Mental Health Nursing Services in Australia:

_Inquiry into the current situation relating to the health, care and wellbeing of mothers and babies in Victoria during the perinatal period_

*Australian College of Mental Health Nurses*
The Executive Officer  
Family and Community Development Committee  
Parliament House, Spring Street  
EAST MELBOURNE VIC 3002

The Australian College of Mental Health Nurses (ACMHN) welcomes the opportunity to provide a submission to the Victorian Parliamentary Inquiry, which covers the current situation relating to the health, care and wellbeing of mothers and babies in Victoria during the perinatal period.

Kim Ryan  
Chief Executive Officer  
Australian College of Mental Health Nurses
1. Our Organisation

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The ACMHN also sets standards of practice for the profession and promotes best practice in mental health nursing.

The College welcomes the opportunity to provide feedback on the preliminary draft of the scoping report on cultural competency policy and practice across Colleges with regards to education, training and standard setting.

2. Introduction

The ACMHN acknowledges the Terms of Reference (TOR) for the Victorian Parliamentary Inquiry on the current situation relating to the health, care and wellbeing of mothers and babies in Victoria during the perinatal period.

This submission will focus on a number of key issues that are relevant to the TOR:

- The availability of high quality mental health services available to women, their babies and their partners during the perinatal period and how access is impacted by sporadic funding, regional inequity and other factors;
- Access to and provision of an appropriately qualified workforce, which is supported by a scope of practice framework that outlines the respective roles that the various perinatal health professionals can play to improve perinatal and infant mental health across a stepped care approach to mental health; and
- Identification of best practice in the provision of perinatal and infant mental health care.

ACMHN has been actively involved in a number of activities as part of its advocacy\(^1\) to improve mental health outcomes for women, their babies and their partners during the perinatal period, including:

- A Perinatal & Infant Mental Health Special Interest Group
- Representation and participation in the Perinatal Mental Health Clinical Guidelines Expert Working Group
- Feedback on the draft NSW Perinatal Mental Health Mother-Baby Unit (MBU) Model of Care
- Delivery of a perinatal mental health online learning program for nurses, focused on non-directive pregnancy care, through the ACMHN professional development portal.

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\(^1\) See Australian College of Mental Health Nurses webpage on Policy and Advocacy, available at http://www.acmhn.org/news-events/policy-and-advocacy
3. General comments

Nurses work across all clinical and service care settings, caring for people from all cultural backgrounds, across the entire life span to address the full spectrum of health care needs. In addition to forming the largest segment of the health workforce, nurses are more geographically dispersed than any other health profession, and as a result, are the most accessible health professionals in Australia.

Mental health Nurses (MHN), Credentialled MHNs (CMHN) and Mental Health Nurse Practitioners (MHNP), work with women, infants, partners and families, experiencing perinatal mental health concerns across all clinical settings – from primary and community care, through to outpatient, inpatient and specialist/tertiary services. MHN, CMHN and MHNP provide evidence-based treatment including family based therapy, CBT, behavioural interventions and interpersonal psychotherapy, relevant to what the individual client needs and the clinical expertise, practice setting, skills and qualifications of the clinician. See Appendix A for an outline of the individual scope of practice of an Australian MHN and Appendix B for additional information about MHNP.

Evidence supports a nurse-led, consultation liaison model for perinatal and infant mental health services (Harvey et al, 2012). Peer support is also seen as an important aspect of recovery, alongside evidence based mental health care delivered by a specialist clinician (Montgomery et al, 2012). The ACMHN understands the Perinatal Emotional Health Program (PEHP) was a service model with a strong evidence base that lent itself well to the scope of practice of MHNs and the flexible and accessible model of care they are able to deliver. The program also garnered extensive support from consumers and professionals across the sector, including women and their families, midwives and GPs.

Language and increasing opportunities for evidence based early intervention and prevention

The increased awareness of partner focused practice has developed considerably over the past 5-10 years and evidence now suggests that one in ten men will experience depression or anxiety during or after their partner’s pregnancy (PANDA, 2017). Perinatal services need to be adapted to support men experiencing poor mental health during this time, and inclusive language should be adopted to reflect the latest evidence. It is particularly important that the term ‘partner’ is used instead of father, in recognition of situations where the father may not be in a primary caregiver role, whereas the mother’s partner may be. Incorrect terminology and language that is not inclusive (for example, information about perinatal mental health services in the community that only refers to ‘mothers’) creates barriers to the early identification of the need for mental health care for partners during the perinatal period.

