Dear Dr Hambleton

Submission to the Primary Health Care Advisory Group

The Australian College of Mental Health Nurses (ACMHN) has made a joint submission to the PHCAG with the Australian College of Nursing (CAN), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Australian Primary Health Care Nurses Association (APNA) and the Maternal Child and Family Health Nurses Australia (MCaFHNA). In addition, there are issues related to nursing workforce development and specifically to the mental health nursing workforce, that warrant the attention of the PHCAG.

Background Information

The recently released report by the National Mental Health Commission on Mental Health Services and Programs notes that over a lifetime nearly half the Australian population will experience mental illness at some point, equating to nearly 7.3 million Australians between the ages of 18 to 85, yet less than half will access treatment. The 2007 National Survey of Mental Health & Wellbeing identified that 20% (3.2 million) had experienced a common mental disorder (anxiety, depression, substance use disorders) in the previous 12 months (ABS 2008). A recent review estimated that 2–3% of Australians (600,000 people) have severe disorders, as judged by diagnosis, intensity and duration of symptoms, and degree of disability (DoHA 2013). Another 4–6% of the population (around 1 million people) have a moderate disorder and a further 9–12% (approximately 2 million people) a mild disorder (DoHA 2013).

It is estimated that 9000 premature deaths occur each year among people with a severe mental illness, leading to a life expectancy average of 20 years less that the general population and 24 years for people with psychosis. Suicide is the leading course of death among people between 15 and 44 years and is more likely among men, ATSI people, and people living outside the major cities (NMHC 2015, p5) - in 2012 alone, 2,500 Australians lost their life to suicide. The mental health needs of Aboriginal and Torres Strait Islander people are significantly higher than those of other Australians.

Many people who experience mental health difficulties also experience compound disadvantage and co-occurring health and mental health issues. Mental and behavioural disorders such as depression, anxiety and drug use, are important drivers of disability. Mental illnesses are the
leading cause of non-fatal disease burden and account for about 13 per cent of Australia’s total burden of disease (NMHC 2015 p6) (after cancers and cardiovascular disease (Begg et al. 2007)). I.e. of the non-fatal disease burden (i.e. years of healthy life lost through illness and disease) in Australia, 24% were lost through the effects of mental illness. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of this burden. In 2013, 31.2% of people in receipt of the Disability Support Pension had a primary medical condition of ‘psychological/psychiatric’ (DSS 2014).

The economic cost of mental ill-health to Australia is enormous. Estimates range up to $28.6 billion a year in direct and indirect costs, with lost productivity and job turnover costing a further $12 billion a year - collectively $40 billion a year, or more than two per cent of GDP. The OECD estimates that the average overall cost of mental health to developed countries is about four per cent of GDP (including intangible costs such as the costs of reduced wellbeing, emotional distress, pain and other forms of suffering). In Australia, this would equate to more than $60 billion or about $4,000 a year for each person who lodges a tax return (NMHC 2015, p6).

The significance of these direct and indirect costs means that mental ill-health not only affects individuals and their families and other support people, but also the standard of living of every Australian and our communities more broadly (NMHC 2015).

**Mental Health in Primary Care & Mental Health Nurses**

Primary care for mental health is a necessary part of a comprehensive mental health care service and an essential part of generalist primary health care (WHO, 2008, p9). It includes early identification, treatment of common mental disorders, management and ongoing care of people with enduring mental illness, referral to mental health specialists and attention to the mental health needs of people with physical problems (WHO, 2008), particularly chronic disease, where there is significant co-morbidity.

The reform of mental health care in Australia, which began with deinstitutionalisation and has been pursued through successive National Mental Health Plans, has placed primary health care firmly in the front line in terms of mental health service provision. The Fourth National Mental Health Plan (2009-2014) identified whole of government collaboration and cross-sector integration as key agenda items – with primary care, prevention and early intervention solidly embedded throughout.

While effective treatments and practice guidelines exist (for both primary care and mental health providers), for a range of reasons, many people with mental health problems do not receive care, do not seek out a health provider or are not treated effectively (Unutzer et al, 2006; Travers et al, 2009; GPQ, 2010). When people with mental health problems do seek help from a health care provider, it is usually a GP. Over 75% of mental health contacts occur between mental health consumers and GPs (GPQ, 2010, p3).
Mental health nursing is a specialised field of nursing which focuses on working with people with mental illness and mental disorder to meet their recovery goals, considering the person’s physical, psychological, social and spiritual needs, within the context of the person’s lived experience and in partnership with their family, significant others and the broader community. Mental health nurses support mental health consumers and their families during life crises and transition periods. They liaise discretely and effectively with a range of health care providers, provide information and education on mental health maintenance and restoration, and coordinate care and provide evidence-informed therapy. Mental health nurses work across the full range of clinical and service settings, and across metropolitan, regional, rural and remote areas – they play a significant role in the health care system and have the qualifications, skills and experience to provide high quality mental health nursing care in all contexts – primary, secondary and tertiary settings.

