Australian College of Mental Health Nurses
Submission to the
National Mental Health Commission’s
Review of Mental Health Services and
Programmes
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Introduction

*Mental health nurses – improving the mental health of the community*

Mental health nurses play a pivotal role in the provision of mental health care and, as such, are well placed to comment on gaps in access to services, workforce needs and the restrictions which prevent them from working to their full scope of capability and practice. Mental Health Nurses place the consumer as being central to all these considerations and the recommendations presented within this document.

While focussing upon mental health nurses it is also important to note that mental health care is provided to consumers across all areas of health and as a result, all nurses need to be better prepared to provide mental health care. For example, estimates of chronic physical illnesses and depression rates experienced by consumers are:

- Parkinson’s disease: 40% experience depression
- Multiple sclerosis: 40%
- Stroke: 10%-27%
- Cancer: 25%
- Diabetes: 25% and
- Chronic pain syndrome: 30%- 54%.

It will consequently be necessary to educate all nurses to give them the knowledge and skills that will enable them to provide access to differing levels of care; from nurses to mental health nurses to nurse practitioners.

In clearly defining the scopes of practice of nurses, mental health nurses and nurse practitioners, we are better able to support and enable nurses to work to their full scope of practice. This also allows for governments to better utilise nurses across all mental health settings.

The ACMHN defines a mental health nurse as one who holds a postgraduate qualification in mental health nursing, but other organisations have less defined and demanding definitions. This issue, along with those around scope of practice, workforce needs and programs in which mental health nurses need to be answered in order to deliver efficient and effective health care to those requiring mental health interventions and service.

In addition, a dedicated mental health nursing workforce strategy needs to be developed as a matter of priority, not only to develop an available workforce, but also to define the relevant scope of practice to develop mental health nurse-led models of care.

Mental health nurses are a much underutilised workforce. The increasing economic burden of health care will require all levels of government to look for opportunities to provide high quality care, and reduce expenditure. The Mental Health Nurse Incentive Program has been shown to provide excellent outcomes for both consumers and the health system, but it isn’t the only program out there that provides such positive outcomes. It is now time governments looked very closely at expanding the role of nurses across all health care settings. Mental health nurses are ready, willing and able.
This submission was developed based on a survey of College members and the aim was to represent the main issues of concern for reform as identified by respondents. The mental health nurse incentive programme (MHNIP) is addressed as a specific programme as this is the major programme that has an exclusively specialist mental health nurse workforce.

**Methodology**

Members of the ACMHN were emailed an invitation to complete an on-line survey (via survey monkey) in September 2014. As well as demographic questions respondents were asked to provide responses to the following questions:

- Please describe the barriers to CMHNs being able to provide accessible and effective mental health nursing services under the MHNIP (281 responses)
- In as much detail as possible describe the changes needed to MHNIP so that CMHNs can provide accessible and effective mental health nursing services (253 responses)
- There are a range of reasons mental health services are not always accessible and effective for consumers. Please describe the barriers or impediments that prevent mental health nurses from fully contributing to delivering accessible and effective mental health services. Include a short description of the context/setting you are referring to (eg CAMHS, Emergency Department, rural areas) in your response (252 responses)
- Please provide suggestions of how mental health nurses have or might efficiently and usefully contribute to improving mental health and recovery, over and above current practice. Your response should focus on practical ideas, such as programs or services that could be introduced or expanded or specific changes that could be made to the way organisations or services operate (509 responses)

The responses were analysed using thematic content analysis, whereby responses were grouped into themes. The recommendations are derived from the dominant themes. That is those that represented the opinion or recommendation of a cluster of respondents.

