CENTRE FOR PSYCHIATRIC NURSING RESEARCH & PRACTICE, SCHOOL OF NURSING, UNIVERSITY OF MELBOURNE

SUBMISSION: PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY

About the Centre for Psychiatric Nursing Research and Practice, School of Nursing, University of Melbourne

The Centre for Psychiatric Nursing Research and Practice is an initiative for psychiatric nurses and other stakeholders throughout Victoria, including clinicians, managers, academics and researchers from metropolitan and rural areas. The Centre works with psychiatric nurses, consumers, carers and other healthcare professionals to bring about the ongoing development and improvement of clinical practice.

The CPNRP has prepared a report which comments on issues raised in the Productivity Commission Issues Paper of May 2005, as well as the Terms of Reference for The Health Workforce Inquiry which are relevant to the Centre.

Aim of the CPNRP

The primary aim of the Centre is to contribute to the ongoing development and advancement of psychiatric nursing practice in order to enhance the well-being of consumers of Mental Health Services. The CPNRP, therefore, recognizes practice as paramount. Research, education and professional development exist to support, be guided by and, where necessary, to challenge current clinical practice. The CPNRP is committed to programs and other initiatives designed to bridge the gap between practice, research, policy development, education and professional development, to promote the unification of psychiatric nursing towards a common, consumer focused goal.

Development of the CPNRP

Funded by the Mental Health Branch of the Department of Human Services, Victoria, the CPNRP is located at the School of Nursing, The University of Melbourne, and is operated in partnership with North Western Mental Health, Melbourne Health. The CPNRP officially commenced operation in November 1999. The CPNRP is funded to address education, professional development and research issues, particularly as they relate to psychiatric nursing practice, with the aim to facilitate and oversee changes in nursing practices in order to improve health outcomes for consumers of mental health services.

Introduction

There are a number of important issues facing the psychiatric/mental nurse workforce, and employers within the mental health sector. It is clear from the evidence presented in this submission that a recruitment crisis in psychiatric nursing in Australia is imminent. Australian research has clearly demonstrated that psychiatric nursing is not a popular career option for undergraduate nursing students (Clinton & Hazelton, 2000; Happell 2002; 2001; 1999; Stevens & Dulhunty, 1997). The under-representation of psychiatric/mental health content within undergraduate curricula has been identified as one of the primary reasons for a relatively small proportion of nursing graduates entering this area of nursing specialty (Clinton & Hazelton, 2000; Farrell & Carr, 1996; Happell, 1998).

It may be argued that exact figures relating to that shortage may not be precisely known with respect to psychiatric/mental health nurses, (the CPNRP is undertaking a research project currently to seek to determine more precise figures for the State of Victoria). However, a number of key points are generally understood and accepted including the fact that the proportion of the population suffering mental illness is more likely to rise than decline into the future, which will necessitate an increase in healthcare professionals treating them. Also, given that the average age of nurses is around 45 years of age and given that demand is likely to out-strip supply in coming years, significant effort, both in terms of policy formation and resource allocation, is required in order to deal with the issue.

Also significant, however, is the view put by Clinton and Hazelton in (2000), that "few attempts have been made to monitor the impact of initiatives directed at reversing the recruitment and retention problems that bedevil the mental health nursing workforce" (Clinton & Hazelton, 2000).

Workforce Planning and Data Collection

The lack of comprehensive and up to date information about the health and community services workforce is a barrier to effective workforce planning, especially of the kind that would inform complex workforce planning and accurately reflect the level and type of training which occurs within the existing workforce. Additionally, there are limited workforce plans to harness this data, and the lack of inter-governmental collaboration in the planning for and provision of services undermines this process. At strategic levels of decision making there are often gaps in linkages between health services. Aged mental health is identified as a key component within mental health but there are currently poor linkages to services required for an aged population.

Furthermore data collection tends to be ad hoc. For Registered Nurses (including enrolled nurses), the Australian Institute of Health and Welfare (AIHW) gathers data from state based registration bodies. The AIHW relies on voluntary return of the data and there is poor understanding by nurses as to how this information is used. The veracity of data collected is questionable at times, and would be difficult to use. There is a variety of information collected but given the areas that a nurse practices in, there is not enough data collected to accurately predict future workforce issues.

Evidence of a mental health / psychiatric nursing shortage in Australia – Analysis of Available Data

Information regarding shortages of registered mental health nurses for this submission has been derived from the *National and State Skill Shortage Lists* produced by the Department of Employment and Workplace Relations (DEWR), The DEWR utilises a variety of methods to monitor and assess skill shortages in Australia; nevertheless, the focus is placed on consultation with employers who have recently advertised vacancies in specified occupations. Information gathered is considered alongside supply and demand trends for each occupation to determine whether skill shortages are evident. Skill shortages are not quantified; the Department simply indicates whether shortages are present or not present. This is in itself problematic, as diverse geographical requirements, for example, cannot be quantified not adequately addressed as a result.

Skill shortage lists for 2002, 2003 and 2004 which are included in this submission were accessed from the DEWR web-site. Skill shortage information relevant to the nursing labour force for 1998, 2000 and 2001 was sourced from the nursing labour force reports produced by the AIHW. According to the explanatory notes to the *National and State Skill Shortage Lists Australia – 2004*, a skill shortage is defined as follows:

> Skill shortages exist when employers are unable to fill or have considerable difficulty in filling vacancies for an occupation, or specialised skill needs within that occupation, at current levels of remuneration and conditions of employment, and reasonably accessible location.

The following table summaries skill shortage information for mental health nurses as outlined in the skill shortage lists produced by the DEWR between December 1998 and March 2004.

Table 1: National and state skill shortages of registered mental health nurses between 1998 and 2004

Location	December 1998	January 2000	February 2001	February 2002	February 2003	March 2004
Australia	S	S	S	S	S	S
NSW/ACT	S	S	S	S	S	S
Victoria	S	S	S	S	S	S
Queensland	S	S	S	S	S	S
Western Australia	N	S	S	S	S	S
South Australia	S	N	S	R	S	S
Tasmania	R	S	S	S	S	S
Northern Territory	S	S	S	N	S	N

S = Shortage R = Shortage in regional areas only N = No shortage indicated

The Department of Human Services also detailed information relevant to the issue of nursing shortages in the report titled *Nurse Labourforce Projections Victoria 1998 –*

2009 (Australian Institute of Health and Welfare, 1999, 2001, 2003a; Department of Human Services, 1999).

