Australian Nursing & Midwifery Federation
VICTORIAN BRANCH

ANMF House
540 Elizabeth Street
Melbourne Victoria 3000

Box 12600 A'Beckett Street PO
Melbourne Victoria 8006

www.anmfvic.asn.au
T 03 9275 9333
F 03 9275 9344
E records@anmfvic.asn.au

ABN 8057 1091192
RTO 3601

# ANMF (Vic Branch) Submission to The Department of Health and Human Services

# Consultation on Victoria's next 10-year mental health strategy

**Lisa Fitzpatrick**

**ANMF (Vic Branch) Secretary**

Please direct queries to

Donna Hansen-Vella ANMF (Vic Branch)

Mental Health Nursing Officer

dhansen-vella@anmfvic.asn.au

21 September 2015

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## Executive Summary

The Australian Nursing and Midwifery Federation (Vic Branch) welcomes the opportunity to respond to *Victoria's next 10 year mental health strategy – Discussion paper (*August 2015). This is an opportunity for the Government to undo some of the damage of recent years, specifically, reversing the detrimental impacts associated with reductions to clinical mental health services.

Reductions have included loss of mobile support and treatment teams, ceasing of clozapine nursing programs in some areas, decreasing dedicated primary mental health positions intended to build capacity, the almost complete cessation of CATT on-call service provision and the loss of public beds including numerous specialist aged persons mental health beds. In addition, new service gaps were created under the auspice of 'recommissioning', including reductions in the hospital and Community Health Centre Alcohol and Other Drugs (AOD) services. This has 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 actually meet the individuals' medical and specific AOD needs.

There has been poor planning for predictable clinical services growth and minimal provisions from the state to support the ongoing maintenance and urgent repairs frequently associated with acts of violence and aggression within clinical mental health services. Amongst these challenges, the next Mental Health Strategy is the mechanism for the Government to transparently translate all of the pre-election commitments, including the vision of providing leadership in mental health policies and programs based on a comprehensive approach to research, evidence, innovation and service delivery and the recognition that treatment of mental illness should be provided by mental health clinicians, psychiatrists, nurses and other allied health practitioners **(Victorian Labor Platform 2014)**

It is unacceptable that people who are acutely unwell with a mental illness have to reach a point of crisis before they are able to access either a bed within a mental health ward (and once they are admitted it is commonly only possible to remain for a very short stay due to pressures to admit other people) or emergency community care from the clinical mental health services. This observation is in no way a reflection of the dedicated clinical mental health workforce, but a symptom of chronic underfunding and lack of recent state policies and governance capable of ensuring that clinical services remain available for people who become acutely unwell. Sadly, as a result of lack of investment in clinical mental health services, many Victorians experiencing an acute mental illness are not afforded evidence based clinical care they deserve. This creates a tension for people working within the clinical mental health services who firmly believe they have a mandate to treat, support and safely manage the acute phase of mental illness. While there is some acknowledgement within the Discussion Paper of the role of clinical mental health services, it is not clear how the new strategy will incorporate the important pre-election commitments that demonstrated an understanding of the issues, and, signaled how a Labor Government would go about making improvements, including not seeking to substitute or delegate specialist clinical mental health services to other providers.

ANMF (Vic Branch) recommends that the next Victorian Mental Health Strategy must articulate what the state responsibilities are in relation to mental health (including access to treatment for the acutely unwell), and, transparently demonstrate how these will be provided. Immediate investment, including financial and workforce resources, in clinical mental health services will be required to enable improved access, and increase capacity within clinical services to respond to the high demand. The current unmet need is significant, and the state Strategy must ensure its investment facilitates clinical mental health services to achieve the proposed outcomes including *'responding to need with effective, coordinated treatment and support'.*

It is understood that a Mental Health Strategy may be broader than the provision of acute and sub-acute clinical mental health services. We support proposals for continuing investment in early intervention, prevention and wider health promotion programs and suggest that the Mental Health Strategy should incorporate the wider nursing and midwifery professions to achieve the proposed outcomes. The discussion paper has not specifically dealt with the actual and potential contribution of the nursing and midwifery workforce, or the importance of physical health and well-being when designing a mental health strategy. However, ANMF (Vic Branch) has provided recommendations that will enable the Strategy to maximize outcomes for the community via the inclusion of Victoria's nurses and midwives. Further, as the peak stakeholder for nurses and midwives, we would welcome participation in the establishment of an ongoing collaborative oversight mechanism, such as a mental health advisory committee (or equivalent) to support progress of the next Mental Health Strategy.

ANMF (Vic Branch) appreciates that not all changes are dependent on additional funding. Some improvements are possible with better use of the existing engagement points that nurses and midwives have with families, for example, the regular appointments with a Maternal and Child Health Nurse (MCHN) or the screening activities undertaken by school nurses. The wider nursing and midwifery workforce must be incorporated within the Strategy especially when there are clear opportunities for early mental health screening and primary intervention.

Within clinical mental health services, significant changes can be achieved by enabling existing Health Practitioners to actually work according to their unique discipline specific skill sets. ANMF (Vic Branch) believes there is maximum benefit to the community if the person who needs Cognitive-Behavioural Therapy could be allocated to the clinical psychologist, and the person with diabetes and serious mental illness whose individual needs required mental health nursing care (including coordination) can be allocated to the mental health nurse. In the immediate to short-term, this would enable people accessing clinical mental health services to actually be provided with evidence based care from the right Health Practitioner (rather than services based on the historical 'generic' case management model). People are not 'cases'.

Mental Health Nurses have the particular expertise and qualifications to make a real difference to people's recovery journey. Enablers that give effect to optimum standards of care are safe workplaces with manageable workloads, and a new Mental Health Strategy that allows them to practice according to their unique skill-set.

**ANMF Recommendation 1:** The next Mental Health Strategy must incorporate all of the pre-election commitments, including the vision of providing leadership in mental health policies and programs based on a comprehensive approach to research, evidence, innovation and service delivery and the recognition that treatment of mental illness should be provided by mental health clinicians, psychiatrists, nurses and other allied health practitioners.

**ANMF Recommendation 2:** The next Victorian Mental Health Strategy must articulate what the state responsibilities are in relation to mental health (including access to treatment for the acutely unwell), and, transparently demonstrate how these will be provided.

**ANMF Recommendation 3**: Immediate investment, including financial and workforce resources, in clinical mental health services will be required to enable improved access, and increase capacity within clinical services to respond to the high demand.

**ANMF Recommendation 4:** Proposals for continuing investment in early intervention, prevention and wider health promotion programs should incorporate the roles of the wider nursing and midwifery professions to realise the proposed outcomes.

**ANMF Recommendation 5:** The development of the strategy must better incorporate measures to address the importance for physical health and well-being, and to ensure all services work towards reducing the associated high morbidity and mortality rates experienced by people with mental illness.

**ANMF Recommendation 6:** Establishment of an ongoing, collaborative mental health advisory committee (or equivalent) to support progress of the next Mental Health Strategy with ANMF (Vic Branch) included being a relevant stakeholder.

**ANMF Recommendation 7:** Introduce policy changes that will facilitate, within clinical mental health services, Health Practitioners to actually work according to their unique discipline specific skill sets rather than the basis of traditional generic case-management models. People accessing services are not 'cases' and deserve access to the right Health Practitioner for their individual needs.

