

**Individual Submission to the Productivity Commission's Draft Mental Health Report
-Andrew Morgan ,RN4 (RPN4)**

I hold a Certificate in Psychiatric Nursing and a Degree in Nursing and have practised in the area of mental health nursing (MHN) for 30 yrs.

I have extensive experience in the area of acute adult mental health nursing in community ,emergency department and inpatient settings.

I am a longstanding member of the College of Mental Health Nurses (ACHMN) and of the Australian Nursing and Midwifery Federation (Vic Branch).

There is common agreement that a mental health nurse is a registered nurse who holds a recognised specialist qualification in mental health.

To clarify the setting in Victoria;

Within the Public Sector, similar to South Australia, the EBA sets education standards for Registered Psychiatric Nurse (RPN) .To work as an Registered Psychiatric Nurse(RPN) 3 level you need to have undergraduate training in mental health nursing or be progressing post graduate studies and at RPN4 level have undergraduate or post graduate qualifications in mental health nursing.

Most private settings have similar expectations.

Whilst there is much to support in the draft Report, I wish to talk against the Draft Reports Recommendations 11.3 with respect to undergraduate MHN training and separate MHN registration.

The Report argues that the number of mental health nurses practicing in Australia — in GP clinics, community health services, and aged care facilities — should be significantly increased. I don't disagree with this expansion.

However the Report highlights that the only way to grow that workforce is to introduce undergrad training and separate registration. It somehow see's this as a way to change what it see's as a poorly valued profession in to a highly valued profession. It has a perception that the current MHN workforce lacks training.

I disagree with both recommendations and believe the status quo with respect to training should be maintained and expanded.

In my view the Report provides no or poor evidence to support the recommendations.

I will talk to 3 points in the Report with respect to this:

1. The draft Report's graph, Figure 11.5 (Attachment 1) reporting to list those nurse's with Specialist MHN qualifications is incorrect.

The Report wrongly assumes that only "credentialed mental health nurses" and those "nurses were solely qualified in the area of mental health nursing" via APRHA (essentially the migrant UK Mental Health Nurse cohort) are the only nurses with mental health qualifications.

The reality is most of the nurses with mental health training are registered as RN's only and so won't show up on any statistic as having specialised training .

By way of example, in the acute community team where I work , a search of the NMBA database reveals that of the 40 permanent MHN's on staff ,28 have MHN qualifications. Of those 20 have undergraduate and 8 post graduate, and 5 are overseas trained with mental health nurse training.

All are listed in APHRA as RN's.

Although all would be eligible to apply for ACHMH credentialing, only one has. None of the overseas trained nurses have the notation "solely qualified in the area of mental health nursing " on their registration.

What this shows is that only 1 of the 28 RN's on my team who fit the criteria as a MHN would be listed on the graph shown in the Report.

Simply put the graph doesn't show a complete picture of those with specialist qualifications and I would suggest the graph massively under represents the number of specialist MHN's in practice currently.

2. The ACMHN Submission (501) to the Commission:

The draft Report appears to rely heavily on the submission from the College and envisages a prominent role for the College with respect to future workforce planning/training. I wish to point out that the College has no legal entitlement with respect to establishing standards of practice for MHN's. They don't govern practice in the same way as the various medical Colleges do.

I am concerned that the College's preference for credentialing led to a bias in the data it provided. The data supplied by ACMHN on Figure 11.5 (**Attachment 1**) only shows credentialed nurses not the 1500 or so other MHN's that are members of the College.

I am also concerned about an inconsistency in the College's direction with respect to MHN training.

The College's Submission argues that nurses employed in mental health services should be appropriately qualified – *"that is, they should be Registered Nurses who have postgraduate mental health nursing qualifications."*

But at the College's recent AGM on the 9/10/19, two motions were put up which contradicted the College's Submission to the Commission and coincidentally, directly supported the Reports Recommendations in 11.3.

Motion 1: **separate MHN registration**, won by a show of hands (probably 60/40 split)
Motion 2: **undergraduate MHN training** , was defeated by 2 votes

Only approx. 250 of the 3000 members eligible voted, hardly a glowing endorsement of the motions or the Reports Recommendations in 11.3.

The Commission should also note that the College is currently without a CEO, and as a consequence almost half of the paid staff have resigned from the College.

3.The UK Model of Undergraduate Mental Health Nurse Training

The Report mentions the three year direct entry (undergraduate) degree in mental health nursing for nurse training in the UK, essentially highlighting its success.

However this appears not to be the case with the NHS MHN workforce down by 6000 in the past 10 years (**Attachment 2**) with difficulties being experienced with worker burnout and recruitment into undergraduate training.

Maintaining and expanding the Status Quo-why is the current post graduate model and registration process reasonable.

1. Mental illness and physical ill health are clearly linked. It could be argued that the crisis in mental health care is because of the chronic attitudinal and funding disconnect between the two. In this context a MHN needs the physical health knowledge that comprehensive undergrad nurse training can provide.

As a profession, nursing wouldn't benefit from the forced separation that separate training and registration would lead to. It risks losing the attitudinal gains that are apparent in the current nursing workforce.

Those that seek undergraduate MHN training have not been able demonstrate that it will create a cohort of new graduates into the field. The Report doesn't provide any research that supports this notion either.