Problems with information available to monitor skill shortages

There needs to be effective coordination between governments, planners, educators and service providers in the collections and sharing of data relevant to strategic planning exercises.

In addition to information that is already readily available, information regarding the following should be collected routinely:

- The number of new graduates entering the field
- The number of new graduates who complete a specialist graduate nurse year in the mental health field
- The number of new graduates who remain in the field following completion of a specialist graduate nurse year and the type of service they are employed by (e.g., acute inpatient, CATT, MST)
- The number of new graduates who exit the field after completing a specialist graduate nurse year and why
- The number of psychiatric / mental health nurses who change speciality and why
- The number of psychiatric / mental health nurses who exit the field and why

With the exception of the developmental disability field, the composition of the psychiatric / mental health workforce is considerably different from other nursing fields. Specifically, there is a substantially greater proportion of male nurses in the psychiatric / mental health nursing field (see section on Victorian Labour Force Statistics). This should be taken into consideration when examining the factors that may impact on future supply.

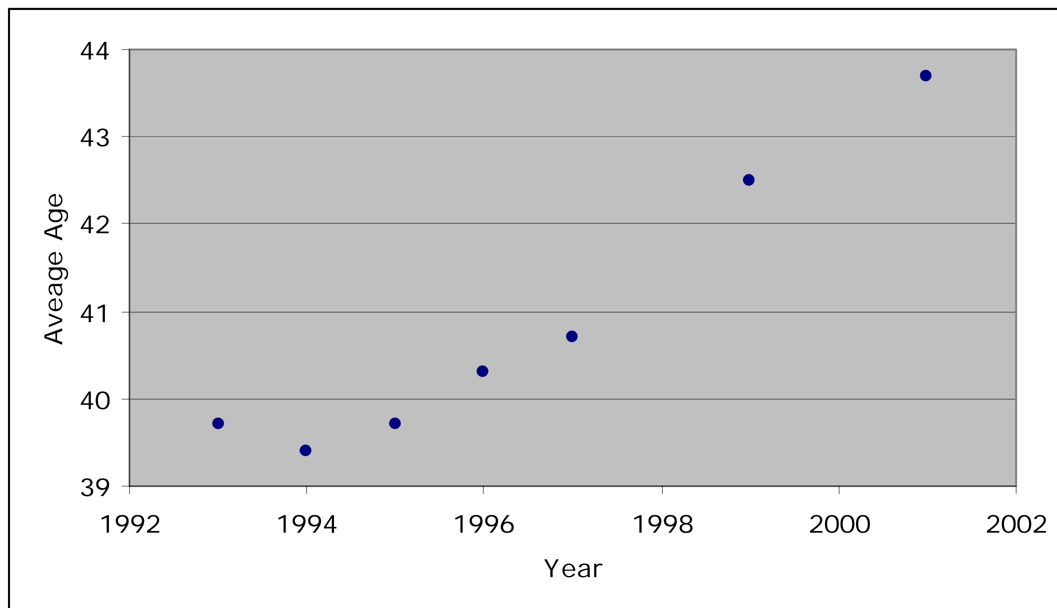
Australian Labour Force Statistics

The following sections are based on statistics obtained from the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare, 1997, 1998, 1999, 2001, 2003a, 2003b). These statistics are presented in full in the Appendix.

Age of Australian psychiatric/mental health workforce 1993 – 2001

As demonstrated in Figure A, the average age of psychiatric / mental health nurses in 1993 was 39.7 years. In 2001, the average age was 43.7 years.

Figure A: Average age of psychiatric /mental health nursing workforce 1993 – 2001



In eight years, the average age of psychiatric / mental health nurses increased by 4 years (approximately 0.5 years per year). If this trend continues, the average age of nurses will be approximately 48.7 years in 10 years.

Percentage of male psychiatric / mental health nurses in Australia 1993 – 2001

As demonstrated in Figure B, with the exception of 1994, the percentage of male psychiatric /mental health nurses has steadily declined from 1993 to 2001.

Average hours worked per week in Australia 1993 – 2001

Between 1993 and 1996, the average hours worked per week by psychiatric /mental health nurses remained fairly stable (37.0 – 37.7 hours / week). However, from 1997 onwards, there was a steady decline in the average number of hours worked per week (36.0 – 34.4 hours / week).

Relationship between percentage of males and average hours worked

There was a strong positive relationship between the percentage of male psychiatric / mental health nurses and the average number of hours worked per week (r = 0.87, p =

0.01). Namely, the average number of hours worked per week decreased as the proportion of male nurses decreased.

