an appropriate funding mechanism that enables clients of nurse practitioners to access appropriate Medicare rebates for approved diagnostic and pathology services ordered by the nurse practitioner in accordance with their scope of practice.

Digital technologies to support mental health clients in rural and remote areas

In the absence of clinicians, digital technologies such as telehealth, telepsychiatry and mobile apps offer possibilities for online assistance in health literacy and therapy where there are high levels of unmet mental health demand – but to be effective they depend on reliable infrastructure and clinician

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[59] AIHW, National Health Workforce Planning and Research Collaboration 2011: *Mental health non-government organisation workforce project final report,* cited in QNU Submission to senate affairs community references committee, 2018.
[60] ibid.

guidance. Helpfully, Medicare rebates are available for telepsychiatry consultation for people with mental illness living in rural and remote areas and should be promoted more widely to communities.

Suicide prevention in regional and rural areas – see chapter 2.

Nurse N – Mental health nurse practitioner, regional area

I am classified as a Registered Psychiatric Nurse and hold numerous other qualifications including a Masters of Nurse Practitioner; Masters of Rural Health; Postgraduate Diploma in Advanced Clinical Nursing (Mental Health); Graduate Certificate in Men's Health Studies; and a Graduate Certificate in Social Science (Male Family Violence).

I am currently employed in a service established to effectively address high prevalence mental health disorders such as anxiety and depression. As a Mental Health Nurse Practitioner, (MHNP) I have two major roles: a clinical role and a significant mental health promotion and prevention role.

I provide rural outreach when safe to do so for those clients who cannot or will not attend an office-based appointment and assessment and support for clients, families and health professionals when clients are hospitalised in smaller rural hospitals who meet the inclusion criteria. I also provide early intervention activities and offer flexible services to rural clients by providing out-of-usual hours appointments to those who cannot attend during business hours.

Working in a rural area means I also provide a raft of health promotion activities including the suite of mental health first aid courses to upskill the community and improve mental health literacy in the community. Other activities included mental health screening at community events such as farmer's evenings, social events and places where farmers congregate such as livestock exchange's (sale yards). MHNPs are also first health responders to environmental and other crises such as bushfires, floods, drought and economic down turn such as the recent dairy crisis.

A typical presentation in my role as a MHNP in a primary mental health rural setting would be as follows:

Mr X was a middle-aged man brought in by police and assessed at accident and emergency. He was a farmer who had a foreclosure notice placed on his farm and subsequently threatened suicide by firearm. He was assessed by a crisis clinician and sent home in the company of his wife with a safety plan in place. Mr X was referred to me on the next working day as he met the inclusion criteria of rural remote outreach for clients who require further assessment and/or treatment.

On assessment, Mr X was initially guarded and sullen. He believed that the best option at this stage was to be left alone. However, he became more engaged as the interview progressed, and reported a 12-18-month history of poor sleep, lowered mood, poor concentration, bouts of crying while alone, reduced libido and an overwhelming sense of shame, failure and futility. He had also noticed a lack of interest in activities that he used to find enjoyable such as reading. He said he had suicidal thoughts over a two-year period due to ongoing drought and the loss from bushfires.

I performed a full mental state exam and suicide risk assessment analysis. The mental state examination revealed no disorder of perception. His thought form was slowed but not suggestive of any formal thought disorder or delusions. His affect was observed as flat, blunt and perplexed and he described his mood as depressed. He spoke slowly and softly, and his speech was dominated by helpless and hopeless themes with suicidal ideations. His judgement regarding self-harm was impaired. He appeared to have partial insight in that he realised something was wrong, but he didn't believe that effective help was available. He had made no previous suicide attempts and denied that the suicidal plans he had thought of were now an option. There appeared to be no known family history of mental illness or suicidal behaviour. He reported stressors as previously documented and

consumed two to three standard drinks per day. He reported being physically well and having an extremely supportive family.

He was given a provisional diagnosis of major depression of at least 18-months. Pharmacotherapy was recommended to bring about the remission of his current depressive illness and to prevent relapse, with focussed psychological strategies to commence when his depression had responded to pharmacotherapy.

The safety plan which was formulated by the crisis clinician was reinforced to both Mr X and his wife. His GP was also given all relevant information and formed part of the safety and treatment plan. Mr X also had all firearms removed and was under the supervision of his wife and adult children.

He was made aware of the increased risk of drowsiness and how this may affect his ability to drive and operate farm machinery. Mr X's wife, who is a nurse, was also aware of these side effects. He was also made aware of the effects of alcohol while taking his medication and that limiting alcohol intake should be considered, with total abstinence being the best action.

In the early stages of treatment, I visited Mr X weekly and made regular phone contact between visits. I performed a mental state examination and suicide risk assessment at each contact. His sleep improved and suicidal ideations reduced, but most of his previously documented depressive symptoms had lessened only marginally. In collaboration with his psychiatrist and GP, I adjusted his medications and introduced psychologically focussed strategies including acceptance and commitment therapy when Mr X had the cognitive ability, energy and motivation to practice and use these skills. This occurred at approximately week eight. Mr X was also informed about diet and exercise to combat weight gain associated with his medication.

Over the next six months, Mr X improved significantly and with agreement from himself and family, the treatment for his major depressive disorder was transferred to his GP.

Challenges

As a MHNP in a regional area, I face a number of challenges, including servicing a large geographical area of 40 000 square kilometres with one autonomous worker. I am also challenged by the inability of NPs to receive a Medicare provider number for approved diagnostic imaging and pathology services so my patients can claim the Medicare rebate. Succession planning and lack of suitable telecommunication equipment are also issues.

Crises are particularly hard to cater for as they are unplanned, affect large numbers of people and often go for extended periods. This is compounded by our small staffing ratio and reduced resources.

People with physical comorbidities

The life expectancy gap between Australians with serious mental illness and the general population is growing. Significantly, nearly 80 per cent of people with serious mental illness who die before the average life expectancy of 79.5 years for men and 84 years for women do so due to physical health conditions, losing anywhere between 10 and 36 years of expected life.[61]

The same research also asserts people with serious mental illnesses, such as schizophrenia and other psychoses, and severe depression and anxiety, experience much higher rates of chronic diseases such as cardiovascular disease, diabetes and respiratory conditions. The report puts the cost of this ill heath at more than $15 billion per year.

Research by the AIHW shows Australians with diabetes have a higher prevalence of poor mental health. The proportion of people who claimed a mental health-related service from the Medicare Benefits Schedule (MBS) in 2008 was twice as high (13 per cent) for those with a diabetes-related MBS service than for those without a diabetes-related MBS service (six per cent).

Studies estimate the life expectancy of people with a severe mental illness is as much as 25 years less than the general population. Many causes of death and illness which contribute to this alarming statistic can be treated or prevented through timely access to targeted health promotion, preventative physical health care and effective chronic disease management. Importantly, the Victorian Mental Health principles require people receiving mental health services to have their medical and other needs, including AOD issues, recognised and responded to.

As our submission shows, nurses across the health system have long played a central role in providing holistic, integrated care for people with mental illness, physical comorbidities and AOD health issues. Our case studies demonstrate how nurse-led interventions can increase early identification and intervention, improve access to treatment and follow-up, and help people with severe and enduring mental illness achieve the same standard of physical health as the general community through sustained and tailored support that includes:

- preventative health support

- comprehensive screening and health assessment with supported referral to appropriate services

- proactive early detection and treatment

- support navigating pathways to affordable and responsive health care

- improved access to and continuity of care achieved through better availability and strengthened coordination and collaboration between specialist mental health, GP and community health services.

Importantly, these nurse-led interventions accord with recommendations made by the Ministerial Advisory Committee (MAC) on mental health in their report, *Improving the physical health of people with severe mental illness: No mental health without physical health,* including that:

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[61] Royal Australian and New Zealand College of Psychiatrists (RANZCP), The economic cost of serious mental illness and comorbidities in Australia and New Zealand, 2016, p4.

- as standard practice, community-based clinical mental health clinics undertake a comprehensive health assessment for all case managed clients on their entry to, and exit from, the service and at regular intervals during the period of treatment and support

- that this assessment provides a systematic appraisal of lifestyle, health and medication side effects and forms part of an integrated physical and mental health plan that is subject to standard review, monitoring and follow-up processes

- that where required, all clients receive supported referral to appropriate services with the case manager/lead worker actively helping the client to engage with that service provider and providing follow up support to ensure ongoing engagement occurs.

