Pre Budget Submission

2013-14
Executive Summary

In 2006 the Council of Australian Governments (COAG) recognised the needs of people with serious mental illness, through the National Action Plan on Mental Health 2006-2011. As a part of this reform, the Mental Health Nurse Incentive Program (MHNIP) was established to enable mental health nurses to work with medical practitioners and psychiatrists to provide coordinated and collaborative care to people with severe and persistent mental illness.

In May 2012, the Australian Government capped the MHNIP services at current levels and undertook an evaluation of the program with a view to considering the future of the program in the 2013-14 Budget. The ACMHN has also commissioned research exploring the role of Credentialed Mental Health Nurses (CMHNs) within the MHNIP and the outcomes achieved through the MHNIP. The ACMHN has also drawn on information provided by Credentialed Mental Health Nurses (CMHNs), general practitioners, psychiatrists, consumers and other program participants regarding the program.

Benefits of the Mental Health Nurse Incentive Program

- Through the MHNIP, collaborative mental health care is available to people with severe and persistent mental illness in primary care settings.

- Consumers receiving services through the MHNIP have severe mental illness, complex needs related to their mental illness and often experience high levels of social and economic disadvantage.

- The MHNIP enables primary health care organisations and CMHNs to deliver a flexible service designed to meet consumers’ needs, focused on wellbeing and recovery.

- Through the MHNIP, significant outcomes have been achieved by people with severe mental illness in the clinical, social and economic domains.

- The MHNIP delivers direct savings to the health system through reduced hospitalisation, and indirect savings to the economy.

The innovative and flexible program structure, the high level of skills and therapeutic approach of mental health nurses, and the support for collaborative practice all contribute to the effectiveness of the program.

Future of the Mental Health Nurse Incentive Program

The ACMHN believes that the Government must commit additional funding to expand the MHNIP so that all people with chronic and complex mental health needs are able to access the MHNIP and to meet the real cost of providing MHNIP services.

Investment is needed to facilitate and support the uptake of the program in under serviced areas, and to develop stronger clinical governance frameworks for health professionals and organisations using the program. Changes to the program structure are also needed to increase access for consumers and remove disincentives for CMHNs, GPs and psychiatrists and organisations to use the program. This submission contains specific recommendations to achieve these goals.
To achieve these goals, the ACMHN is calling for funding of $66 million in 2013-14, and funding of $400 million over 5 years to 2017-18.

This will enable the MHNIP to assist approximately 54,000 people with chronic and complex mental health needs in 2013-14, reducing their reliance on expensive hospital services, improving their physical health, and helping them reconnect socially and economically with their communities.

**Recommendation 1:** The ACMHN recommends that the MHNIP funding be increased to allow for future expansion.

**Recommendation 2:** The ACMHN recommends that priority be given to expanding MHNIP services in locations and among population groups where evidence indicates significant mental health needs exist.

**Recommendation 3:** ACMHN recommends the establishment of demonstration MHNIP services in under serviced areas and population groups or communities with significant mental health needs. These demonstration services can promote the program and support other organisations to establish MHNIP.

**Recommendation 4:** The ACMHN recommends that the program session payments be increased to $275 per session to meet the costs of service delivery.

**Recommendation 5:** The ACMHN recommends that the program session payments be increased annually so that the program remains financially viable.

**Recommendation 6:** The ACMHN recommends future funding for the MHNIP of:

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**Recommendation 7:** The ACMHN recommends that the program structure recognise the central role of the CMHNs and the enable CMHNs, as well as medical practices, to be directly responsible for the program, whilst still requiring a collaborative relationship between the medical practitioner and the mental health nurse.

**Recommendation 8:** The ACMHN recommends that funding be made available to develop a collaborative clinical governance framework supporting pathways to seamless clinical care for the MHNIP.

**Recommendation 9:** The ACMHN recommends that an online administration and claiming system be developed to reduce the administration burden on clinicians and improve data collection.