## Introduction

The Australian Nursing and Midwifery Federation was established in 1924 and is the peak professional and industrial body for nurses and midwives throughout Australia with branches in every state and territory. ANMF (Vic Branch) has more than 73,000 members working across all areas of health and community services, including, but not limited to, the specialist mental health sector, aboriginal health, aged care, alcohol and other drug services, community health, district nursing (including the RDNS Homeless Person Program), emergency departments, general hospitals, local councils, maternal and child health, midwifery services, nurse-on-call, occupational health, palliative care, primary health and general practice clinics, private hospitals and healthcare, prisons and the justice system, rehabilitation services and schools. We are well placed to respond to the discussion paper on behalf of the largest component of the health workforce, midwives and nurses.

This response has been developed through consultation with our members, including those nursing within clinical mental health services. Participation and feedback from members of the workforce who participated in the 'public consultation forums' has also been incorporated.

Similar to the Mental Health Strategy detailed within the *2009 Because Mental Health Matters* policy, it is essential for the States' approach to ensure people with acute mental illness have access to improved clinical mental health services. The Strategy must emphasise and build on the foundation that mental health is everyone's business and be capable of directing primary and secondary health providers to develop and offer care that ensures both physical and mental health needs are central elements to the care provided. Options to achieve this are not explicitly covered within the Discussion Paper. ANMF (Vic Branch) recognises the links between disadvantage and poor health outcomes, and supports use of the social determinants of health model; however, we caution that investment in these areas must be in addition to the provision of acute clinical mental health services, and not to the detriment of evidenced based advances in medical, nursing and psychological studies.

ANMF (Vic Branch) believes that specialist clinical mental health services (acute and sub-acute) have an essential role within any Mental Health Strategy; ultimately they are the only public services mandated with responsibility for clinical treatment, support and the safe management of people who are acutely unwell. The Strategy must clearly articulate their ongoing role, the state investment that will be provided and any major policy changes that are being considered. If the clinical component of the spectrum is not adequately defined and invested in, there will be ongoing experiences of preventable trauma for both people who are trying to access the services and the workforce.

The ANMF (Vic Branch) submission will identify some of the elements that appear to be missing, include responses to questions posed throughout the Discussion paper and some of the Technical Papers. We have also included our recommendations intended to improve the next state mental health strategy. While some may be achievable with modifications to existing policy, it is obvious that many of the recommendations will require a commitment of dedicated funding to enable Victoria to resume its leadership within this area. We suggest all strategies and actions in the next Mental Health Strategy are categorised as immediate (up to 12 months) short term (up to 2 years), medium term (up to 5 years) and long term (up to 7 years).

**ANMF Recommendation 8:** All strategies and actions within the Next 10 year Mental Health Strategy are categorised as immediate (up to 12 months) short term (up to 2 years), medium term (up to 5 years) and long term (up to 7 years).

## Elements not identified within the Discussion Paper and Technical Papers (Omissions)

- The discussion paper indicates the intention to build on the policy framework and directions outlined in the previous 10 year plan published in the *2009 Because Mental Health Matters*, however, it doesn't articulate exactly what needs to be 'adjusted for the contemporary context and changing circumstances'. Given the significant consultations that accompanied the development of the 2009 10 year Strategy (and associated specialist mental health workforce plan) it is critical that, if there are significant deviations from the 2009 plan with regards to the nursing and midwifery workforce the ANMF (Vic Branch) be directly consulted.

- **Mental Health/Psychiatric Consultation Liaison Nurses** - While there is a technical paper regarding 'Mental Health and Physical Health', there does not appear to be discussion about the critical role of mental health/psychiatric consultation liaison nurses (CL Nurse) within general hospitals. ANMF (Vic Branch) is aware of the inclusion and commitment to *"further strengthen"* **(Victorian Government, 2009, p. 61)**the mental health consultation and liaison function in Because Mental Health Matters and advocate that this need is significantly importance right now. There is a plethora of literature on the relationship between physical illness and mental health, and evidence regarding higher incidences of mental health problems in people who are medically ill which contributed to the acknowledgment within the fourth National Mental Health plan. Psychiatric/Mental Health Consultation Liaison Nurses (and psychiatrist) provide essential assessment and treatment to people in the general hospital and assist the general hospital staff through the provision of secondary consultation and education to enable the patient to receive better care. The next Strategy must commit to dedicated funding to ensure that a CL Nurse is allocated in every major hospital. There is already a Victorian network to support these nurses (that currently meets at ANMF (Vic Branch) and the additional CL Nurses would have instant access to peer support and supervision.

- ***Perinatal and Infant Mental Health*** - An obvious omission in relation to the Discussion Paper and associated technical papers is perinatal and infant mental health. This needs to be a distinct part of the Mental Health Strategy, and must incorporate evidenced based initiatives specific to perinatal mental health screening and clinical mental health intervention within maternity services as well as initiatives for improving clinical parent-infant mental health services (bed based and out-patient services).

  At Sunshine Hospital alone, the data regarding implementation of the Perinatal Emotional Health Program (PEHP) found an average reduction in length of stay within maternity services of 1.7 days; calculated a saving of $2635 per patient per stay or $806,310 p.a. based on 306 admissions in 2014. **(Bilbao, 2015)**. The very successful PEHP has recently been defunded by the Federal Government. The result of not providing this program will detrimentally impact on Victorians, and increase the demand on state based maternity services and mental health services.

  The immediate economic impact of not providing state funding will be multiple, including a higher demand on public mental health services and longer lengths of stay within maternity services (related to known neonatal and obstetric risks associated with mental illness) not to mention the long term costs for the entire family of failing to intervene early. The work of these programs have been positively evaluated - outcomes include successes related to providing education and resources to midwives and others working in the provision of maternity services and the secondly, providing direct referral options for women identified as at risk or experiencing mental health issues. The next Mental Health Strategy must provide immediate ongoing funding to ensure the Victorian successes associated with PEHP do not cease at the end of this year.

  Further, ANMF (Vic Branch) recommends dedicated parent-infant mental health outpatient funding

be made available to ensure the community can access specialist outpatient programs based on the Mercy Mental Health Mother Baby Unit outpatient model that is due to cease from October 2015. Having access to clinical care in the community setting can minimize hospital admissions; enhance parent-infant mental health services ability to provide timely support and early intervention; better meet increasing demand of families experiencing mental ill health; prevent child abuse; and improve access throughout metropolitan Melbourne and rural Victoria. This approach has the potential to make use of Nurse Practitioner roles.

There must be a review of the parent-infant clinical mental health inpatient funding formula to enable these specialist units to incorporate as part of the staffing profile, a Maternal Child Health Nurse (at least 3 days per week). MCHN can ensure families are better supported with the specialist knowledge and skill set for the care of their infant during their admissions. The ward MCHN can work collaboratively with the family and mental health treating team to ensure there is an evidence based focus on the infant's needs including the development of infant care-plans, education in relation to feeding options and associated changes, monitoring growth and early milestones and ensuring immunisations are not missed. The ward MCHN can also prepare infant summaries to ensure transfer of ongoing care to the local MCHN once the family is ready for discharge.