- that all clients receive tailored health promotion and targeted interventions as standard practice, including advice and information on smoking cessation, reducing alcohol consumption, healthy diet and nutrition and weight management, sexual health and physical activity

- that all clients are supported to make decisions about their medical treatment and care.[62]

MHNIP and better physical health outcomes

This program is outlined in detail in chapter 4. Importantly, as well as it's positive impact on clients experiencing a mental illness, it was invaluable for clients with comorbidities. As the MAC report states, the program was identified by GPs and the clinical mental health service system as highly successful and 'offers significant potential to link clients of the specialist mental health service system to GP care.'

The holistic approach to care delivered through this service model ensures clients can be managed systemically and in conjunction with the GP for any physical health concerns, with increased opportunities for intervention because the mental health nurse is collocated with the GP. People who have received care through this program have been enthusiastic about the program because it is fully funded (no cost to them) and there is less stigma associated with attending a mental health nurse in a GP clinic.

The MAC report noted that the early practice guidelines for Commonwealth funded mental health nurses working in GP clinics restricted them from seeing patients who were clients of specialist mental health services. However, at least two Victorian divisions of general practice (North East Valley and Geelong divisions) had arrangements with their local AMHS to 'lease' mental health nurses to work for several sessions per week in local general practices while remaining employed by the AMHS. This model provided excellent continuity of care to clients once they were engaged with general practice and supported the AMHS discharge planning. It also ensured that the GP's clients had timely access to acute care when needed.

The MAC report also concurs that significant opportunity exists to strengthen the interface between mental health nurses in GP service settings and the specialist mental health clinicians. We support recommendations in the MAC report that the Victorian Government advocate to the Australian Government to:

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[62] Ministerial Advisory Committee on Mental Health, *Improving the physical health of people with severe mental illness:no mental health without physical health, 2012*, ppi-iii.

- expand the MHNIP and mandate this program to include the physical health of people with severe and enduring mental illness

- expand the sub-contractual model of employment of mental health nurses in general practice through Divisions of General Practice and AMHS

- develop a team-based approach between both service sectors to support the patient to access timely GP care and improve the management of chronic physical disease. This would require expanding the health role for mental health nurses to include support to the specialist mental health clinicians to undertake, review and monitor physical health assessments.

However, we consider MHNIP to be an essential program and have recommended the Victorian Government step in to fund it, in the absence of assistance from the Australian Government. See recommendation 33.

6. CONTINUING TO BUILD AND DEVELOP A SKILLED MENTAL HEALTH WORKFORCE

RC Question 7: What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Achieving anything in relation to improved mental health outcomes depends on the provision of best practice services staffed by a skilled and available workforce. We make the following recommendations, based on the service recommendations throughout our submission.

NB: Workforce measures are addressed elsewhere in our submission are not repeated here.

Integrating a trained and supported peer support workforce

We recognise and respect the role of peer support workers across the system and consider they have a very valuable role to play in supporting clients and amplifying the voice of people with lived experience in decision-making and service delivery. Perinatal Anxiety and Depression Australia (PANDA) described this complementary approach to the Inquiry into Perinatal Services as follows:

'At a public hearing in Melbourne, the Committee heard from PANDA, a not-for-profit organisation established 30 years ago. PANDA provides the only national helpline dedicated to perinatal mental health. PANDA's national helpline is staffed by professional counsellors and around 25 peer support volunteers. At a public hearing in Melbourne, Ms Terri Smith from PANDA explained the staffing arrangement and the roles provided by professionals and volunteers:

We have both a professional staff — professional counsellors, and that is funded through the national helpline, so it is the federal government — but we also have a peer support team, and they are half-funded through state government funding … One of the beautiful things that the peer support volunteers can do is a lot of follow-up calls. The professional counsellors take all the incoming calls to the service now. That is not the model we used to have, but basically as we became more competent, the nature of the calls just started to move up the risk scale. But there is still a large group of women who, once we sort out the key issues for them, can really benefit from the peer support volunteers, who are able to say, 'It happened to me, and I'm fine' — that message of recovery.[63]

The ANMF (Vic Branch) supports models of care where peer support workers undertake standardised training and on-going professional development and complement the work of skilled clinicians whose domain is the provision of clinical care.

Creating safe work places

All employers have the obligation to provide a workplace that is safe and without risk to health under the *Victorian Occupational Health and Safety Act 2004 and* all employees have a right to expect this environment. Health services quickly earn a reputation among staff and prospective staff for the way they care for their employees, and any failure to do so undermines recruitment and retention efforts.

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[63] Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety and Depression Australia, cited in Parliament of Victoria *Inquiry into perinatal services final report,* 2018, p141.

Recent research exploring attrition among the nursing workforce found attrition is driven in large part by workplace stressors, including verbal and physical aggression. It argued the workplace stress of mental health nurses needed to be an urgent priority for governments, industrial organisations, the profession and mental health services, with assertive measures taken to reduce these stressors and strengthen staff well-being.[64]

Occupational Violence and Aggression (OVA)

The ANMF (Vic Branch) recognises OVA is a serious and increasing issue across the health system, as well as in mental health. Research on the experience of Victorian nurses and midwives conducted in May 2017 and published in 2018 revealed more than 95 per cent of respondents had experienced workplace aggression in the preceding 12 months, with 90 per cent experiencing aggression from external sources and just over 70 per cent experiencing aggression from internal sources. These findings prompted the researchers to suggest more targeted and effectively operationalised legislation, incentives and penalties may be required to better address this issue.[65]

The ANMF (Vic Branch) understands this issue is particularly grave in Forensicare, where 2018 VHIMS data reveals almost 250 incidents of staff assaults in 2018. Significantly, many assaults occurred in seclusion, including in the process of secluding and conducting seclusion reviews, dispelling the often-held view that seclusion reduces staff assault.

Under-reporting is also a system-wide problem, due in part to concern among nurses that reporting won't help change the environment while a culture of acceptance and shared responsibility for violence persists. Evidence provided to us by members indicates the prevailing culture prompts nurses to feel that by failing to deescalate a situation, they have failed in their care, and reporting such incidents does not lead to positive change.

This is supported by the above research which showed most respondents accepted incidents of aggression and rarely or never took time off work or sought medical or psychological treatment, organisational or other institutional support, advice or action. Their level of satisfaction with institutional services was mostly neutral to poor.

The ANMF (Vic Branch) views OVA as a serious occupational health and safety risk requiring changes across all systems. Our 10-point plan to end violence and aggression, produced in 2014, is a tool to enable health care organisations to review their management and occupational health and safety systems and ensure OVA is appropriately recognised, represented and included as a risk and actions taken to prevent incidents. It recommends services institute a range of measures to:

- improve security

- identify risk to staff and others

- include family in the development of care plans

- report, investigate and act

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[64] K Foster et al, Workplace stressors, psychological well-being, resilience, and caring behaviours of mental health nurses: a descriptive correlational study', *International Journal of Mental Health Nursing,* Australian College of Mental Health Nurses Inc, 2019.

[65] D Hills et al, 'Workplace aggression experiences and responses of Victorian nurses, midwives and care personnel', 2018

- prevent violence through workplace design

- provide education and training to healthcare staff

- integrate legislation, policies and procedures

- provide post-incident support

- apply anti-violence approach across all health disciplines

- empower staff to expect a safe workplace.[66]

Successfully negotiated in enterprise bargaining agreements in 2016, we continue to advocate for industrial compliance and implementation across all services, including in Forensicare, and seek support from government to expedite this. We also consider that OVA, along with fatigue, bullying and harassment and manual handling, warrant specific regulating, in the same way similar hazards in other sectors, including construction and mining, are regulated.

RECOMMENDATION 53

Commence regulation of OVA as a major hazard within the OHS Act and Regulations. Enforce the state-wide implementation of the ANMF (Vic Branch) 10-point OVA plan across all AMHS and in Forensicare.

RECOMMENDATION 54

Consider implementing more targeted and effective incident reporting, inspection, investigation and accreditation mechanisms and accountabilities, including incentives and penalties, to expedite measures to reduce and eliminate OVA.

RECOMMENDATION 55

Worksafe, as the OHS regulator, investigate complaints of unsafe work environments or practices and take action that holds services to account as provided by the *Victorian Occupational Health and Safety Act 2004.*

Safewards

The Safewards model aims to reduce conflict and containment within mental health services. Staff participating in the model learn how to reduce conflicts and the need for restrictive intervention such as medications, sedations and restraints by recognising the triggers that can put people accessing inpatient care and staff at risk and dealing with them before they escalate.

Originating in the UK and implemented internationally, the Safewards model was developed from a broad body of evidence including a randomised controlled trial conducted by the development team

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[66] ANMF (Vic Branch), 10-point plan to end violence and aggression: a guide for health services, 2017.

which established a decline in conflict at each of the sites using the Safewards model and reported a 36 per cent reduction in seclusion events.