**Recommendation 10:** The ACMHN recommends that the Program should be renamed as the Mental Health Nurse Initiative.
Introduction

The ACMHN believes that:

All people with complex and chronic mental health needs should have access to highly skilled mental health nurses to deliver coordinated, collaborative and holistic primary mental health services which are focused on their needs, wellbeing and recovery.

To achieve this vision, the ACMHN is calling on the Government to expand and enhance the Mental Health Nurse Incentive Program (MHNIP) so that all people with complex and chronic mental health needs can access services through the Program.

The social, emotional and economic cost of mental illness

Mental health and the impact of mental illness is an important issue to the Australian community. Nearly half of the Australian adult population experience mental illness at some point over their lifetime (45 per cent of the population) and one in five adults, or 3.2 million Australians, will experience a mental health difficulty in any year.1 Mental illness will touch the lives of all Australians in some way. The National Mental Health Commission has called for mental health to be a high national priority for all governments and the community.

Mental illness has a significant social, emotional and economic cost. As well as the direct impact of mental illness, it is related to social exclusion, drug and alcohol misuse, unemployment, poverty and welfare dependency, crime, relationship and family breakdown, homelessness, and poor physical health.2 Mental illness costs the Australian community in direct health care costs, lower productivity of people who are unwell and their carers, the cost of other services provided by governments and the loss of lifetime earnings of people who die due to mental illness. Almost $6.4 billion was spent on mental health-related services in Australia during 2009–10.3 But the total socio-economic cost is much much greater. For example, the total socio-economic cost of eating disorders in 2012 is $69.7 billion.4 Despite the significant costs of mental illness to individuals, families and the community as a whole, access to effective services and supports remains limited.

Over the last 20 years, the system and services that support people with mental illness have changed substantially, with a shift from institutional care for people with complex and chronic mental illness to community based services. There are now many service providers with funding from a range of sources that provide care and support to people with mental illness. This includes:

- Carers and informal community support services;
- Specialist public and private mental health services and clinicians;
- Primary Care including GPs and Community Health Services;
- NGOs with expertise in mental health or its comorbidities; and
- Other government services (eg justice, housing, employment).5
Both governments and the sector recognise that highly effective services are “often patchy and not connected and, for reasons of program design or funding, struggle to deliver a truly integrated service response based around the individual’s needs”.

The 2006 COAG Mental Health Package was a substantial investment in the mental health service sector. It provided funding and programs to deliver mental health services within the community and through the primary health system. Through programs like Better Access and Access to Allied Psychological Services, psychological therapies are now widely accessible. The Personal Helpers and Mentors program and other community mental health services have provided much needed support for consumers and their families. The MHNIP is a much needed adjunct to the primary mental health care system, providing ongoing, flexible and low cost clinical treatment and care coordination for people who have complex and chronic mental health needs.

Many of the 2006 COAG initiatives have become an essential part of the service landscape and have been given ongoing or renewed funding. Additional investments were made in the Government’s National Mental Health Reform, particularly the Partners in Recovery program. At the same time, the future of the MHNIP remains in doubt.
The Mental Health Nurse Incentive Program

The MHNIP is an exceptional program that helps some of the most unwell and disadvantaged people in the Australian community regain a meaningful life. Shifting the focus of the health system away from the acute sector to primary care is a strategic priority for governments. This is because the evidence shows it saves money and delivers better health outcomes. The MHNIP has successfully embedded collaborative mental health services within primary care and demonstrates the benefits of this approach:

- patient centred care;
- collaborative practice;
- coordination of care; and
- flexible models of care.

How does the MHNIP work?

Community based primary health care organisations, such as general practices, private psychiatry practices and Divisions of General Practice (now Medicare Locals), can register with Medicare Australia to join the program. Organisations then receive program payments for services delivered by Credentialed Mental Health Nurses (CMHNs). The payments are made for a session of care in which the CMHN may provide a range of services, not just face to face treatment and care. Organisations receive $240 for a 3.5 hour session (with a 25% loading for regional and remote areas), which is used to meet all the costs of delivering the service. This amount has not increased since July 2007.

