

Mental Health Nursing Services in Australia: A How to Guide for Primary Health Networks October 2016

The Australian College of Mental Health Nurses inc.

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Glossary

ACMHN: Australian College of Mental Health Nurses (ACMHN)

CMHN: Credentialed Mental Health Nurses - The Credential for Practice Program is an initiative of the ACMHN and has established the only national consistent recognition for specialist mental health nurses. Credentialing is a core component of clinical/professional governance or self-regulation where members of a profession set standards for practice and establish a minimum requirement for entry, continuing professional development, endorsement and recognition.

GPN: General Practice Nurses - A general practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by a general practice. The scope of practice of a general practice nurse typically covers a broad range of health areas (e.g. wound care, medication management), rather than specialist expertise in a particular area (e.g. mental health).

MHN: Mental Health Nurses – “A mental health nurse is a registered nurse who holds a recognised specialist qualification in mental health [nursing]. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual” (ACMHN, 2010, p.5).

HoNOS: Health of the Nation Outcome Scale

NMBA: Nursing and Midwifery Board of Australia

MHNIP: Mental Health Nurse Incentive Program

MHNP: Mental Health Nurse Practitioners are advanced practice clinical nurses educated at Master degree level who are regulated by the Australian Health Practitioner Regulation Agency (APHRA) and endorsed against the Nursing and Midwifery Board of Australia (NMBA) nurse practitioner standards for practice (2014), which took effect on 1 January 2014. (Refer to appendix for where to find information on the scope of practice for MHNPs)

PHN: Primary Health Network

NMHC: National Mental Health Commission

Aims

To provide readers with a clear understanding of the role of mental health nurses in primary mental health care and possible engagement options for the Primary Health Networks, by:

1. Outlining the scope of practice of mental health nurses and describing the Australian College of Mental Health Nurses (ACMHN) process of credentialing mental health nurses.
2. Demonstrating how Credentialed Mental Health Nurses (CMHN), Mental Health Nurse Practitioners (MHNP) and mental health nurses (MHN) more generally can provide part of an effective stepped care approach to mental health care in primary care settings, augmenting the services available through general practice.
3. Outlining some key points of the Mental Health Nurse Incentive Program (MHNIP), including the strong positive clinical outcomes associated with the program, as evidenced by general practitioners and clients across Australia reporting the value of closer engagement with MHN in effective primary mental health care.
4. Providing assistance to PHNs who would like ACMHN to help facilitate access to MHN in their region.

Introduction

A number of significant events have occurred to support mental health care over the last 10 years.

Two of the more significant reforms included the establishment of Credentialing for Mental Health Nurses (CMHN) by the Australian College of Mental Health Nurses (ACMHN) and the establishment of the Mental Health Nurse Incentive Program (MHNIP) by the Commonwealth government in 2007 (*See note*).

In response to National Mental Health Commission (NMHC) (2015), Review of Mental Health Services and Programs, the Federal Government announced significant changes to the provision of primary mental health care. Primary Health Networks (PHNs) were established and are now at the centre of mental health reform, offering greater flexibility to the provision of mental health care. PHNs and GP and psychiatry practices are expected to establish collaborative arrangements with MHNs under these new arrangements.

The challenge set out by the reforms is significant, including the provision of improved ongoing community care for people experiencing severe and complex mental health conditions. The evaluations of the MHNIP clearly identified the significant role of CMHN in the provision of mental health care in primary health care settings.

A key challenge moving forward will be retaining and growing the MHN workforce across primary care. A number of key factors that will need to be considered by the PHN's, such as remuneration and conditions of engagement/employment that will support the delivery of primary mental health care that achieves the positive outcomes seen with MHNIP.

This document has been developed to provide guidance to the PHN's to support their engagement with CMHN/MHN and MHNIP.

Scope of Practice of Mental Health Nurses

The practice of all nurses in Australia is framed by the regulatory requirements of the Nursing and Midwifery Board of Australia (NMBA), including adherence to relevant competency standards and decision-making frameworks, currency of practice and professional practice and development.

Guidance on the practice of all MHN in Australia is provided by the ACMHN Standards of Practice for Australian Mental Health Nurses 2010 and the ACMHN Scope of Practice of Mental Health Nurses in Australia 2013.

While any Registered Nurse may work in a mental health setting, the ACMHN defines MHN as a Registered Nurse who holds a recognised specialist qualification in mental health (nursing).

MHN's perform a wide-range of roles, functions and activities, from promoting optimal mental health, preventing physical and mental ill health, and providing therapeutic interventions. Taking a holistic approach, guided by evidence, the MHN works in collaboration with people who are experiencing mental ill health, their family and community, towards recovery as defined by the individual.

Note When the Mental Health Nurse Incentive Program (MHNIP) is discussed in this paper, it is referring to the program that operated pre 1 July 2016, before funding for the program was transitioned to PHNs. It is discussed with reference to how CMHN worked in MHNIP. It is recognised that MHNIP, along with other mental health programs, are not stand-alone programs from 1 July 2016.

The scope of practice of MHN in Australia is:

- provided within an holistic theoretical and clinical framework incorporating a range of factors affecting an individual or community; including cognitive, occupational, physical and social factors;
- centred around person-centred and client-focused therapeutic approaches to deliver specialised, recovery-oriented, evidence-based care to people across ages, cultures and settings;
- characterised by engagement and collaboration with clients, carers, families and other members of multidisciplinary teams; and
- underpinned by personal and professional reflection.