Safewards Victoria was trialled across seven services (18 units) over one year. It was extensively evaluated by the Centre for Psychiatric Nursing University of Melbourne with significant and positive results. The state-wide implementation was formally launched in 2016, and the Victorian Managed Insurance Authority, in partnership with the Office of the Chief Mental Health Nurse, committed to a four-year program to consolidate the implementation in the trial sites, expand it to all public mental health services across Victoria, and pilot the model in EDs and acute medical or surgical inpatient units in the later years of the program.

It is currently being trialled in EDs in Bendigo Health and Peninsula Health and will run for one year before being evaluated independently by the University of Melbourne. To consolidate the gains already made and ensure the program's sustainability, it is imperative the Victorian Government funds ongoing education for new and existing nursing staff and enabling the practices to ensure its sustainability.

RECOMMENDATION 56

Fund ongoing education for new and existing nursing staff on Safewards and enabling practices to ensure its sustainability.

Nurse J – Associate nurse unit manager, adult inpatient

I have worked in mental health nursing for 40 years. I have completed a three-year course in psychiatric nursing, a Bachelor of Arts majoring in sociology and psychology, a Graduate Certificate in Family Sensitive Practice and Family Therapy, a Graduate Diploma in Nursing Practice (Mental Health) and a Master's in Advanced Nursing Practice (Mental Health). I have completed a myriad of shorter vocational courses and attended workshops, professional development events and conferences.

I have worked in adult and in child and adolescent mental health, both inpatient and in community settings through my career, as an Associate Nurse Unit Manager (ANUM), a case manager and senior clinical nurse, and a Nurse Manager. I am currently in the role of ANUM in an adult inpatient setting.

For some consumers, this might be the first and only hospital admission; for others, it might be a repeat admission. Each consumer has their story and reasons for their admission, and each person has their own recovery journey to negotiate. Some people are in hospital against their will or may have come to hospital without even basic items; a toothbrush, a change of clothes. Part of my role is to help the person with their hygiene needs, ensure they have nutritious food, listen to their sad or angry stories, and sometimes work with them through difficult emotions such as extreme anger that could lead to violence; distress that could result in self-harm. The nurse is crucial at these times to offer support and encouragement, to de-escalate situations and to offer extra medication. As ANUM, I also support such situations to enable nursing and other staff, consumers and other personnel on the ward to be safe. Facilitating safety, recovery and wellbeing on my shift for everyone on the ward is fundamental to my role.

The provision of written material regarding the consumer's rights under the Mental Health Act (MHA) is essential. I ensure there is always ready access to such material and nursing staff can provide explanations and guide people to resources such as the Independent Mental Health Advocacy service, answer questions, and advocate for the consumer within the multidisciplinary team (MDT) and with others. Of the disciplines in the inpatient unit, nurses spend the most time with the consumer and are in a unique position to advocate for the consumer's wants and needs. We also spend time with families answering questions and providing information about the service, the MHA, the MDT, and other services such as the community mental health services, legal and advocacy services and family and carer support services. Families are offered meetings often to discuss concerns relating to discharge arrangements, and to some extent family dynamics. The inpatient service does not usually offer family therapy, which perhaps occurs more in the community teams, and I think this is a deficit in the inpatient service.

The building is a refurbished one for the purpose of the inpatient unit. There are several shared bedrooms that usually have their own bathroom, but only one single room has its own bathroom. The ward has a separate women's area that contributes to sexual safety on the ward, but all other open areas on the ward (not bedrooms) are shared gender. It has a small courtyard area and little capacity for exercise, unless the consumer has leave from the ward to go outside. There is a small high dependency area on each of the wards, and the ward is always locked. There is some, but not enough provision for separating consumers who may be at low risk from those who may be at higher risk of, for example, sexualised behaviour, violence and aggression or deliberate self-harm.

In its favour, I have found the nursing staff to be a tight knit team, supportive of one another, and capable of robust clinical discussion and decision making. Morale is generally good.

Nurse R - Psychiatric enrolled nurse, adult acute psychiatric ward

I am employed as an enrolled nurse in the classification of psychiatric enrolled nurse in an adult acute psychiatric ward. I love my job; taking care of patients with a large variety of mental illnesses and often making a difference in people's lives, both patients and their families, makes me so happy.

But the system is broken! We don't have enough beds or staff. The amount of violence on the ward has escalated and nurses are assaulted on a daily basis, mostly verbally, but often also physically. For one and a half years we have had a permanent security guard on the ward. This helps a lot, but it is to be reviewed soon and we don't know if we will continue to have this support. This uncertainty makes us feel unsafe.

The illicit drug crystal methamphetamine is causing so many more drug-affected patients coming to the ward with drug induced psychosis and these patients are in most cases very violent towards both nurses and other patients. It is our job as nurses to protect the other patients, so we are often in the firing line of these violent outbursts. This can in the long run cause PTSD and many psychiatric nurses experience this after only a short number of years working in the acute wards.

I have been physically assaulted by a patient on the ward and I was on WorkCover for some time. Luckily our nursing unit manager is fantastic and with her help and the return to work manager, and a lot of hard work, I was able to return. A lot of nurses do not return after assaults.

I recently heard that there has been allocated money to train psychiatric nurses in being more resilient, but we are very resilient – if not we would not be working in these wards.

I often go to work worrying about my safety, my patient's safety and whether I will have to discharge a patient who is not ready yet. We always have patients waiting in the EDs across the service for beds in my ward. These patients have sometimes been waiting for a long time and have been sedated and/or physically restrained and are cared for by staff who are not trained to deal with mental illness.

Psychiatric nursing is so much more than just caring for the physical health of a patient. We have to be like mini psychologists and draw a lot on experience, life learnings and intuition. Often patients are guarded regarding their mental health and you need to form a bond with them through different avenues. Making a risk assessment on a patient is not like taking the temperature with a machine; we need to be able to bond with people and read them, and gauge through questions about patients' interests, family or other things how they are feeling and thinking and their risk of harm to self or others. We also support the families of the patients who have often burned out due to lack of support in the community. These tasks are very time consuming and you often don't have time to do them all.

I usually get to work at 06.45am as I like to get in and have a look at my patient load and plan my day before handover starts at 07.00am which is officially the time I start work. Today I was allocated five patients; usually it is four, but like many days, today we are a nurse short and have to have an extra work load.

I classify my patients according to acuity and fill out the 'shift planner' I have made myself to help me remember everything I need to do during the shift. You need to be super organised to be able to do everything. There are so many tasks to do. Today I left work at 16.00. I had no lunch break, no morning tea break. I made a cup of coffee that I would sip from when in the office. I did manage to have two five minutes break outside the ward but felt very bad about leaving the ward in case

anything would happen and my colleagues would need me. I didn't have enough time to speak to and care for my patients.

I have often been feeling bad when on my way home as I didn't have enough time to care properly for my patients or I had to discharge a patient I did not believe was ready to go or did not have enough support in the community. I sometimes cry when on my way home for the same reasons or because I am so exhausted after my shifts.

I can only work seven shifts per fortnight otherwise I am not able to be there for my family. My kids are adults now so no longer need me as much, and my husband can cook, but if I work more I just feel too exhausted to do anything on my days off.

The workforce is getting younger and younger and less experienced as a lot of experienced staff leave their employment in acute wards due to PTSD, not feeling safe at work and the frustration with the way the system works. Younger and younger nurses are forced into becoming assistant nurse unit mangers and nurses in charge.

I believe adult acute psychiatric wards are not equipped to deal with patients with drug induced psychosis. Patients with this should be separated from other mental health patients. Drug affected patients are very destabilising in the wards. Other mental health patients, who are often vulnerable, are scared of them and this can hinder and prolong their recovery. It is frustrating and saddening that under these conditions we nurses struggle to protect other mental health patients.

I really hope that the Royal Commission into mental health can come up with a plan and solutions to our broken system so we can care for patients with mental illness better and at the same time stay safe in our workplace, retain experienced staff and keep enjoying our work.

Building resilience

Research recommends resilience-building programs across all roles and levels of seniority, with managers in mental health organisations demonstrating caring behaviours and taking genuine steps to ensure mental health nurses feel positive about, and connected to, their workplace and experience psychological well-being. It also recommends mental health nurses take up opportunities in their workplace, and more widely, to enhance their well-being and strengthen their resilience.[67]

Following this research, the ANMF (Vic Branch) is supporting a trial conducted by the Australian Catholic University into the benefit of a resilience education program for nurses working in adult mental health units developed by the Queensland University of Technology. The DHHS is also supporting this project.

