CHAPTER 7

MENTAL HEALTH NURSES

7.1 New funding for mental health nurses was another of the COAG Plan major initiatives designed to improve access to clinical care. Funding of $191.6 million was allocated for mental health nurses to work in a range of clinical teams, including with private psychiatrists and in general practices. The aim was for mental health nurses to assist in coordinating care, managing medication and making links to other health professionals.[1]

7.2 The Australian College of Mental Health Nurses outlined the credentials that mental health nurses must have in order to be eligible for the program:

> …the college has an established credentialing program, renewable every three years, which requires the mental health nurse to provide evidence of postgraduate qualifications in mental health, recency of practice and evidence of contemporary professional development in order to receive the credential. This credential is also a requirement for mental health nurses wishing to participate in the Commonwealth government's Mental Health Nurse Incentive Program.[2]

7.3 Two and a half years into the COAG Plan, the budget for the mental health nurses initiative has been reduced. The committee received evidence about the benefits of the program and factors contributing to the budget cut.

Support for the initiative

7.4 The Australian College of Mental Health Nurses outlined that the aim of the Mental Health Nurses Incentive Program was 'really to get mental health nurses supporting GPs and psychiatrists in the primary healthcare sector particularly with that cohort of clients with severe and enduring illness'. The College observed that resources have tended in the past to be devoted to the hospital sector, due to the long waiting times for treatment, lack of capacity in in-patient services and the difficulty and complexity of the situations of acutely unwell people that present at emergency departments. There has been little attention to addressing the causes of repeat admission. The Mental Health Nurses Initiative was an attempt to redress, at least partly, this imbalance. Mr Santangelo, College President, explained:

> …the provision of mental health support to the primary healthcare sector and ongoing maintenance of care is going to be absolutely crucial in making sure that people stay well.[3]

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1 COAG Plan, p. 10.

2 *Committee Hansard*, 20 May 2008, p. 47.

3 *Proof Committee Hansard*, 20 May 2008, p. 50.

7.5 In Professor Hickie's view, the mental health nurses initiative was one of the more innovative initiatives coming out of the COAG Plan as it was aimed at a clinic level, rather than reimbursing individual providers.[4]

7.6 The Australian General Practice Network (AGPN) was also positive, commenting that the initiative aimed to facilitate 'whole of person' care. Dr McAuliffe, AGPN Mental Health Advisor, outlined some of the service linkages that the mental health nurses initiative had helped to facilitate in her area:

> In our local division, the division has been very active in working with a broad range of providers—including NGOs, disadvantaged schools, those serving Indigenous people—to look at how we can cobble together the links that enable us to best meet the needs of the community in a way that relates to the needs of our community. You need that level of local flexibility and support.[5]

7.7 The committee notes the support for the mental health nurses initiative and commends the effort to use the valuable skills of mental health nurses in primary care settings. The committee also notes that the introduction of this initiative was an acknowledgement of the need to devote resources to coordinating mental health care at a practical level.

Budget cut

7.8 Funding for the initiative was markedly reduced in the 2008–09 Federal Budget, such that it will now have $49.5 million over four years to 2011–12.[6] Professor Calder, First Assistant Secretary DoHA, explained that the initiative had a very slow uptake due to issues of workforce availability.[7] In the same budget, $35 million was allocated to a Mental Health Nurses Training Subsidy, to help increase the number of mental health nurses available.

7.9 Dr Gurr, Comprehensive Area Service Psychiatrists Network NSW, suggested that the initiative had been destined for underspend, as it was set up in a way that did not fit with private sector organisations' priorities. He commented:

> The GPs themselves found it too difficult to organise the infrastructure to arrange for the nurses. The GP divisions in my area did not see any value to them in trying to organise it; it was just another hassle.[8]

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4 *Proof Committee Hansard*, 20 May 2008, p. 22.

5 *Proof Committee Hansard*, 16 May 2008, p. 4.

6 *Proof Committee Hansard*, 16 May 2008, p. 97; see also Community Affairs Committee, Budget Estimates, *Committee Hansard*, 5 June 2008, pp. 152 and 154.

7 *Proof Committee Hansard*, 16 May 2008, p. 97.

8 *Proof Committee Hansard*, 27 March 2008, pp. 62 and 76.

