HACSU

Health & Community Services Union

Better Mental Health for Victoria

Authorised by HACSU State Secretary Paul Healey,
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About HACSU

The Health and Community Services Union (HACSU) is Victoria's only specialist union for the disability, mental health, and alcohol and other drugs industries. We represent the industrial, political, social and professional interests of over 10,000 Victorian workers.

HACSU's members work across public and private mental health, disability and AOD. We work to improve our member's working conditions and the services they provide to vulnerable Victorians.

We're a strong and growing union, and our links into the sectors we cover give us a complete look at the health and community services systems in Victoria. Our members have unique insight into what's needed to deliver safer services for both workers and consumers.

HACSU was founded in 1911 and our long history has shown that when working people come together, we win. We're proud to be a diverse and vibrant union with members dedicated to fighting and achieving major wins in their jobs, their workplaces, and their sectors.

Foreword

Paul Healey, HACSU State Secretary

For years, frontline mental health workers have spoken about how Victoria's mental health system does not deliver for consumers and does not go far enough in building a strong and sustainable workforce. The Royal Commission into Victoria's Mental Health System (RCVMHS) identified and confirmed that the system is broken, and that urgent reform is required to create a system that is fit for purpose.

Consumers deserve a holistic, integrated, and responsive service system, delivered by adequate numbers of multidisciplinary, qualified, skilled, and supported mental health workers. To achieve these broad, macro reforms that require complete philosophical shifts away from how services are currently delivered, it is the view of HACSU and our members that we review the fundamentals of how our consumers are cared for and equally how the workforce are supported to deliver that care.

While preparing this plan, HACSU members have organised meetings in their workplaces, they have invited Members of Parliament to their services, and have attended parliament. They have answered questions in surveys, been part of reference groups and steering committees, and have raised concerns with their officials – all while delivering care to some of Victoria's most vulnerable consumers.

HACSU members are progressive, empathetic, inspiring, and have a deep knowledge and understanding of how to roll out the Royal Commission's recommendations in such a way where they are supported. They know, as I know, that in the most challenging of circumstances, consumers deserve a highly skilled and trained workforce to support them when they need it most.

The plans put forward are designed to bolster the courageous work of the Victorian government in implementing a Royal Commission and with the knock-on effects of the COVID-19 pandemic, they are arguably more important now than ever. To achieve the ambitious agenda set by the Royal Commission, all stakeholders, services, sectors, leaders, and allied organisations must work together in the spirit of collaboration.

We know that these practical steps will ensure that Victoria's Mental Health System is one that will firmly cement Victoria's place as the world leader in mental health care.

Victorians simply cannot wait.

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Paul Healey
HACSU State Secretary

A Safe, Strong and Secure Workforce

In order to deliver on the recommendations of the Royal Commission into Victoria's Mental Health System (RCVMHS), HACSU members know that every facet of the sector must be equally fostered, funded and valued. For far too long, inadequate and inconsistent funding principles and a lack of understanding of what mental health professionals do has plagued the sector. This has resulted in dangerous gaps and silences in all bed-based and community mental health settings and has created a two-tier workforce due to an unfair erosion of wages and conditions.

While some key wins have been achieved such as qualifications allowances for the lived experience workforce and conditions parity for allied health workers with their nursing counterparts, there is still much to do. As a matter of urgency, HACSU members are determined to secure fair wages and conditions for all divisions of the mental health sector.

Ringfencing and Accountability of Funding Services

The Department of Health has agreed that the day rate for hospital-based mental health beds is costed at a revised rate of $1,684.00. While this is an increase from the rates prior to the Royal Commission, it is clear that is still lower than what is required. This has resulted in activity-based funding for services being cut and outrageous instances of public funding blocks being eaten up by unstructured corporate charges with no accountability.

We need to ensure all mental health services have a variety of bed-stock; are fully staffed and able to provide timely recovery focused services. HACSU is proposing a change to the model of funding hospitals receive to run mental health services. By separating the funding and creating accountability to fund all services adequately, across all levels of acuity, the robing of community teams to fund acute bed-based services will be stopped.

Allied Health Pay Parity

Allied health workers are paid upwards of $12,000 less than their mental health nursing colleagues for doing the same job.

While HACSU members welcome the $1.3 billion investment into the mental health workforce, inclusive of 615 allied health positions, 6 transition educators and 53 additional graduate educator positions in the recent State budget, concerns remain regarding the issue of pay parity with their mental health nursing colleagues.

Retention payments won for allied health professionals in the previous round of bargaining were welcomed across the board to assist with staff retention within the public system. Whilst these payments will put allied health at higher equivalent wage outcome, as they are starting from a lower base of pay, this intervention will simply not do enough to bolster an already struggling workforce.

The Royal Commission into Victoria's Mental Health System solidified the state's commitment to lean into community mental health principles inclusive of a focus on prevention measures. HACSU emphatically supports this shift, as we know that a strong focus in community settings drastically reduces

the frequency of inpatient admissions.

Key to this shift is a strong, secure workforce who work together in a team to meet our community members where they are in their mental health journey. Allied health professionals are critical in treating, caring for and supporting people with their mental ill-health and the Andrews' Labor government know this.

Community mental health teams are funded via area mental health and wellbeing services, inclusive of Community and Police Response (PACER), Crisis Assessment and Treatment (CATT), Mobile Support Team (MST), Homeless Outreach Psychiatric Services (HOPS) and Hospital Outreach Post-Suicidal Engagement, and include a range of clinicians who are employed to the same position descriptions but are paid differently based on the type of clinical degree they hold.

The Victorian government has indicated that it wants to double the amount of allied health practitioners in the next 3 years, equating to approximately 1405 new staff. At present this shift will not be possible until the allied health workforce is recognised in the same way as mental health nurses.

To cement this process of moving towards parity, HACSU is also calling on the government to establish state-wide leaders for social work and occupational therapy in the department of health to provide further leadership in practice and research. Modelled on the mental health nursing officer position within the department, it is our view that these roles would also provide critical guidance and leadership for the current allied health educators as well as the wider workforce.

