SA HEALTH

ADULT COMMUNITY MENTAL HEALTH

Report from Greg Stevens of interviews with staff

SUMMARY REPORT

1. OBJECTIVES OF THE REVIEW

- To identify any current or perceived issues within Adult Community Mental Health (ACMH) which may require SA Health intervention
- To provide staff with the opportunity to engage with the reviewer either formally or informally
- To give staff the opportunity to provide a formal statement of allegations of disrespectful behaviours to the reviewer

As part of this process the reviewer (Greg Stevens) is to:

- outline workplace issues
- provide a de-identified summary to SA Health
- make LHNs aware of outstanding matters to be considered by them as part of their forward planning.
- provide a report identifying any formal complaints for follow-up

2. METHODOLOGY

i. Staff identified by location and LHN

Appendix A attached sets out the number of staff interviewed by location and LHN.

The reviewer considers that a reasonable number of meetings were held at each location and within each LHN to enable certain findings to be made

ii. Staff identified by discipline only

Appendix B attached provides the total number of staff meetings held by occupational grouping.

The reviewer considers that a reasonable cross-section of staff within each occupation, with the exception of Medical Officers, was achieved to enable certain findings to be made.

iii. Former employees of Adult Community Mental Health

Former employees of ACMH were excluded from the scope of this exercise. Nonetheless, many current staff spoke freely about their former colleagues, including relatives and friends of such staff. They spoke about the issues those staff had experienced, and the reasons they believed those staff had left the service in recent years.

iv. Mental Health Triage

Mental Health Triage, which is part of CALHN, was included in the scope of the exercise. Some seven employees of the Triage were interviewed on 20 March 2017

These employees expressed their disappointment with the references to their work in the Douglass report. They stated they were themselves well aware of the role of community mental health teams, as many of them had previously worked in them

As to the alleged "inappropriate referrals" they pointed out that they only had the benefit of telephone contact with the consumer, and could not do a complete assessment on this basis

v. Meeting processes and reflections

Interviews were mainly one-on-one, perhaps in the order of 85%. Other groups ranged from two to five staff

Interview questions from the reviewer were relatively unstructured. Staff were not prompted to speak about the Jocelyn Douglass report, although a number of them did so

Most staff were well prepared for what they had to say, and many had written summaries they read from or referred to. Some provided this written material to the reviewer at the time, or at a later date

Meetings generally took 30 to 40 minutes each. A few meetings went for an hour

Staff mainly spoke about their own personal experiences and those of fellow team members

The general impression gained was that they spoke openly, honestly and frankly about these experiences

Some who had particularly harrowing experiences to relate had difficulty, understandably, in the re-telling of their experiences

Incidents that occurred a few years ago, or even longer, were recalled as if they had recently happened. Quite clearly, those staff are still hurting, and particularly so where no acceptable resolution or closure had occurred, which was usually the case

Where these incidents involved allegations of bullying, harassment, intimidation and other disrespectful behaviours, staff had little hesitation in naming the alleged perpetrators. Mercifully, the majority of staff had never been subjected to such experiences. Many of them, however, have suffered the collateral effect of knowing colleagues treated in this way.

Others, who are still working in the system, have been "broken down" by the relentless pressure of unsustainable and uncapped workloads, and of poor treatment by certain managers past and present.

3. FORMAL STATEMENT OF ALLEGATIONS

There were no employees who wished to proceed on a formal basis with their allegations of bullying, harassment or other disrespectful behaviour.

About 15 employees specifically discussed this topic with the reviewer. Most had already decided not to take such action. Those that were undecided were most reluctant to do so, for various reasons, including the somewhat fragile state of their health.

About 30 other employees offered information, some of it second-hand, concerning their understanding of bullying type behaviours towards their colleagues or former colleagues.

There appears to be little understanding of the contents of the Respectful Behaviour Policy and the Guideline, or of the five options set out therein.

The main reasons given as to why the formal process is not being accessed, or if accessed in the past, will not be again, are:

- The lack of support and guidance given by HR generally
- The anonymity of the HR staff handling the complaint
- The length of time taken to resolve the complaint
- The complainant does not get to see the perpetrator's response or the response of any other witnesses
- The complainant is never advised the outcome of their complaint. i.e. Upheld in full / Upheld in part / Dismissed / Not proven
- The complainant is sometimes offered mediation with the perpetrator in obviously inappropriate circumstances
- The complainant is not always told when their complaint has been finalised.

Concerns regarding ongoing and past behaviours

The report identifies that there have been a number of allegations of bullying, harassment, intimidation and other similar behaviours

It is commonly believed by staff that the following common denominators are present:

- The most SA Health has ever done in respect of these issues is to move or second the employee(s) concerned to another position in either ACMH or elsewhere within SA Health
- ACMH management, or at least some of these, know who the bullies are alleged to be, but have not taken any steps to reign them in
- Mental Health Services management, or at least some of them, are merely paying lip service to the requirements of the relevant Policy
- At most they are not only failing to live up to their obligations under the Policy, but also their legal obligations under the Work Health and Safety Act.