As with all Registered Nurses, the scope of practice of individual MHNs will change as their experience and expertise develops, and is influenced by specific factors such as:

- Community context, including health preferences and needs of clients, carers, families, communities and specific populations; and geographical location.
- Professional context including employment conditions, practice setting, service setting and area of specialisation.
- Professional qualities including educational experience; level of competence; personal awareness, insights, background, life experiences and interests; personal nursing philosophy and theories; practice experiences; professional and practice development experiences; and lifelong learning.

Credentialed Mental Health Nurses

In Australia, the NMBA does not recognise or endorse specialty areas of nursing practice. As a result, the ACMHN has developed a specialist nurse professional credentialing program for mental health nurses. The ACMHN Credential for Practice Program is the only nationally consistent approach to identifying a specialist mental health nurse.

The Mental Health Nurse Credential recognises the qualifications, skills, expertise and experience of nurses who are practicing as specialist mental health nurses. It demonstrates to employers, colleagues, clients and carers that an individual nurse has achieved the professional standard for practice in mental health nursing. The Credential also increases awareness of the contribution MHN make to the mental health of the community.

To gain a Credential, applicants must demonstrate that they:

- Hold a current licence to practice as a registered nurse within Australia
- Hold a recognised specialist/post graduate mental health nursing qualification
- Have had at least 12 months experience since completing specialist/postgraduate qualification or have three years' experience as a registered nurse working in mental health
- Have been practicing within the last three years
- Have acquired minimum continuing professional development points for education and practice
- Are supported by two professional referees
- Have completed a professional declaration agreeing to uphold the standards of the profession.

Successful applicants are awarded a Credential that is valid for 3 years.

A Mental Health Nurse Credential was identified by the Commonwealth Government as the entry criteria for nurses working under the Mental Health Nurse Incentive Program (MHNIP), as this is the

only mechanism by which specialist mental health nurse can be identified. The qualifications and experience of these nurses has been integral to the excellent outcomes achieved through the MHNIP (see evidence provided later). The MHNIP has provided an opportunity for CMHN to show the positive outcomes that CMHN can deliver, offering professional high quality specialist mental health care as part of a high performing, multi-disciplinary team.

A Mental Health Nurse Credential provides clients, the community and PHNs with some certainty around the expertise and qualifications of the MHN and the quality of services they can expect when engaging or commissioning a CMHN. There are currently over 1100 CMHNs working across Australia. The ACMHN is transitioning to an online credentialing system at the end of 2016, streamlining the process for nurses and reviewers, while maintaining the same strong emphasis on quality and standards.

Further information about the credentialing process and how to find a Credentialed Mental Health Nurse is available on the College website <http://www.acmhn.org/credentialing/what-is-credentialing>

The Mental Health Nurse Incentive Program (MHNIP)

The Mental Health Nurse Incentive Program (MHNIP) was established in 2007 and designed to provide clients with severe mental illness access to mental health nursing care, through primary care GPs, psychiatrists and Aboriginal Medical Centres.

The ACMHN commissioned and reported on a number of surveys of MHNIP providers¹ and in 2012 the then Department of Health and Ageing undertook an evaluation of MHNIP².

The outcomes were overwhelmingly positive and findings included:

- The benefits created by a model of care which involved credentialed mental health nurses working with eligible medical practitioners received strong endorsement from clients, carers, medical practitioners and relevant peak bodies.
- Improved outcomes for clients receiving treatment and support under MHNIP as a result of improved levels of care through increased continuity, follow-up and service coordination, access to support and compliance with treatment plans.
- An overall reduction in average hospital admission rates and lengths of stay in hospital where admission occurred; increased levels of employment; improved family and community connections; and positive impacts on GP workloads.
- Costs analyses showing savings on hospital admissions on average at approximately \$2,600 per patient per annum, which was about equivalent to the average direct subsidy levels of providing MHNIP.³

It is possible that the positive outcomes of MHNIP could be attributable to the fact the program required MHN to be credentialed, and therefore the workforce had extensive experience as MHN. Nurses with no formal education in mental health and without significant experience as a mental health nurse may not be able to achieve the positive outcomes that have been reported through all the evaluations of the MHNIP.

Appendix 1 provides a number of descriptions of how mental health nurses worked under the MHNIP, including demonstrations of improved client outcomes and significant cost savings.

¹ <http://www.acmhn.org/career-resources/mhnip/mhnip-review>

² HMA (2012), Evaluation of the Mental Health Nurse Incentive Program, Final Report. Department of Health and Ageing.

³ Ibid. (2)

The MHNIP evaluation report is available at -

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-e-evalnurs>

Funding allocated to MHNIP was transitioned from the Department of Health to PHNs from 1 July 2016. Under this funding agreement, PHNs must ensure the continuity of care to MHNIP clients throughout this transition, and are required to engage previous MHNIP providers, where possible, in 2016-17 to achieve this. If the PHN has not provided MHN services before, does not currently have MHNs providing services in their region, or needs to fill a MHN position that has become vacant to ensure service continuity for existing clients, ACMHN is happy to be contacted and can help to facilitate access to MHN as required.