Administrative Workers

Administrative workers are the engine room of every area mental health service and yet have the lowest wages and conditions of the entire sector.

As it stands, there are no career paths or structures for the administrative workers who play a vital role in every area mental health service and team.

There is no meaningful career structure or educational pillars embedded into the sector, which has inevitably resulted in many shifts not being filled and the few administrative workers who are currently employed being extremely burnt out and left feeling undervalued.

The issues to blame for the administrative pressures have resulted in a false economy. As the work must be completed, if administrative workers are not available, it is clinicians who complete the work. This results in less time available to care for consumers and far more stress for all staff.

It is urgent that a stepped out, supported structure be implemented for the administrative workforce, with pay and conditions commensurate with experience and the ability to access training and further education.

All area mental health services require more administrative EFT to ensure the right balance of staff are available for all service users to access. Backfill during break times is essential, as is a review of the role and size of all clinical administration teams in line with significant increase in the size of the service. At present, this does not occur.

As the RCVMHS is requiring far more data

than ever before, HACSU recommend implementing dedicated statisticians at each area mental health service to allow clinicians to focus on their work.

Lived and Living Experience Workforces

The Royal Commission acknowledged the invaluable experience that those with lived and living experience bring to the important work of the mental health sector. While HACSU agrees that lived and living experience workforces must be embedded into every part of the mental health sector, we must ensure that this is not just viewed as a job but is viewed as a career to ensure job security and opportunities for growth.

As well as the qualifications allowance that has been won in our most recent round of bargaining, HACSU are rolling out a structured four pillar program for the lived and living experience workforce. These include practice, management, education, and research and will also apply to the alcohol and other drugs (AOD) lived and living experience workforce.

It is essential the strong career paths and structures are implemented to encourage people to stay within the mental health and wellbeing sector and work towards senior positions. To do this Victoria must move to urgently expand lived and living experience educators in all workplaces to embed practice supervision. These educators should be present in every mental health service to assist the workforce to cope with the rapid expansion of their discipline.

HACSU members know that appropriate support, supervision, and education for the workforce will provide job security and will provide sustainable long-term careers.

Frontline Mental Health Workers

The COVID pandemic has significantly increased the pressure placed on mental health workers and in turn highlighted the need for greater support for this workforce. The RCVMHS recommendations 16 and 59 describe the importance of maintaining healthy and safe workplaces and detail the interventions and supports required to do this. One intervention that already exists is the Nursing and Midwifery Health Program which offers support services for nurses and midwives who have issues related to their mental health, substance use, family violence or any issue affecting their health and wellbeing.

HACSU supports the work of the Nursing and Midwifery Health Program and the services it provides to our nursing members but believe that the rest of the mental health workforce would also benefit from this program. This program must extend its reach to include all workers working in the mental health sector or alternatively for a parallel program to be established that encompasses all those people working within the mental health sector.

Strategic and Sustainable Workforce Development

While HACSU members welcome the 908.6 new FTE fought and won by our members, the issue remains that there are chronic staffing shortages across the mental health sector.

This staffing crisis is exacerbated by what is, fundamentally, an aging workforce.

Recruitment and retention of staff within the Mental Health sector is challenging. HACSU members know that we must see more value placed on the specialised nature of the work required in the sector.

Experienced workers are leaving the sector altogether, due to feeling unsupported, overworked, and understaffed. The experienced workers left in the system are further burdened, by the simple fact that there are not enough of them, so they are relied on more heavily and become the 'go to' person, burning them out at a quicker rate.

The lack of senior, more experienced staff means that there are increasingly more junior staff being put in charge of shifts and into roles that through no fault of their own, they are not professionally or clinically ready for. This inevitably places them under more pressure and increased risk. The knowledge, competency and professional development of these people is further impacted by the lack of more senior experienced staff members to supervise and mentor them.

A major cause of the supply shortage is the mental health graduate intake system. It is one thing to create graduate FTE, but another to be able to fill these positions.

We need more prequalification workers across nursing, allied health, administration and lived experience to support and build interest in the sector and increase the likelihood of the prequalification workers choosing to continue working in the services after graduation.

With these new positions, comes a greater need for support and supervision.

Reintroduction of Direct Entry Nursing to Build Confidence

In the mental health sector, there is a general understanding that undergraduate students aren't given enough support or encouragement to specialise in mental health. Victoria needs more mental health clinicians, and these nurses need to be prepared for a wider scope of practice with increased responsibility and requirements.

There is a clear next step to ensure future mental health nurses are ready for the industry: let Victorian undergraduate nursing students major in Mental Health. HACSU is also recommending examining the efficacy of cross-training across the fields to up-skill the workforce.

The 2020 Productivity Commission called on the development of a three-year direct entry (undergraduate) degree in mental health nursing, similar to options available in midwifery in Australia and general nursing in the United Kingdom. Further, it noted that the number of mental health nurses and allied health clinicians in units, community mental health services, and youth and aged care services needs an immediate expansion. Even prior to the COVID-19 pandemic taking hold, the reliance on overseas staff was beginning to have a negative impact on the sector.

By providing mental health-specific tertiary level education, new graduates are better equipped to deal with the pressures of the work they undertake, and specialised

knowledge can be passed on by experts in the field with a focus on contemporary principles. This intervention would immediately expand the workforce in between study blocks and will provide crucial on-the-job training in preparation for a career in the mental health sector.

Reintroduction of Double Degree in Nursing and Mental Health Nursing

It is projected that by 2030 Australia will have a mental health nurse shortage of over 18,500.

It is estimated that only 7% of Australian nurses focus their education on mental health. With mental health now seen as a national priority area, it is crucial that educational institutions are supported in preparing our workforce for the rapid growth in the sector.

As is stands, there are no accreditation standards specific to the core areas of mental health and the current training for those nurses who wish to specialise are limited. Placements in mental health settings are comparatively very short to those offered in general nursing and the current RN course curriculum does not include content related to mental health. This results in there being no uniformity in mental health education amongst mental health nurses.