**The respondents**

In all there were 581 unique respondents. They were highly experience with 74% having over 10 years’ experience in the mental health field (30% had over 30 years’ experience). Fifty five percent were formally credentialed as mental health nurses. They were dispersed across all states and mainland territories with 27% of respondents residing in New South Wales, Queensland and Victoria respectively. Most identified working in clinical roles (71%) followed by management (10%) and education (10%). The most common practice areas identified were community health (32%), acute care (22%) and primary health care (12%). Some were in private practice (8%) or had a combination of roles (15%).
The first point of contact – Dealing with crisis

*Increase the presence of mental health nurses in emergency departments*

Senior mental health nurses are frequently employed in emergency departments and intake roles. Some respondents suggested that these nurses should be involved in triage whilst others suggested that their scope of practice increase to include limited prescribing and ordering relevant diagnostic tests. Mental health nurse practitioners already fulfil such roles in some areas. Whilst there is not a clear consensus on the role of mental health service staff in the emergency department (and several models of deployment), it is clear that mental health nurses ought to be more involved in the emergency departments. They are ideally placed to undertake assessments, link the individual to the most appropriate services and guide them through the system.

*Established ‘sobering up’ facilities in alcohol / drug hotspots where individuals can ‘sober up’ before being referred for assessment*

Survey respondents spoke frequently about being the first point of contact for people with mental health and associated problems. Many nurses had first-hand experience of working in crisis teams, in consultation-liaison roles in Emergency Departments or as ‘first responders’ for people in crisis. There is anecdotal evidence that an increasing amount of mental health resources are being invested in responding to people who are intoxicated on alcohol or illicit substances. For example, the Queensland Government review of the Mental Health Act 2000 reveals that in 2008-9 there were 5599 emergency examination orders made by police or paramedics in Queensland. By 2012-13 this had increased to 10648. At the same time the number of these where assessment criteria were met (to extend for a further period of assessment) dropped from 42.5% to 31.1% and those that went on to have involuntary treatment dropped from 16.6% to 12.2%. The report acknowledges that most of these people were brought to emergency departments in a state of intoxication (alcohol or illicit substances) often expressing suicidal ideation. Concern was expressed that alcohol and drug intoxication was creating an unacceptable burden on mental health services who are obliged to see people for assessment within a four hour period but often must manage intoxicated behaviour for eight or more hours before a person is sober enough to be assessed. Sobering up facilities are best staffed by generalist nurses with experience in mental health settings.

*State and Territory Mental Health Services*

State or tertiary mental health services deliver services to the population in crisis and are charged to deliver mental health care to those with severe symptoms of mental illness across the lifespan. The services provided are broad and diverse but always include inpatient care and some form of community outreach. Nurses make up over 60% of the workforce of state and territory mental health services (although a smaller percentage are mental health nurses). They deliver services in primary care settings and foster links with primary care services. Respondents commented on issues which created impediments to the efficient running of state mental health services and sometimes constrained their capacity to provide effective recovery focused care.

*Ensure that those in leadership positions in mental health services are appropriately qualified*

As previously mentioned there is a distinction between the mental health nurse and nurses who work in mental health setting with the former having post-graduate qualifications in mental health nursing and relevant on-going practice development and supervision. Nurses in leadership positions

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1 Queensland Health.(2014).*Review of the Mental Health Act 2000:Background Papers*. QH: Brisbane
in mental health including those in charge of wards or in clinical nurse consultant roles ought to be credentialed mental health nurses and this needs to be a mandatory criteria in job descriptions.

*Increase access to psychotherapy / counselling and psychological care*

In many inpatient settings there is little emphasis on therapy and a preoccupation with pharmacotherapy. It is presently difficult to refer people for therapy from tertiary services to primary care services (including the Mental Health Nurse Incentive Programme). A wide range of therapy options were suggested that ought to be provided within tertiary services but are inconsistently offered at the present time. Many could and ought to be offered efficiently through groups facilitated by mental health nurses:

- Cognitive enhancement strategies for older adults
- Exercise and motivational enhancement
- Family therapy / family interventions
- Self-help / support groups
- Trauma informed therapy
- Parenting support
- Metabolic monitoring and other physical treatment
- Wellness Education
- Alcohol & drug related harm minimisation
- Motivational Interviewing
- Mindfulness
- Cognitive Behavioural Therapy

*Decrease the emphasis on triage and assessment and requirements to duplicate assessments at each change of service episode*

A considerable amount of time and resource is typically devoted to assessment and reassessment in mental health services with time consuming assessments required to be re-written at frequent intervals. Reducing duplication and the emphasis on assessment may free-up resources to engage with people in therapeutic activities.