Figure B: Percentage of male psychiatric / mental health nurses 1993 - 2001

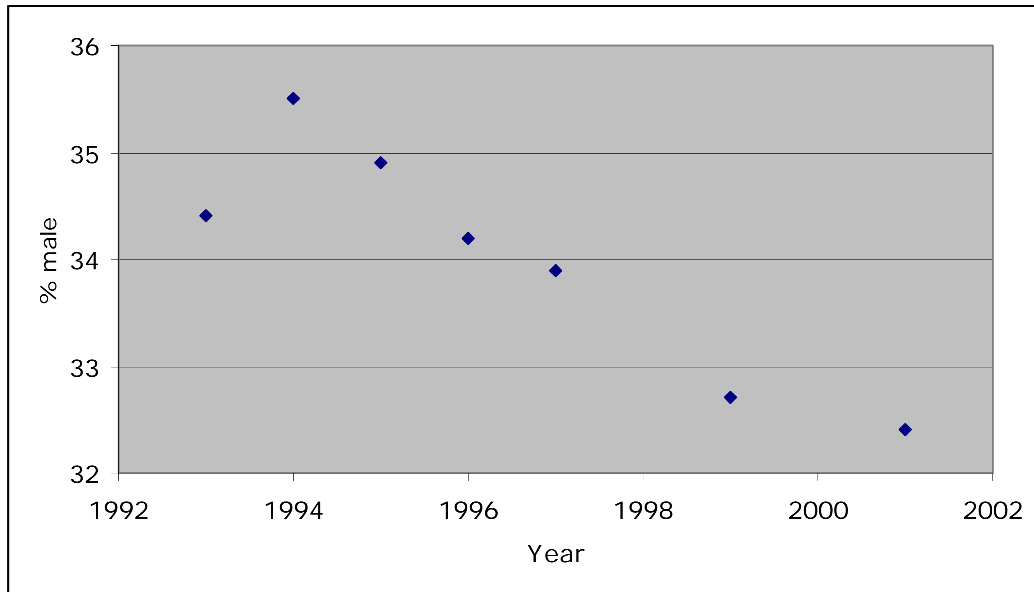
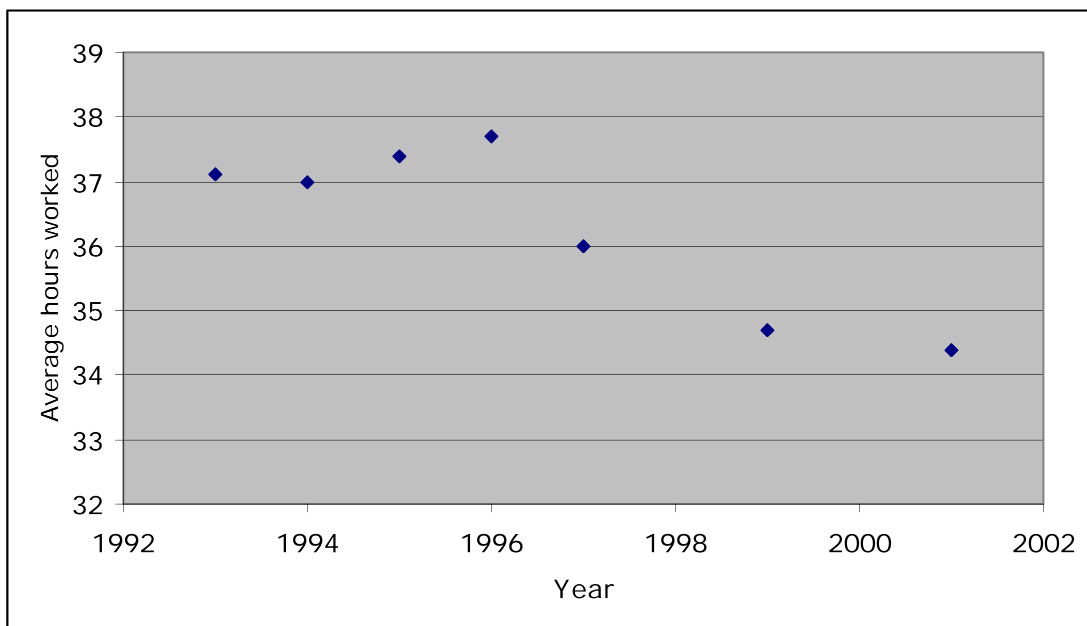


Figure C: Average hours worked per week by psychiatric / mental health nurses in Australia 1993 – 2001



Victorian Labour Force Statistics

The following sections are based on statistics obtained from a DHS funded report produced by the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare, 2004b).

Average weekly hours worked in Victoria 2003

In 2003, the weekly hours worked by nurses in mental health facilities (38.3 hours) were, on average, higher than the hours worked by their colleagues working in other settings (32.1 hours). Also in 2003, nurses employed in mental health facilities were more likely to work 45 hours or more per week (16.8%; average across all other settings, 9.1%) and less likely to work part-time (31.3%; average across all other settings, 60.9%).

Clinical nursing role by gender

In 2003, clinical mental health nurses (34.2%) were more likely to be male than nurses working in all other clinical roles (7.8%).

Nurse role / Main area of activity	% male
Mental health	34.2
Developmental disability	30.7
Management / administration	12.5
Critical care / emergency	11.2
Perioperative	6.5
Disability / rehabilitation	6.4
Medical / surgical nursing	6.3
Other	5.7
Aged care	5.5
Community health	5.2
Education	4.9
Research	3.3
Family and child health	2.3
Clinical support, coordination and assessment	1.4
Midwifery	0.9
Total	7.8

"Overall, from 1995 to 2003, the Victorian nursing labour force increased by 4.7% (from 66,477 to 69,557), while the general population in Victoria increased by 8.9% (from 4,517,378 to 4,917,394 people (ABS 2003)" (Australian Institute of Health and Welfare, 2004b).

Victorian nurse Labour Force projections

The following section is based on a report commissioned by the Victorian Department of Human Services, which detailed a ten-year projection of the demand for, and supply of, the nurse labour force in Victoria between 1998 and 2009 (Department of Human Services, 1999). Note, this report focused on the nursing labour force broadly, and did not specifically examine psychiatric / mental health nurses.

A large number of issues affecting recruitment and retention were raised by the reference group, including the following:

- There are problems attracting sufficient nurses to certain specialty areas including the mental health area
- There is a lack of clinical placements for students, particularly in mental health

Requirement and supply projections

The following tables outline the requirement and supply projections for the Victorian nurse labour force in 2008. Note, the following calculations were based on the number of nurses working in Victoria on 1 July 1998 (56,350; 80.7% of registered workforce), rather than the total number of nurses registered in Victoria on 1 July 1998 (69,811).

Requirement projections					
Year	Constant	Demographic change low	Difference between low growth and constant	Demographic change high	Difference between high growth and constant
1998	56,350	56,350	0	56,350	0
2008	56,350	62,802	6,452	63,114	6,767

- Constant: projections are based on no change in the nurse requirements.
- Demographic change low: projections are based on a change in nurse requirements due to population growth only.
- Demographic change high: projections are based on a change in nurse requirements due to population growth plus ageing effects.