There has been a severe watering down of mental health content within undergraduate nursing degrees. This has resulted in mental health nurses graduating with little knowledge of risk, diagnoses, assessments and treatments, and who are not adequately equipped to work in the sector.

In line with the recommendations of the Australian College of Nursing, HACSU are encouraging all Federal, State and Territory education providers to expand the current Bachelor of Nursing Degree to a four-year undergraduate degree. The fourth year should focus heavily on practical training and clinical hours and should be offered as a dual discipline degree in line with Nursing and Midwifery.

Like other common disciplines found in mental health such as occupational therapy and social work, nursing should be granted a four year-undergraduate and double degree option to increase the knowledge and competence of the graduates, as well as create a direct line of mental health nurses through the system. The more that mental health nurses are valued and afforded the opportunity to have the best education possible, the more likely it is that they will be attracted to the sector.

Cadetships to Bolster Recruitment

HACSU is advocating for the introduction of cadetships for all mental health staffing disciplines, creating a strong and diverse workforce making the mental health sector more accessible by creating alternative skilled entry points alongside university graduates.

This new model of education with a different pathway will increase diversity of staffing across the workforce and provide opportunities for people with different

learning styles. There are already cadetships specifically for the Indigenous population to work in the mental health system and these positions have been a successful addition to the mental health workforce.

Victoria is facing a mental health workforce shortage of practitioners in nursing, occupational therapy, social work, and addiction support. While we acknowledge and support the record levels of infrastructure investment into the mental health sector by building more in-patient beds and community mental health settings like Prevention and Recovery Care Units (PARCs) and Community Care Units (CCU), as well as new full-time equivalent positions coming out of the RCVMHS, the public mental health enterprise agreement and the 2022-2023 Victorian State budget, we are deeply concerned that beds and services will remain closed due to severe workforce shortages. This was made apparent when beds at La Trobe Regional Hospital were forced to stay empty due to a lack of staff.

In the 1990s, Victoria's specialist mental health training programs were axed under the guise of 'efficiency'. What was once a strong training system has since declined, leading to a drop in enrolments and a shortfall of job-ready graduates. This shortfall comes at a time of increase workforce pressures across not only mental health but also family violence and alcohol and other drugs (AOD).

New cadets would receive guidance and support from experienced educators while undertaking hands on training within mental health services to build their careers in the sector to become highly skilled practitioners, ensuring better outcomes for consumers and the entire community.

Mental Health Educators

Our workforce surveys of the sector show the significant time and workload pressures people working in mental health face. There is little to no time for professional and career development, supervision and structured support, and this time pressure is further exacerbated by the COVID-19 pandemic.

As a result, staff often enter the sector only to leave after a few years.

There is significant value in clinical supervision for staff across their career and it will impact worker wellbeing, retention rates and workforce development. Recently nursing educator roles were announced to fill the current gap; however, services need more.

With the increase in graduate and prequalification workers across all disciplines, there is an increased need for mental health educators to train, organise and support these mental health workers as they integrate into the system.

There needs to be a rapid increase in allied health and lived experience mental health educators to support the growth in the workforce, particularly to support the grade 2 and 3 positions.

HACSU recommends increasing the number of educators across nursing, allied health, and the lived and living experience workforces, both in inpatient and community settings to provide much-needed mentoring, training, and support, and ensure Victoria has a sustainable mental health workforce.

Staffing, Safety, and Preventing Burnout

To build a sustainable mental health and wellbeing workforce, with the right mixture of knowledge and skills to meet the growing needs of the community, more staff are needed. Many services currently rely on overseas recruitment, with high recruitment and salary costs. This is poor employment practice and not sustainable in the long term, and has been strongly impacted by the COVID-19 pandemic.

Victorian mental health services need to build a sustainable local staffing strategy. This requires effective recruitment and retention processes, with multiple entry points, excellent professional development and a safe and satisfying working environment. HACSU has developed a clear strategy to improve recruitment and retention, better professional development and better supported working environments.

Mental Health Staffing Profiles

Having access to the right intervention, at the right time, is integral to the experience of consumers and the smooth functioning of the mental health system. We view mental health as a holistic service, rather than silos of disciplines. All professions must work hand in hand for the sector to work. Without one of the pieces the system falls apart. That is why we are advocating for staffing profiles across all disciplines.

Occupational violence has always been a concern throughout the mental health sector. Unfortunately, one of the key knock-on effects of COVID-19 has been a sharp increase in the rates of patient-to-clinician and patient-to-patient occupational violence. This becomes incredibly dangerous, particularly if units and teams are understaffed and burnt out. Mental health workers are far too often put in positions that compromise their safety, often due to a lack of staff.

Staffing profiles historically only apply to nursing staff. HACSU members know that staffing profiles must extended to all those working in the mental health sector.

In addition to the standard staffing profiles, we also recognise that each service is different and with these differences comes a need for specialised skills. We advocate for the inclusion of a further discretionary 3 FTE for services to use as they see fit, to compliment the specialised service that they deliver.

For example, a service may want to employ a dietician, an art therapist, a speech pathologist, more social workers, occupational therapists, lived and living experience workers, or nurses to meet the specific needs of their consumer cohort. These roles could be part- or full-time, or even be shared across various local services. It is imperative that we ensure that the right intervention is available to consumers, their family, carers, and supporters, at the time that they need it.

To better respond to occupational violence and to further solidify where higher profiles of disciplines are required, HACSU members are also asking the government to commit to 12-monthly reviews of incidences of occupational violence. These reviews should apply to all area mental health services and obligate the employers, the department and HACSU to work collaboratively to set targets and implement action plans to reduce violence.

Retention of the Older Workforce

It is widely accepted across the health and emergency services workforces that the loss of corporate knowledge due to retirement is having a negative impact on the emerging workforce, with mental health being no exception.

Mental health is a difficult industry, requiring not only physical and intellectual labour, but also emotional labour. It is commonplace for older mental health workers to retire before they would like to due to a requirement to continue to work full-time hours with little leeway in terms of reducing the workload or altering their duties. Often this results in huge losses of corporate knowledge on the floor, with graduates left to navigate the care of consumers in units or in the community without enough support from experienced mentors.