Mental health nurses are well-placed to provide high quality specialist mental health care in primary care settings - in both private practice and under the Mental Health Nurse Incentive Program (MHNIP), where they have demonstrated significant capacity for providing specialist care that improves consumer outcome, reduces the burden on GPs and other primary care specialists in managing people with mental illness, and has proved to be a cost effective and efficient program – with significant savings identified in hospital admissions, emergency care.

The Mental Health Nursing workforce
A striking feature of medical and nursing workforce training, immigration and workforce deployment has been the piecemeal, reactive nature of change over the past 20 years. A lack of national workforce planning has led to a boom and bust cycle in the supply of the doctor, nursing and midwifery workforces as the system responds in an ad hoc fashion to current under or oversupply. This is compounded by the fact that the Australian health care system has a complex division of funding responsibilities between different levels of government (HWA 2012, p36).

The National Health and Hospitals Reform Commission (2009) noted that, “while the Australian health system has many strengths, it is a system under growing pressure, particularly as the health needs of our population change. We face significant challenges, including large increases in demand for and expenditure on health care, unacceptable inequalities in health outcomes and access to services, growing concerns about safety and quality, workforce shortages and inefficiency” (p3).

Just as the demand for mental health care in primary care settings is increasing, mental health nursing is experiencing current and predicted workforce shortages of significant magnitude as to indicate a service provision crisis (HW 2025). The document Health Workforce 2025 – Doctors, Nurses and Midwives (HW2025) provides the first, long-term, national workforce projections for doctors, nurses and midwives. Workforce supply, demand, training, retention, exit rates and geographic distribution of the professions were considered and mental health nursing and aged
care nursing were identified as key areas for action.

As such, developing and sustaining a specialist mental health nursing workforce should be an important component of any strategy to improve access and equity for people with mental health problems across primary health care services.

A comprehensive response to the mental health nursing workforce crisis will require:

- Scoping the existing workforce. The 2012 National Health Workforce Dataset shows that employed nurses (both registered and enrolled nurses) who indicated they were working principally in mental health comprised about 1 in 16 (6.6% or an estimated 19,048) nurses employed in Australia (290,144). It is unclear how many of those nurses hold a qualification in mental health nursing /mental health. As education and training impact on retention and quality outcomes, this is an important body of knowledge to establish.

- Working with ANMAC to determine the current status of mental health content and clinical placements being provided in undergraduate nursing programs.

In addition, the following responses are also required and are particularly relevant to primary care:

- Determining the mental health literacy of nurses and midwives who work in community and primary care settings - then responding to the identified areas of need in terms of education and professional development.

- Supporting a professional and educational pathway for Practice Nurses and other Primary Care Nurses to undertake specialist mental health nursing education, in order to enhance their capacity to work in a specialist mental health capacity and deliver more truly holistic primary health care.

- Supporting the development of other measures that improve retention, manage demand and boost productivity, which are likely to be the most timely and cost effective means of managing the significant projected nursing workforce shortages (HWA, p3). For example, clinical supervision has been associated with higher levels of job satisfaction, improved retention, reduced turnover and staff effectiveness. Effective clinical supervision may increase employees’ perceptions of organisational support and improve their commitment to an organisation’s vision and goals. Importantly, clinical supervision has been linked to good clinical governance, by helping to support quality improvement, managing risks, and by increasing accountability (Care Quality Commission, 2013, p6).

- Acting on the recommendations of the National Mental Health Commission’s National Review of Mental Health Programmes and Services (2014) to enhance the effectiveness and sustainability of the MHNP initiative (see Appendix 1).

Mental health nurses have the skills and experience to provide specialist mental health care in primary care settings. They are collaborative practitioners, they provide cost effective evidence.
informed care and treatment, and they work across all metropolitan, rural, regional and remote settings. Mental health nurses, as the largest component of the mental health workforce, are a part of any potential solution to the problem of increased demand for mental health services in primary care. It is essential that any plan to develop primary care includes consideration of the not insignificant workforce issues outlined above.

The ACMHN would be pleased to work with the Committee to develop plans to address these issues and to increase access to mental health treatment through primary care for all Australians.

Please do not hesitate to contact me should you have any questions or wish to discuss this submission in greater detail.

Yours sincerely,

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Appendix 1: Mental Health Nurse Incentive Program

The Mental Health Nurse Incentive Program (MHNIP) represents an exemplary model for the effective management of chronic mental health conditions in the primary health care setting, especially for those who are frequent users of medical and health services. Introduced in 2007, the MHNIP provides payments to community-based general practices, private psychiatric practices, and Aboriginal Medical Services (AMS) to engage Credentialed Mental Health Nurses (CMHN) to assist in the provision of coordinated clinical care for people with severe mental health disorders.