- **Sub-Acute Clinical Mental Health Services**
  To enable greater therapeutic options in bed based services, urgent consideration must be given to increasing the availability of mental health nurses within PARC services to ensure that people can receive specialist mental health nursing care in either the step-up or step-down environment and not be required to have an acute inpatient admission in order to access the benefits of intensive mental health nursing care.

- **Safety**
  ANMF (Vic Branch) is actively involved in work to reduce Occupational Violence and Aggression and we continue to have a pro-active role within health services post serious incidents and in relation to new builds. We assess and provide recommendations to ensure that mental health wards and community services are have best opportunity for improved safety, for both the staff and people that are being cared for. Currently, this knowledge and expertise is retained within the union, whereas it could be shared and incorporated within the next Mental Health Strategy to maximize state guidance for safety within workplaces. The next Mental Health Strategy needs to incorporate measures for improving safety for all.

- **Domestic Violence (DV)**
  We note the absence of addressing the concerning issue of DV within the discussion paper and suggest there must be an evaluation of existing screening for family violence within services with the aim of implementing a consistent approach to screening (using the available evidence base) and ensuring updated information regarding the available options and guidance about what should be considered the minimum requirements for a safe responses and support.

- **Emergency Departments (EDs) and Mental Health Nurses**
  ANMF (Vic Branch) recognises that the Discussion Paper has not attempted to look at current ED environments, therefore, the issues associated with not having direct access to mental health nurses within the EDs has not been dealt with. Similarly, this state still doesn't provide a PECC equivalent and this should be considered an option in some of the major Emergency Departments, providing for a more appropriate assessment and short-term treatment environment co-located with ED, where people presenting can receive physical and mental health care. ANMF (Vic Branch) strongly recommends the next Mental Health Strategy should include provisions that will ensure major EDs have mental health nurses rostered. This may include a workforce development program for mental health nurses to be supported to become Nurse Practitioners (located within the major EDs) enabling specialist clinical mental health care at the point of contact.

**ANMF Recommendation 9:** If there are significant deviations from the 2009 Because Mental Health Matters 10 year plan with regards to the nursing and midwifery workforce, ANMF (Vic Branch) must be directly consulted.

**ANMF Recommendation 10:** The next Strategy must commit to dedicated funding to ensure that a CL Nurse is allocated in every major hospital. There is already a Victorian network to support these nurses (that currently meets at ANMF (Vic Branch) and the additional CL Nurses would have instant access to peer support and supervision.

**ANMF Recommendation 11:** Perinatal and Infant Mental Health needs to be a distinct part of the Mental Health Strategy, and must incorporate evidenced based initiatives specific to perinatal mental health screening and clinical mental health intervention within maternity services as well as initiatives for improving clinical parent-infant mental health services (bed based and out-patient services).

**ANMF Recommendation 12:** The next Mental Health Strategy must provide **immediate** ongoing funding to ensure the Victorian successes associated with Perinatal Emotional Health Program do not cease at the end of this year.

**ANMF Recommendation 13:** Dedicated parent-infant mental health outpatient programs must be made available to ensure that the community can access specialist outpatient programs based on the Mercy Mental Health Mother Baby Unit outpatient model that is due to cease from October 2015. This approach has the potential to make use of Nurse Practitioner roles.

**ANMF Recommendation 14:** There must be a review of the parent-infant clinical mental health inpatient funding formula to enable these specialist units to incorporate as part of the staffing profile, a Maternal Child Health Nurse (at least 3 days per week) to ensure families are better supported with the specialist knowledge and skill set for the care of their infant during their admissions.

**ANMF Recommendation 15**: Urgent consideration must be given to increasing the availability of mental health nurses within PARC services to ensure that people can receive mental health nursing care in either the step-up or step-down environment and not be required to have an acute inpatient admission in order to access the benefits of intensive mental health nursing care.

**ANMF Recommendation 16:** Consideration must be given to collaborating with the unions to ensure our Mental Health OHS expertise is incorporated in the next Strategy.

**ANMF Recommendation 17:** The new Strategy is an opportunity to evaluate existing screening for family violence within clinical mental health services with the aim of providing clear expectations about the approach to screening (using the available evidence base) and providing education and training in relation to the options for providing a safe responses and support.

**ANMF Recommendation 18:** The next Mental Health Strategy should include provisions that will ensure major EDs have a mental health nurses rostered. This may include a workforce development program for mental health nurses to be supported to become Nurse Practitioners (located within the major EDs) enabling specialist clinical mental health care at the point of contact.

A**NMF Recommendation 19:** The Government must provide a PECC equivalent which should be considered an option is some of the major Emergency Departments. These services provide more appropriate assessment and short-term treatment environments that are co-located with ED, where people presenting can receive both physical and mental health care.

As stated earlier, ANMF (Vic Branch) believes that specialist clinical mental health services (acute and sub-acute) have an essential role within any Mental Health Strategy; ultimately they are the only public services mandated with responsibility for clinical treatment, support and the safe management of people who are acutely unwell. The Strategy must clearly articulate their ongoing role, the state investment that will be provided and any major policy changes that are being considered. If the clinical end of the spectrum is not adequately defined and invested in, there will be ongoing experiences of preventable trauma for both people who are trying to access the services and the people working within. We do not support proposals by not-for-profit organizations to 'challenge the status quo' in relation to who is best placed to deliver specialist mental health services and call on the Government to be firm in its commitments for clinical mental health services to be retained within the public hospital system, and expanded to meet the communities' needs.

The Strategy needs to articulate the wider aspirations, including acknowledgement that clinical mental health services do not operate in isolation. Clinical Mental Health Services are part of a wider health system and like many health organisations; they are required to work collaboratively with non-government organisations, the private sector, organisations established with responsibilities to address social disadvantage and the wider community. Over the years there has been significant work on partnerships being developed between clinical and non-clinical mental health organisations - now referred to as Mental Health Community Support Services (MHCSS). Consideration must be given to the overlap in terms in relation to community care, and the importance of minimizing confusion about what each service is responsible for.

Mental health promotion and prevention are best addressed from a social determinants perspective. The outcomes of health promotion programs are generally not apparent for quite some time (years, even decades). This creates a tension with regard to the allocation of scarce resources – should they be at the acute/treatment end of the spectrum or at the prevention end? The answer is, of course, both. Significant investment in health promotion must occur in the context of maintaining and expanding treatment options. A successful health promotion initiative may lessen demand on acute services, but not without a significant lead time. We therefore acknowledge the imperative of ensuring more people are able to access specialist clinical mental health services in the short term, and suggest that to strengthen this capacity, better use of discipline specific skills sets and further resources will be required.

We acknowledge the discussion paper's clarity that this Mental Health strategy is broader than treating illness. Therefore, it must include mechanisms that will improve mental health literacy amongst the community, ensure the entire health workforce is educated about mental health service paradigm shifts including supported decision making, recovery oriented practice and trauma informed care and provide dedicated funding for improved mental health promotion, prevention and early intervention strategies across the lifespan.

