

# Sustainable Models for Nurse Practitioners in Public Mental Health and Drug Clinical Services: A Research Report

**Prepared for**

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# Executive summary

## Introduction

In 2008, TNS Social Research was commissioned by the Nurse Policy Branch of the Department of Human Services (DHS) to conduct the review of “Sustainable models for Nurse Practitioners in public mental health and drug clinical services”.

## Background

DHS has a primary focus on ensuring that the health needs of Victorians are met. Workforce is a key priority for DHS. The development of effective and contemporary service models is an essential component of a robust health system able to meet the needs of all Victorians. The use of Nurse Practitioners (NPs) within the mental health workforce was one of the recommendations in *Victoria’s direct care mental health workforce: The use of public mental health workforce study* (DHS 2004).

NPs are registered nurses with advanced educational preparation and experience. NPs are currently working in most Australian jurisdictions and are well-established overseas.

The Health Professionals Registration Act 2005 (s 97) restricts the use of the title ‘Nurse Practitioner’ to nurses who are endorsed by the Nurses Board of Victoria as NPs. In Victoria, registered nurses in Divisions 1, 3 or 4 are eligible to be endorsed as NPs. As of May 2008, there were 39 NPs in Victoria. Seventeen of the 39 Victorian NPs work in emergency medicine<sup>1</sup>. At present, mental health and drug (MHD) services have not utilised NPs to a comparable degree.

## Project objectives

This project addressed the following areas:

- ▶ In which MHD service settings would the implementation of a NP model of care be **immediately most effective** (in the next 1-3 years) in public MHD services?
- ▶ What **roles and responsibilities** could an NP have in such settings?
- ▶ What would be **required of DHS** and MHD services to implement such roles over the next three years?

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<sup>1</sup> Available at <http://www.health.vic.gov.au/nursing/furthering/practitioner>

## Evaluation method

This project involves several levels of research and consulting to meet the project objectives:

- ▶ An establishment meeting was held to ensure that the research and Departmental teams had a shared understanding of the goals of the research, how these would be met by the proposed approach, the scope of the project and the preferred style of project management and communication.
- ▶ A review of the NP models was undertaken using local, interstate and overseas literature to identify models relevant to mental health and drug and alcohol treatment services.
- ▶ Consultations were undertaken with key stakeholders, including 10 nominated MHD services, Departmental staff from the Nurse Policy Branch (NPB) and Mental health and Drugs Division (MDD), peak bodies and unions.
- ▶ Case studies, developed from the consultations with nominated MHD services, exploring implementation options and comparative analysis.

## Conclusions and recommendations

The conclusions and recommendations have been developed to address the three key research questions identified in the project brief.

<b>Research Question 1: In which service settings would the implementation of a NP model of care be immediately (one to three years) most effective in MHD services?</b>
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The research indicated that nurse practitioner models are emerging in a wide range of service settings and involve a variety of roles and responsibilities.

### Within the next year

A number of services examined as a component of this project had Candidates<sup>2</sup> nearing the end of the NP endorsement process and likely to implement mental health or drug and alcohol NP roles within the next year. These were:

- ▶ North East Health – Wangaratta (two mental health Candidates)
- ▶ North Western Mental Health (one Candidate)
- ▶ Southern Health (two Candidates)

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<sup>2</sup> In Victoria a NP Candidate is a Registered Nurse registered under Division 1, 3 or 4 engaged to undertake a course of study and undertake clinical experience leading to endorsement as a Nurse Practitioner. A Registered Nurse engaged as a Nurse Practitioner Candidate (as defined) shall be classified and paid their substantive salary (Australian Industrial Relations Commission, 2006)

- ▶ Moreland Hall (one Candidate)

Refer to Chapter 5 for details of the selection of sites and case studies for this study.

### Priority NP roles for the next one to three years

All of the services examined as case studies in this project revealed were in a position to implement NP roles in the next one to three years. Most were able to identify a suitable Candidate. However, where a suitable Candidate could not be identified with the service most recognised, it was noted that it would be necessary to recruit potential Candidates.

Those services most suited to implement a NP model in the next one to three years (Box 1) were hospital based or residential drug and alcohol services. The capacity of the service to provide a network of support and a team environment was also important in the establishment and sustainability of new NP positions.

The capacity of NP roles to be sustainable in community-based, outreach and home-based services, where there was a requirement for the NP to prescribe, was limited unless other arrangements were in place for patients to receive medications at a subsidised cost.

#### Box 1: NP roles for implementation within the next one to three years

- ▶ Mental health emergency departments triage NP
- ▶ Drug and alcohol withdrawal unit NP
- ▶ Mental health crisis assessment team NP
- ▶ Early intervention team NP
- ▶ Prevention and recovery care (PARC) service NP
- ▶ Mental health service units - including eating disorder clinic NP and mother-baby unit NP

Service settings where a NP model was most likely to be sustainable were identified. These encompassed three broad areas within the public health system. These were the:

1. mental health service system;
2. drug and alcohol service system; and
3. intersecting areas – for example, where mental health and/or drug services intersect with acute health and private or non-government services.

See the appendices for diagrams of the Victorian Mental Health system and Drug and Alcohol Services.

The key considerations in selecting these NP roles for implementation in the next one to three years were:

- ▶ the ease of developing arrangements for prescribing under PBS or for developing arrangements whereby patients' medications are subsidised (as in a number of drug services);
- ▶ the opportunity to undertake a clinical leadership role;

- ▶ availability of clinical support in the form of a clear medical or nursing hierarchy; and
- ▶ the availability of the day-to-day collegial support and a team environment.

Suggested NP roles under each of these areas are identified below:

### **Mental health service system**

In the mental health service system the four priority NP roles selected fell into the clinical area and included roles in Adult Services and state-wide Specialist Services. The suggested roles were as follows:

- ▶ Mental health crisis assessment team NP (Adult Services)
- ▶ Early intervention team NP (Adult Services)
- ▶ Prevention and recovery care service NP (Adult Services)
- ▶ Mental health service units (including eating disorder clinics, mother-baby units, etc.) (state-wide Specialist Services)

### **Drug and Alcohol Services**

Under the drug and alcohol service system the service identified as a priority area for implementation of an NP role fell into the area of residential withdrawal (see the appendices for a diagram of the publicly-funded drug and alcohol service system). It is worth noting that, depending on the nature of the service provider, this role could also involve intersection between drug and alcohol services and private and/or NGOs.

- ▶ Drug and alcohol withdrawal unit NP (Residential withdrawal)

### **Intersecting services**

In the priority NP roles identified as a result of the research, one role intersected both acute health and mental health.

- ▶ Mental health emergency departments triage NP (Acute care and mental health)

In the medium term, a number of other opportunities exist for the implementation of NP roles in different service settings. It was clear from the research that NPs would have the capacity to improve patient outcomes and address a number of service gaps in the provision of community-based, in-home and outreach services, providing clinical health care and psycho-social support. However, some development of infrastructure to support the role is required to ensure that the NP roles are sustainable.

**RECOMMENDATION 1:** Services identified through the case studies were all in a position to implement a NP role in the next one to three years. Service models – where suitable arrangements for supply of medications under Medicare can be supported and where there is a network of support available from a team of professionals and from organisational management – should be supported by DHS to immediately implement NP roles.

**Research Question 2: What roles and responsibilities could a NP have in such settings?**

Research identified a wide range of roles and responsibilities which could be performed by NPs. The provision of clinical leadership within these service areas was a common theme. Commonly suggested roles included:

- ▶ Dual diagnosis and dual disability roles bridging service types to provide patients with holistic and comprehensive care.
- ▶ Pharmacotherapy roles developing and implementing treatment plans for people with drug and alcohol addictions.
- ▶ Leading Clozapine clinics to monitor and support people receiving this medication.
- ▶ Mental health triage roles in emergency departments.
- ▶ Mental health support and behavioural therapy roles to patients with a variety of conditions including depression, post natal depression, eating disorders and conduct disorders.
- ▶ Community-based care generally auspiced by a hospital.

Roles differed in a variety of ways, including:

- ▶ the level of autonomy and clinical judgments required;
- ▶ arrangements for supplying medicines under Medicare and arrangements for patients to access subsidised medications;
- ▶ the level of support provided by the health service;
- ▶ arrangements for clinical governance, supervision and mentoring;
- ▶ the location of the role within the continuum of care;
- ▶ disease focus.

Examination of barriers and enhancers to the role of NP revealed the importance of clearly defining the role to promote a shared understanding about the nature of the work which can be performed by NPs, and to garner the support of other stakeholders.

The highly context-specific nature of the role and the lack of transferability across services were seen as barriers to the broad acceptance of NPs as a sustainable workforce solution. The specialised nature of the role was also attributed with alienating support from medical practitioners' associations, undermined the credibility of the role, limited its transferability and raised providers' concerns about investing in a role which is so specific to an individual.

A set of core competencies which should underpin the role of NPs were identified in the case studies and interviews. These included:

- ▶ clinical practice;
- ▶ leadership;
- ▶ prescribing;
- ▶ counselling;
- ▶ liaison;
- ▶ expert clinical advisor (in service planning and policy development, etc.);

- ▶ clinical research; and
- ▶ clinical education and mentoring.

These competencies are consistent with the National Competency Standards for the Nurse Practitioner<sup>3</sup>.

**RECOMMENDATION 2:** There is a need for clarification of the term ‘Nurse Practitioner’. This is critical to ensuring that NPs are able to engage in appropriate roles and responsibilities and to ensure that the role is better understood and can be distinguished from other medical and nursing roles. DHS should consult with stakeholders to promote and disseminate a clear definition of the role.

**RECOMMENDATION 3:** It is important that the role of Nurse Practitioner is underpinned by a clear set of measurable competencies. DHS should facilitate periodic assessment of The National Competency Standards for the Nurse Practitioner by industry, regulators and other stakeholders to ensure that they are relevant and measurable in the context of mental health and drug services.

**Research Question 3: What would be required of DHS and services to implement such roles over the next three years?**

The research identified a wide range of opportunities for DHS to drive the implementation of the NP role in drug and alcohol and mental health services. There were calls for increased leadership, flag bearing and financial support from DHS to assist services to develop the role of NP and engaging the support of medical practitioners and their representative associations. There was a clear need for relevant legislation and policy to be reviewed at the state and Commonwealth level to support the role of NP within the workforce and to ensure that NPs are recognised under the PBS and MBS.

Health service managers need to actively recruit and develop staff with a capacity and desire to undertake a NP role and ensure that support and development of the role is reflected in workforce planning and policy. A service manager’s responsibilities include developing a positive culture, supporting change management and establishing internal systems to develop and implement NP roles.

**RECOMMENDATION 4:** To ensure that NPs are able to contribute to producing positive patient/client outcomes, Victorian legislation needs to be reviewed to ensure that it reflects current practice and community needs. As a part of the current review of the Mental Health Act 1986 (Vic) the opportunities to recognise the NP role in legislation should be progressed by DHS. Key parts of the Act which should be reviewed to reflect the NP’s level of education and preparation include (*inter alia*) the:

- ▶ definitions;
- ▶ transportation of patients;

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<sup>3</sup>Australian Nursing & Midwifery Council, *National Competency Standards for the Nurse Practitioner*, 1<sup>st</sup> Edition, January 2006. <http://www.anmc.org.au/publications/index.php#national>.

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- ▶ sedation of patients;
- ▶ interim treatment;
- ▶ community treatment orders; and
- ▶ seclusion.

The Mental Health Act 1986 (Vic) should also be examined in detail to ensure that it is consistent with the other relevant Victorian legislation, such as The Drugs Poisons and Controlled Substances Act 1981 (Vic), which does acknowledge and provide for the NP role.

**RECOMMENDATION 5:** To enable NPs to contribute to addressing a number of health service gaps and improved patient outcomes, DHS should engage in further discussions with the Commonwealth Government to secure MBS and PBS recognition for NPs – in line with the recommendations of the Productivity Commission’s 2005 review of Australia’s Health Workforce.

**RECOMMENDATION 6:** There is a need for a NP implementation guidebook to be provided to health services to assist them in developing infrastructure to support the development and implementation of NP roles. It should be presented on the DHS website along with other relevant information. It should contain information to:

- ▶ foster the identification and development of suitable NP Candidates;
- ▶ support health services to recruit suitable Candidates;
- ▶ support development of NP roles;
- ▶ support the sustainability of NP roles; and
- ▶ continue to provide information about scholarships and funding.

**RECOMMENDATION 7:** In order to address issues associated with the current size and disbursement of the NP workforce (such as efficient provision of education; improved confidence of employers; increased sustainability; provision of peer support, etc), DHS should work to develop a NP cohort and provide opportunities for networking and capacity building both within and across all NP categories.

**RECOMMENDATION 8:** In order to inform and engage key stakeholders in the Victorian health sector on matters related to the implementation and sustainability of the NP role, broad ongoing dialogue should be initiated with groups such as:

- ▶ Australian Medical Association, Victoria
- ▶ Royal Australasian College of Surgeons
- ▶ The Royal Australasian College of Physicians: Australasian Chapter of Addiction Medicine
- ▶ The Royal Australian and New Zealand College of Psychiatrists
- ▶ Royal Australian College of General Practice
- ▶ Divisions of General Practice
- ▶ Australasian College of Rural and Remote Medicine.

**RECOMMENDATION 9:** To assist in overcoming financial barriers, particularly for potential NP Candidates in rural areas, DHS should continue to provide and promote awareness of financial support to assist appropriate NP Candidates in progressing to endorsement.

# 1. Introduction

DHS has a primary focus on ensuring that the health needs of Victorians are met. Workforce is a key priority for DHS; the development of effective and contemporary service models is an essential component of a robust health system that is able to meet the needs of all Victorians.

Nurse Practitioners (NPs) are registered nurses with advanced educational preparation and experience. NPs are currently working in most Australian jurisdictions and are also well-established overseas.

The Health Professionals Registration Act 2005 (s 97) restricts the use of the title NPs to nurses who are endorsed by the Nurses Board of Victoria as NPs. In Victoria, registered nurses in Divisions 1, 3 or 4 are eligible to be endorsed as NPs. As of May 2008, there were 39 NPs in Victoria. Seventeen of the 39 Victorian NPs work in emergency medicine<sup>4</sup>. At present, MHD services have not utilised NPs to a comparable degree.

The use of NPs within the mental health workforce was one of the recommendations in *Victoria's direct care mental health workforce: The use of public mental health workforce study* (DHS 2004). It has been contended that opportunities exist to utilise the NP model in order to design new models of care, and to complement emerging approaches to care (such as PARC services, short stay units and other community-based services) and improve patient outcomes. The use of the NP model could also make a valuable contribution to the area of dual diagnosis within both emergency departments and community health treatment programs.

Issues identified with the use of NPs in other areas of the Victorian public health system have included:

- ▶ competition for funding from other health disciplines;
- ▶ opposition from other health professionals including nurses about changes in role and authority;
- ▶ a lack of financial incentives for candidate to pursue further study and the endorsement process;
- ▶ the need to develop infrastructure at health services to ensure that there is a sustainable role for NPs;
- ▶ too few NPs to provide sustainability;
- ▶ a lack of resourcing to provide NPs with the necessary clinical and educational support.

Benefits are generally seen as relating closely to the service area as well as improving the co-ordination of care for clients with complex medical conditions, those who use multiple services or have limited access to services.

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<sup>4</sup> Available at <http://www.health.vic.gov.au/nursing/furthering/practitioner>

## 1.1 Service overviews

### 1.1.1 Mental Health Services in Victoria

A strong and responsive mental health system is vital to aiding those individuals, their families and communities directly affected by mental illness, as well as contributing to the cumulative mental health of wider society. The Victorian Mental Health Strategy (2006) is a whole of government approach to mental health. Many initiatives are currently underway that seek improved targeting of effort to reduce the severity of mental health problems and illness, a greater emphasis on early life intervention, a broader response to the full array of mental health needs, development of a proactive system and cooperation across government and non-government sectors to improve service provision. The public system and publicly-funded non-government providers operate in cooperation with private providers to offer a comprehensive mental health system in Victoria.

The Mental Health Branch of DHS oversees the provision of public mental health services. There are 21 Area Mental Health Boards within the state (13 metropolitan, 8 rural). Each region provides three streams of mental health services:

- ▶ Child and adolescent mental health services (0-18 years)
  - Intensive youth support
  - Continuing care, clinical
  - Acute inpatient services
  - Day programs
  - Conduct disorder services
- ▶ Adult mental health services (16-64 years)
  - Crisis assessment and treatment
  - Mobile support and treatment
  - Continuing care teams
  - Primary mental health and early intervention teams
  - Community care units
  - Acute inpatient services
  - Secure/ extended care inpatient services
  - Homeless outreach services
  - Consultation and liaison services
  - Prevention and recovery care
  - Youth program (early psychosis services)
- ▶ Aged persons mental health services (65+ years)
  - Aged persons mental health teams
  - Acute inpatient services

- Aged persons mental health residential care

In addition to these three streams, there exists state-wide and specialist publicly-funded services within the Mental Health Branch:

- ▶ Victorian Institute of Forensic Mental Health
- ▶ Personality disorder service
- ▶ Brain disorders service
- ▶ Mother-baby services
- ▶ Eating disorder services
- ▶ Koori services
- ▶ Child inpatient unit
- ▶ Dual disability service
- ▶ Neuropsychiatric service
- ▶ Early Psychosis Prevention and Intervention Centre (EPPIC)

At another level, within every stream services are divided into hospital inpatient services and community mental health services.

A diagrammatic overview of the service system structure is provided in the Appendices.

### **1.1.2 Drug and Alcohol Services in Victoria**

The Department of Human Services Victoria's Alcohol and Other Drug (AOD) service system exists to ensure Victorians with alcohol and other drug issues have access to appropriate, timely, effective and quality alcohol and other drug treatment services and interventions to reduce the harms caused to individuals, families and communities by problematic substance use. Service quality is based upon The Victorian Alcohol and Other Drug Quality Framework, which comprises six core standards: Consumer Focus, Evidence-based Practice, Continuous Quality Improvement (CQI), Corporate and Clinical Governance, Workforce Development and Partnerships.

The Victorian alcohol and drug treatment service system has a philosophy of harm minimisation, aiming to reduce the harms associated with inappropriate drug use to individuals and their families and to society as a whole. The alcohol and drug treatment service system comprises a range of private, government and publicly-funded non-government organisations that provide voluntary alcohol and drug treatment, rehabilitation, education and prevention services for adults, young people and Indigenous Victorians, including:

- ▶ residential and non-residential withdrawal services;
- ▶ residential and home-based rehabilitation services;
- ▶ supported accommodation services;
- ▶ counselling consultancy and continuing care services;
- ▶ peer support programs;

- ▶ pharmacotherapy services; and
- ▶ forensic programs<sup>5</sup>.

A diagrammatic overview of each of the service system structure is provided in the Appendices.

## 1.2 Project objectives

Based on the brief, the purpose of the project is to “identify the priorities for implementing Nurse Practitioner (NP) models in publicly-funded mental health and drug services (MHD) in Victoria and to identify the enablers required to establish successful and sustainable roles for NPs”.

The identified priorities must be firmly based on identified client need and where there might be a current gap in provision of services or in a new or emerging model of care. The project will also identify the enablers that must be in place to ensure the role is successful and sustainable.

DHS requires answers to the following key research questions:

- ▶ In which service settings would the implementation of a NP model of care be immediately (one to three years) most effective in MHD services?
- ▶ What roles and responsibilities could a NP have in such settings?
- ▶ What would be required of DHS and services to implement such roles over the next three years?

The outcome will be informed by the exploration of the following broad areas:

- ▶ Which service gaps would be addressed and how would client outcomes be improved by implementing NP models at particular points within the continuum of the clinical service delivery system?
- ▶ What are the enablers and barriers (both system and organisational) for implementing the models in each area?
- ▶ What legislative, policy, procedural or other operational changes are required to facilitate the sustainable introduction of NP models across the state?

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<sup>5</sup> Victorian Government Department of Human Services, *Victoria's Alcohol and Drug Treatment Services: The Delivery*, Melbourne, 1997.

## 2. Evaluation method

This project involves several levels of research and consulting to meet the project objectives:

- ▶ An establishment meeting was held to ensure that the research and Departmental teams had a shared understanding of the goals of the research, how these would be met by the proposed approach, the scope of the project and the preferred style of project management and communication.
- ▶ A review of the NP models was undertaken using local, interstate and overseas literature to identify models relevant to mental health and drug and alcohol treatment services.
- ▶ Consultations were undertaken with key stakeholders, including nominated MHD services, Departmental staff from the Nurse Policy Branch (NPB) and Mental health and Drugs Division (MDD), peak bodies, academics, NPs, colleges and advocacy groups.
- ▶ Case studies, developed from the consultations with 10 nominated MHD services, exploring implementation options and comparative analysis.

The literature and model review primarily included review of government documents and articles from peer reviewed journals. A critical review of relevant legislation was included to highlight opportunities to further develop the role of NP where it would maximise positive patient outcomes.

The consultations were conducted between March and May 2008 and involved either face-to-face or telephone discussions with individuals or small groups. A discussion guide which had been approved by the Department was used to cover a range of topics relating to the need for NPs, appropriate NP models, barriers and enhancers. A copy of the guide is included in the Appendices.

Case studies were developed from face-to-face consultations undertaken with ten health services. These generally involved participation from multiple stakeholders at each service including the Director of Nursing, senior managers and senior nursing staff.

Attempts were made to consult separately with patient advocates from each site. Two services had advocates and the remainder referred the consultants to the Victorian Mental Illness Awareness Council. As this group was already included in the stakeholder interview stage, and because of difficulties identifying issues related to each site, these consultations are reported in the consultation section of this report.

The case studies were prepared by the consultants using a template approved by the Department. Each case study was returned to the case study participants for review to ensure that factual elements were correct and to allow for any further additions or amendments. In one case, the case study was further amended following review from the site. This was done to reduce it to a size and format consistent with the other case studies. No relevant facts were deliberately altered.

All of the data from each of the stages was analysed to develop the conclusions and recommendations.

## 3. Literature review

The aim of this chapter is to review existing practices to the establishment of the NP role to provide insights to the establishment of NPs in the Victorian public mental health system.

### 3.1 Introduction

In Australia, the term Nurse Practitioner (NP) applies to registered nurses with advanced educational preparation and experience who are authorised to practice in an expanded nursing role<sup>6</sup>. NPs can work in a diverse range of clinical settings - from acute hospitals to aged care and community settings.

NPs are required to undertake further education and demonstrate advanced clinical practice. The role of the NP generally includes aspects of care that may have traditionally been performed by other health professionals such as prescribing medicines, referral to specialist services and ordering and interpreting investigations and tests<sup>7</sup>. The Department of Human Services includes the following definition in the NP acronyms and glossary.

*“A NP is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications.”<sup>8</sup>*

### 3.2 International approaches

The role of the NP, although relatively new to the Australian health system, has been established internationally for some time.

#### 3.2.1 The United States and Canada

The role of NP originated in the United States in the 1960s in response to the need for primary health care services in rural areas. A similar program commenced in Canada, in northern rural

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<sup>6</sup> Nurse Policy Branch, Victorian Government Department of Human Services, ‘Nurse Practitioner’, 2008. Available at [www.health.vic.gov.au/nursing/furthering/practitioner](http://www.health.vic.gov.au/nursing/furthering/practitioner)

<sup>7</sup> Nurse Policy Branch, Victorian Government Department of Human Services, ‘Nurse Practitioner’, op. cit.

<sup>8</sup> Australian Nurse and Midwifery Council in Victorian Government Department of Human Services, ‘NPs in Victoria – Acronyms & Glossary’, 2008.

outposts, and in 1967 Dalhousie University in Nova Scotia started the first education program specifically geared for NPs<sup>9</sup>.

Both programs continued until the 1980s when education programs were largely discontinued, in part due to an oversupply of medical staff, and lack of a legislative framework within which to work<sup>10</sup>.

The United States adopted a three-tiered structure – NPs, physician assistants, and certified nurse midwives. As of 2000, there were approximately 95,000 NPs, 40,000 physician assistants and in excess of 8,000 certified nurse midwives.<sup>11</sup>

Specialty areas of NP practice in the United States were initially focused on hospital-based care such as paediatrics, subspecialties of internal medicine and surgery, emergency medicine, and many others. These specialty areas have since expanded to clinics and other unique settings such as home care, long-term care, sports medicine and tropical medicine<sup>12</sup>.

In both Canada and the United States, NPs function under a collaborative model of practice involving all members of a health care team. In the absence of provincial legislation and regulations, NPs work within existing nursing legislation and under protocols or medical directives defined by the NP and the employer. This model may be outlined in a collaborative practice agreement, which is a legal document defining the NP's scope of practice and responsibilities, practice protocols and reporting structure. The collaborative practice agreement is binding among all parties: the NP, the collaborating physician(s), the institution (employer), and/or departmental head(s), and is not transferable from one employer or NP to another<sup>13</sup>.

Mental health NPs working in the United States have performed a wide range of duties and roles, some with a high degree of autonomy. Fisher (2005) provided a range of examples from the United States pertaining to NP roles with disadvantaged community groups experiencing problems accessing traditional mental health services. Examples provided included one NP who reported managing a counselling clinic staffed entirely by nurses and another who established a counselling clinic for HIV/AIDS patients who could not get in to see a psychiatrist. Another NP reported owning her own practice and providing medication management, diagnostic testing, psychotherapy and psychiatric evaluation. She worked full-time in her practice and hired a psychiatrist for five hours per week to consult with her on complex cases and to co-sign documentation designated by the state as requiring a doctor's signature. She also held a contract to provide mental health services to a local adolescent correctional facility<sup>14</sup>.

Throughout both the United States and Canada, adoption of the NP role has led to educational institutions developing courses at masters and doctoral levels to meet the higher level learning requirements of the NP<sup>15</sup>.

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<sup>9</sup> Nurse Practitioner's Association of Ontario, 'History: Primary Health Care Nurse Practitioner (PHCNP) Historical Perspective', 2008. Available at [www.npao.org/history.aspx](http://www.npao.org/history.aspx)

<sup>10</sup> Nurse Practitioner's Association of Ontario, op. cit.

<sup>11</sup> Nurse Practitioner's Association of Ontario, op. cit.

<sup>12</sup> Nurse Practitioner's Association of Ontario, op. cit.

<sup>13</sup> Nurse Practitioner's Association of Ontario, op. cit.

<sup>14</sup> Fisher, J.E., 'Mental health NPs in Australia: Improving access to quality mental health care', *International Journal of Mental Health Nursing*, no. 14, 2005, p.222-229.

<sup>15</sup> Nurse Practitioner's Association of Ontario, op. cit.

### 3.3 Australian approaches

Unlike the United States and Canada, the NP role is new to contemporary Australian health care. Commentators have identified potential opportunities for NPs to contribute to a range of areas, including rural and remote medicine and mental health where NPs could provide cost-effective high-quality care while enhancing the recruitment and retention of mental health nurses<sup>16</sup>.

In 2004, the Australian Nursing and Midwifery Council (ANMC), with assistance from the Nursing Council of New Zealand, commissioned an investigation of the scope and role of Nurse Practitioners and the development of national standards for practice<sup>17</sup>. The three resulting Standards for Nurse Practitioners have been endorsed nationally by all National Nursing and Midwifery Regulatory Authorities (NMRAs).

The competency standards are comprised of three Standards, each of which are measured by a number of competencies. These Standards build on the core competencies for registered nurses and midwives, and the advanced nursing practice competency standards. They provide a nationally accepted framework for assessing competence, including assessment relating to the annual renewal of license processes, overseas trained NPs seeking employment in Australia, and professional conduct matters, and in the development of nursing curricula and student assessment.

The National Competency Standards for the Nurse Practitioner focus on three areas: application of high level knowledge and skills; application of a nursing model with autonomy and authority; and clinical leadership in care, policy and collaboration.

At June 2007, there were 222 NPs in Australia working across at least 30 discipline areas. The disbursement of NPs was as follows<sup>18</sup>:

- ▶ 95 in New South Wales
- ▶ 46 in Western Australia
- ▶ 29 in Victoria
- ▶ 24 in South Australia
- ▶ 15 in Queensland
- ▶ 13 in Australian Capital Territory.

Due to the needs in Western Australia for services in remote areas, the Office of the Chief Nurse currently has in excess of 40 Candidates undertaking scholarship studies at masters degree level. A number of Candidates are completing studies independently, and no statistical information is available related to these numbers<sup>19</sup>.

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<sup>16</sup> Wand, T. and White, K., 'Exploring the scope of Emergency Department mental health NP role', *International Journal of Mental Health Nursing*, no. 16, 2007, p.403-412.

<sup>17</sup> Australian Nursing & Midwifery Council, *National Competency Standards for the Nurse Practitioner*, 1st Edition, January 2006. Available at <http://www.anmc.org.au/publications/index.php#national>

<sup>18</sup> Nurse Policy Branch, Victorian Government Department of Human Services, 2008, op. cit.

<sup>19</sup> Office of the Chief Nursing Officer, Government of Western Australia Department of Health (2007) Available at [www.ocno.health.wa.gov.au/practitioner/](http://www.ocno.health.wa.gov.au/practitioner/)

While different approaches to the NP endorsement processes have occurred between states and territories<sup>20</sup> the National Registration Scheme for Health Professionals will assist in developing a nationally consistent framework for NP endorsement. National consistency will ensure that NPs across Australia meet the same standards and requirements for authorisation.

