Australian Nursing and Midwifery Federation submission to the

DEVELOPMENT OF THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY 2021-2031 CONSULTATION

30 SEPTEMBER 2021

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QUESTIONS

1. To what extent does the aim of the draft Strategy address the key challenges facing Australia's mental health workforce?

Ensuring prevention and promotion are clearly articulated in the Strategy's Aims

While the broader explanation of the draft Strategy's Aim briefly mentions the importance of prevention of mental ill-health and promotion of mental wellbeing, these elements are not visibly articulated in the Strategy's central Aim; 'to develop an appropriately skilled mental health workforce of sufficient size that is suitably deployed to help Australians be mentally well by meeting their support and treatment requirements at the time and in the way that best meets their needs.' This risks these vital elements being overlooked and perpetuating a responsive/treatment-oriented philosophy rather than pressing proactive, preventive approaches to enabling good mental health and wellbeing. It is essential our mental health system has a strong focus on prevention and early intervention across the lifespan, with universal routine screening for people at risk, and expert, tailored care available early in life, early in onset and early in episode through community and primary care settings. Nurses and midwives already have widespread engagement with community members through many successful midwife and nurse-led programs. We recommend expanding and improving a range of these programs to facilitate routine and opportunistic mental health risk screening, therapeutic solutions and referral across the lifespan as a very impactful, cost effective and efficient approach to prevention and early intervention. While the Strategy clearly acknowledges the importance of prevention in a broad sense, it should be more central to its Aims.

Crisis Surge Capacity

Another key challenge facing Australia's mental health workforce and wider health workforce that also provides mental health support, care, and treatment is ensuring capacity and availability due to surges in demand. This has been evident during and following recent crises including the SARS-CoV-2/COVID-19 pandemic, bushfires, flooding, and the NSW mouse plague. The Strategy could better include a focus on mental healthcare during and following crises and the importance of ensuring capacity in the workforce for crises situations when they arise.

Workplace violence in mental health

A key challenge facing the mental health workforce is violence in the workplace. This does not appear to be addressed clearly in the Strategy's Aims or elsewhere. Health workers are at high risk of violence all over the world. Between 8% and 38% of health workers suffer physical violence at some point in their careers.

Many more are threatened or exposed to verbal aggression.[1] As first-line health and mental health care staff, nursing staff are in close and frequent contact with mental health services consumers and their families. From a survey of more than 150,000 nurses, drawn from 160 global samples, overall, about a third of nurses have been physically assaulted, bullied, or injured, while around two-thirds have experienced nonphysical assault.[2] Violence is a frequent and critical factor that affects the workplace safety of nursing and midwifery staff and all health care staff more broadly.[3] Personal experiences of aggression or violence in the workplace lead to serious consequences for nurses and midwives, their patients, patient care, and the organisation.[4]

Nurses and other staff working in mental health cope with significant psychological and physical challenges, including exposure to verbal and physical violence. Nurses who work in mental health environments have a 20 times higher rate of physical violence than those working in public health units.[5]

Nurses exposed to verbal or physical abuse often experienced a negative psychological impact post incident.[6] Nursing staff who are exposed to violence experience increased stress, decreased work satisfaction and have adverse long-term health consequences, this reduces care quality and work morale and increases nurse turnover.[7] [8] Violence against nurses also negatively impacts recruitment and retention of staff which is a significant problem for the nursing workforce employed in mental health.[9]

Workplace violence is a serious and growing problem that affects all health care professionals. Nursing staff experiencing violence in the workplace has become a workplace safety concern to which health institutions worldwide attach considerable importance. Strategies are needed to prevent workplace violence and manage the negative consequences experienced by healthcare workers following violent events. Hospital managements should conduct work stress reduction intervention programs and promote strategies to reduce workplace violence.[10]

Health care organisations must ensure the necessary conditions for enabling and encouraging appropriate actions following violent acts according to relevant protocols. Comprehensive strategies from the perspective of nursing education and training, organisational policy, patient care and staff support are recommended to promote occupational safety in mental health care. Workplaces must also endeavour to create psychologically and physically safe environments for workers. Nurses themselves are also in a unique position to develop and provide assistance to implement prevention programs that can decrease the incidence and prevalence of violence in healthcare environments.[11]

As part of broader work to assist public hospitals and mental health services meet their new obligations to end violence, the ANMF (Victorian Branch) has developed a new guide for health and mental health care services to end violence and aggression. The 10-Point Plan to End Violence and Aggression: A Guide for Health Services uses a traffic-light approach to show hospitals how to move from a high risk to a low risk environment. The Guide is divided into 10 sections based on the ANMF's 10 Point Plan:[12]

1. Improve security
2. Identify risk to staff and others
3. Include family in the development of care plans
4. Report, investigate, act
5. Prevent violence through workplace design
6. Provide education and training to healthcare staff
7. Integrate legislation, policies and procedures
8. Provide post-incident support
9. Apply anti-violence approach across all health disciplines
10. Empower staff to expect a safe workplace

The Guide articulates what a successful organisational response to the prevention of violence and aggression should look like. This work could be examined as a potential avenue for improving the safety of mental health care environments for all staff, as well as mental health consumers and their families.