From 2017-18, PHNs will have the flexibility to decide the best way to ensure the availability of mental health nursing services to those in need across their region.

Key Elements and Future Enhancements for a mental health nurse service

The various reviews and reports on MHNIP have identified elements that should be considered for the ongoing success and operation of MHN in primary care settings, including:

1. Building a strong relationship, undertaking a thorough collaborative assessment and working intensively at the time of referral and/or crisis is required for best outcome.

Key Element: MHN/CMHNs should be able to work with the client for as long as the client meets eligibility criteria, at the level of intensity the person requires and in line with what is possible within the reasonable MHN/CMHN workload.

2. Nurses who have expertise and qualifications in mental health deliver more positive outcomes for clients and their families.

Key Element: Where possible, PHNs should engage CMHNS, given the outcomes CMHNS have achieved to date and the opportunities they present for the delivery of mental health services into the future.

3. In supporting people with mental illness, MHN/CMHNs utilise a range of strategies and approaches.

Key Element: Funding approaches need to consider the range of contact media that MHN/CMHNs engage in to deliver a service including, but not limited to, face-to-face sessions, phone, video, skype, carer support/psycho education, report writing and telehealth service delivery.

4. Under the MHNIP, access to CMHN was constrained by CMHN services needing to occur through an 'Eligible Organisation'.

Key Element: MHN/CMHN (as specialists) can now be registered providers of care, contracted/commissioned directly with PHNs, and to receive direct payment for the services they provide.

Key Element: MHN/CMHNs should be able to work with clients from across multiple practices, this also ensures clients have choice and flexibility (for example, it ensures continuity if a client changes to another GP practice, but wants to continue seeing the MHN).

5. Under MHNIP, access to CMHN was constrained by the client referral criteria. CMHNs were not able to work to their full scope of practice.

Key Element: Eligibility for referral to a MHN/CMHN be extended to any individual who is a client of a tertiary mental health service and who has a mental health care plan, as clinically indicated. This will encourage service integration between tertiary and primary mental health care and ensure better prevention and early intervention, instead of waiting for a MHN to be engaged as a "crisis response" only.

6. MHN/CMHNs have the skills and knowledge to undertake mental health assessment and care planning.

Key Element: That the MHN/CMHN role in developing a Mental Health Treatment Plan be acknowledged and included as a paid service as part of the session.

The Stepped Care Approach

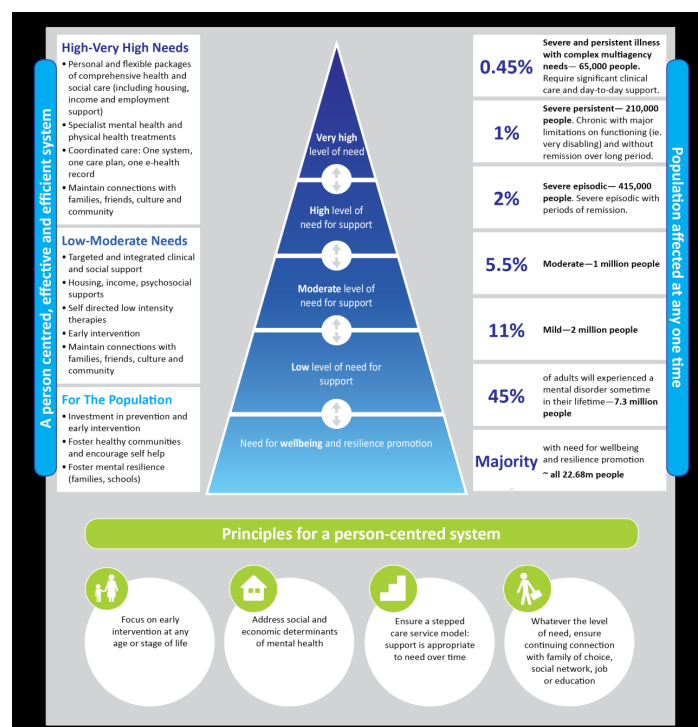
The National Mental Health Commission (NMHC) report *Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services* identified and articulated a population-based model of contemporary mental health care, into which fits a person-centred approach. System design begins with a focus on the needs of the entire Australian population, and on particular population groups based on needs and risks. As noted in the NMHC report, the main features of such a model or approach are:

- Population interventions to support the whole of the community and their health and wellbeing
- Initiatives that prevent mental illness and intervene early to address lifelong illness and support people most at risk
- Measures that support recovery from mental illness in the community
- Keeping people living with chronic, persistent conditions supported in appropriate housing and out of acute care, unless necessary⁴

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. Within a stepped care approach, an individual will be supported to transition up to higher intensity services or transition down to lower intensity services as their needs change. Stepped care is a different concept from 'step up/step down' services.

The definition of stepped care used in the Department of Health PHN Mental Health and Suicide Prevention Implementation Guidance is as follows:

This is outlined in the figure below, taken from the NMHC report.⁵



⁴ National Mental Health Commission, 2014: *The National Review of Mental Health Programmes and Services*. Sydney: NMHC

⁵ Ibid. (4)

There are significant challenges associated with the effective community and primary care management of people with more severe mental illnesses. CMHN working in previous operation of the MHNIP have been focused on the very high needs group under the current operation of the program for severe and persistent mental illness. As has been noted from the Scope of Practice (see pg 4) and demonstrated with the case studies (at Appendix 1), CMHN and MHN have the skills, qualifications and experience to work across the spectrum of care and assist clients with episodic mental ill health, as well as those with very high needs.

