the Australian College of Mental Health Nurses Inc.

Statutory Review of the Western Australia Mental Health Act (2014)

Australian College of Mental Health Nurses submission

January 2022: Condensed

Introduction

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. The primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of excellence in mental health nursing, and by supporting improvement of services and delivery of care to people affected by mental ill-health, their families, carers, support person/s and communities. The ACMHN additionally insists that there is greater emphasis on mental health promotion to reduce the need for people to access mental health services. The ACMHN also sets standards of practice for the nursing profession, is the credentialing body for mental health nurses (MHNs) and promotes best practice of mental health nursing in Australia.

The ACMHN has a growing and active membership in Western Australia (WA) working across a diverse range of settings including public bed-based and community mental health services, hospital consultation and liaison, alcohol and other drug services, forensic services, prisons and correctional health services, Headspace centres, private mental health services, psychotherapy practices, specialist organisations including family violence, refugee and multicultural services, transcultural health, LGBTQIA+ services, general health and community care services, primary health care and medical settings, schools and other educational settings, academic roles including teaching and research positions in higher education institutions throughout the state, infant and maternal health services, women's health, family services, health promotion arenas, child and youth healthcare, aged care services, disability sector and within the public service.

The ACMHN (WA Branch) welcomes the opportunity to make a submission to the discussion paper pertaining to the WA Mental Health Act 2014. The focus of our submission is to reflect the experiences of those in the mental health nursing workforce in relation to their professional practice when working alongside people with lived experience of mental ill-health and psychological distress, their families, carers and other supporters. The ACMHN emphasises that mental health nurses are working within a sector that has been severely under-resourced and many of our members continue to work within environments that are outdated and often not designed or built to address the requirements of contemporary mental health care. We are mindful that at this particular time, there are also increasing reports of high levels of fatigue and distress amongst the WA specialist mental health workforce that does not appear to have had a response. If left unaddressed, this poses a serious threat to any successful implementation of changes intended to realise the objective of the *WA Mental Health, Alcohol and Other Drugs Plan 2015-2025*, which is focused on reform. The Plan was released in December 2015 and outlines the

optimal mix and level of mental health and AOD services required to meet the needs of Western Australians until the end of 2025. The Plan sets the strategic direction for the mental health and AOD sector. It provides a guide for investment decisions and priority setting for the Commission and all levels of government and non-government stakeholders rather than the higher vision of achievement of the highest attainable standard of mental health and wellbeing for the people of Western Australia which is what the ACMHN believes should be the case and the WA Mental Health Act being one part of this vision.

The ACMHN, as a national body, has made multiple references in this submission to the Victoria Royal Commission statements and recommendations, which we believe embody some of the future direction for mental health services within WA and are currently absent within the WA Mental Health Act.

The ACMHN identifies the following key points:

1. People with experiences of mental ill-health, their families, carers, other supporters and communities have a right to receive specialised nursing care and treatment from suitably qualified and experienced mental health nurses. The ACMHN seeks that access via a nationally-regulated clinical workforce who are qualified in mental health be added to the definition of mental health nurse within any amended legislation, with the emphasis being on a recognised mental health nurse via the credentialing process. To enable this, there should be reconsideration of an undergraduate mental health nursing program, as highlighted in the *Productivity Inquiry Report, Mental Health*, stating it should develop a new curriculum standard for a three-year direct-entry undergraduate degree in mental health nursing. In addition, a discrete unit on mental health should be included in all nurse training courses. (Action 16.4)
2. Consistent with Victorian Royal Commission Recommendation 42.2e which states '*The government should also ensure the Mental Health and Wellbeing Act specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint*'; the ACMHN proposes, as essential and necessary requirements, specific inclusion of legislative obligations for building workforce capability and ongoing professional development. This would include, but not be limited to, provisions within the Act mandating co-designed and co-delivered core competencies in cultural safety, gender diversity and sexual safety, supported decision making, advance statements, trauma-informed care, family violence, working with families/carers/support people, upholding human rights, reducing restrictive interventions and ongoing and facilitating clinical supervision. It is proposed that this could also include a mandate that encourages and

supports innovation in mental health nursing practice models.