To better equip graduates and to keep older mental health workers in the sector longer, HACSU is proposing the introduction of an application-based 9 day-fortnight roster for older workers to stay employed longer. It is our view that the 9 day-fortnight should be funded at a full-time rate with a requirement for at least 4-8 hours clinical supervision for graduates and grade 1 and 2 positions. We believe that the extra day off within the fortnight will help our most experienced mental health workers to feel able to continue to work in the sector for longer.

Introduction of Mental Health Officers

Mental health clinicians have unsustainably high caseloads. Compounding issues include case management and high levels of administrative work that could often be completed by non-clinical staff to maximise the time clinicians have to spend supporting consumers on their recovery journey.

There are currently not enough non-clinical staff to support clinicians. This problem will intensify with larger numbers of new graduates and other clinical staff entering the workforce. All services need a significant investment in both additional mental health officers (MHOs) and administrative staff to aid with administrative tasks, transportation, as well as engaging and connecting with services consumers need in the housing and AOD space.

These positions should be entry level with a Certificate IV in Mental Health and kickstart people's employment journey in the sector. At present it is often trained mental health clinicians who are assisting consumers with day-to-day tasks, they are also expected to document all paperwork in relation to group therapy and are routinely unable to assist consumers with escorts due to a lack of staff.

Mental Health Officers would be of great benefit to the day to day running of mental health services and would provide a direct entry level position for Victorians wanting to make the switch into a career in the mental health.

The Crossing

Worker-led rehabilitation, outpatient, outreach, and suicide prevention

Like the COVID-19 pandemic, risky substance misuse and mental ill-health does not discriminate. 1 in 5 Australians will grapple with these chronic health conditions in their lifetime and it has become abundantly clear that crucial interventions for working people, particularly those in the health sector are severely lacking.

While the Andrews' Labor Government must be applauded for its courageous efforts in more than doubling the number of public rehabilitation beds across the state, even with this significant investment, far too many are still being left behind.

Far too often, trade unions are confronted with the stark reality of what working people and their families are forced to go through when trying to access this critical healthcare.

In Victoria, the largely unregulated private rehabilitation services mean that working people are often confronted with re-mortgaging their house, taking out loans, or withdrawing their superannuation to pay for services that can cost up to $30,000 per month. Victoria's rehabilitation system is mostly inaccessible for working people, as most stays are between 3 and 12 months.

In Australia it takes an average of 20 years for a person to seek assistance for addiction due to shame and stigma and this is a trend that is appearing across all shop floors and all industries across the State.

The current system of treatment is not working and requires fresh ideas and methodologies for providing suitable treatment to working people and their families and funding models that work both for patients, employers, and the government.

The public and private AOD sector is not fit for purpose and is inaccessible for working people and their families. Whether it is an employee or a family member of an employee grappling with an addiction, HACSU members know the harmful impacts of not being able to seek timely assistance and the effect this can have on your mental health, relationships, working life and financial position.

Far too often we hear stories of working people who want to cease using but opt not to because they cannot afford treatment, or do not have the support of their workplace. For working people there are far too many barriers to accessing treatment when required.

Accessing critical healthcare for you or your family should never cost you your job or be dependent on your bank balance.

HACSU, along with 32 other Victorian unions, are proposing a tri-partisan collaboration with Odyssey House for a 28-day inpatient treatment facility funded and owned by the trade union movement called The Crossing. The Crossing will include the establishment of an outreach and outpatient service, inclusive of toolbox talks for delegates, health and safety representatives, organisers and working people from all sectors with the support of trade unions, employers and the government and importantly will be free for HACSU members and their families.

We need innovative, sophisticated solutions to complex issues such as addiction. We know that we have the most cost-effective, fit-for-purpose model for working Victorians to ease the burden on our already overcrowded healthcare system.

Workplace support and early intervention are crucial in supporting workers combating addiction and mental health struggles.

The opening of The Crossing will change the lives of workers struggling with risky addiction — as well as their families, their workmates, and their community.

Designing Responsive Therapeutic Environments

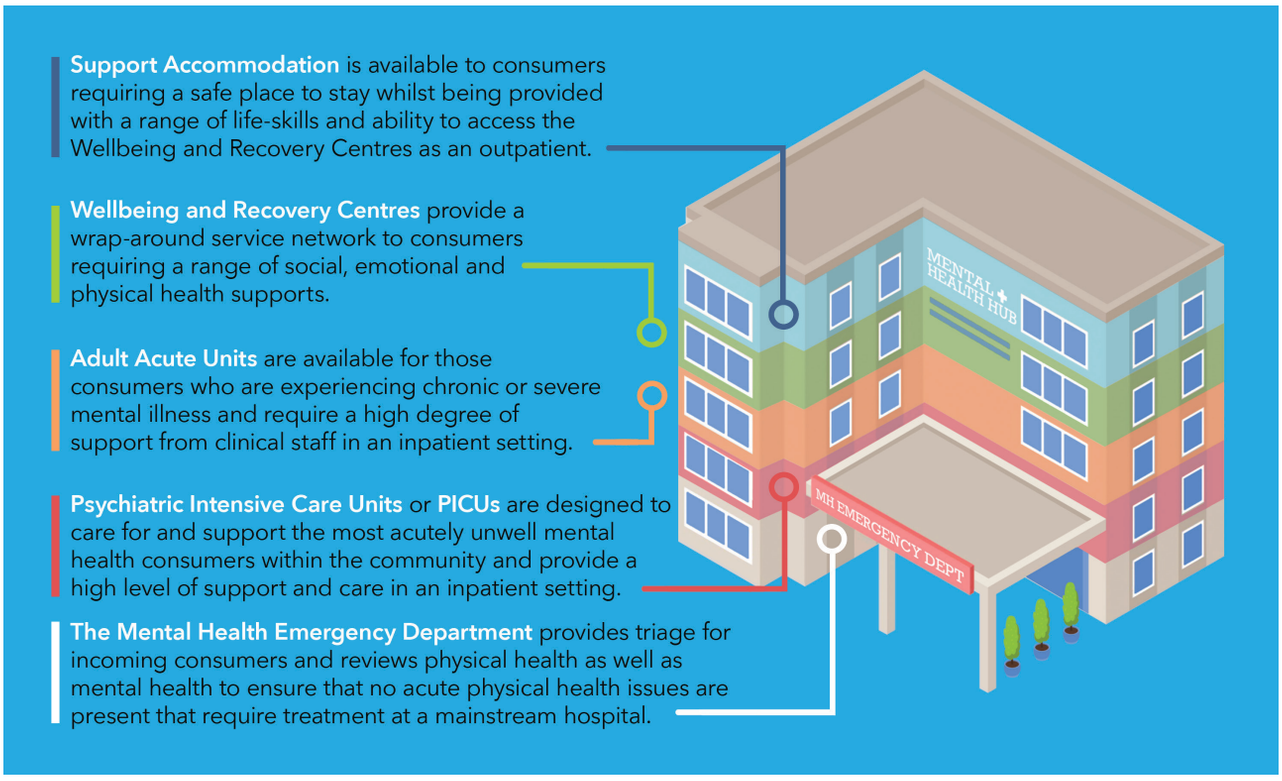
Upgrades for Old Facilities and Smarter Footprints