RECOMMENDATION 57

Deliver resilience education programs for nurses working in adult mental health.

NB: We stress that measures to build resilience among nurses are protective measures, not preventative, and are no substitute for services and government instituting and reporting against OVA prevention strategies.

Providing clinical supervision

The ANMF (Vic Branch) considers effective clinical supervision plays a key role in supporting nurses in their practice and helping them feel positive about, and connected to, their workplace. The importance of clinical supervision is expressed in a range of policy documents including:

- *Supervision guidelines for nursing and midwifery* (Nursing and Midwifery Board of Australia)

- *Joint clinical supervision position statement* (Australian College of Nursing and Australian College of Mental Health Nursing).

- *Clinical supervision for mental health nurses: A framework for Victoria* (DHHS)

The framework states that clinical supervision should be universally considered part of the core business of contemporary professional nursing practice.[68] Despite this strong endorsement, the 2016 mental health EBA provides for only two hours per month and it is not always prioritised.

Combatting fatigue

Fatigue is yet another occupational health and safety issue affecting the work performance and recruitment and retention of nurses and midwives. Recent research shows fatigue is associated with OHS and clinical incidents, with nurses and midwives who reported being at higher risk of fatigue at work more likely to experience OHS incidents compared to those at lower risk of fatigue at work.[69] Factors contributing to fatigue include:

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[67] op cit., p11.

[68] Victorian Government DHHS, *Clinical supervision for mental health nurses: a framework for Victoria.* 2018, p3.

[69] T Shea et al, *Occupational health and safety issues for aged care workers: a comparison with public hospital workers*, 2016.

- the mental and physical demands of work such as the need to concentrate for extended periods of time and the volume of work

- inappropriate/inadequate staffing levels and skill mix

- inappropriate work scheduling and planning, including roster patterns, length of shifts, timing of shifts, rest breaks, recovery time between shifts and extended periods on night shift

- environmental conditions including working in uncomfortable conditions and interacting with other hazards

- the cumulative effects of muscle fatigue, strains and sprains, poorly designed systems of work and work-related travel.

Again, the ANMF (Vic Branch) urges service providers to adopt a risk management approach to work-related fatigue in consultation with employees and health and safety representatives. This includes recognising they are required to eliminate the risk of work-related fatigue and taking a range of straightforward measures to do so, such as:

- implementing a risk management approach that identifies, assesses and controls work-related fatigue factors

- implementing a fatigue management policy and risk management plan

- integrating fatigue prevention into workplace OHS arrangements - including into OHS representation, consultation and issue resolution

- developing action plans that outline management responsibilities, timelines and resource allocation for fatigue prevention at workplace and organisation levels

- providing information, instruction, training and supervision to enable nurses and midwives to perform their work in a way that is safe and without risks to health from work-related fatigue

- communicating with all staff to raise understanding of fatigue risks and required prevention strategies

- equipping managers and supervisors with the knowledge and skills to implement strategies that identify, prevent, assess and control fatigue, and establishing the clear expectation that they do so

- ensuring adequate and agreed nurse/midwife staffing on all shifts

- ensuring an adequate skill mix

- rostering to allow appropriate recovery time between shifts – this includes eliminating double shifts

- eliminating excessive mental and physical demands

- ensuring workplace and surroundings are well lit, safe and secure

- provide training and information to all employees on avoiding fatigue.

We urge all service providers to adopt a risk management approach to work-related fatigue in consultation with the ANMF (Vic Branch), employees and health and safety representatives. This includes recognising they are required to eliminate the risk of work-related fatigue and taking appropriate measures to do so.

RECOMMENDATION 58

Treat fatigue as a major hazard and use the regulatory powers accordingly, and in the interim, provide guidance to employers about their obligation to eliminate the risk of work-related fatigue and adopting a risk management approach to do so.

Building the workforce

Retention – supporting the nursing and midwifery workforce

The Nursing and Midwifery Health Program Victoria (NMHPV), since its inception in 2006, provides a free, independent, confidential health service to support nurses, midwives and students of the profession who may be experiencing health issues related to their mental health, substance use or family violence concerns.

This state-wide service was established in recognition of the challenging work environment for this workforce. It has a unique role in providing a breadth of services with ready access without the person requiring a formal referral. Services include telephone consultations, case management, wellness groups and expert guidance for employers. The program aims to keep members of the workforce well, so they can continue working, and aid recovery where people have become unwell, so they can return to employment. It has also developed a successful 'champion' program, providing training to nurses and midwives about the benefits of the NMHPV and expanding knowledge of the program to better support colleagues in workplaces.

In 2018, the program won the top Australasian Award, TheMHS Award in recognition of its achievements of excellence, innovation and best practice in mental health services. The program is invaluable to the health and wellbeing of the nursing and midwifery workforce, playing an important role in retaining the workforce in the sector. It is funded by the Victorian Government and its continued access by the workforce is imperative.

> **RECOMMENDATION 59**
>
> Continue to invest in and support the highly successful Nursing and Midwifery Health Program Victoria (NMHPV).

Recruitment

The serious and growing shortage of nursing graduates with the skill and expertise to practice in mental health services requires planning and resources that includes improved support for new graduates; opportunities for education and skills development in mental health nursing; greater assistance for rural and remote nurse and midwife managers in their role as preceptors.[70]

Nurses themselves have identified the following ways health care and educational institutions can encourage new graduates and other nurses to pursue a career in mental health as a clinical speciality: providing high quality clinical placements; providing more attractive employment incentives; increasing public awareness about mental health and reducing the stigma associated with it; promoting careers in mental health; and supporting nurses to pursue this specialty.[71] The following initiatives support this agenda.

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[70] B Happell et al, 'It's the anxiety: facilitators and inhibitors to nursing students' career interests in mental health nursing', *Issues in Mental Health Nursing*, (35), 2014, pp50-57.

[71] J Penman et al, 'Voices from the field: regional nurses speak about motivations, careers and how to entice others to pursue mental health nursing', *International Journal of Nursing Education Scholarship, 2018,* Jan 30:15 (1).

> **RECOMMENDATION 60**
>
> Where vacancies exist in the system, cease the precarious employment practice of fixed term contracts for graduate nurses who don't have certainty of on-going employment.

Developing the workforce

Any plan to develop a capable and supported clinical mental health workforce must seek first to optimise the existing nursing workforce and provide professional development as needed to target areas requiring specific additional expertise. It must recognise the qualifications, experience and further education and training staff already have and provide training and education across the specialist mental health workforce and the broader nursing and midwifery workforces. Such education and training should include programs to:

- improve the mental health literacy of the workforce in general hospital settings
- build cultural awareness and cultural safety among mental health practitioners
- increase understanding of the behaviours of people experiencing mental ill health or substance use behaviours
- increase the awareness of nurses and doctors in EDs, of the risks associated with a suicide attempt and the need for clinical mental health services to be accessed without delay, and preferably before the person leaves the ED.

Nursing and Midwifery Workforce Development Fund

In 2018, the Victorian ALP committed to a range of key workforce initiates if re-elected, including a new $50 million Nursing and Midwifery Workforce Development Fund. The fund is designed to expand the existing Registered Nurse and Midwife Graduate Program and establish a new graduate program for enrolled nurses to employ 400 enrolled nurses over four years, including 100 TAFE graduates.

The fund will also provide up to 400 postgraduate scholarships for current nurses and midwives to upgrade their skills, 400 places in programs such as the Postgraduate Midwifery Employment Program, as well as refresher programs for 800 nurses and midwives currently registered but not practising so they can re-enter the workforce. It will also include $10 million for grants, scholarships, graduate jobs and refresher programs for rural and regional students and current nurses and midwives. This will include opportunities in mental health and we welcome this.[72]

Throughout our submission we have demonstrated how nurses and midwives have the skills and knowledge to address mental health, physical health and AOD issues. Our case studies showcase the many ways nurses provide expert care, and the professional development they have undertaken to advance their knowledge and skills set.

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[72] D Andrews, *Media statement: more nurses and midwives to care for Victorians*, 19 July 2018.

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They are a ready and capable workforce, with many eager to upskill and transition into mental health. Scholarships to do so are welcome and highly sought after. The 2016 mental health EBA provides for 110 scholarships per year for four years. This represents a significant shortfall given the number of applications and should be increased to 250 scholarships per financial year at $5 000 each.