CMHN and MHN already work to a 'stepped care' approach, which is based on providing care to people when they need it; having the ability to address factors specific to a person's situation and environment at that time; and working across the health system with a range of health professionals.

The key features of the Scope of Practice which enables the provision of mental health care across the spectrum of stepped care are:

For the population – CMHN/MHN Scope of Practice is provided within a framework which addresses a range of factors affecting an individual or the community including cognitive, occupational, physical and social. This enables work that invests in communities, recognises the culture of the community, and builds trust and strong relationships. For example working directly with Aboriginal and Torres Strait Islander communities; and working with schools and school communities to build wellbeing and resilience.

Low to moderate needs – CMHN/MHN provide person-centred and client focused therapeutic approaches to deliver specialised, recovery-oriented, evidence-based care to people across diverse stages, cultures and settings. This is targeted and based on specific population group needs, such as addressing drug and alcohol dependence, homelessness, unemployment. Services include supporting group activities that address social isolation; connecting people with services that provide and promote physical health stability, employment, housing or other social supports; and addressing the underlying causes of problems.

The focus is on keeping people out of acute care, with the flexibility of visiting people directly at home or in their community enables; and providing care when and where people need it.

Very high needs – CMHN/MHN take a holistic approach, guided by evidence, working in collaboration with other health professionals, and clients and their carer's or family towards recovery as defined by the individual. Their work is characterised by engagement and collaboration with clients, carers, families and other members of multidisciplinary teams. The focus is on keeping people at home or in appropriate accommodation and out of acute care, where it is not necessary.

Information on what stepped care means in terms of mental health nurses scope of practice in terms of clinical assessment, treatment, care coordination, medication management and management of comorbid physical health conditions is explained further in the next section.

Nursing, Mental Health and a Stepped Care Response

All nurses are well placed to help build an accessible, sustainable and effective stepped care response to mental health, for the Australian health care system. The stepped care response is based on levels of acuity; movement of clients across the steps is based on where and how they present, and their level of need for support and interventions. Ensuring the delivery of the most appropriate care requires the best use of the nursing workforce. Enabling flexibility within the health care system and ensuring the nursing workforce is adequately prepared, is essential.

Table 1 demonstrates that an adequately prepared nursing workforce is well placed to provide appropriate support and interventions for clients experiencing various levels of distress and in response to changing needs.

Table 1: Nursing, Mental Health & a Stepped Care Response (ACMHN 2016)

LEVEL OF DISTRESS	LEVEL OF NEED FOR SUPPORT	FOCUS OF CARE	CARE SETTING	KEY NURSES INVOLVED
STEP 5 Severe distress	<i>Very High Level of Need</i> (Risk to life; Severe self-neglect)	Risk assessment Management of critical incidents Medication Treatment	Emergency Departments	Consultation-Liaison MHNs MH Nurse Practitioners (MHNP) Emergency Department (ED) Nurses
			Acute MH Services Acute Care MH Teams	MHN/CMHN/MHNP
			Acute AOD Services	Alcohol & Other Drug (AOD) Nurses
		Acute MH care Medication	Acute MH Acute Care MH Teams	MHN/CMHN/MHNP
STEP 4 Moderate to severe distress	<i>High level of need for support</i> (Recurrent, atypical and those at significant risk)	Brief psychological interventions Medication Education & Management Social support & referral	Emergency Departments	Consultation-Liaison MHN CMHNs MHNP
		Brief psychological interventions Complex psychological interventions Medication Social support & care coordination	Inpatient MH Community MH	MHN
			Primary Care	MHNP CMHN
STEP 3 Moderate distress	<i>Moderate level of need for support</i> (Moderate or severe mental health problems)	Psychological interventions Medication Education & Management	Community MH & Primary Care	MHNP CMHN MHN
		Identifying distress Appropriate Referral Social support	Medical settings Primary Care	Emergency Department (ED) Nurses Alcohol & Other Drug (AOD) Nurses Nurses working in Chronic Disease settings General Practice Nurses
STEP 2 Mild to moderate distress	<i>Low level of need for support</i> (Mild mental health problems)	Guided Self Help Brief psychological interventions	Primary Care	Mental Health Nurse Practitioners Credentialed Mental Health Nurses Mental Health Nurses
		Identifying distress Raising awareness Flagging risk Watchful waiting	Medical settings Primary Care	Emergency Department (ED) Nurses Alcohol & Other Drug (AOD) Nurses Nurses working in Chronic Disease settings General Practice Nurses
STEP 1 Minimal to mild distress	<i>Need for wellbeing and resilience promotion</i>	Recognition MH literacy Mental health promotion	All health care settings Primary Care	All nurses in all settings Practice Nurses Credentialed Mental Health Nurses Mental Health Nurses

Specialist Credentialed Mental Health Nurses, Mental Health Nurse Practitioners and Mental Health Nurses, working in collaboration with General Practitioners and General Practice Nurses in primary care settings can provide improved and integrated care to clients and their families.

