

Australian Nursing and Midwifery Federation submission

PRODUCTIVITY COMMISSION DRAFT REPORT ON MENTAL HEALTH

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Nursing &
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PREAMBLE

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 280,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.



INTRODUCTION

The ANMF welcomes the opportunity to provide feedback to the *Mental Health Productivity Commission Draft Report: Overview and Recommendations* (the Draft Report). As noted in the Draft Report, despite the implementation of a number of innovative and effective programs, desired improvements in Australia's mental health have not been achieved. We support the holistic approach the Draft Report takes to its analysis of the factors contributing to Australia's mental health, and the emphasis on prevention and early intervention, particularly among marginalised groups and under-resourced communities. Many of the recommendations are directed at addressing these wider determinants of mental health.

However, the significant intersection of alcohol and other drug (AOD) misuse with mental ill health is only briefly mentioned, and while the Draft Report discusses the role of nurses in mental health, the impact of midwives is absent.

Mental health is a mandatory, embedded component of all programs leading to registration as a nurse or midwife. It is essential to recognise the extent to which utilising both nurses and midwives, working to the full scope of their practice, improves mental health outcomes for Australia.

Nurses enter the health workforce as generalists – their pre-registration education prepares them for the wide range of roles that a career in the profession offers. This deep generalist education facilitates workforce flexibility, with post-graduate education allowing application of that knowledge directed in a specialist area within the broader context of a person's whole life and health.

People seeking health care are more likely to encounter a nurse or midwife than any other health professional. Working across all points of care delivery or 'touchpoints', across the life spectrum from conception to death, nurses and midwives are uniquely positioned to provide integrated, holistic health care. These wide-ranging touchpoints, combined with the holistic care model that comes from a generalist foundation, inform the unique opportunities nurses and midwives have to support people's mental health.

The ANMF response to the Draft Report comprises two sections. The first illustrates many of the touchpoints where nurses and midwives have opportunities to identify actual and potential mental ill health, provide support and intervention, and refer people to expert services where appropriate. The second section addresses relevant recommendations from the Draft Report, demonstrating how the involvement or increase in nurses and midwives will improve mental health outcomes.



The following principles are the basis for our response to the Draft Report:

- Nurses and midwives have the knowledge, skills and expertise to provide safe, competent care across all sectors, at all levels
- To work effectively, nurses and midwives must be enabled to work to their full scope of practice
- Nurses and midwives provide holistic, problem-based, person-centred care that factors in physical, psychological, spiritual, and socioeconomic needs
- Holistic care delivery by nurses and midwives identifies that mental health is an aspect of overall health
- Nurses and midwives are effectively regulated by the Nursing and Midwifery Board of Australia, and there is no need for additional regulation
- Regardless of the area of practice, nurses and midwives need the time to effectively care for a person's mental health along with other health competing demands
- Individual nurses and midwives sit along a spectrum of mental health knowledge and experience, from generalist foundational theory to highly expert clinical practice underpinned by advanced academic qualifications

Drawn from these principles, the following recommendations are crucial to creating effective planning that will improve mental health care across Australia:

- Strategies to increase the number of nurses and midwives specialising in mental health must be multipronged
- Mental health nursing and midwifery are not seen as safe environments, free from violence. The ANMF Victorian branch's 10 point plan to end violence and aggression¹ should be adopted nationally
- There are too few nurses and midwives specialising in mental health to meet Australia's current needs, and demand is ever increasing
- Holistic approaches to mental health recognise that alcohol and other drug misuse is often both a contributing factor to mental ill health and a symptom management strategy
- The need for more nurses and midwives with both AOD and mental health experience is growing
- Many more scholarships that encourage nurses and midwives to complete post- graduate study in mental health is required
- Mental health nurse practitioner positions need to be made available across the community and hospital settings, along with scholarships to support registered nurses to complete the required Master's program
- Each school across the country should have at least one school nurse who has access to mental health nurses and, as required, to other health professionals



- More nurse- and midwifery-led models of care need to be funded and progressed; integral to this is re-instating the Mental Health Nurse Incentive Program
- The flexibility of a generalist platform means the nursing and midwifery workforce can quickly transition to new roles
- It is more cost effective to provide additional education and support to nurses and midwives than to create a more specialised workforce

NURSING AND MIDWIFERY TOUCHPOINTS

Combined, nurses and midwives are the largest health workforce, with the greatest reach, enabling touchpoints across all areas of health, education and the workplace, in all geographic locations throughout Australia. They are a highly educated, capable and regulated workforce that has long been at the forefront of health care delivery and advancing solutions by implementing practice changes for mental health. The widespread engagement nurses and midwives have with the communities they serve means they are well placed to provide universal mental health and physical health screening, intervention, referral and follow-up through a range of nurse- and midwife-led programs.

The nursing and midwifery professions do not separate mental health from physical health but instead regard them as intrinsically linked. The national approach to better mental health should be underpinned by recognising this health connection between the body and the mind. Nurses and midwives have the expertise to provide holistic, person-centred care that addresses the person's physical, psychological, social and spiritual needs in the context of their lived experience.

Midwives

Over 30,000 midwives are registered in Australia;² they work as essential primary care providers through a woman's pregnancy, from the initial antenatal assessment to completion of care at the end of the postnatal period. Midwives perform complex roles in maternity care services, including, but not limited to undertaking thorough assessments; identifying risk factors for deviations from normal; implementing prevention and intervention strategies; and, consulting with and referring to other health practitioners when required. All this is done while midwives provide holistic and supportive care to women and their families by establishing strong therapeutic relationships.

Midwives engage with women and families at a vulnerable time in their lives. The trust and connection between midwife and woman means these professionals are ideally placed to monitor, identify and facilitate management of perinatal mental ill health. Research consistently demonstrates that midwifery continuity of care models improve maternal mental health outcomes.^{3,4}



In 2010, the Victorian Government allocated funding for the Perinatal Emotional Health Program (PEHP), providing early intervention for women at risk of, or experiencing, perinatal mental health problems, to regional Victorian area mental health services as the major treatment component of Victoria's National Perinatal Depression Initiative (NPDI).

Midwives and nurses were actively engaged in and welcomed the program, because it filled a gaping hole in service provision for vulnerable women. Some midwives were provided with education and training to perform screening of depressive disorders, which they incorporated into their routine antenatal care. At Sunshine Hospital, providing PEHP to 306 women resulted in an average of a 1.7-day reduction in maternity service length of stay, a saving of \$806,310 in 2014.

The loss of this Commonwealth funding stream has negatively affected ongoing education for Victorian nurses and midwives. The gap bridged by this Initiative has reopened, ironically resulting in a decrease in referral and treatment options as risk assessments increase, creating ethical and clinical challenges for midwives in some antenatal clinics.

Maternal, child and family health nurses

Almost 4300 nurses identify their primary area of practice as child and family health.⁵ While the title varies across the country, all states and territories provide midwifery and nursing care for new parents from birth up to age five, significantly contributing to the wellbeing of children and their families. These nurses have the opportunity to develop a longitudinal therapeutic relationship with the child, their primary caregiver, and extended family; in many cases, this continues across the introduction of subsequent siblings.

A key aspect of maternal, child and family health nursing is engagement with all families, at key ages and stages of family and child development, regardless of the presence or absence of risk factors. These nurses promote health, undertake surveillance activities across all health domains, recognise vulnerabilities that may affect optimal growth and development, implement interventions, and initiate referrals to other health providers as required. Monitoring of maternal mental health is an integral component of care provided and has the scope to be utilised further.

The roles of both midwives and maternal, child and family health nurses are critical to promoting optimal mental health and, in turn, strengthening the capacity of mothers and families to provide a safe and nurturing environment for their infant and young child. Optimal maternal health and wellbeing is an enabler to child health, wellbeing and development - conclusive evidence demonstrates that the first 1000 days of a child's life are pivotal to future health outcomes.⁶ The importance of supporting midwives and maternal and child health nurses to make early identification, intervention and referral therefore cannot be overstated.



School nurses

In Australia, 1545 nurses and midwives work in every type of education sector: Government, independent and Catholic; across various age groups from preschool to tertiary level, in different types of school settings from day schools to outdoor residential campuses and special developmental schools. School nurses can be found in metropolitan, regional, rural and remote areas.

The diversity of the school nursing role across jurisdictions in Australia is dictated by the funding models and state or territory education policies. That is, the variability of work setting ranges from the public sector in some jurisdictions, to individual practitioners in private schools with boarding students. The role of school nurses also varies with the education sector, age group/s, setting, program objectives and stakeholder expectations. While the numbers of school nurses have decreased in some jurisdictions or education settings, others have seen an increase or a resumption of the role.

The school nursing scope of practice encompasses a broad range of physical and mental health issues. An integral component of school nursing is health promotion, which has significant potential to reduce stigma around mental health through education. They also provide primary health care, early detection of health or developmental issues and timely intervention, prevention, health education, and chronic condition management. School nurses do this utilising regular screening, education and on-going health and mental health promotion. As a result, they can identify physiological contributors to student change, and can provide personalised health and wellbeing information and guidance that encompasses both physical and mental health. These nurses are usually the only staff member employed in a school that has a health background.

Nurses working in schools build therapeutic relationships with the students, including siblings, and with their parents or primary care givers. School nurses connect to the community and other health professionals within it, such as general practitioners, community groups and the local support available from departments of health. Within the school community, school nurses also develop relationships and become an important resource for teachers.

Teachers set the school culture, know individual students and their families, witness inter-student dynamics, and are experts in learning and normal development for children in the range they teach. This extensive knowledge of their students encompasses aspects of their lives out of school, including caring responsibilities and non-academic pursuits that may contribute to increased stress or, indeed, provide avenues for stress relief. Until secondary school, teachers also observe their students across a period unparalleled by anyone, including parents – six hours a day, five days a week, for most of a year, giving teachers a unique opportunity to detect the earliest indications of change in mental health. The collaborative professional relationship between the school nurse and teachers enables invaluable insights into student assessment, monitoring and ongoing management.



The ANMF's school nurse members report that mental health-related issues comprise an increasing component of their role, both directly and as the result of exposure to mental ill health (e.g. affected family members). Once a problem is suspected, a referral to a school nurse allows for effective assessment triage, support, the provision of early intervention and, when required, referral to expert clinicians.

There are many advantages to increasing the number of school nurses across Australia. Nurses are already embedded in health care while working with the school community, which results in integrated care and communication between schools and health networks. Trusted members of the school community, nurses are often specifically identified by students as a safe person to disclose personal and private information.

Given the breadth of their scope of practice, school nurses are significantly underutilised, with many schools having no nurse at all, or access only to a community nurse who visits schools for specific interventions (e.g. immunisations). This prevents the development of pivotal relationships between the nurse, the faculty, the student body, and the wider school community. Some schools have replaced school nurses with first aiders, who are not equipped to manage complex, ongoing, or multiple health issues. The ANMF recommends that at least one school nurse should be employed in each school across the country, who has access to expert mental health nurses and, when required, other health professionals.