Across Australia, it is generally accepted that a NP should have advanced specialised education at masters level to practice as a NP. In Victoria the NBV requirements for endorsement include completion of an approved clinically-based masters with master level modules of pharmacology/pharmacokinetics. In addition, NPs are generally required to have advanced clinical expertise and complex or advanced decision making.

### **3.3.1 Historical establishment of the NP role**

The NSW Health Department was the first jurisdiction in Australia to introduce the NP concept. In 1995, 10 local pilot projects were established to explore the role, particularly in the areas of safety, quality and effectiveness. This project was completed in 1998 and following evaluation, it was decided to legislate to formally introduce the role<sup>21</sup>.

Legislation was introduced in 1998 (New South Wales Nurses Amendment (NP) Act) to ensure that NPs obtained authorisation by the Nurses Registration Board of NSW before using the title of NP.

As previously mentioned, in 2003 the Australian Nursing and Midwifery Council commissioned research to investigate the scope and role of NPs and to develop national standards for NPs. From this study the National Competency Standards for the NP were developed and released in March of 2006<sup>22</sup>.

Prior to this, Gardner and others (2004) in a report to the Australian Nursing Council defined the NP role as;

*'A registered nurse educated to function autonomously and collaboratively in an advanced and expanded clinical role. The NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to:*

- ▶ *The direct referral of clients to other health care professionals*
- ▶ *Prescribing medications*
- ▶ *Ordering diagnostic tests.*

*The NP role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care*

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<sup>20</sup> Australian Health Ministers Advisory Council, *Nurse Practitioners in Australia: Mapping of state/territory Nurse Practitioner models, legislation and authorisation processes*, 2005.

<sup>21</sup> New South Wales Health, Nursing and Midwifery Office, *[name of publication here]* 2007. Available at [www.health.nsw.gov.au/nursing/npract.html](http://www.health.nsw.gov.au/nursing/npract.html)

<sup>22</sup> Tasmanian Government Department of Health and Human Services, *Nurse Practitioner Report: Suggested Readings*, 2005. Available at [www.dhhs.tas.gov.au/agency/pro/nursepractitioner/reading.php](http://www.dhhs.tas.gov.au/agency/pro/nursepractitioner/reading.php)

*providers. The scope of practice of the NP is determined by the context in which the NP is educated, competent and authorised to practice*<sup>23</sup>.

Gardener et al add that *'the core role of NPs is characterised by complexity, breadth and depth of practice in three domains of practice'*<sup>24</sup>. These domains are dynamic practice, professional efficacy and clinical leadership.

As the planning for NPs evolved throughout each state and territory (with the exception of Tasmania and Northern Territory) the need for a shared conceptualisation of the NP role became apparent. The domains identified by Gardner et al are reflected in the National Competency Standards for the Nurse Practitioner:

- ▶ Standard 1 covers 'dynamic practice' and the four competencies under this standard address health assessment, confidence and clinical proficiency, practice in unfamiliar situations and, lastly, ongoing learning.
- ▶ Standard 2, on professional efficacy, included three competencies dealing with practice within a nursing model of practice, respect for individuals and cultural identity, and autonomous and accountable practice.
- ▶ Standard 3, on leadership, includes two competencies that address engaging in and leading both clinical collaboration and informed critique and influence of health care systems.

## 3.4 Victoria

In 1998 a ministerial taskforce was established to investigate the viability of the NP role. By 2001 the final report of the NP Implementation Advisory Committee was released and the Nurses (Amendment) Act 2000 was passed. The Nurses Board of Victoria released its pre implementation report, *'The Nurse Practitioner'*<sup>25</sup>.

In 2004, the first NPs were endorsed in Victoria, and current information suggests that there are 39 NPs working in Victoria in 12 discipline areas<sup>26</sup>.

### 3.4.1 Victorian mental health workforce issues

The provision of effective mental health care depends on the availability of a skilled mental health workforce. A robust workforce is critical to providing high quality public mental health services and improved patient outcomes. A number of broad issues have impacted on the Victorian mental

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<sup>23</sup> Gardner, G.J., Carryer, S V Dunn & Gardner, A., *Report to Australian Nursing Council. Nurse Practitioner Standards Project*, Australian Nursing Council, Canberra, 2004, p. 85

<sup>24</sup> Gardner, G.J. et al., 2004, op. cit., p.88

<sup>25</sup> Nurse Policy Branch, Victorian Government Department of Human Services, 2008, op. cit.

<sup>26</sup> Nurse Policy Branch, Victorian Government Department of Human Services, 2008, op. cit.

health workforce. These were identified in the 2005 publication, '*Victoria's direct care mental health workers: The public mental health workforce study – 2003-4 to 2011-12*'<sup>27</sup>.

The report identified three significant challenges to workforce planning:

- ▶ A mobile workforce, particularly among younger staff in some occupational groups.
- ▶ The need for increased recruitment to compensate for both mobility and increased service growth.
- ▶ A poorly-distributed workforce relative to client population. The survey recognised the need for better workforce planning to ensure responsiveness to community and service needs.

The impact of workforce planning in the development of NP programs is inexorably tied to these three major challenges and to the key findings of the report, which pointed to a critical mental health workforce shortage in rural areas which is likely to magnify in the future.

The survey undertaken as a component of the Victorian public mental health workforce study showed that mobility was at its highest in rural areas in Division 1 nurses and allied health staff. The report identified the need for significant workforce expansion to meet projected service utilisation to 2011-12.

There were increased demands upon emergency departments to provide mental health services for patients, resulting from major structural reforms over time in the Victorian public health and mental health systems.

The Victorian public mental health workforce study also found that rural areas were found to have much lower proportions of medical staff and Division 2 nurses than metropolitan areas; when taken in context with the mobility issues the result is that rural areas are under-served. Of the total direct care public mental health workforce, 80% of staff were located in metropolitan and outer metropolitan areas, with only 17% in rural areas.

Qualitative evidence with stakeholders suggested a poor distribution of psychiatrists between the public and private sectors, and significant numbers of unfilled psychiatric positions in public services, particularly in remote and rural areas. Stakeholders also identified that some Area Mental Health Services were already experiencing difficulties meeting service demands.

### 3.5 Rural mental health workforce issues

Service gaps in rural and remote areas in relation to mental health services have been identified by the Royal Australian and New Zealand College of Psychiatrists (the College) through their rural health division.<sup>28</sup> While specialist psychiatrist trainee programs exist in eight regional areas, the

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<sup>27</sup> Victorian Government Department of Human Services, '*Victoria's direct care mental health workers: The public mental health workforce study – 2003-4 to 2011-12*' 2005<sup>27</sup>.

<sup>28</sup> The Royal Australian and New Zealand College of Psychiatrists, *Rural Station: The Education Resource for Rural Psychiatry*, 2007. [www.rural.ranzcp.org](http://www.rural.ranzcp.org)

College cautioned that they do not necessarily convert to increased workforce numbers as rural workforce shortages result from a complex range of influences.

The following table indicates the distribution of the Australian population, and the distribution of the Indigenous Australian population, compared to the distribution of psychiatrists.

<b>Table 1. Distribution of population, Indigenous Australians and psychiatrists <sup>29</sup></b>			
	<b>Total Australian population</b>	<b>Total Indigenous population</b>	<b>Total psychiatrists</b>
<b>Major Cities</b> - Capitals plus large coastal towns like Geelong and Wollongong	66%	30%	81%
<b>Inner Regional Areas</b> - Regional towns close to major cities, e.g. Bendigo, Toowoomba, Launceston	21%	20%	16%
<b>Outer Regional Areas</b> - Smaller or more distant rural towns, e.g. Coffs Harbour, Emerald, Albany	10%	23%	3%
<b>Remote Areas</b> - Population centres far removed from larger cities, e.g. Alice Springs, Broken Hill, Port Hedland	2%	9%	0.25%
<b>Very Remote Areas</b> - Small, very isolated towns and sparsely populated regions	1%	18%	0%
<b>TOTAL</b>	100%	100%	100%

The College highlights a number of key areas of concern related to rural mental health nationally, including:

- ▶ provision of Aboriginal Mental Health services;
- ▶ provision of service models appropriate to isolated communities where there is a need for greater emphasis on liaison between different health professionals, visiting services and Telehealth;
- ▶ male suicide rates which are more prevalent in rural areas;
- ▶ the impact of economic recession in some rural areas;

<sup>29</sup> The Royal Australian and New Zealand College of Psychiatrists, 2007, op. cit.

- ▶ concern about stigmatisation resulting in failure to address mental health problems and an increased likelihood of somatisation of symptoms; and
- ▶ the overall shortage of services, particularly in specialist areas such as aged care and child psychiatry<sup>30</sup>.

The College rural website acknowledges the work of NPs, stating: '*In some places you may work with a NP. NPs have additional clinical training, and within certain guidelines, are able to initiate diagnostic investigations, prescribe medication and make limited referrals*'.<sup>31</sup>

## 3.6 Emergency department presentation

The 2007 publication, *Mental Health Care – Framework for Emergency Department Services*, states that, '*In Victoria, there have been increasing numbers of mental health presentations to emergency departments in the six years to 2006...*'<sup>32</sup>. The report added that '*this has occurred within the context of increased awareness of mental illness in the community and decreased general practitioner accessibility*'.

It notes that, '*the mainstreaming of mental health services since the 1990s has changed the way that mental health services have been provided*'<sup>33</sup>.

This increase in service need has seen an Emergency Department Mental Health NP employed by the Central Coast Health Service in NSW. Despite being a skilled practitioner, the clinical guidelines for this position are comprehensive, comprising four volumes, written by the NP and senior area health staff, including psychiatrists and medical staff<sup>34</sup>.

## 3.7 Community-based programs

*New Directions for Victoria's Mental Health Services – The Next Five Years*, was published in 2002, and outlined a strategic direction for future service provision.

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<sup>30</sup> The Royal Australian and New Zealand College of Psychiatrists, 2007, op. cit..

<sup>31</sup> The Royal Australian and New Zealand College of Psychiatrists, 2007, op. cit.

<sup>32</sup> Victorian Government Department of Human Services, *Mental Health Care – Framework for Emergency Department Services*, 2007. Available at [www.health.vic.gov.au/emergency/mh-framework.pdf](http://www.health.vic.gov.au/emergency/mh-framework.pdf)

<sup>33</sup> Victorian Government Department of Human Services, *Mental Health Care – Framework for Emergency Department Services*, 2007, op. cit., p.2

<sup>34</sup> Joyce, M and Santangelo, P., *Clinical Practice Guidelines: NP Mental Health Emergency Department, Vol 4*. Northern Sydney Central Coast NSW Health, 2006.

The document stated, '*Mental Health Care will continue to be provided in the community whenever possible. This requires a range of services to support consumers moving from inpatient facilities to the community, and crisis and relapse prevention services*'<sup>35</sup>.

Cayte Hoppner, Victoria's first mental health NP, was employed by Peninsula Health in a community-based model. Describing her role at the time she states,

*'In my role as a community mental health nurse, I am part of a multi-disciplinary team, working with psychiatrists, medical, nursing and allied health staff to provide comprehensive care to a particular group of clients. Most of my time is spent out on the streets of Frankston and the Mornington Peninsula, caring for some of our community's most vulnerable members. These clients include the homeless, those with chronic psychosis, frequent relapses, unremitting symptoms, substance use and difficult and complex psychosocial issues, who may otherwise not access care and treatment.'*<sup>36</sup>

Sustainability of community-based programs involving NPs can be hampered by the inability of NPs to access the Pharmaceutical Benefits Scheme (PBS). This was a catalyst for Cayte's community-based role being abandoned and her return to a hospital-based role.

### 3.8 Scope of practice issues

A number of issues impact on the ability of authorised NPs to be able to practice to the full extent of their capabilities both in Victoria and nationally. These include limitations in NP access to the Pharmaceutical Benefits Scheme (PBS) Prescriber Numbers, and the Medical Benefits Scheme (MBS) for non medical practitioners.

PBS is a Commonwealth Government system of subsidising prescription medications. All Australian residents have access to medicines at a subsidised price through the PBS. Approximately 80% of medications in Australia are subsidised under this scheme. Only prescribers with a PBS prescriber number can write prescriptions that will be subsidised by PBS<sup>37</sup>.

Funding restrictions associated with Commonwealth control of medications on PBS mean that there is a discord between state and federal legislation. At a state level, legislation allows for NPs to write prescriptions under the Drugs, Poisons and Controlled Substances Act 1981 (Vic) and they can refer patients to other health care professionals. However, at a Commonwealth level,

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<sup>35</sup> Metropolitan Health and Aged Care Services Division, Victorian Department of Human Services, *New Directions for Victoria's Mental Health Services – The Next Five Years*, 2002, p.13 Available at [www.health.vic.gov.au/mentalhealth/publications/plan02/mhp.pdf](http://www.health.vic.gov.au/mentalhealth/publications/plan02/mhp.pdf)

<sup>36</sup> Victorian Government Department of Human Services, *NPs: What do they do? Who are they?*, 2007. [www.health.vic.gov.au/nursing/furthering/practitioner/a\\_day\\_in\\_the\\_life...](http://www.health.vic.gov.au/nursing/furthering/practitioner/a_day_in_the_life...)

<sup>37</sup> Department of Human Services Victoria, Nurse Policy Branch, *NPs in Victoria: Acronyms & Glossary*, 2008. Available at [www.health.vic.gov.au](http://www.health.vic.gov.au)

NPs do not have access to the PBS. This can financially disadvantage patients serviced by NPs outside of a hospital environment because the PBS rebate does not apply. This is a concern for this often economically disadvantaged group.

These issues have been identified by a number of commentators including the Productivity Commission<sup>38</sup>. They were also identified in the NP Service Planning Final Reports, prepared as a component of the Victorian NP Project<sup>39</sup>.

Due to a lack of Commonwealth recognition, NPs do not have access to MBS payments. This is seen as limiting the effectiveness of the NP role especially in regard to referral to specialist medical services. Currently there is a large percentage of NPs working in emergency departments, primary health, community health and mental health that do not have access to outpatient clinics and, therefore, access to specialist medical care is only through a formal referral process. Without MBS provider numbers patients have to be sent to general practitioners to obtain referral letters. This double handling is costly and inefficient and can delay timely medical treatment<sup>40</sup>.

The services plans published by health services indicate that NPs working within a hospital appear to have an opportunity to work as a part of a multidisciplinary team which can assist in overcoming these problems; however, because of the limitations identified, they may find their scope of practice restricted to a prohibitive degree outside of a hospital setting.

### ***3.8.1 Acceptance of nurses practitioners by the medical profession***

While there has been some support for the NP role from the medical profession generally (including from the National Rural Health Alliance and the Doctors Reform Society)<sup>41</sup>, the NP role has attracted opposition from key associations representing the medical profession including the Australian Medical Association (AMA) and the Rural Doctors Association<sup>42</sup>.

The AMA position statement, 'Independent NPs – 2005', states, '*The AMA does not support a role for the independent NP*'. The statement goes on to add, '*the AMA supports a model of primary care that places the general practitioner as pivotal in the primary care team*'.

The position statement unequivocally states,

*'The role of the nurse in the primary care setting does not include:*

- ▶ *Formulating medical diagnosis;*

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<sup>38</sup> Australian Government, Productivity Commission, *Australia's Health Workforce*, 2005.

<sup>39</sup> Department of Human Services, *NP Service Planning Final Reports*, 2008. Available at <http://www.health.vic.gov.au/nursing/furthering/practitioner>.

<sup>40</sup> Australian Government, Productivity Commission, *Australia's Health Workforce*, 2005.

<sup>41</sup> Gunn, A., 'NPs are a benefit not a threat' *Australian Doctor*, March 1998.

<sup>42</sup> Clarke, S., 'Prescribing power and the power to prescribe: NPs in rural and remote Australia', *Alternative Law Journal*, Vol. 6, 2000. Available at [www.austlii.edu.au/au/journals/AitLJ/2000/6.html](http://www.austlii.edu.au/au/journals/AitLJ/2000/6.html)

- ▶ Referring patients to specialists;
- ▶ Independent ordering of pathology or radiology;
- ▶ Prescribing medication and issuing repeat prescriptions; and
- ▶ Deciding on the admission of patients to, and discharge from, hospital'.<sup>43</sup>

In July 2007 the AMA released a paper entitled, '*There is No Substitute for Your Doctor*' in which AMA President Dr. Rosanna Capolingua stated, '*some state and territory Governments risk delivering Australia a second class health system if they continue in their efforts to substitute doctors with lesser-trained health workers*'. This release went on to '*urge patients to speak out against governments who would use task substitution to compromise patient care*'.<sup>44</sup>

In 2006 Dr Eric Calquoun, President of Rural Doctors Tasmania, stated that nurses should remain an integral part of GP-led health care teams, and not be allowed to practice independently.

*'I think this is the thin edge of the wedge. We're talking about prescribing major drugs, the Poisons Act's regulations are being modified so they can prescribe morphine for palliative care patients. Now are they really in a position? My attitude is, if they want to be doctors, let them do a medical degree'*.<sup>45</sup>

The development of clinical practice guidelines for each NP, clearly identifying the scope of practice and the framework within which the NP can practice, has been an attempt to address some of these concerns. However, it is clear that part of the conjecture about the need for NPs relates to the definitions of the role and distinctions between the NP role and other nursing and clinical roles. Elsom et al<sup>46</sup> (2006) emphasise the need for clarity in the terms used to define advanced and expanded practice nursing roles (i.e. clinical nurse specialists and NPs), particularly as there are perceptions that advanced practice is leaning towards being synonymous with medical practice. Clarification of the roles may improve the receptiveness of the medical profession if NPs can be seen as complementing the roles of other health professionals rather than competing with them.

## 3.9 Legislation

In Victoria the role of the NP in mental health and drug and alcohol services is governed by a number of Acts of Parliament and various regulations that are state based. There are differences between jurisdictions. Key Victorian legislation relevant to mental health and drug and alcohol NPs are The Drugs Poisons and Controlled Substances Act 1981 (Vic) which contains the legal framework for authorisation, administration and prescription of medicines in Victoria. This works

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<sup>43</sup> Australian Medical Association NPs Position Statement, 2005. Available at [www.ama.com.au/web.nsf/doc/WEEN-6FK4BX\\$file/AMA\\_Independent\\_Nurse\\_Practitioner\\_Position\\_Statement.pdf](http://www.ama.com.au/web.nsf/doc/WEEN-6FK4BX$file/AMA_Independent_Nurse_Practitioner_Position_Statement.pdf)

<sup>44</sup> Australian Medical Association, *There is No Substitute for Your Doctor*, media release, AMA, 27 July 2007. Available at [www.ama.com.au/web.nsf/doc/WEEN-75GVM5](http://www.ama.com.au/web.nsf/doc/WEEN-75GVM5)

<sup>45</sup> Australian Broadcasting Corporation News Online (2008) Tag: Doctors and Medical Professionals. Available at [www.abc.net.au/news/tag/doctors-and-medical-professionals/](http://www.abc.net.au/news/tag/doctors-and-medical-professionals/)

<sup>46</sup> Elsom, S., Happell, B. and Manias, E., 'The clinical nurse specialist and NP roles: Room for both or take your pick?' *Australian Journal of Advanced Nursing*, 2006, 24 (2).

in concert with the Health Professions Registration Act 2005 (Vic). In relation to mental health NPs, the Mental Health Act 1986 (Vic) is the key piece of state legislation governing mental health service provision.

### **3.9.1 Health Professions Registration Act 2005**

In Victoria the Health Professions Registration Act 2005 is the legislation that relates to the registration of health professions in Victoria. The Health Professions Registration Act 2005 came into operation on 1 July 2007 and repealed the 11 separate health practitioner registration Acts previously in operation (and section 108AL of the Health Act 1958 relating to medical radiation practitioners), including the Nurses Act 1993.

Under section 118 of the Health Professions Registration Act 2005, the Nurses Board of Victoria (NBV) has responsibility to endorse the registration of NPs. Under s 20 (1), registered nurses in Divisions 1, 3 or 4 are eligible to be endorsed as NPs by the NBV<sup>47</sup>. This Act also specifies the role of the NBV's Prescribing Practice Advisory Committee in section 135.

A requirement under s 20 (1) of the Health Professions Registration Act 2005 is that NPs be endorsed under a particular category or categories. These categories were included to provide a logical, clinical basis for prescribing<sup>48</sup>. Approval is sought from the Minister for Health who is asked to consider, and may approve a list of drugs (formulary) for each category. The categories (and lists of drugs) approved to date originated from the first nurses to be endorsed in the area of practice rather than from a strategic system wide perspective.

These categories are currently being reviewed by the NBV and consideration is being given to development of a framework for authorisation that includes the new categories of Mental Health and Drug and Alcohol Services<sup>49</sup>.

Each of these categories has an approved formulary. However, as the formularies have developed as a result of individuals seeking approval from the Minister, the result has been both limited categories and limited formularies. As increasing numbers of nurses seek endorsement as NPs, the need for streamlined, flexible processes will be required to ensure that NPs can be engaged in roles which fully utilise their skills as expediently as possible.

The NBV has explained that while a broader range of drugs are being identified for inclusion in the development of formularies, the individual's prescribing practice will be determined by the individual's own scope of practice. As such, they will not necessarily be able to prescribe all of the drugs associated with a particular category<sup>50</sup>.

The title NP is protected, preventing use of the title NP by anyone who is not endorsed by the Nurses Board of Victoria as a NP.

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<sup>47</sup> Nurses Board of Victoria, *NP*, 2008. Available at [www.nbv.org.au/registration/nurse-practitioner.aspx](http://www.nbv.org.au/registration/nurse-practitioner.aspx)

<sup>48</sup> Nurses Board of Victoria, *Request for submissions for NP prescribing formularies*, 2008. Available at [www.nbv.org.au](http://www.nbv.org.au)

<sup>49</sup> DHS Correspondence June 2008.

<sup>50</sup> *ibid.*

### 3.9.2 The Drugs Poisons and Controlled Substances Act 1981

The jurisdiction responsible for poisons legislation is the state or territory government. The Drugs Poisons and Controlled Substances Act 1981 (Vic) contains the legal framework for authorisation, administration and prescription of medicines in Victoria. Along with the Health Professions Registration Act 2005 (Vic), this is the key piece of legislation impacting on the role of NP in drug and alcohol services. In relation to mental health services, additional legislation in the form of the Mental Health Act 1986 (Vic) also regulates the NP role.

Under Section 4 of the Drugs Poisons and Controlled Substances Act 1981 (Vic) a definition of the NP role is provided:

*“Nurse Practitioner means a nurse whose registration has been endorsed by the Nurses Board of Victoria under section 20 of the Health Professions Registration Act 2005-*

*(a) to use the title Nurse Practitioner; and*

*(b) as being qualified to obtain and have in his or her possession and to use, sell or supply Schedule 2, 3, 4 or 8 poisons that are approved by the Minister under this Act.”<sup>51</sup>*

Authority to prescribe is contained in the Drugs Poisons and Controlled Substances Act 1981 s 13 (1ba). However, in Victoria, the term ‘prescribe’ is not used in the legislation. NPs are authorised to:

*“Obtain and have in his or her possession and to use, sell or supply any Schedule 2, 3, 4 or 8 poison approved by the Minister in relation to the category of Nurse Practitioner specified in the endorsement of that Nurse Practitioner 's registration in the lawful practice of his or her profession as a Nurse Practitioner in the category for which he or she is endorsed.”<sup>52</sup>*

The Health Professions Registration Act 2005 (Vic) was designed to work with the Drugs Poisons and Controlled Substances Act 1981 (Vic). This has resulted in the prescribing arrangements for NPs being independently linked to two pieces of legislation generating a degree of complexity around interpretation of the parameters of the role. However, it has defined the role of NP and provided clear prescribing authority that is linked to the individual and not limited to their employment. Because the authority is not facility based, the legislation allows for portability of authority. Under this legislation NPs have been provided with a legal and practical capacity to work in drug and alcohol services<sup>53</sup>.

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<sup>51</sup> Drugs Poisons and Controlled Substances Act 1981 (Vic), s 4

<sup>52</sup> For the purposes of this paper the term ‘prescribe’ has been used in reference to these activities.

<sup>53</sup> Based upon consultations with the drug and alcohol stakeholders undertaken in the course of this Project.

### **3.9.3 The Victorian Mental Health Act 1986 (Vic)**

The Victorian Mental Health Act 1986 (Vic) (the Act) provides a legislative framework for the care, treatment and protection of people with mental illness in Victoria. It establishes procedures for initiating involuntary treatment, making involuntary treatment orders and independent review by the Mental Health Review Board. Key features of the Act are its emphasis on patient rights and the requirement that treatment should be provided in the least possible restrictive environment and in the least possible intrusive manner. The Act provides that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances<sup>54</sup>. Enacted in 1986, the Act has undergone a series of revisions including major amendments in 1995. NPs are not referred to in the Act because of the recent development of the NP role.

An examination of the Act was conducted as a part of the project methodology, to identify opportunities where the legislation could be reviewed to allow for the inclusion of the NP role in line with current practice and needs. The changes suggested reflect the current workforce shortages in mental health and drug and alcohol services, the practice of mental health nursing, the demand for treatment to be provided locally, the need to remove the burden currently placed upon medical practitioners and, above all else, the need to ensure that consumers have access to timely, appropriate and safe health care.

Key issues the examination of the Mental Health Act 1986 (Vic) revealed included the need for the NP role to be defined under the Act to enable NPs to work to their full capabilities. The preparation and education of NPs needs to be recognised and the NP role should be distinguished from the role of Registered Nurse under the Act. The autonomy and capacity of NPs to exercise clinical judgment also needs to be embedded in the Act. These amendments would relieve pressure from medical practitioners, improve patient outcomes, and better reflect and regulate the current operating practices of health services. Key areas of the Act which require immediate review are the definitions, the transportation of patients, sedation of patients, interim treatment, community treatment orders and seclusion.

At present, NPs are treated under the Act as Registered Nurses. While they are in fact registered nurses with an additional NP endorsement on their registration, the Act does not acknowledge that their education and preparation equips them with a higher level of clinical expertise and the capacity to work with a greater degree of autonomy and the capacity to exercise clinical judgment. The result is that patients often have to wait for care, medical practitioners are unnecessarily burdened with responsibilities which an NP could manage safely and appropriately, and NPs are frustrated by the inability to perform up to their capabilities. Specific examples of problematic areas of the legislation are provided below.

#### **Definitions**

A fundamental issue is the need to include specific reference to NPs in the definitions beyond the mention of 'registered nurses'. Section 7 of the Act provides that:

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<sup>54</sup> Victoria's Mental Health Services. (Available at [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth))

*“authorised person means—*

*(a) a registered medical practitioner; or*

*(b) a registered nurse; or*

*(c) a person who is a member of a class of health service providers prescribed as a class of authorised persons for the purposes of this Part;*

*mental health practitioner means a person who is a member of a class of health service providers prescribed as a class of mental health practitioners for the purposes of this Part;*

*prescribed person means—*

*(a) a member of the police force; or*

*(b) an ambulance officer; or*

*(c) a person who is a member of a class prescribed as a class of prescribed persons for the purposes of this Part;*

*prescribed registered medical practitioner means a registered medical practitioner of a class prescribed as a class of registered medical practitioners for the purposes of this Part.<sup>55</sup>*

NPs should also be defined under the Act to provide for the future development of the NP role in mental health care. While at present registered nurses are acknowledged under the Act, as increased numbers of NPs assume roles in mental health there will be an increased need for clarification of the definitions to ensure that the roles and levels of responsibilities are easily distinguished and that the appropriate levels of accountability are in place. Definition of the role is also vital under the Act to promote recognition of the NP role within the medical fraternity and to clarify the work of the NPs in mental health.

### ***Transporting patients***

The role of NPs in relation to patient transportation raises a number of issues. Firstly, the NP role is not specified under s 9 A 1 (a) (b) (c) of the Act. Secondly, NPs are treated the same as any other registered nurse and are only able to act under authority from a medical practitioner, unless all reasonable steps to secure examination by a medical practitioner have been exhausted.

The Act states:

*“Despite anything to the contrary in section 9, a person in respect of whom a request is made in accordance with section 9(1)(a) may be taken to an appropriate approved mental health service without a recommendation being made under section 9(1)(b) if—*

*(a) a registered medical practitioner is not available within a reasonable period to consider making a recommendation despite all reasonable steps having been taken to secure the attendance of one; and*

*(b) a mental health practitioner considers that—*

*(i) the criteria in section 8(1) apply to the person; and*

*(ii) the person should be taken to an approved mental health service for examination by a registered medical practitioner for the purpose of making a recommendation; and*

*(c) the mental health practitioner completes an authority to transport in the prescribed form containing the prescribed particulars.”*

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<sup>55</sup> Mental Health Act 1986 (Vic), s7

Concerns with these provisions of the Mental Health Act 1986, are that the Act makes provision for a medical practitioner (who may not be as highly experienced and qualified as a NP) to recommend a client to be taken to hospital as an involuntary client. This is a role which would be appropriate to have performed by a mental health NP to ensure patients have access to timely care, as well as to relieve pressure on medical practitioners (particularly in rural areas) and reduce the risk to health services unable to provide appropriate care on site. Furthermore, before being able to act, the NP must still endeavour to first obtain the authority of a medical practitioner.

### **Sedation**

Section 9 B (3) of the Mental Health Act 1986 makes provision for the prescription and administration of sedation for the purposes of allowing for a person to be safely transported. This is particularly important role for NP given that it is often difficult to find a doctor to prescribe particularly after hours.