The intent of MHNIP is to ensure that people with severe and persistent mental illness in the primary health care system receive adequate treatment, case management, outreach support and coordinated care. CMHNs work in collaboration with psychiatrists and general practitioners to provide services that are tailored to the person’s needs, drawing on the CMHN’s skills and experience in working with people who have complex problems. In addition to providing evidence-based mental health treatment, CMHNs:

- assess for, and coordinate the client’s physical health related treatment and services (e.g. in relation to chronic disease)
- undertake mental health assessments, plan and deliver mental health care
- provide medication monitoring, management and support
- collaborate and liaise with other health professionals, government and non-government agencies, and community services to assist people to resolve problems and meet their psychosocial needs
- work collaboratively with the person and their care and support network, including their general practice, to promote a healthy lifestyle and optimal wellbeing.

These services are provided in a range of settings, such as in clinics or the person’s home and are provided at little or no cost to the individual or their family. Evaluations of the program undertaken by the Australian Department of Health1, and the Australian College of Mental Health Nurses, have found that consumers cared for under the program experience significantly improved outcomes in their clinical and personal recovery.

Specifically, the program has led to:

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• greater care continuity, increased follow-up, timely access to support, and increased adherence to treatment plans

• a reduction in the likelihood of unnecessary hospital admissions and readmissions - quantitative data demonstrate that overall mental health hospital admissions decreased by 13.3% for a sample of MHNIP patients in the 12 months following their involvement in the program; along with reductions in the number of emergency department presentations

• a reduction in hospital bed days for the same sample – an average reduction in total number of admission days by 58% and a reduced average length of stay, from 37.2 days to 17.7 days

• keeping people with severe mental illnesses well and connected with the community – there is evidence of increased MHNIP client employment and MHNIP has encouraged and facilitated patients’ increased involvement in social and educational activities

• increased carer support – MHNIP has had positive flow-on benefits to some carers of MHNIP patients and has had other positive impacts including improved family interactions

• cost effectiveness – the DoH (2012) cost analysis suggests that savings on hospital admissions attributable to the MHNIP could be on average $2,600 per patient, per annum. This was approximately equivalent to the average direct subsidy levels of providing MHNIP, which ranged from an average of $2,674 for patients in metropolitan areas to $3,343 in non-metropolitan areas. There are also a large number of un-costed and intangible benefits associated with MHNIP including the impacts of improved health outcomes, enhanced relationships with carers and family members, and the effects on carer social security outlays

• a high level of support from medical practitioners, consumers, carers, and relevant stakeholders for the model of care – MHNIP has had a positive impact on medical practitioner workloads by increasing their time available to treat other patients and improve patient throughput.
The MHNIP is an effective collaborative model of care that is relevant to, and could easily be replicated across, other areas of the health system. It would be particularly relevant where consumers have complex needs; where treatment regimens are complicated and self-management is essential to good clinical outcome; where mental health, social and emotional needs intersect with physical health needs; where isolation and lack of engagement with the community (related to social, physical or mental health issues) contribute to poor health outcomes; where service coordination and collaboration is required for optimal care; and, where there is a significant burden on the primary health care system. The MHNIP model of care would be particularly suitable for people with chronic disease and those in the aged care sector.

Policy enablers
The National Review of Mental Health Programmes and Services, published November 2014, identified a number of actions that government could take to enhance the effectiveness and sustainability of the MHNIP initiative. Of these, we recommend the government:

- end the freeze on the MHNIP to ensure more equitable access to mental health services
- commit to at least maintaining the existing level of funding for the programme – when funding permits, it should grow from its allocation of $41.7 million in 2014–15 to $72 million a year to enable an equitable distribution of funds for the target population
- examine the cost-effectiveness of including extension of Better Access to nurses with postgraduate qualifications in mental health
- extend MHNIP eligibility to include residential aged care facilities and Multipurpose Services
- promote the uptake of the programme by Indigenous Primary Health Care Organisations including Aboriginal Community Controlled Health Services, including opportunities for MHNIP-funded nurses to be a part of the proposed mental health and social and emotional wellbeing teams
- remove the requirement for GPs to write a mental health care plan for referral to mental health nurses under MHNIP where a comparable health plan has been prepared by a specialist mental health professional
- enable individual consumers and primary health networks to contract directly with mental health nurses instead of through an ‘eligible organisation’ to provide greater flexibility and access to specialist mental health nursing care across multiple settings
• train general practice nurses to develop their mental health skills and provide scholarships which enable them to train to become mental health nurses

• include a mandated amount of mental health curricula content and assessed mental health competencies for undergraduate nurse preparation.