Best practice in perinatal mental health care encompasses the mental health of the mother, her partner and the infant. The ACMHN uses the term ‘perinatal and infant mental health’, in recognition of the evidence that the mental wellbeing of the mother (and her partner) during the perinatal period has implications for infant wellbeing and emotional development (Victorian Department of Education, 2013).
The ACMHN understands that work is underway to develop an adaption of the Health of the Nation Outcome Scale for Children and Adolescents (HONOSCA) for infants (HONOSI), which will provide a tool for assessing infant emotional development and attachment, which is of particular importance where the mother and/or her partner experience mental health concerns. It is therefore important that decisions surrounding the funding and development of perinatal mental health services consider the prevention opportunity of developing a system of perinatal care that also seeks to positively influence the emotional development and future mental health of infants. For example if the mother of a newborn was experiencing some anxiety following a traumatic birth, but this is recognised by the midwife during a follow up visit and the mother is able to access some short term early intervention perinatal mental health care, that is a good outcome for the infant as well.

Without this early identification and intervention, the mother may have otherwise been at risk of developing birth related PTSD or postnatal anxiety, requiring more intensive and prolonged mental health care, and potentially impacting on her ability to bond with and nurture her infant. Likewise, an opportunity for more positive outcomes for a family is realised if the mother develops a mental illness during the perinatal period, but the diagnoses is made early (before the symptoms worsen to the point of crisis) and the mother is able to access appropriate specialist mental health treatment without delay (ante-natal depression is the strongest predictor for parenting stress Leigh & Milgrom 2008).”

Feedback from members:

The ACMHN sought input from its members and the Perinatal & Infant Mental Health Special Interest Group regarding the Terms of Reference.

Members in Victoria spoke of a history of sporadic funding and reduced access to care from perinatal mental health services, as a result of funding cuts across acute and community mental health care, despite a strong evidence base for the Perinatal Emotional Health Program (PEHP) program.

“The benefit of the PEHP model was the seamless service delivery the ability to self refer and stakeholder organisations to refer without barriers to accessing the program e.g., GP referrals for Medicare funding. We had numerous support letters from GP’s begging the program (sic) not to be closed and valuing the flexibility of the clinician’s outreach service as well as the secondary consultation the program was providing to health professionals and social services.” – ACMHN member, Victoria.

Maintaining continuity of care in the therapeutic relationship becomes challenging in the context of uncertain and discontinuous funding. Building trust in the therapeutic relationship is important for women and their partners to feel safe to disclose feelings such as anxiety, depression, hopelessness. Factors such as sporadic funding for perinatal mental health care not only creates a gap in service delivery, but has adverse consequences for achieving the best possible outcomes for women, their babies and their partners.

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2 The ACMHN recommends contacting Dr Gordana Culjak (AMHOCN) and Dr Peter Brann (Eastern Health/Monash University) for more information on the project to develop the HONOSI.
“We have found when the funding was cut previously that clients would only be referred to the mental health services in cases of extreme risk to self or baby, and that the early intervention did not always occur for some women who were screened as being at risk”
– ACMHN member, Victoria.

Key features of the feedback from members included:

- Discontinuity in services due to funding for perinatal mental health services being cut and then reinstated resulted in reduced access to care and reduced ability to respond to individual care needs, across community services, as well as higher demand for specialist acute care.

- Limited number of available acute beds, creating a long (and for some women, indefinite) waiting period for a bed in the mother and baby unit, even in metropolitan Melbourne: “we are frequently being advised that there is a 8-10 week wait for mother baby beds.... In the last 12 months I have seen at least one referral to this type of service 'lost' and others left on the wait lists indefinitely”.

- The Victorian Government announced it would reinstate the funding for the Perinatal Emotional Health Program when the Commonwealth Government withdrew the funding for the program in 2015. However, responses from some members in regional and rural Victoria reported that a number of these important services have remained closed, despite those regions experiencing significant demand for care.

- The flexible service the mental health nurse is able to provide, and how important that is for mothers and their partners who need to access a perinatal mental health service (e.g. through home visits, evening appointments etc).