The program is open to patients of the organisation who meet the following entrance criteria:

- they have a diagnosed mental health disorder;
- they experience significant disablement in their social, personal and occupational functioning due to their mental health disorder;
- they have experienced hospitalisation for their mental health disorder or are at risk of requiring hospitalisation in the future; and
- they are expected to require continuing treatment and management for their mental health disorder for the next two years.

The MHNIP provides funding for CMHNs to work collaboratively with medical practitioners in primary health care settings. The range of services the CMHN provides include clinical nursing care, such as mental health assessment, monitoring and treatment, and coordination and collaboration with other services, health professionals, carers and support networks.

The MHNIP is a national program, however growth has been driven by CMHNs who have seen the benefits of providing their services within the primary health care settings. There has been minimal
government investment in promoting the program to general practices, private psychiatry practices and other suitable organisations. As a result, there are some parts of the country where the program has not been implemented.

**MHNIP Key Facts**

- In 2011-12, almost 50,000 people received support from 529 Credentialed Mental Health Nurses through the MHNIP.
- In 2011-12, 444 organisations, including general practices, private psychiatry practices and Medicare Locals used the program.
- The total expenditure on the MHNIP in the six years from 2006-2007 to 2011-2012 has been $100 million.
- The program costs on average $700 per patient per year.
- The program has been growing at around 30% each year.
- People who receive services through MHNIP have experienced significant improvements in their mental health.\footnote{vii viii ix}
- The MHNIP results in savings for the health system through reduced hospitalisation.\footnote{xii}

In May 2012, the Gillard Government announced that the program would be capped at 2011-12 funding and services would be maintained at existing levels. The Government commissioned an evaluation of the program, conducted between May 2012 and October 2012. The evaluation was publicly released on 24 December 2012. The Government has signalled that decisions about the future of the program will be informed by the evaluation.

In August 2012, the ACMHN commissioned Southern Cross University to undertake research exploring the role of Credentialed Mental Health Nurses (CMHNs) within the MHNIP and the outcomes achieved through the MHNIP. This research will be published in early 2013. The research involved surveying CMHNs who deliver services using the MHNIP, and also looked at a sample of client profiles.

This submission and the ACMHN’s recommendations have been informed by both the ACMHN commissioned research and the Government’s published evaluation.

**Who does the MHNIP support?**

The MHNIP is targeted to provide services to people with a “severe and persistent mental illness”.\footnote{*} People who can receive services through this program are likely to be extremely disadvantaged and

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* The ACMHN prefers not to use the terminology severe and persistent mental illness to describe the people who benefit from support through the MHNIP. This terminology is not favoured by consumers and does not
have complex needs related to their mental illness including acute and/or severe symptoms of their mental illness, family, relationship and parenting difficulties or breakdowns, drug and alcohol misuse, criminal histories, unemployment or difficulties in maintaining employment, poor physical health and limited social contact.

Despite the length of time the MHNIP has been operating and the number of people who have accessed the program, there is little information available on the demographic and clinical characteristics of people who received services through the MHNIP. The small scale studies that have been undertaken reveal:

- people being helped through the MHNIP are more unwell than people who are receiving care through public sector community mental health teams;\textsuperscript{xiii}
- Very high rates of problems with activities of daily living and or occupation;\textsuperscript{xiii}
- High levels of unemployment;\textsuperscript{xiv xv} and
- People have history of suicide attempts and or self-harm.\textsuperscript{xvi xvii}

Research commissioned by the ACMHN in 2012 also provides insight into peoples’ complex needs.\textsuperscript{xviii} A sample of 64 client profiles were collected through this project, and CMHNs were asked to provide an outline of the significant problems experienced by the client upon referral. The data show that the issues with which clients presented were considerably more complex than their diagnosis suggested. The following excerpts from this study demonstrate the multitude of issues experienced by some people using MHNIP services.

“a 56 year old female client presented with resistant symptoms of depression, difficulties with domestic, academic and employment functioning, difficulties in parenting & family relationships and episodic mania.”

