Australian Nursing and Midwifery Federation submission to the

CONSULTATION ON THE PRODUCTIVITY COMMISSION REPORT ON MENTAL HEALTH

10 FEBRUARY 2021

Australian Nursing & Midwifery Federation

Part One: Critical Recommendations

1. **Of the recommendations made, which do you see as critical for the Government to address in the short term and why? Please enter your response in the text box (max. 500 words)**

As identified in the Report, the mental health of individuals and communities is multifaceted and complex. An integrated, whole-of-person approach is needed to address these complex and interconnected issues. The importance of nurses and midwives to the provision of holistic, person-centred care including caring for people's mental health and people experiencing mental ill-health, must be acknowledged and utilised to meaningfully improve mental health care in Australia.

Person-centred services that provide holistic mental health care encompassing physical wellbeing and management of co-morbidities are more likely to meet the needs of consumers and lead to better outcomes. Viewing mental health as a component of overall health is also core to reducing stigma. This shift in mindset is key to the successful implementation and adoption of many other recommendations, particularly recommendations 5, 6, 7, 12, 14, and 21, and should be identified as critical to short term implementation.

Most of the recommendations identified in the Report are essential to the success of the system as a whole and cannot be implemented in isolation. However, in the short term the ANMF recommends prioritising strategies that create a person-centred mental health system (recommendation 4), equip workplaces to be mentally healthy (recommendation 7), and increase the efficacy of Australia's mental health workforce (recommendation 16).

At present, many people do not receive the mental health care they require due to limited service availability, funding gaps, lack of cultural safety, convoluted referral pathways, and fragmented care. The first step is to reduce and remove these barriers to care access, by prioritising the integration of new and existing services and programs that are readily accessible, affordable, coordinated, and tailored to the individual's needs. As far as practicable, these interventions should be integrated not only with one another but within the broader health care system, and with the education, human services, justice, and aged care systems. This will facilitate seamless transitions of care, continuity of communication, and opportunistic referrals to mental health support services.

An effective, person-centred health system needs an effective and robust health workforce (recommendation 16) practicing within healthy workplaces (recommendation 7). These two recommendations are essential to advancing every other recommendation.

Every recommendation in the Report relies on skilled health practitioners to provide care, implement programs, conduct research, and evaluate outcomes. It is therefore critical government invests in strategies that effectively utilise the workforce to their full scope of practice and increase workforce capacity to meet demand now and into the future.

Creating positive practice environments by equipping workplaces to be mentally healthy (recommendation 7) will enable the establishment and maintenance of an effective mental health workforce whilst also supporting person-centred mental health goals for the broader community. Being meaningfully employed is linked with improved mental health, and workplace experiences can trigger, contribute to and/or exacerbate mental ill-health or illness. Therefore, positive practice environments are an essential component of a robust mental health system that not only aims to treat mental ill-health but also prevent it.

2. Of the recommendations made, which do you see as critical for the Government to address in the longer term and why? Please enter your response in the text box (max. 500 words)

One of the largest barriers to effectively supporting the mental health of people in Australia is the stigma associated with mental ill-health in Australian culture. This must change if the Report's recommendations are to genuinely succeed. Widening recommendation 8 to include reducing all stigmatising attitudes and behaviours will have even greater health benefits than focusing on mental health stigma alone. Being stigmatised contributes to the development and worsening of mental ill health, and drives self-medication through alcohol and other drug use, particularly in overrepresented groups, including Aboriginal and Torres Strait Islander communities, people who are sexuality, sex and gender diverse, and obese people. Any initiatives addressing mental health stigma should also consider destigmatising these identities and conditions, through exposure, education, and reframing.

Changing cultural practices to equip education facilities (recommendations 5 and 6) and workplaces (recommendation 7) to be mentally healthy will assist in reducing stigma. This work must include health practitioners themselves. One of the unexpected effects of the COVID-19 pandemic is the exposure of, and a shift in, the cultural expectation that health practitioners attend work unless they are too sick to practice safely. Equally problematic but less obvious is the negative culture surrounding the lack of support for health practitioners' mental health.[1] Reforming this culture is vital to ensure all health care staff have safe and supportive workplaces in which to deliver care to others. It is also essential workplaces have support mechanisms that recognise and mitigate vicarious trauma for those working in health systems, as both recipients and providers of care.