*“If a prescribed registered medical practitioner considers that it is necessary to sedate the person so that the person can be taken safely to the approved mental health service, the prescribed registered medical practitioner may administer or direct an authorised person to administer sedation to the person.”*

This highlights the need for NPs to have autonomy and the capacity to prescribe acknowledged under the Act. In its current form, this provision could be interpreted to limited the capacity of NPs to prescribe provided under The Drugs Poisons and Controlled Substances Act 1981 (Vic) and delay patient access to timely appropriate care.

### **Interim treatment**

Section 12 1(a), (aa) and (ab) of the Mental Health Act 1986 (Vic) pertain to provisions for examination and interim treatment of involuntary patients prior to treatment and before the authorised psychiatrist 24-hour review. Review of the Act suggests that mental health NPs have the skills and clinical judgment to assume this role. This is particularly important given the current workforce shortage impacting on the accessibility of medical practitioners and psychiatrists, and the importance to provide patients with timely access to treatment. Currently, people who are experiencing a mental health crisis may be required to wait up to 24 hours for examination by a psychiatrist. Section 12 specifies a range of activities which could be undertaken by a NP prior to the authorised psychiatrist 24-hour review. Section 12 1 (a) (b) - Interim treatment under involuntary treatment order provides:

*‘If a registered medical practitioner employed by the approved mental health service considers that—*

- (a) the person requires any treatment immediately; and*
- (b) the person is unable to consent to that treatment; and*
- (c) the treatment required is of such a nature that it would not be in the best interests of the person to await examination by the authorised psychiatrist under section 12AC*

*the practitioner may on behalf of the person consent to the treatment being carried out until the authorised psychiatrist examines the person under section 12AC.”<sup>56</sup>*

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<sup>56</sup> Mental Health Act 1986 (Vic), s 12

### **Community treatment order**

Nurse Practitioners have the clinical skill and knowledge of patient needs to play a more active role in relation to community treatment orders (CTOs). This would improve patient access to timely care and relieve some of the burden from medical practitioners. Under section 14 of the Mental Health 1986 (Vic) Act, provision is made for a number of roles to be performed exclusively by the authorised psychiatrist.

*“At any time, an authorised psychiatrist may make a community treatment order for a person who is subject to an involuntary treatment order...”*

This is problematic for patients as it may be several days before a psychiatrist is available to see a patient and this could impact severely on patient health outcomes. This role could also include the supervision of community treatment orders, including monitoring of CTOs specified in section 14 (A), extension of CTOs specified in section 14 (B) and variation of CTOs specified in section 14 (C). NPs should also be added as a category that can revoke a CTO as specified under section 14 (C).<sup>57</sup>

### **Seclusion**

Section 82 2 (b) of the Mental Health Act 1986 (Vic) specifies that an authorised psychiatrist is required to approve seclusion or, in the case of an emergency, this may be done by an authorised senior nurse. Similarly, section 82 3A requires an authorised psychiatrist to vary the interval of time between medical examination. Section 82 3B mentions that a senior registered nurse alone or a medical practitioner or the authorised psychiatrist can cease seclusion. NPs could readily perform this role and inclusion in the Act would add clarity to their role.

Several key issues emerge from examination of the Mental Health Act 1986 (Vic);

- ▶ There is a need for the NP role to be defined in the Act.
- ▶ There is a need to distinguish between the role of registered nurse and NP.
- ▶ There is a need for the Act to reflect the autonomy and clinical judgment of NPs and the conditions required before they can act should be fully reviewed.

## **3.10 In summary**

Analysis of the available literature suggests that the NP model could be developed to meet a number of service gaps:

- ▶ rural and remote generalist NPs
- ▶ specific Indigenous mental health NPs
- ▶ aged mental health NPs (metropolitan and rural)

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<sup>57</sup> Mental Health Act 1986 (Vic), s 14

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- ▶ child and adolescent NPs (rural and remote)
- ▶ emergency department mental health NPs
- ▶ community outreach NPs.

Given the current workforce shortage issues impacting on mental health service provision (particularly in rural areas), there is a compelling need for innovative approaches to mental health care. The literature reveals that the use of NPs to assist in addressing medical workforce shortages is well precedented overseas and has had a positive impact.

A number of factors limit the NPs scope of practice, the most critical being exclusion of the NPs under PBS. Because of this and the need for NPs to have clinical supervision and support, the support of the medical profession is an important factor in the sustainability of NP roles.

The Mental Health Act 1986 (Vic) needs to be reviewed to enable NPs to work to their capabilities and contribute to addressing the current workforce skills shortages and to provide improved patient outcomes. The NP role needs to be clearly defined under the Act and distinguished from the role of Registered Nurse. The autonomy and capacity of NPs to exercise clinical judgment also needs to be recognised.

The Mental Health Act 1986 (Vic) should also be examined in detail to ensure that it is consistent with the other legislation, such as The Drugs Poisons and Controlled Substances Act 1981 (Vic) which does acknowledge and provide for the NP role.

This would not only relieve pressure from medical practitioners and be likely to improve patient outcomes, but it would also ensure that legislation reflects the current operating practices of health services and likely develops in the future such as the increased use of NPs. Key areas of the Mental Health Act 1986 (Vic) which require immediate review are the definitions, the transportation of patients, sedation of patients, interim treatment, community treatment orders and seclusion.

## 4. Consultations

This section provides insight into stakeholders views on a range of issues related to the development of sustainable NP roles in Victorian mental health and drug and alcohol services.

### 4.1 Summary of method

A series of face-to-face and telephone interviews were conducted with stakeholders with an interest in the development of NP roles in mental health and drug and alcohol services. Participants from a variety of organisations and backgrounds were consulted including representatives and individuals from:

Alfred Hospital

Australian College of Mental Health Nurses

Bendigo Health

DASWest

Department of Human Services, Victoria

Forensicare

Latrobe University

North East Health – Wangaratta

North-West Mental Health

Melbourne University

Mercy Mental Health

Monash University

Ramsay Health Mildura

Royal Australian and New Zealand College of Psychiatrists

Royal Melbourne Hospital

Southern Health Mental Health Program

St Vincent's Hospital

UnitingCare Moreland Hall

Victorian Mental Illness Awareness Council

Werribee Mercy

## 4.2 The need for Nurse Practitioners

The key focus of this section is to present perspectives on the need for NPs within Victorian mental health and drug and alcohol service sector. Other opportunities for NP's are also discussed.

### 4.2.1 Addressing workforce shortages

Workforce shortages were consistently attributed with the increased need for NPs working in mental health and drug and alcohol services. Participants expressed concerns about shortages of both doctors and nurses with mental health credentials and the difficulties of obtaining timely access to pharmacotherapy expertise in drug and alcohol services. Many participants commented on the international trend to introduce NPs into the workforce to address workforce shortages. This was generally seen as an appropriate and efficient response.

*“Everyone knows that [NPs] were introduced in the UK and the USA to address workforce shortages. They have been doing it for over 20 years. We should be able to do the same.”*

A number of issues related to recruitment and retention have depleted the mental health workforce. This includes a shortage of mental health nurses, increased pressure on GPs to provide support to patients with mental health problems and lack of access to psychiatrists and GPs in rural and remote areas. There is a need for improved community access to mental health care particularly in rural and remote areas. This may provide incentive for health services and GPs to support the use of NPs in mental health. The current low numbers of NPs in rural areas may reflect a range of issues including the broader workforce shortage issues experienced in the bush. Increasing numbers of NPs to address rural shortages needs to be done in consideration of other strategies to address recruitment and retention of health professionals in rural areas (i.e. incentive packages, local recruitment, access to support, supervision and training, etc.). For NPs to work effectively outside of a hospital setting the support of a GP or consultant is required. Given the chronic shortage of GPs and consultants in rural areas, as well as a potential lack of support for the position, this may prove to be a challenge.

Participants also identified a need for NPs to support the provision of after hours mental health care, particularly in rural locations. While the shortage of consultants during the day was noted, gravest concern was for the acute shortage of support for people experiencing a mental health crisis after hours. Related to this was concern about junior medical staff working alone in EDs being unprepared to manage mental health crises.

One of the most commonly mentioned areas of need was in relation to GPs<sup>58</sup>. Many participants felt that GPs were being overburdened by often simple issues which could be well managed with the involvement of an NP. Participants identified a range of mental health issues that could be treated in the GP clinic including common conditions such as depression and anxiety. In addition,

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<sup>58</sup> While GP clinics fall outside of the jurisdiction of DHS, it is important to consider the impact of the GP shortage on the overall Victorian health workforce, public health services and patient outcomes.

NPs could review medication. Most commonly participants suggested that specialised NPs could be involved in operating Clozapine clinics, treating and monitoring clients.

For the NPs to be fully equipped to address the needs of these patients, there was a strong view that the Mental Health Act 1986 (Vic) should be reviewed. It should include amendments to allow NPs to assume a wider range of responsibilities enabling people in a crisis to access timely and appropriate mental health care. Several instances were recounted where nurses felt concern that they were unnecessarily limited in their capacity to offer patients the highest quality of care. This was of particular concern after hours where nurses were practicing at the limits of their authority. There was a strong view that extreme workforce shortages exposed both patients and nurses to risk and that this could be redressed by better use of NPs.

In drug and alcohol services, there were reports of difficulties in accessing addiction specialists, particularly outside of hospitals in community-based treatment programs. Community-based drug and alcohol services reported some difficulties with accessing GPs who are endorsed to prescribe pharmacotherapy, resulting in delays in patients accessing treatment. These issues were particularly problematic in rural areas.

The need to support and complement the services provided by international medical graduates was also seen as a role for NPs. Participants explained that many international medical graduates were employed in both hospitals and GP clinics located in isolated rural environments. Many come from countries where there was not an emphasis on mental illness or addiction medicine in their training and often lack support from a local network of medical practitioners.

*“We need international doctors up here ...and [NPs] are in a position to provide them the support they need. A lot of them don’t have a strong mental health background at all. I had a patient come in and tell us that his GP gave him [antidepressants]. I was pretty concerned ...so I rang the GP and asked him about it. He said that [the patient] told him he was depressed. I asked if he did an assessment and he said he did not know you could do assessments for depression...”*

## 4.2.2 Continuum of care

The role of NPs was seen as appropriate across the continuum of care. Participants generally described a care continuum model which included<sup>59</sup>:

- ▶ Health promotion
  - ▶ Assessment
  - ▶ Diagnosis
  - ▶ Early intervention
  - ▶ Treatment
  - ▶ Crisis intervention
  - ▶ Rehabilitation
- 

<sup>59</sup> This model was derived from an analysis input from a number of those interviewed.

▶ Palliation.

While participants felt that NPs could contribute in all stages of the continuum of care, most described NP roles which were seen as most relevant to assessment, early intervention, treatment, crisis intervention and rehabilitation. Health promotions and supporting people with metabolic syndrome were mentioned by some participants as an element of the NP role rather than a primary focus. Generally, it was seen as relating to promotion of a healthy lifestyle to people with mental health problems or addictions. Diagnosis was seen as being within the domain of the medical practitioner and palliative care was generally seen as a mainstream nursing role.

Rather than just specialising in one stage, most participants felt that the real value of the NP role was in having the capacity to work across the assessment, early intervention, treatment, crisis intervention and rehabilitation stages in order to provide continuity of care and clinical leadership.

*“There is no point in a NP just doing what a nurse can already do.”*

*“The role needs to encompass a higher level of clinical skill and provide leadership across all aspects of the care continuum.”*

There was a strong view that NPs had a capacity to work across a variety of stages; however, limitations under Medicare limited the contexts in which they could operate.

*“I think NPs should be able to work across all stages but the real issue is the context in which they can operate. The problems with prescribing outside of a hospital are what really limits which stages they work in. Anything outside of a clinical setting becomes problematic.”*

### **4.2.3 Core competencies**

A set of core competencies which should underpin the role of NP were identified in the interviews. These included:

- ▶ Clinical practice
- ▶ Leadership
- ▶ Prescribing
- ▶ Counselling
- ▶ Liaison
- ▶ Service planning and policy development
- ▶ Research
- ▶ Education and mentoring.

The need for a core set of competencies was seen as important in distinguishing the NP role from other nursing and advanced practice roles and in promoting understanding about the capabilities of NPs. Improved awareness of the competencies which underpin the NP role was seen as important in gaining the increased support and confidence of medical practitioners and their associates.

While the competencies mentioned appear to be compatible with the National Competency Standards for Nurse Practitioners, the Standards received limited comment, most of which was confined to general mentions (i.e. in relation to

establishing a national framework and supporting educational development, etc.). No specific comment was made about the contents, scope or impact of the Standards on improving understanding about the nature of the NP role or the key NP competencies.

#### **4.2.4 Dual diagnosis specialists**

Increased incidents of dual diagnosis (addiction and mental illness), had also generated concern about the need for dual diagnosis NPs. Proponents of dual diagnosis NPs contend that this is not just about addressing the workforce shortages in mental health, drugs and alcohol, but to see the use of NPs as an opportunity to develop an innovative new role to provide a better quality of care to people with dual diagnosis.

*“It’s not just an opportunity to provide a stop gap until we get more doctors, it is a much needed and specialised role.”*

Participants noted that the increase in dual diagnosis presentations requires clinicians to have a specialised range of skills which goes beyond just knowledge of addiction and mental illness. Dual diagnosis was seen as a dynamic condition in which substance abuse and mental illness combine to generate a complex range of treatment issues. Dealing with patients with dual diagnosis was considered to be more difficult, professionally challenging, time consuming and resource intensive than dealing with patients with a single diagnosis. The need for highly skilled NPs was seen as a practical option for responding to this increasing need and acknowledging that highly specialised skills required for this patient group.

*“It is not just like dealing with substance abuse and mental illness as two separate issues. It’s about having the knowledge and skills to understand the interaction between the two and the devastating impact they can have together on the patient.”*

A reduction in the burden placed upon patients with dual diagnosis was also considered to be a likely outcome of the expanded use of dual diagnosis NPs. Dealing with multiple health care agencies was identified as stressful and time consuming for patients who were often required to go over their story multiple times. There was also concern about lack of an appropriate person to provide case management resulting in patients falling through the gaps and in some cases receiving unnecessary tests and treatments.

*“It is so difficult for them to have to repeat the same story over and over.”*

*“Because they straddle different services they often have to act as their own advocates and case managers...sometimes both services will order the same tests and because there is no one there to work across the specialisations the patient does not get the benefit of comprehensive treatment.”*

There was also concern that the current approach does not focus on holistic care, whereas a NP dual diagnosis model would have the added benefit of ensuring that co-morbidities are addressed.

*“Services often only treat the problem that they specialise in, so often you see patients with chronic health conditions like obesity, diabetes and high blood pressure that remain untreated because everyone focuses upon their mental illness.”*

*“The dual diagnosis NP should focus on holistic care and for some people this will mean not just their mental health and drug problem but a host of other lifestyle issues which are often ignored.”*

Issues surrounding nursing practice and practice arrangements were raised as important considerations in the development of innovative nursing models. Participants felt that the success of a NP dual diagnosis model was not just about training NPs, but also required health services to become actively involved to support the role and to provide structures to support this type of nursing practice. This was seen as challenging, particularly where the services may have different philosophies of care and different clinical governance structures. For example, in some drug and alcohol services there may not be a director of nursing or a nursing hierarchy. In such cases, alternative arrangements between multiple services need to be considered. Similarly, the role of the NP needs to be understood across those services involved. In addition to ensuring that the NP has the skills to work effectively within both services, there also needs to be engagement from the services to undertake planning and resourcing to support the role.

*“Services need to get behind this for it to work. You can’t just say: ‘Oh well we will keep doing the same things and the NP can fit in with us’. They need to also look at how they can make it work... They have to be willing to say that the current approach is not working for our clients so what can we change to make things better?”*

*“They are highly competent professionals and they need to ensure that they can work in both areas and build bridges between them.”*

Opportunities for NPs to work in a number of areas with dual diagnosis patients were mentioned. This was mentioned in relation to a range of services including:

- ▶ Mental health services/ drug and alcohol services and perinatal services
- ▶ Mental health, drug and alcohol services
- ▶ Dual disability services.

#### **4.2.5 Ensuring accountability and risk management**

The development of NP roles was seen by a number of participants as important in addressing service gaps which have resulted in nurses, patients, health services and doctors being exposed to risk. There were several reports of nurses, particularly in rural areas, practicing at the limits of their capability or authority in the area of mental health. In some cases, this was at the request of local GPs unable to respond to the demands placed upon them in crisis situations.

*“It is like palliative care, everyone knows it happens in rural areas. It is a humanitarian issue. We can relieve suffering. Why put someone through it just because we can’t get a doctor on the phone at the right time.”*

Not only was this practice deemed as posing an immediate risk to all concerned, but there were also issues related to ongoing accountability and monitoring where practices may not be conducted in the open and accessible to scrutiny.

The need for NPs with an extended scope of practice was also highlighted in a number of cases where it was clear that some health service systems had failed to accommodate patients needs.

These cases generally involved nurses and medical professionals impacted by workforce shortages, working together to develop ad hoc methods for providing treatment. This was reported in relation to patients experiencing a mental health crisis after hours and in ED situations.

*“They feel they have to manipulate the system to provide care, because if they don’t then patients can’t get the care they need...it happens in many areas not just mental health.”*

This highlighted the need for changes to the Mental Health Act 1986 (Vic) to support an expanded role of NPs. This was seen as vital in those areas experiencing mental health workforce shortages.

A number of service managers also expressed concern about professional indemnity and insurance. They commented that while it was assumed that NPs would be covered by the hospitals insurer there was a lack of certainty around this and a need for official clarification from DHS.

*“I guess we all wonder if something happens as it is such a new role...Are we properly covered...no one seems too confident...[DHS] should clarify this so we know what to say to the hospital exec .”*

#### **4.2.6 Provide community-based care**

There was an increasing community and consumer expectation that mental health care and drug services will be provided (where clinically appropriate), within a community-based setting rather than within a medical environment. Similarly, there is an increasing expectation that clinical care is accompanied by social support. Both of these trends are reflected in government policy, which has led to the initiation of the New Directions policy, PARC and PDRSS services, and has been frequently expressed in literature provided by consumer advocate and carer groups. Furthermore, there has been concern about the imposition of a medical model of care in relation to mental health, drug and alcohol services and the loss of social support and community based care.

The role of mental health NPs needs to reflect community trends and expectations. Issues preventing NPs from working in community-based settings (such as PBS, prescribing rights and MBS limitations) need to be addressed. NPs employed within mental health also need to ensure they have an approach which is compatible with the philosophy of teams providing social and community-based support. Limiting mental health NPs to hospital based care may fail to address these expectations.

### 4.2.7 Improved career path for clinicians

One of the key issues raised in support of the development of NP roles was the need to provide a clinical career path for nurses. This was seen as having multiple benefits including:

- ▶ Raising the bar for clinical leadership
- ▶ Providing a career path for nurses who want to maintain a clinical role
- ▶ Provide a career path other than management and education roles
- ▶ Recognition of the professional competencies required to be a clinical leader and the value of high level nursing practice.

While the improved career path was seen as a benefit by participants involved in service provision and nursing, some medical practitioners and psychiatrists held a converse view. They contended that the focus on career path is misplaced and should be on improving patient outcomes.

*“It should not be about addressing the needs of ambitious nurses, it should be about addressing the workforce crisis.”*

It was asserted that marketing the role of NP would engender the support of the medical profession if it focused less upon the clinical career path of nurses and more upon addressing workforce shortage issues, complementing the role of medical practitioners and improved patient access to care.

*“Rightly or wrongly there is a degree of resentment from doctors, not all but some. You are talking about their turf, so they don’t want to give it up to help someone else’s career. It has to be about improved patient outcomes and taking the stress off doctors.”*

### 4.2.8 Views of advocates

A number of patient advocates associated with health services were consulted to establish their views on the need for NPs and the likely reaction of patients. Some of the advocates had previous experience as nurses and were familiar with the NP’s role and the likely reaction of patients. Others who were less familiar with the concept of NPs were asked to consider how patients might react to receiving certain types of treatment and care traditionally provided by doctors and psychiatrists from nurses. The types of activities this might involve were discussed (i.e. provision of prescriptions, counseling, referrals and medical certificates).

Advocates were consistently supportive of the introduction of NPs in mental health services. They contended that patients were well aware of the workforce shortages and many had been affected by delays in receiving treatment or by having to travel to receive treatment. There was a general feeling that as long as care was provided in a professional and caring manner, patients would generally be happy to receive it. Advocates felt strongly that by relieving the pressure from psychiatrists and GPs people with more acute needs would have a better chance of being seen by a doctor. The point was also made that many patients are used to receiving medical care from people other than doctors.

*“Most people who have received inpatient mental health care are used to receiving care from nurses so it will not be alien to them anyway. Those who have received*

*community treatment are used to the involvement of psychologists, nurses and social workers. There is an assumption that all medical care is currently provided by doctors but that is very misleading.”*

*“They said that there would be a reaction against practice nurses too but that never-happened-people know good care when they see it.”*

Some advocates also felt that patients would feel more at ease in discussing issues with NPs as they would not feel under so much pressure to rush through their consultation. The opportunity to have nursing staff provide additional counselling and psychotherapies was also welcomed.

*“It is what mental health care is supposed to be – holistic and focused up the individual not rushed and all about updating medication.”*

One advocate commented that if a patient did not wish to see a NP they could always opt to wait for a doctor.

*“It is not about forcing change upon people but giving them a good option which meets their needs better.”*

In general, there was a strong support for NPs and a view that they would contribute to patient wellbeing and relieve the pressure of the system.

## 4.3 Barriers

This section explores issues related to the barriers (both system and organisational) for implementing different NP models mental health and drug and alcohol services. It presents attitudinal, legislative and operational barriers.

### 4.3.1 Lack of support of the medical profession

The support of the medical profession was identified as critical in the future development of NP models. This was seen as important in encouraging services to develop meaningful opportunities for NP roles, garnering community confidence, providing clinical mentoring and supervision as well as providing access to meaningful clinical guidelines.

There was strong awareness that doctors associations had publicly expressed concerns about the use of NPs with particular emphasis on the qualifications of NPs in comparison to doctors, scope of practice, and level of autonomy.

However, the public views expressed by medical associations were in contrast to the experience of most participants who reported that individual medical practitioners were generally supportive and cooperative. This perception was held by participants from a number of stakeholder groups including NPs, academics and service providers.

*“They are so used to working with me I have to remind them that I am not a doctor.”*

*“They are terrific and spend time supporting me.”*

The support of doctors was seen as vital to the success of models where the NP is employed outside of a hospital.

Communication about the role of NPs and opportunities to facilitate the support of doctors for NPs in mental health roles needs to be explored promoting the specialist nature of the NPs role. Similarly, much criticism is based upon comparison of NPs qualification compared to doctors. Left unchallenged, this negates the significance of specialisation and generates community uncertainty.

There appeared to be a considerable degree of support from the medical profession for NPs employed within drug and alcohol services.

While there are definite issues with resistance, it is important to note that support from the medical fraternity for NPs has been cited from a number of sources. There have been reports of close collaborative relationships between NPs working in community-based drug treatment services and hospitals. It was common to hear stories about encouragement being offered by psychiatrists and addiction specialists. Generally, this support was noted in situations where a professional relationship had developed between a medical practitioner and a NP. This was supported by anecdotal evidence presented by academics and other stakeholders about positive relations they were aware of where NP/ candidates received encouragement, support and supervision from medical practitioners. Where these situations worked well it was clear that there was a degree of familiarity and interpersonal respect and understanding about how the NP could compliment the role of the medical practitioner and bring their own expertise. Some participants thought that this was initially forged out of necessity because of the demands being placed upon medical practitioners. However, the experience led to an increased appreciation for the NP role and in some cases the emergence of champions.

Mental health professionals were also found to be supportive of NP roles. A number of participants gave examples of psychiatric consultants encouraging nurses to pursue NP endorsement.

Similarly, psychiatrists commented that they felt that the NP roles should be further developed and felt that this could be done in association with the Royal Australian and New Zealand College of Psychiatrists RANZCP working in collaboration with the DHS Mental Health Branch.

Those participants employed in drug and alcohol services also felt that medical practitioners and addiction specialists working in their fields were especially supportive of the NP role.

*“They encourage us to attend conferences and network meetings. They are available to offer advice and review...[name withheld] has been on the working party to establish the role and really encouraged me every step. This is great because it has given me and the [organisational management] confidence.”*

### **4.3.2 Endorsement process**

Several aspects of the NP endorsement process in Victoria were seen as deterring potential Candidates.

There were concerns about the lack of certainty about the endorsement process particularly around the NBV decision making process. To some participants this was seen as subjective. This was compounded by the amount of time taken for the endorsement process and the lack of insurance about employment.

*“It is a lot to expect of people when there is no guarantee that the endorsement process will be successful or that there will be positions available.”*

A few participants expressed concerns about the cost of the masters degree. NPs' salaries may not be sufficient incentive to encourage candidates to pay for a masters degree and/or pharmacy module and go through the endorsement process.

There was also concern that after successfully gaining endorsement, the NP was tied to one service. Related to this was concern about the narrowness of the opportunities afforded to NPs. This was also seen as a disincentive for employers who were concerned about investing resources into one individual who might be difficult to replace if the role was too narrowly defined and if the other NPs could not readily adapt to the role.

*"It is not a generic course, which gives you qualifications that are recognised everywhere. We all know that and accept it to a degree but there should be a lot more that is transferable to provide more incentive for both candidates and employers."*

Related to this was a view that stronger core qualifications would enhance the credibility of the NP role.

*"That's partly why doctors don't get it is because it relates to specific individualised competencies and, therefore, is seen as lacking substance and reliability."*

### **4.3.3 Workforce shortage**

A number of workforce shortage issues impact on the sustainability of the NP role. In mental health and drug and alcohol services the shortage of nurses was seen as limiting the number of appropriate candidates compared to other areas. There were also concerns that the lack of medical practitioners and psychiatrists in rural services limited the numbers of NPs as they could not readily access the supervision or mentoring required.

The small numbers of NPs available also raised concerns that health services could alter their service to accommodate the role only to find they have staffing issues. The small number of NPs in mental health was also seen as potentially having implications for the cost effectiveness of providing training and support.

Mental health service providers will need encouragement and support to address these issues. Training, support and networking may need to be provided via similar techniques used by the rural medical workforce which has similar issues. Flexible approaches will be important in addressing this issue.

*"[DHS] need to pump a lot of resources into services to get groups of NPs up and running and get the hospitals to see it as having some value."*

A number of participants explained that workforce shortages need to be considered in development of NP roles. For while there was a temptation to use NPs to address areas of need this is not necessarily the best way to promote sustainability of the role.

### **4.3.4 Defining the NP role**

It was suggested that there are common misconceptions about the role of NPs within both the health workforce and the broader community.

Lack of clarity about the NP role and how it articulates to the broader system could undermine the employment of mental health NPs. Inconsistent communication messages about the role and

negative statements by the medical fraternity appearing in the media could act as an obstacle to the community acceptance of mental health NPs. This could inflame community concerns about the competence of NPs and scope of practice.

A number of participants felt that issues have arisen because the roles are too related to the specific individual competencies.

*“The roles are just so highly specialised now that there is a lack of clarity around it.”*

The lack of clarity around the roles was seen as contributing to confusion and misinformation.

*“The Mental Health Branch needs to work a lot more with the sector about defining the role and developing a shared view.”*

Some medical practitioners hold the view that the NP role is just a mechanism for giving nurses a career path. The need to clarify the distinction between a clinical nurse specialist and advanced nurses was raised.

*“We keep asking...what is it that NPs can do that the other nurses can't do?”*

*“Are they trying to be doctors or psychologists...?”*

It was argued that the only way to dispel these misconceptions is to clearly define the role, establish a set of clear, transferable core competencies and distinguish it from the roles of other medical professionals and specialist nurses. A number of medical practitioners commented that the need to clearly define the role and its core competencies was pivotal in gaining the support of medical associations.

*“I have heard them say that the role is anything you want it to be. This just undermines the credibility of the role and makes doctors think that if it is that flexible and specialised how could you provide blanket support as the role is always so different you don't know what you are supporting.”*

The National Competency Standards for the Nurse Practitioners received no comment in relation to clarifying understanding the nature of the role and the core competencies which underpin the role. This may indicate a lack of awareness and/or the need for the core competencies to be clearly articulated and promoted.

### **4.3.5 Issues associated with legislation**

Participants made a number of suggestions to improve Commonwealth and Victorian legislation related to mental health and drug and alcohol NPs.

Overwhelmingly the most commonly discussed issues related to the Commonwealth provisions for Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme. There was resounding support for the inclusion of NPs, which is discussed in further detail below. This was seen as a source of great frustration professionally for both NPs and other participants who felt it drastically limited the contribution that NPs could make.

*“It makes no sense to have these highly qualified people restricted to working with doctors because they can't prescribe independently...they want to get out there and help address this [workforce] crisis.”*

*“My clients pretty much live on the street and they are not ever going to pay for medications so until I can prescribe under Medicare I can't help the most vulnerable people.”*

In relation to state legislation, while most participants felt that the provisions under the Drugs, Poisons and Controlled Substances Act 1981 (Vic) were necessarily rigorous, some concern was expressed about the processes associated with the Act. This was generally related to pharmacotherapy and the requirements for authority to prescription.

*“The requirements take away the benefit of having a NP as you have to jump through so many hoops under the Act...if we could vary treatment on the spot it would be much better for patients than waiting for days.”*

Participants identified a number of issues with the Mental Health Act 1986 (Vic) In general, concerns related to the need to define and identify a role for NPs which distinguished them from registered nurses and which afforded them the opportunity to work with an appropriate degree of autonomy. The key changes suggested for the Mental Health Act 1986 (Vic) (the Act) were as follows.