Nurses working in general practice

Nurses working in general practice are integral to the provision of safe, efficient and high quality primary care and are key to the delivery of the agenda for strengthening primary care services. There are many nurses in these roles across the country, with over 12,208⁷ nurses identifying general practice as their primary place of practice. Typically working with a team in general practice, these nurses plan and provide primary health care and education to people of all ages. The flexibility of the role and funding model allows these nurses to engage in longer appointments than most general practitioners, giving people more opportunity to discuss the whole of their health situation, rather than restricting consultation to a single specific issue. As with their colleagues in other sectors, these nurses develop effective therapeutic relationships over a period of months or years, engaging with multiple members of the same family or community.

Despite the growing employment of nurses in general practice, both in Australia and internationally, the scope of practice of nurses in this setting remains poorly understood and their potential underutilised. The role of nurses in general practice is dependent on a range of factors including the general practice profile, practice structure and individual employment arrangements. They are however integral to planning, implementing, co-ordinating, monitoring and evaluating health care within a general practice.⁸ This involves not only assessment and management of the person's immediate problem, but also includes health screening, preventive care, understanding the social



and psychological context, health promotion and health maintenance. If given the opportunity, nurses working in these areas could be used more effectively, providing a more inclusive touchpoint for mental health and suicide prevention.

Community health nurses

The roles of community nurses vary, with over 13,000 nurses identifying that the community is their primary place of practice.⁹ These roles vary from nurses providing care for older people in their home, support for people post admission from hospital and nurses who provide care for people who are experiencing homelessness. Operating from a social model of health that focuses on prevention and health promotion, community nursing often involves culturally and linguistically diverse communities, socio-economically disenfranchised populations, young and marginalised people, all of whom are at higher risk of developing mental ill health than the general population. Their role involves working with and within communities to identify barriers to health and wellness, including mental health, empowering individuals, assisting them to understand their health and interventions. These nurses also act as navigators to assist people in need to move through Australia's complex health sector.

Launched in March 2019, Royal Hobart Hospital's Mental Health Hospital in the Home Unit is a trauma-informed recovery model that allows people experiencing an acute mental illness to receive care, treatment and support at home for up to 14 days, preventing 36 emergency department presentations and acute in-patient stays in the first quarter of operation.¹⁰

Emergency department (ED) nurses

Particularly for marginalised, disadvantaged, or health care averse populations, ED nurses may be the first point of health care contact, and are also at the front line when it comes to people experiencing an acute mental health crisis. These nurses often have considerable experience, and many have or are working towards a postgraduate qualification in emergency or critical care nursing. They care for people requiring support for all health concerns including mental health.



A/Professor Tim Wand leads a mental health liaison team based in the Royal Prince Alfred ED in Sydney. The experienced mental health nurses making up the Mental Health Emergency Department (MHED) team includes a nurse practitioner, and their work complements that of their consultation liaison psychiatry colleagues.

The MHED nurses work as close to triage as possible, relieving some of the ED nursing and medical workload. People who access MHED cross all ages, often with undifferentiated mental health, drug health and behavioural problems. The team provides mental health support to people presenting with both physical and mental health conditions, co-ordinating between mental health services, community organisation, general practitioners, and other primary health care providers.

The MHED model has been extended to two rural local health districts, with all teams scheduled beyond business hours, when fewer supports and services are usually available.

The close working relationship between MHED nurses, ED nurses, and physicians, combined with a collaborative relationship with the consult liaison team, means not every person needs to be referred to the psychiatry team. This reduces wait times for consumers, workload for physicians, and the number of people in ED.

The ANMF's ED members report that the number of people presenting to the ED with mental ill health has significantly increased. This is consistent with the Draft Report's finding that *the rate of mental health presentations at EDs has risen by about 70% over the past 15 years.¹¹* As has been noted in the Draft Report, people presenting with mental ill health have substantially longer waiting times than those presenting with physical health concerns, usually in a setting that is not therapeutic for their condition. With neither designated nor appropriate space for these consumers to wait and be assessed, nor specialised mental health staff, outcomes are rarely favourable for anyone. Consumers face long delays in an inhospitable, noisy, bustling environment; the staff, are confronted by these consumers' frustration, with their agitation often presenting as violent and aggressive behaviour. This can be disruptive and distressing for other consumers.

Royal Darwin Hospital (RDH) is the NT's busiest ED, and the mental health team, which reviews anyone presenting with a mental health concern, is considerably understaffed. In December 2019, there was only one nurse on night duty to assess 218 mental health presentations to RDH, in addition to being the sole person staffing the NT mental health hotline. There is provision for two nurses, but the workload and lack of support has resulted in rapid turnover.



There is clear need for an appropriate clinical space, and for mental health nurses and nurse practitioner expertise in the ED. Employing more nurses with mental health expertise in the ED will address this significant short fall in people getting care when they need it.

Alcohol and other drug (AOD) nurses

The increase in mental ill health is associated with a higher incidence of AOD use, including tobacco, as both a contributing factor and self-medication strategy.¹² The substantial overlap between mental ill health and substance misuse requires AOD nurses to have a thorough understanding of both areas, and how they intersect. Nurses who work in the AOD sector provide holistic, consumer-centred care to improve health outcomes.

The latest data identified just over 1900 Australian nurses working in the AOD sector;¹³ this is a start, but the number of experienced nurses working in this area, and the available services to enable people to get access to care when they need it, must be significantly increased. This provision will be most effective if AOD nursing services are dispersed across multiple key settings, including EDs and within the corrections system, as well as in stand-alone facilities.

Correctional nurses

Nurses in this area work in a team with police services, remand centres and prisons. There are 1720 nurses working in this area across the country.¹⁴ There are so few correctional nurses that our members, report being able to do little more for their consumers than perform triage rather than care, particularly for those with complex mental and physical health concerns.

Mental ill health, particularly undertreated mental ill health, is a substantial risk factor for criminality. Australian researchers have found a rate of psychosis 30 times higher among NSW inmates than the general population,¹⁵ while Victorian data indicates 8% of male and 15% of female prisoners have a psychotic illness, and 5.5% have schizophrenia.¹⁶ In comparison, the national incidence of psychosis is 0.5%, with schizophrenia accounting for around half that number.¹⁷ Not only are incarcerated people more likely to have a mental illness, almost 70% have more than one,¹⁸ making management more complex. For many people with both a criminal history and mental illness, the first arrest often occurred before their first contact with mental health services.¹⁹ Post-release support and follow up is essential as mental health can quickly deteriorate after release.²⁰

Further, this system has neither the necessary cultural ethos nor the resource capacity to assist the imprisoned to develop insight into their substance misuse. There is considerable population overlap between the work of AOD nurses and their correctional counterparts, but they have quite different approaches. AOD nurses focus on harm minimisation, with understanding and often long-term work on the sociological and mental health factors underpinning substance misuse, whereas correctional nurses work within a justice framework.



People who are traumatised or who lack the resources to manage their mental ill health in more therapeutically useful ways, may use alcohol, tobacco, and other drugs to mitigate the symptoms of their disease, relieve the side effects of medication, and dull the pain of existence and memory.²¹ Being able to provide support, insight, and the tools for change are vital components in breaking cycles of recidivism. An effective way to achieve this would be encouraging cultural change within the criminal justice sector to a more harm minimisation-focused approach.

Nursing roles within the correctional system have significant potential to be expanded, from providing more nursing touchpoints for all people having a comprehensive physical and mental assessment to experienced mental health nurses providing ongoing care delivery.

Aged care nurses

Requiring both a broad range of generalist skills and knowledge combined with an understanding of the complex interaction of physical, psychological, and dementing conditions with medications, and multi-organ impairment, aged care nurses care for some of our more frail and vulnerable people. Mental ill health is significant in the aging population. Men over 85 have been identified as the highest risk of suicide,²² and many people living in a residential facility experience high levels of depression and anxiety.²³ Dementia also affects just over half of aged care residents.²⁴ Nurses in residential aged care have therapeutic contact with residents around the clock, and are able to build therapeutic relationships over longer periods.

In addition to the residents themselves, aged care nurses develop relationships with the older person's families and friends, which enables the nurse to connect residents with their support networks when required. Nurses working in aged care, particularly residential facilities are able to notice a change in a person's mental health, adjust care delivery and provide a referral to health professionals with further expertise when required. However, the increasing prevalence of both mental ill health means these nurses need direct access to mental health nursing expertise.

Unambiguously sub-titled *Neglect*, the Royal Commission into Aged Care Quality and Safety interim report²⁵ attributes many of the issues facing the aged care sector to chronic under-staffing, with care further compromised by the replacement of qualified nurses with minimally-trained care workers, who have neither the education nor expertise to detect changes in mental health, assess the effectiveness of interventions, or deescalate volatile situations.



There are currently no secure aged care facilities in the NT. The brand new rehabilitation and geriatric hospital just outside of Darwin has no capacity to provide appropriate around-the-clock care for people with dementia or mental health issues. Instead, these residents are housed in the hospital's geriatric unit, which is neither staffed nor equipped to manage people who require specialised care in environments designed for safety.

While de-escalation education, particularly for care workers and security personnel, would help in reducing the risk to staff and other consumers. At present equipment, including unit computers, are damaged, and staff have nowhere safe to retreat if a person becomes violent. In January of this year, a nurse locked herself in the bathroom and called for help on her personal phone.

Evidence based mandated minimum staffing, including the appropriate balance of registered nurses, enrolled nurses, and care workers (however titled), will allow the community and residential aged care²⁶ nursing workforce to provide holistic care that encompasses physical, mental, and spiritual wellbeing positively improving health outcomes for this vulnerable population.

Nurse navigators

There is a widely accepted view that the mental health care system is intricate, changeable, and often difficult to navigate for both affected people seeking help and those acting on their behalf, particularly for the 'missing middle' – people whose mental ill health is neither significantly acute or grave enough to require emergency mental health services, nor straight-forward and mild enough for low-level community support.

Nurse navigators can help guide people through this complicated landscape of mental health provision to access services that best meet their needs. They support and work across system boundaries and in close partnership with multiple health specialists and health service stakeholders, to ensure consumers receive the appropriate and timely care needed.

These registered nurses, experienced in mental health, are educationally prepared to undertake holistic assessment of the person. They have an intimate understanding of the care needs of consumers with complex mental health presentations, and have the knowledge to guide the person and their family through the difficult route of providing the right level and type of support for conditions that change unpredictably.



Andrew Jackson is a nurse navigator whose 20 years of experience across a wide range of mental health intervention includes high security forensic units, correctional, youth and community services, and general and psychiatric hospital placements. He is involved with consumers from minority groups, First Nations people, young people, and consumers with forensic backgrounds. This diverse experience has given him a passion to advocate for the human rights of individuals to be able to access specialised mental health care with a positive engagement focus.

Andy works at Logan Hospital in Brisbane, where his role is “to provide caring and supportive access for people who understand what it means to have distressing suicidal thoughts or plans in order to improve outcomes for them once they have been formally assessed at Logan ED by Addiction and Mental Health Services.”

The value of his unique role is demonstrated with this case study:

Audrey* said she felt like a nuisance through her regular presentations to the hospital after telling her GP she felt suicidal.

“I am usually sent home after assessment but not being able to get help made me feel alone and stuck, especially after a row with the kids at home,” she said.