7.10 In contrast, the AGPN commended the initiative and had found that it worked well within the division structure:

> …there is certainly a cohort of divisions who have accessed funding to employ a nurse through that measure. That works very well, particularly when it is not viable for a single practice to employ a nurse, with a division employing the nurse and the nurse working sessionally across a number of practices. So we have been very active in supporting it and promoting it, and it has been welcomed by GPs.[9]

7.11 The AGPN considered that it was because of the shortage of mental health nurses that the initiative had not been taken up as much as expected. Dr McAuliffe commented on closer links being forged between private practice and the public sector to make the most of the limited number of mental health nurses:

> One of the things that is happening in a number of divisions is collaboration with the state funded mental health service, looking at how we can work with them to perhaps link what the mental health nurse initiative might do with the services they are trying to provide the community. That has been well received.[10]

7.12 Other witnesses, in raising concerns about the initiative, also pointed to the need for greater public-private collaboration.

Concerns about the operation of the initiative

7.13 Several witnesses considered that specific constraints in the design of the program had limited its uptake. For example, AMSANT explained that there were no options for partial uptake:

> At the moment there is no way you would get pro rate funding. You might employ a full-time mental health nurse and take the risk on Medicare being able to generate the $150,000, which is the amount of money you can get. If you do not get 20 patients a week on average—say you see 10 patients a week on average—you get no money. You have got to meet the full requirement to get the full amount of money.[11]

7.14 AMSANT gave an example of a large Aboriginal health service which had considered taking on a well-qualified mental nurse who was available and interested, but found the financial risk too high. AMSANT noted that a pro rata option would lower the risks associated with taking up the mental health nurse initiative and also allow time for the new service to be fully developed and used. Representatives commented that it might take 12 months or more to get up to a regular schedule of 20 patients a week.[12] The Australian College of Mental Health Nurses also indicated that

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9 *Proof Committee Hansard*, 16 May 2008, pp. 2–4.

10 *Proof Committee Hansard*, 16 May 2008, p. 3.

11 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 30.

12 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 31.

it was a challenge to sustain a practice at the levels required to maintain income through the initiative.

7.15 Mr Thorn, from the Government of Western Australia expressed the state government's concerns that the mental health nurses initiative might result in nurses leaving the government sector to work with GPs or NGOs. He also noted that the state government wanted to ensure that through the initiative mental health nurses would be able to tap into the 'vast experience of the state system' and not be left working in isolation.[13] Mr Thorn considered that discussions with the Commonwealth around this issue had been positive.[14]

7.16 Professor Calder explained that the initiative has been revised to allow 'a flexible funding arrangement whereby we will now accept that the program can pay for public sector nurses to be available to work in the private sector'. She noted that to a large extent and particularly in rural and remote areas, public sector nurses are the only mental health nurses available.[15]

7.17 The Northern Territory Government welcomed changes to the Mental Health Nurse Incentive Program which facilitate shared arrangements between public sector services, private practices and Aboriginal community controlled health services.[16] At the time of the committee's hearing only two organisations in the Northern Territory had sought to employ a mental health nurse under the initiative. The NT Government considered that the small size of organisations in the Territory and lack of available workforce contributed to the low uptake of the initiative.[17] It considered that further improvements to the initiative would include the use of pro rata payments, reviewing the credentialing requirements needed for qualified nurses to be eligible for the program and allowing a broader range of organisations, such as NT Government run primary health care services in rural and remote areas to participate in the initiative.[18]

7.18 The Northern Territory Government also provided the perspective that general nurses are a resource that has been overlooked in the COAG Plan initiatives. The NT Government considered that while specialist services are needed, the prevalence of mental illness is so high that sustainable services can only be achieved by making mental health a core health service. They advocated increasing the mental health skills of the whole primary health sector.[19]

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13 *Proof Committee Hansard,* 7 May 2008, p. 102.

14 *Proof Committee Hansard,* 7 May 2008, p. 102.

15 *Proof Committee Hansard,* 16 May 2008, p. 97.

16 *Proof Committee Hansard,* 1 May 2008, p. 50.

17 *Proof Committee Hansard,* 1 May 2008, p. 50.

18 *Proof Committee Hansard,* 1 May 2008, p. 54.

19 *Proof Committee Hansard,* 1 May 2008, p. 59.

7.19 The mental health nurses initiative shows the limitations to good initiatives when there is insufficient workforce to implement them. In the context of the budget cuts to this initiative the committee emphasises that the need which originally underpinned the initiative, that is better coordination of clinical treatment and other care for people with severe mental illness, remains real and must be addressed.

7.20 The committee is pleased to note that some modifications have been introduced to enable greater use of mental health nurses across the private and public sectors. It suggests that consideration be given to introducing further flexibility into the initiative, for example pro-rata funding to clinics where full service targets cannot be met.