Further, in a climate of responsible economic investments, the Strategy should also seek to decrease duplication of state services where there is also Commonwealth funded service provision available, and make best use of the shifting investments in the area without creating new gaps. ANMF (Vic Branch) is hopeful that the state strategy will reflect all of the commitments made pre-election, including transparent policy that ensures the Government does 'support the public health system and avoid further privatization or contracting out of mental health clinical treatment and rehabilitation services' (Victorian Labor Platform 2014, p. 44).

**ANMF Recommendation 20**: Request that the next Strategy articulate the Governments' firm commitments for clinical mental health services to be retained within the public hospital and health system.

Clinical Mental Health Services are faced with higher rates of community demand for access without provision of adequate funding models to ensure that services are actually provided. For example, Area Mental Health Services have identified that current funding streams to operate the average ward are in deficit approximately $500,000 per annum. ANMF (Vic Branch) understands that this is commonly managed by either the general hospital subsidising the Mental Health budget or the community mental health funding being diverted to the mental health ward, clearly an approach that 'robs Peter to pay Paul' and ultimately detrimentally impacts on consumers/patients. Further, decisions to cease the historical mental health funding grants that may have been used to top-up mental health programs and/or provide specialist programs have contributed to financial deficits. These are now resulting in clinical mental health services implementing service reductions. Clearly this will detrimentally impact on local communities and the realization of any plan for improved Mental Health.

The new Mental Health Act 2014 continues to place emphasis on the decision making powers of psychiatrists, often translating to consumer concerns that there is a reliance on a medical model within inpatient settings. While the workforce seems to be doing their best, many are reporting it feels like a tipping point. Mental Health Nurses have to prioritize their daily work based on service requirements to discharge acutely unwell people much earlier than evidence or professional judgement recommends (including people who require compulsive treatment) to make way for another person. This creates a conflict/tension between providing for the needs of a person in their care, and providing access to care for a person currently not in their care. These processes are accompanied by an enormous amount of paperwork that reduces the time that the mental health nurse can spend with people (and their families). ANMF (Vic Branch) consistently hears our members' frustrations, and we believe this approach must change. Workloads need to be manageable and administrative requirements must be refocused to what is clinically and legally required and essential.

This Mental Health Strategy is an opportunity to recognize that Mental Health Nurses are highly qualified and can make a difference to people's recovery journey if the system allows them to practise according to their unique skill-set. The recent trial of SAFEWARDS at 7 Area Mental Health Services (AMHS) is an example of mental health nurses potential and should be adequately funded across the state. This is nurse led program that originated in the UK and has been associated with more than 15 years of research incorporating the best ways for staff in mental health wards to identify and reduce flashpoints (times or situations where things could go wrong) with the intention of decreasing conflict(s) and the response to such conflict **(Bowers)**

Workforce initiatives, including enabling mental health nurses to work to their unique skill set, and improved acute clinical mental health service capacity must be seen amongst the top priorities, with concerted strategies put in place to address the challenges associated with a finite workforce and an aging population, whose needs are becoming increasingly complex and a clinical system that is currently at breaking point after enduring cut-backs. While the discussion paper attempts to acknowledge the dedicated workforces (clinical and non-clinical) it does not explore in depth the existing constraints within the sector that directly impact on the workforce and subsequently the people accessing the service. An integrated response that optimizes the opportunities to use both specialist and the broader nursing and midwifery workforces is essential if the vision *'All Victorians have the opportunity and right to experience their best mental health'* is to be achieved. Unless mental health becomes everyone's business, the principles of prevention and health promotion will not be fully realised.

Within the Mental Health Sector (clinical and non-clinical) partnerships have operated with very clear understandings of who is responsible for providing acute clinical care. However, the responsibilities have blurred in relation to the provision of sub-acute clinical mental health care. The next mental health strategy should be developed with an intention to examine this issue to ensure that there are appropriate options for clinical mental health sub-acute services to be provided within Victoria. For example, the step-down/step-up beds (known as Prevention and Recovery Centre's - PARCs) are operating primarily with MHCSS staffing and very limited clinical in-reach (commonly only one shift each

day). This has impacted on the ongoing demand on acute clinical mental health beds as people who have ongoing clinical needs (albeit it at the sub-acute level) are not able to access comprehensive clinical care around the clock, or have this need met within Victorian PARCs. It is likely that both clinical and non-clinical have a role in sub-acute, however, in order to relieve some of the pressures on acute clinical there must be a better balance within PARCs to enable both areas to contribute to the overall goal of working towards recovery and the best mental health possible.

**ANMF Recommendation 21**: Clinical Mental Health Services (Acute and Sub-acute) funding requires an immediate review of the current funding formula to ensure that as part of the next Mental Health Strategy, all health services responsible for providing clinical care are receiving the appropriate funding. Improved Clinical Mental Health Services must be considered a top priority.

**ANMF Recommendation 22:** The next Mental Health Strategy should incorporate a mechanism to progress a statewide review of all existing administrative/documentation expectations with the aim of streamlining documentation to ensure that essential legal and clinical documentation is the future basis of what must be completed.

**ANMF Recommendation 23:** The Strategy must build on the positive outcomes from the recent trial of SAFEWARDS at 7 Area Mental Health Services (AMHS), an example of mental health nurses potential and this model should be adequately funded across the state.

**ANMF Recommendation 24:** Workforce initiatives, including enabling mental health nurses to work to their unique skill set, and strategies to address the challenges associated with a finite workforce and an aging population must be articulated in depth to stop the existing constraints within the sector that directly impact on the workforce and subsequently the people accessing the service. Implementation of a 'workforce capability framework' is not the solution as these do not regard the existing expertise and competencies associated with the National Registration regulatory framework.

**ANMF Recommendation 25:** The next mental health strategy should be developed with an intention to examine and address this issue of inadequate access to clinical sub-acute mental health beds in Victoria.

**Is this the right vision for the next 10-year mental health strategy? Why or why not?**

*'All Victorians have the opportunity and right to experience their best mental health'* is a clear vision. The explanation provided under the vision commences by making reference to it being holistic, however the description does not include physical health. The positive dimension of mental health is stated within the World Health Organisations definition of Health, for example 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It would improve the plan if physical health is specifically included from the outset.

### Is this the right scope for the mental health strategy? Why?

*'The mental health strategy is for all Victorians'* does not make the distinction between state and commonwealth responsibilities and may infer that the state Government mental health strategy is all encompassing. Specifically, when community are calling for more than 10 sessions with a psychologist they are referring to Commonwealth initiatives and/or cut-backs that the state has limited capacity to influence. Another example being the 'freeze' on the commonwealth funded Mental Health Nurse Incentive Program (MHNIP) which impacted on the planned expansions within the primary health care settings for communities to access mental health nurses outside the public health system. The cessation of the Commonwealth Funded Medicare Local and the implementation of the Primary Healthcare Networks have resulted in Mental Health Nurse Practitioners and mental health nurses not receiving funding to provide continuity of mental health services to vulnerable clients in the community during this time of transition. This also detrimentally impacted/ limited the state funded clinical mental health services from being able to refer people to this service.

It may be useful to confirm within the scope the elements that the state is responsible for and clarify elements of the proposed state Strategy that the commonwealth has responsibility for. In addition, the requirements for the states' Strategy to align with the Commonwealth National Mental Health Plan, accreditation standards, and Mental Health standards for both services and workforce could be articulated.