Step 1 – General Practice Nurses and nurses in all clinical settings need to be upskilled in promoting mental wellbeing and resilience, as it relates to clients in their clinical community. For example, general practice nurses working with people who have chronic disease need to be well-versed in promoting mental health and wellbeing for this client group as a matter of course, and in helping clients to develop mental health literacy relevant to their physical condition.

General practice nurses should also understand how to identify clients who are particularly at risk for developing mental health problems. They need to be able to recognise and intervene when people present with mental health symptoms, chronic disease or other comorbid mental health needs and physical illnesses, and they need to be able to collaborate with CMHN/MHN/MHNP to ensure that people with mental illness receive the level of intervention and specialist care required.

The Mental Health Nurse Scope of Practice extends to the provision of mental health promotion, mental health literacy and the development and maintenance of wellbeing and resilience. This enables work that invests in communities, recognises the culture of the community, and builds trust and strong relationships. For example, working directly with Aboriginal and Torres Strait Islander communities; and working with schools and school communities to build wellbeing and resilience.

Step 2 – Once a General Practice Nurse has identified someone at risk, or who is presenting with mild to moderate distress related to a mental health issue, an initial screening assessment is appropriate. General Practice Nurses can be upskilled to undertake a series of mental health assessments using evidence based assessment tools such as the Kessler 10, BASIS-32, and/or Beck Depression rating scale. Depending on the outcome of this initial assessment, the person can then be referred to the GP and/or the CMHN/MHN/MHNP for further assessment, and a Mental Health Treatment Plan established.

The Mental Health Treatment Plan should be made with the client and carer. The General Practice Nurse's input to the plan can focus on monitoring the person's physical health care and liaising with the GP and/or the CMHN/MHN. At Step 2, the CMHN/MHN/MHNP provides the mental health support required to assist the client in mild-moderate distress through the provision of guided self-help, or brief psychological interventions as appropriate.

CMHN/MHN provide person-centred and client focused therapeutic approaches to deliver specialised, recovery-oriented, evidence-based care to people across diverse stages, cultures and setting. This targeted integrated clinical and social support helps people to maintain connections with family and community. The focus is on keeping people out of acute care and enhancing their ability to participate in their community by working with them to identify problems early and assisting engagement with low intensity directed self-help. Providing help when and where people need it, with the flexibility of visiting people at home or in their community, is important.

In this step, CMHN/MHN/MHNP can also run support groups for clients, carers and/or significant others, as carer support is an important element to take the pressure off all levels of service. Psycho education, advanced care planning and regular maintenance monitoring can all be included in the Mental Health Treatment Plan.

Step 3 – Clients with moderate or severe mental health issues who have moderate support needs should receive specialist, coordinated care from a CMHN/MHN/MHNP. At this step, the CMHN/MHN/MHNP is the point of engagement for direct GP clinic, psychiatrist or other primary

health service referred clients. In addition, the CMHN/MHN/MHNP will work with tertiary referred clients to support their ongoing recovery.

CMHNs/MHN/MHNP work with clients to stabilise their mental health, and ensure their health needs are being managed holistically. This may include linking clients with other community-based services, working with significant others, providing psycho-education, strengthening their personal support systems, delivering evidence based therapeutic interventions as required, medication management, and assessing and addressing early warning signs. It is likely that clients in this step will at least initially require more intensive sessions, along with phone support. As clients recover, support can be provided with less frequency and intensity, however, some maintenance contact should be expected, acknowledging the episodic nature of mental illness.

Step 4 – Clients experiencing moderate to severe distress and with a high level of need for support, may be referred from the tertiary sector to a GP, Psychiatrist, Mental Health Nurse Practitioner or other primary care services, such as Aboriginal Medical Services, for ongoing treatment, which may include a number of health professionals in a team management approach.

The CMHN/MHN/MHNP would work closely with the client and GP/psychiatrist to establish a strong engagement and therapeutic relationship with the primary providers. This may include the provision of complex psychological interventions, combined treatments, medication management, social and carer supports, and addressing early warning signs for relapse or acute deterioration.

CMHN/MHN/MHNP take a holistic approach, guided by evidence, working in collaboration with clients, carers and other health professionals, towards recovery as defined by the individual. Their work is characterised by providing specialist mental health interventions, supported and coordinated clinical care. It is likely that clients in this step will require intensive support, including regular sessions (e.g. weekly or twice weekly), regular phone support (e.g. daily), service linkages, social support and care coordination, medication management, mental state monitoring and risk assessment.

Step 5 – Clients with a very high level of need will be cared for by MHN, CMHN and MHNP in acute care settings.

Mental Health Nurses as a part of PHN Clinical Governance

CMHN and MHN can play a central role in the PHN Clinical Councils given their experience and expertise in delivering mental health care across a broad spectrum of clinical settings in collaboration with many other health professionals, and are already working in a stepped care approach of service delivery. Nurses are very familiar with coordinated care, as well as the need for integration and collaboration.

Mental health nurses represent the largest mental health workforce in Australia and work in all contexts of care. MHN can therefore provide insights and advice about mental health care services and delivery from across the continuum, providing a valuable contribution to developing and progressing mental health strategies or other related health reforms. MHN are often the only mental health professional providing care in some areas, in particular regional and rural areas of Australia.