2. To what extent do the aim and objectives provide a strategic framework to develop the mental health workforce the Australian community needs?

While the Strategy's Background and Definition of the Mental Health Workforce clearly identify the breadth and diversity of the nature of mental health, the priority settings that the Strategy has included should be expanded and specified to reflect this acknowledgement more clearly; health settings, mental health settings, and other settings is too vaguely defined within the Aim and Objectives, and overlooks the priority settings that sit within each of these. The ANMF recommends that specific settings should be defined more clearly within the Strategy's Objectives to ensure a targeted, planned, and contextually relevant approach is taken to each. For example; aged care, maternity care, disability care, regional, rural, and remote areas, and child/adolescent care, refugee and asylum seekers, people experiencing homelessness, and Aboriginal and Torres Strait Islander people risk falling through the cracks if not highlighted specifically. We present further information below.

Nurses and midwives in rural, regional, and remote areas

Although Australia's mental health workforce comprises a broad range of professions, most healthcare providers in rural, regional, and remote areas are nurses, and to a lesser extent, midwives (discussed in greater depth below). Due to the size of the nursing workforce, nurses play a central role in providing initial, holistic, and accessible physical and mental health care to those individuals in rural and remote settings.

As the Strategy identifies, all nurses provide mental health care as an integral part of caring for the individual, recognising the complex interrelationship between physical and mental health. They are in a position to respond to the high premature mortality/morbidity rates of individuals being treated for mental illness caused by physical illnesses, such as cardiac disease, diabetes and metabolic related disorders. Early prevention, early diagnosis and identifying suicide risk in the treatment and management of mental health problems are essential in achieving positive outcomes for individuals. It is imperative, therefore, that nurses and midwives in rural, regional, and remote centres have opportunities for continuing professional development to maintain their mental health knowledge base, to best ensure these critical interventions occur.

For many nurses and midwives in rural, regional, and remote practice, their role includes making initial assessments of mental health problems, and then identifying appropriate referral pathways to nursing colleagues with specific post graduate mental health qualifications, nurse practitioners, and/or other health professionals. While these may be located rurally, they are more likely to be found in regional or metropolitan centres, or at best provide services under a fly in, fly out model of care.

Access to mental health experts for rural, regional, and remote health professionals and the communities in which they practice, is variable and quite often costly for the individuals and their families if travel is incurred to obtain these services.

Given the fact there may be delays in accessing mental health experts, it is imperative that nurses and midwives in rural, regional, and remote centres are educated on de-escalation strategies, for their own safety and that of other people in the facility, where the person is experiencing an acute episode or has a severe mental health condition.

Particular problems arise for staff in rural areas when people experiencing psychotic episodes present to their facility. An example given by NSW ANMF members is that emergency departments in smaller hospitals in that State are gazetted to hold mental health patients under the Mental Health Act. Staffing in these rural gazetted hospitals is minimal and becomes unsafe when staff need to manage people with severe mental health conditions who are escorted by the police to the health facility for assessment. The risk is increased when this occurs overnight as there may only be two staff for the facility, when staff have limited mental health experience for managing high risk, and when delays occur in transporting the person to a more appropriate facility, once assessed.

In a survey undertaken by the NSW Branch of the ANMF, members were asked about their experiences accessing Mental Health Intensive Care Unit (MHICU) beds for individuals with severe mental health conditions.[13] Responses from nurses in rural areas highlighted that due to the distance and associated risks involved in transferring these people to approved MHICUs, staff in the rural facility are often required to manage these high care mental health individuals for extended periods.

Seclusion is very often the only safe option available for managing these high-risk individuals. Safety for nurses and midwives practising in rural and remote areas is clearly an issue due to multiple factors such as low staff numbers, isolation, distance from and accessibility to, mental health services/experts in major centres.