*Improve information systems and flows*

A considerable amount of time is spent by staff in state mental health services collecting information or undertaking clerical duties. Any activity which is not in the service of the service user, requires duplication of information or takes clinicians away from direct care roles ought to be scrutinised. Where the task is primarily clerical (e.g. entering information) then clerical support ought to be provided to enable clinical staff to spend time with people in therapeutic activities.

*Enabling and extending the roles of mental health nurses for the benefit of service users*

A clear theme emerged from the survey indicating that mental health nurses identified that their professional capabilities are often under-utilised or constrained by the narrow range of practice settings and limited number of programmes they can work under. This means that their skills in assisting people address the most complex mental health and social problems are often not available to those who most need them. Bureaucratic requirements and role constraints of state mental health services also can constrict and confine the roles of nurses so that they are unable to realise their therapeutic potential. Thus nurses who may be highly trained, experienced and skilled in delivering psychosocial interventions or psychotherapy are deployed in roles which make little
demonstrable contribution to positive outcomes. In part because this may be because their qualifications and skills are not recognised. Survey respondents articulated a desire to lead on a range of holistic mental health interventions and frequently identified the context of these expanded roles as sitting across NGO, primary care and acute settings and indeed do so as programmes allow.

That programmes delivering psychotherapy or focused psychological strategies such as Better Access be provided by registered health professionals with appropriate post graduate qualifications and supervised experience, including mental health nurses

In keeping with the recommendations of King \(^2\) programmes purported to be delivering psychological strategies such as Better Access should be delivered by those who are appropriately qualified and this includes mental health nurses. The threshold to deliver services ought to be postgraduate qualifications in mental health that specifically prepare people to deliver the programme outcomes. This would include most mental health nurses and possibly exclude some allied health professionals who do not have post graduate qualifications. Mental health nurses are prepared to work with people with high complexity and symptom severity. Presently mental health nurses are excluded from working under the Better Access programme despite sometimes being the most well qualified service provider available.

Expand MBS item numbers to include adequate reimbursement for MHNs to lead therapeutic group based activities.

Group activities have a long tradition in mental health service provision. They are a cost effective way to deliver education and therapy. Therapeutic group activities are often pivotal to people’s personal recovery and group intervention is essential to most family therapy. Group work is an essential component to programmes such as Dialectical Behavioural Therapy which is one of the few proven interventions for people with complex post-traumatic stress issues and chronic self-harm behaviour.

Survey respondents described a need for expanding opportunities to work with people in groups and be reimbursed for the provision of these services. Access to MBS item numbers for Mental Health Nurses led group intervention would provide one means to expand the provision of group work. Mental health nurses in private practice, in GP partnerships and the NGO sector expressed a desire to facilitate or lead a range of therapeutic groups and indeed already do through various complex partnerships.

Mental health nurses value self-help and acknowledge the important function of self-help groups and peer support in mental health recovery. Often self-help groups require a degree of professional support and facilitation to be established in the community. Mental health nurses often have the experience and desire to assist in establishing or facilitating such groups e.g. hearing voices groups or personal recovery groups.

Nurses and other non-specialists ought also to be able to lead general health maintenance and exercise groups to address the burgeoning problem of metabolic syndrome and obesity amongst those diagnosed and treated for mental illness.

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Enable direct referral to mental health nursing services working under the mental health nurse incentive programme or other GP / NGO practice settings

Mental health nurses working in programmes such as MHNIP may be known to have specialist skills which may be especially beneficial for those people who are using acute or other tertiary services. These service users will have already been assessed by experts. Considerable inefficiencies are apparent at present in terms of acute mental health services attempting to engage a GP (often at times of crisis) to write a mental health care plan to access these services. Tertiary mental health services ought to be able to refer to the mental health nurse directly and thereby expedite rapid follow-up.