The Act should include and define the role of NPs in the definitions provided under the Act. This is required to clarify the role of the NP within the provisions of the Act.

NPs should be distinguished from registered nurses and senior registered nurses as currently referred to in the Act. At present, the Act makes provision for registered nurses and senior registered nurses to perform a range of duties. These duties are often permitted under the direction of a medical practitioner or psychiatrist or under certain conditions including emergencies and when a medical practitioner is not available. While these provisions clearly apply to NPs (who are registered nurses) they do not adequately reflect the skill level, clinical judgment or degree of autonomy of NPs. Resources and time are often unnecessarily wasted in attempts to comply with these conditions when a matter could be readily addressed by a NP. It remains imperative that registered nurses maintain their roles under the legislation given that sufficient number of NPs are not yet available to address all patient needs. However, the Act should acknowledge the seniority and expertise of the NP and expressly distinguish them from registered nurses.

A number of other provisions under the Act were identified where it was felt that NPs had the hands on knowledge of the patient and the clinical judgment to take appropriate action without placing additional burden upon medical practitioners. It was also felt that the Act did not reflect current practice in relation to these provisions negating the significant clinical role played by nurses in the context of the current workforce shortages. Most importantly NPs working with patients can provide a timely response to patient needs without requiring them to wait, sometimes for days, to see a medical practitioner or psychiatrist. To accommodate improved patient outcomes it was asserted that the Act should:

- ▶ Allow NPs as well as medical practitioner to recommend a client to be taken to hospital as an involuntary client
- ▶ Allow the NP to provide the examination for treatment before the authorised psychiatrist 24 hour review
- ▶ Add NP as a category that can supervise a community treatment order
- ▶ Add NP as a category that can revoke a community treatment order
- ▶ Allow a NP to be able to authorise seclusion

- ▶ Allow a NP to be notified of seclusion as well as the authorised psychiatrist
- ▶ Allow a NP to be authorised to vary the interval of the medical examination of patients placed in seclusion
- ▶ Allow a NP to be identified as a category of staff who can cease seclusion
- ▶ Recognise NPs as autonomous clinicians able to act (within their scope of practice) without seeking approval of a medical professional.

A number of other issues related to legislation and the role of NPs were identified by participants.

A need for a psychiatrist to sign off on reports for the Guardianship and Administration Board reports for Centerlink payments and medical certificates was identified. These were seen as routine tasks which could readily be undertaken by a NP, particularly as that NPs often have a much more intimate knowledge of a person's condition and are well placed to make clinical judgments and to write accurate reports or sign certificates. The need to involve a medical practitioner often meant that the patient required two medical visits rather than one, placed added burden upon the medical practitioner and added to the delay in responding to patients needs.

In some circumstances, there was a lack of clarity under the legislation about the role of the NP resulting in confusion about what were requirements of the health service and what were requirements of the legislation.

*“Doctors do things because that is the way it has always been done here. If the legislation said that a NP could do A, B and C it would be easier to instigate change.”*

#### **4.3.6 Views on Pharmaceutical Benefits Scheme (PBS)**

Participants expressed concern that the lack of recognition of NPs under the PBS restrictions impacted on the NP's scope of practice particularly in cases where they work in a location which does not have a hospital pharmacy.

Patients serviced by mental health NPs outside of a hospital environment were seen to be disadvantaged because they do not have access to the Medicare rebate and have to pay to have their script filled at a pharmacy. This was a concern because many people who have mental health issues were reported to also experience economic disadvantage.

The support of a GP or consultant to sign prescriptions, referrals and requests for diagnostic tests provided opportunities for mental health NPs to work within a hospital or health service. This highlights the need for supportive health services to adapt and accommodate the role.

*“Within a hospital you can have access to provider numbers but you are limited in doing community care roles.”*

*“It is a problem with outreach, although with the support of GPs I can work around it but it would really stop the NP working in some services.”*

*“It just disadvantages clients who are already vulnerable.”*

### **4.3.7 Views on Medicare Benefits Scheme (MBS)**

Due to a lack of Commonwealth recognition, NPs do not have access to the MBS which limits their ability to refer patients to a number of other health providers and to request diagnostic investigations.

In the mental health field, the NP is likely to be working with the primary care coordinator and/or within a hospital environment. As such, the capacity to refer should not have an impact on patient care. There may be concerns about externally provided diagnostic tests such as pathology, radiology and ultrasound being billed back to the individual rather than the hospital. However, where the NP is working within a hospital as a part of a multidisciplinary team with mental health patient's diagnostic authority could be shared or costs billed back to the hospital.

*“This is such a limitation and a waste of resources and patient's time. We constantly have to get doctors to either see a patient we have already seen or approve our recommendation.”*

### **4.3.8 Limitations in the scope of practice**

At present, NPs have limited opportunity to work autonomously outside of a health service setting due to Commonwealth Government regulations regarding access to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). The NPs scope of practice can be influenced by a medical practitioner and in some settings this could prove to be very limiting. Mental health services need to accommodate the potential limitations to maximise the skills of the NP and ensure that he or she is retained in a meaningful position.

Mental health NPs working within a hospital generally have an opportunity to work as a part of a multidisciplinary team where the GP as the primary care coordinator. In these cases, lack of access to PBS is more readily mitigated. The NP is able to prescribe (those medications within the approved scope of the NP), and the patients can obtain medications under PBS, supporting the GP's treatment once the client returns to the community setting.

A number of problems were identified involving mental health NPs finding their scope of practice limited to a prohibitive degree outside of a hospital setting. In one case, this had resulted in a community-based NP role working with homeless people with mental illness being abandoned and the NP returning to work within a hospital environment.

In one drug and alcohol community-based withdrawal service, the NP model was reported to be working well with a NP candidate working as a service coordinator providing clinical leadership in a number of areas, including pharmacotherapy. This role was seen as successful and sustainable with opportunities for implementing a similar role in other services operated by the same organisation. The intention was that, once endorsement is gained, the NP would provide pharmacotherapy and continue her work as a clinical specialist in the area of addiction treatment within a community-based context.

Success factors identified in this case included strong commitment for the role from the organisation and immediate managers, established partnerships and support from GPs in the community and an organisational culture of community-based nursing in which nurses have often acted as clinical care leaders.

The importance of providing an appropriate scope of practice was also linked to workforce retention. Concerns were expressed about the potential for limitations in the scope of practice, resulting in NPs lacking the opportunity to utilise their skills in challenging and stimulating roles. This was seen as likely to impact on retention of NPs and reducing the interest of potential Candidates.

*“It is very disheartening to see the disappointment when [someone has] worked so hard and been so motivated and then is unable to put it all to good use...It makes others think twice about following the same path.”*

#### **4.3.9 Obtaining the support of service providers**

Service providers have expressed concern about the resources involved in educating the organisation about the NP role, developing a supportive work culture, and in redesigning services to accommodate NPs. Some providers are concerned that they may invest resources into the role, or even sponsor further study, and then lose the NP.

The mental health NP workforce is subject to the same pressures as other health sector employees and employers, community and government need to work with mental health NPs to develop strategies to address these issues.

Funding the role to ensure that it was sustainable was mentioned by some service providers. While in the main there was an expectation that DHS would need to provide additional funds to support the role several service providers had alternative approaches. One saw the responsibility of the organisation to fund the role as a component of their overall approach to workforce planning. Another felt that the role would pay for itself by reducing reliance on locums and freeing up the time of psychiatrists, psychologists and medical consultants. Generally, there was concern that the preparedness of the organisation to fund NPs would be enhanced if advocates of the role had the capacity to demonstrate a business case. Several felt that DHS could provide support with this and they emphasised the importance of evaluating the roles to maintain an evidence base for the success of the role.

#### **4.3.10 Meaningful roles**

The importance of ensuring that NPs can undertake appropriate and meaningful roles was identified. Situations were described where, despite having been endorsed, NPs were unable to work with any degree of autonomy, unable to prescribe, write reports or provide treatment. On some occasions the role was limited by legislation (such as the Mental Health Act, 1986 (Vic)), lack of the service developing appropriate procedures to support the work of the NP and lack of understanding from the medical profession about the capabilities of the NP.

*“We need to make sure that people can use their skills and continue to be challenged. If we only allow NPs to undertake traditional nursing roles then people will rightly ask ‘Why would I bother?’”*

## 4.4 Enhancers

A number of factors were identified as enhancers of the development and implementation of the NP role.

### 4.4.1 Support of the health service

One of the key enhancers identified was the need for a supportive and proactive health service or employer.

Organisational level support was seen as important in the sustainability of the role and included establishment of working groups, developing guidelines for the role, revision of policy and practices to include NPs, including a budget for NPs in workforce planning strategies, ensuring appropriate clinical governance structures, articulating medico-legal requirements and developing an organisational change strategy to create a positive culture.

Participants stated that employers should provide support for Candidates in the form of study leave, financial contributions for books and fees, and providing job security by committing to the role following their endorsement. The need for written agreements between the Candidate and the health service was seen as important in ensuring the commitment and obligations of both parties.

The health service or employer was also seen as having an important role to play in developing procedures and protocols to ensure that the NP has the capacity to work effectively in the role (i.e. establishing protocols for prescribing, etc.).

*“They arranged for a doctor from the hospital to provide clinical supervision.”*

*“They gave me help to write the clinical guidelines.”*

*“I write the reports and they have a doctor to just sign off on them.”*

Assessing the culture of the health service and the roles of nursing staff within the departments was also seen as important in developing sustainable roles.

*“If you look at mental health triage it is nurse led so it’s not a stretch, but this is not the same in all clinical settings.”*

Participants felt that the ideal situation would be for health services to develop a number of positions (up to 10 depending on the size of the organisation) so as to maximise the benefit of inputs, develop a supportive cohort, enable a mentoring program to be established and demonstrate the value of the role to the organisation. A number felt that government funding would be useful to act as an initial incentive in getting a NP program up and running.

*“If they provided funding for a program it would ensure that hospitals take it on seriously rather than just one at a time, which is hardly the best approach.”*

### 4.4.2 Endorsement requirements

While the endorsement process was seen as being in need of improvement (as previously discussed) the endorsement requirements were generally welcomed. Most participants held the

view that requirements need to be aimed at attracting the highest calibre nurses with the capacity to undertake a clinical leadership role. NPs were seen as having an enormous responsibility, one that required sound preparation and accountability. Aspects of the endorsement requirements such as the years of experience, educational qualifications, development of clinical practice guidelines and endorsement by the NBV were all seen as necessary, as were the preliminary interview and expert interview.

*“The process could definitely be better managed and people criticise the implementation of the process... we support the actual steps involved in the endorsement process. It needs to be rigorous and it is.”*

Some concerns were expressed about the academic requirements from a number of participants associated with drug and alcohol services who felt that it was unreasonable to expect NP Candidates to undertake a masters degree. They felt that additional training could be provided through specialised professional development programs for nurses. Interestingly, this view was not shared by most participants, including NPs and NP Candidates.

Overwhelmingly, the academic requirements were seen as positive and contributing to theoretical basis of evidence-based practice. This was also seen as necessary to ensure that NPs were able to make fully informed clinical decisions and move beyond a ‘technician’ role. The need for a masters level qualification was seen as important in contributing to the credibility of the course and the skills of NPs. There was strong support for stringent academic requirements to provide NPs with advanced skills as well as to improve the confidence of the medical profession.

*“Once they see that the courses provide NPs with advanced skills in physiology, pharmacy, diagnostics, and health assessment it will change a lot of views.”*

*“This is what distinguishes the role from other forms of nursing. It’s a leadership role...if you can’t muster the enthusiasm to do a masters degree then you need to question how you would handle the role.”*

The academic requirement was seen as ‘professionalising’ the nursing career path and promoting retention and career progression.

*“How many other professions are there that don’t require postgraduate study?”*

The protection of the NP title under legislation to only be used by a person who is appropriately endorsed, was seen as positive and maintaining the integrity of the role.

#### **4.4.3 Support of medical practitioners**

One of the common threads in successful implementation of a NP role has been the support provided by individual medical practitioners. A number of addiction specialists were attributed with encouraging and teaching NPs working in drug and alcohol services. Similarly, in mental health a number of psychiatric consultants were identified as actively providing supervision, support and mentoring. Many participants recalled examples of GPs in both rural and metropolitan areas supporting NPs and NP Candidates.

Many participants felt that it was important for more discussion to be undertaken with various medical practitioner associations, colleges and divisions to address their concerns and develop partnerships to promote NPs.

*“At the moment the nay sayers have all the attention... more needs to be done to engage [other associations] in high level consultations.”*

*“They are not all against the idea... The [Department] really needs to get out there and talk to them and give a voice to those that are likely to be supportive.”*

*“I have been invited to talk to some of the Divisions about my role. I feel that this is important to gain their support and dispel the myths.”*

Some participants also felt that the publication of more research papers promoting positive outcomes and the contribution of NPs would enhance the credibility of the role and build support of the medical profession. Another suggested the identification of ‘champions’ to be encouraged to present positive experiences with NP to their peers.

#### **4.4.4 Clear governance structures**

The need for clear governance structures was emphasised to not only provide protection for the NP and the health service but also for their co-workers. There was a view that at present the clinical governance requirements varied and that clearly articulated structures would encourage greater confidence from all stakeholders.

*“Who do they report to? Where does the buck stop? What measures are in place if an adverse event occurs? Is it covered by insurance? These are all grey areas that still need to be addressed.”*

The need to articulate arrangements about medico-legal issues to co-workers, particularly medical practitioners, was seen as important in ensuring that they understood their role in relation to the NP. They were then able to provide support and recognise scope of practice of the NP.

*“The consultants are fine with it but the registrars have a fit over it. They get very nervous because they are scared they will be responsible if something stuffs up.”*

*“I don’t think most doctors would have a problem if the medico-legal situation was a lot clearer.”*

There was particular concern that some community-based services and drug and alcohol services do not have clinical governance structures in place, requiring special arrangements to be developed. In one case where this had occurred the NP commented,

*“It was really no big deal, we just had to change the chain of command so that I answer to a medical officer from the hospital as well as the manager of [the service].”*

#### **4.4.5 Working a part of a team**

While a number of NPs were identified who worked successfully in relatively autonomous community-based roles, there was a strong view that the best environments for recently endorsed NPs were those that had strong clinical governance structures in place. Also ideal were those positions which afforded opportunities for face-to-face supervision and routine interaction with a multidisciplinary team and medical practitioners.

In relation to drug and alcohol services it was contended that residential withdrawal services afforded optimal conditions for the sustainability of the role.

*“I will be able to prescribe but I am nervous about it. It is a lot different to a doctor. I would be on my own. A doctor does an internship rather than being told you can do it on your own.”*

The psychological support afforded by working as a member of a team was also considered to be important especially considering the demands of the role upon the individual.

#### **4.4.6 Support from DHS**

There was a consistent view that DHS could enhance the development of NP roles in mental health by assuming a stronger role in leadership and direction. Other specific suggestions included:

- ▶ funding of project officers to work across hospitals to provide hands-on face-to-face support to assist in the development of NP roles in different categories;
- ▶ providing incentives to organisations which develop and expand upon NP roles;
- ▶ working with drug and alcohol services to develop clearer nursing structures;
- ▶ providing treatment guidelines for dual diagnosis, particularly in mental health and eating disorders;
- ▶ providing a campaign to build momentum and set targets for the number of health services developing roles and the number of NPs in drug and mental health services;
- ▶ providing more information and examples of how it can work and what needs to be done
- ▶ providing incentives for organisations developing NP group programs rather than just one-off positions;
- ▶ identifying flag bearers and champions to promote the role to the medical fraternity;
- ▶ promoting the NP role as a workforce solution not just an opportunity for nurses;

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- ▶ developing support networks across the health services developing models;
- ▶ providing materials on how to implement a NP role;
- ▶ undertaking evaluations to provide an evidence-based to demonstrate the success of the role.

## 5. Case studies

### 5.1 Summary of method

A number of health services had been working on implementing NP roles and models and some are close to having authorised NPs.

Case studies were developed from consultations undertaken at 10 health services identified by DHS and agreed by the project advisory group. The health services selected represented the full spectrum of clinical services as well as exposure to the NP role. They included metropolitan, regional and rural providers, services where mental health services are co-located with acute services as well as standalone, where drug services were co-located with mental health and standalone. The organisations also had different levels of organisational readiness, awareness and experience of NP roles more broadly as well as specifically in mental health or drug roles from little or no experience to those where considerable progress had been made.

All services nominated representatives to participate in a face-to-face consultation with a member of the consulting team. In most cases the consultations involved a small group discussion of three to four people. Participants were generally senior health service managers, Directors of Nursing and senior nursing staff. Several potential NP Candidates also participated.

Case studies were based at the following sites:

- ▶ Alfred Mental Health
- ▶ DASWest
- ▶ Forensicare
- ▶ Mercy Mental Health
- ▶ Mildura Base Hospital
- ▶ North East Health – Wangaratta
- ▶ North West Mental Health
- ▶ St Vincent's Hospital
- ▶ Southern Health
- ▶ Unitingcare – Moreland Hall

A number of broad themes and issues emerged across the case studies. There was strong interest in the development of NP roles at all of these services, with most of the sites already having NPs and/or NP Candidates.

## 5.2 Broad issues impacting on the service

A number of broad issues were identified as impacting on the services. These included:

**Lack of access to mental health practitioners in EDs** and the need for appropriately trained staff to provide mental health triage. This results in inappropriate treatment, increased inpatient admissions, delays in patients accessing appropriate care and patients leaving without having been treated.

**Workforce shortages** including lack of addiction specialists, GPs and mental health professionals. This impacted on the capacity of services to provide for the needs of an increasing and ageing population. This is compounded by issues of retention and is most challenging in rural locations.

**Demands on health services** to provide cost-effective high quality care for increasingly complex health issues and increased rates of chronic disease.

**Changing community expectations** driving the demand for increased and high quality community-based and outreach services including withdrawal and mental health services.

**Increased incidents of dual diagnosis** presentations and the increased complexity of patient condition contributing to the need for more comprehensive treatment models.

**Treatment models in rural areas** resulting in health care professionals working in isolation without access to a supportive team.

**Problems in providing patients with access to timely care** including inpatient care.

## 5.3 Barriers

The case studies revealed a number of barriers impacting on the services.

**Clarification of the NP role** was a key barrier in gaining the support of medical practitioners and psychiatrists working at the service. Related to this was the need for practice guidelines and policies to recognise the NP role and the importance of clarifying how the NP would work with medical practitioners. There was also concern that the role was often confused with other advanced practice nursing roles, resulting in a lack of appreciation about the need for the role. Clarification of the importance of both academic qualifications and experience was also seen as important in dispelling misconceptions.

**Supporting the role** was seen as important in sustainability of the role. This included the need for funding to be available to develop and implement a NP role, to provide staff to work with the service and to support the Candidates, and for the service to be prepared to fund the salary and the ongoing structures to support the NP program.

**Prescribing rights** were an issue in both mental health and drug and alcohol services. While there were generally ways around the prescribing issues if a NP was working within a hospital or residential service, the inability for clients to access subsidised medication was seen as a major barrier to NPs having useful and fulfilling roles in many community-based services. This was seen as just one element of extended practice and the need to support all aspects of extended practice was emphasised.

**Identifying a suitable Candidate** was a barrier at some sites. While most services were able to identify a suitable Candidate, in some cases time was required for the person to undertake the masters degree. There was some concern about Candidates not lasting the distance and withdrawing or moving on and the service wasting its investment. Related to this was concern that a NP Candidate is expected to maintain interest without a guarantee of employment in the role at the end of the process.

**The endorsement process** was seen as too long, complex and unpredictable – acting as a disincentive to many potential Candidates.

**Development of nursing structures** to support NPs was seen as important, particularly in drug and alcohol services where many do not have a nursing model of care.

## 5.4 Enhancers

Examination of the case studies revealed a number of factors which were seen as enhancing the development and implementation of the NP role. These are outlined in summary:

**Existing NPs** at the health service were seen as strengthening opportunities for future roles. Related to this was the idea that the service was 'systems ready' with mechanisms (i.e. governance structures, working groups, policies and procedures, etc.) to support the development and implementation of new NP roles. There was also a view that the cohort would offer peer support and that the service was generally receptive and supportive of NPs.

**Provision of funding** was seen as an important enhancer. While most services were prepared to pay for the ongoing salary of the NP, most wanted funding to provide support in the initial development and establishment of the role. The involvement of project officers was suggested, as well as funding to support the development of policies and practice guidelines.

The **positive and supportive attitude** of the service management and staff was seen as a vital factor in driving the success of the role. This included the support of management and medical professionals for the NP role as well as for staff education. The capacity of the role to address service gaps was seen as a critical way to increase support for the role.

**Innovative service models and multidisciplinary teams** were seen as important in providing the type of flexible structure that would embrace the NP role.

**Providing access to medication** was a key consideration to many service types. While some were able to overcome limitations with access to Medicare by providing medication to patients through the hospital pharmacy, other services adopted ways around this (i.e. sharing provider numbers, access to doctors to approve prescriptions, and paying for the cost of medication) to ensure that patients were not required to pay high costs for medication.

## 5.5 Roles and responsibilities

The case studies revealed the potential for NPs to be employed in a wide range of service types and in a range of roles and responsibilities.

Research identified a wide range of roles and responsibilities which could be performed by NPs. The provision of clinical leadership within these service areas was a common theme. Commonly suggested roles included:

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- ▶ dual diagnosis and dual disability roles bridging service types to provide patients with holistic and comprehensive care;
- ▶ pharmacotherapy roles developing and implementing treatment plans for people with drug and alcohol addictions;
- ▶ leading Clozapine clinics to treat, monitor and support people receiving this medication;
- ▶ mental health triage roles in emergency departments;
- ▶ clinical leadership roles in mental health services including assessment, support and treatment (i.e counselling, behavioural therapy, psychotherapy, CBT, medication, etc.) for patients with a variety of conditions including depression, postnatal depression, eating disorders and conduct disorders;
- ▶ community-based mental health care generally auspiced by a hospital;
- ▶ physical health monitoring such as annual examinations, testing, assessment and referral.

Roles differed in a variety of ways including:

- ▶ the level of autonomy and clinical judgments required;
- ▶ arrangements for prescribing under Medicare and arrangements for patients to access subsidised medications;
- ▶ the level of support provided by the health service;
- ▶ arrangements for clinical governance, supervision and mentoring;
- ▶ the location of the role within the continuum of care;
- ▶ disease focus.

## 5.6 Overview

The case studies reveal that health services are experiencing a number of gaps resulting largely from workforce shortages. The NP role is seen as a positive development which would assist in addressing a number of service gaps and produce positive patient outcomes and make a significant contribution to addressing the workforce shortages affecting mental health and addiction medicine.

While the services are at various stages of readiness to develop and implement NP roles they are receptive to help and support from DHS to facilitate the immediate development of increased NP roles. Support in the form of funding of project officer positions to assist in the development of the roles will be most critical in the services capacity to develop the roles and working with the organisation to develop a strategy for organisational change management. Funding and organisational support was seen as critical to sustainability.

The case studies revealed that all of the services were in a position to implement NP roles in the next one to three years. A number of services had Candidates nearing the end of the endorsement process and likely to implement NP roles in the next year. These were:

- ▶ North East Health – Wangaratta (two mental health Candidates)
- ▶ North Western Mental Health (one Candidate)

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- ▶ Southern Health (two Candidates)
- ▶ Moreland Hall (one Candidate).

All of the other services expected to be able to implement NP roles in the next three years are given support from the DHS. The critical issue in achieving this related to staffing with the ability to identify and/or hire suitable Candidates.

## Alfred Psychiatry case study

The Alfred is a major tertiary referral teaching hospital. Specialist services include trauma services, emergency and intensive care, comprehensive cancer services, blood diseases, respiratory medicine, melanoma, bone marrow transplant, cardiology/cardiovascular services, neurosurgery, general and specialist surgery and medicine, psychiatry and diagnostic services.

The Alfred provides acute and mental health care services to the local community as well as providing a number of state-wide programs both within the acute general hospital and in mental health. The Alfred has the state-wide beds for Psychiatric Intensive Care and the state-wide Mental Health HIV program. These services are provided in partnership with other community providers.

Alfred Psychiatry comprises both adult hospital and community-based services and a child and adolescent community-based service. Psychiatric nurses are strongly represented in the broad range of clinical program areas.

Alfred Psychiatry employs approximately 265 full-time staff who have provided these services since the transfer of psychiatric services to general hospitals in 1995. Since then, the program structure has continued to evolve toward a mainstream health setting with less emphasis on psychiatric inpatient facilities and increased emphasis on community mental health services provided in partnership through a structured mental health alliance. This major metropolitan health service employs more than 150 nurses with diverse roles who play a critical role in the delivery and coordination of care of people with mental illness.

### 5.6.1 NP program status

In July 2004, The Alfred Emergency Department NP project started as part of the DHS Emergency Department NP project. The role has since become a sustainable component of the health care delivery mode of the Emergency Department (ED). It has expanded to include a third NP Candidate, employed in 2005.

The implementation of NP roles in Bayside Health is via the Bayside NP Service Plan Development Project, designed to promote and prioritise the development of NP positions across the service. The Bayside NP Steering Committee, which has broad and high level representation from the three Bayside campuses, oversees the project.

The introduction of the NP role in the ED has been associated with a reduction in the number of patients who do not wait to be seen and treated despite increasing numbers of patients, decreased treatment times for patients, and improved patient satisfaction<sup>60</sup>.

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<sup>60</sup> Victorian Government Department of Human Services, Bayside Emergency NP Final Report, unpublished, 2005, quoted in *Bayside NP Service Plan Development Project Report*, p.7.

### **5.6.2 Broad issues impacting on the service**

Issues impacting on the service which are related to the new NP role include the following:

- ▶ Problems with “do not waits” who leave the service area. At this stage whether these people did or did not require medical attention is unknown.
- ▶ ED doctors at times will sedate patients with significant behavioural disturbance awaiting transfer to inpatient services or awaiting transfer to out-of-area mental health facilities. Sedated patients cannot be adequately assessed for 24 hours which can then delay other treatments and interventions. There are issues around the sedation protocols. The on-call registrars are often caught in the middle of this and find it difficult to prioritise these demands.

### **5.6.3 Current NP roles**

#### **Psychiatric Triage NP Role**

The Alfred Psychiatry is currently at the stage of finalising the Psychiatry Triage NP model to go to the Consultants group for their approval. The Psychiatry Triage NP within The Alfred Emergency Department was one of the 11 NP roles identified across the service as priority. Across Bayside Health there are currently six NP positions. The Psychiatric Triage NP role was modelled on the best features of those.

The target client population for the Psychiatry Triage NP is patients with mental health problems presenting to The Alfred Emergency Department. The service gap/opportunity identified was the lack of dedicated Psychiatry Triage Service based in the Emergency Department, contributing to long waiting times for these patients, or “failure to wait”. An opportunity to improve the timeliness and effectiveness of care given to this patient group was recognised<sup>61</sup>, whilst establishing clinical practice guidelines with a clear risk stratification to support general triage will be a cornerstone of the role.

The new NP role will refer directly to the Consultant. If a patient shows signs of a complex problem (delirium or co-morbidity), they are not referred to the NP, but will be taken on for review by the psychiatric registrar. If their condition is straightforward and with a clear psychological presentation, they will be triaged and assessed by the NP. For the first three months, the NP will work weekdays only. This means only four days (shifts) on out of a possible seven will be covered, with the additional day utilised to establish clinical practice guidelines to support and build sustainability of practice.

Psychiatric Nurses in EDs already have extended responsibilities (e.g. referring patients for admission to the psychiatric inpatient unit). Previously the Psychiatric Triage Nurse referred to the Psychiatric Registrar to review patients with high prevalence disorders and self harming behaviours for clearance or treatment advice, who in turn discusses management and treatment with the on-call Consultant. These patients are often required to wait through this process and may leave the ED in frustration or create a disturbance in the ED environment. The Psychiatric

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<sup>61</sup> Victorian Government Department of Human Services, *Bayside NP Service Plan Development Project Report*, 2006, p.13.

Triage NP role will focus on reducing the number of “do not waits”, limited prescribing for acute patients, and pathways for suicide prevention (ensuring rigorous assessment on the patient’s second presentation). The expectation is that the full impact of this new position will not be known for up to two years.

Within Bayside Health, all NP positions have to be signed off by the NP Reference Group. Implementation of the role is guided by a Reference Group which is less formal, but which ensures that, if issues arise, the support, guidance and supervision are in place to deal with proactively. The implementation team consists of the Director of the Emergency Department, the ED Nurse Manager, the Associate Director of Operations and Nursing (Psychiatry), the CATT Manager, and the Head of Consulting and Liaison Psychiatry. In addition, the Psychiatry Triage NP will have weekly supervision with the Head Consulting Psychiatrist, as needed and up to daily supervision with the consultant, and report to the manager of the CATT. The NP sits in on the Senior Psych Nurse management group, within which key risks are identified. This group meets every two weeks (alternately dealing with professional development and operational issues). NP attends and reports on this meeting.

### **Benefits of Psychiatric Triage NP role**

The specific benefits to clients and the community that this role provides include reduction in waiting times for patients with mental health issues presenting to the ED, more flexible health services, and improved liaison and co-ordination with community service providers.

