

Submission to Productivity Commission inquiry into 'The Social and Economic Benefits of Improving Mental Health'

APRIL 2019

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Recommendations

Recommendation 1

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There needs to be an immediate increase of funding for more PICU/MHICU beds and units across the State. Long admissions in under resourced HDU beds is not only costly but inappropriate to the clients who require a higher level of care due to acuity.

Reinstate, increase and quarantine the funding of the Mental Health Nurse Incentive Program to improve community mental health services.

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An improved data collection at a national level that collects and collates data across all states and territories through a standard format that is openly transparent and allows data collected to be easily accessed.

Emergency Department KPIs for mental health need to be appropriate and separate from the KPIs for medical/surgical clients.

The current activity-based funding model needs to be remodeled to focus on improved client outcomes rather than simply counting occasions of service as the means for funding.

Recommendation 3

There needs to be a State-wide requirement that the recruitment of suitably qualified mental health nurses is a priority. The creation of more Clinical Nurse Specialist level two (CNS II) positions may encourage the recruitment and retention of senior mental health nurses.

Nurses have the competencies for medication administration and need to case manage clients on complex medication regimes. All staff should be back filled in all services to ensure staffing ratios are kept optimum for both client care and safety. Vacant positions must be filled to ensure safe client care.

The numbers of nursing staff on duty need to be appropriate for the number of patients and their acuity to ensure patient safety is not compromised.

There is a need to have sufficient numbers of nursing staff on all units on all shifts across all mental health facilities and services, to be able to provide a safe and best care possible. NSW Health adopts the NSWNMA 2018 Ratios claim as the minimum nursing numbers required on each shift. Nurse to Patient Ratios are only a minimum and patient acuity must always be considered and appropriately managed.

That the NSWNMA 2018 Ratios claim be adopted as the minimum nursing numbers required on each shift.

That skill mix must be taken into consideration in recruitment and rostering decisions. Rostering and planning to ensure they address shortages in mental health nursing staff, address training, recruitment, and retention of mental health nurses.

Recommendation 4

The NSW government should be held accountable for its current lack of action as an employer in the NSW Health services in regard to bullying and the high level of violence impacting on its staff in the workplace.

That NSW Health develop specific patient management and treatment pathways for patients using ICE.

There needs to be a real transparent commitment from management at all levels to ensure psychological health of the mental health nursing workforce is protected.

Clear leadership with robust governance processes is required at all levels of management, this includes nursing leadership, with consistent State-wide processes and models of care will help drive the required culture change at all levels

Recommendation 5

Reinstate school nurse positions across all public schools in NSW NSW Health urgently needs to commission a public mental health perinatal unit.

Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing/care workers (however titled, who are unregulated).

The NSWNMA has approximately 65,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

We currently have over 2500 members who work in specialty of mental health. We consult with them in matters that are specific to their practice.

We welcome the opportunity to provide a submission to this Inquiry.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

A handwritten signature in black ink, reading "Brett Holmes", is enclosed within a red rectangular border.

BRETT HOLMES
General Secretary

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Productivity Commission inquiry into ‘Inquiry into the economic impacts of mental ill-health’

INTRODUCTION

The NSW Nurses and Midwives’ Association (NSWNMA) welcomes the Australian Governments Productivity Commission’s inquiry into ‘Inquiry into the economic impacts of mental ill-health.

The Association acknowledges the need for an inquiry into the mental health funding model and economic efficiencies that can have an impact on improved outcomes for the users of the mental health services.

The mental health funding model must support current international trends and best practice principles for patient centred care, trauma informed care and crisis prevention strategies.

Patient safety and staff safety has always been a priority of the NSWNMA and our members, along with evidence based clinical practice that provides best care for the individual.

Despite increased funding for mental health services over many years by both federal and state governments, the improved outcomes required are not markedly evident. Consumers and mental health professionals alike are dissatisfied with current funding model and the care level that this model provides.

We understand that this inquiry is about the mental health and wellbeing of Australia's population generally. There is no question that improving any individual's mental health will provide flow on benefits for the individual, their employer and the community.

Poor mental health is the result of multiple contributing risk factors, including education, housing, social supports, community supports, family supports, cultural supports, age and location. To provide good holistic mental health interventions and supports through the life span requires a whole of government approach to mental health across all government portfolios and at all levels of government from commonwealth, state and local government bodies.

Nurses are well positioned in the support of people throughout their life span. Nurses are across all aspect of health and are the largest profession in the health workforce making up over 50% of the workforce in NSW. The Association's response to this inquiry is framed in the context of the NSW nursing perspective, as this is our core business and our member's area of practice.

Key issues facing mental health nursing are – safe nurse to patient staffing levels, appropriate skills mix, chronic bed shortages, adequate community mental health nursing positions, increasing workloads, funding models, and work health and safety issues in mental health.

It is positive that mental health in the work force has been included in the terms of reference for this inquiry. Often overlooked is the mental health of the nursing workforce, as the focus is often on the outcomes for service users without consideration to supporting the mental health of the nursing workforce that provide the care to those service users requiring mental health interventions in the community or in hospitals.