“a 46 year old male client who, on presentation, was extremely anxious, paranoid, living in a boarding house and was not leaving unit or able to attend to daily needs. He found it difficult to go shopping, worried that if he went out people may want to harm him. He did not work, did not socialise with anyone and came to the GP practice in an anxious fearful state. Has a history of childhood abuse and dysfunctional family background with physical abuse.”

“a 21 year old female client who was anxious, had probable Attention Deficit Hyperactivity Disorder, a borderline personality trait. She had a fractured relationship history, and a history of impulsivity, self-destructive behaviours. She had a history of self-harm, poly-substance abuse history, and a previous conviction for assault. Her family relationships were under stress, she was not employed and lacked meaningful daytime activity.”

support the philosophy of recovery. People who receive support through the MHNIP have complex needs, arising from the interrelationship between their mental illness and the society in which people live. While it is commonly understood that low prevalence disorders are ‘severe mental illness’, the MHNIP is not limited to people with a particular diagnosis. The ACMHN will use the alternative phrase of people with complex and chronic mental health needs.
Integrated, recovery oriented services

Through the MHNIP, consumers are receiving holistic recovery-oriented services, which are integrated with primary health care services. This integration delivers benefits such as reduced stigma, increased monitoring of physical health, and improved access for consumers to other health care providers, as well as improved access to mental health support. A strength of the MHNIP is that it can be adapted to meet the needs of diverse communities and primary health care providers.

“I like how the nurse can interact with the GPs and other services to aide or assist the problem solving your issues”.
Client testimonial, Mental Health Nurse Service Client Questionnaire 2011, Greater Eastern Primary Health.

“The people I see appreciate the de-stigmatised location a general practice offers, as well as the flexible access to my services, which increase and decrease to meet their current needs”
Christopher Biggs, Bayside General Practice Network, Melbourne, Victoria.

“We provide access to high quality care in a non-confrontational one-stop-shop type arrangement. It is far less confronting to receive ones mental health services in a GP setting as opposed to public health.”
Comment by Credentialed Mental Health Nurse™, Lakeman and ACMHN, unpublished research.

“The service also engages with the local Aboriginal community...because the MHNIP provides greater flexibility and responsiveness... Community feedback is that mainstream services often keep doing the same thing in reacting to crisis events only and do not progress any further with social, emotional and physical situations. The MHNIP provides continuity and consistency for Aboriginal community members. It allows one person to walk with them and connect them into services whilst support them when other providers have moved on.”
John Parkinson, CMHN, St John of God Healthcare, Warrnambool Victoria.

The MHNIP provides funding for primary health care organisations to offer an ongoing service with the intensity and duration of support adapted to the needs of clients. Credentialed Mental Health Nurses support consumers to clarify and realise their goals, by building consumers’ capacity to ‘self-manage’ and reduce their reliance on health and other services. This approach is explained by mental health nurses:

“Under the MHNIP I am able to work holistically, within a strengths based framework to assist patients in learning how to self-manage their symptoms”.
Comment by Credentialed Mental Health Nurse™, Lakeman and ACMHN, unpublished research.

A strength of the MHNIP is that it can be adapted to meet the needs of diverse communities and primary health care providers. Through the MHNIP, services can better support particularly disadvantaged populations, including people who are homeless, Aboriginal and Torres Strait Islander people, and people with an intellectual disability.

Whilst the MHNIP is primarily used within general practices, among the many services that have adopted the MHNIP to better support their clients are:

- headspace centres
- Addiction services
Disability employment services

Universities

Schools

Homelessness services and

Private hospitals.

Outcomes achieved through the MHNIP

Through MHNIP, significant outcomes have been achieved by people with complex and chronic mental health needs in the clinical, social and economic domains. The research commissioned by the ACMHN into the outcomes achieved by the MHNIP, identified a number of common outcomes achieved by consumers accessing MHNIP services:

- improved relationships and community participation (social inclusion);
- increased employment and study;
- reduced symptoms of mental illness or improved mental state;
- improved physical health;
- more appropriate use of medication;
- reduced hospitalisation and use of public mental health services;
- improved access or better engagement with services;
- reduced coercive interactions (with mental health services, criminal justice and child protection systems);
- improved capacity for independent living.