The benefits to the organisation identified<sup>62</sup> as associated with the priority NP roles included the following:

- ▶ efficient, timely health care delivery: prevention of hospital admission, improved co-ordination of patient care, improved access to health services, etc.;
- ▶ provision of increased clinical and professional leadership for nursing staff in clinical areas;
- ▶ increased emphasis on the implementation of evidence based practice through the development of NP clinical practice guidelines;
- ▶ encouragement and support of increased nursing research and quality improvement activities;
- ▶ increased opportunities for interdisciplinary collaboration to improve client outcomes and service delivery;
- ▶ development of a clinical ladder for nurses with significant experience and expertise who wish to continue to deliver clinical care;
- ▶ recruitment and retention of nursing staff to clinical areas within the organisation;
- ▶ NP roles improve career opportunities for nurses. NPs continue on in practice, the same as a medical practitioner, enjoying the opportunities to develop with the changes in medical practice, and increasing their skills in teaching and liaison as their role evolves. They also pave the way for others to follow.

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<sup>62</sup> *ibid*, p. 21

### 5.6.4 Other potential NP roles

Other areas where a NP role would be useful were identified:

- ▶ Clozapine co-ordination and monitoring.
- ▶ of people on Community Treatment Orders (CTO) and conducting physical examinations. This is routine medical work with a large administrative burden that is currently not always done effectively.
- ▶ Electro Convulsive Therapy (ECT) requires a complex medical team. An NP would reduce the numbers by potentially replacing the registrar.
- ▶ Drug and alcohol withdrawal management with limited prescribing. This is a contained, highly manageable area and is a key in identifying service gaps NPs can fill. However, The Alfred has developed a training program for registrars in this area instead of a NP role.
- ▶ Aged psychiatry was considered another ideal area for NPs, particularly in residential nursing homes where there are patients with delirium and dementia, and over-prescribing often occurs.

### 5.6.5 Barriers

The Bayside NP Project report (2006) identified a number of barriers or constraints to the implementation of NP roles. These included the following: confusion and misunderstanding of the NP role; the temptation to use NP roles as stop gap measures; relating NP roles to other health professionals roles and the current model of care; identifying NP Candidates; role conversion; identifying internal funds for development of NP roles; the cost of the masters qualification; resources; insurance issues; and legislative restrictions. Actions to address each of these were provided<sup>63</sup>.

There are tensions in big hospitals around EDs. The issues relating to waiting and treatment times are highly political.

The challenge is to find NP roles that are an extension of nursing practice, not just replacing an existing role where local decisions and supports offer practice extension.

One of the risks is that the NP will be seen as the answer to all problems. In reality, their role will be limited.

Too often when service gaps are explored and new NP roles identified, they are claimed to be excellent training roles for registrars.

The Alfred ED is 'change ready'. However, with 34 individual consultant psychiatrists, it is crucial to clarify the NP roles and how NPs will work with psychiatrists, and to determine which patients the NPs can see and which should be referred to a psychiatrist or medical practitioner. This necessitates the development of protocols with guidelines and boundaries.

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<sup>63</sup> *ibid*, p. 11-27.

### **5.6.6 Enhancers**

There is considerable commitment to NPs. It is seen as an excellent career pathway for nurses who have a different eye for detail, rapport with others and high level skills.

The NP Psychiatric Triage role envisaged originally was for extra support for Triage, counselling people in ED and assisting with patients at risk of self-harming. However, there was no real scope of practice extension. The new role had to be conceptualised differently and differentiated from Triage: more than an alliance with ED Triage and CATT.

Funding for the development of the role has been the main issue. This has now been acquired through the Mental Health Initiative Funds.

It is important how the medical practitioners view the NPs, but also how the other nurses view them. The NP has to demonstrate leadership. This role must be accepted by the others.

The time delays were useful because they allowed time for conversation which led to better planning and conceptualising of the role.

### **5.6.7 Sustainability**

Based on the premise that sustainability was a crucial issue, Bayside Health (2006) identified a number of local and organisational strategies. Local strategies included the following:

- ▶ Information regarding NP roles on the Bayside Health intranet.
- ▶ The establishment, of local working groups to support the development and implementation of NP roles. The conduct of these groups was to be based on guidelines for membership and responsibilities.
- ▶ The design of Bayside Health education and mentorship guidelines to ensure consistent approach to educational and professional support of NPs.
- ▶ The expectation that NPs be given one non-clinical day per week in the first year of their candidacy for development.
- ▶ Informal networking between NPs and NPCs both within and external to the organisation.
- ▶ Organisational strategies included the continuation of the Bayside NP Steering Committee, a variety of multidisciplinary forums to promote the NP role, and engagement of NPs/NPCs in organisational committees and working groups relating to Advanced Nursing Practice<sup>64</sup>.

### **5.6.8 Other issues**

There are some strong medico-legal issues, particularly to do with self-harm and the need for thorough consultation. Consultants do not want to be compromised regarding this and it holds back NPs in mental health; hence, the role for NPs in prescribing Clozapine since most patients who use it are more stable and do not present the same risk.

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<sup>64</sup> *ibid*, p. 30.

## 5.7 DASWest case study

DASWest provides services to the Western Metropolitan Region and aims to offer flexible, practical support and treatment for individuals and their families who are affected by substance abuse. These services cover all the western suburbs of Melbourne and extend to the Barwon and Grampian regions of rural Victoria. They are aimed at four broad groups: adults, young people, women and children, and persons with a diagnosed mental illness who also misuse substances. The region serviced is one of the most multicultural in the Melbourne Metropolitan area.

DASWest's services are provided from a number of locations, including the Western Hospital, a range of specific sites in Footscray and Sunshine and through outreach services to locations across the Western Metropolitan region, including community agencies and private homes.

DASWest works in collaboration with the local community to offer non-judgmental, flexible and practical support and treatment for individuals and the families. The service approach is based on the principles of harm minimisation, while working with the client towards long-term recovery or stabilisation. A wide range of treatment options are offered, catering for the diverse range of individuals and cultural groups within the community served by DASWest.

DASWest has approximately 80 staff across a range of professional disciplines including:

- ▶ nurses
- ▶ social workers
- ▶ psychologists
- ▶ welfare workers
- ▶ community development workers
- ▶ physicians (with a specialty in addictions) both on staff and sessional and
- ▶ a childcare worker.

### 5.7.1 NP program status

No NP positions within DASWest at present, only senior nurse positions.

### 5.7.2 Broad issues impacting on the service

It was reported that the Western Region of Melbourne has less GPs per head of population than elsewhere in the state, coupled with large population growth and associated health needs. This resulted in difficulties in finding available general practitioners, conducting timely consultations and addressing the growing need for pharmacotherapy.

Within the DASWest services physician time has been contracting due to competing demands on their time. Poor access to treatment has contributed to poor utilisation rates of health services in general among young people.

Use of a NP would ensure a more seamless service for these young people in relation to meeting many of their multiple health needs and a smaller drop out rate between treatments.

Most importantly, having a NP available and on staff will ensure that the community is able to access services of a higher calibre and which are better integrated and seamless. It would also

create opportunities for nurses who wish to focus their career development on clinical rather than management opportunities and would allow them to become part of a senior nurse group within DASWest, offering supervision and mentoring within the context of a teaching nurse team. This would ensure a capacity to attract and retain quality practitioners to this sector and ensure the ongoing development of the nursing workforce.

There is general agreement that the NP role would work well in DASWest and there have been informal discussions with potential Candidates.

### **5.7.3 Current NP roles**

Nil.

### **5.7.4 Potential NP roles**

Currently, DASWest assists approximately 3,500 clients per year who access a wide range of inpatient and community-based clinics including: home-based withdrawal, counselling, specialist pharmacotherapy program, outreach programs and a community residential withdrawal program for both adults and young people (12–21 years of age).

DASWest has identified a number of areas where NPs would assist in filling service gaps and ideally believes that it would benefit from a NP in dual diagnosis, capable to fill these existing service gaps. The NP would be ideally placed for dealing with many of the needs of these diverse clients across the DASWest suite of services.

At this early stage, the model envisaged is that of a NP who fulfills a range of roles and responsibilities across the different areas of the service, rather than roles restricted to a specific area. The following represents the broad treatment and clinical areas in which the involvement of the NP would enhance and streamline services offered to clients.

**Primary Health services.** This service would enhance the service able to be offered to clients and take an opportunistic approach to health interventions whilst clients are engaged with the alcohol and other drug service. The involvement of the NP could include:

- ▶ administering sexual health screening
- ▶ communicable disease and blood borne virus screening
- ▶ general pathologies
- ▶ urine drug screening
- ▶ pregnancy testing
- ▶ head to toe nursing assessments
- ▶ vaccinations
- ▶ young people's health
- ▶ general men and women's health.

**Symptomatic Medications.** A NP would be able to enhance and make more immediate the treatment offered to clients, whilst at the same time maintaining a focus on clients' mental health diagnoses. Medications prescribed could include those for:

- ▶ withdrawal medication to reverse neuroadaptation in both inpatient and outpatient programs in Youth and Adult Services; and
- ▶ substitute pharmacotherapy – Suboxone, Methadone, etc. in inpatient and outpatient in Youth and Adult Services.

**Other health-related medication and management.** Many general medical conditions can have an adverse and prolonging effect on a client's withdrawal or treatment experience. A NP could be involved in the management and treatment of many of these conditions to enhance the client's withdrawal and general health outcomes; they include:

- ▶ asthma assessment/medication and management
- ▶ diabetes assessment/medications and management
- ▶ allergies and their impact on withdrawal
- ▶ acquired brain injury assessments
- ▶ responding to blood borne viruses after diagnosis – vaccination
- ▶ antibiotic medications – for infections.

**Infectious Disease Management.** There are conditions which can complicate the management of clients within the context of withdrawal programs or other community-related health interventions. The NP could act as a primary/ secondary consultant to other staff to ensure better management of clients where infectious diseases and condition stand to have an impact on their and, at times, other clients' treatment.

These conditions could include:

- ▶ needle stick injury and management;
- ▶ communicable disease testing and vaccinations for both clients and staff;
- ▶ acting as a consultant and liaison with and management of infectious or communicable conditions such as scabies or communicable conditions in residential settings, such as lice or gastroenteritis.

**Dual Diagnosis Capacity.** The NP will have a central role in ensuring the management of clients with co-occurring mental health and substance misuse disorders. Some statistics place co morbidity of these conditions at greater than 60% of our clientele.

The focus of this identification and treatment would be on high prevalence disorders such as anxiety and depressive conditions, given the low access to GPs clients experience and the high prevalence of these disorders, particularly in light of the directive from DHS (2007) Key Directions in Dual Diagnosis. The NP would liaise between mental health and drug and alcohol specialists, and between clinical and community services. They would be directly involved in the assessment, diagnosis and treatment of patients and also teach and mentor other nurses and other disciplines in this specialised area.

**Pharmacotherapy.** There is an increasing demand on the health system for access to these specialist programs with a commensurate decrease in the health systems' capacity to provide for this demand. The NP would be well placed to prescribe for and treat addictions and concurrent mental disorder not treated, under supervision and mentoring from a senior addictions consultant

located within the DASWest team. The NP would be supported by the consultant psychiatrist and support patients with:

- ▶ antidepressant medication – clinical depression;
- ▶ antipsychotic medications – dose adjustment and recommencement of treatment;
- ▶ anxiolytic medication – anxiety disorders;
- ▶ hypnotics;
- ▶ antiemetic;
- ▶ analgesics;
- ▶ sedatives; and
- ▶ nutritional supplements.

### **5.7.5 Enhancers**

All levels of nursing staff at DASWest would welcome this role. The team is used to change and innovation, hence is highly adaptable to introduction of NPs.

It would be necessary to discuss with doctors how they would interact with the NPs. The DASWest physician and Visiting Medical Officers are all interested in introducing NP positions and have initiated discussions towards this. Addiction doctors have fought long and hard to establish an addictions specialty, and they are supportive of the development of NPs specialising in this area.

Western Health would be highly supportive of DASWest introducing NP positions.

Nurses in the drug and alcohol area apply skills across a wide range of clinical settings. The day-to-day clinical practice in the drug and alcohol area is well suited to the introduction of NP roles. The drug and alcohol area has a diverse discipline base; hence professionals are more accepting of each others' disciplines and are very accustomed to working collaboratively

### **5.7.6 Sustainability**

Resources required would include financial support for masters level study. Some shared arrangement between DHS and the service would have to be negotiated to cover costs of this study.

This role would need to be seen as a core funded aspect of service delivery to ensure its ongoing viability and included in the Funding and Service Agreement for the DASWest service.

## 5.8 Forensicare case study

Forensicare provides a range of specialist mental health services to people in the care of the Victorian justice system.

These include inpatient services at the Thomas Embling Hospital, community services, and mental health units at the Melbourne Assessment Prison and the Dame Phyllis Frost Centre. Forensicare also provides consultant psychiatric services to regional prisons operated by Corrections Victoria.

Due to the complex needs of patients, Forensicare also participate in liaison with a diverse number of other community based health and community service providers including Turning Point, Moreland Hall, Buoyancy Drug and Alcohol Counselling as well as consultation with the Department of Youth Justice services.

Forensicare has 118 beds at Thomas Embling Hospital, 16 beds at the Melbourne Assessment Prison and 20 beds at the Dame Phyllis Frost Centre.

### 5.8.1 NP program status

There are not currently any NPs or Candidates working at Forensicare. However, support for the development of the NP role has been expressed by the senior management of the organisation. Other stakeholders, including the nurses, psychologists and senior psychiatrists, have indicated receptivity to the development of a NP role.

### 5.8.2 Broad issues impacting on the service

A number of issues currently impact on this service. These include the mental health workforce shortage which has limited the availability of mental health staff including doctors, psychiatrists and mental health nurses. This has impacted patients' opportunities to receive timely assessment and treatment. It has also placed a significant burden upon medical professionals working within the service.

There is a continuing effort to provide innovative models of care to address increasing patient needs in a cost-effective and sustainable way in rural areas and other areas of workforce shortage.

The service is increasingly providing care to people with complex health problems involving dual diagnosis. There is a need to provide holistic and comprehensive care to patients.

### 5.8.3 Current NP roles

There are no current NPs or Candidates employed at this service.

### 5.8.4 Potential NP roles

A number of potential roles are currently being considered within the organisation. At present the role which has received the most consideration is in violence reduction.

This role would involve:

- ▶ consulting on psychopharmacology;

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- ▶ risk assessment;
- ▶ intervention; and
- ▶ advising on placements.

This role was seen as covering inpatient treatment and community treatment acting primarily as a consultant on reduction of violence. This may involve consultation with other professionals as well as some direct care. This is not seen as a crisis intervention role, but rather the NP would be a clinical leader in the area of violence reduction and would be used as a resource across the service and for other services.

Forensicare has a strong focus on collaboration and liaison with mental health and drug and alcohol service providers. They have a long tradition of working as a part of multidisciplinary teams involving a range of professionals from diverse disciplines. They see the NP as having an opportunity to provide critical specialist insight in a range of contexts, including policing, judiciary, mental health and drug and alcohol services.

Forensicare is experienced in collaborating with other services, government agencies and healthcare providers. Accordingly, the role of the NP provides an opportunity for the development of clinical leadership across services to promote positive outcomes for the patient and the community. This role would provide the NP with an opportunity to work as a specialist in the area of violence reduction, bridging disciplines including psychiatry, law, psychology and social work.

Expertise and knowledge of psychopharmacology is important in the role. However, prescribing is not a key focus of the role. Prescribing is currently well serviced through other professionals and not an issue in prisons. As this role is not seen as crisis intervention the capacity to prescribe is not essential. However, should a need arise for the NP to prescribe, clinical guidelines would outline a process to support this using with the service providing the drugs or to enable the NP to access a prescription from a medical consultant. In community-based settings the NP would be working as a part of a multidisciplinary team with other team members who have a provider number.

In relation to clinical governance, the NP role would be seen as a clinical leadership role. With a core focus on clinical leadership the role would not entail management responsibilities. The role would fit within existing and effective nursing structures with the NP position, sitting under the Director of Nursing Practice who would provide support and mentoring. Medical mentoring would be provided by a senior psychiatrist. Other support would be provided through senior psychologists employed at the service. This process would be supported by the Director of Psychological Services.

In addition, pharmacological supervision would be provided by the Pharmacy Committee which is the usual mechanism for overseeing prescribing patterns, etc.

A number of positive outcomes were identified for the patient, the service and the community. Outcomes for the service included:

- ▶ improved retention of nurses by providing a clinical career path;
- ▶ promoting efficient use of psychiatric consultant time; and
- ▶ addressing workforce shortage issues resulting from limited numbers of psychologists and psychiatrists.

Outcomes for patients included:

- ▶ providing improved timely, access to specialist mental health services;
- ▶ increasing the number of patients receiving appropriate levels and type of care;
- ▶ improved accessibility of specialist mental health services to patients in regional locations;
- ▶ improved access to appropriately qualified persons to undertake assessment, intervention and maintenance activities;
- ▶ decreasing rates of relapse, supporting community placement, reducing the need from crisis care;
- ▶ systemic integration of services resulting in improved continuity of care and reduction in the number of different services involved in care reducing the burden on patients;
- ▶ improved opportunities for comprehensive and coordinated treatment of people with dual disabilities;
- ▶ reduced risk of harm and distress to patients and the community;
- ▶ access to a broader range of treatment options; and
- ▶ access to early intervention.

Benefits to the community included:

- ▶ cost-effective way to improve access to specialist mental health treatment;
- ▶ reduction in the number of untreated patients discharged without support into the community;
- ▶ reduced offending;
- ▶ relieving mental health workforce shortages; and
- ▶ improved support to other service providers via secondary consultations.

### **5.8.5 Other potential roles**

Several other potential opportunities for the development of NP roles were identified.

#### **Consulting with prisons**

Forensicare currently provides a psychiatric consulting service to a number of regional prisons, sending a psychiatrist to each location generally for one session per week at each location. The use of NPs within this service would provide an opportunity to offer a cost-effective and more comprehensive and accessible service to prisoners with mental health issues, reducing the time constraints on consulting psychiatrists. They could also provide additional support in psychopharmacology, assessment and treatment. This would ultimately improve patient outcomes, enable the service to offer more cost-effective services and support prisoners to make a successful return to the community.

### **Dual diagnosis**

This was identified as an area of need, with dual diagnosis patients often suffering from inconsistent care as they straddle two areas of service. Some patients can be turned away from services if seen as too difficult, or referred to the other service area. Dealing with multiple service providers often results in duplication of services and can add to patient burden in terms of having to access multiple services and provide the same information repeatedly.

The NP could be involved in assessment, development of treatment plans, delivery of or advising on psychopharmacology and providing of behavioural or psychotherapeutic interventions.

A NP model could streamline the delivery of health services, producing positive health outcomes for the patient and the community (i.e. reduced cost from over servicing, reduced behaviours of concern, reduced readmission to inpatient services, ongoing maintenance in the community). This approach would ensure that patients receive comprehensive and holistic care.

### **5.8.6 Barriers**

Several barriers were identified. These were generally issues related to development of the role which the service planned to address as the roles are developed. Issues identified included:

- ▶ There is a need for the potential roles to be clearly defined. Policy and clinical guidelines to support the role also need to be considered. Senior nurses at Forensicare are aware of NP projects in other mental health services and will consult with these services. At a state and national level, policy and guidelines have been developed and Forensicare will incorporate them into local policy and guidelines. A Forensicare reference group will be established to formulate and monitor policy and clinical guidelines to support the role.
- ▶ The service needs to identify a suitable Candidate. At present there are a large number of nursing staff with postgraduate degrees (achieved through support provided by Forensicare). While none have commenced an approved masters degree this was not considered to be prohibitive because of the sound academic tradition within the organisation. There was confidence that previous academic support was linked to a high level of nursing staff. Over the past five years the service has supported over 20 mental health staff with postgraduate study to doctoral level. This has involved significant financial support to pay for fees and books and time release for study. As such, they are committed to providing a NP Candidate with similar support to access an approved masters degree. They also felt that this degree of support would be likely to contribute to retention in the role, as has been their experience in other areas.
- ▶ While Forensicare would be prepared to include the funding of the role within their overall workforce budget, it was felt that additional funds to develop and implement the role and provide ongoing support as future roles are developed would be important.

### **5.8.7 Enhancers**

A number of enhancers were identified for this service. These included the following:

- ▶ Forensicare would be prepared to make a substantial contribution to the payment of university fees, books and time allowance for study. The organisation has a commitment to developing the mental health workforce as it has demonstrated through its support of higher education.

- ▶ The organisation has a sound record in providing support for medical consultants, psychiatrists and psychologists. It was recognised that while there was support for the development of a NP role, it would be necessary to ensure that the organisational culture is able to accommodate the role. There was confidence that the organisational philosophy would assist in facilitating this. In recent years the service has promoted an integrated service model in which team members from different disciplines work collegially. This approach has found support from nursing staff, psychologists and psychiatrists. The NP role could readily fit into this existing approach.
- ▶ The organisation already has a strong governance framework which could readily accommodate NPs.
- ▶ Issues with the mental health workforce shortage have increased receptivity towards innovative methods to providing outreach and rural mental health services.

### **5.8.8 Sustainability**

The service recognises that the positions will require ongoing support, development and evaluation. They are committed to working to develop several roles which will establish a peer cohort for the NPs. The Director of Nursing Practice and the Forensicare Reference Group will be responsible to prepare the workplace and culture for the position and to provide ongoing support for the NP(s). Processes for practice and workforce development, education, quality improvement, research and benchmarking are well established at Forensicare.

## 5.9 Mercy Mental Health case study

The Mental Health Program, operated by Mercy Health and Aged Care, is an adult psychiatric service providing services to adults in western Melbourne, as well as some specialist services to mothers throughout Western Victoria. The service pays particular attention to the differing cultural groups within the community, providing bi-lingual case managers in Greek, some African languages and Vietnamese. It also provides the services of a dual diagnosis worker.

Mental health services are delivered via specialist teams. Acute services include the following: Intake and Referral or Triage Service; Crisis Assessment and Treatment Team (CATT); The Psychiatric Unit (a 24-bed ward in the Werribee Mercy Hospital); the Homeless Outreach Psychiatric Service (Footscray); and the Mother Baby Unit (six-bed and cot unit in Werribee Mercy Hospital). In addition, the Consultation and Partnerships Team supports general practitioners and other primary health providers in the treatment of a number mental health disorders. Rehabilitation Services includes residential rehabilitation programs, an outreach rehabilitation service to people in their own homes, and a support program.

### 5.9.1 NP program status

Mercy Mental Health service does not have any NP positions at present. The service has not been in the position to support them, due to a lack of flexibility in the budget and staff numbers to undertake the project.

The service has created a Grade 5 Emergency Liaison nurse position and this is seen to be working well. If this position did not exist, it is likely that a NP position for this role would be considered.

### 5.9.2 Broad issues impacting on the service

Mercy Mental Health provides service for adults across a broad and diverse area, from Footscray to Little River. The issues for the two ends of the area covered are different, with huge growth at one end and a high migrant population at the other.

The CATT is working beyond capacity. CATT supports many of the people who are discharged early because of demand for inpatient beds, by providing a home visit in the first week after discharge. At present CATT cannot keep up with the demand for this service.

The service has a particular problem providing support to patients on discharge. On discharge, patients often need an appointment within a week. At present the only arm of the service that can provide this is CATT, which impacts on their capacity to provide acute treatment and early intervention.

Doctors are in short supply. Hence, the senior doctors are overworked in providing direct service to clients rather than providing supervision for junior colleagues and other staff. This promotes a vicious circle where it is difficult to recruit good staff because the work is not rewarding but we cannot change the work until more capable medical staff are recruited.

### **5.9.3 Potential NP roles**

At this stage, rather than spreading its efforts thinly, the Mercy Mental Health service is focusing on plans for one position, that of NP outpatients.

#### **NP outpatients**

Mercy Mental Health is considering developing the model of care for the position NP outpatients which would provide an outpatients' clinic to support patients on discharge. The hospital pharmacy could dispense medication at a slightly reduced cost. The mental health service would cover the cost for the patient until the Commonwealth accepts NPs into the PBS system.

It is estimated that such an NP would be able to see about 15 patients per week.

The service believes that it is unlikely it would be possible to get a doctor to be responsible for such an outpatient clinic. At this stage, discussion on this has taken place between the Area Manager, the Director of Clinical Services, and the other managers in the service.

In order to provide the necessary coverage and to ensure that the position was sustainable, more than one NP Candidate would be required. Before the outpatients clinic could start up, two NPs would be required for it to function.

To train one person for this position would require 1.4 EFT to provide the necessary coverage, allowing for training and support time. Both the trainee and their trainer would need time off-line. This trainee also would have to commit time to the masters component of their development program.

It is envisaged that funding of a trainee NP position would be shared between Mercy Mental Health and DHS. This would require negotiation between the two parties.

NP positions would provide a career path. This would help both attract nurses to the service.

### **5.9.4 Barriers**

The NP positions can be very "Candidate dependent"; if the Candidate does not perform or leaves, the status of the position can be negatively affected. However to change a model of care it is essential to be able to guarantee staffing of that model.

The prescribing rights issue was seen as a real barrier to extending the NP role beyond that of the hospital.

Some changes are required to the Mental Health Act, particularly in relation to involuntary orders. It would not be necessary or advisable for NPs to take over all authority for involuntary orders, but, for example the authority to change orders, discharge and admit a patient, without the necessity for a doctor to sign-off, would be useful.

### **5.9.5 Enhancers**

The gap that the NP outpatients would fill has been clearly identified: the need exists now.

The Emergency Department Team, with whom the NP outpatients would interact on a regular basis, is highly competent and would be supportive.

### **5.9.6 Sustainability**

For the position to be established and sustained, the requirements from the service would include:

- ▶ development of the model of care, including location in the service (relationships and functions);
- ▶ resources and sustainability
- ▶ commitment to the training involved, in terms of both time and funding;
- ▶ planning from the top of the organisation;
- ▶ leadership across the organisation;
- ▶ ongoing supervision for the NP;
- ▶ support for the NP from managers, clinical staff and other co-workers;
- ▶ a clear understanding of all costs involved;
- ▶ ongoing commitment to the training of the NPs over the 10 years that it will take to create the pool.

The capabilities and attributes of Candidates for the position would be important to its sustainability. Selection criteria for the NP Candidates would need to include:

- ▶ a strong commitment to the role;
- ▶ the drive and initiative necessary to implement a new position;
- ▶ academic ability to cope with the required study;
- ▶ ability to operate independently and autonomously; and
- ▶ good communication skills.

## 5.10 Mildura Base Hospital case study

Mildura Base Hospital is a 146-bed (level 1) tertiary teaching hospital built and operated by Ramsay Health Care in a contractual arrangement with the Victorian Government. The hospital provides public hospital services on behalf of the Victorian Government to the Northern Mallee Region. This population includes Indigenous Australian communities.

The hospital provides a range of Acute Services including Emergency, Maternity, Intensive Care, General Medicine and Surgery, Medical Imaging, Pathology, Dialysis, Mental Health (inpatient and community services) and a range of Ambulatory Services.

The Mental Health Service provides a full range of support including:

- ▶ Child and Adolescent Mental Health Service (CAMHS)
- ▶ Aged Persons' Mental Health Service (APMHS)
- ▶ Adult Persons' Mental Health Service (AMHS)
- ▶ Acute Response Service (ARS)
- ▶ Continuing Care and Mobile Support Teams
- ▶ YEPS - Youth and Early Psychosis Service
- ▶ Primary Mental Health and Early Intervention Service (PMH&EI)
- ▶ Dual Diagnosis Service
- ▶ 12-bed Inpatient Unit (IPU).

The health service is operated by a private contractor, Ramsay Health Care. This is a unique arrangement in Victoria. This has an impact on staff as they are employed by a private contractor rather than through a public health service.

### 5.10.1 NP program status

No current NPs or Candidates

### 5.10.2 Broad issues impacting on the service

As with other regional areas, Mildura has experienced difficulties in attracting and maintaining suitability qualified and skilled medical, nursing and mental health staff. This workforce shortage has been compounded by a number of factors including the distance from Mildura to nursing training centres and universities offering nursing courses (which can limit the accessibility of further training including masters degrees), the loss of senior nurses to private practice and the increased opportunities for nurses in Melbourne and Adelaide.

While the service has experienced difficulties accessing medical staff in the past, it is now better supported by medicos, including community-based general practitioners. However, it was noted that the area is still under-served by medical officers.

### **5.10.3 Current NP roles**

There are no current NPs in the health service. However, the service previously developed a proposal for the implementation of a NP role. At the time there was a lack of availability of medical officers to support the role. The result was that a lot of time and effort had been used to develop a model for NPs that was not fully developed due to these staffing and support issues. This was a significant disappointment for the staff involved and highlighted the need for medical staff input in the development stages.

### **5.10.4 Potential NP roles**

The role of the NP was well regarded by the nursing staff and there were considered several areas of the service where the use of NPs would increase the quality of services offered to patients and provide opportunities for staff advancement.

Clinical Governance for all NP positions could be convened by the hospital and incorporate the Director of Clinical Services, Consultant Psychiatrist; Chief Pharmacist; Medical Officer; Carer/Consumer Consultant; NP Candidate; senior nurses; senior management representatives; social worker; psychologist; dual diagnosis worker; and in the case of a drug and alcohol NP, representation from the drug and alcohol service.

Potential roles identified included:

**Working on the Acute Response Team** – It was noted that there is difficulty getting Medical Officers to go out with the team. The team sometimes has to come back to get a doctor. A NP would fill this need. Medication prescribed as part of the emergency response is administered by the hospital. NPs would not need to write ongoing prescriptions for drugs as clients are always referred back to the treating doctor for these.