2. Recent research suggests there was actually an increase between 2013 and 2017 in the supply of mental health nurses, from 83 .6 to 85 .8 FTE per 100,000 population (Source: Mental Health Services in Brief 2019,AIHW).So something is working.

3.In my area mental health network ,of the 149 graduates nurses commencing in mental health program for the years 2013-2017 ,30% had gone on to complete post graduate studies in MHN within 2-3yrs.

I understand there is little difficulty in attracting new grads to work in mental health. We need to continue to provide, increase and develop support mechanisms (ie. scholarships, clinical support positions, transition to specialty practice programs) to encourage this group to complete post grad training and continue on in the mental health field.

4.A major barrier to recruitment is the number of placements available during training and graduate entry positions. This is a direct relationship between this and the number of public mental health beds. Increased bed numbers will increase mental health nurse numbers.

5. Consideration could be given to funding a program that would provide a wage to those undertaking a full time post grad diploma and embedded them into community mental health services. In Victoria this could easily be an expansion of the existing Community Training Positions.

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Attachment 1

Figure 11.5 Specialist mental health nurses by type of training ^a



^a Sole qualification in mental health refers to nurses whose registration indicated they were not qualified to work as a general nurse. Post-graduate specialist training in mental health refers to nurses who were **credentialed** by the Australian College of Mental Health Nurses. Data for nurses with a sole qualification in mental health were only available from 2013. The number of post-graduate specialists in 2008 was estimated as a linear interpolation of 2007 and 2009 values.

Sources: ACMHN (2018); NMBA (2019).

Attachment 2

a)

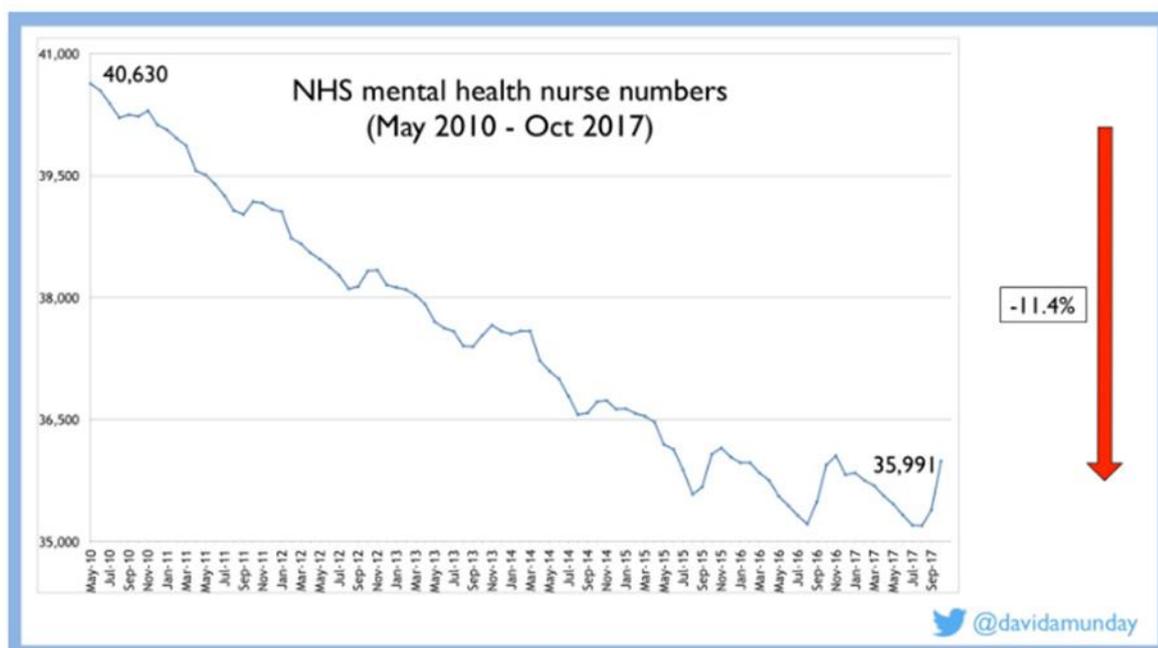
NHS England loses 6000 Mental health Nurses in 10 years- Recruitment and Training Crisis

The number of mental health nurses in England has slumped by more than a tenth over the past decade, new figures have revealed. This is despite commitments from both Theresa May and her predecessor, David Cameron, to boost resources for mental health services, which many professionals say are now in crisis. The total mental health nursing workforce has decreased by 10.6% since 2009, according to the Royal Collage of Nursing.

While numbers of mental health nurses have grown in some areas, such as community care, they have fallen elsewhere. Numbers are down by a quarter (25.9%) in acute care and inpatient care-where the number of mental health nurses has fallen by more than 6000 over the decade.

Source: Michael Savage, The Guardian Online 19/5/2019

b)



c)

The report used data from a sample of 16 universities for the years 2013/14 and 2014/15, and used a different method of analysing attrition than that used by the Nursing Standard survey. It reported an average dropout rate of 33.4%, with the highest rates in learning disability (39%) and **mental health nursing (35%)**. In a survey of 3,447 student nurses, it found that clinical placement experiences, finances and academic pressures were the most commonly listed reasons why students considered leaving courses. Of the students surveyed, 63% said they would not have applied for their nursing degrees if they had had to pay their fees.

Source: NHS Staffing Trends, Retention & Attrition-The Health Foundation, Feb 2019