Nurses are leaders in Australia's health care system. They make significant contributions to the delivery of health care across a range of settings, professions and locations, and are experts in providing collaborative and client-centred models of care. Nurses have a breadth of knowledge on the delivery of health from clinical, administrative, educational and research perspectives.

There is a significant amount of health reform occurring across Australia which will guide and impact how health is delivered into the long term, this includes reforms in primary care, mental health, and managing chronic disease – three of the largest areas impacting the health system. Each of these areas also directly or indirectly relates to mental health, and the role of mental health nurses, as people living with mental ill health often have increased chronic disease comorbidity and are significant users of primary health care.

The mental health nursing perspective of health care delivery, improvement and reform can greatly contribute to these deliberations. Mental health nurses, and nurses more broadly, are the profession that are managing health care services 24/7 365 days a year, across the country.

Engaging mental health nurses: Maximising service delivery outcomes in the primary health setting

Prior to the transition of the program to the Primary Health Networks from 1 July 2016, the Mental Health Nurse Incentive Program (MHNIP) provided non-MBS incentive payments to eligible community based general practices, private psychiatry services and other appropriate organisations (such as PHNs and Aboriginal Medical Services) who engage mental health nurses to coordinate treatment and care for people with serious mental illness requiring clinical intervention and complex care coordination. This funding model was unique since payment did not involve claiming via an MBS item number. It is for this reason that careful consideration should be given to how best to ensure the elements of MHNIP that helped make it so successful are not lost during the transition, and that other areas of the MHNIP service delivery model are improved and expanded upon.

Evidence of the effectiveness of this model of service delivery has been well-documented by a number of reviews.⁶ Clients receiving treatment and support under MHNIP experienced improved outcomes through increased continuity of care – including through home visits, follow-up and care coordination, access to support and greater compliance with their treatment plans. There was evidence of an overall reduction in average hospital admission rates and lengths of stay in

⁶ HMA (2012), Evaluation of the Mental Health Nurse Incentive Program, Final Report. Department of Health and Ageing.

hospital where admission occurred; increased levels of employment; improved family and community connections; and positive impacts on GP workloads.

Additionally, cost analyses showed savings on hospital admissions on average at approximately \$2,600 per patient per annum, which was about equivalent to the average direct subsidy levels of providing MHNIP.

There are a number of foundational elements of this unique primary MHN service delivery model that were crucial to the overall success of MHNIP and positive outcomes for clients. To achieve and – ideally – exceed these outcomes through the commissioning of these services by the PHNs, it is recommended these elements form the basis of PHNs model for commissioning these MHN services:

- **Recognition of need for flexibility in service delivery:** CMHN/MHNs need to adjust their service delivery in response to their clients' individual needs. Their ability to continue delivering positive outcomes for their clients based on individual needs hinges on their contractual, payment and reporting arrangements recognising this need for flexibility. For example, the length of time spent face to face with each client may vary depending on what individual clients need or can manage at a given point in time. Sometimes more coordination of care (such as phone calls, working with the family to develop their ability to support the client etc.) will be required in addition to face to face clinical intervention with the client. Similarly, a session with a client may include psychosocial support and that may involve the mental health nurse meeting with the person in their home, or accompanying them so they can go to the shops to buy their groceries. Psychosocial support for people with complex mental illness is highly important.
- **Recognition of travel time and care coordination if a client fails to attend:** Remuneration recognising travel time of the CMHN/MHN is necessary to allow MHN the flexibility to conduct home visits, or to meet the needs of those whose experience of mental illness impacts on their capacity to attend. There may be a number of reasons that people with mental illness do not keep appointments, such as apathy, anhedonia, reduced social drive, loss of motivation, lack of social interest, and inattention to social or cognitive input. Enabling MHN the flexibility to pursue clients who have not attended in this way, also decreases the likelihood that there will be a deterioration in the person's mental state as a result of dropping out of treatment. Remuneration also needs to acknowledge the care coordination role the CHMN/MHN typically engages in to follow up with a client if they miss an appointment, and that for people with mental illness, care-coordination, including liaising with a person's family, other health practitioners and support services, can take a significant amount of time.
- **Recognition of continued professional development (CPD) and clinical supervision:** CMHN/MHNs also require a portion of paid time to allow for continued professional development (CPD) and clinical supervision. Both clinical supervision and lifelong learning are core elements of the *Standards of Practice for Mental Health Nurses in Australia* (ACMHN 2010). They are crucial to ensuring the CMHN/MHN workforce remains highly skilled and up-to-date with developments in best practice so they can continue to deliver positive outcomes for people with severe and persistent mental illness.
- **Clinical decisions:** The decision to discharge a client from the CMHN/MHN service is a clinical one requiring close knowledge of the individual's clinical history and should be made by the CMHN/MHN in collaboration with the client's GP and/or psychiatrist. Standard discharge criteria can act as a guide, but also need to be applied in the context of each client's own circumstances. While some clients may appear to be doing well (for example, from a low HONOS score), their illness may be quite episodic and monthly contact with a CMHN/MHN may be the key driver behind their ability to manage their illness in the community and stay out of hospital. Flexibility regarding client engagement is critical to support effective client care.

- **Reporting:** CMHN/MHN are keen to provide information that may help to improve outcomes for people with severe mental illness and address service gaps. However, current reporting requirements appear to lend themselves more to a straight fee-for-service model, rather than the variable, highly individualised clinical and coordination role of the CMHN/MHN formerly delivering services under MHNIP. This is therefore also time that must be taken into account in the remuneration structure of the MHNs given the level and frequency of reporting the CMHN/MHN are currently required to engage in.