4. COMMON THEMES

i. Pressure of workload

The most consistent theme that was related dealt with the daily pressure of workload. There were never enough hours in the day to complete tasks. Many staff worked for additional hours in their own time. Overtime or time in lieu was rarely applied for, and even more rarely, granted.

Additional clients, appointments and visits arose on a daily basis. Caseloads are uncapped. With sick leave on the increase, more staff working reduced hours, and the demands of recording required, left less time than ever to deal with consumers.

Failure to back fill for both planned and unplanned leave created additional pressures. This was particularly felt by teams when vital positions such as Team Manager and Clinical Co-ordinator were left vacant, sometimes for weeks on end.

Many staff feared that plugging the gaps that arose on a daily basis put them and their colleagues at risk of missing something important that could result in dire consequences if not dealt with.

There seems to be currently no universally accepted method of measuring caseloads / workloads of staff in community mental health. It might well be that the case that such a measurement would assist in evening out some of the current caseloads / workloads

Unlike bed based services, where there are limits placed on the occupancy levels, community services appear to have no such limits, no waiting lists, and a lack of clarity as to who can be accepted as a consumer. This has resulted in a mismatch between the expectations as articulated in the business rules and what can realistically be provided within current resources[1].

ii. Time for staff training and development

There was little time left for participating in staff training and development. In any event many staff reported a lack of interest in, and support for, such activities from managers. Some staff reported having to fund, either wholly or partially, and take leave for, their own professional development

iii. Burn-out

There were two “main groups” that stood out in reporting burn-out, and a high degree of negativity and helplessness.

The first were the older, experienced, mainly nursing clinicians, typically in the age group 50 to 60 years. Most of these had a minimum of 25 years overall mental health nursing experience. Many had also worked in wards and other units. They had seen quite a few of their colleagues take what they described as "early retirement", in the past five years. They were still in the main looking at the prospect of another 10 to 15 years of further employment at ACMH. Many of them did not believe they would "last the distance" unless conditions improved.

The second were the younger, less experienced, mainly allied health professionals, typically in the age group 25 to 35 years. They had, in the main, less than five years ACMH experience. They worked in the community sphere in mental health because that was what they had always wanted to do. In the main, they found it a constant "battle" to keep up with the workload. Many reported they experienced disrespectful behaviours from their managers. Their predominant issues included lack of backfill, delays in the recruitment process, arbitrary roadblocks to stop innovative projects, little respect for their specific skills and work, inadequate training and resources, and feeling they were putting themselves in the "firing line" when raising issues.

Many in this group were looking at reducing their hours to part-time (some had already done so), or moving on to other positions elsewhere

iv. Pressure to meet KPIs

More generally, staff reported that they were put under pressure to meet their various KPIs, to deal with complex consumers, and meet their legal obligations. An environment of friction and stress was created which made it difficult for both staff and managers to fulfil their respective roles. The outcome was therefore seen as "horizontal violence" due to frustration with a system not perceived to be functional.

v. Overtime

A constant issue that was raised in relation to staff seeking approval for overtime when for example working through meal breaks, or working past the normal shift length. Staff have been informed that if they think they might be in this position, they could contact the appropriate person an hour beforehand and notify them and seek approval.

Staff pointed out the impracticality of such an approach, particularly in situations of rapid response, or on being in the middle of a difficult consumer contact or visit.

vi. Casualisation

Many staff expressed concerns regarding the increasing "casualisation" of the ACMH workforce, and the negative effect on the employees concerned, other team members, and the consumer.

Those staff who were on a series of short term contracts expressed the difficulties they were experiencing in getting out of this process, and into ongoing employment. Contracts could be as short as 3 months duration. They were sometimes not renewed until after the previous contract had expired

vii. Model of Care

Issues relating to the current integrated Model of Care frequently arose. The majority of staff considered that this model was not suitable for either themselves or the consumer. There were others that believed, with refinements, that continuing this model, well managed, would be the best way to go. Needless to say, these competing views were being expressed within the teams, at times leading to conflict occurring.

I should also report a view that was held by some, that a return to a model of acute and non-acute care had seen differentials in workloads arising in the two streams in the past.

viii. IR issues

Some issues arose during the course of this review that had industrial relations implications. I will not report on these in any detail as they were referred to at the last Industrial Liaison Forum

Suffice to say that at the LHN which had commenced a "Community Redesign Project", a number of staff commented unfavourably on what they saw as a "tokenistic" consultation process with staff engagement

Many were also very critical of the lack of an evidentiary basis for a proposal to consolidate the 5-day and 7-day operational models across the LHN

ix. Backfilling, vacancy management, and recruitment

This Report has already made mention of the difficulties that staff experience with the backfilling (or lack thereof) process, the vacancy management process, and the lack of delegation in HR matters available to Team Managers in particular.