Where a mental health plan is currently required a comparable plan (which is often more comprehensive) prepared by a specialist health professional in a tertiary service e.g. clinical nurse consultant, psychiatric registrar or consultant psychiatrist ought to suffice to enable access to nursing services. Where further follow-up may be required by a GP, nurse practitioner or psychiatrist with whom the mental health nurse is aligned, the mental-health nurse may arrange this.

Provide MBS item numbers to enable mental health nurses to work directly with individuals, families, employers and education providers

Mental health nurses form the backbone of state mental health services, and assume senior clinical roles in all sub-specialty services. Nevertheless, their capacity to work in primary care settings is constrained by existing funding mechanisms and the capacity or vision of state health services to extend their reach to schools, and growing services such as Headspace. Mental health nurses do work in organisations such as Headspace under the MHNIP, ATAPs or as nurse practitioners. However, since the freezing of the MHNIP in 2012 no further expansion has been possible.

There are also constraints inherent in using the MHNIP and other programmes which impede the Mental Health Nurse from responding flexibly and efficiently to service users, not least the requirement for a mental health plan. Indeed, this is a problem for organisations such as Headspace generally which purports to offer a one stop wrap around health service which ought to be experienced as a seamless service but is actually made up of an amalgam of different programmes.

In order to access many clinical services which a young person may be assessed as needing by a specialist triage clinician the young person must often find a GP (non-specialist) for the sole purpose of writing a mental health plan to refer them back to receive the service that they were assessed as needing. This plan often requires a diagnosis to be conferred when the purpose of the intervention may be to prevent a problem escalating to the point that a diagnosis is warranted or a psychosocial formulation is more appropriate.

Assuming that the medical benefit scheme remains the principle means of funding health services. A range of MBS item numbers should be available to mental health nurses independent of a mental health plan to enable them to work with people directly to address their mental health needs. These ought to include items for assessment, case co-ordination, brief-psychological interventions, family work, and longer term group and individual therapy. This would provide a means for activity based funding to enable them to work in organisations such as Headspace. These need to be sufficiently funded to enable a wage to be drawn comparable to that of a senior nurse in the public sector with little or no gap fee required (as youth and the seriously mentally ill rarely have resources to pay additional part charges).

Nurse practitioners presently have access to some MBS item numbers but these are so underfunded that a significant co-payment is needed to enable the nurse to make more than a subsistence income.
Workforce Development

To enable a robust and responsive workforce which is aligned with and facilitative of a recovery, and contemporary evidenced based practices a commitment to supporting people in their development as mental health nurses is necessary.

Service user / consumers should be involved at every level of education and service development

The respondents supported and deemed essential the involvement of service users in meaningful ways in the educational preparation of all health professionals at both undergraduate and postgraduate levels. Appropriately remunerated service users ought to be involved in the governance and day to day activities of state mental health services. This may include but not be limited to the employment of consumer consultants and peer support workers.

Strengthen & support post-graduate MHN education through an increase in Commonwealth supported places for courses that develop MHN clinical capabilities in providing psychotherapy and other talk based interventions, entrepreneurship, life-span and recovery models/competencies.

The mental health nursing workforce is ageing and has suffered from recruitment and retention problems. There are severe shortages of nurses currently with Health Workforce Australia estimating a current shortage of 109,000 or 27% of the workforce\(^3\). This problem is anticipated to worsen over time with particular shortfalls in the mental health area. There is a projected shortfall of 13000 nurses working in the mental health field by 2025 based on assumptions of high demand and current domestic graduates, as well as skilled migration. Yet survey respondents reported difficulties accessing affordable and relevant training and education. In order to ensure the best outcomes for service users and to address anticipated skills shortages it is imperative that the government support post-registration education and training through commonwealth supported places on reputable courses.