“Before getting help with Andy, I had lots of people all telling me what to do but I would get confused with their different advice so I would just hurt myself to cope.

“I felt like no one listened to me or knew how I felt.”

Andy describes the navigator service as focused on assisting consumers with complex mental health needs to have quality of life and a better understanding of how the hospital and the various health care professionals along the journey could help with the support of family and friends.

**name changed*

Nurses’ broad preparation and skill-set, augmented with specialist mental health experience, positions them to holistically, adequately, and appropriately meet the biopsychosocial needs of people with complex mental health needs. Nurse navigator positions have been employed in the United States since the early 1990’s, with increasing use of this role over recent years to improve care coordination and navigation of the healthcare system and access to services.

In Australia, this model of care is used in varying ways across the states and territories to coordinate care and is referred to by various titles, including nurse navigator. In 2015, Queensland Health introduced 400 nurse navigator positions to ensure appropriate care and coordination of services along a consumer’s entire health care journey, helping them and their families/carers to navigate the healthcare system.



The advantages of registered nurse navigators, experienced in mental health care, are outlined below:

- Nurse navigators understand the roles of the other members of the multi-disciplinary team and can effectively refer on to, and collaborate with, the most appropriate health care professional or non-clinical provider to meet clinical and non-clinical needs;
- They work closely in care teams with other health care professionals such as the older person's General Practitioner (with a shared high level of health literacy, thus improved messaging of the person's care needs) and with the wider multi-disciplinary team members;
- The assurance of a qualified and regulated health care practitioner who practices under the governance of the Health Practitioner Regulation National Law Act (2009) and a risk mitigating Professional Practice Framework which includes standards, codes and guidelines;
- The ability to formulate a comprehensive picture of the consumer regarding all aspects of their physical and mental health;
- Nurse navigators present sound value for money.
- Nurses are accustomed to involving the person and their families/carers in understanding care needs, employing a person-centred approach to implementing care plans to ensure continuity of care through changing needs and levels of acuity; and
- When issues arise outside of their scope of practice, the nurse navigator is able to assess when referral might be required to another navigator, such as to a financial navigator.

The more rural or remote an area, the more likely it is that nurses will be the most prevalent qualified and regulated health practitioners available. They understand the unique challenges of rural and remote communities. It makes good economic and geographic sense, therefore, to use these health practitioners as the navigator for the mental health services. Rather than bringing in a health professional or other worker who is unknown to the older person or their family/carers, these nurses are already known and trusted by the local community, an aspect especially important in Aboriginal and Torres Strait Islander communities where nurses have established trusted relationships. In addition, nurses in these settings work collaboratively with Aboriginal and Torres Strait Islander health workers and their health practitioner or health professional colleagues, to provide culturally safe mental health care.

It is our view that the role of nurse navigator in mental health should be implemented nationally. The role is ideally tailored to the scope of practice of registered nurses, due to the comprehensive nature of their assessment skills and knowledge of the mental health sector. Appropriate funding will be essential to ensure adequacy of staffing numbers to enable the nurse navigator to take the time required to work with the consumer and their support network. This funding should connect the nurse navigator to the consumer as part of the discharge team process in tertiary facilities or in primary care settings, such as general practices.



Mental health nurses

Specialists in an area of health that intersects with every part of health care, mental health nurses perform invaluable work with people who have emerging and established mental ill health. Nurses working in mental health add clinical experience to their generalist foundation, with many nurses in the speciality having or working towards a postgraduate mental health qualification. The expertise of mental health nurses cannot be underestimated, in both the direct provision of care and through education: of consumers, families, colleagues across sectors and specialties, and of the wider community.

Over 22,000 nurses identify their primary area of practice as mental health.²⁷ As the Draft Report notes:

mental health nurses are a critical part of the current mental health workforce, being the largest clinical occupational group dedicated to mental health, and one of the most geographically dispersed and cost-effective sources of expertise for combined management of mental and physical health and care coordination. The number of mental health nurses practicing in Australia — in GP clinics, community health services, and aged care facilities — should be significantly increased.²⁸

The ANMF agrees. Australia has too few mental health nurses to meet present demand, a situation that is shared across the developed world. The causes are multifactorial, including unsatisfactory workplace conditions, concerns about violence, and stigma. These issues must be comprehensively addressed if the sector is to attract new nurses, and retain those already working in the specialty. This response discusses a number of strategies to address these issues in the ANMF's response to recommendations 11.1 and 11.6 (below).

Mental health nurse practitioners

Like their peers in other sectors, mental health nurse practitioners (NPs) work collaboratively, at an advanced level, to translate their deep experience and knowledge into specialised, holistic care. They are Master's degree prepared practitioners with extensive experience and expertise in mental health.

The scope of practice of the NP working in mental health builds upon registered nurse practice, enabling NPs to manage episodes of care, including wellness focussed care, as a primary provider of care in collaborative teams. NPs use advanced, comprehensive assessment techniques in screening, diagnosis and treatment, applying best available knowledge to evidenced-based practice.

Substantially underutilised in Australia, there is broad scope for their inclusion as both clinicians and educators in all the nursing areas discussed above. Barriers to greater uptake include:

- Financial obstacles, as the programs leading to endorsement can cost over \$20,000
- Difficulties accessing Master degree programs, as many education providers require registered nurses to have support from their employer, and



- Employment insecurity, as there is no guarantee a registered nurse undertaking the course of preparation will gain employment as a NP on completion, as there are very few positions.

ANMF members commonly express their concerns regarding employers requiring them to develop business cases to create an NP position before they can begin studying and gain employment.

Nurse-led models of care

NPs and mental health nurses have substantial experience in delivering nurse-led models of care. Whilst the term ‘nurse-led model of care’ does not entertain a strict definition, it typically is applied where nurses take leadership, provide a supervisory role or practise without the direct supervision of another health professional in delivering care.²⁹ This may occur where the nature of the treatment is particularly amenable to nursing care, for example in the treatment of acute or chronic conditions, the provision of preventative interventions, where regular monitoring or treatment is required, where a treatment cannot be administered by the individual or their carer, or perhaps, where the individual requires frequent holistic reassessment. The appropriateness of nurse-led models is also apparent where there is a lack of availability of other health staff (such as in regional, rural and remote locations),³⁰ and/or limited resourcing of health services.³¹

Meta-analyses of nurse-led services in OECD countries has provided evidence to suggest that nurse-led models of care are at least as good as traditional physician-led models.³² Whilst the scope of nurse-led models of care is significant, where models have been implemented there have been notable positive outcomes. Evidence has been provided for clinical benefits in delivery of care such as a reduction in short term risk factors and positive behaviour change (e.g. reduced smoking and improved diet adherence). People receiving care have also indicated an increased perceived quality of life and general health status, satisfaction in the delivery of their care and there has been an overall increase in the uptake of treatments.^{33,34,35,36}

Increasing strain on healthcare systems and a shift towards the empowerment of consumers, allowing them to play a more active role in their healthcare will see the increased development and adoption of nurse-led models of care.³⁷

The Mental Health Nurse Incentive Program (MHNIP) was an excellent example of a nurse-led model of care. Nurses working within the program had mental health expertise, and were able to provide community-based care that was individualised, timely, coordinated, and cost effective. A review and analysis of published literature on the MHNIP found it was largely beneficial to people with severe and persistent mental illness, provided greater access to mental health care in primary health settings, and was highly valued by service recipients.³⁸ Measurable outcomes included overall mental health and social functioning for people, decreased Health of the Nation Outcome Scales (HoNOS) scores, increased engagement with employment, and reduced acute hospital admissions that resulted in an average cost saving of \$2,600 per consumer, annually.



MHNIP funding was folded into Primary Health Networks (PHNs) in 2016, which effectively closed the program. The result has been increased burden on the public health system. The ANMF Victorian Branch has reported that this represents a significant loss for consumers, many with complex, trauma-based mental illness, who relied on these mental health nurses.³⁹

The ANMF recommends that the MHNIP program is re-instated across the country and that registered nurses who have completed a postgraduate diploma in mental health nursing and have gained experience are able to deliver the MHNIP program. Nurse-led models, including those led by nurse practitioners, should be strongly considered in future planning for mental health and suicide prevention going forward.

ANMF'S RESPONSE TO DRAFT REPORT RECOMMENDATIONS

The following section will address a number of draft recommendations and requests for information made in the Draft Report.

Recommendations

DRAFT RECOMMENDATION 5.2 — ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS

DRAFT RECOMMENDATION 5.4 — MBS-REBATED PSYCHOLOGICAL THERAPY

DRAFT RECOMMENDATION 5.5 — ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY

DRAFT RECOMMENDATION 5.6 — PRACTITIONER ONLINE REFERRAL TREATMENT SERVICE

DRAFT RECOMMENDATION 5.7 — PSYCHOLOGY CONSULTATIONS BY VIDEOCONFERENCE

DRAFT RECOMMENDATION 5.8 — INCREASE CONSUMER CHOICE WITH REFERRALS

DRAFT RECOMMENDATION 5.9 — ENSURE ACCESS TO THE RIGHT LEVEL OF CARE

The ANMF endorses these recommendations. As was noted in our response to the 2019 Medicare Benefits Schedule Review Taskforce Report from the Nurse Practitioner Reference Group (attachment A), we support MBS benefits for teleconferencing and mental health plans being extended to primary and community health nurse practitioners and to mental health nurse practitioners as providers. Widening access to these services allows faster implementation of the recommendations, and facilitates equity of access for geographically and socioeconomically distanced populations.

DRAFT RECOMMENDATION 6.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED

DRAFT RECOMMENDATION 6.2 — INFORMATION CAMPAIGN TO PROMOTE SUPPORTED ONLINE TREATMENT



Supported and self-directed online treatment programs give thousands of Australians easy and cost-effective access to structured education about sub-acute and low to moderate level mental health conditions. The nature of delivery and the way the programs are framed contributes to reducing stigma, and allows for flexible learning in a non-threatening environment. The ANMF supports the expansion and promotion of existing programs, particularly those that target children and young people, and that facilitate problem solving and coping behaviours. We note, however, that the word “nurse” does not occur at all in this chapter, despite the scope for mental health nurses (particularly nurse practitioners) in the creation, evaluation, and promotion of these programs, and as clinicians in supported models.

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

The segregation of mental from physical health can perhaps be most starkly seen in EDs. People presenting to EDs with significant mental health concerns face wait times far longer than do consumers with equally serious physical ailments. These environments are not conducive to support mental health care delivery. The combination of delay, and a setting that is highly clinical, loud, abrupt, and tense, contributes to the high level of aggression and violence common in emergency departments.

Many hospitals have embraced nurse practitioners in emergency, as they can assess and treat large numbers of stable, predominantly ambulant consumers in a fast stream setting, without need for consultation with their medical colleagues. Uptake, or even facilitation, of mental health nurse practitioners in the department, however, has been far slower. Along with the need to increase mental health nurse practitioners in EDs, it's important to embed mental health nurses in emergency departments, and facilitate more emergency department nurses undertaking mental health qualifications.