Improved mental and physical health

Consumers accessing the MHNIP have experienced reduced symptoms of mental illness. Specific symptoms, which mental health nurses have reported had resolved or are under control, include self-harm, paranoia, delusions, hallucinatory experiences, and agoraphobia. These improvements are also evidenced by quantitative outcome measures collected as part of the program, as sample of which were collected as part of the ACMHN commissioned research.

Another positive clinical outcome associated with the Program include stabilising medication and, in some circumstances, reducing medication. The expertise of mental health nurses means they can educate consumers about their medications and help them make informed decisions about their medication.
The physical health of people accessing the MHNIP has also improved. Mental health nurses draw on their understanding of physical health, illness and medical treatment to support people who have chronic physical health conditions, such as diabetes and cardiovascular disease. This includes supporting people to adopt a healthier lifestyle, as well as monitoring physical health and collaborating closely with General Practitioners to improve physical health.

“...One client with schizophrenia and diabetes has lost 25 kilos and decreased her diabetes medication, after I took her to see the public dietician and diabetic clinic. I helped her to monitor her blood sugar levels, took her to Heartmoves sessions and for regular walks. She now travels independently to visit her daughters interstate, walks daily, has friends and is enjoying her life...”
Comment by Credentialed Mental Health Nurse™, Lakeman and ACMHN, unpublished research

**Improved relationships and social inclusion**

People with complex and chronic mental health needs often experience family and relationship breakdowns and are socially excluded. The research commissioned by the ACMHN paints a vivid picture of a program that is effective at improving quality of life for people through re-establishment of their connections with families and communities.

“...one client has a long history of agoraphobia. She had had her children removed from her care. While she was linked with an intensive mental health team, she still only saw them once a fortnight and progress was very limited. The children’s behaviours had also escalated when they were removed as they wanted to remain in their mother’s care.

I worked with this client providing exposure therapy at her home three times per week, and also worked on social needs. She now has her children back in her care and is attending a mental health social rehab program most days per week.

Without the MHNIP and the ability to put so much time into one client, we would have potentially had a future situation of not only her mental health deteriorating, but that of her children too...”
Comment by Credentialed Mental Health Nurse™, Lakeman and ACMHN, unpublished research

**Economic benefits**

There is limited evidence available to quantify the economic impact of these outcomes. Small scale studies within the private hospital settings have identified cost savings from reduced hospital stays. Similarly consistent feedback from mental health nurses and consumers and the ACMHN commissioned research strongly indicate that MHNIP reduces hospital admissions and hospital stays, and improves participation in employment and study by consumers and carers.

“...One man in his 40s came to me as an alcoholic, in a difficult marriage and with three young children, he was about to lose his job as a managing director and his marriage was all but over. He has been off alcohol for over a year, has successfully separated and is now a very caring and supportive parent to his young children, he has taken control of his position at work and had developed boundaries and skills that are enhancing his self-esteem.”
Comment by Credentialed Mental Health Nurse™, Lakeman and ACMHN, unpublished research.
“One client has had over 30 hospital admissions and six in a row before I started working with her in 2008. She has had only one overnight admission in the four years since”.
Comment by Credentialed Mental Health Nurse™, Lakeman and ACMHN, unpublished research.

How are these outcomes achieved?

These exceptional outcomes have been possible because the MHNIP enables collaborative and flexible models of care.

- Services are provided to the client when they are required, in a timely fashion. The MHNIP provides mental health nurses with the flexibility to provide services when, where and as frequently as the client needs. This flexibility is critical as it enables nurses to put the client at the centre of their care and support.