The strategies which the ANMF considers can aid capacity building for the rural and remote mental health workforce, include:

1. Structured clinical placement opportunities in rural and remote health care facilities, for nursing and midwifery students, to promote the integration of physical and mental health, as well as showcase the benefits of country living.
2. Opportunity for nursing students to work before fully qualified, such as the successful Registered Undergraduate Student of Nursing (RUSON) model operating in Victoria.
3. Improving support for newly graduated nurses and midwives in rural and remote health facilities to aid retention; as well as assisting rural and remote nurse and midwife managers in their role as preceptors of beginning registered practitioners.
4. Mental health-specific continuing professional development of registered nurses, enrolled nurses and midwives working in rural and remote locations, facilitated by managers of clinical leaders (both time release and funding assistance).
5. De-escalation education for all nurses and midwives practising in rural and remote centres, in the management of people with mental illness.
6. Encouragement of registered nurses and midwives to undertake post graduate mental health programs, with the flexibility of distance education modules.
7. Targeted quarantined scholarship funding for nurses and midwives to undertake post graduate level studies in mental health, to work in rural and remote areas.
8. Targeted quarantined scholarship funding for mental health nurse practitioners to work in rural and remote areas.
9. Provision of scholarships for education and professional development specifically in dementia care for all nursing staff and care workers in rural aged care.
10. Provision of positions in rural and remote locations for mental health Nurse Practitioners.
11. Support for Nurse Practitioner-led models of care.
12. Support for mental health programs related to Australia's First Peoples such as the continuation of the Graduate Certificate Indigenous Mental Health and Well-being conducted by Southern Queensland University.

3. Are there any additional priority areas that should be included?

Mental Health Stigma

While the issue of stigma in terms of working in the mental health sector is acknowledged in the Strategy, in terms of that which is experienced by people experiencing poorer mental health and wellbeing is not so well identified and could be improved. To develop the mental health workforce the Australian community needs, this type of stigma should also be acknowledged in the strategy as an element of it Aims and Objectives.

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

Foregrounding Person-Centred Mental Health care

The importance and need for person-centred, culturally safe care are noted within the Strategy but does not appear to be clearly or specifically acknowledged and included within the identified Priority Areas. The mental health of individuals and communities is multifaceted and complex. An integrated, whole-of-person approach is needed to address these complex and interconnected issues. The importance of nurses and midwives to the provision of holistic, person-centred care including caring for people's mental health and people experiencing mental ill-health, must be acknowledged and utilised to meaningfully improve mental health care in Australia.

Person-centred services that provide holistic mental health care encompassing physical wellbeing and management of co-morbidities are more likely to meet the needs of consumers and lead to better outcomes. Viewing mental health as a component of overall health is also fundamental to reducing stigma. This shift in mindset is key to the successful implementation and adoption of the Strategy and should be identified as critical to short term implementation.

While priority areas identified in the Strategy are essential to workforce reform and the success of the system as a whole, the ANMF recommends prioritising strategies that create a person-centred mental health system, equip workplaces to be mentally healthy, and increase the efficacy of Australia's mental health workforce. An effective, person-centred health system needs an effective and robust health workforce practicing within healthy workplaces.

Workplaces that Support and Promote Mental Health and Wellbeing

The Strategy identifies the improvement of workplace health safety and wellbeing as among the priority areas (5.3). This priority could be developed further to acknowledge that creating positive practice environments by equipping workplaces to be mentally healthy will enable the establishment and maintenance of an effective mental health workforce whilst also supporting person-centred mental health goals for the broader community.

Being meaningfully employed is linked with improved mental health, and workplace experiences can trigger, contribute to and/or exacerbate mental ill-health or illness. Therefore, positive practice environments are an essential component of a robust mental health system that not only aims to treat mental ill-health but also prevent it.

Nursing and midwifery are emotionally demanding professions and deficiencies in nurses' and midwives' mental wellbeing, characterised by low vitality and common mental disorders, have been linked to burnout, low productivity, absenteeism and presenteeism. Mental health nurses and other mental health workers are required to engage in effective therapeutic interactions with clients in emotionally-intense situations. An integrative systematic review identified that three related concepts are relevant in the context of workforce attrition and burnout in mental health nursing: emotional labour, emotional exhaustion (an element of burnout), and emotional intelligence (or self-protection).[14] The systematic review highlighted that emotional labour can inspire personal growth of emotional intelligence among mental health nurses. Recommendations for clinical practice included:

1. Promotion of supportive work environments
2. Involving nurses in shared decision-making
3. The provision of ongoing professional development opportunities that facilitate the development of emotional intelligence and resilience among mental health nurses.

Problems with poor mental health in the nursing and midwifery workforce can exacerbate issues with workforce recruitment, retention, and turnover which are themselves significant issues in Australia.