The Royal Hobart Hospital’s emergency department, has a Psychiatric Emergency Nurse role that requires 5.84 effective full time nurses to run, but is currently staffed at under half that, while the trial of a similar position at Launceston General is unlikely to be granted ongoing funding, despite its success. In addition, there must be appropriate beds available for those consumers that require admission – the Royal Hobart Hospital reduced inpatient psychiatric beds from 42 to 32 in 2015, despite a 95% occupancy rate, and the new unit only has a 32-bed capacity.

The Victorian government’s ED mental health and AOD hubs are an effective program that combine specialised care in a dedicated physical space that is designed for therapeutic interaction, in the same way fast track and resuscitation cubicles are designed for specialist physical health interventions. Similar to a road trauma consumer being rapidly assessed by specialists, and then transferred for urgent surgery or to intensive care, a person acutely unwell with an AOD or mental health condition is admitted to a specialist short-stay unit, assessed, treated, and appropriate outreach support follows. If innovative programs like the ED mental health and AOD program were



implemented nationally, this would ensure timely, quality care, improve outcomes for the individual and reduce the likelihood of re-presentation.

In some cases, as is discussed throughout this response, some people need care for a combination of physical, mental health and AOD concerns; better integration of all aspects of health not only enable recognition of multiple aspects of a presentation but also facilitate an interdisciplinary, inter-specialty approach to management. The ANMF supports this model, where nurses, nurse practitioners, allied health and specialist medical staff provide discipline-specific care.

DRAFT RECOMMENDATION 8.2 — CHILD AND ADOLESCENT MENTAL HEALTH BEDS

As the onset and development of different mental health conditions occur at different ages, and given the additional vulnerability of this population, young people who require in-patient treatment should be placed in dedicated, separate units.

The ANMF supports the recommendation to increase the number of child and adolescent health service (CAMHS) beds. It is essential these are accessible in rural and regional areas, as well as in metropolitan facilities, to avoid consumers and their families being required to travel for care. This access will also prevent treatment delays and prevent deterioration and longer admissions.

Of course, increasing these bed numbers will require an increase in mental health nurses to staff those beds. One of the disincentives reported by members working in mental health is the untenable workload. Nurse-to-patient ratios mandate an evidence-based number of consumers per nurse, and the skill mix of direct-care staff in each unit, factoring in the setting, acuity, and care required. Ratios are a floor, rather than a ceiling, staffing method. They reflect the minimum number of nurses needed to provide timely, quality care, with supplementary nurses added in times of higher acuity. Instituting nurse-to-patient ratios in mental health generally, and in child and adolescent mental health units in particular, would ensure the right mix and number of staff, thereby allowing nurses to provide the specialised care needed.

DRAFT RECOMMENDATION 10.1 — CONSUMER ASSISTANCE PHONE LINES

Many ANMF members work in consumer assistance phone lines and they explain that sometimes there is a gap in managing referrals. Service providers need robust frameworks for receiving referrals outside of normal business hours. Mental health nurses and nurse practitioners can be better utilised to fill this gap in the consumer experience.

Consumer phone lines are only of use if calls can be answered promptly, with operators having enough time to establish rapport, develop trust, and deliver the appropriate support and advice. As was described in part one, under *Emergency department nurses*, this is not the case in the Northern Territory, despite the mental health hotline serving a population with Australia's highest suicide rate. Funding for phone support services must therefore be dedicated for that purpose, with staffing numbers that reflect the workload of the service.



In contrast, in Victoria, each acute mental health service has a telephone triage, but the mental health nurses performing triage have few referral options for consumers who fall into the ‘missing middle’ category: people with moderate mental illness, particularly those whose illnesses are too complex or enduring to be assessed by Crisis Assessment Treatment Teams (where they still exist) or for inpatient admission, but not considered severe enough to meet the high threshold to access constrained specialist mental health services. These consumers are often referred back to their GP who may be at a loss themselves regarding treatment and support.

Further, outcome evaluations for a functional consumer assistance phone line should not be assessed based on the duration of each call and number of calls taken per operator but rather consumer surveys, number of referrals, timeliness of referrals being actioned, and care outcomes.

DRAFT RECOMMENDATION 11.1 — THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY

A comprehensive mental health workforce strategy is required. The ANMF agrees with the Draft Report recommendation that the federal government *set targets to attract and retain workers, and establish a system to monitor and report progress in achieving the targets.*⁴⁰ We note, however, that it is only possible to set and meet these targets with an accurate baseline against which to measure. The strategy must accurately capture and monitor the current number of nurses and midwives working in mental health, including those who have a postgraduate qualification in mental health.

National data on how many nurses have mental health qualifications is not available and the ANMF suggests that the data presented in Volume 1 of the Draft Report are not accurate. Figure 11.5 of the Draft Report states that close to 85% of mental health nurses did not have a specialist mental health qualification. However this calculation only considers specialist qualification mental health nurses who are either sole-qualified (i.e. educated in the UK or through the former vocational mental health pathway), or those who have undertaken voluntary credentialing by the Australian College of Mental Health Nurses. This approach leaves out both registered nurses who have completed a general nursing degree followed by a mental health postgraduate qualification and enrolled nurses working in mental health, creating a statistic that understates the strength and expertise of the mental health nursing workforce.

There is a tool already in place that, with minor additions, could quickly and inexpensively elicit generate the data needed to establish the baseline numbers of nurses currently working in mental health, and their level of qualification. This tool is the questionnaire that is already a component for registration renewal with the Nursing and Midwifery Board of Australia (NMBA).

The additional questions should encompass, but not be limited to, nurses and midwives who identify as having a postgraduate qualification in mental health. Questions could also be asked about the mental health services nurses and midwives provide. The resulting data could then be used to identify areas of shortfall, direct education



funding, workforce priorities, and to measure outcomes of interventions designed to increase the number and utilisation of mental health nurses.

For guidance, we refer the Productivity Commission to the Royal Commission into Victorian Mental Health Services' interim report, which speaks to the need to collate and publish the profile of the mental health workforce across all geographic areas, disciplines, settings and sub-specialties; the need to institute mechanisms for continuing data collection and analysis of workforce gaps and projections; and the importance of regular mapping of the workforce to meet these gaps.

DRAFT RECOMMENDATION 11.3 – MORE SPECIALIST MENTAL HEALTH NURSES

Accreditation standards should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing

The ANMF does not support this recommendation. There is no evidence this expensive, lengthy process will create the much needed mental health nursing workforce. It could however have significant unintended workforce consequences.

The sole supporting commentary for this recommendation in the Draft Report is that UK mental health nurses are *highly valued as recruits by providers of mental health services in Australia*.⁴² It is important to note that in the last nine years 5000 British mental health nurses have left the sector,⁴³ with nursing losses as high as 25.9% in some areas.⁴⁴ Mitigation strategies in the UK have included *supporting students to embark on more flexible undergraduate degrees in mental health or learning disability training with an ambition of an extra 4,000 people in training in five years' time*.⁴⁵ Along with ongoing retention mitigation strategies for the nursing workforce, Australia needs to learn the lesson the UK are experiencing and maintain current education requirements, that is providing a generalist nursing foundation.

A generalist basis for mental health nurses allows for greater flexibility, for both the workforce and for employers, than a narrow entry qualification. Introducing a qualification that restricts nurses' capacity to practice at a time when the UK model are considering greater flexibility is not wise. As we have heard from our direct entry midwife members, scope for employment outside metro areas is reduced, as many organisations in rural and remote areas prefer the flexibility of hiring dual qualified practitioners. The career paths of most nurses cross a range of sectors, with opportunities and areas of practice that did not exist at the time they first registered.

Supporting a nursing workforce that has a generalist foundation informed by embedded mental health content improves population health not only in designated mental health services but across the board, for many reasons. Nurses intersect with consumers' life journey at every point, as does mental ill health. Recognising nurses and midwives as key players in identifying potential or actual stressors and ill health facilitates earlier interventions from reframing and support referral to specialised mental health services.



Further, an essential element in destigmatising mental ill health is to enfold it as a part of overall health, alongside physical health, rather than treating it as a separate and unrelated issue. For best care, we need integration, rather than further separation. Mental health support must be regarded as part of overall health and wellbeing. The same determinants that increase the risks of physical illness contribute to the likelihood of mental ill health. The connections between physical and mental health are explicit yet, too often, they are treated as separate creatures. An integrated, collaborative, cross-sector approach would contribute to destigmatising mental ill health, within the health care professions as well as across Australia more broadly.

In addition to greater utilisation of nurses and midwives at health ‘touchpoints’, the specialty of mental health nursing absolutely demands discrete treatment and intervention programs. This expertise in skills and knowledge needs to be built from the starting point of a nursing generalist foundation. As with other kinds of health care, when people have acute, complex, or treatment-resistant mental health, the care and interventions required are highly specialised. However, nurses and midwives working in intensive care units build on their generalist foundation, with experience, education, and an understanding of the roles of their colleagues in other areas of nursing practice. So, too, it is important for mental health nurses to have experience of caring for people with physical illness as it is for nurses and midwives working in other areas to have a foundational understanding of mental ill health.

Rather than investing in a program that requires multiple, onerous hurdles to implement, the ANMF recommends that, if there is demand, education providers are encouraged to provide an undergraduate program that both meets the requirements of the ANMAC accreditation standards for a registered nurse, enrolled nurse or midwife and provides specialised theory and practice in mental health – a major in mental health nursing. The additional theory and practice in mental health nursing would enable innovation in program delivery and capture undergraduate students who are interested in a course with a strong focus on mental health, without creating the regulatory burden of a separate registration qualification.

It is also essential that quality clinical placements are a part of all undergraduate programs leading to registration. Clinical placements that provide a variety of mental health care delivery settings with good role modelling and support will foster students’ interest and future career opportunities in mental health. Further supporting post-graduate mental health qualifications through scholarships and fee relief would result in more mental health specialist nurses.

The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health should be assessed

The majority of ANMF Branches oppose the creation of a specialist register for mental health nursing, as there is no resulting clinical or workforce benefit. A specialised registration system will however create a significant unintended consequence of disadvantaging experienced, competent mental health nurses who do not have post-



graduate qualifications in the specialty. Again, inclusion and a whole of health approach is an integral element in reducing mental ill health.

DRAFT RECOMMENDATION 11.6 — MENTAL HEALTH SPECIALISATION AS A CAREER OPTION

The ANMF agrees with the Draft Report that health students across all the professions would benefit from clinical placements across a wider, more representative range of settings.