OCMHN scholarships	Semester 1		Semester 2	
	Applications	Offers	Applications	Offers
2019	167	64		
2018	168	62	113	56
2017	163	62	95	58
2016	164	62	95	57
2015	152	62	94	55

NB: The ANMF (Vic Branch) has also been active in this area. In November 2018, the Branch allocated $500 000 for scholarships to members undertaking postgraduate education, including registered nurses and midwives undertaking graduate certificates or graduate diplomas in mental health and enrolled nurses undertaking diploma and advanced diploma studies in AOD. We awarded twelve scholarships to study the specialty of mental health nursing – six in metropolitan Melbourne and six in regional Victoria – and will continue with this program next financial year.

Access to education with scholarship opportunities must be complemented with facilitation of post graduate course placements

RECOMMENDATION 61

Increase postgraduate course placements to get rid of the funnel effect.

RECOMMENDATION 62

Fund 250 Office of the Chief Mental Health Nurse scholarships per year at $5 000 each to meet the high demand and increasing cost of post graduate education.

Expanding mental health nursing transition to speciality practice programs

Transition to specialty practice programs provide the opportunity for employers to prepare and develop registered and enrolled nurses to transition into the clinical specialty of mental health. These programs are attractive to either graduate nurses who have an interest in the clinical area or more experienced nurses who haven't previously worked in mental health and wish to move into the specialty and be supported to do so successfully.

The community mental health nursing workforce represents a significant proportion of overall service delivery. It needs to grow to support best practice community models of care designed to reduce acute illness and ED presentations and admissions. Investing in the community mental health nursing

transition to speciality practice program is therefore imperative. This program encourages and facilitates nurses to move from an inpatient unit into a community setting

Transition to specialty practice programs. provide a structured and supported learning pathway for nurses to transition into a variety of clinical areas.in mental health across the state.

RECOMMENDATION 63

Provide funding to support 100 Nursing Transition to Specialty Mental Health permanent employment positions for graduate nurses and nurses with experience both outside and within the mental health sector and encourage all services to run a six to twelve-month program.

RECOMMENDATION 64

Provide on-going support and funding for post registration study and transition to practice programs in both regional Victoria and metropolitan Melbourne including for enrolled nurses wanting to work in mental health.

Expanding the RUSON program

RUSON stands for a Registered Undergraduate Student of Nursing. A RUSON is currently enrolled in undergraduate nursing study at university, has already successfully completed more than 12 months of their Bachelor of Nursing Degree and is registered with AHPRA as a student nurse. Under the delegation and supervision of registered nursing staff, RUSONs work in acute or subacute care and aged care settings as part of the healthcare team, helping nurses to provide patient care.

This program has received very positive feedback from services and nursing staff. We consider the model would translate particularly well to PARCs, CCUs and acute inpatient units (but not High Dependency Units) for final year students who have completed clinical placements in metal health, and could support other mental health workforce development initiatives, particularly in regional areas.

RECOMMENDATION 65

Expand the RUSON model to mental health services including PARCs, CCUs and acute inpatient units.

Workforce development to support Aboriginal health care

The Victoria Parliamentary Inquiry into Perinatal Services report also notes:

> The Committee heard of the need for more Aboriginal and Torres Strait Islander graduates to be trained in health professions to support Aboriginal and Torres Strait Islander women throughout the perinatal period. The Committee is pleased that there are scholarships to support Aboriginal and Torres Strait Islander students, however it is concerned that these are not being taken up at the desired rate and that more can be done to promote scholarships in Aboriginal and Torres Strait Islander communities. Thus, the Committee recommends that the Victorian Government conduct a public education campaign targeted at Aboriginal and Torres Strait Islander communities to raise awareness of scholarships that are currently available for Aboriginal and Torres Strait Islander

health professional trainees. This campaign should also include a funded, schools-based element to support and encourage Aboriginal and Torres Strait Islander students and school leavers.[73]

The ANMF (Vic Branch) supports this recommendation and the following Victorian Government programs:

- the Aboriginal Cadetship Program (Nursing, Midwifery and Allied Health)

- the Aboriginal Enrolled Nurse Cadetship Pilot Program

- the Aboriginal Graduate Program (Nursing, Midwifery and Allied Health)

- the Aboriginal Postgraduate Nursing and Midwifery Scholarships Program.

These programs recognise the essential role Aboriginal nurses, midwives and allied health practitioners play in positively influencing the health of Aboriginal clients. Between 2013 and 2017, 85 Aboriginal nursing, midwifery and allied health cadet positions were funded with the program implemented at regional and metropolitan health services including, Barwon Health, Bendigo Health, Eastern Health, Latrobe Regional Hospital, Monash Health, the Royal Women's Hospital, St Vincent's Hospital Melbourne and Western Health.

We welcome the addition of the Aboriginal Health Worker (Mental Health) traineeship program in late 2018. This three-year program pays trainees to work under supervision in Victorian health services while they are supported to complete a Bachelor of Health Science (Mental Health) from Charles Sturt University. On completion of the program, the trainees will have a mental health qualification that will allow them to work in clinical roles, similar to a social worker or other clinicians in a mental health team.

We encourage progress on extending and promoting these vital programs, including the opportunity to transition to an AHPRA regulated health practitioner such as a registered nurse.

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[73] Parliament of Victoria Family and Community Development Committee *Inquiry into perinatal services: final report*, 2018, p317.

7.   PREPARING FOR CHANGE

RC Question10: What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

We consider the following four strategies essential to ensuring lasting change:

1. Wherever possible achieve bipartisan support.

Nurses, midwives and the community at large do not like health care being kicked around like a political football. It is incumbent on the Government and Opposition to identify opportunities for bipartisan support.

RECOMMENDATION 66

The Australian Government, through COAG provide targeted quarantined funding for:

-   incentives to recruit mental health nurses, nurse practitioners and nurse navigators to assist in regional and rural nurse-led models of care in general practice and community-based programs
-   mental health nurse navigators to help people living in regional and rural areas to traverse the health system and access appropriate care

mental health specific continuing professional development of registered nurses, enrolled nurses and midwives practising in mental health in regional and rural areas.

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2. Legislate or find other mechanisms to embed reforms as needed.

Many of the initiatives outlined in our submission have been achieved in part because of the commitment of our members to the provision of quality care. This means they have been willing to include many care initiatives in their enterprise bargaining agreements (EBAs). While they are rightly proud of their achievements, they recognise that bargaining for improvements to quality care means the measures are ever vulnerable and could be easily lost in the next EBA round. It is incumbent on the government and service providers to put other mechanisms in place to secure these crucial reforms.

3. Initiate a staged plan for achieving fair funding by 2030.

Despite mainstreaming of mental health services in Victoria in the 1990s (in which Victorian public mental health services that had been directly provided by the Victorian government through staff engaged as members of the Victorian Public Service were outsourced to the general public health system) public mental health services remain a differently funded and managed component of the public health system.

This even extends to registered and enrolled nurses who work in some parts of the public health system, specialising in mental health nursing, being employed under a different enterprise agreement than all other nurses in the public health sector. Nurses working in specialist inpatient mental health services do not have the benefit of the Safe Patient Care Act as nurses do in most general and specialist nursing inpatient areas. The source of nurses working in public mental health services is from the same pool as those available to work in general health settings, and the distinctions left over from the pre-mainstreaming time do little to enhance mental health nursing as other nursing specialties.

Separating mental health funding risks perpetuating the disparity in accessing services for people suffering mental ill health.

We have recommended the Victorian Government increase funding to match the percentage of the population experiencing serious mental illness – currently estimated to be 3 per cent. This is likely to require a staged approach, which needs to be designed and put in place now.

Given widespread expectation that the need for mental health services will continue to grow, we note that a staged approach which sees funding increase by an additional .2 per cent per year over the next 10 years – with the aim of achieve funding of 3 per cent by 2030 – may well see the system as challenged then as now, We therefore also encourage the development of a mechanism to ensure funding keeps pace with growth and need.

We also urge the commitment to invest equally in mental health services no matter through which organisations they are delivered so services aren't neglected and suffer from a tiered service delivery model.

RECOMMENDATION 67

Require NGOs that receive government funding for services including residential rehabilitation services to employ registered nurses in these service across all shifts to equip them to admit more complex patients. Ensure sufficient funding to enable this outcome.

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4. **Invest heavily in nursing workforce development strategies now to keep the pipeline moving.**

Whatever shape Victoria's mental health system takes, the programs outlined here and the heath care needs of people living with mental illness and comorbidities demonstrate that the system must include nurses and midwives, as leaders and clinicians. Now is the time to invest in this workforce to keep the pipeline flowing.

We urge bipartisan support so that state initiatives are co-ordinated with the support of the Commonwealth to the benefit of the workforce and the community requiring access to services.

8.   ADDITIONAL COMMENTS

RC Question 11: Is there anything else you would like to share with the Royal Commission?