Implementing preventive strategies is essential for the long-term mental health of people in Australia. We know preventive interventions are more effective than reactive measures, both financially and in terms of outcome. It is therefore critical to focus on early intervention and building resilience in infant, child, adolescent (recommendation 5) and tertiary students' (recommendation 6) mental health.

1. Ross CA and Goldner EM (2009) Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *Journal of Psychiatric and Mental Health Nursing* 16 (6), p.558-56doi: 10.1111/j.1365-2850.2009.01399.x; Galbraith, N., Boyda, D., McFeeters, D., & Hassan, T. (2020). The mental health of doctors during the COVID-19 pandemic. *British Journal of Psychiatry Bulletin* 2020-04-28, 1-4. doi:10.1192/bjb.2020.44

Ensuring strong social support (recommendation 19) and substantively expanding housing and homeless services (recommendation 20) need to be prioritised by governments. Poverty and homelessness are strongly associated with mental ill-health. International experience demonstrates that providing financial support[2] and housing[3] are the most effective and inexpensive solutions. This will substantially contribute to improving mental ill-health, and address generational cycles of poverty, homelessness, under education, underemployment, and mental ill-health.

Part Two: Implementation Issues

1. **Of the critical recommendations identified in the previous questions, are there any significant implementation issues or costs you believe would need to be considered and addressed? Please provide your response in the text box (max. 500 words)**

   Historically nurses and midwives have been expected to provide mental health care interventions in addition to other clinical care without increased time to do so. As a result, the success of these interventions and the holistic care nurses and midwives can provide is compromised. If person-centred mental health care is to be prioritised, the value of time needed to provide mental health care must be acknowledged. Health practitioners, including nurses and midwives, need dedicated time to effectively care for a person's mental health along with their other health care requirements, particularly where mental health is at risk or compromised by comorbidities. This requires increased funding for additional nursing and midwifery positions across the board, not just in mental health care settings. To address the priority areas identified in the Report, this is particularly important in perinatal and early parenting settings, and schools.

   If the mental health workforce is to be fully utilised, moving beyond a system that has GPs as the gate keepers to specialised Medicare funded mental health services (such as those provided by mental health nurses and psychologists) must also be considered. As identified in our submission to the review, the ANMF called for the reinstatement of nurse-led programs such as the Mental Health Nurse Incentive Program (MHNIP), which allowed mental health nurses to provide cost effective community-based mental health care. Despite demonstrable improvements in clients' overall mental health and social functioning, and correlated reductions in hospital admissions alongside increased levels of employment, funding for this successful program was frozen, then diverted into a general flexible funding pool. These funds are no longer quarantined for the provision of effective, efficient care by qualified mental health nurses.

   The efficacy of Australia's mental health workforce is compromised by entrenched ways of working and poor utilisation of practitioners aside from GPs in mental health care referral and management pathways.

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2. Allas T, Maksimainen J, Manyika J, and Singh N (2020) An experiment to inform universal basic income *McKinsey & Company* https://www.mckinsey.com/industries/public-and-social-sector/our-insights/an-experiment-to-inform-universal-basic-income#
3. García I, Kim K (2020) "I Felt Safe": The Role of the Rapid Rehousing Program in Supporting the Security of Families Experiencing Homelessness in Salt Lake County, Utah. *International Journal of Environmental Research and Public Health* 17(13):4840

Medicare funded referral pathways for health practitioners other than GPs would allow opportunistic mental health care referrals to take place without delay or additional consultation, streamlining the process for consumers and reducing overall costs. The ANMF therefore suggest creating funded pathways for health practitioners other than GPs, such as nurse practitioners and midwives to refer to Medicare funded mental health care services.

The core issues of recommendation 8 present the largest hurdles to its implementation. Challenging pervasive, long held beliefs about mental illness and ill-health will require a significant, multipronged approach across multiple industries not just the health sector alone. This will require a monumental shift in the culture and the attitudes of people living in Australia. Collaboration across sectors to work towards the re-branding of mental health and ill-health will be critical.

Adequate social support payments for all recipients, from those on unemployment benefits to people receiving disability and pension payments, would alleviate the stress of poverty and food uncertainty on mental health.