Many of Victoria's mental health facilities are outdated and do not meet current safety guidelines. While we welcome the Victorian Governments 2022/2023 budget commitments towards this, for the safety of consumers and workers, audits must be committed to for the entire State.

An audit of all mental health facilities to identify the issues and risks, and a subsequent upgrade to these facilities to meet current guidelines and ensure the physical environments of the units provide the best possible outcomes for consumers, as well as staff working within the services, is much needed.

While HACSU members welcome the expansion of community teams, many of them are stationed in buildings that are not fit for purpose. Many do not include therapeutic spaces, with no ability to conduct group work. Often, they do not even have enough desks for the workers. The footprints provided are simply too small and are placing unrealistic demands on our members to provide care and manage risk.

Following the audit of mental health facilities including bed-based units and community teams, clinics, PARCs and CCUs, a priority action list and a plan for refurbishments must be actioned to ensure that all legacy sites are upgraded and all amenities are standardised across the State, to ensure that no matter what postcode you live in, your service will be state of the art.



Redesigning Therapeutic Environments

Many of the serious service breakdowns and violent incidents are occurring within adult acute units. There are multiple precipitating factors, including staffing shortages, inadequately trained staff, inappropriate skill mix, the prevalence of substance affected clients, aged clients, a lack of forensic facilities, etc. A key problem is that consumers with physically and/or sexually violent behaviours continue to be inappropriately placed in acute units, which increases the risk within the therapeutic environment and impacts the recovery of other consumers with chronic mental illness. It is a case of the bad behaviours of a small minority impacting the treatment, care and support of the majority.

The RCVMHS recommendations highlighted the need for a redesign of bed-based service to provide safer environments, including the capacity for gender-based separation within inpatient units and new models of care.

Worryingly, the government has commissioned builds that have inadequate footprints with no capacity for outdoor space or community settings in mental health facilities such as gyms, classrooms, art and music therapy rooms, or chillout spaces. As a matter of principle, these builds must cease.

HACSU members want to see the creation of more Psychiatric Intensive Care Units (PICUs) with specific staffing profiles that include highly trained staff to provide services to consumers with violent and aggressive behaviours, to ensure our adult acute units can be the safe and supportive treatment environments they are designed to be. HACSU is proposing the use of a model of co-design of services alongside those with lived and living experience of mental illness to ensure services meet their intended needs.

Our plan for Mental Health Hubs involves building service environments to suit consumer needs, rather than the current hospital medical model we currently see in most services. Services will involve a 'step-down' model, whereby consumers can enter the system at any level, depending on the acuity of their illness.

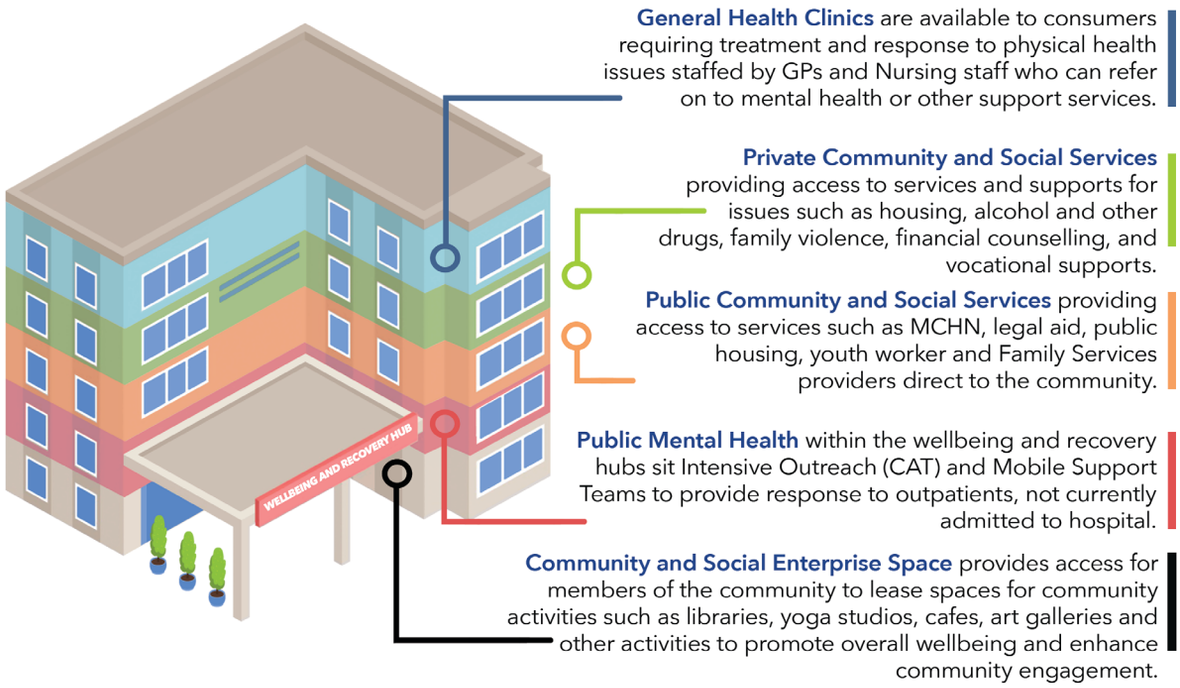
Wellbeing and Recovery Hubs Coupled with Supported Accommodation

HACSU is recommending the co-design of holistic wellbeing services.