Working people who experience mental ill health require supportive and trusting workplace environments to guard against issues such as absenteeism and presenteeism. Workers who are employed in unsupportive environments have poorer outcomes, while factors such as awareness and openness about mental illness, collegial support and managerial support can assist people experiencing mental ill health to be and feel productive and valued in the workplace. Protective factors for improved mental health among nurses have been found to include; better general health, cohabitation with a spouse or partner, healthy sleeping and eating habits, not being an informal carer as well as a paid carer, and not working nights.[15]

The Strategy could better address employers' responsibility to their staff in providing safe, supportive environments and for promoting mentally healthy practices in the workplace. Employers are also responsible for supporting employees who experience mental health issues. With employers, professional and industrial organisations are important partners and advocates for promoting and supporting mentally healthy workplaces. A key priority of the ANMF and all our state and territory Branches is ensuring the health and safety of our members, as well as all nurses, midwives, and carers, at work. The ANMF provides representation, support, and advice, including helping members make a claim for workers' compensation.

The ANMF acknowledges that existing workers' compensation schemes may not adequately address workplace mental ill health. The current system can be experienced as adversarial - pitting employers against workers, dis-incentivising both claims and support. This can result in employers displaying a lack of empathy and instead rigidly adhering to budgetary factors and policies unfit for purpose, which can exacerbate the causes of mental ill health and risk for employees. Further, the ANMF also recommends that the Strategy place special focus upon the mental health and workplace safety with regard to mental health and risk of healthcare workers themselves. By effectively supporting those who care for the overall wellbeing and mental health of the general public and community, and ensuring that their workplaces are safe, mentally healthy, and supportive, a strong, productive, and effective health and mental health workforce can be sustained.

Diverse and Vulnerable Special-Needs Groups

While the background paper makes brief mention of some of Australia's particularly vulnerable groups, the Strategy appears to almost completely omit any mention of specific population groups that must have their needs foregrounded so that care for them can be effectively planned, coordinated, and delivered. These groups include but are not limited to; refugees, asylum seekers, older people, people with a disability, people with dementia Gender and Sexually Diverse (GSD)/LGBTI+, culturally and linguistically diverse communities, people experiencing homelessness, veterans, and incarcerated people. The Strategy must be expanded and reworked to ensure that these groups are clearly incorporated and accounted for. Simply applying a 'whole of population' scale and approach is not sufficient to address the needs of diverse groups whose experiences, needs, and preferences are so dissimilar and often poorer than the mainstream population.

Gender and sexually diverse mental health

Mental ill health disproportionally impacts upon people from gender and sexually diverse GSD groups.[16] As a conservative estimate, GSD people are likely to account for at least 11% of the total Australian population based upon the most recent surveys. This estimate is conservative, as reliance on self-reporting and issues with definitions are likely to have significantly underestimated the actual number of GSD people within the Australian community. The proportion of younger people who identify as GSD people is also greater than older population groups, indicating that over the coming years, the proportion of GSD identifying people is likely to increase.

Despite recent advances in achieving equality for GSD people, such as the legalisation of marriage between members of the same sex, GSD people can experience persistent marginalisation, discrimination, and stigma both within the wider community and its institutions such as schools and workplaces, and within health and mental health care contexts. Further, the discrepancies between GSD people and the mainstream population can interact with other social and demographic factors in a compounding fashion. For example, being a GSD person who is also a member of another disadvantaged/marginalised group such as an Aboriginal and/or Torres Strait Islander Australian, a member of a culturally and linguistically diverse (CALD) group, socioeconomically disadvantaged, living in regional or remote Australia, or indeed a woman, can mean that a person faces further challenges to accessing safe, effective, quality health and mental health care and poorer health and mental health outcomes.

Gender and sexually diverse people are a disadvantaged group whose general health, health risk factors, and especially mental health appear to be poorer than the mainstream population. Gender and sexually diverse people have:[17]

- experienced and continue to experience systematic marginalisation and discrimination in the community and healthcare systems;
- higher rates of smoking and alcohol consumption;
- poorer access and engagement with health and mental health services;
- greater risk of poor mental health, especially depression, anxiety, and psychological distress;
- poorer health and mental health outcomes;
- greater risk and rates of self-harm, suicidal behaviours, ideation, and death from suicide, and;
- higher incidence of homelessness, a compounding factor for the development and exacerbation of mental ill health (see also ‘Housing and homelessness, below).

Health and mental health care professionals may require focussed, evidence-informed information, education, and support to provide safe, quality care to GSD people. This is because GSD people and the specific issues they face and that are important to them may not receive sufficient coverage and attention in current health and mental health care preparatory or continuing professional development programs. The ANMF urges the Strategy to identify GSD people as a key group within its scope. Supporting and resourcing focussed research, initiatives, and programs addressing the disproportionate mental health burden faced by GSD people in Australia has the capacity to make a significant and meaningful difference to a considerable proportion of the Australian population, their families, and significant others.

Housing and Homelessness

The intersection between homelessness and mental ill health is a key concern for the ANMF, and as such, we are keen to see the Strategy focus sufficient attention on this important issue as part of its scope. The links between mental ill health and homelessness have long been acknowledged, but less so understood and effectively acted upon. The ANMF supports the premise that ill health, both physical and mental, are causes and consequences of homelessness.