The foundations underpinning the MHNIP provide an opportunity for PHNs to develop a service model for CMHN/MHN that continues to achieve positive outcomes for people with severe and persistent mental illness. They also provide the necessary platform on which to harness the opportunities created through the PHNs to address the geographical inequities identified in past reviews of MHNIP and to expand on this very successful primary mental health care model to better meet the mental health needs of the community.

The 2016-17 Transition Period

The ACMHN recognises that for 2016-17 PHNs are expected to commission CMHN/MHN services via the current network of MHNIP providers with the primary objective of ensuring continuity of care. From 2017-18, PHNs will be able to determine the best way to make mental health nursing services available where required.

Funding available for mental health nursing services in 2016-17 will be generally commensurate with 2015-16 funding, and additional funding will be allocated in regions that currently have service levels that are less than the weighted national average.

To manage the transition period, issues that will need to be considered by the PHNs include:

- Managing existing contracts with bodies who were 'eligible organisations', namely GPs and psychiatrists, either practices or individuals in their own practice.
- Recognising some CMHN/MHN were engaged directly by the previous Medicare Locals or PHNs.
- Recognising some CMHN/MHN were engaged through contractual arrangements and some were directly employed.
- Acknowledging that the previous payment or claim mechanism was through Medicare, which will now be through PHNs.
- The previous MHNIP payment was \$240 per session, which hadn't increased for 9 years, and that the level of actual payments to CMHN varied, based on employment/engagement relationship with the eligible organisations and/or the individual negotiations.
- Recognising that CMHN/MHN also spend a considerable amount of time engaging in other tasks that do not involve clinical face to face contact, including person centred care coordination, travel time, CPD and reporting that are still important for delivering a quality service that is responsive to individual needs.

The ACMHN recommends that for the 2016-17 period, including for those PHNs who will receive funding for mental health nursing services for the first time, that the following claim and payment process will be the most workable in the short-term:

- PHNs manage and maintain existing contracts with GP or psychiatry practices
- CMHN/MHN submit their claim forms directly to the PHNs. If necessary, the GP or psychiatry practice could sign the form before it is submitted.
- CMHN/MHN submit claim forms based on a timeframe that best suits their work schedule, and there are minimum mandatory payment timeframes for the PHNs in which to make the payments.

- CMHN/MHN currently employed directly by PHNs continue to be so until the end of 2016-17 when new processes/arrangements may be established by PHNs.
- Previous workplace or contractual arrangements between CMHN and Eligible Organisations (including where PHNs were 'Eligible Organisations') should remain in place (i.e. honoured by the PHN) until end of 2016-17.
- The sessional payment needs to increase to reflect the actual costs associated with the provision of mental health nursing services and increases in costs and should be calculated on the basis of CPI as a minimum, i.e.

Year	CPI increase at 3%	Rate per session
2007		\$240
2008	\$7.20	\$247.20
2009	\$7.42	\$254.62
2010	\$7.64	\$262.27
2011	\$7.87	\$270.49
2012	\$8.11	\$278.60
2013	\$8.36	\$289.96
2014	\$8.61	\$298.57`
2015	\$8.96	\$307.53
2016	\$9.23	\$316.76
2017	\$9.50	\$326.26

The processes listed above will ensure continuity of service to clients, improve consistency of payments made to CMHN/MHN, simplify the process for claiming, simplify the process for the PHN's in the initial 12 months and enable mental health nurses to be employed while the new funding and service delivery arrangements are being established by PHNs.

APPENDIX 1: How mental health nurses work in different settings

The report *Achieving through collaboration, creativity and compromise*⁷ highlights how CMHN have kept many people out of hospital and helped them back into the workforce or other meaningful social lives – leading not only to benefits for the individual, their family and community, but the overall economy. It demonstrates how CMHN have been able to practice autonomously – using and adapting their extensive knowledge, skills and experience according to client's needs. The report also identifies case studies for CMHN working across different settings and population groups.

The practice examples that follow are written by CMHN describing their different approaches and ways of working within primary care settings in Australia.

Achieving social justice, reducing stigma and collaborating across the community sector

Practice Setting: A CMHN working in Kings Cross, NSW in collaboration with an addiction specialist GP.

Clients: Clients who were living with chronic mental and physical ill health, usually including severe alcohol and drug dependence. A significant number of the clients were street homeless or living in unstable situations; had experienced childhood trauma and incarceration; and had not seen a doctor for many years. Addressing physical health needs, in particular long-standing conditions, was prioritised, supporting access to treatment - and new problems were then identified.

Collaborations: The CMHN established a close relationship with the Salvation Army and Centrelink – two agencies providing assistance to long-term unemployed people. The Salvation Army Employment Plus scheme identified 90 clients on Newstart Allowance who were living with chronic mental and physical ill health. In consultation with Centrelink, social support needs were reassessed, with many people transferred to the Disability Support Pension and provided with priority housing.