**Clozapine clinic** – The Clozapine clinic is an area that is already up and running. There is a very close working relationship between the medical and nursing staff in this clinic. The work of the senior nurse is highly regarded and supported by her colleagues. Upgrading this role to a NP would recognise the work already being done and free up medical staff for other duties. It was also seen as an area where there would be little departure from current practice and therefore likely to be successful and sustainable, promoting the role of the NP within the service. There is a very close working relationship between the GP and the senior nurse. A discussion on the inclusion of ECT Nurse was included here as this senior nurse also has the role of ECT Nurse.

**Emergency Department** – Supporting the Emergency Department, and providing case management so that some patients may not need to be admitted (a step down option). This role would need to be a dedicated triage role, potentially attached to the ARS.

**Working with the drug and alcohol unit** – There was seen to be a significant need for NPs in the drug and alcohol service. It was noted that medical staff are not available after hours and may feel they lack the level of specialisation to treat some of the more complex conditions. Patients with dual diagnosis are seen as particularly likely to benefit from the NP role as this is an area of particular specialisation. It was noted that withdrawal and rehab services are particularly lacking, with patients ending up as inpatient admissions when a community-based support option would be preferable. With the home-based services, a NP could utilise their skill in the event of an emergency out of office hours. Mental Health Services Dual Diagnosis could share a NP with the local Drug and Alcohol Services run by a local non-government agency.

**Supporting the maternity unit** – There was also seen to be a particular need for NPs in postnatal care, dealing with depression. It was noted that pharmacotherapy options are poor in this area and these patients would require medical monitoring and the ability to order pathology would be seen as advantageous.

It was noted that the identification of need for a NP position must include a link between staff interest and service gaps – there are not enough NPs or people interested in the role to meet potential areas of demand.

### **5.10.5 Barriers**

For all of these positions it was noted that the availability of funding was the first issue, both for a project officer to prepare a plan and build support for the NP role, and for remuneration of NP and support for their training. There were not seen to be significant barriers at a regulatory or organisational level, though it was noted that Medical Officer support was essential.

Availability of senior staff and their capacity and willingness to take up additional training was seen as a barrier – particularly without guarantee of a position. The need for scholarship for staff was raised. It was also noted that regional staff may need more options, or more flexible study modes, to meet their needs as courses are currently capital city based. There were seen to be several models currently working with medical staff that may be transferable using the internet or video conferencing.

It was also considered that there is a lack of financial incentive to staff as the NP role would not necessarily attract a higher pay bracket.

### **5.10.6 Enhancers**

There are already some nurses working in advanced clinical roles supporting medical officers. The Clozapine clinic was an example provided where the nurse was clearly providing a leadership role.

In addition, there are several areas where lack of medical officers is problematic – the ARS and drug and alcohol service being examples. In these areas, the advanced skills of a NP were seen as offering patients a more tailored, less restrictive form of care.

There were seen to be many roles for NPs that were not reliant on prescribing, but focused more on clinical skills and case management. While prescribing per se was not seen as a major issue, this certainly broadened the scope of practice for potential NP roles.

There was seen to be a need for mentoring and support of the NP outside of line management and potentially outside of the organisation. This could focus on collaboration with specialist services in the area of practice.

### **5.10.7 Sustainability**

Sustainability of the applicants, rather than the NP positions, was seen as the biggest issue. It was commented that in regional areas the drought has caused many families to leave their homes and move to the city to get work. There was concern that a unique position could be developed for a particular nurse to find that family circumstances had rendered it obsolete. The need for recruitment and retention packages for NPs to move and remain in regional Victoria was discussed.

## 5.11 Moreland Hall case study

Moreland Hall is a drug and alcohol service which provides a range of treatment and education services, including community and home-based withdrawal services across the northern suburbs of Melbourne. Separate community residential services are provided for adults and younger people. Moreland Hall is operated by UnitingCare and as such, is not-for-profit.

Leslie-Anne Curran Place is a 12-bed facility located in Heidelberg providing residential support to assist adults to withdraw from a range of drugs and alcohol. This service provides for increasingly complex clients with a range of issues including psychiatric and social problems. The services works with community general practitioners.

### 5.11.1 NP status

At present one NP Candidate is employed. She has undertaken an application review and preliminary interview by the NP advisory committee and is currently preparing for the next stage in the process, which will be the assessment by an expert panel. Preparation has already commenced for this process with the engagement of a number of professionals including a pharmacist, Community GPs and representatives from the UCMH management team.

### 5.11.2 Broad issues impacting on the service

There is an increasing need to provide community-based withdrawal services which offer a high level of clinical competency. Service consumers are presenting with an increasingly complex range of medical and psychiatric conditions, as well as social issues which require expertise in diagnosis, intervention and treatment. There is a need for expert clinical practitioners to provide clinical support. As community expectations have changed and drug and alcohol services strive to maintain their accessibility, there is an increasing need to provide these services in a community-based environment and for those services to be able to manage a complex range of conditions.

There is currently a well documented shortage of medical practitioners working as GPs and a limited number of addiction specialists and psychiatrists. The use of NPs can relieve the demands upon these professions and improve access to treatment by decreasing waiting times for assessment, admission and the development of treatment plans.

There is also a need for increased access to pharmacotherapy within the community. It can be particularly challenging to find people with the authority to prescribe drugs such as Buprenorphine and Methadone. It is also particularly challenging to find sufficient access to a prescriber with the accessibility to allow for pharmacotherapy regimes to be tailored on a daily basis according to the individual's needs.

### 5.11.3 Current NP roles

The following sections detail the current model of the NP role adopted at the service. This role provides an example of a NP model which could be replicated at other similar drug and alcohol services.

The NP Candidate is employed in the current role as coordinator of a community-based adult residential withdrawal unit. Emphasising the importance of developing a role which fully utilised

her skills, she indicated that her new role was “the ideal role for a NP” and would provide her with the scope and challenge to fully develop and implement the role.

Committed to a career in clinical practice, the role of coordinator at this unit provided the opportunity for a high level of clinical contact with staff and patients and the opportunity to collaborate with other stakeholders such as GPs, psychiatrists, support agencies and family/carers in a way which utilises her expertise and provides a high level of clinical insight.

### ***Gaps that the role addresses***

Pharmacotherapy at this service is currently provided by a small number of community general practitioners. Due to the increasing demands upon their time, access to medical practitioners with endorsement to prescribe pharmacotherapy can be limited. A NP role at this service will increase patient access to timely, accessible, tailored pharmacotherapy.

The NP Candidate is currently in the process of applying to the NBV for endorsement. Once she has completed the endorsement process and her formulary is approved by the DHS Drugs and Poisons Unit, the service will have increased capacity to offer pharmacotherapy which meets the needs of individual patients and relieve some of the pressure on medical practitioners.

It is also expected that the presence of a NP at this service would reduce delays in admitting patients. At present patients cannot be admitted without the patient having seen a medical practitioner for the purpose of prescribing a treatment regime. Due to limited access to these general practitioners, appointments to commence pharmacotherapy may only be available one to two days per week. This results in some clients requiring pharmacotherapy waiting up to two weeks from the time of assessment until admission. In comparison, clients requiring alcohol withdrawal can generally be admitted within a few days. Community general practitioners complete medication charts for the clients’ admission and post them to LACP. Once this has been sent back to the unit the patient can be admitted. It is estimated that the implementation of the NP role would enable people to be admitted much faster than in the current system. This would not only result in improved outcomes for patients but also reduce vacancies at the service.

### ***Scope of practice***

The present role as coordinator involves oversight of all aspects of the withdrawal treatment process including supervision of day-to-day clinical care, urinary tests, administering breathalysers, counselling and behaviour management, supervising a clinical care team, liaison and collaboration with other service providers and agencies, providing clinical advice (including to GPs who call seeking an expert opinion). Gaining endorsement will provide the Candidate with increased scope to work independently and drive the range of services offered. She will also be available to consult with other programs within Moreland Hall. Most importantly, achievement of prescribing rights will enable the service to offer more timely access to pharmacotherapy for withdrawal.

In order to provide appropriate care to the increasing number of patients presenting with dual diagnosis, she expressed aspirations to undertake a dual diagnosis NP role in the future. As part of the current dual diagnosis strategy response (dual diagnosis, key directions and priorities for service development), she has commenced visiting the Austin Mental Health Unit with a psychiatric consultant conducting rounds. She has also considered other factors that would be required for this model to work, including the need for increased experience, development of a different formulary and development of clinical guidelines, etc.

### ***Clinical governance***

Arrangements for clinical governance of the role will include the development and ratification of Clinical Practice Guidelines (currently being developed), formation of an Expert Panel (including a pharmacist and medical practitioners and an addiction specialist – Dr. Mike McDonough. While this panel will be used as a part of the endorsement process, it will also provide continued oversight as the Drug and Alcohol Service does not have a medical director. She will access more practical day-to-day support and clinical supervision from one of the local GPs with whom she has forged a strong professional relationship.

### ***Arrangements for supervision, mentoring and training***

To add to her professional support base which includes local GPs and regular contact with other medical personal involved in addiction medicine, the Candidate has initiated development of a collegial network with other NPs, including some from the Austin Hospital Mental Health Service and Southern Health. She also attends regular training sessions related to addiction and has presented papers with a GP at conferences.

### ***Support infrastructure***

This position is supported by the organisational management, UnitingCare Moreland Hall, and a committee has been established to oversee administration of medications and to provide review and support.

### ***Funding of the position***

The Coordinator's position is currently funded as a part of the overall management of the service and is paid for by UnitingCare as a component of a DHS contract. Once the Candidate is endorsed, UnitingCare Moreland Hall will seek appropriate remuneration from DHS to support employment of a NP and ongoing clinical implementation.

### ***Opportunities for collaboration with other providers***

This role requires a high level of skill in liaison and collaboration with other health professionals, governmental support agencies, families and carers and social support agencies. As such, the Candidate is familiar with the skills required to work collaboratively across a number of organisations. It is anticipated that when endorsement is gained, these skills will be used to some degree across Moreland Hall including the other UnitingCare withdrawal services.

### ***Outcomes for patients, the service and the community***

Key outcomes for patients will include access to more timely individualised pharmacotherapy and a reduction in the waiting time prior to admission. The service is benefited by having access to a highly skilled cost-effective health professional who relieves some of the burden from medical staff, while providing a high quality of care. The service is also supporting nurses to improve their career path which in turn contributes to staff retention. The community benefits by improved access to health professionals specialising in addiction who have the capacity to provide a high quality of care and cost effectively address an area of workforce shortage.

## ***5.11.4 Potential opportunities for NP models***

A number of opportunities were identified for NPs working in drug and alcohol services. These included opportunities at community-based residential withdrawal treatment units where it is important to be able to meet client needs for medication. An appropriate prescriber is often difficult

to access in such services due to workforce shortages impacting on the number of GPs, the requirement for medical practitioners to have endorsement to prescribe pharmacotherapy and the tendency for addiction specialists to work with the hospital environment.

Opportunities were also identified in the areas of home-based withdrawal and youth services for the same reasons identified above. This model may have limitations as a result of prescriber number issues.

### **5.11.5 Barriers**

No barriers to the successful implementation of the NP role were identified in relation to this model with the current Candidate.

Access to best practice pharmaceuticals for client care is limited due to overall unit funding costs and this will result in limited access to appropriate medication for clients.

### **5.11.6 Enhancers**

A number of factors were identified as contributing to the success of the role.

The support of the organisation and their capacity to embrace innovative models of care contributed to the viability and sustainability of the role. While in this case the NP Candidate did not obtain support for further study, she emphasised the need for this to be offered to allow suitable Candidates the opportunity to pursue a NP career path, as well as to ensure that the organisation or health service has a strong commitment to and investment in developing the role of NPs.

Support from addiction medicine specialists, GPs and psychiatrists and the willingness of the individual Candidate to develop collegial professional support networks was also an important contributor to the success of the model. In this case, the Candidate is well known and respected within the drug and alcohol area and has the professional and personal support of a number of medical practitioners and addiction specialists. This support takes the form of mentoring, offering a forum for review, discussion and supervision. She has worked collaboratively with some medical practitioners on research and conference presentations.

Ongoing support and mentoring was seen as important, particularly as the NP undertakes new clinical responsibilities such as prescribing medication.

While acknowledging that the educational requirements can be a disincentive to some, overall the Candidate supported the need for a masters level qualification. She commented that working in drug and alcohol services in a prescribing role required practitioners to have a robust theoretical understanding about pharmacy and addiction.

### **5.11.7 Sustainability**

In order for a NP role to be sustainable at this service this role will require the continued financial support of the organisation, establishment of ongoing arrangements for clinical supervision (given that the current service does not have a medical director) and establishment of links with an addiction medicine physician to provide clinical supervision to the NP.

## 5.12 Southern Health case study

The Southern Health Mental Health Program provides mental health services to persons aged up to 64 years with a mental illness and/or those with alcohol or other drugs issues.

Southern Health provides a range of inpatient and community-based services covering a broad spectrum of mental disorders. These services include community and rehabilitation services, child and adolescent services, drug and alcohol services as well as a range of other support services.

South East Alcohol and Drug Services (SEADS) recently joined with Southern Health. SEADS provides a comprehensive regional program for the management of issues relating to drugs and alcohol. Service types include inpatient detoxification, outpatient withdrawal, home-based withdrawal, adult counselling, youth counselling, family alliance counselling, dual diagnosis, acquired brain injury, Addiction Medicine Unit (based at Monash Medical Centre Clayton and Dandenong Hospital), Needle Syringe Program, Primary Care Clinic and drink drive education.

The provision of services is organised by geographical catchments focusing on the southern region with SEADS services also being offered in south east suburbs of Melbourne.

### 5.12.1 NP program status

Southern Health currently has one NP working in the emergency department at Dandenong Hospital, and a further Candidate in the emergency department at Monash Medical Centre Clayton. Further to this, Southern Health has just received funding to appoint a project officer to progress two NP roles in Renal Services. In the area of mental health two Candidates have applied for endorsement. A number of other people who would be suitable Candidates in mental health have been identified. In SEADS, one person is commencing initial investigations about seeking endorsement. The development of roles for NPs has been supported through a decision memorandum to the Executive Management Team at Southern Health. A strategic framework for NP roles is currently in draft form, and once endorsed by the Southern Health NP Steering Committee, will inform the development and governance of NP roles across Southern Health.

### 5.12.2 Broad issues impacting on the service

A number of issues have been identified as impacting on the need for NPs at this Area Mental Health Service (AMHS).

Broad issues include the need for increased access to high level mental health and drug and alcohol specialists. This need stems from overall declines in the mental health workforce, limited numbers of addiction specialists and the emergence of increasing numbers of patients with complex mental health needs, dual diagnosis and earlier onset of illness.

One of the key issues identified was the need for high level professionals with a capacity to liaise across all program areas and to provide a high level of critical analysis. This need reflects the increasing number of patients straddling multiple program areas and service types and the need for expertise in crossing these boundaries.

The recent merge between Southern Health and SEADS increases the opportunity for patient outcomes to be improved through the high level involvement of NPs working in the mental health and drug and alcohol areas.

### **5.12.3 Current NP roles**

A number of opportunities for development and implementation of NP roles were identified throughout Southern Health AMHS.

It is anticipated that they would operate in a clinical leadership role collaborating across a number of areas to provide holistic and comprehensive care to patients with complex diagnosis.

While the mental health service does not currently have any endorsed NPs, two people have applied for endorsement and are waiting for a response from the NBV. A number of other interested people could be identified by the service as being of a suitable calibre to undertake candidacy. The broader Southern Health service has one number of NPs working successfully in the emergency department at Dandenong Hospital and a supported NP Candidate working in the emergency department at Monash Medical Centre Clayton. An application has been successful to commence role development for two NPs in renal services as part of the Victorian NP Project.

Infrastructure which has been established to support and develop the NP roles at Southern Health includes the development of a strategic framework for NPs, currently in draft form, an assistant director of nursing to lead the development of NP roles across the service and a NP Steering Committee which meets bi-monthly. The Southern Health Strategic Framework for NPs will inform the development and governance of NP roles across Southern Health. It is anticipated that this framework will be completed, ratified by the Steering Committee and circulated in June 2008.

Providing a high level of clinical insight, these roles could include working across a number of areas, for example, acute and mental health, mental health and drug and alcohol, mental health and eating disorders, outpatient and inpatient services, maternal and child services and, paediatrics and mental health.

### **5.12.4 Potential NP roles**

Two key potential NP roles were identified – one in the mental health area and the other in the drug and alcohol area. In addition, several other opportunities were identified where a NP role could enhance care.

#### **South East Alcohol and Drug Service (SEADS)**

This NP model involves the NP working in the alcohol and drug area with SEADS. The NP would provide a high level of clinical consultation collaborating with mental health and other service providers including acute care providers and community based care.

It is envisaged that the NP could contribute to all aspects of care including assessment, treatment (including advice on pharmacotherapy and CBT), withdrawal and liaison with community-based agencies and GPs. Working in this high level position the NP would also contribute to service development.

It is anticipated that the involvement of a NP with expertise in drug and alcohol assessment and treatment and across service focus would promote patient outcomes by:

- ▶ Providing patients involved with multiple service providers with a more efficient and comprehensive approach to health care
- ▶ Improving care to people with dual diagnosis
- ▶ Reducing waiting times and improving access to timely care and support
- ▶ Reducing the burden of dealing with multiple providers
- ▶ Preventing relapse
- ▶ Reducing length of stay and supporting continued community-based care.

It would contribute to the health service by relieving the demands on medical officers, psychiatrists and addiction specialist for routine management of patients (i.e. admission, discharge, prescribing, writing medical certificates, preparing reports, development of treatment plans etc.). In a community-based context where a NP may experience difficulties in prescribing, a theoretical understanding of pharmacotherapy and pharmacology would tribute to the quality of care provided.

The governance structure and generic position descriptions for NPs at Southern Health forms part of the Strategic Framework for NPs.

At present one nurse working in SEADS has initiated NP candidacy. This role is supported by the senior management of SEADS and the Director of Nursing Mental Health and the Executive Director.

### ***Eating disorders NP***

This NP model involves a NP working as a clinical leader within the AMHS Eating Disorders Program.

Patients with eating disorders often have complex needs including mental health issues, accurate health needs and drug and alcohol addiction. An increased number of paediatric patients are presenting with eating disorders. At present the eating disorder program is not fully integrated as a part of the mental health service. It sits across outpatients, inpatients, and mental health and acute. Development of the program is required to address the increased numbers of patients with eating disorders and to ensure that the complex health needs of patients are addressed in a comprehensive and consistent manner.

The role would involve high level involvement as a part of a multidisciplinary team. A key focus of the role would involve collaboration across departments and providers including acute health and, increasingly, paediatrics. While there are a number of mental health nurses working in this area, the introduction of a NP to provide specialist clinical leadership would facilitate the development and expansion of services offered and facilitate collaboration across all areas. While Consultation and Liaison roles exist the role of NP would be different in that the focus is broader and encompasses the delivery of clinical care. This may include:

- ▶ Liaison, consultation and collaboration with other departments and community-based agencies;
- ▶ Stakeholder engagement
- ▶ Service planning

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- ▶ Assessment
- ▶ Treatment
- ▶ Advising and review of care plans
- ▶ Use of high level psychological skills including CBT.

As a part of a multidisciplinary team, this role would be focussed on high level consultation and collaboration and would require minimal involvement in prescribing. However, where prescribing is required, it could generally be done through the hospital pharmacy or where the NP is working in a community-based service the usual mechanisms for prescribing can be used. Working at a high level, the NP would use knowledge of pharmacotherapy and pharmacology to provide advice, review and to develop treatment plans.

This model provides opportunities to improve patient outcomes including:

- ▶ Earlier diagnosis and treatment
- ▶ Improved consistency of care
- ▶ A more comprehensive model of care and earlier identification of co-morbidities
- ▶ Reduced burden in dealing with multiple service providers and health professionals
- ▶ Access to a high level of specialised care accommodating the specialist care for subpopulations (such as young men and children)

The governance structure and generic position descriptions for NPs at Southern Health forms part of the Strategic Framework for NPs.

### **5.12.5 Other opportunities for NP models**

A number of other opportunities were identified for the development of a NP model.

This included use of the role in:

**Prevention and recovery care services (PARC) services** providing support with recovery and rehabilitation. PARC services provide residential support services for people experiencing a mental health problem but who do not require a hospital admission. In the continuum of care, they sit between adult acute psychiatric inpatient units and a client's usual place of residence. PARC aims to assist in averting acute inpatient admissions and facilitate earlier discharge from inpatient units. NPs working in a PARC service would be ideally placed to provide clinical treatment and clinical case management. This would be particularly useful given that the role of a PARC is clinical and socially oriented usually undertaken in partnership with a PDRSS. A NP could undertake a high level role as a clinical consultant while utilising collaborative skills to bring about comprehensive, holistic treatment options for patients. The NP would have a greater opportunity to work collaboratively with a PDRSS than would medical officers and psychiatrists. This could reduce the current burden upon medical practitioners and psychiatrists and reduce the patients interface with a large number of clinical providers.

**Mother and Baby Unit** currently provides six beds located at Monash Medical Centre. The Mother Baby Unit is a six bed and six cot unit for women with a psychiatric illness associated with childbirth. The catchment area for Monash Mother Baby Unit is the South East of Victoria. The NP role would provide high level mental health support and clinical leadership across the range of services supporting patients.

### **5.12.6 Barriers**

Several barriers were identified which need to be addressed. These are outlined as follows:

- ▶ The endorsement process was seen as a deterrent to many potential Candidates because it is a long, complex and unpredictable process.
- ▶ There is a need for the work of NPs to be better supported with the development of treatment guidelines to support treatment planning for people with eating disorders and dual diagnosis.
- ▶ There is a need for clearer nursing structures to support the role of the NP in Drug and Alcohol Services.

### **5.12.7 Enhancers**

From a broad perspective across each of the proposed roles, a number of factors likely to enhance the implementation of the NP role at Southern Health were identified. These included:

- ▶ The willingness of the senior management including the Director of Nursing and Executive Director to provide ongoing support and mentoring to NP Candidates. The development of the Strategic Framework for NPs, will also underpin this.
- ▶ A number of senior medical officers have expressed support for the NP role in mental health. The Mental Health Service will work to garner further support across the organisation with the Director of Nursing (Mental Health) expressing a desire to undertake the leadership role championing the role of mental health NPs throughout the organisation.
- ▶ Preparedness to provide support to approved Candidates to undertake a masters degree. Southern Health has demonstrated the capacity to support the continuing education of its nursing workforce, with a designated Nurse Education Department and the Graduate Mental Health Nursing Program which currently provides a number of opportunities to enable nurses to undertake postgraduate study.
- ▶ Opportunities to develop NP support networks across the broader Southern Health network linking in NPs working in a range of different specialities. Opportunity to liaise with the assistant director of nursing leading the development of NP roles across Southern Health.
- ▶ Access to medical consultants, addiction specialists and psychiatrists employed by Southern Health with a capacity and interest in providing clinical mentoring and supervision.
- ▶ A philosophical approach to the NP role which sees the NP as a clinical leader working a part of a multidisciplinary team contributing a range of skills and expertise across the continuum of care and forging sustainable relationship between service providers. According to this view the NP role is not focussed on prescribing, as there are a number of other professionals with this capacity, but rather on providing expert clinical nursing advice and critical analysis at every stage of care from early intervention to discharge. It should be noted that this would not prohibit a NP from prescribing. One of the NPs in Southern Health is endorsed to prescribe and a process exists for examining prescribing rights.
- ▶ Clinical governance of the role in Mental Health would be provided through the Director of Nursing Mental Health.

- ▶ Evaluation and monitoring of the role was identified as an important element of sustainability and the expansion of the model.

### **5.12.8 Sustainability**

Funding would pose a barrier at this stage with the need for additional DHS funds to support the implementation of the role.

The need for ongoing support to NPs was identified as important in sustaining the role. It was asserted that there needs to be an ongoing commitment to developing NP roles and providing resources to support them once they are implemented.

## 5.13 Northeast Health Wangaratta case study

The central operations of Northeast Health Wangaratta (NHW) are located in the rural city of Wangaratta. NHW services 28 townships beyond the rural city boundary with a catchment population of 90,000 and a geographic area of 42,923 square kilometres. The major hospital has 212 inpatient beds, ranging from the acute care to long term and intermediate care.

This region is covered by an integrated mental health service which operates principally through four services: The Wangaratta Community Mental Health Service, the Kerferd Unit, the Integrated Primary Mental Health Service and the Aged Psychiatry Service.

The Wangaratta Community Mental Health Service provides 24 hour crisis assessment and treatment, mobile intensive support and case management of people suffering from mental illness in the Central Hume sub-region who are aged between 16 and 65 years. Outreach clinics are based at Benalla, Mansfield, Myrtleford, Yarrawonga and Bright.

The Kerferd Unit, a service for adults including the aged and with links to the regional Child and Adolescent Mental Health Service, provides 24 hour inpatient assessment, diagnosis and treatment of acute mental illness. The purpose built unit contains 20 beds, including provision for high level supervision.

The Aged Psychiatry Service provides community based psychiatric assessment and treatment to persons over the age of 65 years. The service also provides support and education to residential facility staff and to other aged care service providers and GPs.

### 5.13.1 NP program status

Northeast Health Wangaratta has been engaged with the NP since the DHS Phase 2 pilot in 2001. NHW has eight NP Candidates, two of which are in mental health. The service supports the role of the NP in multi-practitioner teams.

In June 2007, NHW Division of Psychiatry created two positions for NP Candidates. Both of these positions are located in the community mental health team on the campus of Wangaratta Hospital.

It is the aim of this NP initiative to have staff members who provide a broad scope of psychiatric nursing practice, provide strong clinical leadership and have overall involvement in service development activities such as committee membership and policy development. NHW nursing leadership saw NPs as an important way forward in rural settings and important to clinical governance.

### 5.13.2 Broad issues impacting on the service

One of the key issues impacting on the North East Mental Health Services is the lack of resources resulting from rural location.

Rural NP Candidates have to be particularly resourceful in their roles and build strong professional links with other clinicians both within and external to the service. Because of a limited amount of clinicians in rural settings, NP Candidates are often required to be resourceful in their assessment and management of patients and cannot always rely on more senior or experienced members of the clinical team being available to assist them. Additionally, they have limited clinical staff with whom they can reflect on their work and undertake clinical supervision.

### **5.13.3 Current NP roles**

Broadly the NP Candidate roles have been divided into short-term and long-term management of patients. Short term covers the crisis assessment role within the team while the long term role covers the support and management of long-term patients within the community. This delineation of roles has provided team clinicians with NP Candidates to oversight the overall running of the community psychiatric population managed by the community team.

The community mental health team was seen as a sound area in which to commence the NP Candidates' roles. The necessity for high level clinical decision making and management was ever present within the team and it was believed that such roles could enhance the overall functioning of the team and level of patient care.

From a governance perspective the NP Candidates are line managed by the community team leader, receive educational guidance and support from the education and research team and ultimately answer to the area mental health manager.

- ▶ Supervision is provided by a senior psychologist, which removes the process somewhat from a nursing focus. Clinical mentorship is provided by a senior psychiatrist.
- ▶ A NP working group ran on a monthly basis during 2007 but is yet to meet this year. There is a high degree of uncertainty as to what such a body can contribute to the NP Candidates and what the role of the NP Candidates is to such a group. This has probably been compounded by the fact that the NP Candidates have had difficulty clearly articulating their roles.
- ▶ These two positions have been funded from within the service with the exception of external grants for the pharmacology units. Both Candidates receive full pay while on their designated study days.
- ▶ Both Candidates have regular opportunities to interact with the other NP Candidates at NHW but have had minimal interaction with external mental health NP's.

Implementation attempts have faltered because structures and systems to support the new concept have not been in place. In addition, there is a pervasive belief that Mental Health Nurses are advanced practitioners already and the pathway to NP is seen as legitimising this. The reality is that when the nurses begin their candidature they need to pioneer a new governance framework where they are truly accountable for clinical leadership and decision making.

### **5.13.4 Potential NP roles**

Mental health NPs would be useful in dealing with complex clients, particularly:

- ▶ Mental illness and substance misuse
- ▶ Mental illness and personality disorders
- ▶ Eating disorders, personality disorders and substance abuse
- ▶ Young adults
- ▶ Physical co-morbidity, in particular metabolic syndrome, diabetes and its consequences with persons who are unable to follow treatment and diet regimes
- ▶ Physical screening, including ordering and interpreting blood tests and providing health care based on results.

### **5.13.5 Barriers**

To date the NP model has been shaped to favour the clinical over the psycho-social approach. Amalgamation of mental health with general hospitals resulted in preference for the clinical over the psycho-social model of care. The Mental Health Act 1986 has a key principle of promoting self reliance, but, in reality, the clinical model focuses on review of medication. This is a barrier for mental health nurses

Identifying suitable Candidates with the professional skills for this team leadership role. NPs are involved in policy, education, mentoring, research and writing (present practice in journals) roles. In addition, the NP in mental health needs to be a leader of the team that manages complex clients. Some of this lack of confidence is a result of secondary stigma from working with persons with mental illness.

In general nursing, the opportunity to be specialists are considerable (oncology nurse, breast care nurse, palliative care, diabetic nurse educator, etc.). Psychiatric nursing has not emphasised the opportunities for specialties within the specialty of mental health and this has had an effect on nurses looking at NP roles and expansion of what they are currently doing.