3. Consistent with Victoria Royal Commission Recommendation 42.2a which quotes '*The government should also ensure the Mental Health and Wellbeing Act provides a diverse range of comprehensive, safe and high-quality mental health and wellbeing services'* (State of Victoria, 2021, p. 11); the ACMHN proposes inclusion of legislative obligations mandating for all mental health bed-based environment budgets to include clear and adequate provisions for funded resources to enable the workforce to work therapeutically with people including, but not be limited to: purchasing and replenishing models such as Safewards Model of Care resources; purchasing and replenishing sensory modulation equipment; providing resources for group therapies and activities every day and evening; and adequate IT devices for access to advocates. It has already been demonstrated that it is insufficient for these requirements to be articulated in guidelines or departmental policy, given these have not been sufficiently influential to effect sustainable implementation.
4. It is essential to ensure that proposed legislative changes do not have a negative impact on mental health nurses utilising professional clinical judgement and decision-making skills when assessing and responding to consumers risk towards self and/or others and having clear risk assessment pathways and processes which support patient involvement and self-determination.
5. There should be adequate resources and programs of learning and development to uphold the stated provisions for families, carers and supporters.
6. Safety for all is a significant issue and this impacts on our members and all people involved. Enhancing the actual and perceived safety of mental health nurses is essential to achieving further reductions in the use of seclusion and restraint in mental health settings.
7. It may assist any guidance developed for health services and the workforce regarding implementation and adherence with any amendments of legislation to include template policy, procedures and plans. We suggest that this would reduce the potential for interpretation inconsistencies (and therefore practices) and minimise inefficiencies associated with each organisation needing to independently create these.
8. The ACMHN seeks an approach of an independent centralised Mental Health Practice Standards Unit committed to the effective delivery of the WA Mental Health Act. The ACMHN also proposes that these responsibilities would be enriched by establishing a Clinical Advisory Group to inform the Practice Standards Unit work. This must include mental health nurses from the clinical workforce, mental health nurses in leadership positions and

mental health nurses in learning and development/education/research positions alongside other workforce representatives. Provision of such a Unit and its functions within this legislation is the only way to provide certainty of consistent services and interventions to people with lived experiences of mental ill-health, their families, carers and supporters, the workforce and service providers.

9. This Practice Standards Unit could potentially offer:
    a. Education and training programs on safeguards and supported decision-making for consumers, families, carers and supporters, as well as the mental health workforce,
    b. Provide for advance statements and nominated persons registers,
    c. Support service providers to ensure consumers receive a statement of rights and responsibilities on entry to the service and to ensure the statement is provided in a range of languages and formats,
    d. Increase consumer leadership and participation in all activities to reduce compulsory treatment,
    e. Support the design and implementation of local programs, informed by data, to reduce compulsory treatment,
    f. Make available workforce training on non-coercive options for treatment that is underpinned by human rights, safety, cultural sensitivity and supported decision-making principles,
    g. Practice improvement and support to providers of acute mental health inpatient services to work towards elimination of seclusion and restraint, and to embed trauma-informed care as part of practice,
    h. Co-design with mental health services and people with lived experience a range of programs and supports aligned with the strategy that focuses on:
        i. Working with each mental health service (public, private, not for profit and residential) to investigate local data and practices in order to identify priority areas for change,
        ii. Making workforce training available for services, and
        iii. Supporting services to embed safety systems such as Safewards program.
    i. Support service providers to ensure the mental health advocacy service is informed and updated of consumers under 18 years of age placed on Form 1A and all other consumers placed on treatment orders within designated time frames.
10. The ACMHN seeks for the legislation to mandate that a standardised post event seclusion protocol, for the person who is subject to the intervention, be implemented.
11. The ACMHN membership has raised the inadequacy of forensic mental

health services within the state and that people who have offended are potentially not afforded their full rights as they would have via the Criminal Law Mentally Impaired Accused (CLMIA) as they are held under the WA Mental Health 2014. The ACMHN requests an urgent review of the CLMIA to ensure alignment with any amendments to the WA Mental Health Act 2014.