PRODUCTIVITY COMMISSION ISSUES PAPER QUESTIONS WITH NSWNMA RESPONSES

QUESTIONS ON STRUCTURAL WEAKNESSES IN HEALTHCARE

Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?

QUESTIONS ON FUNDING ARRANGEMENTS

Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?

How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?

Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?

How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?

Funding of mental health services

Inadequate funding of the public mental health services in NSW over many years (since the implementation of deinstitutionalisation in NSW) and 'leakage' of mental health funding

to other areas of health has created systemic issues within the NSW mental health services¹.

This forced Local Health Districts (LHDs) to create budget saving at the cost of evidenced based best practice reducing optimum care and safety of clients and staff.

The impact of reduced funding has resulted in cutbacks in the operation of public sector community services, freezing of staff employment, and other cost measures to meet the budget restrictions. The impact of this tight fiscal strategy continues to be evident with its impact on clinical outcomes in many NSW mental health services.

Poor leadership by the state government, along with restrictive budget constraints has led to mental health services being poorly resourced. This is evident in the high employment rate of a non-specialised and inexperienced mental health workforce along with the difficulty many mental health services have retaining senior mental health qualified nurses. This has led to the level of safety for clients and staff reaching a critical state.

Rather than showing true leadership by addressing the issues, the state government has stepped back, absolving itself from its overall responsibilities to the public mental health system and its employees. LHDs have now become corporate entities in their own right, with the autonomy to make business decisions that are more driven by strict budget imperatives than evidenced based best practice for best patient outcomes.

LHDs have had to resort to low cost mental health measures in order to remain in budget, all at the cost of evidenced based best practice that ensures better safety of clients. This tight fiscal strategy has had a detrimental effect on staffing levels and skill mix in mental health units and community mental health services.

¹ Auditor-General's Report Performance Audit, Mental Health workforce, NSW Health 2010, https://www.audit.nsw.gov.au/sites/default/files/pdf-downloads/2010_Dec_Report_Mental_Health_Workforce.pdf.

In NSW 'Nursing Hours Per Patient Day' (NPPD) is used as the NSW government's response to 'Nurse to Patient Ratios'. There have been immense discrepancies in many LHDs following an investigation by the NSWNMA of the nursing hours mandated under NPPD. The Association believes this lack of adequate nursing numbers on shifts has had a direct impact on the safe care for patients in those LHDs. This type of discrepancy for short term budget gains places patients at risk of poor outcomes, increase the inefficiencies in the system all under the guise of short term savings but long term financial cost to the service. This is due to longer admission times, relapses with more frequent readmissions adding to the poor outcomes for the service and patients.

It's well documented that mental health remains underfunded in proportion to the total burden of disease in Australia². The focus on an accounting model that provides care to fit a budget (that is not currently proportional to the size of the actual need) can only exacerbate inefficiencies in care provision. But by bearing the higher initial cost for improved resources to provide evidenced based best practice and best care to patients, far outweighs the short-term financial gains, when compared over the long term.

Due to understaffing and high workloads, services are only able to provide reactive measures to client management. The focus needs to be on prevention, with robust comprehensive community and hospital-based services to prevent people from reaching crisis through best practice approaches, early intervention and increased support in regional areas. We need a comprehensive team approach to management of patients before the crisis occurs, with seamless holistic support at all levels. However there still needs to be quality services available for those who do end up in crisis. One cannot be effective without the other.

² AMA Position Statement, Mental Health – 2018, Executive Summary <https://ama.com.au/position-statement/mental-health-2018>

One of the problems with the NSW public system is that there are not enough inpatient beds and admitted patients are being discharged so their bed can be made available for those more acutely ill waiting in the Emergency Department (EDs) or in the community. The inpatient near discharge is often deemed less acutely ill and discharged early due to the urgency of a bed being required, but without the discharge planning required due to the emergency of the situation.

Chronic shortage of Mental Health Intensive Care Unit (MHICU) beds

The inefficiencies of short-term savings can also be demonstrated with the number of Mental Health Intensive Care Unit (MHICU) sometimes called Psychiatric Intensive Care Unit (PICU) beds across NSW.

There were previously 62 PICU beds across NSW. In 2014 the Association wrote to the then Acting Director of the NSW Mental Health Branch to express our concern that this bed number for NSW was inadequate. The number of PICU/MHICU beds was recently reduced by approximately 20% to 52 beds across NSW, due to one major facility down grading its beds to High Dependency Unit (HDU) status, as it was unable to safely manage PICU/MHICU clients in an out dated facility. It was estimated in 2014 that there were a further 270 HDU and Obs beds across NSW Mental Health services acting in the role of de facto MHICU/PICU beds.

PICU beds catered for the highly disturbed mental health patients who are unable to be cared for safely within Local Health Districts (LHD) acute care options and are funded at the highest level of funding of any mental health service in NSW. This is in order to allow a higher level of staff to patient ratio to safely manage the patients who are in an acutely disturbed mental state. PICU/MHICU beds are constantly in short supply across the State due to very high demand, waiting times can often be weeks at a time (if a bed does become available).