CMHN Focus of Care: The CMHN was able to spend quality time with clients, using a narrative approach to determine the underlying cause of their many and varied problems. This usually involved spending an hour with each person to build trust and then develop a plan to address the current and underlying symptoms of their illness. Addressing the significant social and physical health needs was the first step in supporting clients to address mental health issues and other issues within their life, leading to significantly improved health and wellbeing outcomes.

'Walking together': providing continuity and consistency for Aboriginal community members

Practice Setting: A private hospital in Warrnambool use a team of CMHNs to work across a large geographic area, with most contact occurring in the client's own environment.

Clients: Many clients had not received specialist treatment opportunities at public mental health services, due to increasing referrals and demand. The uniqueness of the service is the flexibility that it allows CMHNs to deliver care on an as needed approach and work directly with GPs to address their specific concerns about clients.

Collaborations: A multidisciplinary case management approach to providing clinical and social care was adopted, whereby the CMHN engaged with clients, other health professionals and clinical

⁷ ACMHN 2011 Mental Health Nurse Incentive Program: Achieving through collaboration, creativity and compromise. http://www.acmhn.org/images/stories/Media/Monographs/acmhn_2011_mhnip_monograph_web.pdf

service providers where appropriate. The service engages with the local Aboriginal community, including addressing longer term disability. There are multiple and complex health problems and some services could not work with them over a longer period. Gaining trust and rapport with the community was vital to address unhealthy lifestyles, provide coping skills and increase resilience.

Outcomes: Due to the ability to meet clients in their own homes, there was a noticeable reduction in hospital admissions. In the 2008 financial year there were 33 in-patient admissions from 77 clients; which reduced in the 2009 financial year to 24 admissions from 134 clients; and in 2010 had reduced further to 8 admissions from 180 clients.

Community feedback raised concerns that existing mainstream services often react to crisis events only and did not progress any further with social and emotional wellbeing and physical situations. In this case one person was able to work with the community and connect them to services.

A Women's Wellbeing Group was also developed and facilitated by CMHNs, with the goal to promote social inclusion and healthy lifestyles and build self-esteem. The flexibility of the service to encompass such a program, provided services to women who would not otherwise be able to access specialist mental health care.

Evidence of outcomes and savings of over \$20,000 per client

Practice Setting: A CMHN who was a private practitioner, was contracted by a private psychiatrist under MHNIP.

Contractual Arrangements: A framework for conducting the service was developed which provided structure and clear guidelines for the provision of care for clients, role clarity between the CMHN and other health care providers, continuity of care through implementation of weekly clinical meetings, and the offer of three monthly case reviews between the CMHN, the psychiatrist, clients and their significant others.

Focus of Care: Services were to be conducted primarily in clients homes (dependent on risk assessment), as this would provide a more accurate assessment and greater understanding of the individual's problems, concerns, issues and lifestyle. It also allowed for greater engagement with families.

Outcomes/Assessment Data

The impact of the MHNIP on the following was assessed:

- Clinical symptoms
- Percentage of families involved in the treatment and care of the person
- Collaboration and coordination of care
- Rates of hospitalisation
- The health care dollar

Data was collected over a period of 15 months and found the following outcomes:

- Decrease in severity of symptoms - average admission Health of the Nation Outcome Scale (HoNOS) score was 23 and the average discharge HoNOS score was 6.
- 72% of families had involvement in the treatment and care of the individual. The others were not involved either because the client refused or, in a very small percentage, decided not to be involved.
- During the period of the study we liaised with and referred clients to over 40 different agencies, organizations or professional bodies.
- Hospitalisations were reduced – there were only a small number of clients (15) for which data could be produced that reflected their episodes of hospitalisation 12 months prior to entry and

12 months after entry into the MHNIP. Prior to care, admissions (including day client admissions) totalled 230. Twelve months after care under MHNIP admissions had decreased to 138.

The savings identified for each client were estimated to be in excess of \$20,000 per client over the study period.

In this case, a privately practicing CMHN was able to work with a private psychiatry practice to deliver the following:

- Continuity of care
- Access to support on a psychological and practical level
- Closer monitoring of clients who were acutely unwell and support continued outpatient treatment
- Support objective observations in the homes of clients facilitating better quality information
- Increased emotional support for the client which enhances their response to treatment

Appendix 2: Mental Health Nurse Practitioners (MHNP)

Mental Health Nurse Practitioners (MHNP) are advanced practice clinical nurses educated at Master degree level. They provide an expanded and extended scope of practice for the mental health specialty and offer clinical leadership and expertise to the mental health sector that is recognised by peers, colleagues and service providers.

MHNPs are regulated by the Australian Health Practitioner Regulation Agency (APHRA) and endorsed against the Nursing and Midwifery Board of Australia (NMBA) nurse practitioner standards for practice (2014), which took effect on 1 January 2014.

Useful links regarding MHNP is available at:

Australian College of Mental Health Nurses

<http://www.acmhn.org/images/stories/NPSIG/MHNPPBrochureApril16.pdf>

Australian College of Nurse Practitioners

https://acnp.org.au/sites/default/files/1173/anp_dl_fa_print.pdf

Nursing and Midwifery Board

<http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations.aspx#nurse>

If you have any questions, or would like to discuss any of the information contained in this document, including to discuss or obtain ideas regarding commissioning or service delivery models for the delivery of mental health nursing services, please contact ACMHN on 02 6285 1078 // 1300 667 079 or via email at enquiries@acmhn.org.