Australian Rural Nurses Inc. AARN

ANZCMHN

ROYAL COLLEGE of NURSING Australia

Supplementary Information to the Senate Select Committee on Mental Health

1. Introduction

The Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA) welcomed the opportunity to meet with the Senate Select Committee on Mental Health on 4 July 2005. Questions posed by the Committee which were taken on notice at that time, have been responded to in the following paper, to provide additional information for the Inquiry deliberations.

2. Response

2.1 Different State/Territory Legislation

The question was posed as to the practical difficulties, which arise for the nursing profession and others, as a result of the different legislation across the States and Territories.

As stated in our joint submission the different Mental Health Acts across Australia impede the seamless delivery of service to clients from a national perspective, leading to a fragmentation in care. Although much work has been undertaken to review the many different Mental Health Acts with a view to having a single national Mental Health Act. this has not eventuated. The lack of consistency in State and Territory legislation means that mental health clients are often lost to follow up care, as a consequence of transferring the clients across boarders. A client cannot be engaged in involuntary treatment in a different state unless they are assessed and meet the assessment criteria for involuntary admission or treatment.

Some issues are:

- Mental Health Acts across the states and territories do no have the same legal powers and do not use the same terminologies. In one state a nurse may be able to detain a client for assessment for 24hrs, where in another, a medical doctor may be the only health professional who can detain a client for assessment.

- The differences in the powers of the Acts and the terminologies requires all staff who choose to move across state and territory boarders, to familiarize themselves with new Acts and terminologies, ultimately impinging on the ability of staff to effectively use the required act in a timely and efficient manner.
  This becomes confusing for clients, staff, relatives and auxiliary services such as police.
- In addition the Mental Health Acts there are other legislations that are affected by these geographical boundaries such as, Guardianship Act, and the Crimes Act.
  If a client lives in NSW and an AVO or DVO is taken out against them by a relative in the ACT, the system is not conducive to the communication of such information.
- As we have seen recently from the Cornelia Rau case, if a client goes interstate, which is easy to do, it is not easy to transfer them back to their treating team and relatives. Not engaging in necessary treatment will only protract the period of time the client is unwell.
- An example of the difficulties in transferring a client back to their home state or territory is when staff from the receiving treatment team are required to be at the border, so that the client can be legally assessed at the border, which is often isolated and a distance from the treatment facility. If a client is being transferred or accepted by air the receiving team must be at the airport to assess the client.
  If at any of these jurisdictional borders the client does not fit the criteria for involuntary admission or they do not agree to a voluntary admission they must not be detained.
  This can be a very time consuming, costly and stressful process for all involved.

When considering the impact different States and Territory legislation has on the nursing profession and client care delivery, the different requirements for nurse regulation must also be taken into consideration. Currently some regulatory authorities require evidence of ongoing education while others do not have this system in place. As with mental health legislation different terminologies are used for nursing personnel such as 'Level 2' nurses, or 'clinical nurse specialist'. To ensure a consistent standard of practice for the profession, clients and employers, there needs to be a nationally consistent requirement for the registration of nurses for all specialties, with a consistent terminology framework, and requirements for maintenance of ongoing competence.

2.2 Nurse Educational Preparation for Mental Health

The question posed related to the adequacy of the undergraduate curriculum for nursing students and competencies from that educational preparation, in the field of mental health, particularly pertaining to rural and remote area nursing.

In 2002 the National Review of Nursing Education report *Our Duty of Care* made the following recommendation on the minimum level of qualification for registered nurses:

> *Recommendation 22*
> *To ensure that registered nurses are appropriately prepared for their professional roles, the minimum level of qualification for entry to practice as a registered nurse should remain a university-based bachelor degree, with a minimum length equivalent to six full-time semesters.*

The Review Report and its recommendations, including the above recommendation, was endorsed by the Minister for Health and Ageing and the Minister for Education, Science and Training, providing unequivocal support for the university entry level of registered nurses.

The Australian Health Workforce Advisory Committee's National Mental Health Working Group produced its report in 2003: *Australian Mental Health Nurse Supply, Recruitment and Retention.* This project did not question the entry level education for registered nurses, however it did identify concerns regarding the adequacy of undergraduate nurse education in relation to mental health content and practice as well as lack of accessibility to, and consistency of, postgraduate mental health nurse education.