2. What do you believe is required for practical implementation of these recommendations? What do you feel are the key barriers and enablers? Please provide your response in the text box (max. 500 words)

Despite the capacity of the nursing and midwifery workforces to achieve positive outcomes across recommendations 4-18 and 21, nurses are poorly identified as providers within the Report and midwives are wholly absent. Nurses and midwives are critical providers of mental health care from cradle to grave, particularly when prevention is paramount, yet they have been overlooked in the action areas. To enable person-centred care, it is essential to recognise the extent to which utilising nurses and midwives, working to the full scope of their practice, offers immediate and sustainable gains for the health of individuals and the community.

For example, nurse practitioners (NPs) should be utilised as lead health practitioners in mental health care management and referral pathways. In part, they are prevented from doing so by funding barriers and lack of recognition. Recommendation 23 describes funding arrangements to support efficient and equitable service provision. This section doesn't specifically discuss Medical Benefits Scheme (MBS) rebates for NPs working in settings where they are detecting and intervening in emerging and established mental ill-health, including: community health; alcohol and other drugs and dual diagnosis; prenatal clinics; antenatal care; maternal, child and family health; and aged care. The ANMF notes that the MBS Taskforce[4] ignored the NP Reference Group's 14 recommendations[5] and replaced them with three ill-conceived recommendations that all reduced, restricted or required medical oversight for NP scope of practice and MBS funding access. We strongly recommend the expert Reference Group's 14 recommendations be adopted and the three Taskforce recommendations be disregarded.

4. Medical Benefits Schedule Review Taskforce (2020) *Final Report: An MBS for the 21st Century* https://www.health.gov.au/resources/publications/medicare-benefits-schedule-review-taskforce-final-report
5. Report from the Nurse Practitioner Reference Group (2018) https://www1.health.gov.au/internet/main/publishing.nsf/content/BEB6C6D36DE56438CA258397000F4898/$File/NPRG%20Final%20Report%20-%20v2.pdf pp. 9-10

The PC Report recommends a three-year direct entry mental health nurse bachelor qualification be introduced to address nursing workforce shortages in mental health. The ANMF does not support this recommendation. There is currently no pathway for registration of mental health nurses under the National law. The costly and arduous process of implementing this recommendation presents a barrier to building an effective mental health nursing workforce and is poor use of resources with no guarantee of successfully addressing shortages.

The foundational preparation of nurses and midwives equips them with the skills and knowledge to provide mental health care. Better use of already qualified nurses and midwives is an easy and cost-effective strategy to increase the efficacy of Australia's mental health workforce and recognises that not all mental health care occurs in mental health services.

The ANMF recommends bolstering the nursing mental health workforce by implementing strategies focusing on attraction, retention, and progression such as providing:

– Well supported, quality mental health clinical placements in final year nursing qualifications;
– Substantive, well-resourced transition-to-practice programs in mental health and community health, for both registered nurses and enrolled nurses;
– Clear pathways that encourage and support progression to clinical nurse consultant and nurse practitioner roles specialising in mental health; and,
– Scholarships to assist with the costs of post-graduate education in mental health.

3. Are there clear steps you believe need to be taken to ensure the recommendations are successfully implemented? Please provide your response in the text box (max. 500 words)

Workforce retention

While the Report addresses recruitment strategies to increase specialty mental health workforces, there is almost no discussion of retaining staff in these workplaces. While tackling the issue of stigma and mental health may well increase the number of people interested in working in the field of mental health, our members working in mental health tell the ANMF that they leave jobs they love because of high stress, inadequate staffing, and unsafe work environments.

These issues are traditionally left to individual workplace agreements to address, but a national strategy should include:

- minimum threshold standards for safety measures;
- mechanisms demonstrated to mitigate known high stress workplace (e.g. clinical reflective supervision provided by employers in work time);
- mandated adequate breaks between shifts (including when on-call);
- mandated adequate breaks in the shift (i.e. meal breaks to be taken or automatically paid); and,
- Nurse practitioner employment pathways, management education and support networks for health practitioners.

Nurses and other staff working in mental health cope with significant mental and physical challenges, including exposure to verbal and physical violence. Nurses who work in mental health environments have a 20 times higher rate of physical violence than those working in public health units.[6] In addition to the measures described above, the ANMF also calls for the national adoption of the ANMF Victorian Branch's 10 point plan to end violence and aggression in workplaces (https://www.anmfvic.asn.au/~/media/files/ANMF/OHS/10pointplan-guidance-A4-FA-Web.pdf), and for the incorporation of these requirements into the model Work Health and Safety Regulations.