Supply projections						
Year	Base model	Increase losses by 25%	Decrease losses by 25%	Decrease losses by 50%	Increase graduates by 1,500	Increase graduates by 1,800
1998	56,350	56,350	56,350	56,350	56,350	56,350
2008	57,598	54,678	60,794	64,299	63,886	65,148

The six supply scenarios outlined above are as follows:

- Base model. Assumes current workforce dynamics rates are retained.
- Increase losses by 25 percent. Assumes greater losses from the labour force.
- Decrease losses by 25 percent. Assumes lower losses from the labour force.
- Decrease losses by 50 percent. Assumes very high improvement in labour force retention rates.
- Increase graduate output by 1,500. Assumes a high increase in the number of graduates.
- Increase graduate output by 1,800. Assumes a very high increase in the number of graduates.

Balancing supply projections with requirements

The requirement projections in 2008 based on a change in nurse requirements due to population growth only suggested 62,802 nurses would be required. The requirement projections in 2008 (based on a change in nurse requirements due to population growth and ageing effects) suggested 63,114 nurses would be required. Examination of the supply projections table indicates that these requirements would only be met if nurse losses from the labour force were decreased by 50% or graduates were increased by 1,500 or 1,800. Stated another way, if the 1998 workforce dynamics were retained or there were greater losses from the workforce or the losses from the workforce were decreased by 25%, Victoria would not meet the requirement projects for 2008.

Comparison with requirement and supply projections for 2003

In 2003, there were 69,557 registered nurses in Victoria (Australian Institute of Health and Welfare, 2004a). If we assume that only 80.7% of the registered workforce was currently engaged in nursing work, as in 1998, approximately 56,145 nurses were working.

This is very close to the supply projections outlined in the Nurse Labourforce Projections document calculated on the basis of the Base Model (56,717). This suggests that 1998 workforce dynamics were retained. Consequently, as of 2003, Victoria did not appear to be on target to meet the requirement projections calculated on the basis of a change in nurse requirements due to population growth only (59,489). This further indicates that, in 2003, Victoria was not on target to met the requirement projections for the nurse labour force in 2008 based on population growth only or population growth plus ageing.

Implications for psychiatric / mental health nursing

Unfortunately, specific nurse labour force projection requirements are not available for the psychiatric / mental health field, although it would be very useful if these were calculated and made publicly available in the future. Notwithstanding, given the greater difficulties recruiting new nurses to this specialty area, as well as retaining experienced

nurses, these nurse labour force projections outlined above do not augur well for the psychiatric / mental health nursing field. It appears unlikely that the psychiatric / mental health nursing labour force will meet future requirements based on population growth plus ageing, unless a concerted effort is made to improve recruitment and retention in this area.

The following section is based on a report commissioned by the Victorian Department of Human Services, which outlined Victorian public mental health workforce requirements to meet projected service growth to 2011 – 12 (Department of Human Services, 2005). Findings detailed in this report also indicate a shortage of suitably qualified nursing staff in mental health to meet projected demand.

"The increased need for staff within the public mental health system is likely to occur at the same time as the supply of potential workers is shrinking, placing increased pressures on public mental health services to compete with other service sectors for qualified staff. The impact of workforce ageing may place further pressures on staff availability. The forecasts made in the study assume that future patterns of staff mobility will reflect those occurring over 2001-02. However, 41 per cent of staff employed at 30 June 2002 were aged 45 or over. It is therefore quite possible that turnover may exceed current estimates as a greater proportion of staff reach retirement age" (p. 2).

Indeed, according to figures presented in this report, a 25% increase in Division 1 and 3 nursing staff is required to meet future service demand (Department of Human Services, 2005: 28). Such an increase would be unprecedented. Australian figures from 1993 to 2001 are used to demonstrate the point (see Table 2). From 1993 to 2001, there was a 12.3% increase in registered mental health nurses. Without substantial changes to current recruitment and retention practices, the chances of meeting future service demand are slim.

Table 2: Number of registered mental health nurses in Australia

	1993	1994	1995	1996	1997	1999	2001
Number of registered mental health nurses	9,066	9,408	9,428	9,415	10,112	9,958	10,184

Projections and requirements for Division 1 nurses

The following table outlines the current and forecast workforce supply of nurses registered in Division 1 in Victoria, as well as the additional and total requirements to meet workforce demand in 2011-12. The final row in the table outlines the projected workforce deficit in Victoria in 2011-12; namely, there will be a shortage of 3,273 (1,129 FTE) Division 1 nurses.

Current supply (30 June 2003)	55,086	42,061 FTE
Additional nurses required by 2011-12	6,713	5,304 FTE
Total requirements as of 2011-12	61,799	47,365 FTE
Forecast supply in 2001-12	58,526	46,236 FTE
Workforce deficit in 2011-12	3,273	1,129 FTE

Education, Training and Research

The Centre for Psychiatric Nursing Research and Practice has provided a leadership role in research and education with the aim of effecting more positive attitudes towards psychiatric nursing as a career. This includes a major research project investigating the impact of clinical experience and theoretical education on students' attitudes towards people experiencing a mental illness and psychiatric/mental health nursing as a career specialty. An interim report has been included and a number of publications arising from this study have been submitted for consideration in refereed journals. The CPRNP also undertook a statewide evaluation of specialist mental health nursing Graduate Nurse Programs on behalf of the Mental Health Branch, Department of Human Services.

From the education perspective, the CPNRP developed the subject "Preceptorship in Psychiatric Nursing" as an important recruitment strategy. The aim of the subject is to encourage psychiatric/mental health nursing clinicians to develop a more positive attitude to nursing students and thereby encouraging them to gain a more realistic and open attitude towards psychiatric/mental health nursing. The popularity of this subject has been significant, with more than 500 clinicians completing the program (primarily registered nurses) and with demand exceeding the resources available to meet it.

Undergraduate nursing education in Australia is currently comprehensive in design. It is intended to prepare graduates for practice at a beginning level in a wide variety of health care settings (including mental health). Specialisation into specific fields occurs at a postgraduate level. However, in many nursing specialties, including psychiatric / mental health nursing, postgraduate qualifications are not mandatory for practice in the specialist field. It is ultimately the decision of employers as to whether or not they insist on the qualification. The availability of nurses with the desired qualifications will likely impact on the extent to which employers are likely to insist on these qualifications.