The case management driven service has influenced staff perceptions of role and skills. Case management (particularly in rural areas) has had the effect of usurping any leadership or creativity as nursing staff grapple with high workloads and emphasis on the medical model.

Autonomous community positions mean that this group of nurses is not in a position to be clinical leaders. They lack role models that demonstrate how to influence their field or gain a professional profile. A lot of community staff work autonomously, so perceive themselves as doing what NPs do anyway.

There is some confusion in nursing around prescribing roles. Triage is an example of a situation where skills are certainly at the advanced practice level and could be taken further with a NP leading this and writing protocols for responding to psychiatric crisis.

The demand for mental health services has increased substantially, clients complexity has increased, workloads have increased and managers struggle to release people to attend staff development when they have competing demands to cover the workload. For mental health nursing students, the push has not been on continuing on their education, from undergraduate to postgraduate qualifications.

NP positions are not described in EBAs. NP Candidates have to prepare themselves and define the role.

Negative attitudes of some academic staff in university nursing programs towards mental health nursing contributes to the stigmatising of mental health work and to mental health nurses believing they are not suitable for NP roles. In a very short time (5 years) the requirement for nursing undergraduate programs to have a member of staff who was a mental health specialist was lost and most subjects were taught with an absence of mental health.

Universities have raised the expectation that they can provide the complete package to prepare a NP. Some graduates are frustrated with this and alienated by the academic model. Perhaps, in future, nursing programs at particular universities might specialise in fields, for example mental health.

The attitudes of colleagues can be negative. Many consider study leave and reading time to be a perk and become resentful or aggrieved.

NPs in mental health have had some difficulty in differentiating their new roles from the previous roles they have been required to perform within the community mental health team. Part of this problem has arisen from the fact that mental health services have only recently been mainstreamed with general health and thus the mental health NP Candidates don't come from a broader health background. This may be impacting on their overall understanding of clinical governance across the health continuum and their responsibilities to the Nurse Board of Victoria and the executive of NHW.

The scope of practice has been an area the NP Candidates have struggled with -- differentiating what they had previously done, what they need to change and do differently in the future. An added difficulty has been that the team members have had a professional relationship with the NP Candidates for many years and therefore struggle to see them in a different light performing a different role.

### **5.13.6 Enhancers**

There is not the abundance of high standard potential NP Candidates, especially in rural communities. There need to be efforts made to cultivate those with potential, whether they are new practitioners to the field or well experienced practitioners. Candidates could be encouraged to take on a masters degree by allowing extended study time for Candidates and supporting Candidates.

Providing opportunities for mental health nurses to develop the professional and leadership skills required to undertake NP roles. These opportunities are limited due to the medical model and emphasis on short term admissions and case management services.

A cohort approach would be beneficial: NPs from a number of hospitals banding together to form a support group.

Changes to the Mental Health Act are needed, so that NPs as well as "mental health practitioners" can certify patients, write and review Community Treatment Orders (CTOs) (currently patients are assessed by the nurse, but certified by the mental health practitioner who often has less training in mental health.) The Act should be changed to allow NPs to revoke or take someone off a CTO when they no longer require it. Also, it is disempowering for nurses when they (and allied health staff) are responsible for 95% of a patients care, while doctors are responsible for signing off on their work and decision making. The after hours crisis response is undertaken by nurses but the Mental Health Act gives the decision making power to medical staff. If NPs could utilise the Mental Health Act in a productive capacity without seeking out a psychiatrist this would add value to the role of the NP and nurses may see how the NP position could produce outcomes for themselves and the clients.

### **5.13.7 Sustainability**

The following points were identified as important in ensuring the sustainability of NP positions.

1. The role of the NP in the organisation must be conceptualised/ differentiated. Clarity is needed around whether an NP is needed or whether upskilling will meet the service gaps.

2. Those working with the NP must understand the role and responsibilities of the NP, and their relationship with him/her. Candidates need to continually work on this and, therefore, must be crystal clear about what they do and why.
3. Case management systems need to allow for expanded roles (e.g. beyond medical models).
4. There needs to be others in the system who will be the champion for the NPs.
5. NPs themselves need to influence others about their new role and responsibilities. The team needs to see them as different to what they were before.
6. Access to tertiary education support for nurses in rural areas:
  - ▶ Financial issues. Undertaking a masters can cost up to \$20,000. Potential Candidates are often under financial pressure, for example, they often have children at school or university in major centres.
  - ▶ Nurse Policy Branch and Royal College of Nursing scholarships have been invaluable. However, with the latter, limitations on availability to Division 3 nurses and sometimes inconsistent boundary rules have disadvantages some potential applicants.
  - ▶ Time pressures. Potential Candidates are often time poor, with demanding work schedules and family responsibilities.
7. An advocate within the employer organisation and assistance in navigating information sources (regarding scholarship, study leave provisions, publication or conference opportunities) are both useful. Access to supportive librarians to assist with research and literature reviews.

### **5.13.8 Other issues**

There appears to be confusion in the NBV about how NPs are to be classified. The title needs to be kept generic, because attempts to over-specify lead to too narrow a scope of practice. The generic title is about where the formular sits. There is room to move within the NBV classification.

## 5.14 NorthWestern Mental Health case study

NorthWestern Mental Health (NWMH) is the mental health arm of Melbourne Health. Its mission is to ensure the delivery of comprehensive and integrated mental health services to residents of the northern and western regions of metropolitan Melbourne by building on the State and Commonwealth reform objectives. It is one of the largest publicly funded providers of mental health services in Australia and operates in partnership with Northern Health (Northern Hospital, Broadmeadows Health Service, Bundoora Extended Care and Craigieburn Health Service) and Western Health (Sunshine and Western Hospitals).

NWMH provides comprehensive hospital-based, community and specialist services to youth, adults and aged people who live with a serious mental illness. These services can be split into three streams:

- ▶ Youth: 15 to 24 years
- ▶ Adult: 18 to 65 years
- ▶ Aged: 65 years and over

The overlap of the age groups between youth and adult services promotes a continuum of care that best suits the person's needs, e.g. age at which first episode psychosis occurs. NWMH also provides a variety of regional and state-wide speciality services across a range of mental health programs.

### 5.14.1 Broad issues impacting on the service

The priority issues for NWMH as a public mental health service include:

Service capability and growth – NWMH has a catchment area that has the greatest population growth within the state with suburb corridors such as Melton and Craigieburn. The challenge is to match service development through integrated primary care initiatives such as Superclinics.

Access – NWMH has 120 acute beds which are almost at 100% occupancy. However, a coordinated bed management program has reduced waiting times especially in emergency departments.

Financial management – NWMH is charged with providing an efficient service within the constraints of a limited budget and accordingly controlled expenditure.

Clinical workforce – Recruitment and retention of a skilled workforce is a complex challenge especially when our clinical nursing workforce is ageing at an average of 42 years old.

### 5.14.2 NP program status

NWMH has been involved with the NP program since the second round of demonstrations in 2004.

### 5.14.3 Current NP roles

NWMH is in the final stages of implementing their first NP role, NP CATT (Crisis Assessment and Treatment Team), at Northern Hospital. It is envisaged that this role will be replicated elsewhere across the service, and that other NP roles will be piloted.

## NP CATT

The information about the NP CATT project provided here was based in information from both interviews and from the 2005 project report to the Department<sup>65</sup>.

The NP Demonstration Project was implemented at the Northern Crisis Assessment and Treatment Team at NWMH, with funding provided by DHS, based on a joint application from NWMH and the Centre for Psychiatric Nursing Research and Practice, University of Melbourne<sup>66</sup>. The demonstration funding was for a 12-month period. The establishment phase of the project, funded by NWMH, included the development of the evaluation framework which involved a benchmarking study comparing the decision making of the NP Candidate with that of a registrar, based on patient outcomes and patient and co-worker satisfaction ratings. The development program for the NP Candidate ran concurrently with this.

This NP position was considered to be a seed project and a pilot of the guidelines and job description of the NP. The CATT clinicians have a senior role, hence they are already specialist clinicians. The clinical practice guidelines for the NP CATT were developed around this role. The Candidate is in the final stages of preparation.

- ▶ The aim of the new position was to ensure prompt, appropriate and seamless service delivery to the clients of the services. The major advantage was considered to be provision of more timely and responsive service and the potential benefits were most likely to be realised outside normal business hours<sup>67</sup>.

The CATT made up was traditionally consultant psychiatrist, psychiatric registrar, nurses and allied health professionals, with nursing and other staff having extensive clinical experience and employed at a senior level. The NP role differs from that of senior psychiatric nurse in that the NP Candidate was expected to have greater understanding, depth and knowledge and skills in psychiatric nursing, and expanded into areas not previously thought to be within the confines of psychiatric nursing. By providing a responsive and high quality clinical interventions service, the NP role complements rather than replaces the medical practitioners' role while avoiding duplication of effort.

The Northern CATT NP project focused on four of five identified extensions to practice:

- ▶ Limited prescription of psychotropic medication
- ▶ Ordering of diagnostic testing
- ▶ Referral to specialists
- ▶ Authorisation of absence from work certificates.

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<sup>65</sup> Wortons, J., Johnstone, H. and Happell, B, *Northern CATT NP Demonstration Project*, report to Department of Human Services, Centre for Psychiatric Nursing Research and Practice, Carlton, 2005.

<sup>66</sup> *ibid*, p.7

<sup>67</sup> *ibid*, p.23

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- ▶ The fifth extension to practice related to admitting and discharging privileges was not addressed in the project<sup>68</sup>.

The project implementation process included the following:

- ▶ Close monitoring and direction by the executive committee
- ▶ Collaboration with key stakeholders via a number of approaches, including:
  - The Project Advisory Committee, comprised of representatives of key stakeholder groups
  - Consultations with individual stakeholders to guide the implementation of policies and procedures
  - Membership of the Peninsula NP Project Team facilitated information exchange and mutual learning
  - Membership of the state-wide NP Network facilitated the development and monitoring of progress
  - Provision of education regarding the project to key stakeholders as required.
- ▶ Provision of clinical supervision for the NP Candidate by the consultant psychiatrist to ensure safe and competent practice.
- ▶ Changes required for the project to proceed included the following: development of internal policies and procedures to enable medication prescription initiation as per the Limited Medication Formulary within current legislative guidelines developed for the project; development of policies and procedures to enable the initiation of diagnostic/ pathology testing; and countersigning of referrals to specialists and authorisations of absence from work certificates by the consultant psychiatrist<sup>69</sup>.
- ▶ The project evaluation concluded that, on average, consumers and carers were very satisfied with the care and treatment they received from Northern CATT, whether assessed by the NPC or receiving the usual treatment. There was an overall improvement in participants' mental health and social functioning (HoNOS Total Score) between referral and discharge. The average duration of Northern CATT treatment for participants treated by the NP Candidate was not significantly different<sup>70</sup>.
- ▶ The project demonstrated a number of cost savings. These resulted from the following: a decrease in the time needed to facilitate medical officer reviews by CATT clinicians (decrease in hours transporting clients to and from home to Northern Hospital); increased productivity (decreased need for ancillary service); and savings to the client and the community through more time-effective services and duration of treatment<sup>71</sup>.

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<sup>68</sup> *ibid*, pp. 12-13

<sup>69</sup> *ibid*. p.14

<sup>70</sup> *ibid*. p.22

<sup>71</sup> *ibid*. p.34-35

### 5.14.4 Potential NP roles

NWMH is committed to the development of the NP role, seeing it as a key role and the pinnacle of a nursing career. In the long term, NWMH sees the need for 20 to 30 NPs operating in the workforce of about 700. NWMH intends to have a rolling NP development project, which moves around services. As one NP position becomes established, another will be initiated. When the NP CATT position is fully established in July 2008, another NP role will become the focus of the program.

A number of NP positions have been identified as possibilities, although, at this stage, no formal moves have been made towards establishing them. Four of these potential roles are outlined here.

**NP Consultation Liaison role:** This NP would be a specialist in behaviour disturbances. Their role would be to see all patients with behavioural disturbances, conduct assessments, and oversee care co-ordination. They would also be responsible for the education and training of nurses in this specialisation, and would contribute to policy development in relevant areas (for example, the use of mechanical restraints).

**NP E-CATT position:** This NP would be located in the Emergency Department (ED) and fulfill enhanced CATT roles; basically acting as the CATT member in the ED.

**NP Drugs and alcohol:** This NP would be a specialist in drugs and alcohol (D&A), located in the General Hospital. Although many hospitals have a D&A Liaison Nurse, the NP would have the authority to prescribe a broader range of medications, and to order and possibly conduct tests.

**NP Metabolic Monitoring Clinic:** This is an emerging NP role. NWMH is currently setting up a Metabolic Monitoring Clinic. The NP would provide care related to the physical health of mental health patients, particularly the side-effects of antipsychotic drugs. The NP would be able to conduct weight checks, tests and screenings, usually conducted or approved by a doctor. NWMH is considering advertising for expressions of interest from any qualified NPs later in 2008.

### 5.14.5 Barriers

A number of potential barriers to the implementation of NP roles were identified. Budget pressures are a major concern at NWMH. Funding support of new and seed programs is difficult to identify. Discord from the Candidate's colleagues can be a barrier to success. Failure by the organisation to anticipate and prepare for role and responsibility changes was a potential barrier. Creating the footprint in which the NP will work is the next stage. This will include discussions with doctors and other associates. Other advanced roles can become competitors to NPs, impeding their implementation. One example of this is the advanced role of physician assistant.

The Demonstration Project Report<sup>72</sup> identified the following barriers:

- ▶ The attitude of key stakeholders, particularly the sensitivities of medical staff.
- ▶ The NP Candidate's knowledge of medical care and treatment, for example psychopharmacology and diagnostic testing.

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<sup>72</sup> *ibid.* pp.24-25

- ▶ The need for the NPC to seek authorisation from the consultant psychiatrist necessitated them working within conventional office hours.
- ▶ The ‘newness’ of the NP role posed a challenge<sup>73</sup>. With time and increased understanding of the role, discomfort with it would diminish.

### **5.14.6 Enhancers**

A number of factors which enhance the implementation of the NP role were identified. Good leadership from management and from the director of clinical services was considered crucial, because NP implementation program requires internal champions. It was also considered important to co-opt members of relevant areas of the service, for example Pharmacy, to the NP program steering group. The Candidate must be well supported. It is important that they are not isolated, or they can believe that they are on their own. Candidates require support with their academic work and clinical supervision must be of a high standard. Candidates usually need financial support to be able to undertake the required education components. In addition, the calibre of the Candidates is important. They must be capable and persistent – it takes resilience to succeed. If the Candidate leaves, the program falters.

State-wide NP policy needs to impact on clinical roles. DHS Nurse Policy Branch was described as “heading in the right direction” to resolve these blockages. Although progress was evident, there are not enough NP projects across the State to create the critical mass required to ensure full support for individual programs.

- ▶ A number of enhancers were identified in the Demonstration Report<sup>74</sup>. These included support from the relevant service; the executive committee in particular, was seen as crucial. The impact of legislative and policy barriers was minimised by the CATT environment where medications were available on impress, hence not requiring the NPC to have a provider number. Support of other relevant departments, pharmacology and pathology, were important.

### **5.14.7 Sustainability**

A number of factors on which the sustainability of the NP CATT role depended were identified<sup>75</sup>. These included the following:

- ▶ The management of the Northern Area Mental Health Service continuing to support the implementation of the NP role.
- ▶ The NP Candidate continuing to pursue relevant studies in preparation for endorsement by the NBV.

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<sup>73</sup> *ibid.* p.26

<sup>74</sup> *ibid.* pp.26

<sup>75</sup> *ibid.* p.6

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- ▶ For the role to achieve its maximum benefits, the NP would require access to federal funding via the Medicare Rebate Scheme and a provider number from the Health Insurance Council.
- ▶ An impediment to sustainability is the opposition to NP role voiced by key organisations, including the Australian Medical Association and the Australian College of Psychiatrists.

## 5.15 St Vincent's Mental Health case study

St Vincent's Mental Health provides clinical services to adults 16 to 65 years of age through a range of programs including the 44-bed Acute Inpatient Service, two community mental health services (Clarendon and Hawthorn), a 20-bed community care unit and extended residential rehabilitation service, as well as specialist services provided on a regional or state-wide basis.

The adult acute inpatient unit includes an extra care unit for people with more intensive care need. Treatment is planned and provided by a team that includes psychiatrists, psychiatry registrars/ medical officers, psychiatric nurses, social workers, psychologists, pharmacists and occupational therapists, as well as case managers from the community clinics. Five mental health inpatient beds at St Vincent's Mental Health are available for Koori patients from across Victoria. Psychiatric Triage provides advice and screening assessment for all new referrals to the service on a 24 hour, seven day per week basis.

The Community Mental Health Services (Clarendon and Hawthorn) provide integrated, multidisciplinary care that connects the Continuing Care, Clinical & Consultancy Service, the Crisis Assessment and Treatment Service (CATS), the Mobile Support and Treatment Service (MSTS), and the Homeless Service. Coordinated care is provided through collaborative partnerships of community mental health staff and private psychiatrists and General Practitioners. The Footbridge Community Care Unit provides 24-hour nursing and allied health support to 20 residents in a homelike setting.

Specialist services include education and support for primary health care providers treating people with high prevalence disorders such as depression and anxiety, or young people at risk of developing serious mental illness. The Consultation and Liaison Psychiatry Service assists with psychiatric assessment and management of general medical and surgical patients at St Vincent's Hospital. The state-wide Victorian Transcultural Psychiatry Unit (VTPU) works to improve mental health services for people from culturally and linguistically diverse backgrounds. Northern Nexus (Northern Dual Diagnosis Service) provides assessment, staff education and tertiary consultation to staff of mental health services and drug and alcohol services about consumers with both mental illness and drug and alcohol problems.

### 5.15.1 Victorian Dual Disability Service

Victorian Dual Disability Service (VDDS) is a joint initiative of the mental health programs of St Vincent's and Melbourne Health. VDDS is publicly funded through the Mental Health Branch of the Department of Human Services. Established in 1999, the aim of the VDDS is to position the service system to better respond to existing and future demand for care by building on the strengths of the current system, developing an appropriate mix and level of service and implementing new and innovative approaches to Victorians with a dual disability.

The VDDS is a specialist service for Victorians over the age of 16 who have an intellectual disability and a psychiatric illness (dual disability). VDDS works with the State's 21 Specialist Mental Health Services, providing assessment, staff education and tertiary consultation to Victorian Area Mental Health Services for those individuals with intellectual disability and mental illness. The service provides phone consultation and advice about the Victorian disability and mental health service systems to carers, families and workers from government and other

agencies. Clinical help is only provided in conjunction with the staff of public mental health services.

The VDDS is moving into the third year of a three-year pilot program – Enhanced Regional Service Response (ERSR). The purpose of this project is to further fund and develop an effective service response for those people in the North and West Metropolitan Region (NWMR) who meet the ERSR criteria. This is to be achieved by improving the pathways of access to state funded mental health and disability services for people with dual disability and by building the capacity of disability services client service teams, behaviour intervention support team practitioners, mental health clinicians and rehabilitation support workers to more effectively identify, screen and manage the mental health needs of people with an intellectual disability who have a diagnosed or suspected mental illness. A NP could facilitate the ERSR delivering time limited treatment and management which is within the scope of the ERSR.

### **5.15.2 NP program status**

St Vincent's Mental Health, as an organisation, has not rushed to implement NP roles, primarily because staff retention has not been a pressing issue.

Although St Vincent's Mental Health has been interested in the potential for implementation of NP roles for six years, no NP positions have been implemented. The service does not want to be left behind other services in taking up workforce development initiatives. However, in relation to the implementation of NP roles, it is keen to build on the success of other initiatives. The management team believes that it is important to manage expectations in terms of what roles and responsibilities the NP would fill. The organisation is now keen to follow-up on successful pilots elsewhere.

The VDDS has a potential Candidate for a Mental Health Dual Disability NP position who is a credentialed nurse with the necessary academic qualifications.

### **5.15.3 Broad issues impacting on the service**

Workforce issues are a high priority at St Vincent's Mental Health, with workforce development featuring as one of St Vincent's Mental Health's three strategies.

Although, generally, retention of quality nurses has not been a major issue, it is believed that younger recruits who achieve the highest level currently possible by the time they are in their late twenties will need additional incentives for them to remain at St Vincent's and flourish as professionals. These young, high-achieving nurses, in particular, have "an enthusiasm for autonomy" that the NP role can satisfy.

Establishing career paths for nurses is a key issue for the future. As a service, St Vincent's has a number of nurses at RPN Level 4. For example, most members of the CATT team are in this category. Many of these nurses are relatively young and need career goals to aspire to, and the service needs ways to recognise and utilise their clinical expertise. The service wants to ensure that a clinical career pathway is available to these nurses, and that a management pathway is not their only career development option.

Effective care of dual disability is important across a continuum of service delivery and between multiple teams. Dual disability patients need focused and expert clinical interventions, and without these they can block acute, rehabilitation and secure patient beds. The complexity of

presentation can be daunting to many clinicians, posing an obstacle to effective assessment and decisive intervention, which can reduce patient flow through.

Finally, the Victorian Dual Disability Service is now moving into the third year of the pilot of the Enhanced Regional Service Response pilot. If a decision is made to roll the service out state-wide, workforce issues will need to be considered as a priority. Dual disability is an area to which it has been difficult to recruit. This is an area in which team members need a high degree of competence in order to function. However, the current structure does recognise the senior clinician role, but provides no development pathway once the clinicians are recruited. Feedback from exit interviews indicates that lack of career opportunities within the Service has contributed to a problem with retaining staff.

### **5.15.4 Current NP roles**

To date, no NP positions have been implemented at St Vincent's Mental Health. However, the position Mental Health NP in Dual Disability is in the early stages of development. The need for the program has been identified and the extensions to scope of practice drafted. This development has taken place under the guidance of the NP Working Group at St Vincent's Health, established 12 months ago under the Chief Nursing Officer. The Working Group's role has been to ensure that, prior to the implementation of the NP position, all issues that may arise are addressed in advance. To this end, it has explored all the clinical and governance background issues associated with the implementation of the NP position.

### **5.15.5 Potential NP roles**

#### ***Mental Health NP Dual Disability Services***

The focus of the proposed Mental Health NP Dual Disability position is on adding value to the existing continuum of care. The draft proposed extension to the scope of practice associated with this new role covers five key areas: clinical practice; education; research; leadership and counselling.

In terms of clinical practice, the key extensions relate to both reviewing of and making recommendations to adjust psychiatric medication (within a specified limited formulary) in collaboration with the medical practitioner; the monitoring, evaluation and review of psychotropic medication; and initiating diagnostic tests from a specified limited menu. These areas are considered key because they are the most concrete extensions of scope.

Other clinical extensions relate to the following: longitudinal assessment and diagnosis of Pervasive Developmental Disorder; providing behavioural assessment, intervention and support based on Applied Behaviour Analysis and Positive Behaviour Support. Other roles could include assessment, co-ordination and management of integrated service responses between Mental Health Services, Disability Services, NGOs and the private sector.

Extensions to the educational role cover provision of education and training to mental health clinicians and education to individuals with dual disabilities and their families and carers. Research extensions could focus assessment and treatment of mental disorders in intellectual disability and ensuring practice is evidence based. Leadership involves, in partnership with the treating team and the clinical director of the service, establishing links with relevant external bodies, participating in workplace and professional organisations, promoting collaboration with specialist services, and advocating on behalf of people with dual disability. The counselling role

providing advice and support to patients, families, carers and other professionals and clinical supervision for mental health clinicians and direct carers.

The Mental Health NP would assist in maintaining the momentum of treatment of complex dual disability patients. St Vincent's Mental Health employs the Strength Model of Case Management (Rapp & Goscha 2006), '*assisting clients to establish and pursue life goals, utilising their strengths and resources in their day-to-day lives*'. The NP has an important role to play with communication issues that allow the model its best chance of success.

### **5.15.6 Barriers**

There is no Dual Disability NP model elsewhere in Australia, in what is a complex and state-wide service. Implementation of the Mental Health NP Dual Disability role is, to a large degree, conceptualised as establishing a precedent. Although there are some international precedents in New Zealand, Canada and in the United States, there are no local Dual Disability NP models to follow. At St Vincent's, the NP Dual Diagnosis role will provide complementary clinical services that contribute to best practice and take service quality to the next level. In addition, this role will bridge across areas of health care, for example, by providing primary care while treating anxiety. In addition, it would cross professional silos and avoid professional blind spots. Hence this role would form an extension of practice; for example they might focus on getting patients off medication and on to other forms of treatment, rather than prescribing.

The scenarios around the implementation of the new NP role need to be worked out carefully, trialled and evaluated. Highly specialised services are very committed to their territory and potential role conflict or confusion is best avoided by anticipating and preparing for situations where this might occur.

The calibre of individual Candidates is important. NP Candidates need to have commitment, determination and perseverance. This is particularly true of those who establish new positions, because they are the trail-blazers.

### **5.15.7 Enhancers**

NP Candidates need financial support so they can complete their post graduate studies. Some form of cadetship program, with bonding to the service following completion of study, may be effective.

NP Candidates need study leave support and flexibility and negotiability of rostering to complete academic requirements.

St Vincent's has recently implemented a professional development record system that enables staff to track their professional development activities, also a requirement for credentialed nurses. Some support for the development of an online system for this facility would be very useful.

Development of peer support networks for Candidates.

Strong support from the management team is important. The management team needs to articulate where it wants to position St Vincent's in terms of implementation of these new roles.

Information about other pilots is extremely useful. Individuals involved can use their personal networks, for example, through the Centre for Psychiatric Nursing at University of Melbourne, to access information about state-wide, interstate and international initiatives.

DHS could help de-mystify NP roles, by providing clear, highly-accessible information about what they look like and the support structures they require to be successful. This information could be provided in a page on the Nurse Policy Branch website.

### **5.15.8 Sustainability**

NP positions will not be sustainable if they need to be funded from existing budgets. Converting existing positions to NP positions is far more difficult than creating new positions. This was one of the barriers to implementation of the initial NP program.

Management support is essential. NP roles need to be integrated into the organisation's workforce development strategy.

The preparatory groundwork, to prepare management and work teams to accept the new role, is extremely important in ensuring the acceptance and sustainability of NP roles.

## **6. Nurse Practitioner roles identified**

Participants in the stakeholder interviews and case study consultations were asked to identify specific sustainable NP roles which would address service gaps at their service and which could be implemented in the next one to three years. The following is a list of all NP roles mentioned within the scope of the current project.<sup>76</sup>

Many participants suggested service settings where a NP role could be introduced, without clearly outlining a specific role for the NP. In some of the case studies, suggestions tended to reflect the level of planning already undertaken for NP implementation at the service. Those who were more advanced along the journey were able to be more specific about how the role would work.

All participants in the case studies were interested and keen to develop NP roles and had identified gaps in their service which could be addressed by NPs. While only a few were at the stage of identifying specific responsibilities, the provision of clinical leadership within these roles and service areas was a common theme.

The list has been provided to act as an overview of the diverse range of roles and service areas identified by participants in the case studies and consultations undertaken as a part of this project.

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<sup>76</sup> A number of possible NP roles were mentioned which fell outside of the scope for the current project. These included roles within general practices such as providing mental health assessment and counseling, as well as supporting international medical graduates in small rural practices.

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This is by no means an exhaustive list of all potential NP roles. It has been divided under the three headings to reflect the main areas with the health service system where roles were identified.

These are the:

1. Mental health service system
2. Drug and alcohol service system; and
3. Intersecting areas - for example, where mental health and/or drug services intersect with acute health and private or non-government services.

### ***NP Roles located within Drug and Alcohol service settings were:***

- ▶ Indigenous mental health NP
- ▶ Mental health in-patient's assessment team NP
- ▶ Early intervention team mental health NP
- ▶ Crisis assessment team NP (ED and community models)
- ▶ Prevention and recovery care (PARC) services NP
- ▶ In-patient mental health eating disorders NP
- ▶ In-patient mental health depression NP
- ▶ Child and adolescent mental health NP
- ▶ Clinical support and liaison NP - for international medical graduates in rural hospitals
- ▶ Forensic mental health NP to consult in prisons
- ▶ Forensic mental health NP to consult in prisons
- ▶ Mental health outpatients NP
- ▶ Acute response team NP
- ▶ Mother and baby unit mental health NP (supporting post-natal mental health care including PND)
- ▶ Psychiatry Triage NP (including Clozapine co-ordination and monitoring, CTO monitoring, ECT )
- ▶ Aged psychiatry NP (including psycho geriatric health care)
- ▶ Metabolic Monitoring Clinic NP
- ▶ Conduct disorders NP in mental health services.

### ***NP Roles located within Drug and Alcohol service settings were:***

- ▶ Drug and alcohol withdrawal NP
- ▶ Drug and alcohol rehabilitation NP
- ▶ Clozapine clinics (including treating and monitoring clients)
- ▶ Pharmacotherapy NP
- ▶ Forensic drug and alcohol NP (in treatment, withdrawal and rehabilitation)

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NP roles in intersecting service areas - for example, where mental health and/or drug services intersect with each other, with acute health and/or with private or non-government services were:

- ▶ Mental health ED triage NP
- ▶ Primary health services NP
- ▶ Symptomatic medications NP (focusing on prescribing for people with mental illness including those with co morbidities i.e. STDs, diabetes, infections, etc.)
- ▶ Infectious Disease Management NP
- ▶ Dual diagnosis NP (i.e. co-occurring mental health and drug and alcohol issues)
- ▶ Dual diagnosis perinatal care NP
- ▶ Drug and mental health community outreach NP
- ▶ Mother and Baby Unit, drug and alcohol NP
- ▶ Mother and Baby Unit dual diagnosis NP
- ▶ Dual disability NP (i.e. intellectual disability and mental health care)

In addition to these roles there were strong calls for roles which fell outside of the public health system and, therefore, outside of the scope of this project. Most prominent among these were calls for the increased use of NPs within GP clinics and located within residential aged care homes.