People experiencing homelessness often present with severe and unremitting symptoms of mental ill health and with significant barriers to accessing appropriate service provision. Current availability of accommodation is wholly inadequate, and the need for appropriate housing and mental and physical health services is urgent. For those experiencing the dual burdens of mental illness and homelessness, a 'housing first' model with integrated and supportive housing and a variety of housing options to suit the individual and their needs may be a meaningful and effective approach. This could be identified within the Strategy.

Significant mental ill health occurs in between 30–50% of people who are homeless. This may however be an underestimation, as people who are homeless also face greater isolation and poorer engagement with health and mental health systems for diagnosis, treatment, and support. Homeless people are considerably more likely to suffer from alcohol (8.1% to 58.5% of people) and drug dependence (4.5% to 54.2% of people) than the age-matched general populations. The prevalence of psychotic illnesses and depression (2.8% to 42.3% of people) and personality disorders are also higher.[18] Models of mental health care and social care that can best meet the mental health needs of people who experience homelessness requires further investigation and attention within the Strategy. Whilst homeless outreach teams traditionally have crossed boundaries, the reduction of dedicated programs has reduced the ability to cross boundaries and leave catchment areas. The Royal Commission into Victoria's Mental Health System has gone further and recommended that access to local mental health and wellbeing services and area mental health and wellbeing services should be flexible and should not require providers or consumers to rigidly adhere to boundaries for service delivery.[19]

Young people who are homeless in Australia have extremely high rates of psychological distress and psychiatric disorders. Action addressing housing and mental health for young people in Australia is vital, as homeless youth are at risk of developing psychiatric disorders and possibly self-injurious behaviour the longer they are homeless. The ANMF supports research and evaluation of current and emerging models of housing support for people with mental ill health or who are at risk of mental ill health or homelessness and advances that this should be an issue for workforce reform addressed within the Strategy.

In Victoria, supportive residential services (SRSs) are privately owned businesses that provide a shared living environment and personal support to individuals of varying age ranges. Many residents in 'Pension Level' SRS originally came from the closures of psychiatric institutions; today this population is ageing and suffering

from increasingly debilitating chronic diseases related to a lifetime of poor symptom management, social isolation, poor diet, and the adverse effects of long-term psychotropic medication. Residents experience a wide range of psychological, physical, intellectual and alcohol and other drug related disabilities. The SRS residents living with chronic, complex and enduring mental illness are some of the most marginalised and vulnerable members of our community. Overall, they are cared for by an unskilled workforce. A review of the provision of service for those within SRS who experience mental illness is timely, along with improvements to implementation and support for a better skilled and qualified workforce including nurses and mental health nurses and improved integration with primary care, general practice, allied health, and specialist services.

Along with this, integration of service systems to better facilitate care of people experiencing homelessness and mental ill health, as well as those at risk, is required. This could involve;

1. review of current resourcing and provision of care models;
2. ensuring programs are enabled to follow the homeless person and provide treatment, care and support where they need it, and not be blocked by archaic boundaries and catchment areas;
3. recognition of the social determinants of health and the impact of adverse childhood experience and trauma on future health outcomes;
4. integration of services such as health, housing and mental health to better facilitate intervention for the prevention of ill health and recovery from ill health;
5. recognition of chronic disease and comorbid health on mental illness and more effective hospital discharge planning;
6. access for marginalised groups who may be precluded from receiving care due to 'no formal diagnosis' being recorded such as those who are Medicare ineligible, with poor support networks and / or no significant other, and;
7. enhanced training and education for emergency services, first responders, and health and mental health care staff on complex presentations and how to respond and provide care to people who are experiencing homelessness and mental ill health, in the least restrictive way.

Further examples of successful approaches in Victoria include:

- The provision of nurse-led homeless persons programs that employ mental health nurses to work alongside drug and alcohol nurses, community nurses and HIV nurses all of whom are trained in the trauma informed care approach and have good knowledge of the services available to ensure their patients' needs can be supported;
- The continuation of 'fast track' appropriate public housing for people with these complex needs at an earlier point than the current 15 years or more with a requirement for ongoing engagement with the nursing service;

- Recognition of recent data on triggers for 'new homelessness' to ensure that victims of domestic violence (and their children) can access safe refuges and be protected to make transitions to affordable housing;
- Encouragement of partnerships/amalgamations/mergers between homeless services to reduce expenditure on overheads and allow funds to go to direct service provision, and;
- Ensuring that there is interface with homeless strategy that increases the availability of accommodation.