The graduate year is generally where clinical consolidation from theory to practice occurs. In the mental health field it is sometimes undertaken in collaboration with a university. The CPNRP undertook an extensive statewide evaluation of the specialist psychiatric / mental health graduate nurse programs. The findings indicated that key stakeholders consider this program to be important as a recruitment and retention strategy. However, a number of key stakeholders highlighted the highly variable skill level of graduates entering the program. Many graduates who enter the specialist GNP have a low level of understanding regarding mental health issues. This low level of understanding was attributed to the inadequacy of mental health content in undergraduate nursing programs. Due to the inadequate preparation of undergraduate nursing students, the education and training packages developed by services need to begin at a fairly basic level and graduates required intensive support, particularly in the earlier stages of the programs.

As mentioned above, in 2003, the CPNRP was commissioned by the Victorian Department of Human Services to undertake a research project on the Graduate Nurse Program in Victoria, and some of the findings are detailed below. Overall, there was a high level of satisfaction with GNPs; this was true for graduates and other key stakeholders.

The broad strengths / benefits of specialist GNPs in mental health nursing cited by interviewees included:

- GNP are viewed as a sound recruitment strategy – the number and standard of graduates applying for and completing these programs is high
- GNP provide the opportunity to expose a greater number of individuals to mental health nursing. Specialist GNPs help to raise an awareness of mental illnesses and mental health nursing skills.
- GNP are typically flexible; they are generally able to meet the individual, expressed needs of graduate nurses within the program
- The varied clinical experiences and acute inpatient placements provide graduates with a sound opportunity to consolidate their clinical knowledge and skills
- The theoretical component was often highly regarded; however, issues associated with workload were raised by a substantial number of interviewees
- Good support structures (particularly preceptorship); moreover, clinical staff and educators were typically highly committed to the programs
- The specialist GNP has provided substantial benefits to other staff members (e.g., clinical and senior staff members are required to review and revise their practice), as well as consumers of mental health services
- The specialist GNP has assisted the development of linkages across the mental health system

A number of key stakeholders highlighted the highly variable skill level of graduates entering the program. Many graduates who enter the specialist GNP have a low level of understanding regarding mental health issues. This low level of understanding was attributed to the inadequacy of mental health content in undergraduate nursing programs. Due to the inadequate preparation of undergraduate nursing students, the education and training packages developed by services need to begin at a fairly basic level and graduates required intensive support, particularly in the earlier stages of the programs.

Some interviewees indicated a need for guidelines surrounding mandatory training components for graduates upon commencement of specialist GNPs. Services require guidelines around initial education and training for newly graduated nurses so they can meet basic occupational health and safety requirements. One interviewee suggested that an ‘educative tool kit of mandatory training’ be developed for specialist GNPs.

It is of particular concern, that Australian nurses as a professional group may not necessarily be sufficiently educationally prepared with the right training and skills to meet the future demand for psychiatric / mental health nurses. Due to the small proportion of the curriculum devoted to psychiatric / mental health nursing, academics with a background in this specialty tend to be in the minority, and therefore their capacity to influence the curriculum and enhance a positive image of psychiatric / mental health nursing is limited. Aged mental health care, for example, which is clearly

an area of increased future demand given the ageing of the population, is often seen as an area where nurses merely learn to bathe and feed a client. The reality is far from the case.

Anecdotal evidence suggests that students at an undergraduate level are also actively discouraged, by academics to go into these areas of mental health practice. Strategies need to be developed within the nursing profession to deal with this. Aged mental health is an expertise area with skills required in a variety of areas but treated with disdain by universities and health networks. It also has implications to most areas of nursing with its expertise in brain injury, delirium which is poorly covered in an undergraduate course and undervalued as a skill.

Community nursing training is now minor in Australia in spite of the shift from hospital based care to community based care leaving Australia without an adequately prepared workforce for this role. Aged and mental health have expertise in these areas but are poorly drawn on. Community nurses require special expertise in aged care nursing, wound care, identification and support for commonly occurring mental health conditions such as depression, chronic disease self management skills

Aged Persons Mental Health Services

Although it is obvious that the entire health workforce requires attention, there are certainly specific areas that warrant particular consideration. Aged care and Mental Health have historically been two clinical specialties that suffer greater challenges in recruiting and retaining a skilled and sustainable workforce. Combining the two specialties in APMH raises notable concerns. The Australian population is ageing, many are developing depression for the first time in later life, there is an increasing presentation of behavioural disturbances associated with brain disorders, for example dementia, and an increasing number of referrals to APMH services of individuals under 65 years of age with complicated medical or behavioural issues co-occurring with existing mental illness.

One of the largest APMH services in Australia, (requests to remain anonymous) currently employs approximately 420 staff. Of these approximately 90% are nursing staff; with 70% of the 90% division 2 nurses. Many of the Division 1 and Division 2 nurses have little or no specific mental health education and on average the age of the nursing workforce sits at 46 years. This situation is dire and is certainly not a workforce in need of a generic model for care. Our aged population has contributed to the development of a democratic and progressive country; they deserve the absolute best in healthcare. This includes governments investing in an adequately skilled workforce.

To create such a sustainable workforce requires innovation, promotion, careful consideration of educational needs and ongoing support within this context. A robust, skilled and proactive workforce is required to meet the projected demands of the future in this area. Again, the points made earlier in this submission regarding organizational change and practice development are equally important in this context. Factors concerning a accountability, delegation and supervision can only be attained through the development of a specialized workforce in APMH.

Regulation of the health workforce

Although our current health workforce faces many challenges, the worsening shortages of key health professionals are probably the direst. In terms of the recruitment and retention difficulties and the disparity in workforce distribution, many of the constraints to addressing the imbalance have existed for years.

Over the past decade both national and state reports have been released from various organizations that identified multiple gaps in the healthcare system. It is unfortunate that we now find ourselves a decade later, in an increasingly complex environment, with many of the issues identified then, still on the agenda now. Questions are currently being raised regarding the more formal introduction of a generic health worker to 'complement' as some might suggest, our contemporary health needs.