Acute mental health and forensic mental health care

The 2014 Report of the Review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* made several recommendations relevant to forensic mental health care, including:

> *Recommendation 50: The Victorian Government should commission a multi-disciplinary team to develop a model of care to identify and develop the requirements for service delivery, supervision arrangements, management and operation of the youth forensic facility.*

> *Recommendation 100: A new medium-secure forensic mental health facility should be established as an approved mental health service for adults with a mental illness who are subject to supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic).[74]*

The ANMF (Vic Branch) supports these recommendations and notes they were reiterated in the 2016 report of the review into hospital safety and quality assurance in Victoria. This report described 'ignored red flags in forensic mental health' as follows:

> *Inadequacies in the acute mental health system impact on the broader community and the justice system. At the time of arrest, 17 per cent of people arrested were being treated by a public mental health service.*

> *In order for patients to receive safe and high-quality care, they must receive it in an appropriate setting that is able to cater to their specific needs. For acutely unwell prisoners who require compulsory treatment, or who have a court order to be detained for psychiatric assessment and/or care, this setting is Thomas Embling Hospital (TEH). TEH is Victoria's only forensic facility able to provide compulsory treatment for patients who are acutely unwell and require treatment but have refused it. Victorian prisons are, appropriately, not allowed to provide this kind of treatment.*

> *TEH provides care for three types of patients:*
> - *forensic patients found not guilty or unfit to be tried under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (forensic patients)*
> - *security patients (prisoners) who require compulsory mental health treatment under the Mental Health Act 2014*
> - *civil patients of area mental health services unable to be managed in the community and who require compulsory treatment under the Mental Health Act in a highly secure environment.*

> *In 2003, Forensicare identified that demand for these beds had outstripped availability, leaving patients with serious mental illness untreated, and therefore at increased risk of self-harm and suicide, violence to staff, exacerbation of their illness, and reoffending after being released.*

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[74] Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 report*, Melbourne, 2014, p430.

Since then, demand has continued to escalate, and to date there has been no change in access to compulsory treatment services. In 2014 the Victorian Ombudsman noted:

'For over a decade concerns about the capacity of the Thomas Embling Hospital have been repeatedly raised and to date no additional forensic mental health services have been made available for prisoners. The inability to provide sufficient mental health services to acutely unwell prisoners can be detrimental to their mental health, leading to instances of self-harm and even death.'

In 2014 the Victorian Auditor-General stated that 'indicators of under-capacity within prison and compulsory mental health facilities have become extreme.' The prison system is burdened with a large number of acutely unwell prisoners to whom it is not authorised or able to provide appropriate care. Only those who are exceptionally mentally unwell are currently being admitted to TEH for treatment, with the threshold for certifying prisoners for compulsory treatment driven by availability of beds, not just a prisoner's mental health needs. The danger of this is not only exacerbation of illness in the prison environment but the reality that people with mental illness being inappropriately detained in prison will be released into the community untreated.

Safety and quality of care for those who are certified for compulsory treatment is also a significant concern. Patients who are admitted to TEH risk receiving inadequate care, as the hospital is under a significant amount of pressure to expedite the return of prisoners to prison. Further, patients are waiting longer periods before being admitted to TEH and in a facility where it is not possible for them to receive safe and appropriate care. In 2014 a Victorian Auditor-General report noted the average number of days between prisoners being certified for compulsory treatment and their admission to TEH has increased from 5.3 in 2009–10 to 22.2 in 2013–14. Waiting times have climbed further over the past year… Currently fewer than 40 per cent of certified prisoners are transferred to a TEH bed within 28 days, against a target of 95 per cent. As Forensicare's submission to this review notes:

During 2015, at any one time there were on average ten male prisoners being held in prison, acutely unwell and refusing treatment, identified by a psychiatrist as meeting criteria for compulsory treatment under the Mental Health Act 2014, but unable to access a hospital bed.

One result of the long waiting times for treatment is that TEH patients are presenting as more unwell upon admission. This is unsurprising given the significant increase in the volume of prisoners who are on 'lockdown' while awaiting transfer… The latter involves prisoners who are acutely suicidal or have severe behavioural disturbances being locked in a cell for 23 hours per day.

We are unlikely to be saving money by scrimping on funding for forensic mental health beds. Poor access to treatment means a more unwell prison population and may lead to significant social and economic costs for patients, their families and the healthcare system in the long run.

There is no ambiguity or disagreement about the problem. It has been covered in the public domain in Auditor-General and Ombudsman reports at various points, and has been raised repeatedly by the department's past and present Chief Psychiatrists and by boards of Forensicare. A recent departmental document summarised this issue:

There is a clear need to improve the availability and quality of mental health secure treatment options for high-risk forensic patients, security patients (prisoners) and high-risk civil patients, and to improve the availability and quality of mental health care available to correctional facilities and both transitional and post release environments.

There is also no ambiguity or disagreement about the solution needed. The Victorian Law Reform Commission's Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act is only the most recent of many recommendations for a new medium security unit for forensic mental health patients to be established.

The Victorian Government's commitment to a small number of additional beds at TEH is a welcome one. These beds will improve care but will not provide the substantial increase in provision that is required. [75]

The Review makes the following recommendations which we support:

-    as part of the current development of a mental health infrastructure plan, the department develops a forensic mental health infrastructure sub-plan to address other needs including additional high-security beds and a specialist adolescent inpatient unit to meet the needs of young people.
-    the forensic mental health infrastructure plan includes a clear timeline to implement the Victorian Law Reform Commission's recommendation to expand medium-security forensic bed capacity. [76]

However, we consider demand is well known and seek an immediate commitment to address the shortfall of beds and the demands on prison nurses, illustrated in the case study that follows.

RECOMMENDATION 68

Build three 20-bed state-wide semi-secure inpatient units with dedicated nurse staffing. As well as providing for forensic patients, this provision would mitigate the risks inherent in admitting people with extreme behaviours to general acute mental health wards, enabling nursing staff to focus on nursing care and recovery rather than behaviour management.

RECOMMENDATION 69

Provide funding to recruit additional nurses working in prisons.

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[75] Victorian Government Department of Health & Human Services, *Targeting zero Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care Report of the Review of Hospital Safety and Quality Assurance in Victoria, 2016,* pp138-141.

[76] ibid.

Nurse D – Prison nurse

I have worked in mental health in a variety of settings since 1996. Settings include geriatric psychiatry, long term secure mental health rehabilitation, community mental health, acute psychiatric inpatient services, registered nurse undergraduate education (psychiatric placements) and registered psychiatric nurse education. My qualifications include a Bachelor of Health Science (Nursing) and a Postgraduate Diploma in Advanced Clinical Nursing (Psychiatric Nursing).

In my current position, I can perform four roles in any given week: unit nurse, risk assessment nurse, risk review nurse or reception nurse. As unit nurse, I work on the complex and challenging behaviour unit. As the risk assessment nurse, I assess prisoners identified as being at risk of suicide or self-harm. As the risk review nurse, I review prisoners who are considered high risk for suicide and/or self-harm and are on a management plan to ensure their safety. As reception nurse, I undertake mental health assessments, identify the mental health needs and initiate treatment or care of prisoners who have arrived at prison direct from police cells or the courts.

The needs of my client base tend to vary in that they generally do not always present with an Axis I diagnosis, but most will at some point have a history of being diagnosed with some type of personality disorder (Axis II). The primary definition of our work is with clients who have a history of complex and or challenging behaviour. We do not work with families during periods of incarceration.

'Keeping people out of hospital' for nurses in this environment means treating a patient on a voluntary basis to keep them from being 'certified' and hospitalised under the Mental Health Act 2014. All nurses also play an active role in managing prisoners at risk of suicide, especially when working in the 'at risk' and 'risk review' roles. The unit nurse also plays a role in suicide prevention, working with individual patients for three months. The reception nurse could play a greater role in suicide prevention, but time pressures make this very difficult.

The provision of recovery orientated mental health practice is the underpinning principle of the nurse's role on this unit. This includes supporting the patients on their journey in recovery, facilitating the development and ongoing review of a recovery plan, planning for admission and discharge, and providing a recovery treatment program once a week. When it comes to the management of a patient's wellbeing, this is managed in conjunction with another provider, but the unit has the prime responsibility for monitoring, managing and implementing an education program in relation to healthy diet, exercise and medication management with a focus on metabolic syndrome. Given the limited consultant support and often inexperience of the registrar team, it is prudent that all the mental health nursing practitioners have a significant amount of experience which is reflected in the ongoing care and management.

The service is accountable to the Department of Justice (including Corrections Victoria) and works closely with the Office of the Chief Psychiatrist and the Chief Mental Health Nurse.