## 7. Conclusions and recommendations

The conclusions and recommendations have been developed to address the three key research questions identified in the project brief.

**Research Question 1: In which service settings would the implementation of a NP model of care be immediately (one to three years) most effective in MHD services?**

The research indicated that nurse practitioner models are emerging in a wide range of service settings and involve a variety of roles and responsibilities.

### **Within the next year**

A number of services examined as a component of this project had Candidates<sup>77</sup> nearing the end of the NP endorsement process and likely to implement mental health or drug and alcohol NP roles within the next year. These were:

- ▶ North East Health – Wangaratta (two mental health Candidates)
- ▶ North Western Mental Health (one Candidate)
- ▶ Southern Health (two Candidates)
- ▶ Moreland Hall (one Candidate).

### **Priority NP roles for the next one to three years**

All of the services examined as case studies in this project revealed they were in a position to implement NP roles in the next one to three years. Most were able to identify a suitable Candidate. However, where a suitable Candidate could not be identified with the service most recognised, it was noted that it would be necessary to recruit potential Candidates.

Those services most suited to implement a NP model in the next one to three years (Box 1) were hospital-based or residential drug and alcohol services. The capacity of the service to provide a network of support and a team environment was also important in the establishment and sustainability of new NP positions.

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<sup>77</sup> In Victoria an NP Candidate is a Registered Nurse registered under Division 1, 3 or 4 engaged to undertake a course of study and undertake clinical experience leading to endorsement as a Nurse Practitioner. A Registered Nurse engaged as a Nurse Practitioner Candidate (as defined) shall be classified and paid their substantive salary (Australian Industrial Relations Commission, 2006)

The capacity of NP roles to be sustainable in community-based, outreach and home-based services, where there was a requirement for the NP to prescribe, was limited unless other arrangements were in place for patients to receive medications at a subsidised cost.

**Box 1: NP roles for implementation within the next one to three years**

- ▶ Mental health emergency departments triage NP
- ▶ Drug and alcohol withdrawal unit NP
- ▶ Mental health crisis assessment team NP
- ▶ Early intervention team NP
- ▶ Prevention and Recovery Care (PARC) service NP
- ▶ Mental health service units - including eating disorder clinic NP and mother-baby unit NP

Service settings where a NP model was most likely to be sustainable were identified. These encompassed three broad areas within the public health system:

1. Mental health service system
2. Drug and alcohol service system; and
3. Intersecting areas - for example, where mental health and/or drug services intersect with acute health and private or non-government services.

See the Appendices F and G for diagrams of the Victorian Mental Health system and Drug and Alcohol Services.

The key considerations in selecting these NP roles for implementation in the next one to three years were:

- ▶ The ease of developing arrangements for prescribing under PBS or for developing arrangements whereby patients' medications are subsidised (as in a number of drug services);
- ▶ The opportunity to undertake a clinical leadership role;
- ▶ Availability of clinical support in the form of a clear medical or nursing hierarchy; and
- ▶ The availability of the day-to-day collegial support and a team environment.

Suggested roles NP under each of these areas are identified below:

**Mental health service system**

In the mental health service system the four priority NP roles selected, fell into the clinical area and included roles in Adult Services and State-wide Specialist Services. The suggested roles were as follows:

- ▶ Mental health crisis assessment team NP (Adult Services)
- ▶ Early intervention team NP (Adult Services)
- ▶ Prevention and Recovery Care service NP (Adult Services)

- ▶ Mental health service units including eating disorder clinics, mother-baby units, etc.) (State-wide Specialist Services)

### Drug and Alcohol Services

Under the drug and alcohol service system the service identified as a priority area for implementation of a NP role fell into the area of residential withdrawal (see the appendix for a diagram of the publicly-funded drug and alcohol service system). It is worth noting that depending on the nature of the service provider, this role could also involve intersection between drug and alcohol services and private and/or NGOs.

- ▶ Drug and alcohol withdrawal unit NP (Residential withdrawal)

### Intersecting services

In the priority NP roles identified as a result of the research, one role intersected both acute health and mental health.

- ▶ Mental health emergency departments triage NP (acute care and mental health)

In the medium term, a number of other opportunities exist for the implementation of NP roles in different service settings. It was clear from the research that NPs would have the capacity to improve patient outcomes and address a number of service gaps in the provision of community-based, in-home and out-reach services providing clinical health care and psycho-social support. However, some development of infrastructure to support the role is required to ensure that the NP roles are sustainable.

**RECOMMENDATION 1:** Health services identified through the case studies were all in a position to implement a NP role in the next one to three years. Service models – where suitable arrangements for supply of medications under Medicare can be supported and where there is a network of support available from a team of professionals and from organisational management – should be supported by DHS to immediately implement NP roles.

### Research Question 2: What roles and responsibilities could an NP have in such settings?

Research identified a wide range of roles and responsibilities which could be performed by NPs. The provision of clinical leadership within these service areas was a common theme. Commonly suggested roles included:

- ▶ dual diagnosis and dual disability roles bridging service types to provide patients with holistic and comprehensive care;
- ▶ pharmacotherapy roles developing and implementing treatment plans for people with drug and alcohol addictions;
- ▶ leading Clozapine clinics to monitor and support people receiving this medication;
- ▶ mental health triage roles in emergency departments;
- ▶ mental health support and behavioural therapy roles to patients with a variety of conditions including depression, postnatal depression, eating disorders and conduct disorders;

- ▶ Community-based care generally auspiced by a hospital.

Roles differed in a variety of ways, including:

- ▶ the level of autonomy and clinical judgments required;
- ▶ arrangements for supplying medicines under Medicare and arrangements for patients to access subsidised medications;
- ▶ the level of support provided by the health service;
- ▶ arrangements for clinical governance, supervision and mentoring;
- ▶ the location of the role within the continuum of care;
- ▶ disease focus.

Examination of barriers and enhancers to the role of NP revealed the importance of clearly defining the role to promote a shared understanding about the nature of the work which can be performed by NPs and to garner the support of other stakeholders.

The highly context-specific nature of the role and the lack of transferability across services were seen as barriers to the broad acceptance of NPs as a sustainable workforce solution. The specialised nature of the role was also attributed with alienating support from medical practitioners associations, undermining the credibility of the role, limiting its transferability and raising providers' concerns about investing in a role which is so specific to an individual.

A set of core competencies which should underpin the role of NP were identified in the case studies and interviews. These included:

- ▶ Clinical practice
- ▶ Leadership
- ▶ Prescribing
- ▶ Counselling
- ▶ Liaison
- ▶ Expert clinical advisor (in service planning and policy development, etc.)
- ▶ Clinical research
- ▶ Clinical education and mentoring.

These competencies are consistent with the National Competency Standards for the Nurse Practitioner<sup>78</sup>.

**RECOMMENDATION 2:** There is a need for clarification of the term 'nurse practitioner'. This is critical to ensuring that NPs are able to engage in appropriate roles and responsibilities and to ensure that the role is better understood and can be distinguished from other medical and nursing roles. DHS should consult with stakeholders to promote and disseminate a clear definition of the role.

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<sup>78</sup>Australian Nursing & Midwifery Council, *National Competency Standards for the Nurse Practitioner*, 1<sup>st</sup> Edition, January 2006. Available at <http://www.anmc.org.au/publications/index.php#national>.

**RECOMMENDATION 3:** It is important that the role of Nurse Practitioner is underpinned by a clear set of measurable competencies. DHS should facilitate periodic assessment of The National Competency Standards for the Nurse Practitioner by industry, regulators and other stakeholders to ensure that they are relevant and measurable in the context of mental health and drug services.

**Research Question 3: What would be required of DHS and services to implement such roles over the next three years?**

The research identified a wide range of opportunities for DHS to drive the implementation of the NP role in drug and alcohol and mental health services. There were calls for increased leadership, flag bearing and financial support from DHS to assist services to develop the role of NP and engage the support of medical practitioners and their representative associations. There was a clear need for relevant legislation and policy to be reviewed at the state and Commonwealth level to support the role of NP within the workforce and to ensure that NP are recognised under the PBS and MBS.

Health service managers need to actively recruit and develop staff with a capacity and desire to undertake a NP role and ensure that support and development of the role is reflected in workforce planning and policy. Service manager responsibilities include developing a positive culture, supporting change management and establishing internal systems to develop and implement NP roles.

**RECOMMENDATION 4:** To ensure that NPs are able to contribute to producing positive patient/client outcomes, Victorian legislation needs to be reviewed to ensure that it reflects current practice and community needs. As a part of the current review of the Mental Health Act 1986 (Vic), the opportunities to recognise the NP role in legislation should be progressed by DHS. Key parts of the Act which should be reviewed to reflect the NP's level of education and preparation include (*inter alia*) the:

- ▶ definitions
- ▶ transportation of patients
- ▶ sedation of patients
- ▶ interim treatment
- ▶ community treatment orders
- ▶ seclusion.

The Mental Health Act 1986 (Vic) should also be examined in detail to ensure that it is consistent with the other relevant Victorian legislation such as The Drugs Poisons and Controlled Substances Act 1981 (Vic) which does acknowledge and provide for the NP role.

**RECOMMENDATION 5:** To enable NPs to contribute to addressing a number of health service gaps and improved patient outcomes, DHS should engage in further discussions with the Commonwealth Government to secure MBS and PBS recognition for NPs – in line with the recommendations of the Productivity Commission's 2005 review of the Australia's Health Workforce.

**RECOMMENDATION 6:** There is a need for a NP implementation guide book to be provided to health services to assist them in developing infrastructure to support the development and implementation of NP roles. It should be presented on the DHS website along with other relevant information. It should contain information to:

- ▶ foster the identification and development of suitable NP Candidates
- ▶ support health services to recruit suitable Candidates
- ▶ support development of NP roles
- ▶ support the sustainability of NP roles
- ▶ continue to provide information about scholarships and funding.

**RECOMMENDATION 7:** In order to address issues associated with the current size and disbursement of the NP workforce (such as efficient provision of education; improved confidence of employers; increased sustainability; provision of peer support, etc.), DHS should work to develop a NP cohort and provide opportunities for networking and capacity building both within and across all NP categories.

**RECOMMENDATION 8:** In order to inform and engage key stakeholders in the Victorian health sector on matters related to the implementation and sustainability of the NP role, broad ongoing dialogue should be initiated with groups such as:

- ▶ Australian Medical Association, Victoria
- ▶ Royal Australasian College of Surgeons
- ▶ The Royal Australasian College of Physicians: Australasian Chapter of Addiction Medicine
- ▶ The Royal Australian and New Zealand College of Psychiatrists
- ▶ Royal Australian College of General Practice
- ▶ Divisions of General Practice
- ▶ Australasian College of Rural and Remote Medicine.

**RECOMMENDATION 9:** To assist in overcoming financial barriers, particularly for potential NP Candidates in rural areas, DHS should continue to provide and promote awareness of financial support to assist appropriate NP Candidates in progressing to endorsement.

# Appendix A: Health services interview guide

## Introduction

- ▶ Thank participant/s
- ▶ Introduce interviewer
- ▶ Brief explanation of the project purpose, method and place of this consultation
- ▶ Role of TNS as an independent social research team
- ▶ Confirm interview length explain any taping, note-taking and reporting
- ▶ Reconfirm confidentiality, voluntary participation and get restatement of consent
- ▶ Ask if there are any questions before starting.

## Questions

### **Role and relationship with nursing/NPs in the service**

Firstly, I would like to ask you some background questions.

- ▶ Could you tell me a bit about your positions and the nature of your involvement with nursing and/or NPs?
- ▶ How would you describe the nature of the services and the patients /clients you support at <INSERT SERVICE NAME> ?
- ▶ What is the nature of the mental health and drug services currently provided?
- ▶ Do you perceive any gaps in the services currently provided?
- ▶ What are the emerging models of care in mental health and drug services of relevance to your service?
- ▶ Has your service ever previously considered developing a role for mental health or drug services NPs? (If 'Yes' describe what happened)

### **Mental health and drug services NPs role**

#### **Now I wanted to ask your views on the role of mental health and drug services NPs.**

- ▶ What is the need for mental health and/or drug services NPs at this service?
- ▶ At what points in the continuum of mental health services do you see the role of mental health or drug services NP as being most beneficial/effective?
- ▶ In which areas of your mental health/drug services would the implementation of a NP model of care be most effective in the next one to three years? Why?
- ▶ What sort of roles and responsibilities **could** mental health or drug services NP perform?

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- ▶ What sorts of roles **would** you like to see them perform?
- ▶ Thinking outside of your service, what other types of mental health and drug services do you think could implement a mental health or drug services NP role in the next one to three years?
- ▶ What roles and responsibilities could a mental health or drug services NP have in such settings?
- ▶ Thinking about shared service models for NP in mental health and drug services, what opportunities might exist at your service and other providers? In what contexts might a shared service model approach be most relevant?

### **Barriers and enhancers**

**In this next section will discuss barriers and enhancers. These may include a broad range of system based factors relating to procedural, operational, legislative or policy issues etc.**

- ▶ What are the barriers to the successful implementation of a mental health or drug services NP model at this service in the next one to three years? What about at the system level?
- ▶ What factors are likely to enhance successful implementation of a mental health or drug services NP model at this service the next one to three years? What about at the system level?
- ▶ What barriers would need to be addressed to ensure that the position was sustainable at your service ... and more broadly?
- ▶ What factors are important to enhancing sustainability of the model at the service level ...and more broadly?

### **Conclusion**

- ▶ What do you think the future holds for the mental health and drug services NP role?
- ▶ Are there any other comments you would like to make about mental health and drug services NPs?
- ▶ Thank and close.

# Appendix B: Issues list (March 2008)

This document is a component of the 'Sustainable Models for NPs in Public Mental Health and Drug Clinical Services' project being conducted by TNS Australia on behalf of the Department of Human Services, Victoria. This document contains a list of issues and their implications identified at the mid point of the current project. These issues have been extracted from the literature and the NP Service Planning Final Reports. The broad issues identified include:

- ▶ Shortages in the mental health workforce
- ▶ Lack of clarity about the NP role
- ▶ Supporting community based care in the scope of practice
- ▶ Support of the medical profession for the NP role
- ▶ Limitations under PBS and the cost of drugs
- ▶ Lack of access to Medicare provider numbers and MBS
- ▶ Limitations in the scope of practice
- ▶ Financial and career disincentives
- ▶ Service providers concerns
- ▶ Lack of a critical mass to supply the need and develop and maintain professional development.

## ISSUE: SHORTAGES IN THE MENTAL HEALTH WORKFORCE

A number of issues related to recruitment and retention have depleted the mental health workforce. This includes a shortage of mental health nurses, increased pressure on GPs to provide support to patients with mental health problems and lack of access to psychiatrists and GPs in rural and remote areas, coupled with the limited numbers of NPs currently working in rural regions.

### IMPLICATIONS

There is a need for improved community access to mental health care particularly in rural and remote areas. This may provide incentive for health services and GPs to support the use of mental health NPs. The current low numbers of NPs in rural areas may reflect a range of issues including the broader workforce shortage issues experienced in the bush. Increasing numbers of NPs to address rural shortages needs to be done in consideration of other strategies to address recruitment and retention of health professionals in rural areas (i.e. incentive packages, local

recruitment, access to support, supervision and training, etc.). For NPs to work effectively outside of a hospital setting, the support of a GP or consultant is required. Given the chronic shortage of GPs and consultants in rural areas, as well as a potential lack of support for the program, this may prove to be a challenge.

## ISSUE: LACK OF CLARITY ABOUT THE NP ROLE

There is evidence to suggest that there are common misconceptions about the role of NPs within both the health workforce and the broader community.

### IMPLICATIONS

Lack of clarity about the NP role and how it articulates to the broader system could undermine the employment of mental health NPs. Inconsistent communication messages about the role and negative statements by the medical fraternity and the AMA appearing in the media, could act as an obstacle to the acceptance of mental health NPs. This could inflame community concerns about the competence of NPs and scope of practice.

## ISSUE: SUPPORTING COMMUNITY BASED CARE

There is an increasing community and consumer expectation that mental health care and drug services will be provided (where clinically appropriate), within a community-based setting rather than within a medical environment. Similarly, there is an increasing expectation that clinical care is accompanied by social support. Both of these trends are reflected in government policy, which has led to the initiation of the New Directions policy, PARC and PDRSS services, and has been frequently expressed in literature provided by consumer advocate and carer groups. Furthermore, there has been concern about the imposition of a medical model of care in relation to mental health, drug and alcohol services and the loss of social support and community-based care.

### IMPLICATIONS

The role of mental health NPs needs to reflect community trends and expectations. Issues preventing NPs from working in community-based settings (such as PBS, prescribing rights and MBS limitations) need to be addressed. NPs employed within mental health also need to ensure that they have an approach which is compatible with the philosophy of teams providing social and community-based support. Limiting mental health NPs to hospital-based care may fail to address these expectations.

## ISSUE: SUPPORT OF THE MEDICAL PROFESSION FOR THE NP ROLE

A number of doctors and their associations have publicly expressed concerns about the competence of NPs to provide a high quality of care. The key issues relate to the qualifications of NPs in comparison to doctors, scope of practice and level of autonomy. There have also been reports of resistance from nursing staff.

### IMPLICATIONS

It is important that mental health NPs are well supported by doctors. Support from doctors is important to ensure that NPs can perform their role and have access to meaningful clinical guidelines, training, support and supervision. The support of doctors is vital to the success of the role, particularly where the NP is employed outside of a hospital. It is also likely that without doctors' support, other stakeholders such as consumers and the public may fail to support the NP role.

Lack of support from other nursing staff could have implications related to a lack of support for the NP. This may be most problematic in cases where senior nurse managers do not support the role.

Communication about the role of NPs and opportunities to facilitate the support of doctors for NPs in mental health roles needs to be explored promoting the specialist nature of the NPs role.

Similarly, much criticism is based upon comparison of NPs qualification compared to doctors. Left unchallenged, this negates the significance of specialisation and generates community uncertainty.

## ISSUE: LIMITATIONS UNDER PBS AND THE COST OF DRUGS

Funding restrictions associated with Commonwealth control of medications on PBS mean that there is a discord between state and federal legislation. At a state level, legislation allows for NPs to write prescriptions and they can refer patients to other health care professionals. However, at a Commonwealth level NPs do not have access to the PBS. This is seen as impacting on the NPs' scope of practice where they are working in a location which does not have a hospital pharmacy.

### IMPLICATION

This disadvantages patients serviced by mental health NPs outside of a hospital environment because they have to pay to have their script filled at a pharmacy. This is a concern when many people who have mental health issues experience economic disadvantage. However, opportunities exist for mental health NPs to work within a hospital or health service with the support of a GP or consultant to sign prescriptions, referrals and diagnostic test requests, etc. This highlights the need for supportive health services to adapt and accommodate the role.

## ISSUE: LACK OF ACCESS TO MEDICARE PROVIDER NUMBERS

Due to a lack of Commonwealth recognition, NPs do not have access to the Medicare Benefits Scheme (MBS) and are limited in referring patients to a number of other health providers and in requesting diagnostic investigations.

### IMPLICATIONS

In the mental health field, the NP is likely to be working with the primary care coordinator and/or within a hospital environment. As such, the capacity to refer should not have an impact on patient care. There may be concerns about externally provided diagnostic tests such as pathology, radiology and ultrasound being billed back to the individual rather than the hospital. However, where the NP is working within a hospital as a part of a multidisciplinary team with mental health patients, diagnostic authority could be shared or costs billed back to the hospital.

## ISSUE: LIMITATIONS IN THE SCOPE OF PRACTICE

NPs have limited opportunity to work autonomously outside of a hospital or health service setting due to Commonwealth Government regulations regarding provider number access, access to the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme. The NPs' scope of practice can be governed by a medical practitioner and in some settings this could prove to be very limiting. Mental health services need to accommodate the potential limitations to maximise the skills of the NP and ensure that he or she is retained in a meaningful position.

### IMPLICATIONS

Mental health NPs working within a hospital appear to have an opportunity to work as a part of a multidisciplinary team and with the GP as the primary care coordinator. The NP is able to prescribe within the hospital setting (those medications within the approved scope of the NP) supporting the GP's treatment once the client returns to the community setting. Mental health NPs may find their scope of practice limited to a prohibitive degree outside of a hospital setting.

## ISSUE: FINANCIAL AND CAREER DISINCENTIVES

NPs' salary may not be sufficient incentive to encourage Candidates to pay for a masters degree and/or or pharmacy module and go through the endorsement process. There are concerns that there is no guarantee that the endorsement process will be successful or that there will be

positions available. Many NPs have also expressed reservations about the length of time required to qualify and gain endorsement.

## IMPLICATIONS

This could impact on the recruitment of mental health NPs and may require the development of incentive packages and greater provision of job security.

## ISSUE: SERVICE PROVIDERS CONCERNS

Service providers have expressed concern about the resources involved in educating the organisation about the NP role, developing a supportive work culture, and in redesigning services to accommodate NPs. Some providers are concerned that they may invest resources into the role, or even sponsor further study, and then lose the NP.

## IMPLICATIONS

The mental health NP workforce is subject to the same pressures as other health sector employees and employers; community and government need to work with mental health NPs to develop strategies to address these issues.

## ISSUE: LACK OF A CRITICAL MASS TO SUPPLY THE NEED AND DEVELOP AND MAINTAIN PROFESSIONAL DEVELOPMENT

The small numbers of NPs available raised concerns for health services that they could alter their service to accommodate the role only to find that they have staffing issues. The small number of NPs in mental health can also have implications for the cost effectiveness of providing training and support.

## IMPLICATIONS

Mental health service providers will need encouragement and support to address these issues. Training, support and networking may need to be provided via similar techniques used by the rural medical workforce which has similar issues. Other collaborative strategies have been used across NP sites to provide training opportunities demonstrating the need for flexible approaches.

## Appendix C: List of roles

Participants in the research were asked to identify specific NP roles which they thought would be sustainable at their service in the next one to three years. The follow is a list of all NP roles mentioned within the scope of the current project.<sup>79</sup> It is worth noting that many suggested service settings where a NP role could be introduced without distinguishing this from the specific role of the NP. In the case of the participants at services consulted as a component of the case studies, suggestions tended to reflect the level of planning already undertaken for NP implementation at the service. All were interested and keen to develop roles and had identified gaps in services which could be addressed by NPs. While only a few were at the stage of identifying specific responsibilities, the provision of clinical leadership within these roles and service areas was a common theme. The list has been provided to act as an overview of the diverse range of roles and service areas identified by participants in the case studies and consultations undertaken as a part of this project. This is by no means an exhaustive list of all potential NP roles. It has been divided under the three headings for ease of access. The considerable degree of overlap between mental health and drug and alcohol areas was recognised by participants.

### ***Primary mental health focused roles***

- ▶ Emergency departments (mental health triage NP)
- ▶ Indigenous mental health NP
- ▶ Mental health in patients assessment team NP
- ▶ Early intervention team mental health NP
- ▶ Prevention and Recovery Care (PARC) services NP
- ▶ NP roles within a mental health service unit (i.e. eating disorder clinics, depression, etc.)
- ▶ Child and adolescent mental health NP
- ▶ Clinical support and liaison NP (for international medical graduates in rural hospitals)
- ▶ Forensic mental health NP to consult in prisons
- ▶ Mental health outpatients NP
- ▶ Acute response team NP
- ▶ Mother and baby unit mental health NP (supporting postnatal mental health care including PND)

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<sup>79</sup> A number of possible NP roles were mentioned which fell outside of the scope for the current project. These included roles within general practices, such as providing mental health assessment and counselling, as well as supporting international medical graduates in small rural practices.

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- ▶ Psychiatry triage NP including Clozapine co-ordination and monitoring, CTO monitoring, ECT, etc.)
- ▶ Metabolic monitoring clinic NP
- ▶ NP CATT (in both EDs and community teams)
- ▶ NP consultation liaison role specialising in conduct disorders in mental health services

### ***Drug and alcohol focused roles***

- ▶ Mother and baby unit
- ▶ Drug and alcohol NP (supporting post-natal drug and alcohol treatment and care)
- ▶ Drug and alcohol withdrawal NP
- ▶ Drug and alcohol rehabilitation NP
- ▶ Aged psychiatry NP (including psycho geriatric health care)
- ▶ Drug and mental health community outreach NP
- ▶ Clozapine clinics (including treating and monitoring clients)
- ▶ Pharmacotherapy NP
- ▶ Primary health services NP
- ▶ Forensic drug and alcohol NP (in treatment, withdrawal and rehabilitation)
- ▶ Symptomatic medications NP (focusing on prescribing for people with mental illness including those with co morbidities i.e. STD's, diabetes, infections, etc.)

### ***Dual diagnosis focused roles***

- ▶ Infectious disease management NP
- ▶ Dual diagnosis NP (i.e. co-occurring mental health and drug and alcohol issues)
- ▶ Perinatal care NP (for people with a dual diagnosis)
- ▶ Dual disability NP (i.e. intellectual disability and mental health care)
- ▶ Mother and baby unit dual diagnosis NP

## Appendix D: Consultation list

Moses Abbatangelo (DASWest)  
Silvia Alberti (DHS)  
Tracey Beaton (DHS)  
Jeff Benham (Mildura)  
Trish Bulic (Southern Health)  
Isabell Collins (VMIAC)  
Ms Mary Coole (Footscray Hospital)  
Maureen Cuskelly (Northeast Health Wangaratta)  
Sandy Dewhirst (ACMHN)  
Stephen Elsom (ACMHN and Melbourne University)  
Peter Fahy (North East Mental Health)  
Peter Fahy (Northeast Health Wangaratta)  
Robin Fisher (DHS)  
Patricia Green (Royal Melbourne Hospital)  
Helen Haines (Northeast Health Wangaratta)  
Bridget Hamilton (St Vincent's Mental Health Services)  
Sue Henderson (Monash University)  
John Hickey (DHS)  
Diane Hawthorne (Werribee Mercy/DASWest)  
Cayte Hoppner (NP)  
Malcolm Hopwood (RANZCP)  
Brian Jackson (North West Mental Health)  
Robyn Jackson (DASWest)  
Sandra Keppich-Arnold (Alfred Hospital The Alfred Psychiatry)  
Susan Kid (Bendigo Health)  
Dimce Kotevski (DASWest)  
Felicity Lawrence (The Bronte Centre at St Vincent's)  
Gerry Lee (Latrobe University)

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Trish Martin (Forensicare)

Rod Mann (DHS)

Richard Marks (DASWest)

Rose McCrohan (Moreland Hall UnitingCare)

Dr Michael McDonough (DASWest)

Anna McKenry (DASWest)

Dr Cris Mileskin (St Vincent's Mental Health Services)

Emma Montgomery (DHS)

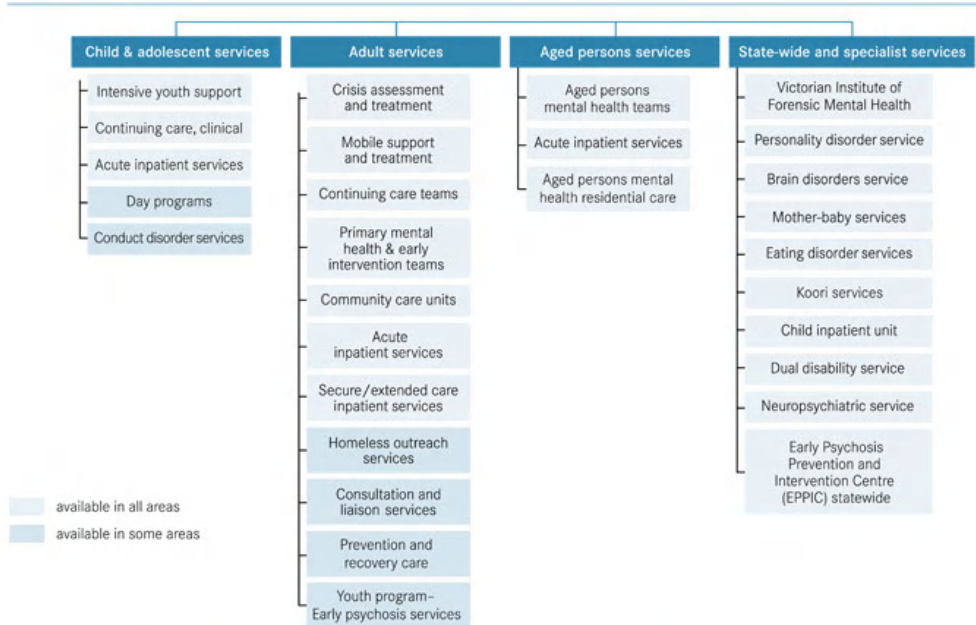
Adele Morrison (Ramsay Health Mildura)

Natisha Sands (Melbourne University)

# Appendix E: Mental health service overview

## Victorian Mental Health Service System

### Clinical



### Psychiatric disability rehabilitation and support services



# Appendix F: Drug and alcohol service overview

**Victoria's Specialist Alcohol and Drug Services**  
**The Framework for Service Delivery**