There is no doubt that the health workforce requires urgent and comprehensive attention; that is without question. What is concerning is the impetus towards a model that appears to hold up a generic worker as the ultimate solution. It is clear that the workforce requires a greater degree of flexibility if we are to keep pace with the shifting needs of individuals, groups and larger communities. It is however also blatantly clear that the key professions, who are crucial to providing an efficient, effective and quality health system, must be strengthened for the future.

In the current healthcare climate there are many pressures on the workforce from both a micro and macro level. These are complex issues within a complex and disconnected system, increasing the difficulty of providing relevant, evidence based quality care.

As with generalist health, the mental health sector struggles with many of these issues; especially in terms of providing a skilled and sustainable workforce. However, the notion of a generic worker as the 'solution' is not seen as a viable nor particularly desirable strategy.

If governments are seriously considering a generic model for our healthcare system then surely the recent United Kingdom (UK) pilot experiences would raise a number of concerns. In particular the large proportion of unregulated levels of workers within the UK model is of concern to any system proposing quality and effectiveness of care. If Australia is seeking to provide quality and be responsive in healthcare then surely there is a limited role for unregulated workers. It is vitally important as a nation that we do not purely follow the example of other countries but carefully consider the best options for the context in which our work is done. Although regulation of health professionals has some limitations, surely it is an essential safeguard for the community. It would be entirely unfortunate if Australia was to adopt yet another model for our healthcare system without considering innovation in practice, a commitment of realistic funds to our community focused model and the development of strategies to harness and extend the strengths of our current system.

Recent discussions about the "generic mental health worker" suggest this concept may be viewed as a strategy to overcome the inability to recruit sufficient skilled and educated nurses to work in the mental health field. The idea of the "generic mental health worker" relies on the assumption that the work of psychiatric/mental health nurses and other mental health professionals can be reduced to a number of tasks able to

be undertaken by workers with less training and a perceived ability to perform a number of functions at a relatively superficial level. In contrast, the essence of psychiatric/mental health nursing equates to considerably more than its component parts, and requires a high level of skill and knowledge to enable the highest possible standard of care to be provided.

Moving between states for Nurse Practitioners, medication endorsed Division 2 nurses and mental health nurses working within statewide Acts is complicated. Mutual agreements work around this but should have similar frameworks.

The different structure required for the two levels of nursing (VET requirements and university) limits cooperation between TAFE, university and workplace. The different qualifications required for supervision complicates this with nurses with education backgrounds at Masters level and higher, requiring a Cert IV to teach and supervise students for TAFE.

Demand

An important point to realize in today's health care environment in Australia is that consumers are referred to hospitals primarily because they need nursing in conjunction with their medical treatment. Indeed many consumers with acute health care issues will be treated and nursed within the community.

The demands placed on mental health services for acute care are likely to increase considerably, meaning that the need for a highly qualified, skilled and experienced psychiatric / mental health workforce will become a greater rather than lesser imperative. In order to achieve the quality of service required, rather than focusing on a more economical alternative, a systematic evaluation of the psychiatric / mental health nursing workforce is essential. Based on our experience of research and practice within the field, we would envisage that the following approach to the psychiatric / mental health nursing workforce be adopted as an overriding framework:

- Division 2 nurses with specific qualifications in psychiatric / mental health nursing. Under the supervision of Division 1 (with endorsement) or Division 3 nurses, Division 2 nurses are able to undertake a number of roles in providing care for clients experiencing mental health problems within inpatient and potentially within community settings. While the nature of the care provided by these nurses is necessarily limited by their level of skill and knowledge, given appropriate training and support, practices may be able to expand to include other areas such as medication administration

- Registered nurse (the equivalent of the nurse currently registered on Division 3 or Division 1 with endorsement). This group would provide the majority of the direct care. Using knowledge and skill to provide a combination of physical and psychosocial treatments to provide nursing care in order to meet the needs of individual consumers

- Advanced practice nurses. This category includes nurses with postgraduate qualifications and a high level of skill and experience in a specific area of psychiatric / mental health nursing. These nurses may provide direct care to consumers, or may act in a consultancy role to other nurses and allied health professionals. This category includes: psychiatric nurse educators, psychiatric nurse consultants, senior psychiatric nurses, clinical nurse specialists, psychiatric consultation and liaison nurses and nurse practitioners.

Enhancing Current Systems

A major concern for health services is the mobility of an ever shrinking workforce. If workers are dissatisfied with their employment they have many options available to them. Health services must look to models that enhance work environments; making them desirable to stay, not leave. This includes a focus on healthy workplaces that are inclusive of workers, have a genuine shared vision supported by management, and have individuals motivated to lead in a proactive team.

Health services must do this collectively with their staff to ensure that everyone is aligned in a common direction. Regardless of the model of healthcare, these factors are crucial to sustainability of the workforce as recognised in the United States of America (USA) with their Magnet Hospital recognition program. The Magnet Hospital program was created in the USA in a similar environment, in terms of workforce shortages, to what we now experience in Australia in 2005.

Factors that support and nurture a workforce ultimately improve recruitment, and probably more importantly in the Australian context, retention rates. This is evidenced by health research undertaken in proactive orientation schemes and as a result of Magnet Hospital status.

In addition to enhancing the broader work environment, specific attention must be directed toward improving multidisciplinary teamwork; especially so in the context of initial and ongoing interprofessional learning. This process allows for some of the limiting professional boundary issues to be lessened and creates a greater climate of interprofessional understanding regarding roles and responsibilities, hence improving team productivity.

In enhancing current systems, practice development must also be a high priority for Australian healthcare services. A greater emphasis, with the accompanying resources, is required to ensure the workforce remains skilled and current within an ever changing environment. Practice development involves providing the conditions for professionals to learn and change at work.

Doing it Differently: Models of care in Adult Acute Psychiatric In-Patient Units

It could also be argued that in Mental Health Services in Victoria in 2005, many health professionals, especially Mental Health Nurses (MHN), attempt to deliver care from a perspective and knowledge of models past. Mental health nurses are crucial to the delivery of effective care and deliver this both across the lifespan and the continuum of illness-health. In today's environment the challenges in doing so are even more pressured. In the past lengths of stay were longer, MHN's were more able to be proactive and integral in ongoing therapeutic programs and had space and time available to offer more than custodial care. No doubt there are services that provide some of this, however for the most part acute psychiatric services, especially acute adult inpatient units AAIPU, are not able to deliver effectively in this area. This is a constant source of frustration for many MHN's.