HDUs and Obs units are often required to perform the same function as PICUs and manage highly disturbed clients for extended periods of time. HDU and Obs beds are not funded at the same rate as MHICU Services by the NSW Ministry and do not receive the same resourcing.

This has an impact on risk and the length of admissions and the rates of seclusion for these highly disturbed clients, as seclusion can often be the only safe option available.

The centralisation of the majority of MHICU beds in the Sydney metro region, the geographical location of rural mental health HDUs and Obs units in NSW leaves patients and staff at a disadvantage.

Privatisation of mental health services

Community based public mental health services have been neglected, with under resourcing and now lacking capacity to provide the care needed, to the point of 'failure' due to chronic underfunding.

Non-government organisations (NGOs) have been moving into the public community mental health sector. NGOs do not have to meet the same high standards and requirements that a government-based mental health service must adhere to. This allows the NGO to operate at a lower cost to the government service. However one must ask the question, is the care that NGOs are able to provide of the same quality and standard as a public mental health community service?

Community based mental health providers are failing. They do not have the skilled staff or resource capacity to ensure provision of safe patient care as required. The state government or the LHD is then expected to rescue these services to ensure care provision continues.

An example is the Neami Dubbo Mental Health Rehabilitation & Recovery Centre facility which opened in 2012-13 and co-located on the grounds of the Dubbo Base Hospital. Neami National, a non-government mental health organisation that provided support services to people with mental illness, had management of the \$7.2 million, 10-bed facility. The NSWNMA branch at Dubbo Base Hospital raised concerns about safety and blurred lines of responsibility regarding the facility operation in 2014. The facility was eventually handed back to the Far West LHD due to ongoing management issues. This facility was again put out to tender to be managed by another community-based provider following this initial failure.

The victims in this failure of mental health privatisation are always the clients of the service.

Only a regulated highly skilled nursing model will be able to provide the superior level of care required to ensure best patient outcomes, but this model needs to be resourced appropriately and supported by adequate management of funding.

The Mental Health Nurse Incentive Program (MHNIP) is an example of a very efficient program with good outcomes for clients. This program was put on hold and since has had its funding directed to Primary Health Networks (PHNs).

This means PHNs no longer need to employ community mental health nurses under the MHNIP. This has been a great loss to the community mental health sector clients due to the outcomes this program was achieving by maintaining many mental health clients in their community.

Recommendation 1

Improved funding and transparency is desperately needed for mental health services along with the immediate reversal the current government strategy for the privatisation of mental health services.

There needs to be an immediate increase of funding for more PICU/MHICU beds and units across the State. Long admissions in under resourced HDU beds is not only costly but a disservice to the clients who require this high level of care due to acuity.

Reinstate, increase and quarantine the funding of the Mental Health Nurse Incentive Program to improve community mental health services.

QUESTIONS ON MONITORING AND REPORTING OUTCOMES

Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?

Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?

To what extent is currently collected information used to improve service efficiency and effectiveness?

Data Collection

Accessing current information and data on mental health is very difficult and complex due to different reporting mechanism. There is a need for improved data collection at a national level that collects and collates data across all states and territories through a standard format that is openly transparent and allows data collected to be easily accessed for ongoing research purposes. This would help with state and territory and local LHDs in future planning needs for work force and long term strategies. Accessing current information is very difficult, complex and almost impossible.

Key Performance Indicators

Meeting Key Performance Indicators (KPIs) appears to drive the model of care we are providing, LHDs are forced to meet budget driven funding models rather than care models

that promote best practice and positive client outcomes based on patient centred care, trauma informed care and crisis prevention strategies. NSW Emergency Departments are under enormous pressure to meet time constraint created by KPIs. This has caused a need to fast track mental health clients through EDs to meet their KPIs.

The current activity-based funding model needs to be remodelled to focus on improved client outcomes rather than simply counting occasions of service as the means for funding. More occasions of service do not necessarily equate to better care. The model required needs to be based on prevention and focus on best client outcomes with the client at the centre of care, rather than focusing solely on a medical model driven by occasions of service to secure funding. We need a model that rewards a care approach and is preventative based.

Recommendation 2

An improved data collection at a national level that collects and collates data across all states and territories through a standard format that is openly transparent and allows data collected to be easily accessed.

Emergency Department KPIs for mental health need to be appropriate to and separate from the KPIs for medical/surgical clients.

The current activity-based funding model should be remodelled to focus on improved client outcomes rather than simply counting occasions of service as the means for funding.

QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS

Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?

What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?

What could be done to reduce stress and turnover among mental health workers?

Psychological injuries

How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?

Mental health nursing specialty

A lack of acknowledgment by LHDs for the competency, education and experience of specialist mental health nurses has resulted in experienced mental health nurses feeling totally undervalued.

This has led to experienced mental health nurses either moving to other areas of health, often to other positions outside of mental health that are eager to utilise their skill sets or leaving the profession altogether. This has had a detrimental effect on staffing levels and skill mix in mental health inpatient units and community mental health services. To manage the loss of experienced mental health nurses LHDs have resorted to a 'genericisation' of senior nursing management positions in mental health services.