Mental health theory is already a mandatory part of all education leading to nursing and midwifery registration, but quality clinical placement in the specialty is not common, and in some cases, an aged care placement incorporating care of residents with dementia is substituted. As was comprehensively discussed in the Educating the Nurse of the Future report:

...when it comes to placement hours, quantity is not a guarantee of quality. Students may spend many hours on placements, but gain little if the venues are inappropriate, supervision poor, and durations short... short rotations should be avoided, and the final year's placements should be planned as a bridge between education and work.⁴⁶

Recent research from the UK demonstrates the importance of final year clinical placements for nursing students. Although half the participants began their degree with a preconceived clinical specialty they wanted to work in once registered, only 14% retained that preference when applying for a post-graduate position. In comparison, three quarters of students reported their final year placements 'significantly influential' in determining where they wanted to work.⁴⁷

Contributing factors to these decisions included the placement environment, degree of support from mentors and clinical staff, and being able to see the effects of their work on consumers' lives; positive placements increased likelihood of the newly qualified nurse selecting the specialty, and negative experiences convinced them to apply elsewhere.⁴⁸ Well supported, quality mental health clinical placements in final year will increase the number of nurses and midwives interested in working in the specialty, either immediately upon registration or following a period of consolidation of clinical practice.⁴⁹

Providing substantive, well-resourced transition-to-practice programs in mental health and community health, for both enrolled nurses and registered nurses, will also attract graduates, and help retain them within the area. There is also need for mental health nurses to have clear career paths that encourage and support for clinical nurse consultants and nurse practitioner development, particularly in community health. This will involve both scholarships to assist in paying the costs of post-graduate education, and ensuring there are viable work opportunities once nurses have achieved the qualification.



DRAFT RECOMMENDATION 11.7 — ATTRACTING A RURAL HEALTH WORKFORCE

As discussed in the ANMF's response to recommendation 11.6, above, clinical placements are a strong determiner of graduates' first career decisions. Supported rotations in the final year of qualifications, and a greater number of transition to practice programs for early career nurses, will contribute to more nurses and midwives working in rural communities. Clear professional pathways to a variety of career outcomes, including nurse practitioner qualification, will also assist newly qualified nurses and midwives to pursue work in under-served areas.

Addressing professional isolation is important. While greater use of video conferencing is one strategy, it is not without problems, as reported by one of our NSW members:

Last year there were cutbacks in funding so that travel and accommodation is reduced and tightly restricted. I used to travel to Newcastle 3-4 times a year to meet with Clinical Nurse Consultant and mental health nursing leadership colleagues. This no longer happens. I may get one trip this year. Using videoconferencing isn't as great as it sounds for education and meetings. The main issue is that the remote person remains isolated and isn't able to interact spontaneously as if they were in the meeting face to face. My Clinical Nurse Consultant meeting goes for three hours. By videoconference or phone that's very draining and not achievable. The remote person also doesn't have the benefit of networking around the meeting or training e.g. at morning or afternoon tea break. – Clinical Nurse Consultant, NSW

The same member notes that:

While initiatives like the Rural Locum Assistance Program have value, the “pool of people who can just walk in and replace clinicians is very small and decreasing” – without a supply of experienced, appropriately qualified clinicians, programs like these won't succeed. – Clinical Nurse Consultant, NSW

The NSW member notes an additional logistics issue, familiarity with the required software, as health services use different medical records systems. Consistency within and across states would allow locums to step straight in as relievers, as expertise with systems takes time, and is increasingly necessary as the transition to electronic medical records becomes more universal. Addressing these logistical barriers would materially contribute to reducing the strain on clinicians in rural locations.

DRAFT RECOMMENDATION 12.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS

DRAFT RECOMMENDATION 12.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS

The current cycles of funding contributes to the fragmentation of mental health services identified in the Draft Report, affecting access, uptake, and optimal health outcomes. The end of funding cycles too often results in changes to qualifying criteria, program name and service provider, making it difficult for health care providers,



including nurses and midwives, to make the best use of programs that would be effective and appropriate for consumers.

These changes also add avoidable challenges for consumers, as it becomes unclear and confusing. Consumers don't know where to access help and which services are available, particularly if they are returning to the mental health system after a period of good health. The people most affected by these changes are those in highest need: people with complex, chronic, and significant mental ill health. Funding and program instability, the increased effort of connecting with appropriate services, the work of demonstrating they meet qualifying conditions, and changes in both providers and clinicians, reduce consumer engagement and trust.

Funding uncertainty also contributes to workforce attrition. When highly effective programs end, specialised and experienced health professionals in mental health can no longer deliver these services. Members of the ANMF in these situations, report feeling as though they were abandoning consumers who they had a trusted therapeutic relationship.

For all these reasons, the ANMF agrees that extending the length of funding cycles and guaranteeing continuity of psychosocial supports is desirable. This will create certainty for both providers and consumers of mental health services.

DRAFT RECOMMENDATION 16.1 — SUPPORT FOR POLICE

Responding to acute mental health crises plays a large and increasing role in police work across the country, prompting the requirement of a number of national management strategies that fall in to two broad categories. The first approach aims at education to improve the awareness of different types of mental illness, how they may present, and strategies that facilitate de-escalation and management of these situations to reduce the risk of harm to the consumer, police, and bystanders. An example of this approach is the NSW Police Force Mental Health Intervention Team four-day training program.

The second approach is to incorporate mental health practitioners into policing, with versions ranging from co-locating a mental health clinician in the Police Operations centre for advice, risk assessment, and the creation of policy (e.g. Tasmania, Western Australia), to creating co-responder teams of police officers and mental health clinicians who attend suspected or confirmed mental health crises as second responders (e.g. Victoria). Queensland has three distinct programs that incorporate mental health practitioners with police, each serving a specific purpose, and both the ACT and NSW utilise both police education and embedded mental health practitioners in their response.

The ANMF recommends a combination of interventions, tailored for regional differences in both policing and population, be adopted across the country. Police officers are not exempt from being influenced by the stigmatising



and prejudicial beliefs about mental health that permeate through the country, resulting in the type of targeted education delivered in NSW being needed more widely. Culturally competent responders who recognise that behaviour may be linked to mental ill health, and implementing communication and de-escalation techniques is useful. Adding expert mental health clinicians as available resources, both at Police Operations and on the ground, makes heightened situations safer for all involved.

DRAFT RECOMMENDATION 16.3 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

DRAFT RECOMMENDATION 16.4 — INCARCERATED ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The Draft Report comprehensively discusses the connection between mental ill health, particularly if untreated or undertreated, and contact with the criminal justice system. While the matter of appropriate, timely intervention is explored, identifying existing and emerging mental ill health is a precursor for accessing assistance. Screening of all people taken into custody is important, but will only be effective if there are adequate resources to provide appropriate interventions.

This means first ensuring there are sufficient correctional nurses to meet the needs of those in their care. Yet, though both mental and physical ill health are overrepresented in this population, there are so few correctional nurses that, our members working in the sector report being able to do little more for their imprisoned consumers than perform triage rather than care. Funding for and recruitment to correctional nursing positions is a vital prerequisite for ensuring mental health care provision for people interacting with the criminal justice system at every level from detention to serving a sentence.

In addition, mental health nurses should be employed in the sector to provide direct therapeutic care, and to provide education and support to their correctional colleagues, both nurses and other staff, and the incarcerated population. Both groups, staff and inmates, are subject to mundane routine with the potential for high levels of stress, which is not conducive to good mental health; providing information and education about resilience and stress management will improve the health outcomes of all involved, and may contribute to a calmer environment.

The growing complexity of this population's presentation requires fundamentally changing the model of care to a stronger emphasis on expert clinical care provided by professionals who are able to address the multiple aspects of the individual's situation, not their mental health in isolation.

An important additional consideration is alcohol and other drug (AOD) misuse, which is often a coping strategy to manage, particularly, trauma-based mental ill health. There is overwhelming evidence that people in prison are more likely than the general population to have AOD and/or mental health issues.⁵⁰ People with a dual diagnosis of mental illness and substance use disorder are also over-represented in Australia's prisons.⁵¹ An estimated 65% of prison entrants in Australia had used illicit drugs in the past year, compared to approximately 16% among the general population.⁵² Any substantial change to mental health management in prisons must therefore incorporate AOD management.



A crucial element to this approach being successful is continuing education for practitioners providing care, with facilitation for AOD and mental health nurses to work within correctional facilities. Further, correctional nurses require support to undertake AOD and/or mental health qualifications.

There are currently far too few qualified nurses available to provide the integrated clinical care needed, particularly for complex cases that encompass physical and mental ill health along with socioeconomic issues. Funding of both educational opportunities and positions for cross-specialist nurses will help address this shortfall. Support for nurse-led programs would ensure more consumers benefit from specialist nursing care and treatment; effective consumer advocacy to ensure adequate access to appropriate treatment; and help navigating the service system.

The ANMF suggests that harm minimisation programs, provided by qualified nurses, be extended to the correctional sector. While this would involve significant cultural change, extending these services offers greater opportunity for health engagement, preventing complications that result in acute hospital presentations, and will save lives. The ANMF supports providing access to needle and syringe exchange programs in prisons as recommended in Responding to Blood-borne Viruses in Australian Prisons.⁵³

Creating community-based transition services for people with identified need for mental health support will help improve reintegration and reduce the risk of reoffending.

It is also essential that specific funding be provided at both federal and state and territory levels for Aboriginal and Torres Strait Islander peoples to undertake appropriate training across a number of roles, including post-graduate mental health nursing.

DRAFT RECOMMENDATION 17.1 — PERINATAL MENTAL HEALTH

As identified in the Draft Report, supporting the mental health and wellbeing of children and families has been a long-term government priority at all levels, but outcome improvements for this cohort have been few.

Increasing surveillance of perinatal and infant mental health has been implemented in midwifery and maternal, child and family health nursing practice frameworks. The Draft Report suggests the assessment tools and processes are underutilised in practice; uptake of additional measures will necessarily require longer consultation times and timely referrals to mental health specialists and support services.

Tasks are often added to midwifery and nursing practice, which increases workload, with no corresponding increase in the resources (particularly staff) that allow these additional components of care to be effectively completed and documented. The result is that midwives and nurses must choose between regularly working through unpaid time (meal breaks, or after their shift has ended), or compromising or omitting some other aspect of care. Investment in the workforce will be critical to enable this early intervention initiative.



DRAFT RECOMMENDATION 17.2 — SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL CHILDREN

The ANMF supports the recommendations in this section, and note that maternal, child and family health nurses are experts in their field of practice. A core component of their work is to support the social and emotional development of pre-school aged children and their families. The ability to fully perform this role is often limited by lack of time, staffing resources, and insufficient referral pathways. Expansion or implementation of services in this area should utilise and invest in the existing expertise held by maternal, child and family health nurses by increasing funding for point of care service delivery and innovative practice in family community health.

DRAFT RECOMMENDATION 17.5 — WELLBEING LEADERS IN SCHOOLS

Teachers set the school culture, know individual students and their families, witness inter-student dynamics, and are experts in learning and normal development for children in the range they teach. This extensive knowledge of their students encompasses aspects of their lives out of school, including caring responsibilities and non-academic pursuits that may contribute to increased stress or, indeed, provide avenues for stress relief. Until secondary school, teachers also observe their students across a period unparalleled by anyone, including parents – six hours a day, five days a week, for most of a year. This gives teachers a unique opportunity to detect the earliest indications of change in mental health. The collaborative professional relationship between the school nurse and teachers enable invaluable insights into student assessment, monitoring and ongoing management.

There are many advantages to increasing the number of school nurses across Australia. Nurses working in schools build therapeutic relationships with the students, subsequent siblings, primary care givers over many years. Already embedded in health care while working with the school community, their presence results in integrated care and communication between schools and health networks, from general practitioners to the state or territory department of health. Within the school community, school nurses develop relationships and become important resources for teachers.