Some staff also recounted what they regarded as poor selection practices, particularly those that resulted in nepotism in appointments, which they regarded as not being made on merit. Some examples of these were given.

It appears that the composition of selection panels may be at the heart of this issue. It was alleged that persons who had relationships and /or friendships sat, sometimes together, on selection panels , which then produced what could be seen as inappropriate appointments. In other words, they were alleged to have conflicts of interest that should have precluded them from such involvement.

There was another selection panel where it was alleged that two members of the panel had endeavoured to coerce the third member of the panel into agreeing with their scoring of the applicants.

There appeared to be no attention paid by Senior Managers and HR to issues surrounding attraction and retention of staff, the protracted recruitment process, turnover of staff, and lack of HR advice and support. There are also issues surrounding the adequacy of making acting appointments, and the ability of staff to express an interest in such positions.

x. EAP

There was not a great deal of acknowledgement given to the Employee Assistance Program. Staff felt they were "brushed off" by Managers and HR who, instead of giving advice and support, simply said "go and use the EAP". Staff would prefer to see a recognition of the vicarious trauma inherent in this work, and their feelings of being unsafe and put at risk. They would like to see training given in how to cope with this workplace, and some training in e.g. crisis intervention

xi. Role clarity

There appear to be some current tensions and ambiguities regarding the respective roles and responsibilities of operational managerial staff and Heads of Units, which it would seem still have not been clarified

5. FINDINGS AND SUMMARY

An overall summary of the themes that were most in evidence can be found in Appendix C attached.

The findings that now follow relate to that group of staff who chose to present themselves for interview. They reflect their views and experiences. There were numerous other issues reported, some of which relate to a single employee, who could be readily identified. I did not go out and seek the views of senior managers and medical staff, nor did I seek the views of any HR managers in the LHNS:

i. In respect of the Douglass summary report, those employees who had read it, by and large expressed support for its conclusions

ii. As set out in 4 (i) above I find that the single most consistent theme was the daily pressure of workload, as influenced by all of the many unplanned and unexpected events that occur from day to day that impact on that workload. This applies to a greater or lesser extent to every team in ACMH

iii. As set out in 4 (iii) there are many employees who are currently in survival mode. Examples in two key groups are given. It is quite remarkable that most teams are working as cooperatively and collegially as they seem to be.

iv. However even in the best of teams, there may come a "tipping point" or a "breaking point". If that occurs the survival of the individual will become paramount

v. I refer to paragraphs 4 (v), 4 (vi), 4 (viii) and 4 (ix). They all have HR and / or IR ramifications

vi. The situation discussed in paragraph 3 paints a very disturbing picture. That the formal allegation process is regarded with so much suspicion and mistrust that it is not being utilised is of great concern. To put it bluntly it means, if true, that there are ACMH employees who should have been investigated, and had findings made about their behaviour, who are free to continue with those behaviours.

vii. To enable SA Health and the three LHNs to develop an effective management response in relation to allegations of bullying, harassment and disrespectful behaviour received by the reviewer, a de-identified summary analysis of these allegations could be provided in an agreed format.

viii. In addition, the three LHNs may be interested in receiving collated information that relates to their own particular LHN. This could be broken down further to site-specific themes and issues whilst still de-identifying the employees who provided the information.

Greg Stevens
May 2017

Adult Community Mental Health

Staff Meetings held by Work Location

NALHN		
Salisbury	25	
Modbury	9	
		34
CALHN		
Woodville	23	
Tranmere	32	
		55
SALHN		
Marion	24	
Noarlunga	29	
		53
Mental Health Triage	7	7
Total:		**149**

Appendix B

Adult Community Mental Health

Staff Meetings held by Discipline

Nurses (L1 – 3)	83
Allied Health (L1 – 3)	38
Administration	16
Managers	10
Medical Officers	2
	149

Appendix C

Adult Community Mental Health

Common Themes Emerging From Interviews

Model of Care & System Issues	Disrespectful Behaviour	Well-Being	Workload Issues	HR Issues
The impact of the Community Redesign process (including industrial fallout) What is or is not the most appropriate model of care Lack of training, mentoring, development opportunities Lack of delegation to Team Managers Consolidation of 5-day and 7-day operational models Tensions between roles of operational senior staff and Heads of Units	Bullying by certain managers and team leaders Lack of respect for their specific skills (Allied Health) No confidence in the process or management of formal bullying claims	Burnt-out staff Staff reducing their hours to part-time Loss of experienced staff High degree of negativity and feelings of helplessness Individual team members supporting each other very much in evidence Lack of support for the Employee Assistance Program	Unsustainable and uncapped workloads Less time to deal with consumers Daily plugging the gaps Mismatch between expectations and what can be provided No accepted method of measuring workloads / caseloads	Lack of back-filling Unfilled vacancies Short-term contracts Unpaid overtime Poor selection practices (including acting appointments) Delays in recruitment process

[1]. Review of Southern Adelaide LHN Mental Health Services, December 2015