When advertising for staff a number of LHDs have removed specialty criteria for mental health nursing experience. The loss of mental health nursing experience from the specialty of mental health has seen a loss of mental health management positions to other disciplines, particularly in community setting. This creates inefficiencies in the staffing of mental health services as you can have a manager with no mental health experience in charge of a mental health facility/unit. This impacts negatively on the clinical outcomes for the patient.

The decline in a qualified and highly experienced specialist mental health nursing workforce will leave less experienced junior nurses without adequate mentorship and role modelling by senior specialist mental health nurses. The qualifications, knowledge and competencies of senior mental health nurses is an invaluable resource we cannot afford to lose. The mentorship they provide must be available to nurses new to the specialty of mental health.

Community mental health

Non-nursing mental health professionals, such as allied health staff, are now employed in public community mental health teams and are required to manage clients on complex medication regimes without any real understanding of the medications side effects, complications or management protocols (for example clozapine). The Association is gravely concerned as this is poor practice and could lead to an extended treatment time, or worse still, a fatal outcome.

Our members working in the community have expressed deep concerns that staff are not being back filled when they go on leave. Care is compromised as clients cannot be managed appropriately due to already high work loads of community mental health staff.

One rural community team reported that their service had not been able to recruit staff in to the vacant community positions for some time (five full time positions out of seven). The two staff that were case managing clients were asked to close client's cases to help reduce the number on their books to a manageable level (even though many of the clients may have still needed ongoing case management).

Use of Community Treatment Orders (CTOs)

The Association is of the opinion that high case management numbers along with poor recruitment to positions and the use of a non-nursing staff in community mental health service have contributed to an over reliance on the use of CTOs in the community setting.³

It is difficult for nurses working in a system that relies on the coercive powers of the Mental Health Act with the use of involuntary admissions and CTOs, to embrace a holistic person centred, trauma informed model of care.

An increase in the use of coercive powers is an indication of a system that is in crisis due to insufficient resourcing and under staffing and lack of leadership, as the nursing workforce does not have the capacity to intervene effectively and early.

Nurses are faced with reactive intervention opportunities only and are forced to prioritise their efforts to those requiring immediate crisis care over preventative care interventions. There is a need to have sufficient numbers of nursing staff on all units on all shifts, to be able to ensure that the safety of patients is not compromised.

³ How shortcomings in the mental health system affect the use of involuntary community treatment orders. 2016
<https://www.publish.csiro.au/ah/fulltext/AH16074>

Community mental health work force

Number of community MH care service contacts NSW 2007-08 and 2016-17

(Table 1)^{4 5}

				Difference	% Difference
Years		2007-08	2016 -17		
Total service contacts		2,072,440	3217760	1145320	55% increase
Patient numbers		108755	128133	19378	17% increase
Average service contacts per patient		19.1	25.1	6	31% Increase

Comparing the number of community mental health care service contacts NSW for the years 2007/08 and 2016/17, we can see a 55% increase in number of services contacts over this period. Average service contacts per patient have increased by 31%. We can see occasions of service increase by 55% but patient numbers only increased by only 17% over this period.

⁴ Mental health services in Australia 2007–08 page 35,
<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-2007-08/contents/table-of-contents>

⁵ Community mental health care services 2016-17 tables
<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/community-mental-health-care-services>

Total nursing work force numbers for NSW 2007 and 2016

(Table 2)^{6 7}

			Difference	% Difference
Years	2007	2016 (Oct)		
Total Number of NSW Nurses employed	77035	93316	16176	21 % increase

The total nursing work force numbers for NSW have only increased by 21% overall during this period.

If we take this increase of all nursing numbers in NSW to be consistent with mental health and community mental health nursing numbers, then the mental health nursing community work load has increased by 34% (when the percentage difference of increased patient contact (table 1) is compared to the percentage difference in the increase to nursing workforce numbers (table 2)).

That means the community workload for nurses is 34% more in 2017 than their previous work load in 2008. This work load increase for community mental health is unsustainable and forces staff to work beyond their capacity, which can only create poor outcomes for patients.

⁶ Nursing and midwifery labour force 2007, Oct 2009.

<https://www.aihw.gov.au/reports/workforce/nursing-and-midwifery-labour-force-2007/contents/table-of-contents>

⁷ Nursing and Midwifery Board of Australia Registrant data, Reporting period: 1 October 2016 – 31 December 2016

<https://www.nursingmidwiferyboard.gov.au/about/statistics.aspx>

These results highlight two issues. Firstly, the over work of mental health nurses with a 34% increase over the period 2017 to 2016. The second issue this highlights, is activity-based funding, is this the right mechanism for funding services? If services are receiving funding based on their activity level (occasions of service), then where is the incentive to provide a service that improves peoples mental health and the preventative measures that reduce the need for occasions of service?

Does the funding model need to be based on results that achieve positive outcomes for clients, perhaps a model based on population numbers with mechanisms that account for cultural and location factors that incentivise preventative measures?