The Wellbeing and Recovery Hub is available to all consumers requiring support across a range of social, emotional, and physical health issues. The purpose of the hub is to promote overall health and wellbeing through a wrap-around model and service provision. Consumers can access the centre as either an inpatient or an outpatient when needing support with physical health issues, co-morbidity, housing, financial counselling, criminal justice, and family violence.

This area of the hub is designed to provide support for many issues that exacerbate people's experience of mental illness and would be operated by peer workers who themselves come to the field with a lived experience of mental ill-health and illness. From the hub, referrals are made to the community for ongoing case management through either community mental health or continuing care services.

These hubs will run 24 hours a day, 7 days a



week with a range of allied services available to consumers throughout each day.

Supported Accommodation is the final section of the centre whereby people can stay independently in accommodation, whilst transitioning out of the acute system and into the community or people who may have substantial housing issues and require a safe place to stay whilst transitioning back into the community. This group of consumers can continue to access the Wellbeing and Recovery Hub when staying in the Supported Accommodation. They are also provided with a range of coordinated life-skills classes to ensure consumers can enjoy a healthy life in the community.

By providing a model such as this in the community, consumers experiencing enduring mental illness are less likely to regress into severe illness requiring acute mental health services.

Integration of Mental Health & Alcohol, Drug and Gambling Support Services

The Royal Commission into Victoria's Mental Health System has called for the integration of treatment, care, and support to people living with mental ill-health and risky substance misuse.

While the Andrews Labor government has made a record investment in more than doubling the amount of public residential rehabilitation beds, Victoria still ranks second last in the country by way of residential beds per 10,000 head of population. Furthermore, Victoria has a dangerous lack of detoxification beds and serious workforce shortages plagued with inconsistent funding cycles.

HACSU members know that the more that the AOD sector, inclusive of harm reduction services, is underfunded, the more the burden will continue to fall to the mental health workforces.

While HACSU members welcome investments in graduate certificates for the allied health workforce in addiction and interventions such as the newly announced drug and alcohol hubs, there must be an immediate examination of how these sectors should be successfully integrated.

We know that the most urgent concern of HACSU members, service delivery providers and community members alike, is the potential cannibalisation of the AOD sector. HACSU members are delighted to see further AOD EFT appearing in public area mental health services across the state however, there are grave fears that this will lead to a migration from the public AOD sector to the public mental health sector. This will lead to waiting lists being further exacerbated and a further inability for patients who present to mental health services to access alcohol and other drug services quickly and efficiently.

The growth of the public mental health sector must be commensurate with the public AOD sector, inclusive of harm reduction services.

To achieve successful integration, HACSU supports moves towards state-based enterprise bargaining agreements for the AOD sector and is urging the government to commit to scrapping the funding re-tendering process for services with a proven track record. Consistently forcing services into tenders for funding that they already receive causes unnecessary stress and inevitably leads to job insecurity, heavy casualisation, more occupational violence incidents and poor outcomes for community members and the AOD workforces.

The AOD sector is insecure, largely unregulated, and leaves the workforce vulnerable to exploitation. Currently, there is limited career progression and a need for additional new graduates to enter the workforce. To effectively recruit and retain, both government and industry must work together to map clear career progressions with proper wages and conditions. Investing in the AOD workforces will take pressure off the mental health workforces, which currently carries the weight of insufficient AOD services.

Both workforces must be bolstered in tandem to cement wages, condition and career progression while simultaneously stamping out bad behaviour from private providers and scrapping tendering. This will halt the over-reliance on private providers.

HACSU acknowledges the important work of the Andrews' Labor Government in initiating a sector wide investigation into the private rehabilitation sector. The findings of the report by Health Complaints Commissioner

Karen Cusack were damning and disturbing, and oftentimes it is Victoria's most vulnerable who are taken advantage of who then inevitably end up on the public waiting list or in the care of HACSU members.

It is clear we need action in this space, to ensure that private sector providers can operate safely, workers can feel confident in their work, and patients, carers and families can be confident that the care being provided is safe and appropriate.

As well as a sector wide EBA for the public sector, HACSU is calling on the government to implement the following in the private sector:

1. Mandatory registration and/or licensing for all private AOD providers.
2. A registration scheme for the AOD workforces.
3. A framework for the private sector, guided by leadersof the public sector and peak bodies.
4. Enforceable legislation and penalties for providers who fail to meet industry standards
5. An accessible, approachable, and confidential method for families, friends, workers, and patients to report private providers who pressure or manipulate clients into accessing their superannuation on compassionate grounds or re-mortgaging their house without independent financial advice, particularly when there are breaches in the duty of care.

When surveyed, a staggering 100% of HACSU members stated that a residential rehabilitation, outpatient, and outreach service with detox capability attached or close to their area mental health service would positively impact their quality of care.

For HACSU members integration means seamless care between the mental health and AOD sectors. Key to this success is urgently dragging the public AOD sector up to the wages and conditions afforded to the public mental health sector.

A Holistic Justice Response

Expansion of the PACER Model

Research has found that both mental health-based response models and co-responding police-mental health programs have strong linkages with community services and reduce pressure on the justice system. Mental health triage, streamlining or reducing police involvement, and facilitating timely access to mental health services is also important in reducing the risk of violent interactions. However, given the limited investment to date, officers suggest that programs and initiatives are often ad hoc and restricted in geography and scope.