Undergraduate nurse preparation requires a mandated amount of mental health curricula content and assessed mental health competencies

The majority of nurses working with people with mental health problems are non-specialist but ought to have the basic competencies to work effectively with people with mental health problems in any setting. Unfortunately, since the introduction of comprehensive nursing training and loss of statutory recognition of mental health nursing as a specialty the mental health and illness component of most undergraduate programmes in Australia has become marginalised and some universities struggle to provide a rich and positive clinical experience in the mental health field. Exposure to quality learning experiences has been found to be positively correlated with a desire to work in the mental health field and positive attitudes towards people with mental health problems. The average number of mental health and illness theory hours across comprehensive nursing programs has been found to be 106 hours (range 15 to 359) with clinical experience in mental health ranged from 0 to 352 hours\(^4\). This variability in programme content and process and general poverty of content is likely to have a negative impact on consumers and ought to be addressed through mandated minimum content and experiential mental health components in undergraduate nursing courses.

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Supporting an evidence base for Mental Health Nurse activities

Currently there are few if any meaningful bodies of ring fenced research monies available for mental health nursing. Current roles, as well as the expanded Mental Health Nursing roles forwarded in this document requires robust research and evaluation to ensure maximum patient benefit, cost effective evidenced based outcomes and professional accountability. The establishment of such research monies would underpin the expansion of both education and clinical practice.

The Mental Health Nurse Incentive Programme

The Mental Health Nurse Incentive Program (MHNIP) is a government funded program which since 2007 has enabled mental health nurses to work in primary care settings in collaboration with general practitioners (GP) or private psychiatrists. The programme specifies that:

* Mental health nurses work in collaboration with psychiatrists and general practitioners to provide services such as monitoring a patient’s mental state, managing medication and improving links to other health professionals and clinical service providers. These services are provided in a range of settings, such as clinics or patient’s homes and are provided at little or no cost to the patient.\(^5\)

Eligible organisations are community based organisations that have the services of a GP or psychiatrist registered with medicare. These organisations then apply to engage the services of a credentialed mental health nurse and are allocated a number of sessions each week. The organisation may claim an establishment grant of $10000 if they engage a mental health nurse for between 5 and 10 sessions per week, or $5000 for between 1 and 4 sessions per week.

Patients eligible for involvement in the programme must have a diagnosed mental illness which has a significant impact on social, personal or work life, have a history of hospitalisation or be at risk, and be expected to need ongoing care over at least a two year period. The GP or psychiatrist, employed to treat the patient by the organisation participating in the MHNIP, is required to be the main person responsible for the patient’s clinical mental health care and must develop a GP Mental Health Treatment Plan (or equivalent) with specific reference to the roles and responsibilities of both doctor and nurse. The nurse may then work with the individual for as long as is needed, providing such services as specified in the plan. The eligible organisation makes a claim once a month for sessions provided. A session is a 3.5 hour block of time in which the nurse must have face to face contact with at least two people (on average) and is reimbursed at $240 per session. The nurse is responsible for collating regular outcome data (Health of the Nations Outcome Scale) and considering ongoing eligibility for patients in the programme at least every three months.

Operation and Outcomes of the Programme

There has been extensive commentary on and evaluation of the MHNIP. The ACMHN has commissioned and reported on several surveys of the MHNIP providers\(^6\) and in 2012 the Department of Health and Aging undertook an evaluation of the programme\(^7\). It has consistently been found to have met the needs of the target population despite being seriously underfunded. Both the formal evaluation and ACMHN commissioned surveys found that the programme improved service user outcomes, kept people out of hospital and was associated with positive occupational and social outcomes. A snapshot of outcome data collected in one study\(^8\) suggested that people typically demonstrated a constellation of problems of greater degree of severity than usually seen

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\(^6\) [http://www.acmhn.org/career-resources/mhnip/mhnip-review](http://www.acmhn.org/career-resources/mhnip/mhnip-review)


on admission to hospital in Australia. Improvements in symptoms and problems of living were clinically significant and importantly personally meaningful outcomes were also evident.