12. The ACMHN has a requirement as a standard of the profession for clinical supervision to be undertaken. The ACMHN has a preference for a documented requirement that the Authorised Mental Health Practitioner (AMHP) who is a nurse is required to undertake a minimum standard of one hour per month of formalised documented clinical supervision, supported by their organisation. Ideally these senior practitioners should be recognised as credentialed mental health nurses via the ACMHN as part of the gazetting as an AMHP.
13. The ACMHN does not support unregistered practitioners in the role of AMHP, i.e. social workers. As a minimum, they should be required to show evidence of being a credentialed mental health social worker prior to gazetting as an AMHP.

Mental health nurses provide specialist mental health care

A mental health nurse is a registered or enrolled nurse who holds a recognised specialist qualification in mental health nursing. This also extends to mental health nurse practitioners who have a regulated advanced scope of practice. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who are living with mental ill-health, their family, carers and community, towards recovery as defined by the individual (ACMHN, 2010).

The scope of practice of mental health nurses in Australia is:

- nested within a holistic theoretical and clinical framework encompassing the biological, cognitive, cultural, educational, emotional, environmental, functional, mental, occupational, physical, psychological, relational, sexual, social, and spiritual aspects of individuals and communities;
- distinguished by person-centred and consumer-focused therapeutic approaches, to deliver specialised, recovery-oriented, evidence-based care to all people, from all cultures, across the lifespan and developmental stages, across diverse settings;
- characterised by engagement and relationships with consumers; partnerships and collaboration with carers, families, significant others, other members of the multidisciplinary team, and communities;
- underpinned by personal and professional reflection (ACMHN, 2013), the scope of practice of mental health nurses in Australia encompasses a wide range of

> nursing roles, functions, responsibilities, accountabilities, activities and creativities, modalities and innovations; and is founded upon ethical decision-making. This diversity is fundamental to promoting optimal physical and mental health; preventing physical and mental illness; and providing therapeutic interventions and treatment to support the physical and mental health preferences and needs of individuals, communities and population groups.

The scope of practice of mental health nurses in Australia is influenced by diverse contextual, cultural, educational, environmental, ethical, financial, informational, political, regulatory and/or legislative, social, technological, and other factors. Consequently, the scope of practice of mental health nurses in Australia is dynamic - responding effectively to change and developing over time.

Mental health consumers, their families and communities have a right to receive nursing care and treatment from suitably qualified and experienced nurses, that is, mental health nurses.

The WA Mental Health Act 2014: What is working within the Act, what is not working within the Act, and how this impacts mental health nurses.

Membership has recognised that the *Mental Health Act 2014* is an improvement on the previous in relation to rights for the consumer, expansion of the Authorised Mental Health Practitioner role and the Senior Mental Health Practitioner role specifically.

However, it was recognised early in implementation, that the reform and implementation of the Act was inadequately resourced within multiple systems. Factors highlighted from this include:

- The burden and length of the MHA e-learning package resulting in consistently poor completion mental health compliance.
- Limited avenues for advice regarding *Mental Health Act* processes and pathways, especially during afterhours.
- Inconsistent and ill-defined relationships between the Mental Health Tribunal and Mental Health Advocacy Service.

These systematic issues when coupled with the erosion of the senior mental health nursing structure and the routine practice of consultant psychiatrists who delegate their burdened workload to nursing staff results in increased pressure on mental health nursing workforce to conduct paper-based tasks which in turn reduce the

face-to-face time between mental health nurses and consumers.

Mental health nurses have highlighted the burden of excessive paperwork in the current requirements for seclusion and restraint forms. These are primarily completed by mental health nurses within acute settings and during times of high ward acuity. Mental health nursing staff in these settings have inadequate systems to reduce repetition. The motivation to reduce seclusion and restraint events should focus on the best possible treatment for the consumer at that time to promote their and others safety. As mentioned above, therapeutic models of care such as Safewards, should be prioritised within acute settings as an ongoing and sustainable approach to reducing conflict and containment.

As mentioned above, improved resources and electronic support systems should be available to complete discharge planning and electronic signatures by mental health staff with consumers.

Mental health nurses have also expressed concerns on the lack of clarity regarding the content of Community Treatment Order parameters, resulting in a seemingly punitive approach towards consumers, particularly around substance use.

A lack of accessibility to databases which hold information of endorsed traditional healers is a concern raised by our membership and ultimately leads to an inability in the provision of this right.