Currently, the Crisis Assessment and Treatment Teams (CATTs) in Victoria are the primary mental health-based response to mental health crisis incidents. It is estimated that at least 30% of public mental health consumers also experience harmful drug and alcohol use, and HACSU members have reported that CATT deployments to community members experiencing complex, co-occurring mental health and AOD issues have dramatically increased with the COVID-19 pandemic.

In theory CATTs operate 24-hours, however the reality stands in stark contrast to this. Inefficiencies and lack of availability mark police perceptions of CATTs. Police can experience extensive delays waiting for their arrival. Additionally, since their inception, CATTs have suffered from the same shortage of mental health services available to the Victorian community. This has mirrored the issues with mental health-based responses internationally. An additional issue with the current operation of CATTs is the general lack of consultation and collaboration between police and mental health services. Given that mental health crises often constitute either public nuisances, threats to the safety of individuals, or disturbances, officers will continue to attend incidents alongside CATTs. For this reason, promotion of interagency cooperation and collaboration must continue to occur.

The PACER model encompasses a multi-disciplinary, collaborative approach in a very tangible sense. Often when community members are transported to police stations by PACERs, the mental health practitioners can conduct psychiatric assessments on site and are therefore able to determine the patient's next steps. Police can access mental health records, while the mental health professional can access criminal justice data about, for example, arrest records, warrants, prior police contacts and so on.

Reviews of the PACER program has demonstrated significant improvements in response times, as well as enhanced interactions with, and outcomes for members of the community when compared with usual services. Another benefit of a multidisciplinary team was the accessibility of both health and police data. Privacy concerns prevent police from accessing information about a person's health records and mental health practitioners from accessing police information. A team consisting of both a police officer and a clinician is equipped to access timely information and use this to identify and attempt to implement an appropriate disposition in the community members best interests.

It is widely accepted that the Police, Ambulance and Clinical Early Response (PACER) model has successfully enabled emergency services agencies including police, mental health, and ambulance services to streamline their response to community

members experiencing a mental health crisis. The model has begun to ensure that multiple emergency services teams are not continually required on the front line and has improved the capacity of these services to respond. PACER has also been shown to enable reductions in presentations to emergency departments by diverting people to more appropriate and less restrictive environments and facilitated direct admission to acute inpatient mental health services when people in crisis were assessed in the community or transported to a police station for assessment. Despite these ongoing successes, currently PACERs are employed on an ad hoc basis, are insufficiently funded, and only operate in certain locations.

The reality in Victoria today, based on a lack of adequate resourcing, is that police are all too often the first, and sometimes only, responders to members of the community experiencing a mental health crisis. Mental health crises are best addressed by a health-based response.

Introduction of Dedicated Emergency Services Workers and Emergency Trial Site

Police and paramedics are at the frontline of our broken mental health and wellbeing system. However, they lack the specialist mental health knowledge and experience to safely and effectively provide the treatment care and support that is now a substantial proportion of their daily work. The loss of dedicated, specialist CATT teams has not delivered positive outcomes.

It is our view that Victoria should also initiate a trial of a co-located mental health emergency department with the capacity to triage patients and to reduce ramping and ED waiting times.

Recommendation 10 of the RCVMHS final report calls for emergency services' responses to time critical mental health crises to be led by health professionals, rather than police. We have heard from our members and research has shown that the current PACER model works. However, the model remains chronically under-funded. Alongside dedicated CAT Teams, we need more mental health workers and more police available 24 hours a day to form part of the existing emergency services response teams to support the needs of the community. This will be particularly important in the successful rollout of the public drunkenness repeal, and it is with this in mind that HACSU believes that the government must fund a full-time Social and Emotional Wellbeing Workforce as called for in the National Strategic Framework for Aboriginal and Torres Strait Islander People.

This workforce requires dedicated, specialist training in mental health to de-escalate critical risks and enhance community, staff, and consumer safety.

Reducing the Harms of Prison

HACSU members know that the public health burden created by the gaps and silences that are present in the housing, alcohol and other drug, and family and domestic violence, will often fall to them in the public mental health system. Arguably the most urgent system failure is present in Victoria's prison system.

It is widely accepted that there is an undeniable link between imprisonment and poor health. Prisoners have far higher rates of challenging health conditions than that of the general population with little access to appropriate and ongoing treatment while incarcerated. Most incarcerated Australians exit the prison system thus reinforcing the urgent need for investments in appropriate after care.

It is HACSU's view that addressing these critical health matters would drastically reduce Victoria's recidivism rate. In Victoria, 43.6% of prisoners released during 2019-19 returned to prison within 2 years.

This could not be more urgent. At any one time there are approximately 40,000 Australians detained in the prison system with over 80,000 cycling through each year. Our prison population have far greater rates of mental ill-health, risky substance misuse, chronic and communicable diseases, injury, disability, and poor dental health. It is estimated that 2 in 3 prisoners had used an illicit substance in the year prior to incarceration, 2 in 5 drank alcohol at risky levels and 1 in 3 had a long-term health condition or disability.

Worryingly, Victoria is imprisoning more people than it ever has, with female prisoners being the fastest growing rate in the western world, and Aboriginal women being the most incarcerated group on the planet. Government figures estimate that two third of Victorian female prisoners are family violence victims, but according to legal and social services the figure is closer to 95%.

Women, like most prisoners, tend to have shorter stays in prison for non-violent offences such as possession or petty theft. However, these short stays are still negatively impacting their health and quality of life thereafter, inevitably creating more pressure on Victoria's already overburdened public mental health sector.

To drastically reduce the harms associated with prison, HACSU suggests the following:

1. A more comprehensive forensic health assessment inclusive of disability, acquired brain injuries, learning and education abilities, mental ill-health, risky substance misuse and chronic and communicable diseases within 24 hours of entering prison.
2. Specialised mental health facilities in prisons. The Victorian Ombudsman Debra Glass stressed that this should be urgently addressed to decrease the risk of the affected prisoner, staff, and other prisoners. It is estimated that 54% of Australian prisoners have a history of suicide attempts or self-harm.
3. The introduction of forensic AOD treatment services and harm reduction services (such as Needle and Syringe Programs) at every prison. Uncapped access to pharmacotherapy and an increase to Hepatitis C treatment.
4. A dedicated post-release health and welfare service to improve the overall wellbeing and return to work prospect of prisoners in the community inclusive of mental ill-health, disability, addiction and harm reduction support, family violence support, housing and skills and job training/retraining capability.