To make the gains required to meet the long-term goals for mental health, there will be a period of high costs to implement the strategies and resources required for future long term benefits to be achieved.

Recommendation 3

There needs to be a State-wide requirement that the recruitment of suitably qualified mental health nurses is a priority. The creation of more Clinical Nurse Specialist level two (CNS II) positions may encourage the recruitment and retention of senior mental health nurses.

Nurses have the competencies for medication administration and need to case manage clients on complex medication regimes. All staff should be back filled in all services to ensure staffing ratios are kept optimum for client care and safety. Vacant positions must be filled to ensure safe client care.

The numbers of nursing staff on duty need to be appropriate for the number of patients and their acuity to ensure patient safety is not compromised.

“Often we work understaffed. Patients that are supposed to be in specials are placed on care level 2 due to lack of staffing.”⁸

There is a need to have sufficient numbers of nursing staff on all units on all shifts across all mental health facilities and services, to be able to provide a safe care. NSW Health adopts the NSWNMA 2018 Ratios claim as the minimum nursing numbers required on each shift. Nurse to Patient Ratios are only a minimum and patient acuity must always be considered and appropriately managed.

Workforce development

Nurses and midwives make up the largest proportion (over 50%) of the health workforce in NSW and are in a unique position to promote good mental health across all sectors of health intervention.

Qualified and experienced RNs and ENs in acute mental health areas are required to make informed clinical decisions based on their education and expert knowledge. This is paramount for delivery of optimal health care to clients and is critical to maximising the safety of both clients and staff.

With the introduction of a combined registration for general and psychiatric nurses, mental health units are now included in the university education curriculum and modules for all nurses and the hours required are limited due to the comprehensive curriculum required.

The Association informed the NSW Minister for Mental Health in 2016, of our ongoing concerns that many nurses are being employed in acute mental health units with only a very basic mental health knowledge and education (at a novice level).

⁸ Member comment from NSWNMA Mental Health Members Survey: Engagement and Observation in Mental Health Inpatient Units, October 2018.

Mental health care is a specialty area, poor mental health skills and limited knowledge in this specialty area can compromise patient care and safety, resulting in poor outcomes for clients and the service, including higher use of seclusion, longer admissions times and possible relapse following discharge.

“Untrained and inexperienced staff including security not acceptable more happening more and more with no support to them or other members of the team. Once you had to hold a qualification to work in specialised field now any one can do it”⁹

To help ensure a comprehensive understanding of mental health, the Association recommended provision of a comprehensive education and learning program across the LHDs for nurses new to the specialty of mental health nursing, similar in format to new graduate ‘Transition to Mental Health Nursing’ program for new graduates.

We are pleased to say that a state-wide education project is now in its development stage. We believe a similar program would be of benefit nationally.

Across services, very junior nurses are being promoted to senior levels including mental health Nursing Unit Managers and Clinical Nurse Specialist (CNS) grades. There have been situations where first year registered nurses are being in charge as team leaders in acute mental health forensic units.

Inexperienced junior nurses, with limited knowledge of mental health are managing nursing teams that care for highly complex and high-risk clients, with minimal support or leadership available to them. This strategy cannot possibly provide best outcomes for clients and places

⁹ Member comment from NSWNMA Mental Health Members Survey: Engagement and Observation in Mental Health Inpatient Units, October 2018.

unreasonable responsibilities and stress on those nurses new to mental health. This practice is one of the key factor for nurses new to mental health leaving the profession prematurely.

We believe an initiative to employ Nurse Practitioners (NPs) in mental health units to act as role models for other staff new to mental health. Another initiative the Association believes would be effective is the ongoing employment of senior mental health nurses when they are considering retirement, rather than losing their valued experience on retirement, these senior nurses are offered part time employment as mentors for nursing staff working in mental health services.

Skill mix

Skill mix is more than a variation in the qualification of nursing staff rostered on duty. Skill mix encompasses the level of experience on each roster, staff can be novice to highly experienced. Skill mix can impact on the care and safety of clients and staff.

When clients are suffering from an acute illness, a high level of skill and intensity of nursing is required to manage their recovery safely and efficiently.

The available research indicates dilutions of skill mix will have adverse effects on the care to consumers.

“Both the numbers and the skill mix of nursing staff can greatly influence seclusion and restraint use. Sufficient staff must be present to make timely observations and implement alternatives very early in a situation that could become a behavioural emergency. Short staffing can contribute to greater use of restraint and seclusion -- not just because of the numbers, but because the way we tend to behave when we are short staffed can intensify a conflict. When we are short-staffed, we feel stressed and pressured and become more directive (eg, issue commands and orders, use confrontational limit setting), which can lead to greater use of restraints or seclusion to more quickly resolve a crisis.”

Alternatives to Restraint and Seclusion in Mental Health Settings: Questions and Answers From Psychiatric Nurse Experts, Laura Stokowski, 2007.¹⁰

Due to the poor retention of senior mental health staff and the lack of ability for LHDs to recruit. Extended time delays in processing applications (months) and lack of applicants with the knowledge required for the positions means mental health units frequently relying on 'pool staff' from the general wards to make up numbers. Pool staff with minimal level mental health knowledge can create more risk due to their lack of understanding with managing complex mental health clients and safe care provision can be compromised.