One significant gap in this service is the current allocation of EFT. No matter how many patients the unit has, whether it be 30, 25 or 10, the nursing allocation remains the same: Three nurses across the two day shifts and three on night duty. The nurse allocated to manage the complex and challenging behaviour in this unit overnight, is also responsible for a second unit while also managing and assessing risk overnight for the entire prison population.

Another area of concern is that no intensive case management staff are allocated to work on weekends. This means the role of managing acutely unwell patients becomes the responsibility of the reception nurse on a Saturday. This is a role that is unfunded and not accounted for in the allocation of EFT.

We have very little consultant support ourselves and have to mentor junior registrars. This requires a great deal of resolve and patience on behalf of the nurses who are required to manage a complex and challenging group of patients as well as inexperienced and junior medical staff.

The nursing team is made up of many international nurses with varying degrees of training and understanding of team work, and this also effects service delivery. Unsurprisingly there is a high attrition rate, which often means experienced nurses are replaced with graduate nurses with little or no experience in mental health.

Excessive paperwork

Members consistently, insistently and persistently raise concerns about the time required to meet administrative and documentation requirements and the time this takes away from direct patient care. We recommend a state-wide review of all existing administrative/documentation expectations, with a view to streamlining documentation to essential legal and clinical documents only, to free up time for patient/client care.

> **RECOMMENDATION 70**
>
> Conduct a state-wide review of all existing administrative/documentation expectations, with a view to streamlining documentation to essential legal and clinical documents only.

PROMPT

We draw the Royal Commission's attention to the PROMPT trial, a local initiative to address the significant number of mental health-related calls to Ambulance Victoria (AV) in the Barwon region.

At present, ambulances respond on average 15 times a day to calls involving mental health patients in the Barwon region (in 2018, AV responded to 5360 mental-health-related cases). Mental health patients often do not require a traditional ambulance response, but instead, a comprehensive mental health assessment and management.

Barwon Health, in consultation with Ambulance Victoria, is conducting a 'proof of concept' trial for the Prehospital Response of Mental Health and Paramedic Team (or PROMPT) from 6 May 2019 to 27 July 2019. This trial will establish a time-limited team comprising an experienced ambulance paramedic, working in an unmarked vehicle with a specialist mental health nurse. The trial will be operational from Thursday evening to Monday evening (reflecting the period that typically sees the highest proportion of mental health presentations), with a single shift running 2:30pm-11:30pm.

Referrals to PROMPT will come via Ambulance Victoria, either after being assessed by enhanced mental health triage (AV 000 referral service) or by paramedics in the field (infield referral). Ambulance Victoria will do much of the evaluation using a $10,000 grant, completing an evaluation report, including a statistical analysis, within the last quarter of 2019.

The primary assessment outcome will determine the proportion of eligible patients who are referred to alternative pathways who otherwise would have been transported to an emergency department for mental health assessment and care.

We welcome this initiative and the opportunity it provides for a trained and skilful mental health nurse to provide direct patient care and generate system efficiencies.

FULL LIST OF RECOMMENDATIONS

All recommendations are to the Victorian Government/DHHS unless stated otherwise.

FIXING FUNDAMENTALS FIRST

1. The Auditor General recommended the Victorian Government develop a new mental health plan that integrates service, capital and workforce planning. We recommend the plan also identify specific, evidence-based outcomes to be achieved; the best mix of services to achieve them, including the most practical service regions based on community needs; the organisations to be involved in achieving them; the specific investment and workforce measures to support each outcome; and the reporting and evaluation mechanisms built in to ensure best practice is maintained.
2. Make a clear commitment that clinical mental health services will remain in the public hospital and health system and are not at risk of being compromised by service separation models of funding
3. Develop and implement a mental health funding model whereby services, no matter where they are accessed, can integrate and adjust, removing service fragmentation for consumers/clients.
4. Match investment in public clinical mental health services to the proportion of the population with a severe mental illness – estimated to be 3.0. per cent.
5. Work with the ANMF (Vic Branch) to revise the current funding model and reporting mechanisms for public sector community mental health teams (CMHT) to reflect accurately all work required of the role.
6. Provide dedicated oversight of allocated funding to health services to ensure transparent accountability for the delivery of agreed services and workforce measures.
7. Recognise the importance of the nursing and midwifery workforce to high quality mental health care by investing in that workforce and legislating nurse to patient/client ratios in in the Safe Patient Care Act for all inpatient mental health settings, including PARCS and Transitional Support Units.

PREVENTION AND EARLY INTERVENTION

8. Optimise existing midwife and nurse led programs to provide universal mental health risk screening, early intervention, health promotion, therapeutic solutions, referral and follow-up across the lifespan.
9. Adopt universal mental health risk screening tools for scheduled and opportunistic use across midwife and nurse-led lifespan programs including pre and postnatal, school nursing programs, community outreach, GP clinics, EDs and aged care.
10. Provide additional funding to health services to increase consultation times to provide for scheduled mental health risk screening.
11. Increase the capacity of maternal and child health services to strengthen their focus on mental health by:
    - enabling the Universal MCH Service to commence involvement during the antenatal period for enhanced mental health risk screening and early intervention
    - maintaining funding commitments to the Enhanced MCH service to meet the increasingly complex needs of families and children, including mental health needs.
    - maintaining support to the MCH Line so it can keep pace with demand and provide a targeted and proactive MCH nurse led outreach service

- embedding the practice of referring clients to perinatal mental health nurses where screening requires and providing sufficient perinatal mental health nurses to meet demand.

12. Implement the recommendation in the final report of the inquiry into perinatal services to create a Perinatal Mental Health Plan, as an adjunct of the 10-year Mental Health Plan, that articulates the following:
- universal mental health screening for women during the perinatal period
- universal screening for family violence
- ensuring health professionals have clear pathways for treatment of women and families
- training health professionals in mental health screening and bereavement care
- funding and expansion of a state-wide perinatal emotional heath program (PEHP) program.

13. Provide funded access for women to midwife postnatal care, including mental health risk screening, via midwife home visits, early parenting centres and phone counselling as required for at least seven days.

14. Provide recurrent funding for state-wide peri-natal emotional health programs (PEHP) with adequate EFT. See recommendation 12.

15. Expand mother/parent baby units across the state to include eight beds and eight cots and enable them to operate 24 hours a day, seven days a week; and include a maternal child health nurse (at least three days per week) as part of the staffing profile to support families in the care of their infant during their admissions.

16. Extend and enhance the current primary school nursing program to include mental health nurses to conduct individual assessments on students and run mental health education, promotion and prevention programs for students, parents and school staff. We recommend 0.5 EFT per 500 students.

17. Extend and enhance the current secondary school nursing program to include mental health nurses to provide appropriate mental health intervention, professional clinical nursing, mental health assessments, physical care, holistic support and coordination between the school and community-based mental health and support services. We recommend 0.5 EFT per 500 students.

18. Encourage CAHMS and youth mental health services across the state to work together to deliver the CYMHS model to provide seamless care across this age range.

19. Reintroduce and expand the MST and IMYOS intensive outreach services as stand-alone teams.

20. Retain the nurse-led model of care provided in CCUs but better integrate therapeutic environments to allow for ease of transition and promote well-being and recovery.

21. Introduce a discipline-specific model of care in the community where nurses who are an AHPRA regulated workforce are qualified to lead all aspects of clinical care allowing other disciplines to complement the care needs and provide expertise consistent with the inpatient service model. SEE RECOMMENDATION 5 on funding and reporting

22. Strengthen Aged Persons Mental Health (APMH) teams to include aged persons mental health nurse practitioners to provide in-reach services to residential aged care services so older people with mental health conditions are identified and responded to appropriately.

SUICIDE PREVENTION

23. Develop and implement a state-wide consistent approach to suicide prevention that includes:
    - increased service capacity in EDs
    - preventative community-based services providing step-up and step-down care
    - specialist services and risk management for people with AOD issues
    - assertive outreach services
    - immediate access to social supports in relation to debts, housing and employment.

24. Develop a state-wide consistent approach to acute care that: increases skill capacity in EDs so people can access clinical mental health services provided by a mental health nurse without delay, and preferably before they leave the ED; enables people who are acutely suicidal to remain in an acute ward until their thinking shifts toward living; provides assertive discharge options and follow-up.

25. Provide education and training for nurses and doctors within EDs to increase their awareness about the risks associated with a suicide attempt and the urgent need for clinical mental health services to be accessed without delay, preferably before the person leaves the ED.

26. Expedite the implementation and evaluation of the six ED Mental Health and AOD hubs and commit to expanding this program pending impactful evaluation.