School nurses can identify physiological contributors to student change, and can provide personalised health and wellbeing information and guidance that encompasses both physical and mental health. Their scope of practice centres on primary and preventative health care, early intervention, chronic health management, and education. Their interventions include screening, immunisation, and education across a wide range of physical and mental health conditions, including AOD, family violence, and sexual health. Trusted members of the school community, nurses are often specifically identified by students as a safe person to disclose personal and private information.

The ANMF's school nurse members report that mental health-related issues comprise an increasing component of their role, both directly and as the result of exposure to mental ill health (e.g. affected family members). Children as young as five are exhibiting mental illnesses including anxiety, self-harming, and significant behavioural issues,⁵⁴ demonstrating the vital need for educators at all levels from early childhood upwards to have evidence-based



knowledge embedded in their qualifications that will equip them to be able to identify concerns around mental health. Once a problem is suspected, a referral to a school nurse allows for effective assessment triage, support, and when required referral to expert clinicians.

Given the breadth of their scope of practice, school nurses are significantly underutilised, with many schools having no nurse at all, or access only to a community nurse who visits schools for specific interventions (e.g. immunisations). This prevents the development of pivotal relationships between the nurse, the faculty, the student body, and the wider school community. Some schools have replaced school nurses with first aiders, who are not equipped to manage complex, ongoing, or multiple health issues. In other areas, one nurse alone has no capacity to add mental health management to an increasing workload relating to chronic disease (including allergies) and integration.

The ANMF suggests that the intent of recommendation 17.5 would be best served by utilising school nurses to coordinate and oversee mental health management in schools, rather than teachers, for all the reasons outlined above. While there are too few school nurses, this is through reduced opportunity rather than interest, and this sector of the workforce could be available far more quickly than upskilling teachers who, as noted in the NSW Teachers Federation's submission to the Commission, already have an untenable workload.⁵⁵

DRAFT RECOMMENDATION 18.1 — TRAINING FOR EDUCATORS IN TERTIARY EDUCATION INSTITUTIONS

DRAFT RECOMMENDATION 18.2 — STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS

It is vital that tertiary educators have training and guidance around mental ill health risk factors, mitigating interventions, signs, symptoms, referral processes for their students. The transition to tertiary education is difficult for many students, for reasons both academic and sociological. The expectation of increased academic self-direction and autonomy occurs alongside reduced support, particularly for students who are living away from home, often for the first time. This dislocation from the familiar is particularly significant for students from rural, remote, and international backgrounds, who are also confronted by substantial cultural change. So much change so quickly, across so many fronts, contributes to both dropout rates and the onset or worsening of depressive and anxiety-based mental ill health.

Schizophrenia most often first manifests between late adolescence and mid-twenties,⁵⁶ coinciding with the age most students first enter tertiary education, increasing the need for academic staff to have the skills and knowledge to identify a potential problem, approach the student, and be able to appropriately refer them for assessment and support.

However, the majority of mental ill health in this population, as in the broader community, is at the less severe end of the spectrum, and can respond well to prevention and early intervention. Services provided should include



information sessions at the beginning of each semester (as students will not retain all the information provided in orientation week, particularly if they don't think at the time that it will be relevant to them), peer-support programs (where appropriate), and on-site counselling services that are linked with but separate from academic programs and have clear referral pathways to mental health nurses when required.

Mental health nurses should have input in the review and drafting of the Tertiary Education Quality and Standards Agency and Australian Skills Quality Authority standards applying to education institutions' requirements around student mental health and well-being, including staff education.

Information request 18.2 – what type and level of training should be provided to teaching staff to better support students' mental health and well-being?

Mental health and well-being training for educators could include a stand-alone, level IV competency based unit that includes information about stigma, risk factors, stressors, preventative measures, signs and symptoms of mental ill health, management strategies (including less effective and unhelpful measures, like alcohol and other drug misuse), supports available, and referral processes.

As mental health nurses, including mental health nurse practitioners, have both the broad knowledge necessary and the expertise required for competent training delivery, they must be involved in the creation and delivery of foundational and continuing education for tertiary sector staff.

DRAFT RECOMMENDATION 19.2 — CODES OF PRACTICE ON EMPLOYER DUTY OF CARE

Psychosocial risk is a growing area of concern to ANMF members. A recent study identified the far-reaching impact of violence on nurses and midwives: 47% of the 3,612 respondents had experienced an episode of violence in the previous week, and 8% had experienced violence in the six months prior to completing the survey. Only a third of those surveyed documented all episodes of violence; of the 28% who sustained an injury as the result of a reported episode of occupational violence, two-thirds indicated they were provided with inadequate information, support, and follow-up. Even though surveyed nurses and midwives reported psychological injuries most often, fewer than half were given access to counselling following an episode of violence. The majority of participants believed occupational violence was inevitable, and increasing in both frequency and severity.⁵⁷

Despite the evidence of an increase in psychosocial risks, the Boland Review⁵⁸ found a widespread view that the lack of Workplace Health and Safety (WHS) Regulations addressing psychosocial health contributes to its neglect in workplaces. The lack of regulation makes it difficult for employers and, as there are no legally enforceable processes and rules addressing psychosocial hazards in detail, it is difficult to assist ANMF members who have encountered psychosocial risks.

Sexual harassment, which is a type of psychosocial hazard, is a significant concern to the ANMF and its members.



A survey recently conducted on this issue found that less than half of workplaces where respondents had worked had proper preventative measures in place, including mandatory training for staff, a clear workplace policy, an effective complaints mechanism, or access to workplace health and safety processes.⁵⁹

Mechanisms currently available place emphasis on individual reporting of issues, like sexual harassment; a more useful approach would be a WHS structure that encourages the significant cultural change necessary. For these reasons, though the ANMF broadly supports this draft recommendation, we do not believe Codes of Practice are adequate to assist employers to meeting their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Instead, the ANMF strongly supports incorporating these requirements into the model WHS Regulations. Providing a clear legislative framework within which to manage psychological health issues would assist all stakeholders.

Information request 19.2 — personal care days for mental health

Some workplace agreements already have these kinds of provisions in place as the result of industrial bargaining; for example, the Nurses and Midwives (Victorian Public Health Sector (Single Interest Employers) Enterprise Agreement, allows three single days of personal leave a year without any documentation and three occasions of up to three consecutive days with a statutory declaration,⁶⁰ the ACT Public Sector Nursing and Midwifery Enterprise Agreement 2017- 2019 has a similar provision, capped at seven days annually,⁶¹ while the Nurses and Midwives (Queensland Health) Award requires a medical certificate for any period of absence of more than three days (with no restriction regarding frequency).⁶² These provisions not only allow employees covered by this agreement to balance their work obligations with their mental health but also reduce avoidable burden on the health care system, because unwell nurses and midwives don't need to visit a GP solely to obtain a medical certificate. This provision is, however, the exception, and many workplaces require evidence to be submitted for all absences.

It will take time for the recommended measures, if adopted, to reduce stigma about mental health. For that reason, classifying some of the personal leave employees have as being 'personal leave' may not have the intended effect. Rather than apportioning a number of days for personal care/mental health, legislation mandating a percentage or set number of days of personal leave to be accessible without documentation (e.g. medical certificate) may be more effective.

DRAFT RECOMMENDATION 19.3 — LOWER PREMIUMS AND WORKPLACE INITIATIVES

Workplace compensation assessment, like so many other instances, treats mental health very differently from physical health. As noted in the Draft Report, this is partly an issue of supporting evidence, partly related to the adversarial approach used by work compensation systems, and partly that the nature of the most common mental health conditions (anxiety, depression, and post-traumatic stress disorder) may be initiated or compounded by work-related incidents, but often have their backgrounds in childhood or adolescence. Privatised worker



compensation programs compound the situation, as there is a strong inbuilt incentive to deny or delay claims in order to maximize profit, rather than alleviate workers' legitimate injuries.

The ANMF believes it is essential that workplace supports and compensatory mechanisms recognize and mitigate vicarious trauma for those in health systems, as both recipients and providers of care.

DRAFT RECOMMENDATION 19.4 — NO-LIABILITY TREATMENT FOR MENTAL HEALTH RELATED WORKERS COMPENSATION CLAIMS

The ANMF supports this recommendation, as *mental injuries are frequently made worse by the prolonged contest to obtain compensation.*⁶³ A similar scheme is currently being piloted in Victoria for a range of state government-funded staff and first responder volunteers, from Emergency Services Telecommunications Authority employees to child protection and youth justice staff.⁶⁴ Providing immediate access to clinical treatment would address this concern and get employees back to work more quickly, which benefits all stakeholders in the Australia's workers' compensation systems.

DRAFT RECOMMENDATION 20.1 — NATIONAL STIGMA REDUCTION STRATEGY

The ANMF agrees that stigma reduction is a vital component in tackling mental health, and supports the recommendation. Stigma is a contributing factor in the development and worsening of mental ill health, and self-medication through misuse of alcohol and other drugs, among a number of overrepresented groups, including First Nations communities, people who are gender and sexually diverse, and obese people. Any initiatives that address stigma around mental health should also consider destigmatising these identities and conditions, through exposure, education, and reframing.

DRAFT RECOMMENDATION 23.1 — REVIEW PROPOSED ACTIVITY-BASED FUNDING CLASSIFICATION FOR MENTAL HEALTHCARE

Activity-based funding provides payment to mental health care providers based on the number and mix of consumers treated, which is intended to reflect workloads and give providers an incentive to deliver services more efficiently.⁶⁵ The ANMF is concerned that, as it does not drive quality of care or service delivery improvement, moving to this model in the community mental health space may create unhelpful incentives for treatment and thus unintended consequences. As was remarked when activity-based funding was first implemented by the Independent Hospital Pricing Authority:

*Applying a generic form of activity-based funding to mental health risks perpetuating an inappropriate hospital-centric model of psychiatric care.*⁶⁶

While activity-based funding may provide an opportunity for community mental healthcare services to be more equitably resourced, considerably more work must be done to ensure that such a funding model is effective in this



space. In addition, previous international evaluations do not suggest activity-based funding has been unequivocally effective or beneficial.⁶⁷ The model can lead to exponential growth in health spending, as it encourages diagnosis and treatment. Increasing treatment claims can also lead to reintroduction of productivity limitations and waiting lists. These phenomena have been noted in the Netherlands, where the move from block funding to activity-based funding in 2000 resulted in an exponential increase in the number of mental health diagnoses, causing the mental health budget to multiply by almost 2.5 times within 15 years.⁶⁸

Value/outcome-based systems promote increasing the value for consumers in terms of the number and quality of mental health outcomes achieved, as opposed to the number of visits made; they prioritise achieving and maintaining good mental health as a strategy to mitigate to the more costly care associated with poor mental health. In community mental health, at least, the delivery of quality mental health and wellbeing outcomes may be a more suitable approach than focusing on activity targets and consumer volume.

The ANMF therefore encourages the Productivity Commission to explore other options, such as value/outcome-based funding for community mental health care, rather than adopting a potentially problematic activity-based funding model.