- People with complex and chronic mental health needs require the services of highly skilled mental health professionals. This group of people often have complex conditions including comorbid physical health conditions. Credentialed Mental Health Nurses are nurses with specialist qualifications and experience working with people with severe mental illness. Credentialed Mental Health Nurses bring bio-medical knowledge of mental illness, psychotherapeutic skills and a psycho-social rehabilitation focus, which enables the delivery of a holistic service.

- Collaboration of health care professionals and social support programs are essential to support people with complex health conditions. Too often this group of people have fallen through the gaps due to poor collaboration. The MHNIP funding covers the activities of collaboration such as liaison with other providers, support provided to carers, advocacy and case conferencing.

- Recovery for people with complex and chronic mental health needs encompasses both clinical and personal recovery. For people to achieve their optimal level of functioning and quality of life, both concepts of recovery are embraced. Person centred, recovery oriented services can be delivered through this program.
Future of MHNIP

The Government’s evaluation and the research commissioned by the ACMHN both clearly demonstrate that the MHNIP delivers much needed specialist mental health nursing services to people with chronic and complex mental health needs. However, the evaluation, the research commissioned by the ACMHN, as well as feedback from CMHNs, GPs and other program participants, have identified a number of barriers which reduce the effectiveness of the MHNIP. These barriers must be addressed when considering the future of the MHNIP.

Funding for future growth

The MHNIP was designed as a demand driven program, open to any organisation which met the eligibility criteria. Since 2008-09, the growth of the program has exceeded the Government’s forecasts. The MHNIP had grown approximately thirty percent per annum before it was capped in May 2012. The MHNIP evaluation highlighted the lack of MHNIP services in a number of states and territories. When the current cap was introduced, many organisations were concerned as they were unable to respond to growing demand for the program. There is unmet need for MHNIP services and strong support from program participants for further growth of the program.

Given the significant needs of people assisted through the MHNIP, the ACMHN strongly believes it should continue to expand so that all people with chronic and complex mental health needs can access services. However, we recognise that in the current fiscal environment, this may be a challenge and that the Government requires greater certainty and control over the program expenditure.

The ACMHN believes that the current mechanism to cap the program inhibits the capacity of services to deliver recovery-oriented, consumer-centred care. It is also inequitable as it is based on past funding patterns rather than future needs and is administratively burdensome.

Recommendation 1: The ACMHN recommends that the MHNIP funding be increased to allow for future expansion.

Recommendation 2: The ACMHN recommends that priority be given to expanding MHNIP services in locations and among population groups where evidence indicates significant mental health needs exist.

Increase accessibility of the MHNIP

While the MHNIP is delivering very effective services where it has been adopted by primary health care services, the program is not accessible to all people with chronic and complex mental health needs. Geographic coverage is inconsistent across the country with 45% of CMHNs providing services situated in Victoria, compared with 5% in Western Australian and none in the Northern Territory.

Some of the reasons that the uptake of the MHNIP has been limited in some locations include:

- General practitioners and psychiatrists lack knowledge about the program and are unwilling to take on the responsibility of meeting the requirements of this unfamiliar program;
- The availability of qualified mental health nurses who are willing to take up a position outside the public sector; and
The level of program payments compared with the costs of running the program.

Only 283 general practices and 90 private psychiatry practices were registered with the program in 2011-12 although an unknown number of practices may have been able to make the program accessible to their patients via a brokerage system through the Divisions of General Practice/Medicare Locals.

There are also some population groups or communities which would benefit from MHNIP services, including Aboriginal and Torres Strait Islander people, people who are homeless, and areas of social disadvantage. The establishment of MHNIP services for these groups or communities should be a priority.

The establishment and growth of the program has required leadership and commitment by Credentialed Mental Health Nurses, who have promoted the program to general practices and psychiatry practices. The ACMHN has also supported the growth of the program by promoting it to Credentialed Mental Health Nurses, providing advice and support and facilitating access to other nurses already using the program. As Credentialed Mental Health Nurses and organisations have successfully established the program, they have shared their experience and encouraged other nurses and organisations to follow their example, thus creating some clusters where the program is more widespread.