The scope section of the Discussion paper also mentions the technical papers, as stated previously, ANMF (Vic Branch) is concerned that there is not a dedicated technical paper on perinatal and infant mental health.

### Why would a new strategy for mental health be important to you?

The previous mention of omitting reference to physical health is obvious again within the section of the Discussion paper. It could be improved by inserting 'physical' into the first sentence so it reads as "Good *physical*, mental health and social and emotional well-being is fundamental to a thriving Victorian community" and then including the same reference (or expansion of treatment to integrated treatment approaches that can address the high rates of chronic illness and related mortality) when discussing what people need in paragraph four.

The three elements included as the 'backdrop for a renewed vision' are very limited. It would be beneficial to include other relevant matters such as implementation of the new Mental Health Act and associated paradigm shifts that have not yet been fully realised within the mental health sector (including the previous Governments lack of education and training programs about these changes to for doctors and nurses in the wider health setting), translation of the Governments pre-election commitments to policy, alarming rates of increasing rates of chronic illness and associated mortality and under previous Government the eroding of clinical mental health beds that has placed Victoria amongst the lowest in the country making it more difficult to meet the needs of the community.

### Do these principles reflect what is most important to you?

While there is nothing 'wrong' with the guiding principles that have been included within the discussion paper, it appears to introduce another set of parameters for services to consider. It would be beneficial to consider aligning them to existing quality measures such as the National Accreditation Standards for Mental Health Services and National Standards for Mental Health Services.

**What other principles would you want to inform the mental health strategy? Why?**

Considering our response above and the statement that the principles are to *guide the design, development and delivery of services* , it would be beneficial to include within the guiding principles 'safety', 'promotion and prevention', 'access to specialist services', 'delivery of care and recognition and responses to clinical deterioration', 'partnerships and shared care' and "qualified workforce'. The rationale for this suggestion is to align mechanisms that already exist to the ongoing plan to maximize the success.

**Do you agree with taking on outcomes approach in the strategy?**

While not opposed to the use of an outcomes approach, it would be essential for the Strategy to clearly describe for each outcome the variety of organisations involved and their respective roles. Specific workforce measures be associated with each outcome. The next Mental Health Strategy must also outline the Governments' ongoing investment for each outcome, including improvements. The outcomes must be capable of being measured, and be supported by a sound evidence base. This part of the Strategy must be provided in plain language to ensure the entire community can understand the approach.

**ANMF Recommendation 26:** The outcomes approach must clearly describe for each outcome the variety of organisations involved and the specific workforce measures that are associated with the outcome to ensure the vision can be achieved.

**ANMF Recommendation 27:** The next Mental Health Strategy must outline the Governments' ongoing investment for each outcome, including improvements.

**ANMF Recommendation 28:** The outcomes must be capable of being measured, and be supported by a sound evidence base. This part of the Strategy must be provided in plain language to ensure the entire community can understand the approach.

Should the next Strategy rely on an outcomes approach, there must be additional inclusions of the following four outcome measures to ensure improvements and greater accountability in these high risk areas:

- **Improve Mental Health Literacy of the workforces working in the general hospital setting (non-mental health settings).**
  A KPI could be set aiming for annual targets for an ongoing education and training program (for example Mental Health First Aide) of at least 1o% every year of general hospital workers completing the course.
  This outcome measure could be further assisted by the expansion of Psychiatric Clinical Liaison Nurses in every major public hospital, to enable patients admitted for physical illness with a co-existing acute mental health condition to receive integrated care.

- **Older people and their families have access to strengthened Aged Persons Mental Health (APMH) teams, including APMH Nurse Practitioners who can provide in-reach services to residential aged care services, to ensure older people with mental health conditions are identified and responded to appropriately.**

- **The physical health gap experienced by people with severe mental illness is reduced**. Actions to assist this measure must involve the routine monitoring by nurses for metabolic syndrome, dental concerns and other indicators of physical ill health. High risk groups will also be offered an evidenced based individual program that targets factors known to contribute to chronic illness. If physical illness is identified, the nurse will work with the person (and with consent, their family) to ensure collaborative treatment is provided to reduce the prevalence of physical illness.

- **Known Neonatal and Obstetric risks associated with mental illness will be reduced.**
  All public maternity services will provide evidence based screening to identify women requiring a mental health assessment or intervention in the antenatal period and post-partum period. The women identified will receive prioritized access to perinatal integrated and holistic mental health care to decrease known neonatal and obstetric risks associated with mental illness and enable reductions in hospitalizations associated with such risks.

**ANMF Recommendation 29:** There must be additional inclusions of the following four outcome measures to ensure improvements and greater accountability in these high risk areas:

- Improve Mental Health Literacy of the workforces working in the general hospital setting (non-mental health settings).

- Older people and their families have access to strengthened Aged Persons Mental Health (APMH) teams, including APMH Nurse Practitioners who can provide in-reach services to residential aged care services, to ensure older people with mental health conditions are identified and responded to appropriately.

- The physical health gap experienced by people with severe mental illness is reduced.

- Known Neonatal and Obstetric risks associated with mental illness will be reduced.

**Enabling Genuine Choice: What do you think about including this outcome as a priority in the next 10-year strategy for mental health in Victoria? What measures or indicators would demonstrate this outcome is being delivered?**

The inclusion of the statement '*public mental services offer a limited range of therapeutic interventions' is* detrimental towards the dedicated staff who work within these services and we suggest it is reworded. Similarly, the statement *'Medication remains the primary, and often only treatment offered to most people – despite increasing evidence for a wide range of other effective options'.* The statements reflect the constraints of an underfunded clinical mental health system and dedicated staff that are required to 'move people on' and a legal framework that often places responsibility for treatment decisions on psychiatrists. If it is necessary to include, then we seek appropriate reference to the context be made.

Inpatient wards are not able to provide reasonable length of stays (even if that is indicated), and health practitioners often have to prioritise acutely unwell patients for early discharge way before they are ready to leave. Similarly, people in the clinical community mental health service have little choice about which heath practitioner they are allocated or the model of care that will be available. The health practitioners in clinical mental health services rarely have the freedom to provide care to their full discipline specific skill set; many are required to operate as a generic case manager and at times, allied health are having to provide psycho-education about physical health and psychotropic medications which they are not actually qualified to do. People are not 'cases'. Some community teams are operating without a single nurse within, and most are not actually providing multidisciplinary care to individuals. Having people employed from a mix of disciplines does not translate to multidisciplinary care for the consumer; in fact, multidisciplinary care seems to occur more within the general hospital setting than in mental health.

**What is your view about the proposed actions?**

The proposal to abolish 'catchment restricted access' is recognized as a suggestion for providing ultimate choice. It has merit if it is able to be accompanied by a mechanism that adequately addresses the issue of people living in the local area potentially being unable to access their local service. Would this be possible only when they had available appointments that no-one from the local area required? Is this ever the situation as ANMF (Vic Branch) consistently hears from members that they can't see all the people in the area now? What about the impacts for the people who need to be linked to other services in their local area, this may introduce new occurrences of people falling between the gaps. While facilitating choice to use a service other than the one in your local area may be desirable for some, it could be problematic for the people in the local area who may be unable to access their local service as a result, and could potentially expose them to further disadvantage if they had to travel to another region.