- Variability in the usage of mental health nursing services in perinatal mental health care, and missed opportunities:
  - ‘I am a credentialed mental health nurse, but unfortunately my skills, knowledge and expertise are not utilised near enough within the service...the focus is more on the input of psychologists’.
  - ‘In rural areas we are more accessible and certainly much more cost effective than other professions.’

- The value of the perinatal mental health nurse consultant in providing consultation services to other health care professionals, equating to increased access to expert advice and support for health practitioners when planning care for women with mental health support needs. Feedback from members indicated that antenatal and postnatal services held the perinatal mental health nurse consultant role in high regard, because it provided specialised clinical advice and assessment, and access to specialist mental health care for the women receiving antenatal and postnatal care.
4. Specific comments

Developing capacity in the perinatal workforce

All segments of the perinatal workforce (GPs, nurses, midwives, private obstetricians and lactation consultants) have a role to play in perinatal mental health. Access to perinatal mental health care relies on early intervention, and prevention in perinatal mental health relies on the broader workforce having the knowledge and skills to:

- monitor and provide basic screening for all pregnant women and new mothers
- identify those at increased risk of mental illness during the perinatal period who may be in need of more regular follow up and assessment
- refer those assessed as experiencing mental health concerns to specialist mental health services (e.g. a credentialed mental health nurse, mental health nurse practitioner or psychologist)

All nurses are well placed to help build an accessible, sustainable and effective stepped care response to mental health, for the Australian health care system. The stepped care response is based on levels of acuity; movement of clients across the steps is based on where and how they present, and their level of need for support and interventions. Ensuring the delivery of the most appropriate care requires the best use of the nursing workforce. Enabling flexibility within the health care system and ensuring the nursing workforce is adequately prepared, is essential. Table 1 demonstrates that an adequately prepared and developed nursing workforce across the spectrum of stepped care is well placed to provide appropriate support and interventions for clients experiencing various levels of distress and in response to changing needs.

As indicated by Table 1 above, general primary care nurses could take a more active role in perinatal & infant mental health, supporting GPs and increasing access to mental health screening for women and their partners during the perinatal period. i.e. With appropriate support and training, the General Practice Nurse could provide monitoring and screening of pregnant women and new mothers during pre-natal visits and at key points in the first year of the child’s life (for example, when the infant is three, six and twelve months of age, or more frequently if deemed clinically appropriate). The GP practice nurse could take over when the midwife concludes the episode of care and the woman and her family are referred back to the GP. Increasing the role of GP nurses in perinatal and infant mental health care is appropriate and necessary to link those in need of perinatal mental health care with a perinatal mental health service at every step of the stepped care service continuum. Access to clinical supervision could be provided by a credentialed mental health nurse or mental health nurse practitioner, either in person, or via skype, email and phone.
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<tr>
<th>LEVEL OF DISTRESS</th>
<th>LEVEL OF NEED FOR SUPPORT</th>
<th>FOCUS OF CARE</th>
<th>CARE SETTING</th>
<th>KEY NURSES INVOLVED</th>
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<tr>
<td>STEP 5</td>
<td>Very High Level of Need</td>
<td>Risk assessment</td>
<td>Emergency Departments</td>
<td>Consultation–Liaison MHNs MH Nurse Practitioners (MHNPs) Emergency Department (ED) Nurses MHN/CMHN/MHNP</td>
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<td>(Risk to life; Severe self-neglect)</td>
<td>Management of critical incidents</td>
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<td>Acute MH Services Acute Care MH Teams Acute AOD Services Alcohol &amp; Other Drug (AOD) Nurses</td>
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<td>Medication Treatment</td>
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<td>STEP 4</td>
<td>High level of need for support</td>
<td>Brief psychological interventions</td>
<td>Emergency Departments</td>
<td>Consultation–Liaison MHN CMHNs MHNP</td>
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<td>(Recurrent, atypical and those at significant risk)</td>
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<td>STEP 3</td>
<td>Moderate level of need for support</td>
<td>Psychological interventions</td>
<td>Community MH &amp; Primary Care</td>
<td>Midwives Emergency Department (ED) Nurses Midwives in Chronic Disease settings General Practice Nurses</td>
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<td>MHN/CMHN MHN</td>
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<td>Identifying distress Appropriate Referral</td>
<td>Medical settings Primary Care</td>
<td>Midwives in Chronic Disease settings General Practice Nurses</td>
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<td>Social support</td>
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<td>STEP 2</td>
<td>Low level of need for support</td>
<td>Guided Self Help</td>
<td>Primary Care</td>
<td>Mental Health Nurse Practitioners Credentialed Mental Health Nurses Mental Health Nurses</td>
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<td>(Mild mental health problems)</td>
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<td>STEP 1</td>
<td>Need for wellbeing and resilience promotion</td>
<td>Recognition MH literacy Mental health promotion</td>
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<td>Midwives All nurses in all settings Practice Nurses Credentialed Mental Health Nurses Mental Health Nurses</td>
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Relevant to this suggestion, the ACMHN is in the early stages of a Commonwealth Government funded project to develop a Mental Health Scope of Practice for Primary Care Nurses, and to upskill GP nurses and other nurses working in primary care settings, to provide mental health care relevant to their scope of practice. This will ensure that GP nurses and other primary care nurses provide an integrated stepped care service, in collaboration with MHNs, CMHNs and MHNPs as specialist mental health clinicians. The aim of this project is to improve the mental health knowledge and clinical skill of all nurses, especially General Practice nurses, and others providing primary health care, such as those working with people who have chronic disease, and/or alcohol & other drug issues. With appropriate training, nurses working in General Practice can play a vital role in the prevention, screening, early identification and referral of people who experience physical and mental health problems – so that they receive treatment and ongoing care, thus improving the mental and physical health outcomes of all Australians.