Where there are service gaps, more active guidance, support and leadership is needed to encourage organisations, general practitioners, psychiatrists and mental health nurses to establish the program. Appropriate organisations could be supported to introduce the program and to become demonstration MHNIP services in under serviced locations. These organisations could then raise awareness of the program and become a source of advice, support and leadership to others.

**Recommendation 3:** ACMHN recommends the establishment of demonstration MHNIP services in under serviced areas and population groups or communities with significant mental health needs. These demonstration services can promote the program and support other organisations to establish MHNIP.
Funding to meet the program costs

The MHNIP payments need to cover the costs of delivering services to people with mental illness. Organisations are currently paid $240 for a 3½ hour session (equating to $68.57 per hour), which has not increased since the program commenced in July 2007. In comparison, mental health professionals can receive around $120 per hour under the Access to Allied Psychological Services Program. According to a 2011 survey of mental health nurses, more than 65% of those working in the MHNIP earn less than they could in other mental health nursing roles. If the program is not financially viable, general practices, psychiatry practices, Medicare Locals and other primary health care organisations won’t be able to continue to deliver this much needed service.

**Recommendation 4:** The ACMHN recommends that the program session payments be increased to $275 per session to meet the costs of service delivery.

**Recommendation 5:** The ACMHN recommends that the program session payments be increased annually so that the program remains financially viable.

Future funding required

The ACMHN has modelled the future funding required for the MHNIP. A significantly higher level of funding is needed at the outset to address the diminishing value of program payments over recent years and to redress the impact of the current capping arrangements. Once these initial changes have been implemented, it is estimated that growth could sustainably be held at around 14% per year for the forward estimates period.

The funding estimate is based on:

- Continued growth of the Program, but within a capped allocation;
- Increased session payments to ensure program is financially viable for organisations;
- Funding for strategies to expand the program in areas and populations of high need; and
- Investment in an online administration and claiming system;

**Recommendation 6:** The ACMHN recommends future funding for the MHNIP of:

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- This will enable the MHNIP to assist approximately 54,000 people with chronic and complex mental health needs in 2013-14, reducing their reliance on expensive hospital services, improving their physical health, and helping them reconnect socially and economically with their communities.
- In 2013-14, the funding increase would support the engagement of an additional 79 mental health nurses and expand the reach of the program to an additional 100 primary health care organisations.
Program payment structure

Mental health nurses are critical to the success of the MHNIP. They have embraced the MHNIP as it provides funding for the delivery of mental health nursing services within primary care settings. Mental health nurses have been the driving force that has led general practices, private psychiatry practices and Divisions of General Practice (now Medicare Locals) to register for the program and persevere with it. They have marketed the program to organisations and designed viable business models which enable organisation to use the program; CMHNs manage the considerable program administration including taking responsibility for the monthly claims that must be submitted to Medicare; CMHNs also ensure that the services they provide comply with the Program guidelines.

Despite this, the MHNIP payment structure fails to recognise the central role of mental health nurses in the management and administration of the program. Nurses are unable to register their private practices with the program and are not able to be paid directly by Medicare for the mental health nursing services they deliver. This has created an additional administrative burden for nurses, general practitioners, psychiatrists, organisations and the Government, reduced financial incentives for nurses and organisations, and, at times, impacted on the clinical relationship between nurses, medical practitioners and patients.

Over the life of the MHNIP, CMHNs have consistently reported to the ACMHN that their inability to receive payment directly from Medicare for the services they provide are a barrier to their engagement in the MHNIP. The ACMHN commissioned research found that whilst the clinical relationship with referring or collaborating medical practitioner was satisfactory, the relationship with the medical practitioner as the eligible organisation or employer was the cause of issues and tension. This relationship casts the CMHN in a dependent role which is inconsistent with the position of CMHNs as highly qualified and experienced health professionals. CMHNs strongly believe this aspect of the MHNIP undermines their professional status as autonomous health practitioners.