The intention to undertake wide-scale implementation of supported decision making mechanisms is welcomed. ANMF (Vic Branch) has some specific recommendations to make in relation to Advanced Statements based on an interactive session at a recent forum we held. Specifically, wide-scale implementation of Advanced Statements should be accompanied by an education and training program using a tiered approach including:

- Mandatory comprehensive face to face training for all staff working within clinical mental health services
- Mandatory training (face to face and/or online) for doctors and nurses in Emergency Departments including how to identify if an Advance Statement has been prepared and the legal requirements associated with it
- Voluntary training for health practitioners in the remainder of the general hospital about how to identify and why they are a good idea

- Training for doctors and nurses within primary health care settings
- Design and implement an awareness campaign for the broader community about what is an Advance Statement and how to make one with the aim of most of the community having one prepared
- ANMF (Vic Branch) should be invited to participate in the DHHS and RANZCP joint project on enabling supported decision making noting that it is intended to develop tools and resources that support shared decision making.

**ANMF Recommendation 30:** The immediate wide-scale implementation of Advanced Statements should be implemented based on an education and training program using a tiered approach described above.

**What else could be done to achieve this outcome?**

- Enable health practitioners to actually work according to their qualifications and skill sets and for consumers to have informed choices about the right health practitioner to meet their needs. For example, for a person with acute psychosis it may be that the mental health nurse is most appropriate whereas for a family with a child with suspected Asperger's Disorder it may be that the psychologist is the most appropriate health practitioner. It would assist if a guideline was developed and available that accurately described the differences and enabled people to better understand who holds specialist mental health qualifications and what each health practitioners associated skill sets are in order to be able to make informed choices. Of course, services would need to support people to work to their fullest unique roles.
- To enable greater therapeutic options in bed based services, consideration must be given to increasing the availability of mental health nurses within PARC services to ensure that people can receive specialist mental health nursing care in either the step-up or step-down environment and not be required to have an acute inpatient admission to access mental health nursing care.
- In the context of the NDIS being rolled out commencing July 2016, people may have greater choice in accessing services from allied health practitioners, however they will not necessarily have increased option to access mental health nurses via the NDIS. It appears that such access remains within the clinical mental health system.
- There should be capacity for all Health Practitioners that have undertaken training regarding Advance Statements to be able to sign them if a person (unrelated to them) requests and has capacity to do so

**Supporting Children and Families: What do you think about including this outcome as a priority in the next 10-year strategy for mental health in Victoria? What measures or indicators would demonstrate that this outcome is being delivered? What is your view about the proposed actions? What else could be done to achieve this outcome?**

It is appropriate to include this as an outcome, however as previously stated, ANMF (Vic Branch) believe it is also critical to have a perinatal and infant outcome measure also.

In relation to the children and families outcome, the papers give inadequate regard to the critical role performed by Maternal and Child Health Nurses within the MCH Service and Early Parenting Centres, and – in promoting optimal mental health.

Additionally, we note there is a plethora of research indicating the first three years of a child's life are a critical period in a child's physical, social and psychological development, and that these early years set the foundation for health outcomes and behaviours into adulthood (Baldwin, 2001; Tomison and Poole, 2000). This period therefore represents an enormous opportunity for health and support services to make the most significant difference, and conversely is a period when babies and young children are most vulnerable.

It is also well recognised that strategies aimed at the early years of a child's life – and which promote prevention or early intervention – have the most enduring outcomes and are most cost effective. The Honorable Philip Cummins, Emeritus Professor Dorothy Scott and Mr. Bill Scales observed in their Report to the Protecting Victoria's Vulnerable Children Inquiry [the Report] January 2012 that:

> *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* (Cummins, P., Scott, D. and Scales, B., 2012, p. xxxiv)

ANMF (Vic Branch) concurs with this assessment and submits it is critical that the MCH Service and Early parenting Services be better resourced to meet the increasingly complex mental health care needs of Victorian Children and families.

Additionally we submit that inadequate regard has been given to School nurses who perform a critical role in supporting young children and young adults to achieve optimal health, wellbeing and development. School nurses support students to navigate their way through an increasingly complex array of health and wellbeing issues that if left unresolved, would reduce engagement, compromise school retention and adversely affect academic outcomes and/or learning capacity. For example, school nurses commonly support students to manage issues relating to:

- Mental Health - anxiety, depression, self-harm and suicide prevention, and school refusal, relationship issues, parental mental health issues
- Autism spectrum disorders, ADHD, conduct disorder
- Family violence
- Bullying - cyberbullying, sexting, inappropriate circulation of nude photos of underage students
- Sexual Health - education regarding contraception; sexually transmitted infections; unplanned pregnancy or fear of an unplanned pregnancy; referral and education regarding reducing risk of and / or managing sexual assault; same sex attraction, gender diversity, GLBTIQ issues; presence of pornography
- Refugee Health / support – trauma related issues, support for students from refugee background or who are subject to immigration detention
- Homelessness / "couch surfing" due to severe home or welfare problems
- Health issues – eating disorders, body image, obesity, nutrition, epilepsy, anaphylaxis, diabetes, hygiene, continence issues
- Family ill health - parents/ family members with health issues such a cancer
- Food assistance like breakfast clubs
- Alcohol / drug use – education re harm minimisation strategies

Despite this critical role, the capacity of the PSNP is unhelpfully constrained through existing funding. ANMF (Vic Branch) contends existing funding is not adequate to meet increasing student population numbers and the increasingly complex needs of students and families. On this point, ANMF (Vic Branch) notes that school nurse to student ratios vary significantly with some school enjoying ratios of 1 to 800 but others experiencing ratios far higher and up to 1 nurse to 1800 students. It is imperative that resourcing to the PSNP be increased to meet increasing demand arising from increasingly student

numbers and the increasingly complex nature of health and wellbeing matters. Furthermore, this action will enable the school nurses to undertake more timely assessments and ensure that any health and development matters are identified early and interventions put in place in a timely way.

A Mental Health Strategy would be enhanced with recognition of their accessibility to families, and their current responsibilities in relation to screening and early identification of particular vulnerabilities or issues.

**ANMF Recommendation 31:** Early Parenting Centres - ANMF (Vic Branch) recommends that additional funding be provided to early parenting centres to enhance their ability to provide timely support and intervention, and to better meet increasing demand of families at children at risk in metropolitan Melbourne and throughout rural Victoria.

**ANMF Recommendation 32**: The contribution of School Nurses must be incorporated within the next Strategy. Further, ANMF (Vic Branch) recommends that:

- Additional Primary School Nursing Program (PSNP) nurses are employed within Victorian Primary Schools to reduce existing PSNP workloads; and enable nurses within the PSNP greater opportunity for direct contact and intervention with children and families at risk.
- A minimum of one state funded registered nurse be employed within the Secondary School Nursing Program (SSNP) in every Victorian secondary school.