Women, maternal, child, and family mental health

The Strategy and Background Paper conspicuously omit any mention of women, children, or babies. This is clearly a critical oversight and must be rectified by ensuring that the final strategy clearly identifies women, babies, and children as key priority groups to consider specifically and specially in any National Mental Health Strategy. While good mental health is essential to the overall health of both men and women, women experience some mental health conditions at higher rates than men; around 1 in 6 women in Australia will experience depression and 1 in 3 women will experience anxiety during their lifetime. Women also experience post-traumatic stress disorder (PTSD) and eating disorders at higher rates than men. Depression and anxiety can affect women at any time in their life but there is an increased chance during pregnancy and the year following the birth of a baby. Up to 1 in 10 women experience depression while they are pregnant and 1 in 6 women experience depression during the first year after birth. Anxiety conditions are thought to be as common with many women experiencing both conditions at the same time. Severe perinatal depression, anxiety and exposure to intimate partner violence are among the leading causes of maternal death. Maternal depression during pregnancy is associated with preterm birth, low birthweight and early cessation of breastfeeding.

The omission of a focus on babies and children within the Strategy is also significant. The ANMF argues that maternal support and treatment to improve mental health and wellbeing should be available especially to women with identified risk factors from pre-conception until the child is 12 months of age. Mental health and wellbeing are established early in life and provides children with the foundation for all aspects of their development including physical, educational, social, emotional and cognitive development. Parents, carers, and other significant adults play an important role in their child's development and in building and protecting their mental health and wellbeing. While many children who have good mental health carry it with them through life, there is a proportion of children in Australia (around one in seven), who will experience a mental health condition during childhood, and we need to better support these children. Given that half of all mental health conditions in adulthood begin before the age of fourteen, acting early, during childhood is vital and must be included within the Strategy.

Almost 4,300 nurses identify their primary area of practice as child and family health. While the title varies across the country, all states and territories provide midwifery and nursing care for new parents from birth up to age five, significantly contributing to the wellbeing of children and their families. These nurses have the opportunity to develop a longitudinal therapeutic relationship with the child, their primary caregiver, and extended family; in many cases, this continues across the introduction of subsequent siblings.

A key aspect of maternal, child and family health nursing is engagement with all families, at key ages and stages of family and child development, regardless of the presence or absence of risk factors. These nurses promote health, undertake surveillance activities across all health domains, recognise vulnerabilities that may affect optimal growth and development, implement interventions, and initiate referrals to other health providers as required. Monitoring of maternal mental health is an integral component of care provided and has the scope to be utilised further.

The roles of both midwives (see section below) and maternal, child and family health nurses are critical to promoting optimal mental health and, in turn, strengthening the capacity of mothers and families to provide a safe and nurturing environment for their infant and young child. Optimal maternal health and wellbeing is an enabler to child health, wellbeing, and development - conclusive evidence demonstrates that the first 1,000 days of a child's life are pivotal to future health outcomes. The importance of supporting midwives and maternal and child health nurses to make early identification, intervention and referral therefore cannot be overstated and must be included within the Strategy. Midwives and mental health nurses are cost effective health professionals well placed to provide holistic care to women. The nursing and midwifery workforce must be supported to continue to expand their knowledge of the specialty of perinatal mental health.

Midwifes and Mental Health

The ANMF notes that midwifery and midwives do not appear to have been included in the definition of the mental health workforce and do not appear elsewhere in the document or priority groups or areas. The Strategy's omission of midwives is a significant gap. Midwives are a key driver to improving mental health for people in Australia. This reality is, however, not reflected in the Strategy which also overlooks perinatal care, pregnancy, babies, and children within its scope.

The importance of care during and following pregnancy on maternal and child wellbeing, the role of midwives in improving perinatal nutrition, screening for alcohol and other drug use, establishing a therapeutic relationship with the woman and the family, providing support and resources on issues from post-partum depression to family violence, and minimising birth-related trauma, the profession is not mentioned. Women regularly disclose personal information to a midwife during an antenatal clinic visit and it is critical that clinical guidelines and accessible referral points are available. Midwives report that an inability to appropriately

refer a woman who requires additional support or treatment occurs regularly in some antenatal clinics. In contemporary practice, most hospital employed midwives screen women antenatally and re- test postnatally using the Edinburgh postnatal depression scale. This screen forms part of the antenatal clinic template of visits. Additionally, midwives discuss family violence, substance misuse and other psychosocial issues as part of the usual holistic woman centred approach to care. Capacity building the midwifery workforce in the area of perinatal mental health makes economic sense as the improved ability to detect and refer women who require support or treatment will greatly improve prevention and early intervention to minimise the known costs of perinatal depression on society.