"The ward is frequently short staffed, or staffed with nurses who are casuals, from agencies or other wards which again increases the workload"¹¹

LHDs are attempting to address tight budget constraints by the employment of lower cost un-regulated workers to staff mental health units such as Assistants in Nursing (AINs).

The Association strongly opposes this staffing budget measure, as we are of the opinion that this situation creates a severe risk to patients and staff and would compromise high quality care, resulting in higher use of seclusion, longer admissions and poorer outcomes for patients. (Appendix 1).

In a study conducted at the Northern Sydney LHD 'Direct care activities for assistants in nursing in inpatient mental health settings in Australia: A modified Delphi study', looks at the direct care activities that were seen as acceptable to be performed by AINs. What was not found acceptable was the activity of "Conducting MSE Notify of change of Mental

¹⁰ Alternatives to Restraint and Seclusion in Mental Health Settings: Questions and Answers From Psychiatric Nurse Experts, Laura Stokowski, 2007. <http://www.medscape.com/viewarticle/555686>

¹¹ Member comment from NSWNMA Mental Health Members Survey: Engagement and Observation in Mental Health Inpatient Units, October 2018.

State”.¹² The mental status examination (MSE) or mental state assessment is one of the core components of mental health nursing.

“Sometimes the ward is under staffed or RN is replaced with an AIN, who are not trained to deal with mental health issues, not able to do medications, this makes the ward unsafe”

“Regularly understaffed, using security officers”¹³

Unqualified workers are only able to perform a custodial role in the acute mental health setting; this is in contradiction to a holistic person centred care approach and impacts on the best possible outcomes for clients under this model of care.

“The time that nurses spend with each patient in any inpatient mental health setting would conceivably include such activities as mental state assessment and assessment of risk, attempting to understand the patient’s perspective of their current situation, as well as implementing strategies to meet the care needs of those patients.”

Care zoning in a psychiatric intensive care unit: strengthening ongoing clinical risk assessment.¹⁴

Recommendation 3

As a workforce development strategy, we believe initiatives need to be developed and incentives need to be in place to retain our valuable experienced mental health nursing workforce to mentor nurses new to mental health, to help grow our own specialist mental

¹² Direct care activities for assistants in nursing in inpatient mental health settings in Australia: A modified Delphi study’, Cowan, Brunero, Lamont, Joyce, Collegian (2015) 22, 53-60, (https://www.academia.edu/17320227/Direct_care_activities_for_assistants_in_nursing_in_inpatient_mental_health_settings_in_Australia_A_modified_Delphi_study)

¹³ Member comment from NSWNMA Mental Health Members Survey: Engagement and Observation in Mental Health Inpatient Units, October 2018.

¹⁴ Care zoning in a psychiatric intensive care unit: strengthening ongoing clinical risk assessment, Antony Mullen, Vincent Drinkwater and Terry J Lewin, Journal of clinical Nursing (23, 731–743, doi: 10.1111/jocn.12493) 2013, page 732
https://www.researchgate.net/publication/259314776_Care_zoning_in_a_psychiatric_intensive_care_unit_Strengthening_ongoing_clinical_risk_assessment

health nursing workforce. Mental health nursing requires a sound theoretical base upon which experiential mentoring can establish the necessary interpersonal and competency skills needed for safe practice.

A consistent education and learning program for nurses new to the specialty of mental health nursing at a national level to ensure a high and consistent understanding of mental health for the health nursing workforce.

That the NSWNMA 2018 Ratios claim be adopted as the minimum nursing numbers required on each shift. (Appendix 2).

That skill mix must be taken into consideration in recruitment and rostering decisions. Rostering and planning to ensure shortages in mental health nursing staff, address training, recruitment, and retention of mental health nurses are addressed.

QUESTIONS ON MENTALLY HEALTHY WORKPLACES

What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?

QUESTIONS ON REGULATION OF WORKPLACE HEALTH AND SAFETY

What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs?

What workplace characteristics increase the risk of mental ill-health among employees, and how should these risks be addressed by regulators and/or employers?

QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS

Psychological injuries

Work place Health and Safety responsibilities

NSW Health reports that around 40% of violent episodes occur in mental health units. Prevention and early intervention of mental health disorders are critical elements in reducing exposure to violence, from there, providing treatment early and preventing relapses.

The primary goal of work health and safety legislation is to ensure that workplaces do not cause harm. This includes psychological harm. Employers have a duty to ensure that both physical and the psychological health of their employees is not harmed while at work.

Ensuring a positive work place culture helps build positive mental health of employees. The economic benefits to the employer are staff retention, reduced sick leave, improved productivity and lower worker's compensation costs.