**ANMF Recommendation 33:** To increase the capacity of MCH Service to optimize health, wellbeing and development and therefore establish a strong foundation for future learning, ANMF (Vic Branch) recommends Government give consideration to:

a) Increasing resourcing to the Universal MCH Service

b) Improving data collection mechanisms to ensure Universal MCH Service funding is provided in real time and matches increasing demand created by increasing population and enrolments

c) Exploring mechanisms for the Universal MCH Service to commence MCH nursing involvement during the antenatal period

d) Reviewing funding mechanisms to the Enhanced Maternal and Child Health service to meet the increasingly complex needs of families and children.

e) Supporting the highly respected MCH Line to:

   I. Meet increasing demand for the service

   II. Explore the feasibility of providing a targeted and proactive MCH nurse led outreach service

   III. Facilitating greater connectedness between the MCH Line and the Universal and Enhanced MCH Services such as through re locating the MCH Line from the North Eastern Victoria Region to Central

**NOTE:** *Funding for the above 3 recommendations would not necessarily fall within the direct responsibility of the Mental Health and Drugs Division but reflect a whole-of government collaborative approach*

**Improving the social and emotional wellbeing and mental health of Aboriginal people and their communities: What do you think about the proposed strategic actions? What key policy directions, strategic investments and actions should be considered as part of the Aboriginal social and emotional wellbeing action plan? Is there any action we should take immediately?**

The proposed outcome should be expanded to include both spiritual and physical health noting that this population already has a reduced life expectancy. All treatment for mental and physical illness should be integrated and respectful of their cultural identity. The stated intention to include Aboriginal organisations is essential. Consideration should also be given to the provision of education programs to build cultural awareness and cultural safety amongst mental health practitioners.

**ANMF Recommendation 34:** Consideration must be given to the provision of education programs to build cultural awareness and cultural safety amongst mental health practitioners.

**Preventing and Reducing Suicide: What do you think about the proposed actions?**

ANMF (Vic Branch) recognises that this outcome is associated with National activities with the same focus. It may be beneficial to ensure state actions are aligned with any National plans for preventing and reducing suicide. The proposed action *to 'develop a whole-of government suicide prevention framework and action plan for Victoria'* may result in less deaths, however the Government must also have an immediate approach that enables implementation of some international recommendation such as those outlined in the United Kingdom's National Inquiry into Suicide and Homicide by People with Mental Illness **(Appleby, L., KApur, N., Shaw, J., Hunt, I.,While, D., Flynn, S., Windfuhr, K. and Williams, A., July 2013)**.

Specifically, there needs to be statewide consistent care that enables improvements including:

- Increased awareness amongst Emergency Departments and GPs of the predictors and a capacity for clinical mental health services to be accessed without delay, preferably before the person leaves the ED.
- In addition, if financial difficulties or homelessness are present, measures to ensure that the person is going to receive advice on debts, housing and employment must be arranged immediately, preferably prioritizing this person.
- Strengthen specialist services and risk management for people who are misusing alcohol or drugs
- Introduce or maintain assertive outreach services
- Continue the successful safety focus on inpatients wards, including measures to prevent absconding and ensure safe design. Support for people who are acutely suicidal to be able to remain within the acute ward for the time that is required to shift their thinking towards living, is also essential

**What else could be done to achieve this outcome?**

Given the uncontested evidence that a previous suicide attempt is the biggest predictor of completed suicide, the role of Emergency Departments in relation to this outcome is critical, however not mentioned within the discussion paper. Emergency Departments must be provided with contemporary education and training to improve their understandings and response to people who present post a suicide attempt.

**ANMF Recommendation 35:** The state Strategy must include state-wide education and training for nurses and doctors within Emergency Departments 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

**ANMF Recommendation 36:** The Strategy must continue the successful safety focus on inpatients wards, including measures to prevent absconding and ensure safe design. Support for people who are acutely suicidal to be able to remain within the acute ward for the time that is required to shift their thinking towards living, is also essential.

**Reducing Disadvantage and increasing social and economic participation:**

**What do you think about including this outcome as a priority in the next 10-year strategy for mental health in Victoria? What measures or indicators would demonstrate this outcome is being delivered?**

Inclusion of this outcome is supported, particularly given it seeks to incorporate social determinants of health and a stated outcome of reducing disadvantage. This outcome pulls together many elements that contribute to poorer outcomes for people, and, a well-coordinated response is required to make any real head way to this population group. Up until now, there seems to be some fragmentation between services, and at times, the risk of people not accessing services because of the dual stigma associated with homelessness as well as mental illness. The September edition of the Australian Nursing and Midwifery Journal (ANMJ) published a feature article *No Place Like Home: nurses and midwives tackling homelessness* **(Kedele, R., September 2015, pp. 20-25)** and included the work of the Victorian RDNS Homeless Person Program. It included the story of a man in his 30's that had experienced numerous periods of homelessness since his teenage years. He also struggled with alcohol and drug misuse and other trauma. It was through the non-judgmental approach and active follow-up of the nurses that he was allocated a place of his own with health issues being addressed. RDNS Homeless Person Program nurses describe many people they have cared for as being some of the most vulnerable in our state, and the fact that the nurses are accepted by the people they assertively outreach to.

**What is your view about the proposed actions?**

While all of the actions listed have application to an overall Mental Health Plan, they do not appear related directly to this outcome. Suggested below are proposed actions to achieve this outcome.

**What else could be done to achieve this outcome?**

- Ensure that nurse led homeless persons programs employ mental health nurses to work alongside drug and alcohol nurses, community nurses and HIV nurses all of whom are trained in the trauma informed care approach and have good knowledge of the services available to ensure their patients' needs are able to be addressed.
- Continue to provide 'fast track' to appropriate public housing for people with these complex needs at an earlier point than the current 15 years or more with a requirement for ongoing engagement with the nursing service

- In recognition of recent data on triggers for 'new homelessness' ensure that victims of domestic violence (and their children) can access safe refuges and be protected to make transitions to affordable housing
- Encourage partnerships/amalgamations/mergers between homeless services to reduce expenditure on overheads and allow funds to go to direct service provision
- Ensure there is reference to a statewide homeless strategy that actually increases the availability if accommodation

**ANMF Recommendation 37:** Responding to Homelessness must be part of the next Strategy and incorporate the following actions

- Ensure that nurse led homeless persons programs are supported to employ mental health nurses to work alongside drug and alcohol nurses, community nurses and HIV nurses all of whom are trained in the trauma informed care approach and have good knowledge of the services available to ensure their patients' needs are able to be addressed.
- Continue to provide 'fast track' to appropriate public housing for people with these complex needs at an earlier point than the current 15 years or more with a requirement for ongoing engagement with the nursing service
- In recognition of recent data on triggers for 'new homelessness' ensure that victims of domestic violence (and their children) can access safe refuges and be protected to make transitions to affordable housing
- Encourage partnerships/amalgamations/mergers between homeless services to reduce expenditure on overheads and allow funds to go to direct service provision
- Ensure there is reference to a statewide homeless strategy that actually increases the availability if accommodation

**Responding to need with effective coordinated treatment and support:**

**What do you think about the proposed actions? What else could be done to achieve this outcome?**

**What measures or indicators would demonstrate that this outcome is being delivered?**

The stated actions, including the realization that it must *'involve planned investment in inpatient and community-based services, targeted to areas experiencing critical service gaps and demand pressures, and a clear strategy for residential aged care services'* are agreed with. For too long the mental health funding for bed based services has been inadequate and as previously stated, has needed to be subsidised by the general hospital or the community mental health funding, both of which have ramifications for other patients. In addition, the significant growth within some areas needs to be catered for.