Anecdotally, MHN's express an urgent desire to offer therapeutic care but commonly describe themselves as custodians within a predominately medical approach. An attractive change from this model, one that may encourage the disenfranchised to return, would be a shift in AAIPU models of care to something more inclusive of the therapeutic approach. A shift to a more genuine consumer orientated model of care would be very positive.

The position of the CPNRP, therefore, regarding models of care in Adult Acute Psychiatric In-Patient Units in Victoria, is that a systematic, inclusive and well planned evaluation urgently occurs; with resulting data informing consumer orientated contemporary models of care.

Evidence is readily available to support the need for review and subsequent innovation in In-Patient care. In reflecting on the position of In-Patients Units, the Sainsbury Centre for Mental Health (2005, p46) state that "the key to understanding life on acute wards is the expectations that they will fulfill a number of clearly defined roles and functions…the in-patient policy implementation guide stresses the need for a philosophy of care to be explicitly user focused"

Consumer Involvement in Healthcare

The Centre also affirms the position of local mental health consumer bodies when they discuss the need for a congruent model of care in in-patient units commensurate with the philosophy (and legal obligation) to 'do the patient no harm' (VMIAC, 2005). This requires an extensive organizational re-engineering of in-patient care and must include the adoption of genuine consumer-focused models. In their position as leaders, Mental Health Nurses are instrumental in initiating and progressing change, and are key influences in the provision of effective multidisciplinary care.

It is surprising that the impact and growth of consumer participation is nowhere mentioned in the productivity commission discussion paper and terms of reference. The only oblique reference is an assumption made in the document that consumer expectations need to be "conditioned" so that they do not outstrip what can efficiently be delivered.

Australian case studies of best practice consumer participation projects show that while this is a fear on the part of many providers and healthcare organizations, the reality is very different (Consumer Focus Collaboration, 2001). Most comparable western countries would acknowledge the importance of consumer participation, and in fact, have consumer participation activities and their promotion tied into funding arrangements, as in the UK.

Consumer participation in health is considered a cornerstone of modern healthcare delivery. In fact, consumers are also in this light, a part of the healthcare workforce, with their own roles, ideas and solutions.

According to the document *Improving health services through consumer participation* (Consumer Focus Collaboration, 2000), there are four main reasons for why consumer participation is important.

1. Participation is an ethical and democratic right

2. Participation improves service quality and safety and helps gain health service accreditation.

3. Participation improves health outcomes.

4. Participation makes services more responsive to the needs of consumers.

The discussion paper isolates remote and indigenous communities as needing special attention. Consumer participation in itself is a tool for engaging marginalised communities and should be at the forefront of a discussion paper wanting to address equity and access in health and any strategies that can assist the process.

There is a need to ensure that consumer groups will have an opportunity to respond to this discussion paper.

<u>Service quality / job satisfaction</u> are noted as "unrealized opportunities" in the foreword of the productivity commission foreword. Consumer participation provides a clear

strategy to address this. If services are more in tune with consumer needs, and communication between providers and consumers is improved, with expectations and clarity of values on both sides, then these as yet “unrealized opportunities” become potential areas for growth and benefit.

The positive potential between consumer participation in healthcare, service delivery and staff, have been articulated as:

> Improvements can be made to services as a result of involvement, leading to better relationships between users or carers and staff, and perhaps increased job satisfaction among those working in the service. Targeting services to users' needs may improve the cost-effectiveness of those services (Simpson, House, 2003)

In its 2004 report on Patient and Public involvement in health, the UK Department of Health found that outcomes of patient involvement included:

- Improvement in patient satisfaction is a clear outcome of patient involvement
- Patients perceive a wide variety of benefits including greater confidence,
- reduction in anxiety, greater understanding of personal needs, improved trust, better relationships with professionals and positive health effects
- Greater control over their own lives and conditions
- Greater knowledge and understanding of their condition(s) and healthcare needs
- More appropriate use of health services
- Positive health effects
- More positive relationships with their own doctors

Outcomes for professionals were cited as:

- Professionals value the personal rewards of patient involvement but also see the process as a means of managing consultations more effectively
- Improved understanding of patient’s health problems
- Increased patient compliance
- Greater trust with patients
- Patient satisfaction
- Better management of the consultation process

Public involvement

In the same document, the following excerpt indicates why the British government is committed to patient and public involvement in health care.

Public involvement influences the policies, plans and services of primary care trusts and partnership work enables learning, resources and expertise to be shared across local health economies. People involved in primary care service planning believe that public involvement leads to better understanding of healthcare needs, improved health services, less health inequality and health improvement. People outside primary care trusts see improvement in the health of local communities as a crucial long-term outcome.

And:

> Leadership, board commitment and inclusion in strategic planning are all important for the success of public involvement, which should be a shared corporate responsibility.

The background to the importance of consumer participation in the delivery of health, and therefore its impact on the healthcare workforce is as follows:

- Adds to service quality
- Services more in tune with community needs
- Better communication between consumers and providers
- Moral/philosophical/principles
- Right to be involved

Attitudes within general health services towards psychiatric consumers contributes to inequity and difficulty accessing services. Consumer participation in training of providers is an essential aspect of changing this. Consumers need to be supported and resourced to fulfill their roles as valued members of healthcare organizations, with a range and choice of ways to participate, at all levels.

Consumers can also assist with promoting the "priority of evaluation in the workforce culture". We are already trained healthcare accreditors, but this role needs to be expanded. Consumers are well placed to train staff in organizational change, and to be involved in service evaluation and monitoring. These are vastly under explored areas in Australia, and we languish far behind other comparable countries in developing the potential of consumers to engage in the very principles and policies we aspire to.

There is real reason to support the view that health policies should be independently evaluated, and that responsibility for monitoring of outcomes from policy development & implementation should be separated out. Consumers should be a part of this process. They are the people who are in a key position to determine service quality and whether or not policies have been implemented effectively.