Bullying is endemic in the health sector with the 'NSW Health 2018 people matter' survey reported 21% of people said they had experienced bullying in the past year and 39% had witnessed bullying in the last year.¹⁵

Violence and aggression in acute mental health is a well-known and a well-documented occurrence. Dr Pich, University of Technology Sydney (UTS), recently completed a study 'Violence in Nursing and Midwifery in NSW: Study Report' looking into the experiences of NSW Nurses and Midwives and violence at their workplace. The study involved over 3500

¹⁵ People Matter Employee Survey 2018
<https://www.psc.nsw.gov.au/reports---data/people-matter-employee-survey/agency-and-cluster-reports>

nurses and midwives making it one of the largest studies undertaken on this topic worldwide.¹⁶

Preliminary results from the study were presented at the 6th International Conference on Violence in the Health Sector in Toronto in October 2018. A copy of the report provided to the NSWNMA on this study is attached. (Appendix 3).

Key findings from the study include:

- 47% of nurses & midwives had experienced violence at work in the week prior to completing the survey
- 80% of nurses & midwives had experienced violence at work in the 6 months prior to completing the survey
- 76% perceived that the frequency of violent episodes was increasing

In mental health, 94% of nurses were involved in an episode of violence in last 6 months.

Of great concern to the Association are the perceptions of nurses and midwives about the approachability and lack of support of management following an episode of violence as identified in the recent research by Dr Pich.

While NSW Health has acknowledged the need to address safety culture and made it an element of their 12 point plan. The actions put in place to support the development of an improved safety culture have been misplaced and have so far failed to impact on addressing this important issue. Safety culture in NSW Health will not change without a significant change in the attitudes and demonstrated behaviours of leaders.

Leadership is instrumental in driving change and improvements to staff safety and the NSWNMA is firmly of the view that significant work will need to be done in order to refocus

¹⁶ Violence in Nursing and Midwifery in NSW: Study Report
<https://www.nswnma.asn.au/wp-content/uploads/2019/02/Violence-in-Nursing-and-Midwifery-in-NSW.pdf>

attention and change behaviours of leaders to ensure that safety of staff is given the priority it deserves.

Methamphetamine

Nurses & midwives in NSW are facing increased levels of violence arising from patient use of methamphetamines. While alcohol use is still responsible for greater numbers of aggressive and violent incidents, it is the nature of violence associated with ICE that makes it such a serious concern.

Methamphetamine is notorious for its association with violence characterised by its capricious and often bizarre nature and is a significant public health concern.

Based on data collected from wastewater analysis¹⁷, methamphetamine use appears to disproportionately affect some regional areas in NSW and yet these are the areas least likely to have access to training, security or sufficient staff to allow for a duress response in an emergency.

The impact from drug use has affected the ability of mental health facilities and services to manage clients efficiently dependant on the nature of the substance use.

Managing clients while they withdraw has a significant impact on the resourcing of mental health services and a significant burden on costs.

¹⁷ Drug and alcohol research connections, Wastewater analysis - what does it mean for AOD policy and practice? May 2018, <http://connections.edu.au/opinion/wastewater-analysis-what-does-it-mean-aod-policy-and-practice>

Review of the model Work Health and Safety laws

The 'Review of the model Work Health and Safety laws' report by Marie Boland, 'Recommendation 2: Make regulations dealing with psychological health'¹⁸ places psychological health very high on the list of recommendations. The primary duty of an employer is to ensure that its employees are not exposed to risks that would impact negatively on their psychological health during their work.

Safe Work Australia recently published 'Work-related psychological health and safety: A systematic approach to meeting your duties'.¹⁹ This guide outlines how employers can help protect their employee's psychological health. If we examine the high job demands outlined in this document there is no doubt that mental health nursing is very high on the list as a sustained highly demanding occupation. But as evidence from NSW Health and Dr Pich's report shows it nursing workforce (employees) are poorly supported by NSW Health, with very poor organisational change management frameworks in place.

How can mental health nurses provide a holistic person centred care model to clients with improved efficiencies in their work when they themselves are suffering from psychological harm due to poor workplace management practices including a chronic lack of resourcing and management support?

'NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022',²⁰ has addresses 'Culture and approach' and 'Leadership and governance' as enablers in the plan. These enablers must also be applied to include the staff that are employed in mental

¹⁸ Review of the model Work Health and Safety laws Final report December 2018

Marie Boland

https://www.safeworkaustralia.gov.au/system/files/documents/1902/review_of_the_model_whs_laws_final_report_0.pdf

¹⁹ Work-related psychological health and safety: A systematic approach to meeting your duties' Safe Work Australia.

https://www.safeworkaustralia.gov.au/system/files/documents/1806/work-related_psychological_health_and_safety_guide.pdf

²⁰ NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022,

<https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mh-strategic-framework.pdf>

health services to ensure the vision for mental health outlined in the five year plan is achieved.

Leadership towards organisational change must provide guidance to staff on alternative and evidenced based clinical practice. Leadership by management is not demonstrated through the basic control measure of policies and checkbox list enforcement alone. The plan must recognise the essential role of leaders in the development of a safety culture and ensure that leaders demonstrate commitment to staff safety in their decisions and behaviours.

Recommendations 4

The NSW government must be held accountable for its current lack of action addressing its own shortcomings as an employer in the NSW Health services in regard to bullying and the high level of violence impacting on its staff in the workplace.