While planning is underway for an expansion of beds at Mercy Mental Health, the same is required at Monash Health Casey with suburbs expanding at a faster pace than the available beds. There is also mention of the new transitions support units, however, there has not been clarity yet about the staffing requirements for these new beds. ANMF (Vic Branch) believes people within these new units will continue to have needs for mental health nursing care; however the inclusion of nurses has not been confirmed at the DHHS level. If the stated aim of providing care to people with co-occurring intellectual disability and a mental illness is the focus of these units, then they must include mental health nurses.

Clinical community mental health services will also need a funding review; they are not likely to experience the same changes that the MHCSS will experience in relation to the roll-out of the NDIS. In addition to the funding review, it is necessary to consider mechanisms that will enable people to move away from the 'case management model' towards a contemporary clinical mental health service system that enables health practitioners to provide services according to their qualifications and discipline specific skill set/professional scope. This would ensure that people could see the right professional at the right time. It would also enable employers to maximize the 'all-rounder' expertise of mental health nurses and enable the psychologists to be available to provide specific psychological therapies.

**ANMF Recommendation 38**: The next Strategy must immediately provide clarity regarding the two new Transitional Support Units (TSUs) being built that are intended to provide care to people with co-occurring intellectual disability and a mental illness. Specifically, the strategy must confirm that people admitted to TSUs will receive care from nurses.

**ANMF Recommendation 39:** Clinical community mental health services need a funding review; they are not likely to experience the same changes that the MHCSS will experience in relation to the roll-out of the NDIS.

**Recognising and responding to the experiences of trauma:**

**What do you think about including this outcome as a priority in the next 10-year strategy for mental health in Victoria? What measures or indicators would demonstrate that this outcome is being delivered? What is your view about the proposed actions? What else could be done to achieve this outcome?**

While it is entirely appropriate to include trauma and trauma informed care as an outcome there are three points that we want to make. Firstly, a large number of the existing clinical mental health workforce has experience workplace trauma and the ongoing impacts from this not being addressed. This must be acknowledged and urgent supportive strategies implemented that will enable people to process their workplace exposure and experiences of trauma. Second point is that the implementation of trauma informed care training has not been extensive enough to embed practice changes at the direct service provision level. It is clear to the ANMF (Vic Branch) when meeting with members within the wards the majority are not aware of the training, and those who are report that it is difficult to access the limited training available. Third and finally on this matter, the trial of Mental Health Trauma Training within the Emergency Departments was only implemented at three EDs as part of the trial, so there is a very long way to go to ensure this outcome can realized.

**ANMF Recommendation 40**: Trauma Informed Care (TIC) should be an ongoing element of the next Mental Health Strategy. However, to embed TIC into practice, there must be:

- Acknowledgement and an evidence based response for the large numbers of the existing clinical mental health workforce who have experienced workplace trauma and the associated impacts of it. Governments', and in turn employers, must acknowledge the situation and plan for and provide urgent supportive strategies that will enable people to process their workplace exposure and experiences of trauma.

- There needs to be further implementation of planned trauma informed care training in order to embed practice changes at the direct service provision level.

- Funding for widespread implementation of Mental Health Trauma Training within the Emergency Departments (EDs) is required to ensure the positive evaluation at the 3 sites can be replicated within all E.Ds.

**Developing a capable and supported workforce:**

**What do you think about including this outcome as a priority in the next 10-year strategy for mental health in Victoria? What measures or indicators would demonstrate that this outcome is being delivered? What is your view about the proposed actions? What else could be done to achieve this outcome?**

The first action to 'develop and implement a comprehensive strategy for recruitment, retention and development of the mental health workforce' sits broadly within the previously developed mental health workforce strategy. An assessment of what actions were achieved in collaboration with key stakeholders including ANMF (Vic Branch) will clarify what is outstanding. ANMF (Vic Branch) recommends that the workforce strategy must be capable of providing for the training and education needs of both the specialist mental health workforce as well as the broader nursing and midwifery workforces.

The Government needs to immediately invest in effective strategies that will reduce the current workforce stress and trauma, and, reinforce employment safeguards. Improving investment in clinical mental health services may decrease pressures that currently contribute to dissatisfaction for all.

ANMF (Vic Branch) does not support the implementation of '*mental health capabilities'* as these do not regard the existing expertise and competencies associated with the National Registration regulatory framework.

With regard to the next Mental Health Strategy, to ensure that the vision can be achieved, specific workforce measures must accompany each of the proposed outcomes. Any plan to develop a capable and supported clinical mental health workforce must recognize existing qualifications and experience the workforce has already attained in order to appropriately invest in courses that can develop the workforce on a deeper level. This may include training in evidenced based psychological therapies for all clinical Mental Health Practitioners as well as increasing the number of Mental Health Nurse Practitioners across the state. ANMF (Vic Branch) have included numerous recommendations throughout this submission that relate directly to 'workforce' that must be part of the next Strategy.

Finally, greater emphasis on discipline specific service provision can enable people who are unwell to actually receive the right service from the right Health Practitioner rather than continuation of some of the historical generic approaches.

**ANMF Recommendation 41**: The next Strategy needs to incorporate an education and training program for the wider health workforce on recent reforms such as the Mental Health Act legislative changes and associated paradigm shifts from substituted decision making to supported decision making, implementation of recovery oriented services and trauma informed care (TIC) to ensure that people with mental illness are receiving appropriate and legally compliant care whenever they come into contact with the health system. For example, it has been previously stated that TIC training and education has been provided to Emergency Departments (ED) when the fact is that only 3 EDs were included in the state-wide training.

**ANMF Recommendation 42:** The workforce strategy must be capable of providing for the training and education needs of both the specialist mental health workforce as well as the broader nursing and midwifery workforces.

**ANMF Recommendation 43:** The plan to develop a capable and supported clinical mental health workforce needs to recognize the qualifications, experience and further education and training that staff already have, with capacity to develop the dedicated workforces on a deeper level

## Reference List


Appleby, L., KApur, N., Shaw, J., Hunt, I.,While, D., Flynn, S., Windfuhr, K. and Williams, A. (July 2013). *The National COnfidential Inquiry into Suicide and Homicide by People with Mental Illness.* The Univeristy of Manchestor.

Bilbao, F. H. (2015). Implementing a Perinatal Emotional Health Program in a Metropolitan Melbourne Maternity Hospital. *ANMF (Vic Branch) Australian Nurses and Midwives Conference.*

Bowers, L. (n.d.). *model technical*. Retrieved September 14, 2015, from SAFEWARDS: http://www.safewards.net/

Cummins, P., Scott, D. and Scales, B. (2012). *Report of the Protecting Victoria's Vulnerable Children Inquiry.* Victoria: Department of Premier and Cabinet.

Kedele, R. (V 23, September 2015). No place like home: nurses and midwives tackling homelessness. *Australian Nursing & Midwifery Journal*, 20-15.

Victorian Government. (2009). *Because Mental Health Matters.* Mental Health and Drugs Division, Department of Human Services.

(n.d.). *Victorian Labor Platform 2014.*