The ACMHN strongly believes the definition of a mental health practitioner under section 538 related to section 222 and 238 must be amended.

> *A mental health practitioner is a person who, as one of the following, has at least three years' experience in the management of people who have a mental illness —*
>
> *(a) a psychologist;*
>
> *(b) a nurse whose name is entered on Division 1 of the Register of Nurses kept under the Health Practitioner Regulation National Law (Western Australia) as a registered nurse;*
>
> *(c) an occupational therapist;*
>
> *(d) a social worker.*

A psychologist, occupational therapist or social worker <u>do not</u> possess the skillset in physiological observations to be able to adequately and safely monitor a consumer in either a restraint or seclusion situation.

Will a change in the Act improve this for mental health nurses?

Regarding section 222 and 238 and the exclusion of inadequately skilled workforce, this improves standards for the consumer.

The enhanced requirement of credentialing as a mental health nurse for gazetting for AMHP ensures those undertaking this enhanced role are suitably experienced and qualified.

If a change in the Act is not needed, how can change be achieved? Policies, procedures, guidelines and education.

The establishment of a Mental Health Practice Standards Unit with the brief outlined to deliver on critical workforce enhancement requirements of:

- Evidenced-based education and training program provision on safeguards and supported decision making,
- Continuing to support services to embed Safewards Model of Care,
- Increase collaboration with the consumer and peer workforce leadership, integration and participation in all activities to reduce compulsory treatment and enhance consumer-centred care planning and delivery,
- Support the design and implementation of local programs, informed by data, to reduce compulsory treatment,
- Make available workforce training on non-coercive options for treatment that is underpinned by human rights, safety and supported decision-making principles,
- Support practice improvement and support to providers of acute mental health inpatient services to work towards elimination of seclusion and restraint, and
- Embed trauma-informed care as part of effective practice.

The ACMHN proposes mandating an outline of the responsibilities of the independent Mental Health Practice Standards Unit within the legislation which would provide transparency and also ensure people impacted by the legislation are aware of the different entities and their responsibilities in relation to this legislation. The need for ongoing learning and development programs for the workforce cannot be underestimated. As stated earlier, we seek that such requirements are included in the legislation to ensure the broad vision can be achieved.

Final comments

The ACMHN recognises that the Act maintains a focus on actions associated with compulsory treatment and recommends more inclusions of safeguards intended to minimise restrictions to human rights. We would welcome the inclusion of a mandate of rights for all people accessing the services irrespective of whether this is within an authorised unit, i.e.: includes general health beds for a primary mental health presentation and emergency department areas, whether they are designated as voluntary/informal or subject to compulsory treatment. This aligns with the professional standards and codes for mental health nurses to advocate for and uphold the preferences and rights of all people in their care.

The ACMHN proposes specific legislation that includes a requirement for all mental health bed-based environment budgets to encompass clear and adequate provisions for funded resources. This would enable the workforce to practice therapeutically with people including, but not be limited to, purchasing and replenishing Safewards resources, purchasing and replenishing sensory modulation equipment, providing resources for daily group therapies and activities every day and evening and adequate IT devices for access to advocates and paperwork completion.

More broadly, the ACMHN suggests that there will need to be adequate resources and programs of learning and development to uphold the stated provisions for families, carers and supporters.

The Australian Charter of Healthcare Rights (second edition) describes the rights of people using the Australian Health System including access, safety, respect, communication, participation, privacy and feedback (Australian Commission on Safety and Quality in Health Care, 2019). Most health services will have policy and procedures that includes the provision to discuss and provide written information on these and undertake other actions to raise awareness. It may be useful to ensure there is reference to these in the updated Act.

Recent Australian research suggests nurses have concerns/unease and can experience fear associated with managing aggressive or violent consumers without restrictive measures. The issue of fear at work as a feature of clinical practice in mental health nursing is as yet not fully elucidated. Personal and clinical experience for mental health nursing staff has not significantly changed over the past 14 years with findings reported by Bigwood and Crowe (2008) being mirrored in more recent studies conducted by Power et al. (2020), Muir-Cochrane et al. (2018), and others.