The ACMHN also provides continuous professional development (CPD) and has developed perinatal mental health elearning modules available to members and non-members which can be accessed through the ACMHN CPD portal. Providers and organisations can also apply for ACMHN endorsement of professional events, educational activities or products (e.g. online training and resources) via the College website.

The ACMHN wishes to note that training, education and the upskilling of the broader health workforce in perinatal mental health is necessary, but that the degree of success of such endeavours is also to a degree dependent on the extent to which the broader policy environment and service system supports implementation by individual health professionals on the ground. For example, a perinatal mental health service that is insufficiently funded and therefore experiencing service uncertainty or disruption, will create a situation for women their infants, partners and families in which they have limited or no access to appropriate mental health care, unless (or until) they reach a point of crisis.

As highlighted earlier, this may have short, medium and long term ramifications for the infant’s wellbeing and emotional development, as well as for the mental health and wellbeing of the mother, her partner and the family unit.

**Culturally safe services**

Research suggests there is an evidence gap in the literature relating to indigenous women’s experiences of acute mental health care (Bradley et al, 2015). An evidence gap also exists for immigrant mothers, particularly around the development of cultural safe, validated assessment tools for identifying immigrant women at risk of experiencing perinatal mental illness (Playfair et al, 2017).

Access to high quality perinatal care which meets the needs of individual women and their families also relies on all perinatal services being supported to provide culturally safe care. In their literature review, Bradley et al (2015) also point to available evidence indicating that indigenous women find birthing in hospital traumatising when culturally safe practices are absent.

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3 There is an important distinction between cultural safety and cultural competency/cultural awareness. For further information and references, see [http://catsinam.org.au/policy/cultural-safety](http://catsinam.org.au/policy/cultural-safety) [Accessed 10 July 2017]
Meanwhile, a study of pregnant immigrant women found there is lack of cultural safety in assessment tools which can create challenges for identifying mental health concerns that arise during the perinatal period, due to the questions reflecting western culture and the variable quality of translated assessment tools and translator services (Playfair et al, 2017).

The ACMHN recently provided a submission to the draft Scoping Report on cultural competence in education, training and standard setting, which is being developed by the Migrant and Refugee Women’s Health Partnership. Activities such as this scoping project would be useful for informing gaps in care and workforce gaps in Victoria for women, their babies and their partners, who are in need of perinatal care and support.

The ACMHN maintains relationships with organisations such as the Congress of Aboriginal and Torres Strait islander Nurses and Midwives (CATSINaM) and the Migrant and Refugee Women’s Health Partnership. The ACMHN recommends the Victorian Government actively involve these organisations when developing cultural safety in Victorian perinatal care services.