Providing a clear legislative framework within which to manage mental health issues would assist all stakeholders. This legislation should also mandate a percentage or set number of days of personal leave to be accessible without documentation (e.g. medical certificate) to allow for leave for mental health.

Funding uncertainty

The current cycles of funding contribute to mental health service fragmentation, which affects access, uptake, and optimal health outcomes. Extending the length of funding cycles and guaranteeing continuity of mental health supports would create certainty for both providers and consumers of mental health services.

Funding uncertainty also contributes to workforce attrition. When highly effective programs end, specialised and experienced health practitioners in mental health can no longer deliver these services. Members of the ANMF have reported that when funding changes resulted in the closure of or altered admission criteria to these programs, they felt as though they were abandoning consumers with whom they had trusted therapeutic relationships. This not only negatively affects the person seeking care, who must find a new practitioner and repeat work previously done, but reduces the health practitioner's sense of job satisfaction.

This uncertainty could be resolved by guaranteeing longer periods of dedicated funding, and reinstating the Mental Health Nurse Incentive Program, as described in our response to part 2, question 1.

Part Three: Critical Gaps

1. **Do you believe there are any critical gaps or areas of concern in what is recommended by the PC? Please provide your response in the text box (max. 500 words)**

   As outlined throughout this response and our previous submission, nurses and midwives are a key driver to improving mental health for people in Australia.

6. Niu, S.F., Kuo, S.F., Tsai, H.T. et al. (2019) Prevalence of workplace violent episodes experienced by nurses in acute psychiatric settings. *PLOS ONE* 14(1). doi.org/10.1371/journal.pone.0211183

This reality is, however, not reflected in the recommendations. Indeed, despite the focus in recommendation 5.1 on the importance of care during and following pregnancy on maternal and child wellbeing, the role of midwives in improving perinatal nutrition, screening for alcohol and other drug use, establishing a therapeutic relationship with the woman and the family, providing support and resources on issues from post-partum depression to family violence, and minimising birth-related trauma, the profession is not mentioned in the Report. Research consistently demonstrates that midwifery continuity of care models improve maternal mental health outcomes, yet midwives are not even included in the "Occupational titles of people working in mental health" (Box 16.1, page 702). A recent report estimates the first year costs (i.e. from conception through to the first year of a child's life) of perinatal depression and anxiety is $877 million, extending to a lifetime cost of $7.3 billion.[7] The ANMF strongly recommends midwives be identified and included as key contributors to mental health care for women and families.

Enrolled nurses are also overlooked in the Report. Providing on-going support and funding for transition to practice programs in mental health care and post-registration education for enrolled nurses should be a high priority for the government.

Nurses and midwives have the expertise to provide holistic, person-centred care that addresses the person's physical, mental, social and spiritual needs in the context of their lived experience and in partnership with carers. They play a key role in monitoring and supporting the mental health of consumers at every touchpoint across the lifespan as a core component of basic care delivery. It should be recognised that the fundamental solution to enhanced mental health in Australia is better utilisation of nurses and midwives. Within current models, nurses and midwives are limited in their capacity to address mental ill-health to their full capacity alongside the existing complexities within their roles. In developing a new mental health strategy, the nursing and midwifery workforce must be supported to continue to expand the breadth and depth of their work in supporting mental health. Investing in additional nurses and midwives to better utilise their intrinsic ability to support mental health monitoring and interventions is a cost effective solution to improving the outcomes of existing infrastructures and a fundamental component to enhancing mental health in Australia.

The importance of data collection is woven through the Report, though not included in any specific recommendation (with the partial exception of 5.1). Without robust, valid data, there can be no evaluation of the effectiveness of mental health interventions, or evidence-informed decisions about future care delivery. It will not be enough to gather information: the data must be robust, complete, accurate, and consistently collected and collated across systems, departments and jurisdiction so it can be easily compared.

7. PwC Consulting (2019) The cost of perinatal depression and anxiety in Australia https://www.pc.gov.au/__data/assets/pdf_file/0017/250811/sub752-mental-health-attachment.pdf p.14