The programme has essentially been frozen since 2012 with the number of sessions capped, a freeze on new organisations joining. Despite announcements of funding increases the number of sessions actually provided following the freeze reduced from 160,000 (in 12/13) to 150,000 (in 13/14) (by 383 eligible organisations) at a cost of $39,689 million. For mental health nurses working within the programme the freeze has impacted upon many of them negatively, with ongoing uncertainty about the future, often reduced session allocations (and thus income) and a lack of capacity to build their practice. Thus people who may benefit from participating in the programme are effectively excluded. There is a general anxiety regarding being critical of aspects of the programme in the current political environment in which funding is only committed year by year, and the employment status of people within the programme is tenuous. Surveys of nurses working within MHNIP since the freeze suggests that many are demoralised by the handling of the freeze and frustrated in their attempts to negotiate with the Department of Health and Ageing (in part because the Department often refuses to deal directly with the nurse and will only respond or communicate with the eligible organisation).

There has been considerable variability in how nurses have engaged with eligible organisations. Some nurses have been employed on contract by medicare locals and cover a wide catchment area and have some employment protections. Others have engaged with practices as ‘sole traders’ and have assumed responsibility for hiring rooms, obtaining insurance and so forth for a percentage of the sessional payment. The relationship with the eligible organisation was the most commented on aspect of the programme by surveyed nurses.

There are also differences in the way the nurses have realised their roles within the programme. Many nurses who operate within the programme are highly experienced specialists and have niche skills. Surveys of nurses who have elected to work in the programme have found them to be very experienced (mean age 50.7 years) with often decades of experience in senior nursing roles in the public sector. They are highly qualified, with 71% having explicit training in psychotherapy as well as holding at least a graduate diploma in mental health nursing. For example some are experienced psychotherapists, child and youth experts or have specialist expertise in working with specific groups such as those with eating disorders. The MHNIP has enabled people with highly complex needs to obtain these services. For some nurses the MHNIP is one but one funding pathway to enable people with complex needs to obtain psychotherapy or specialist services and they may utilise other pathways if available. The MHNIP nurse may assume complex roles in relation to the person depending on their needs. In practice, this appears to be like a clinical case manager with considerable autonomy and flexibility to build a therapeutic relationship and then employ or adapt psychotherapeutic strategies as needed to assist the person address the problems.

**Recommendations relating to MHNIP**

*That the MHNIP be retained, uncapped and enabled to expand*

There was overwhelming support for the continuation of the programme and some certainty is needed regarding on-going funding beyond 12 month periods. There are elements of the programme which are unique and are essential to the success of the programme:

- The MHNIP enables nurses to work with the person for as long as they meet eligibility criteria and as intensely as required within the session allocation and workload of the nurse. This

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10 [http://penny-wright.greensmcs.org.au/content/estimates/estimates-mental-health-nurse-incentive-program](http://penny-wright.greensmcs.org.au/content/estimates/estimates-mental-health-nurse-incentive-program)
enables the nurse to build a relationship, undertake a thorough collaborative assessment and work intensively at the time of referral and crisis.

- The sessional payment tied to an average of two face to face encounters provides some flexibility in dealing with the issue of people not attending scheduled appointment times (which is not uncommon when people have complex needs). It also allows for telephone or internet consultations or to contact and liaise with other agencies.
- The flexibility which the programme presently affords has enabled some mental health nurses to provide specialist, niche psychotherapeutic services to people with a high levels of need. This exceeds the expectations of the programme as it stands.
- Credentialed mental health nurses are well qualified and typically highly experienced in working with patients with severe and complex mental health and social problems.