That fear is an issue for mental health nurses is perhaps not surprising. Mental health nurses experience a higher rate of physical aggression than nurses in any other health care settings or other professionals within the mental health environment (Muir-Cochrane et al, 2018). The lifetime risk of assault for nurses in mental health settings is estimated to be 'approaching 100 per cent' (Renwick et al, 2019). This high risk of assault is known to negatively influence emotional, social and psychological wellbeing in nurses and can generate a range of physical injuries such as open wounds, bruising and sprains, and emotional injuries including self-doubt, confusion, anger, guilt, shame and an increased risk of developing post-traumatic stress disorder.

Fear of assault has also been shown to influence clinical decision-making in relation to management of aggression, seclusion and restraint (Doedens et al, 2020; McKeown et al, 2019; Muir-Cochrane et al, 2018; & Renwick et al, 2019). Staff feelings and perceptions of their own personal safety have been associated with use of coercive containment methods such as seclusion and restraint in mental health settings.

Similarly, it can be challenging for mental health nursing staff to transfer their theoretical understanding of recovery and trauma-informed care into practice when the model of care delivery, ward culture, education and resources do not assist in facilitating and promoting this. Ongoing support and implementation for research-based frameworks, such as Safewards, can empower nursing staff to deliver safe and effective care, with improved consumer autonomy and secondary reduction in conflict and containment events (Fletcher et al, 2017; 2019).

Workplace safety for nurses is a significant issue in achieving organisational and professional goals around reduced incidence of seclusion and restraint. Accordingly, addressing the work environment to enhance actual and perceived safety of nurses is essential to achieving further reductions in seclusion and restraint in mental health setting.

The ACMHN is committed to ensuring the best possible care delivery for mental health consumers whilst also honouring the government's directive to reduce, and where possible eliminate, seclusion and restraint events. It is clear that to achieve this there needs to be increased safety for both consumers and the workforce, particularly nursing staff. Improving the actual and perceived safety of nursing staff is crucial to reduce the use of seclusion and restraint.

ACMHN believes the actions that will increase safety in care and safety at work include:

1. A continued and sustained focus on improving safety for all within Australian mental health services, including the provision of appropriate funding for safety-related activities.
2. The provision of sufficient inpatient and community mental health facilities to meet the demand.
3. Provision of clinical supervision for all mental health nursing staff across both public and private sectors.
4. Ensuring vacant mental health nursing positions are filled.
5. Ensuring all nurses working in mental health services are appropriately qualified and supported to engage in continuous professional development.
6. Ensuring the skill mix of personnel recruited to mental health services includes leadership from experienced mental health nurses and that less experienced nurses are supported to develop their knowledge and practice skills.
7. Inexperienced nurses with limited mental health knowledge and skills should not be promoted to senior nursing positions (nurse manager, team leader).
8. Ensuring nurse-to-patient ratios and skill mix across all shifts appropriately reflect consumer needs and clinical acuity.
9. Ensuring service funding models reflect clinical realities.
10. Systems that support clinical service delivery are consumer-focused with information readily available in all settings the consumer interacts with, including the innovation of consumer accessibility to participate in outcome input and monitoring.
11. Exploring and implementing innovative models focused on improving safety in care, such as the *Scottish Patient Safety Program – Improving Observation Practice* which reflects a shift in mind-set based on emerging good practice within mental health inpatient culture and practice, utilising a proactive intervention based approach to care, treatment and safety based on prevention, early recognition and early response strategies to address potential or actual consumer deterioration of health, wellbeing or risk. This approach applies proactively to all consumers in the ward. This represents a move away from centralising the use of observation status to determine and describe the nature and extent of care, treatment and safety planning and associated intervention and interaction an individual requires. Instead, care, treatment and safety planning are guided by the identified specific clinical needs of the individual.

The opportunity to specifically address a reduction in duplication of actions that are currently delivering little value to the consumer, system enhancement, mental health nurses working to their full scope of practice and ensuring they have time to care is too important to miss at the regulatory level. The ACMHN recognises that this would provide people with lived experiences of mental ill-health, their families, carers and supporters, the workforce and service providers with adequately funded legislative mandates instead of reliance on historical approaches of departmental guidance whereby implementation is elective.

This submission by the ACMHN outlines possible avenues for improving the proposed legislative revision. We anticipate and encourage joint participation in the progression and ongoing development of the Western Australian Mental Health system.

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