The CMHNs who are delivering services through the MHNIP are experienced and highly qualified specialist nurses. All CMHNs hold a minimum postgraduate diploma in mental health nursing or a specialist first degree in psychiatric and mental health nursing, and around a third have at least one Masters degree. The research commissioned by ACMHN found that almost a quarter of CMHNs have undertaken additional degrees or higher qualifications in some form of counselling or psychotherapy, and a further 48% had professional development level training. Further, more than a quarter had a qualification in alcohol and drug addiction. CMHNs are health professionals who have the skills, experience and capacity to practice autonomously within their scope of practice. The MHNIP must be structured in such a way that the professional status of CMHNs and their central role in managing and administering the program is recognised.

Recommendation 7: The ACMHN recommends that the program structure recognise the central role of the CMHNs and the enable CMHNs, as well as medical practices, to be directly responsible for the program, whilst still requiring a collaborative relationship between the medical practitioner and the mental health nurse.
Support for collaborative clinical relationships

Mental health nurses, general practitioners and psychiatrists work collaboratively under the MHNIP. However, unclear clinical governance frameworks and confusion of clinical and employment/contractual relationships threaten the effectiveness of the collaborative clinical relationship. Resources and tools that support and guide health professionals to establish effective collaboration arrangements for the MHNIP would reduce confusion and increase the confidence of health professionals in using the Program. The MHNIP administration also needs to reflect the importance of the clinical governance relationship between the general practitioner or psychiatrist and the mental health nurse, and their respective roles in the delivery of services. Improving the clinical governance arrangements for the MHNIP will ensure all stakeholders can be confident that the program is delivering high quality care to consumers.

**Recommendation 8:** The ACMHN recommends that funding be made available to develop a collaborative clinical governance framework supporting pathways to seamless clinical care for the MHNIP.

Investment in program infrastructure

While the MHNIP has delivered outstanding clinical and social outcomes for consumers, behind the scenes, clinicians have struggled with an old fashioned administration system. In 2012, clinicians must fax or post forms to the Department of Human Services to receive their payments. The system imposes unacceptable administrative burdens on clinicians and the Department of Human Services. An online administration and claiming system is needed so that clinicians spend more time providing services and less time completing their paperwork. An online system would also enable collection of more accurate data about the program to inform future program development.

**Recommendation 9:** The ACMHN recommends that an online administration and claiming system be developed to reduce the administration burden on clinicians and improve data collection.

Program name

The name of this program, the Mental Health Nurse Incentive Program, is misleading as it suggests that payment is an incentive to undertake an activity. In fact, the MHNIP is a program funding payment. Program payments are made to organisations upon the delivery of services according to the program guidelines. Organisations rely on the program payments to cover all the costs associated with delivering the Program. The ACMHN believes the name of the program should be changed to reflect the type of Program it is and its purposes. This would assist with the marketing and promotion of the Program to general practitioners and other primary care organisations.

**Recommendation 10:** The ACMHN recommends that the Program should be renamed as the Mental Health Nurse Initiative.


7 Lakeman, R, Research commissioned by ACMHN, 2012, unpublished

8 Palmer, A and Taemets, E, Translating MHNIP into a working model and producing positive outcomes in private practice, Private Mental Health Alliance Newsletter August 2009;

9 Meehan T and Robertson S, Clinical profile of people referred to mental health nurses under the Mental Health Nurse Incentive Program, IUMHN, 2012 in press

10 Palmer, A and Taemets, E, Translating MHNIP into a working model and producing positive outcomes in private practice, Private Mental Health Alliance Newsletter August 2009;

11 ACMHN, Mental Health Nurse Incentive Program: Achieving through collaboration, creativity and compromise, Canberra, 2010.

12 Meehan T and Robertson S, Clinical profile of people referred to mental health nurses under the Mental Health Nurse Incentive Program, IUMHN, 2012 in press

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14 Palmer, A and Taemets, E, Translating MHNIP into a working model and producing positive outcomes in private practice, Private Mental Health Alliance Newsletter August 2009.

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