Including nurses who are also registered as midwives, there are over 35,000 midwives in Australia. They work as essential primary care providers through a woman's pregnancy, from the initial antenatal assessment to completion of care at the end of the postnatal period. Midwives perform complex roles in maternity care services, including, but not limited to undertaking thorough assessments; identifying risk factors for deviations from normal; implementing prevention and intervention strategies; and, consulting with and referring to other health practitioners when required. All this is done while midwives provide holistic and supportive care to women and their families by establishing strong therapeutic relationships.

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

Midwives engage with women and families at a vulnerable time in their lives. The trust and connection between midwife and woman means these professionals are ideally placed to monitor, identify and facilitate management of perinatal mental ill health. Research consistently demonstrates that midwifery continuity of care models improve maternal mental health outcomes. Research consistently demonstrates that midwifery continuity of care models improve maternal mental health outcomes, yet midwives are not even included. The ANMF strongly recommends midwives be identified and included as key contributors to mental health care for women and families.

School Nurses

While mental health in schools is briefly mentioned in the Strategy, it is not well-detailed and must be integrated into the Strategy further. In Australia, over 1,500 nurses and midwives work in every type of education sector: Government, independent, and Catholic; across various age groups from preschool to tertiary level, in different types of school settings from day schools to outdoor residential campuses and special developmental schools. School nurses can be found in metropolitan, regional, rural and remote areas. The prevalence of mental ill health is rising among children, adolescents, and young people. Early intervention is essential in supporting young people, and care provided within schools to support emotional well-being is recommended as part of this process. School nurses are also able to provide personalised health and wellbeing information and guidance which is vital to the provision of person-centred health and mental health care. School nurses can have a vital role in supporting young peoples' mental health, although a number of barriers exist which impact on school nurses' ability to work in schools or grow skills and capacity dealing with mental health issues in these roles.

The diversity of the school nursing role across jurisdictions in Australia is dictated by the funding models and state or territory education policies. That is, the variability of work setting ranges from the public sector in some jurisdictions, to individual practitioners in private schools with boarding students. The role of school nurses also varies with the education sector, age group/s, setting, program objectives and stakeholder expectations. While the numbers of school nurses have decreased in some jurisdictions or education settings, others have seen an increase or a resumption of the role.

The school nursing scope of practice encompasses a broad range of physical and mental health issues. An integral component of school nursing is health promotion, which has significant potential to reduce stigma around mental health through education. They also provide primary health care, early detection of health or developmental issues and timely intervention, prevention, health education, and chronic condition management. School nurses do this utilising regular screening, education and on-going health and mental health promotion. As a result, they can identify physiological contributors to student change, and can provide personalised health and wellbeing information and guidance that encompasses both physical and mental health. These nurses are usually the only staff member employed in a school that has a health background.

Nurses working in schools build therapeutic relationships with the students, including siblings, and with their parents or primary care givers. School nurses connect to the community and other health professionals within it, such as general practitioners, community groups and the local support available from departments of health. Within the school community, school nurses also develop relationships and become an important resource for teachers.

Teachers set the school culture, know individual students and their families, witness inter-student dynamics, and are experts in learning and normal development for children in the range they teach. This extensive knowledge of their students encompasses aspects of their lives out of school, including caring responsibilities and non-academic pursuits that may contribute to increased stress or, indeed, provide avenues for stress relief. Until secondary school, teachers also observe their students across a period unparalleled by anyone, including parents – six hours a day, five days a week, for most of a year, giving teachers a unique opportunity to detect the earliest indications of change in mental health. The collaborative professional relationship between the school nurse and teachers enables invaluable insights into student assessment, monitoring and ongoing management.

The ANMF's school nurse members report that mental health-related issues comprise an increasing component of their role, both directly and as the result of exposure to mental ill health (e.g. affected family members). Once a problem is suspected, a referral to a school nurse allows for effective assessment triage, support, the provision of early intervention and, when required, referral to expert clinicians.

There are many advantages to increasing the number of school nurses across Australia. Nurses are already embedded in health care while working with the school community, which results in integrated care and communication between schools and health networks. Trusted members of the school community, nurses are often specifically identified by students as a safe person to disclose personal and private information.

Given the breadth of their scope of practice, school nurses are significantly underutilised, with many schools having no nurse at all, or access only to a community nurse who visits schools for specific interventions (e.g. immunisations). This prevents the development of pivotal relationships between the nurse, the faculty, the student body, and the wider school community. Some schools have replaced school nurses with first aiders, who are not equipped to manage complex, ongoing, or multiple health issues. The ANMF recommends that at least one school nurse should be employed in each school across the country, who has access to expert mental health nurses and, when required, other health professionals.