DRAFT RECOMMENDATION 24.1 — FLEXIBLE AND POOLED FUNDING ARRANGEMENTS

The Productivity Commission's proposal to develop regional funding pools where the level of these pooled funds would be linked to existing MBS rebate data for allied health professionals, controlled by State/Territory Government, and administered by Regional Commissioning Authorities (RCA) may perpetuate existing inequities in under-serviced areas. The Draft Report does not appear to provide clarity regarding the size/population of such regions, nor how they would be defined and demarcated. In regions that already lack sufficient access to mental health care services, or where populations engage less frequently with mental healthcare (e.g. regional and remote areas), funding pools may be inequitable and insufficient to ensure effective and appropriate levels of service and care. Since the Productivity Commission is keen to do away with unnecessary layers of administrative complexity, further work is necessary to explore, assess, and explain how the introduction of RCAs would improve and streamline existing governance arrangements and reduce complexity rather than adding a new layer of funding.

DRAFT RECOMMENDATION 25.5 — REPORTING SERVICE PERFORMANCE DATA BY REGION

The ANMF supports this recommendation. Without robust, valid data, there can be no evaluation of the effectiveness of mental health interventions. Data needs to inform future care delivery. As discussed in the Draft Report, the data needs to be quality data that is complete, accurate and can be easily compared.

It is also essential that the data collected is effectively used by Government at all levels and by service providers. Nurses and midwives collect a large proportional amount of data and it takes time to collect. Data needs to be



collected in an intuitive manner and it has to be a part of the workflow. The data needs to be reported as outlined in the recommendation at a national level but it should also be reported internally at service level. It is vital that data collected is evaluated carefully to ensure nurses and midwives are not collecting data that is not useful, as ANMF members tell us that at times they become frustrated as they continue to collect data that is not used effectively.

DRAFT RECOMMENDATION 25.8 — REQUIRING COST-EFFECTIVENESS CONSIDERATION

It is essential that programs be both evidence-based and cost-effective. The ANMF notes that, across sectors and specialties, locally and internationally, nurse- and midwifery-led models of care (like the Mental Health Nurse Initiative Program)⁶⁹ are equal to or better than medical models in terms of cost and effectiveness.

As outlined earlier in this response, the Mental Health Nurse Incentive Program (MHNIP) was established by the Federal government in 2007 with the aim to provide access to cost-effective mental health services in primary health care settings. MHNIP provided funding for general practices, private psychiatric practices and Aboriginal health and medical services to employ mental health nurses. Mental health nurses employed in these roles worked collaboratively with general practitioners, psychiatrists and psychologists to provide care for people experiencing severe and persistent mental illness, with the nurse working as the main coordinator of care.

MHNIP provided:

*a non-[Medicare Benefit Schedule] incentive payment to community based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.*⁷⁰

The Health of the Nation Outcome Scales (HoNOS) was a tool build into the program to measure effectiveness, requiring people be assessed at admission to a service, and again at 90-day follow up, with the result recorded on a scoring system. HoNOS result analysis found consistently improved scores, which demonstrably correlated to improved outcomes in terms of employment, connection with the community, and fewer acute mental health facility admissions.

MHNIP was well regarded by all stakeholders. Consumers found service provision flexible and accessible, reporting greater continuity than engagement with other health services, and experienced less stigma. Mental health nurses appreciated the autonomy of working as an individual clinician, the flexibility and scope to establish a therapeutic alliance with service users reporting that they could provide more holistic care than when working in acute public mental health settings. General practitioners emphasised the value that the MHNIP nurses provided, including improved mental health care of consumers, enhanced collaboration between different mental health care providers, and freeing up time for them to provide other services.



The Department of Health evaluation of MHNIP⁷¹ explored the appropriateness, effectiveness, and efficiency of the program, and found that, in addition to measurable outcomes,

there are a large number of un-costed and intangible benefits associated with MHNIP, including the impacts of improved patient outcomes, enhanced relationships with carers and family members, and the effects on carer social security outlays. Examination of these impacts would require an extensive enhancement to existing data collection processes. The evaluation findings suggest a comprehensive economic analysis would find these benefits to be positive.⁷²

Funding for the MHNIP was transferred from the Department of Health to the Primary Health Networks (PHN) in July 2016. Though consumers and staff were reassured that PHNs should ensure the continuity of care to MHNIP program consumers, the observed results were less than positive. For Victoria, the ANMF Victorian Branch notes in its submission to the Royal Commission into Victoria's Mental Health System that:

PHNs abruptly informed specialist mental health nurses they would no longer be employed, leaving people residing within those PHN catchments, including many Victorian regional towns, without access to the essential mental health nursing care previously available under the MHNIP. At the time of this change, the ANMF (Vic Branch) understood the North Western Melbourne PHN was the only network within Victoria increasing its mental health nurses under the new 'flexible' funding model. The Western Victorian Primary Health Network reduced its mental health nurses from 10 to two in the Ballarat area, affecting approximately 250 clients. Each nurse had a minimum caseload of 25 clients, with some caring for up to 40 clients at any one time.

The funding change effectively cut clients off from trusted professionals and asked them to start their treatment again elsewhere. As all health professionals know, trusted therapeutic relationships take years to build and are crucial to people managing their illness and staying out of hospital. As well as jeopardising real and significant client gains, mental health nurses considered the move undervalued their vital work and demonstrated yet again that the struggles of people with serious mental illness were invisible to decision-makers.⁷³

MHNIP provided a positive, effective and well-regarded service. The change to funding arrangements effectively ended the program, leaving a deficit in Australia's mental health services landscape – a landscape that is already somewhat barren of appropriate, well-funded, well-utilised, person-centred services for those suffering severe and persistent mental illness. The ANMF recommends the MHNIP be reinstated. Further mental health nurses with experience and a postgraduate qualification in mental health should be able to access the MHNIP funding without any further regulatory barrier such as credentialing.



DRAFT RECOMMENDATION 7.1 – PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES

DRAFT RECOMMENDATION 10.2 – ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYS

DRAFT RECOMMENDATION 10.3 – SINGLE CARE PLANS FOR SOME CONSUMERS

DRAFT RECOMMENDATION 10.4 – CARE COORDINATION SERVICES

DRAFT RECOMMENDATION 13.3 – FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE

DRAFT RECOMMENDATION 22.2 – A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY

As identified in these draft recommendations there are gaps and overlaps in service provision, disparities in access for some populations and a lack of effective implementation and integration of some services and programs resulting in less desirable outcomes and an ineffective mental health care system in Australia. Thus, the ANMF supports the development of a new whole-of-government, holistic, National Mental Health Strategy that provides clear direction on how services are to be provided, integrated and evaluated with a focus on improving the lives of people with mental ill health, and their carers, families and community groups.

Nurses and midwives have the expertise to provide holistic, person-centred care that addresses the person's physical, psychological, social and spiritual needs in the context of their lived experience and in partnership with carers. They play a key role in monitoring and supporting the mental health of consumers at every touchpoint across the lifespan as a core component of basic care delivery. Thus, it should be recognised that the fundamental solution to enhanced mental health in Australia is better utilisation of nurses and midwives. Within current models, nurses and midwives are limited in their capacity to address mental ill health to their full capacity alongside the existing complexities within their roles. In developing a new mental health strategy, the nursing and midwifery workforce must be supported to continue to expand the breadth and depth of their work in supporting mental health. Investing in additional nurses and midwives to better utilise their intrinsic ability to support mental health monitoring and interventions is a cost effective solution to improving the outcomes of existing infrastructures and a fundamental component to enhancing mental health in Australia.

The ANMF supports a transparent established process for Government to consider mental health programs or interventions. It is important however, for the process to not only consider the cost of the intervention but also the quality of the program, the outcomes consumers have achieved, evidence based practice and having the right qualified health professional undertaking care requirements.

The MHNIP is a good example of a cost effective program. Through its evaluation there were many effective outcomes achieved, not just cost savings and cost effectiveness, but quality care. Consumers, their families and collaborating health professionals all agreed that this was an important program. As outlined throughout this response this program should be re-instated throughout the country.



CONCLUSION

The ANMF is pleased with the depth and breadth of the Draft Report, which reflects the whole of life, whole of government approach that is needed to meaningfully and comprehensively reduce and manage mental ill health in Australia.

A number of areas where the inclusion of more nurses and midwives would result in better outcomes for consumers and communities were overlooked. In addition, the role of midwives in detecting and intervening in pregnancy and perinatal mental ill health was omitted from the Draft Report, and the intersection between mental ill health and AOD was not addressed.

The ANMF supports many recommendations made within the Draft Report and has outlined how further investment in nursing and midwifery in a number of areas will significantly contribute to the population's mental health. The ANMF does however, oppose the measures outlined in recommendation 11.3, as there is no evidence this expensive, lengthy process of a mental health nursing sole qualification or speciality registration would provide a solution to the recruitment and retention issues for mental health nurses.

Our nursing and midwifery membership have identified adequate staffing, resources, and support for both post-registration study and for those transitioning into the mental health field, as enablers to recruitment and retention in mental health.

Thank you for this opportunity to provide feedback on the comprehensive Draft Report.



REFERENCES

1. ANMF (Victorian branch). 2017. 10 point plan to end violence and aggression: a guide for health services <https://www.anmfvic.asn.au/~/media/files/ANMF/OHS/10pointplan-guidance-A4-FA-Web.pdf>
2. National Health Workforce Dataset. 2016. Nurses and Midwives NHWDS 2016 Fact Sheet <https://hwd.health.gov.au/webapi/customer/documents/factsheets/2016/Nurses%20and%20Midwives%202016%20-%20NHWDS%20factsheet.pdf>
3. Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF, Silva DR, Downe S., Kennedy HP, Malata A and McCormick F (2014) Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet* 384(9948):1129-45
4. Sandall J, Soltani H, Gates S, Shennan, A, Devane, D (2016) Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full>
5. Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2017 <https://hwd.health.gov.au/publications.html>
6. Moore TG, Arefadib N, Deery A, and West S. 2017. The First Thousand Days: An Evidence Paper. Parkville, Victoria; Centre for Community Child Health, Murdoch Children's Research Institute <https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/CCCH-The-First-Thousand-Days-An-Evidence-Paper-September-2017.pdf>
7. Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2017 <https://hwd.health.gov.au/publications.html>
8. ANMF National School Nursing Standards for Practice: Registered Nurse (2019) http://anmf.org.au/documents/reports/ANMF_National_School_Nursing_Standards_for_Practice_RN_2019.pdf
9. Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2017 <https://hwd.health.gov.au/publications.html>
10. Tasmanian Government. 2018. Press release: Mental Health Hospital in the Home service improving patient care http://www.premier.tas.gov.au/releases/mental_health_hospital_in_the_home_service_improving_patient_care
11. Mental Health Productivity Commission Draft Report Overview and recommendations (2019) <https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf>
12. Australian Institute of Health and Welfare. 2020. Alcohol, tobacco & other drugs in Australia <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions>
13. Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2017 <https://hwd.health.gov.au/publications.html>
14. Ibid
15. Butler T and Allnutt S. 2003. Mental Illness Among New South Wales Prisoners, New South Wales Corrections Health Service p. 19
16. Victorian Institute of Forensic Mental Health. 2013. Submission 306 p. 14
17. Morgan VA, Waterreus A, Jablensky A, et al. 2011. People living with psychotic illness. Canberra: Australian Government Department of Health and Ageing. <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-psych10>
18. Bebbington P, Jakobowitz S, McKenzie N, Killaspy H, Iveson R, Duffield G & Kerr M. 2017. Assessing needs for psychiatric treatment in prisoners: 1. Prevalence of disorder. *Social Psychiatry and Psychiatric Epidemiology* 52(2):221-9
19. Morgan VA, Morgan F, Valuri G, Ferrante A, Castle D & Jablensky A. 2013. A whole-of-population study of the prevalence and patterns of criminal offending in people with schizophrenia and other mental illness. *Psychological Medicine* 43(9):1869-80
20. Cutcher Z, Degenhardt L, Alati R and Kinner SA. 2014. Poor health and social outcomes for ex-prisoners with a history of mental disorder: a longitudinal study. *Australian and New Zealand Journal of Public Health* 38(5):424-9
21. Smith L, Yan F, Charles Me et al. 2017. Exploring the Link Between Substance Use and Mental Health Status: What Can We Learn from the Self-medication Theory? *Journal of Health Care for the Poor and Underserved* 28(2s):113-131
22. Life in Mind. No date. *Suicide facts and stats* <https://www.lifeinmindaustralia.com.au/about-suicide/suicide-data/suicide-facts-and-stats>