That NSW Health develop specific patient management and treatment pathways for patients using ICE.

There needs to be a real transparent commitment from management at all levels to ensure the psychological health of the mental health nursing workforce is protected. Clear leadership with robust governance processes is required at all levels of management, this includes nursing leadership, with consistent State-wide processes and models of care will help drive the required culture change at all levels

QUESTIONS ON JUSTICE

What mental health supports earlier in life are most effective in reducing contact with the justice system?

QUESTIONS ON EDUCATION AND TRAINING

Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?

Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?

How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?

Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?

School Nurse Positions and public mental health perinatal beds

There needs to be a comprehensive national system-wide approach to mental healthcare that address the needs of the population before they are affected by poor mental health.

True mental health reform must include a holistic approach that looks at the whole of life for prevention and social supports for all people in our society. Investment in mental health prevention begins before birth and continues throughout school years, adulthood to retirement and beyond.

No one contests current evidence that mental health is influenced by psycho-social factors and that many severe mental disorders which appear in late adolescence or early adulthood may be associated with risk factors that manifest themselves in early childhood and early schooling.

Long term studies indicate the absence of interventions in childhood for mental health problems may have profound socio-economic consequences in adulthood. The economic consequences of failure to nurture and protect children from mental ill health is the very

high cost of care in their adult life and the children affected will not be able to achieve their full potential.²¹

We all understand the long term economic benefits of promoting the mental health and wellbeing of children. Most of these benefits of early mental health intervention through perinatal and early childhood can often have greater impact outside health such as criminal justice and improved education prospects.

The US private prison enterprise base their future planning algorithms on the literacy rate of 8 to 10 year old's in the population as "literacy levels have been shown to have a direct correlation with each person's future success rates, or the likelihood they'll become involved in the criminal justice system" ²²

Improved performance has long term benefits for the individual and their community. But true holistic support for the individual must be provided by supporting at risk parents through robust mental health perinatal programs and by the increased availability of mental health perinatal beds across the state. NSW currently relies on private beds to cover perinatal interventions.

School nurses can assist in providing coverage for early intervention of students.

NSW school nurse numbers have been on a marked decline over recent years due to NSW Education budget measures. This valuable early childhood school resource has been replaced by Student Learning Support Officers (SLSOs) now supervising health care

²¹ MAKING THE LONG-TERM ECONOMIC CASE FOR INVESTING IN MENTAL HEALTH TO CONTRIBUTE TO SUSTAINABILITY FROM A HEALTH, PUBLIC SECTOR AND SOCIETAL PERSPECTIVE

Written by David McDaid, under the IMPACT contract to support the European Pact for Mental Health and Well-being

²² Basic Literacy A Crucial Tool To Stem School To Prison Pipeline May 12, 2017, https://www.huffingtonpost.com/entry/basic-literacy-a-crucial-tool-to-stem-school-to-prison_us_59149393e4b01ad573dac1dd

required by students. SLSOs are often expected to perform duties far beyond their training and competency levels.

School nurses hold a position of trust and have a high level of respect in the school community. They have the skills and competencies to provide the health care required by the student and can also have a direct role in the provision of mental health care to students.

Psychosis often develops in adolescence or early adulthood; the longer it goes unrecognised, the more impact it can have on quality of life of the individual and increase the costs related to the health, social wellbeing and social inclusion of the individual and the community.

Recommendation 5

Reinstate school nurse positions across all public schools in NSW.

NSW Health urgently needs to commission a public mental health perinatal unit.

Conclusion

The specialty of mental health nursing appears to be at the mercy of cost constraints, understaffing and high workloads that are creating a situation where a low cost business model is adopted in mental health services with the ability to only provide reactive measures to client management.

The focus needs to be on prevention. Robust comprehensive community and hospital-based services must be provided to prevent people from reaching crisis point. Best practice approaches, early intervention and increased support in regional areas is required. We need a comprehensive team approach to management of patients before a crisis occurs, with seamless holistic support at all levels.

Nurses are well positioned in the support of people throughout their life span as nurses are across all aspects of health care and are the largest profession in the health workforce making up over 50% of the workforce in NSW. Often the mental health of the nursing workforce is overlooked. In our view supporting the mental health of the nursing workforce is imperative.

We need to ensure appropriate support for training is available to develop nurses at a clinical level to work safely and be able to change the culture from budget driven efficiencies to an effective recovery orientated and trauma informed care. This approach will be far more effective in improving the safety and outcomes for clients. However without the right leadership at all levels of management, true change and long term efficiencies cannot be realised.

The Association strongly advocates that all NSW LHDs adopt nurse to patient ratios as a minimum staffing level in their mental health services as this is the minimum nursing numbers able to provide the best care possible.

Appendices

Appendix 1: Assistants in Nursing (AINs) in PICU - the evidence to oppose.

Appendix 2: Ratios A claim to put patient safety first 2017.

Appendix 3: Violence in Nursing and Midwifery in NSW Study Report



Submission to Productivity Commission inquiry into 'The Social and Economic Benefits of Improving Mental Health'

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