ACMHN Feedback on the National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues

Thank you for inviting the Australian College of Mental Health Nurses (ACMHN) to provide feedback on the National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues.

The ACMHN response provides some overarching comments followed by more specific feedback on particular areas in response to the consultation questions.

General feedback

Firstly, the ACMHN wishes to commend the efforts of the Commission on producing a detailed, practical guide for health services delivering care for people experiencing poor mental health. Overall it is a detailed and extensive document with clear and relevant information for governing bodies, managers and clinicians.

Some further feedback is provided below:

- The ACMHN notes that at the beginning of the document there was an explanation in relation to the use of the terms consumers, patients and people, however the interchange of these terms throughout the document is still confusing. The ACMHN prefers to use phrases such as “people experiencing mental illness”, “people accessing mental health care” rather than ‘consumer’ or ‘patient’.

- Page 49 makes reference to the screening not being undertaken by a person not trained in mental health, and while we completely agree with this, as we know nurses are comprehensively trained at an undergraduate level with highly variable exposure to mental health content and placement opportunities. We also know there are many nurses working in acute mental health units that are not trained in mental health. The ACMHN believe that in the absence of mandated mental health training in the undergraduate curriculum and/or a requirement for mental health nurses on acute wards to have specialist qualifications and skills in mental health, it may be erroneous to assume that the Nursing Unit Manager (for example) would necessarily be aware of the degree of variability in knowledge, skills and training between individual registered nurses on the ward.

- Page 56 the term ‘attention seeking’ is used. We believe this is a derogatory term and minimises the distress of the person. It also adds to the stigma and negative image of people who self-harm. We believe it more appropriate to say is ‘highly distressed’. For further guidance on appropriate language, refer to [http://www.mindframe-media.info/for-media/reporting-self-harm/quick-guide](http://www.mindframe-media.info/for-media/reporting-self-harm/quick-guide)
The last paragraph on page 75 is unclear:

“Partnering with consumers enables members of the workforce who are not specialist mental health workers to effectively incorporate the person’s own knowledge about their health into comprehensive care planning.” From this statement there is an implication that the main justification for why it is important to partner with consumers is to assist the non-specialist mental health workforce, when in fact it is simply a reflection of evidence-based best practice. It is necessary to effectively incorporate the person’s own knowledge about their health into comprehensive care planning whether the worker is a specialist mental health worker or not.

Will the actions identified in this guide support health services to deliver health care to people with mental health issues?

As indicated earlier, the user guide provides a range of practical strategies to deliver quality and safe mental health care to people experiencing a mental health concern. For example, the strategy outlined on page 11 about building enabling workforce to spend time in different settings is an excellent suggestion. There are examples of where this has been done and it has significantly improved the care pathway.

Are there any gaps or duplication in the content?

**Clinical supervision:** There are many references to the benefits of clinical supervision throughout the document, which the ACMHN fully supports. However it should also be noted that at times clinical supervision may not be as accessible, particularly on rural and remote locations where the resources to support clinical supervision are not as readily available. In these situations the use of technology such as videoconferencing, telehealth services etc can assist in facilitating clinical supervision and complex case review for the mental health workforce in rural and remote Australia.

There is also no reference as to whose responsibility access to supervision is and who pays for it. There is no reference to ensuring clinical supervision is provided by those with appropriate skills and training. It should be noted that an experienced, good clinician may still require additional skills development and training in order to provide quality clinical supervision.

**De-escalation and responding to violence and aggression:** The document makes a number of comments about de-escalation and the skills required. The ACMHN wishes to note that a key challenge identified in the literature points to reduction approaches in many psychiatric units tending to focus on de-escalation techniques, which by definition, place nursing staff in a situation where an individual’s behaviour has already begun to pose a risk and requires an immediate response (Tomagová et al., 2016; Johnson, 2010).
The ACMHN recommends that this section focus on the need for a cultural shift in reduction approaches from an aim focused primarily on de-escalation, to an approach in which the main priority is to support the adoption of evidence-based practices that seek as much as possible to prevent behavioural escalation from occurring in the first place (Johnson, 2010); thus making both people accessing mental health care, and the staff delivering it, safer and improving care quality overall. Such a shift requires leadership and support from government and organisations to transition their service model and achieve the necessary buy-in from frontline staff to ensure successful implementation.

It is also recommended that the document specify the need for good observation skills and how these and good interaction with people can prevent behavioural escalation from occurring in the first place. Of greatest importance though is the acknowledgement that in order for frontline staff to be able to engage in evidence based clinical observation practices, significant changes are needed at team, management, service and organisational levels to enable this to occur.

We need to start the dialogue before escalation, this in itself is a risk mitigation strategy referencing page 18. We believe there is room in the document for comments around staff and the fact they are working in stressful environments and how this can inadvertently influence their perceptions (such as perceptions of risk) and behaviour. There is a reference to a safe environment but no reference to there being a safe environment for all people including the workforce. The work the ACMHN has completed in 2017 with funding from the National Mental Health Commission on seclusion and restraint use tells us that if staff do not feel safe there is a higher risk of restraint and seclusion of consumers.

**Carers:** The inclusion of carers is somewhat lacking throughout the document. There are comments about the importance of the inclusion of carers but there are opportunities for their inclusion for example page 11, 2.11 in our opinion could include carers.

Service design includes consumers however a specific reference to the inclusion of clinical staff who are providing services on the ground on a daily basis, would also provide significant value and help to ensure that the underlying intention of service design is translated into practice.

There is reference to ensuring information exchange occurs across the organization. We believe there should also be greater emphasis on exchange of information outside the organisation. For example, we know there are still issues with general practice receiving discharge summaries following person’s a presentation to the emergency department or an acute inpatient admission. In the context of the highest risk for suicide being immediately post discharge, these discharge summaries and immediate follow up are of critical importance (*Lifespan Emergency and Follow Up Care Research Summary*, Black Dog Institute, 2017).
Are there examples of current practice that could be included as practice resources?

ACMHN Clinical Supervision model agreement:

It is the position of the ACMHN that clinical supervision is a core component of contemporary professional mental health nursing practice and it is central to practicing within the ACMHN Standards of Practice for Australian Mental Health Nurses: 2010. The ACMHN has developed a range of clinical supervision resources which are intended to be used in conjunction with one another. One of these resources recommended by the ACMHN is a Clinical Supervision model agreement template. A clinical supervision agreement is a formal agreement outlining the details of the arrangement, which should be discussed and agreed prior to commencing a clinical supervision arrangement. For further information, see http://www.acmhn.org/about-clinical-supervision

Use of Improvement and review committees following the use of seclusion or restraint:
Throughout the document there is reference to reviewing incidents of seclusion and restraint. It is important to review these incidents and the ACNMHN suggests that a specific review committee be established to review all incidents of seclusion and restraint. To align with existing evidence based practice, the committee should include consumers and carers as well as clinical staff. As an established committee that reviews all incidents there is greater opportunity to identify trends and opportunities for service improvement. Rather than this being perceived as a punitive review process it could be established as an improvement and capacity building committee, looking for barriers and enablers to support further reduction of incidents of aggression and seclusion and restraint use.

Thank you again for the opportunity to provide feedback. We are happy to be contacted if you require further information.

Yours sincerely

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