The Australian and New Zealand College of Mental Health Nurses (ANZCMHN) has a position statement on *Mental Health Nursing Education* (Issued Feb 2004) which states that, as a result of the Mental Health Reform Agenda in western industrialised countries over the past three decades (including Australia), and new treatments for mental illness, the scope of practice for mental health nursing has expanded. The number of hours of mental health education within the current comprehensive undergraduate nursing degree curriculum is variable across the country and falls far short of the desired number of theoretical and clinical hours. The ANZCMHN position paper on undergraduate nursing curricula (referenced below) states that: *undergraduate curricula should comprise a minimum of the equivalent of one academic session with identifiable and explicit mental illness course content, and 150 hours of mental health clinical practicum.*

The comprehensive undergraduate nursing degree program provides a broad educational base for the beginning practitioner in nursing. Transition programs must be in place in all areas of work in which these neophyte nurses enter to practice. In addition, postgraduate programs in specialty areas of practice, such as mental health nursing, are available in some universities, which can better prepare nurses to confidently deal with health consumers presenting with mental health illnesses. These programs however, are often not easily accessible to those nurses practicing in rural and remote areas due to costs involved in travel.

The most critical issue facing all States and Territories in regard to mental health services is the lack of appropriately qualified and skilled staff. The three author organizations to this paper therefore request that the Committee echo recommendations of the reports mentioned in this paper, for a) improved national consistency, and increased hours of theoretical and clinical content for mental health nursing in undergraduate nursing programs; and b) increased funding for scholarships for rural and remote nurses to specifically undertake mental health postgraduate programs.

2.3 Mental Health Education Programs for Enrolled Nurses and Other Health Workers

As noted in our joint submission, research indicates that people living in rural and remote Australia are more vulnerable to mental health problems and mental illness than their metropolitan counterparts, due to exposure to higher levels of poverty, unemployment, substance misuse, child abuse, domestic violence and social isolation (Victorian Health Promotion Foundation 1999). Nurses working in these areas therefore need to be able to deal appropriately with people presenting with symptoms of mental health illness. However, as outlined to the Committee, the Association for Australian Rural Nurses found that although a high percentage of

nurses in rural areas had to intervene in mental health issues they did not have mental health qualifications.

Aboriginal Health Workers

Currently there is no universal curriculum for Aboriginal Health Workers (AHW). Therefore any Mental Health component can be somewhat ad hoc. Work is currently being undertaken to develop a national framework for AHW training, and this framework includes two mental health 'streams'. One is a clinical stream for AHWs who are dealing directly with an Indigenous persons suffering from a mental health disorder. The other is a community stream for AHWs who are employed as liaison officers and may need to advocate on behalf of mental health clients and their families. This new program aims at having all AHWs competent to certificate 4 level.

A more comprehensive program is delivered by Charles Sturt University. This is an undergraduate degree program called 'Indigenous Mental Health'.

In addition, there are a number of 'Social and Emotional Health' Centres throughout the country that provide mental health services to the Indigenous community. Many of these centres are also registered for training AHWs. The centres are managed through the National Aboriginal Community Controlled Health Organisations (NACCHO). More information is available at www.naccho.org.au.

The Association for Australian Rural Nurses' project 'Mental Health Emergencies' includes AHWs in the identified target group of health professional for workshops.

3. Conclusion

As stated in our submission and at the Hearing, the Association for Australian Rural Nurses, the Australian and New Zealand College of Mental Health Nurses and Royal College of Nursing Australia believe that a significant issue in regard to mental health service delivery is the lack of qualified and experienced mental health nurses. The strategies suggested in reports such as the "Australian Mental Health Nurse Supply, Recruitment and Retention Report 2003", "The Report of the National Review of Nursing Education 2002", "Scoping Mental Health Nursing Workforce 1999" and the "International Mid-Term Review of the Second National Mental Health Plan for Australia 2001" need to be implemented as a matter of urgency in order to ensure quality of care for mental health patients both in medical and community settings.

We would be pleased to provide any further assistance required by the Committee in relation to the issues outlined in our submission or those discussed in the Hearing.

4. References

Australian Health Workforce Advisory Committee 2003 *Australian Mental Health Nurse Supply, Recruitment and Retention* AHWAC Report 2003/2 Sydney

Australian & New Zealand College of Mental Health Nurses Position Statement: *Mental Health Nursing Education* Feb 2004 available on website: http:// www.anzcmhn.org/pdf/ANZCMHN_Education_Position_Statement.PDF

Australian & New Zealand College of Mental Health Nurses Position Paper: *Mental Health Course content of Undergraduate Nursing Curricula in Australia* Retrieved from the website: http://www.anzcmhn.org/News/news_position01.html on 7 Feb 2005

Commonwealth of Australia 2002 *National Review of Nursing Education 2002 Final Report: Our duty of care.* Department of Health and Ageing and the Department of Education Science and Training, Canberra.

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