Conclusion

Whilst there are numerous challenges confronting the psychiatric/mental health nursing sector, as outlined in this submission, it is also clear that the issues are surmountable, providing sufficient resources are allocated to the sector. However, any solution to current workforce shortages must also take into account psychiatric/mental health nurses as key stakeholders, and seek their views and input, particularly in policy formation and research. Nurses are the single largest professional grouping within the health sector, and yet their views are insufficiently represented when it comes to policy formation and resource allocation.

Further, to simply replace one grouping, such as psychiatric/mental health nurses who may be in short supply, with another such as a generically trained healthcare worker, is no real solution, but rather a temporary and short-sighted fix to a long-term problem. In an environment of growing healthcare demand, a sophisticated and long-term policy must be developed which maintains high professional standards, allows for required flexibilities and maintains as paramount consumers' right to the best possible health and treatment outcomes.

Recommendations

1. The development of system wide organizational cultures that are adaptive, proactive, trusting and committed to a cohesive, collective vision in service delivery.
2. The development of system wide organizational cultures that value and openly recognises the contributions of all stakeholders in care.
3. An articulated, collaborative strategy that facilitates multisectorial communication
4. An inclusive approach within and between members of the multidisciplinary team and across the continuum of care
5. Comprehensive education that addresses specific learning needs of the in-patient clinicians; and that this education embraces an interprofessional approach.
6. An articulated support strategy within identified models that augment existing support models
7. That a systematic, inclusive and well planned evaluation urgently occurs; with resulting data informing consumer orientated contemporary models of care.
8. Those models of care have at its core, 'the basics' of respect, consideration and listening and valuing the consumer voice as the rule, rather than the exception.
9. Introduce models of care that actively utilises therapeutic strategies to reduce the use of more restrictive practice; for example high dependency and seclusion.
10. A model that proactively engages service uses in the design, implementation and evaluation of care.
11. That funding be provided to explore strategies to increase the profile and attractiveness of psychiatric/mental health nursing as a career preference for undergraduate nursing students, such as introducing a major stream in psychiatric/mental health nursing to enable specialization at undergraduate level, as a means to recruit students with a specific interest in this area of practice
12. Increased funding to provide training opportunities for registered nurses in the mental health field, such as the CPNRP "preceptorship in psychiatric nursing"---

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Appendix: Australian mental health / psychiatric nursing labour force 1993 – 2001

A description of the Australian mental health / psychiatric nursing labour force from 1993 to 2001 was derived from the nursing labour force reports produced by the Australian Institute of Health and Welfare (AIHW) (Australian Institute of Health and Welfare, 1997, 1998, 1999, 2001, 2003a, 2003b).

Information relevant to the following variables was obtained from these reports:

- Clinicians employed in nursing (registered and enrolled)
- Clinicians employed in mental health / psychiatric nursing (registered and enrolled)
- Sex of clinicians employed in mental health / psychiatric nursing
- Age of clinicians employed in mental health / psychiatric nursing
- Work setting of main job for mental health / psychiatric nurses, and
- Hours worked per week in the mental health / psychiatric nursing field

Data relevant to the first variable – clinicians employed in nursing – is outlined in Table 3. Data relevant to each of these variables is outlined in Table 3.

Table 3: Registered and enrolled nurses employed as clinicians in nursing (Source: AIHW Nursing labour force reports 1993 – 2002)

Characteristic	1993	1994	1995	1996	1997	1999	2001
Registered	147,238	155,752	151,485	154,210	154,388	157,613	159,699
Enrolled	48,499	48,997	44,207	43,248	42,823	42,436	42,053
Total	195,737	204,749	195,692	197,458	197,211	200,049	201,752

Table 4: Characteristics of registered and enrolled nurses employed as clinicians in mental health / psychiatric nursing (Source: AIHW Nursing labour force reports 1993 – 2002)

Characteristic	1993	1994	1995	1996	1997	1999	2001
Registered mental health nurses	9,066	9,408	9,428	9,415	10,112	9,958	10,184
(% of all clinicians)	6.2	6.0	6.2	6.1	6.6	6.3	6.4
Enrolled nurses working in the mental health field	2,068	1,944	1,820	1,840	2,181	2,215	1,893
(% of all clinicians)	4.3	4.0	4.1	4.3	5.1	5.2	4.5

Characteristic	1993	1994	1995	1996	1997	1999	2001
Percentage of male nurses	34.4	35.5	34.9	34.2	33.9	32.7	32.4
Age							
Average (years)	39.7	39.4	39.7	40.3	40.7	42.5	43.7
Frequency (%)							
<30	12.9	13.4	13.6	13.1	12.7	. .	. .
30 – 39	39.2	39.2	37.4	34.7	31.6	. .	. .
40 – 49	32.9	32.8	34.3	36.5	38.5	. .	. .
50 – 59	11.9	11.6	12.6	13.3	14.7	. .	. .
60 +	2.4	2.2	2.1	2.4	2.5	. .	. .
Hours worked per week							
Average	37.1	37.0	37.4	37.7	36.0	34.7	34.4
(% 35 + hours)	78.4	77.1	77.0	75.4	72.3	69.2	66.9

Based on an examination of the information outlined in this table, the following trends were noted:

- The average age of clinicians employed in the mental health / psychiatric nursing field has increased relatively consistently from 39.7 years in 1993 to 43.7 years in 2001.
- Between 1993 and 1997, the overwhelming majority of clinicians were aged between 30 and 49 years of age.
- During this same period, there was little change in the proportion of clinicians who were less than 30 years of age or 60 years of age or older. In contrast, the proportion of clinicians aged 30 – 39 years steadily decreased as the proportion of clinicians aged 40 – 49 years steadily increased. There was also a steady increase in the number of clinicians who were aged between 50 – 59 years.
- The average number of hours worked per week by clinicians employed in the mental health / psychiatric field demonstrated a steady decline from 1996 (37.7 hours) to 2001 (34.4 hours).
- Indeed, the proportion of clinicians working full-time (35 hours or greater) has, without fail, dropped each year from 1993 (78.4%) to 2001 (66.9%).
- Compared to all preceding years, there was a notable reduction in the proportions of registered mental health nurses and enrolled nurses working in the mental health field who worked in excess of 40 hours per week.