Inclusion of Trauma-Informed Care across all perinatal services

All people accessing health care bring with them a personal history and there may be elements of this history that can be a source of trauma. People with a history of trauma are particularly vulnerable to experiencing disparities in health care and health outcomes, and are at risk of being re-traumatised by their experiences when accessing health care (Reeves, 2015). The Australian health system generally does not adequately take account of the impact of trauma on a person’s mental health and health outcomes, and this is evidenced by the lack of awareness and focus on trauma and trauma informed care in health policy, practice and services (Mental Health Coordinating Council, 2013).

Women and their partners entering a perinatal care service may have experienced fertility issues, miscarriage, or have a history of a traumatic birth, or death, of another child. They may have experienced trauma unrelated to pregnancy/birth (e.g. domestic violence, childhood trauma, sexual assault), but which still has the potential to impact on their engagement with a perinatal health service and on health outcomes. It is therefore important that all members of the perinatal care team adopt a trauma-informed approach and trauma-informed practices to support the best possible health outcomes for women, their partners, babies and families.

Reeves (2015) recommends “sensitive inquiry” into a person’s trauma history as the ‘first step’ to providing trauma-informed care e.g. assessment that takes account of trauma during the antenatal period may reveal some anxieties about the pregnancy and/or birth, while a post-natal assessment conducted shortly after the birth may provide an indication of whether debriefing and counselling is required. Health practitioners may experiences barriers to conducting this screening (Reeves 2015) (e.g. time limitations). Workforce competence in asking questions about past trauma needs to be developed in order to facilitate timely assessment and referral to services in the antenatal and postnatal period. Training in trauma informed care is available via MHPOD (2012) and the Blue Knot Foundation has developed a resource to support the implementation of trauma informed care, titled *Practice Guidelines for the Treatment of Complex Trauma & Trauma Informed Care and Service Delivery* (2012).
5. Conclusion

Mental health nurses have the specialist skills, knowledge and experience to provide flexible access to perinatal mental health care for women, infants, partners and families, and to meet the growing need for these services into the future. The mental health nursing workforce are specialists in the provision of mental health treatment and are also well-placed to support GP nurses (either in person or remotely via digital health), midwives and other nurses to better recognise and respond to mental health concerns. Mental health nurses in Victoria have a proven track record of delivering high quality perinatal care that is responsive to the unique needs of women, their babies and their partners. The ACMHN recommends that the Victorian Government seek to utilise the mental health nursing workforce to the fullest extent possible to maximise access to high quality, evidence based mental health care, including mental health care provided during the perinatal period.

If the Family and Community Development Committee requires any further information regarding these comments, or would like to discuss any aspect of this feedback in more detail, including the workforce project and CPD portal, please contact the ACMHN.
Appendix A: Scope of Practice of Australian Mental Health Nurses (ACMHN, 2013)

SCOPE OF PRACTICE: ALL MENTAL HEALTH NURSES

“A mental health nurse is a registered nurse who holds a recognised specialist qualification in mental health [nursing]. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual” (ACMHN, 2010, p.5).

1. The scope of practice of mental health nurses in Australia is:
   • nested within a holistic theoretical and clinical framework that encompasses the biological, cognitive, cultural, educational, emotional, environmental, functional, mental, occupational, physical, psychological, relational, sexual, social, and spiritual aspects of individuals and communities
   • distinguished by person-centred and consumer-focused therapeutic approaches, to deliver specialised, Recovery-oriented, evidence-based care to all people, from all cultures, across the lifespan and developmental stages, across diverse settings
   • characterised by engagement and relationships with consumers; partnerships and collaboration with carers, families, significant others, other members of the multidisciplinary team, and communities
   • underpinned by personal and professional reflection.

2. The scope of practice of mental health nurses in Australia encompasses a wide range of nursing roles, functions, responsibilities, accountabilities, activities and creativities, modalities and innovations; and is founded upon ethical decision-making. This diversity is fundamental to promoting optimal physical and mental health; preventing physical and mental illness; and providing therapeutic interventions and treatment to support the physical and mental health preferences and needs of individuals, communities and population groups.

3. The scope of practice of mental health nurses in Australia is influenced by diverse contextual, cultural, educational, environmental, ethical, financial, informational, political, regulatory and/or legislative, social, technological, and other factors. Consequently, the scope of practice of mental health nurses in Australia is dynamic - responding effectively to change and developing over time.
SCOPE OF PRACTICE: THE INDIVIDUAL MENTAL HEALTH NURSE

1. The scope of practice of the individual mental health nurse in Australia is framed by the scope of practice of all mental health nurses in Australia (see Part One).