Overcoming Housing Instability

Mental health and homelessness are intersecting issues. Poor mental health is a risk factor for homelessness; homelessness can cause deterioration in an individual's mental health.

HACSU members have identified a plethora of knock-on effects of the homelessness crisis and its negative impacts on their work. Often community teams work as HOPs teams, and unfortunately discharging patients to homelessness is a common occurrence. Members have indicated that the entirety of the mental health system is not working to its fullest potential due to insecure housing, couch-surfing and the inevitable deterioration of a patient's mental health if they know that they have nowhere to go after treatment.

While HACSU members applaud the Andrews' Labor Government's record $5.3 billion investment to build over 12,000 public housing dwellings with projected job creation at 43,000. This will represent a 10% increase in the overall Victorian social housing stock and will house approximately 1% of those seeking housing. For Victoria to reach the social housing average, it's estimated we would need to build at least 3,400 dwellings annually until 2036. As a movement, we know the housing crisis has become more urgent due to direct and indirect economic impacts of COVID-19.

HACSU members have also identified serious issues with the Big Housing Build rollout. Often community members are provided housing away from their community, without social and medical infrastructure to support new dwellings. This has led to community teams being called out multiple times daily to new government housing builds, yet another drain on resources.

It is HACSU's view that:

1. Every new housing build must be near existing programs, social and medical infrastructure OR
2. Investments must be made to co-design new builds with this infrastructure and
3. Urgent explorations of co-located, co-designed modular housing must occur to build housing quickly, efficiently and with exceptional green credentials.

Investing in early intervention programs that support those experiencing mental health issues can prevent a deterioration of mental health, helping prevent homelessness. The Victorian Inquiry into Homelessness found that two key areas of early intervention support that can be provided to people with mental health issues to prevent homelessness:

1. Improvement of cooperation between mental health and homelessness services so that the system is easier to navigate and individuals at risk of homelessness are identified earlier. Orygen Youth Mental Health noted that severe episodes of mental health issues and particularly episodes of trauma led to an increased likelihood of homelessness.
2. Mental health services should be supported to identify people at risk of homelessness and liaise with homelessness services to ensure they do not lose their accommodation and suffer further adverse mental health outcomes. In addition, it may be beneficial for mental health services to proactively monitor and provide support to individuals they engage with and who are at risk of homelessness. Such support could be stepped up or down at periods of crisis.

Every area mental health service needs a fit for purpose reconnection housing hub inclusive of onsite mental health and addiction support and job training/retraining opportunities as an expansion of the Foyer Model to cater to those who present with complex health issues. This will ensure that patients are not discharged from wards and community settings into homelessness and to provide an option for community teams who identify community members who are at risk.

Tobacco Harm Reduction

Smoking rates in Australia have plateaued, but rates remain high for people who have a mental illness. According to the Australian Institute of Health and Welfare, people with mental health conditions are twice as likely to smoke daily and people with high levels of psychological distress were twice as likely to smoke.

A recent study conducted by The Royal Melbourne Hospital for the International Journal of Mental Health Nursing found that their mental health consumers are dying more than 30 years earlier than the general population. This worrying statistic is attributed to the fact that 74% of those surveyed smoked tobacco. The deaths were attributed to such diseases as cardiovascular disease (39%), respiratory conditions (23%) and cancers (20%).

Consumers who smoke and have co-occurring mental health conditions or substance abuse disorders have longer durations of smoking, lower rates of quitting and do not have adequate access to quit tools. Worryingly, those with mental health conditions are more likely to die from health complications related to smoking rather than their mental health condition.

It is reported that Australian men with mental illness live nearly 16 years less and women live 12 years less than those who do not have a mental illness and these figures can be attributed to high smoking rates.

From 2013–2016, the reduction in the adult smoking rate in Australia slowed dramatically despite consistent large price increases and the implementation of plain packaging. In comparatively similar countries, rates of smoking are falling further by implementing a broader range of measures, including a range of alternative, lower-risk nicotine-based products. According to a 2019 McKell Institute Report on tobacco harm reduction, 'smoking rates are declining faster in many other countries than in Australia, especially where tobacco harm reduction strategies are available. Smoking rates in the UK and US are lower than in Australia for the first time.'

There has been a longstanding belief that smoking cigarettes can curb and relieve stress and there is evidence from the mental health workforce that smoking cessation, curfews, and lack of available staff to escort patients to designated smoking areas, cause unnecessary stress to their consumers and heightened behaviours of concern.

With this in mind, it is our belief that harm reduction measures should be immediately implemented to aid our members to assist consumers to quit smoking. These measures should include every available tobacco harm reduction measure inclusive of e-cigarettes.

It is a terrible waste of resources, and a heartbreaking idea, that our members dedicate their lives to helping our community through mental health challenges, only to have far too many die from smoking related diseases.

The National Health Service run by Public Health England have recognised that admission to secure mental health facilities, should be viewed as an opportunity to intervene with pragmatic harm reduction measures to reduce smoking rates.

As the use of vaping products is part of the national quitting smoking strategy, specialised vaping products that cannot be used as weapons or to do another harm, have been introduced across mental health units with promising results. These safe e-cigarette options have also been introduced into every prison shop across England and Wales.

It is HACSU's view that trials should be conducted within mental health facilities, much like those conducted by the National Health Service, to investigate the viability of the introduction of e-cigarettes to halt aggression and behaviours of concern from consumers and to begin to reduce the smoking rates of mental health service consumers.

Summary

HACSU acknowledges the traditional owners and continuing custodians of the land and sea on which we live and work. We pay our respects to elders past, present and emerging. As unionists, we pledge our ongoing solidarity with the traditional owners, and all Aboriginal and Torres Strait Islander peoples, in their struggle for recognition of sovereignty, historical truths and justice.