27. Increase the capacity of hospitals to manage mental health crises by funding a consultation liaison nurse in every Level 1, 2, and 3 hospital (as defined in the Safe Patient Care Act).

28. Fund additional inpatient beds in regional Victoria and specialist mental health nurses to ensure people admitted with suicidal behaviours or ideation can receive specialist treatment and care until their thoughts have moved toward living.

29. Reintroduce stand-alone CATTs for each AMHS and ensure they are led by mental health nurses.

30. Adopt successful post discharge initiatives such as the HOPE program in all health services and expand to include sufficient mental health nurses in the staffing profile so anyone who has attempted suicide can access a nurse specialising in mental health and no-one falls through the gaps.

31. Roll out the successful PACER program to all AMHS and transition to coverage for 24 hours per day.

IMPROVED HEALTH CARE JOURNEYS

32. Invest in and prioritise the community-based response for people living with mental illness by funding PARC and YPARC services to employ specialist mental health nurses on every shift, providing 24-hour clinical mental health nursing care seven days per week.

33. Reinstate and fund the acclaimed MHNIP program so clients can resume their therapeutic relationships with mental health nurses and receive the identified benefits to their physical and mental health, the program expertise is retained, and the cost and capacity benefits to the health system continue.

34. Introduce the highly successful nurse navigator role in Victoria, commencing with mental health clients, including CALD clients – this would improve the sustainability of the mental health system by ensuring people living with mental health issues access the care they need, by the right practitioner, when they need it.

35. Invest in the strategic use of nurse practitioners to augment the nursing workforce by funding nurse practitioner positions across perinatal mental health, ED hubs, aged persons' mental health, CYMHS, AOD and mental health and in regional and rural community health centres to help meet

demand for efficient and effective mental health care and provide a much-needed career pathway for nurses who are candidates for endorsement as a nurse practitioner.

36. Implement the recommendation of the Mental Health Complaints Commissioner to:
    - implement trauma-informed care as a primary prevention strategy in recognition of the prevalence of trauma among people accessing acute mental health inpatient services and the re-traumatising impacts of sexual safety breaches
    - develop tiered approaches to implementing trauma-informed care to ensure mental health service staff with the appropriate skills and capabilities lead responses to sexual safety breaches and ensure pathways to trauma-specific care are clear and available
    - develop plans for minimum infrastructure requirements to support sexual safety in mixed-gender environments and piloting and evaluating single-gender units.

37. Renew efforts to embed trauma-Informed care across services, equipping services to adopt a whole-of-organisation approach that embeds trauma-Informed care into workplace policy, practice and culture. This would include:
    - acknowledging the significant existing clinical mental health workforce who have experienced workplace trauma and its associated impacts and providing urgent supportive strategies that enable people to process their workplace experiences of trauma
    - delivering mental health trauma training across all EDs.

38. Fund a dedicated nursing role to build and monitor reducing restrictive intervention compliance by:
    - providing regular training and refresher training for all direct care staff and security personnel
    - leading/coordinating:
      - collaborative nursing care planning
      - communication with consumers about the reason for any restrictive interventions
      - collaborative reviews after each restrictive intervention
      - debriefing and support for consumers, carers and relevant parties.

39. Expand the successful hospital-in-the-home program to mental health.

ADDITIONAL MEASURES FOR UNIQUE COMMUNITIES

First Australians

40. Consistent with our views in chapter 2, we encourage the Victorian Government and VACCHO to recognise the importance of including culturally appropriate perinatal mental health screening as a key service and take steps to ensure it is funded and built in to the service provision.

CALD

See recommendation 34.

People experiencing homelessness

41. Support nurse-led homeless persons programs to employ mental health nurses to work alongside AOD nurses, community nurses and HIV nurses, all of whom are trained in trauma-informed care and have good knowledge of the services available to ensure their clients' needs can be addressed.

42. 'Fast track' people with these complex needs to appropriate public housing and require ongoing engagement with the nursing service.

43. Recognise the strong association between homelessness and family violence and ensure victims of domestic violence (and their children) can access safe refuges and be protected to make transitions to affordable housing.

44. Encourage public sector governance of homeless services to reduce expenditure on overheads and allow funds to go to direct service provision.

45. Ensure people with a dual disability admitted to Transitional Support Units (TSUs) receive regular and ongoing care from nurses.

Women living in vulnerable or high-risk situations

*46.*Review existing screening for family violence within clinical mental health services and provide clear guidance and professional development about the best approach to screening and providing safe responses and support, including new solutions to ensure women living in vulnerable or high-risk circumstances receive home nursing care safely and nurses are safe when they provide it.

AOD

47. Build capacity of health services with appropriate specialist treatment services, e.g. detox beds and residential rehab services staffed by AOD nurses – the general hospital bed environment is not appropriate for detox.

48. Consider better overall integration of AOD services in the health system, including co-locating AOD services with community mental health to reduce fragmentation and delays and facilitate seamless service delivery and continuity of care.

49. Introduce incentives to encourage medical and nursing staff to complete additional postgraduate education and/or ongoing professional development in mental health and AOD to maintain best practice treatment.

50. Introduce mechanisms to encourage, where possible, participation from family members to support their loved one as they go through treatment.

51. Fund additional specific provisions for the assessment, care and treatment of people over 65 with mental health and AOD issues.

52. Pursue through COAG, an appropriate funding mechanism that enables clients of nurse practitioners to access appropriate Medicare rebates for approved diagnostic and pathology services ordered by the nurse practitioner in accordance with their scope of practice.

People with physical comorbidities

See recommendation 33.

BUILDING AND DEVELOPING A SKILLED WORKFORCE

53 Commence regulation of OVA as a major hazard within the OHS Act and Regulations. Enforce the state-wide implementation of the ANMF (Vic Branch) 10-point plan to reduce occupational violence and aggression (OVA) plan across all AMHS and in Forensicare.

54. Consider implementing more targeted and effective incident reporting, inspection, investigation and accreditation mechanisms and accountabilities, including incentives and penalties, to expedite measures to reduce and eliminate occupational violence and aggression (OVA).

55. Worksafe, as the OHS regulator, investigate complaints of unsafe work environments or practices and take action that holds services to account as provided by the Victorian *Occupational Health and Safety Act 2004*.

56. Fund ongoing education for new and existing nursing staff on Safewards and enabling practices to ensure its sustainability.
57. Deliver resilience education programs for nurses working in adult mental health. NB: We stress that measures to build resilience among nurses are protective measure, not preventative, and are no substitute for services and government instituting and reporting against OVA prevention strategies.
58. Treat fatigue as a major hazard and use the regulatory powers accordingly, and in the interim, provide guidance to employers about their obligation to eliminate the risk of work-related fatigue and adopting a risk management approach to do so.
59. Continue to invest in and support the highly successful Nursing and Midwifery Health Program Victoria (NMHPV).
60. Where vacancies exist in the system, cease the precarious employment practice of fixed term contracts for graduate nurses who don't have certainty of on-going employment.
61. Increase postgraduate course placements to get rid of the funnel effect.
62. Fund 250 Office of the Chief Mental Health Nurse scholarships per year at $5 000 each to meet the high demand and increasing cost of postgraduate education.
63. Provide funding to support 100 Nursing Transition to Specialty Mental Health permanent employment positions for graduate nurses and nurses with experience both outside and within the mental health sector and encourage all services to run a six to twelve-month program.
64. Provide on-going support and funding for post registration study and transition to practice programs in both regional Victoria and metropolitan Melbourne for enrolled nurses wanting to work in mental health.
65. Expand the RUSON model to mental health services including PARCs, CCUs and acute inpatient units.
66. The Australian Government, through COAG provide targeted quarantined funding for:
   - incentives to recruit mental health nurses, nurse practitioners and nurse navigators to assist in regional and rural nurse-led models of care in general practice and community-based programs
   - mental health nurse navigators to help people living in regional and rural areas to traverse the health system and access appropriate care
   - mental health specific continuing professional development of registered nurses, enrolled nurses and midwives practising in mental health in regional and rural areas.
67. Require NGOs that receive government funding services including for residential rehabilitation services to employ registered nurses in these service across all shifts to equip them to admit people with more complex health care needs. Ensure sufficient funding to enable this outcome.
68. Build three 20-bed state-wide semi-secure inpatient units with dedicated staffing. As well as providing for forensic patients, this would mitigate the risks inherent in admitting people with extreme behaviours to general acute mental health wards, enabling nursing staff to focus on nursing care and recovery rather than behaviour management.
69. Provide funding to recruit additional nurses working in prisons.
70. Conduct a state-wide review of all existing administrative/documentation expectations, with a view to streamlining documentation to essential legal and clinical documents only.

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