2. The scope of practice of the individual mental health nurse in Australia is also influenced by a number of more specific factors including, but not limited to, the:

   - **community context** in which the mental health nurse practises, including:
     - health preferences and needs of consumers, carers, families, communities and specific population groups e.g. individuals and groups across the lifespan and developmental stages, refugee groups, forensic populations, culturally and linguistically diverse groups, Aboriginal and Torres Strait Islander peoples
     - location e.g. jurisdiction; and also remote, rural, urban or metropolitan area

   - **professional context** in which the mental health nurse practises, including:
     - context e.g. politics, industry, institution, not-for-profit, private, public
     - employment conditions e.g. available resources, enterprise bargaining agreements, policy and procedure, private contracts, skill mix of team, state/territory laws, specific demographic of consumer cohort
     - practice setting/role e.g. autonomous or independent practitioner, part of a multidisciplinary team; administration, advisory, clinical, education, leadership, management, policy, quality improvement, research
     - service setting and area of specialisation e.g. acute care services; addiction services; bed-based/inpatient services; clinics; community managed or non-government organisations; community mental health services; consultation-liaison services; correctional settings; Defence health; detention centres; e-health; early intervention, illness prevention and health promotion services; forensic services; Indigenous services; older people services; private practice and primary health care services; rehabilitation services; residential care; services for children, adolescence and young people; services for culturally and linguistically diverse populations.

   - **professional qualities** of the mental health nurse, including:
     - educational experiences e.g. level of education (undergraduate or postgraduate) including undergraduate majors and/or postgraduate sub-speciality(ies) e.g. specific population group; psychotherapy or focused psychological strategies; and/or undergraduate and/or postgraduate research; and/or education and/or management and/or leadership studies
     - level of competence e.g. attitudes, behaviours, capability, experience, knowledge, skills and values
     - personal awareness and insights, background, life experiences and interests
     - personal nursing philosophy and theories utilised
     - practice experiences e.g. undertaking regular clinical supervision, providing clinical supervision
     - professional and practice development experiences
     - lifelong learning e.g. additional specialist training in psychotherapy, family therapy or focused psychological strategies
The scope of practice of individual mental health nurses will change and develop as their expertise and experience develops in specific areas of practice.

Appendix B: Mental Health Nurse Practitioners (MHNP)

Mental Health Nurse Practitioners (MHNP) are advanced practice clinical nurses educated at Master degree level. They provide an expanded and extended scope of practice for the mental health specialty and offer clinical leadership and expertise to the mental health sector that is recognised by peers, colleagues and service providers. MHNPs are regulated by the Australian Health Practitioner Regulation Agency (APHRA) and endorsed against the Nursing and Midwifery Board of Australia (NMBA) nurse practitioner standards for practice (2014), which took effect on 1 January 2014. Useful links regarding MHNP is available at: Australian College of Mental Health Nurses http://www.acmhn.org/images/stories/NPSIG/MHNPBrochureApril16.pdf Australian College of Nurse Practitioners https://acnp.org.au/sites/default/files/1173/anp_dl_fa_print.pdf Nursing and Midwifery Board http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/EndorsementsNotations.aspx#nurse If you have any questions, or would like to discuss any of the information contained in this document, including to discuss or obtain ideas regarding commissioning or service delivery models for the delivery of mental health nursing services, please contact ACMHN on 02 6285 1078 // 1300 667 079 or via email at enquiries@acmhn.org.

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8 Further information about ACMHN endorsement of professional events, educational activities and products is available at http://www.acmhn.org/images/stories/Resources/Endorsement_Application_Form_June_17.pdf
Mental Health Coordinating Council (MHCC) 2013, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA).

MHPOD, (2012). *Course: Trauma and Mental Health*. Produced by Cadre Pty. Ltd. and the Psychosocial Research Centre of the University of Melbourne for the Project Steering Committee, on behalf of the Mental Health Workforce Advisory Committee (MHWA). Copyright: Cadre Pty. Ltd., Sydney.

Kezelman, C., & Stavropoulos, P., (2012). *Practice Guidelines for the Treatment of Complex Trauma & Trauma Informed Care and Service Delivery*, Blue Knot Foundation - Formerly Adults Surviving Child Abuse (ASCA).