*That the programme be uncoupled from the ‘eligible organisation’ and the nurse deal directly with the Department of Health and Aging*

- It is unclear whether the MHNIP has provided an incentive to employ nurses and in most instances the nurse appears to have been entrepreneurial in marketing their services to eligible organisations. They are typically engaged on a contractual or sessional basis similar to people referred to clinicians under the Better Access Initiative. They also typically carry their own indemnity insurance and often rent their own rooms or equipment.
- Nurses engaged with medicare locals are an exception in that engagement with medicare locals frequently allows nurses to work with patients across multiple practices. This is desirable but the current specifications regarding eligible organisations make it difficult for this to occur in other circumstances.
- Credentialed mental health nurses as specialists ought to be the registered providers of care and deal directly with the Department of Health and Aging as other health professionals’ deal with medicare. They ought to be able to be paid directly for the sessions they provide in a similar manner. This change would not impede organizations and practices from negotiating a contractual relationship with nurses as they do presently, which is frequently to provide sessions at or for a practice with a percentage of the billing being retained by the practice for overheads.

*That eligibility for referral to MHNIP should be extended to anyone with a mental health plan who are clients of tertiary mental health services when clinically indicated.*

- Presently referrals can only be received from doctors working within the eligible organisation. This is problematic for several reasons:
  - Many people who present to tertiary mental health services do not have a regular GP or have a tenuous relationship with bulk-billing medical centres. Where it is deemed appropriate people ought to be able to be referred directly from tertiary services (Emergency departments, inpatient units or community mental health teams) to the mental health nurse. The mental health nurse is often in a good position to assist the person engage with a medical practitioner and others to complete a meaningful care plan. Indeed case coordination and care planning is an area of expertise of mental health nurses.
  - Health professionals from other practices may wish to refer clients to the mental health nurse in order to utilise his or her particular skill set / expertise but this is not possible without transferring the mental health treatment plan to a medical doctor within the eligible organisation (which is rarely desirable if the individual has a good relationship with their treating doctor).
  - The person may wish to exercise their right to change medical doctors or elect to attend another medical practice. However, should they do this the nurse is obliged
to cease involvement with the person unless they are engaged with the other eligible organisation.

- It is directed that MHNIP services be at low or no-cost to the patient. However, there is no restriction placed on the practice or medical doctor to charge what they wish for a medical consultation. A change in the policy of the practice or the circumstances of the individual may mean that an individual cannot afford the part payment for medical consultation. In such circumstances the nurse may cease seeing people despite having established a productive therapeutic relationship with the individual. Such practice policy changes can also reduce the number of potential new referrals to the nurse despite no diminishment of need in the community.

**That the MHNIP sessional payment be increased and indexed to the CPI**

- To date it has largely been senior and highly experienced mental health nurses who have elected to work in the MHNIP. For many the incentive was primarily to be able to practice their craft in an effective manner outside of the public mental health system in which roles may be constrained by institutional dictates.
- The MHNIP sessional payment has not increased since the introduction of the programme in 2007. Meanwhile wages in comparable public sector positions (Clinical Nurse Consultant or Clinical Nurse Specialist) have increased significantly. The disparity in potential earnings in the MHNIP is now of such a magnitude that it presents a disincentive for senior nurses to enter the programme.

**That the role of the mental health nurse in developing a mental health care plan be highlighted and promoted in the interest of facilitating the best outcomes possible for consumers**

- The treating doctor is designated as being responsible for the mental health plan. At the present time mental health nurses are frequently co-opted into preparing a mental health care plan for which the treating doctor is reimbursed. This should be acknowledged as a reasonable expectation of the mental health nurse and included in sessional time, particularly when they are the mental health specialist working in collaboration with a general practitioner.
- Mental health nurses are specialists in mental health assessment, case formulation and care planning. A treatment or care plan is or ought to be a living document and focused on the person’s personal as well as clinical recovery. The mental health nurse typically assumes a significant role in the person’s life and recovery journey. Whilst the nurse is involved with the individual the responsibility for formulating and updating the mental health care plan should be considered a joint responsibility between the treating doctor, mental health nurse and consumer.

**Peer Reviewed Publications Examining the Mental Health Nurse Incentive Programme**


See Also: [http://www.acmhn.org/career-resources/mhnip/mhnip-review](http://www.acmhn.org/career-resources/mhnip/mhnip-review)