23. The prevalence of anxiety among older adults in nursing homes and other residential aged care facilities: a systematic review (2016). Abstract available at <https://www.ncbi.nlm.nih.gov/pubmed/26552603>
24. Australian Institute of Health and Welfare. 2012. Dementia in Australia p. 33 <https://www.aihw.gov.au/getmedia/199796bc-34bf-4c49-a046-7e83c24968f1/13995.pdf.aspx?inline=true>
25. Royal Commission into Aged Care Quality and Safety. 2019. *Interim report: neglect, volume 1* <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf>, *Volume 2 - Hearing Overviews and Case Studies* <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-2.pdf>
26. Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2017 <https://hwd.health.gov.au/publications.html>
27. Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2017 <https://hwd.health.gov.au/publications.html>
28. Mental Health Productivity Commission Draft Report Overview and recommendations (2019) <https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf>
29. Richardson A, Cunliffe L. New horizons: the motives, diversity and future of nurse led care. *Journal of Nursing Management*. 2003; 11: 80-4.
30. Hakanson C, Douglas C, Robertson j, Lester L. Evaluation of a rural nurse-led clinic for female sexual dysfunction. *Australian Journal of Rural Health*. 2014; 22: 33-9.
31. Khair K, Chaplin S. What is a nurse-led service? A discussion paper. *The Journal of Haemophilia Practice*. 2017; 4(1).
32. Caird J, Rees R, Kavanagh J, et al. The socioeconomic value of nursing and midwifery: a rapid systematic review of reviews. London: Institute of Education, University of London, 2010
33. Lloyd AR, Clegg J, Lange J, et al. Safety and Effectiveness of a Nurse-Led Outreach Program for Assessment and Treatment of Chronic Hepatitis C in the Custodial Setting. *Clinical Infectious Diseases*. 2013; 56(8): 1078-84.
34. Ndosi M, Lewis M, Hale C, et al. The outcome and cost-effectiveness of nurse-led care in people with rheumatoid arthritis: a multicentre randomised controlled trial. *Annals of the Rheumatic Diseases*. 2014; 73(11): 1975.
35. Schadewaldt V, Schultz T. Nurse-led clinics as an effective service for cardiac patients: results from a systematic review. *International Journal of Evidence-Based Healthcare*. 2011; 9(3): 199-214.
36. Tappenden P, Campbell F, Rawdin A, Wong R, Kalita N. The clinical effectiveness and cost-effectiveness of home-based, nurse-led health promotion for older people: a systematic review. *Health Technol Assess*. 2012; 16(20): 1-72.
37. Larsson I. Nurse-led Care and Patients as Partners Are Essential Aspects of the Future of Rheumatology Care. *The Journal of Rheumatology*. 2017; 44(6): 720.
38. ibid
39. Fitzpatrick, L. State Secretary. Secretary's report: "Mental health nurses under threat". Australian Nursing & Midwifery Federation Victorian Branch. On the Record. July 2018. p.3.
40. Mental Health Productivity Commission. 2019. *Draft Report volume 1* p. 376
41. State of Victoria. 2019. *Royal Commission into Victoria's Mental Health System, Interim Report, Parliamentary Paper No. 87 (2018–19)* p.537 https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcmhs.files/7615/7949/7906/Interim_Report_FINAL.pdf
42. Mental Health Productivity Commission. 2019. *Draft Report, volume 1* p. 386
43. Royal College of Nursing. 2019. Chronic staff shortages could compromise aims of NHS long term plan, warns RCN <https://www.rcn.org.uk/news-and-events/news/chronic-staff-shortages-could-compromise-aims-of-nhs-long-term-plan-warns-rcn>
44. Nurses.co.uk. 2019. The number of mental health nurses has dropped by 10.6% in 10 years <https://www.nurses.co.uk/nursing/blog/the-number-of-mental-health-nurses-has-dropped-by-106-in-10-years/>
45. The Guardian. 2019. NHS England loses 6,000 mental health nurses in 10 years <https://www.theguardian.com/society/2019/may/19/mental-health-nursing-numbers-6000-fall-nhs-england>
46. Schwartz S. 2019. Educating the Nurse of the Future: Report of the Independent Review of Nursing Education <https://www.health.gov.au/sites/default/files/documents/2019/12/educating-the-nurse-of-the-future.pdf> p. 40
47. Wareing M, Taylor R, Wilson A and Sharples A. 2017. The influence of placements on adult nursing graduates' choice of first post. *British Journal of Nursing*. 26(4):228-33



48. Ibid.
49. Foster K, Withers E, Blanco T et al. 2019. Undergraduate nursing students' stigma and recovery attitudes during mental health clinical placement: A pre/post-test survey study. *International Journal of Mental Health Nursing*. 28(5):1068-1080
50. Australian Institute of Health and Welfare. 2019. The health of Australia's prisoners 2018 <https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true>
51. Young JT, Heffernan E, Borschmann R et al. 2018. Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. *The Lancet Public Health*. 3(5):e237-e48
52. Australian Institute of Health and Welfare. 2017. National Drug Strategy Household Survey 2016: Detailed findings. <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>
53. Hepatitis Australia in collaboration with AIVL, NAPWHA and AFAO. 2017. Responding to Blood-borne Viruses in Australian Prisons: A community collaboration for an improved policy response to BBVs p. 3 <https://www.hepatitisaustralia.com/Handlers/Download.ashx?IDMF=fe7972cf-7529-4ca4-b4a9-45cf93c2fce1>
54. Cook, H. 2019. Principals sound the alarm on mental illness in primary school kids The Age <https://www.theage.com.au/national/victoria/principals-sound-the-alarm-on-mental-illness-in-primary-school-kids-20190402-p51a25.html>
55. NSW Teachers Federation. 2019. *Submission to the Australian Government Productivity Commission on the Social and Economic Benefits of Improving Mental Health* https://www.pc.gov.au/_data/assets/pdf_file/0009/240849/sub305-mental-health.pdf p. 6
56. Department of Health. 2011. Estimating the number of people with psychotic illness treated by public specialised mental health services <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-psych10-toc~mental-pubs-p-psych10-exe~mental-pubs-p-psych10-exe-est>
57. Pich J. 2018. *Violence in Nursing and Midwifery in NSW, NSWNMA and UTS*, 3-33. Online: <https://www.nswnma.asn.au/wp-content/uploads/2019/02/Violence-in-Nursing-and-Midwifery-in-NSW.pdf>
58. Boland M. 2018. Review of the model WHS laws: *Final report, Safe Work Australia* https://www.safeworkaustralia.gov.au/system/files/documents/1902/review_of_the_model_whs_laws_final_report_0.pdf
59. Australian Council of Trade Union. 2018. Sexual Harassment in Australian Workplaces Survey Results, ACTU, 8. Online: https://www.actu.org.au/media/1385284/a4_sexual-harassment-survey-results_print.pdf
60. Australian Nursing and Midwifery Federation (Victorian branch). 2016. *Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020* [http://www.anmfvic.asn.au/~media/files/ANMF/EBA%202016/Nurses-and-Midwives-Vic-PS-SIE-EA-2016-2020-amended clauses 61.5\(b\) and 61.5\(c\).p. 69](http://www.anmfvic.asn.au/~media/files/ANMF/EBA%202016/Nurses-and-Midwives-Vic-PS-SIE-EA-2016-2020-amended clauses 61.5(b) and 61.5(c).p. 69)
61. Australian Capital Territory Public Sector. 2017. *Public Sector Nursing and Midwifery Enterprise Agreement 2017- 2019* https://www.cmtedd.act.gov.au/_data/assets/pdf_file/0003/1266186/Final-Draft-Nursing-Midwifery-Agreement-2017-2019.pdf clause 109.25 p. 61
62. Queensland Industrial Relations Commission. 2018. *Nurses and Midwives (Queensland Health) Award State 2015 - 2018 State Wage Case* https://www.qirc.qld.gov.au/sites/default/files/nurses_and_midwives_swc18.pdf clause 20(d) p. 48
63. Royal Australian College of Psychiatrists. 2017. Public insurance schemes: advocating for mental injury claimants, <http://ranzcp.org/news-policy/policy-and-advocacy/position-statements/public-insurance-schemes-advocating-for-mental-in>
64. <https://www.premier.vic.gov.au/improving-mental-health-support-for-emergency-workers/> 12 June 2019
65. Rosen, A, McGorry, PD, Hill, HR. 2012. The Independent Hospital Pricing Authority and mental health services: it is not a case of "one size fits all". *Med J Aust*; 196(11):675-7
66. Ibid p. 675
67. Wand A. 2014. Activity-based funding: implications for mental health services and consultation-liaison psychiatry. *Australasian Psychiatry*. 22(3):272-6
68. De Jong G. 2017. Activity-based funding in mental health: a disastrous path. *Australasian Psychiatry*. 26(1):27-9.
69. Department of Health (2012) Evaluation of the Mental Health Nurse Incentive Program <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-e-evalnurs-toc~mental-pubs-e-evalnurs-exe>
70. Happell B, and Platania-Phung C. 2019. Review and analysis of the Mental Health Nurse Incentive Program. *Australian Health Review* 43 (1):111-119



71. Australian Department of Health. 2016. Mental Health PHN circular 1-12 January 2016: *Mental health reform implementation circular 1/2016 – questions and answers for Primary Health Networks (PHNs)* <https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular1>
72. Ibid
73. Australian Nursing and Midwifery Federation (Victorian Branch). 2019. *Submission to the Royal Commission into Victoria's Mental Health System* <https://www.anmfvic.asn.au/~/media/files/anmf/submissions/anmf%20vic%20branch%20submission%20to%20royal%20commission%20into%20victorias%20mental%20health%20system%2040719.pdf>