Alcohol and other drug (AOD) nurses

Alcohol and drug use does not appear to be well incorporated as a priority within the strategy. The increase in mental ill health is associated with a higher incidence of AOD use, including tobacco, as both a contributing factor and self-medication strategy. The substantial overlap between mental ill health and substance misuse requires AOD nurses to have a thorough understanding of both areas, and how they intersect. Nurses who work in the AOD sector provide holistic, consumer-centred care to improve health outcomes. The latest data identified just over 1,900 Australian nurses working in the AOD sector; this is a start, but the number of experienced nurses working in this area, and the available services to enable people to get access to

care when they need it, must be significantly increased. This provision will be most effective if AOD nursing services are dispersed across multiple key settings, including EDs and within the corrections system, as well as in standalone facilities.

Correctional Facility Nurses

Mental health for people who are incarcerated in correctional facilities appears to be overlooked by the strategy. Nurses in this area work in a team with police services, remand centres and prisons. There are 1,720 nurses working in this area across the country. There are so few correctional nurses that our members, report being able to do little more for their consumers than perform triage rather than care, particularly for those with complex mental and physical health concerns.

Mental ill health, particularly undertreated mental ill health, is a substantial risk factor for criminality. Australian researchers have found a rate of psychosis 30 times higher among NSW inmates than the general population, while Victorian data indicates 8% of male and 15% of female prisoners have a psychotic illness, and 5.5% have schizophrenia.16 In comparison, the national incidence of psychosis is 0.5%, with schizophrenia accounting for around half that number. Not only are incarcerated people more likely to have a mental illness, almost 70% have more than one, making management more complex. For many people with both a criminal history and mental illness, the first arrest often occurred before their first contact with mental health services. Post-release support and follow up is essential as mental health can quickly deteriorate after release. Further, this system has neither the necessary cultural ethos nor the resource capacity to assist the imprisoned to develop insight into their substance misuse. There is considerable population overlap between the work of AOD nurses and their correctional counterparts, but they have quite different approaches. AOD nurses focus on harm minimisation, with understanding and often long-term work on the sociological and mental health factors underpinning substance misuse, whereas correctional nurses work within a justice framework.

Nurses and Telehealth

While the Strategy does briefly include telehealth as one priority area, nurse and midwife involvement in this has been overlooked. This must be rectified particularly as telehealth for mental health has become vitally important due to crises such as COVID-19. The Australian telehealth initiative began in 2011 with the National Digital Economy Strategy. By July 2011, the Commonwealth Government had introduced Medicare funded health services via communication technologies to support access for people in remote, rural and outer metropolitan areas to medical specialists' services. The funding enabled nurses in general practice, midwives, nurse practitioners, midwives with an endorsement for scheduled medicines and nurses in Section 19(2)1 exempt settings, co-located with a person receiving a medical specialist service via Telehealth on-line video consultation, to provide a percentage of the rebatable telehealth services. These consultations could occur in the person's home, a general practice, residential aged care facility, Aboriginal Medical service or,

in the case of nurse practitioners, midwives with an endorsement for scheduled medicines or remote area nurses, in their practice facility or other settings.

Access to mental health services in rural and remote locations can be greatly augmented by the use of telehealth technology. Telehealth mental health services can be used to link a person requiring mental health care with mental health experts in major centres, such as a mental health nurse practitioner, and/or medical mental health specialists. Greater utilisation of telehealth for mental health care provides several benefits, including: convenience for the person seeking care and their families by not having to travel long distances, incurring travel and accommodation costs; less disruption to family life for the individual by being able to remain in their community; ability for family or friends to more easily accompany the person to their consultation; ability for the nurse or midwife involved in the person's care to participate in the consultation, if agreeable by all parties; easy access to expert advice and treatment discussions; better range of choice in health professional/s involved in care; educative opportunities for nurses and midwives in rural and remote locations; and, the opportunity for better integration of services and collaborative practice for health professionals.

4. The draft Strategy seeks to balance the need for nationally consistent approaches that support the reform agenda with sufficient flexibility for states, territories and service providers to pursue priorities that reflect their specific contexts and challenges across occupations and settings (public, private and community-based). To what extent does the draft Strategy achieve an appropriate balance?

Overall, the Draft Strategy appears to balance the need for nationally consistent approaches that support the reform agenda with sufficient flexibility for states, territories and service providers to pursue priorities that reflect their specific contexts and challenges across occupations and settings (public, private and community-based).

The Royal Commission into Victoria's Mental Health System has boldly made 65 recommendations, including specific Workforce recommendations, in its 2021 Final report. Many of these recommendations, including Recommendation 57 conduct ongoing workforce data collection, analysis and planning, are also objectives of the National Strategy. However, the final report is more comprehensive, with implementation already occurring. The Workforce Strategy and implementation plan is due to be released by the end of 2021, and has already conducted targeted consultation on the Strategy.

Because of the Royal Commission, Victoria has the potential for being the trail blazer for a contemporary mental health system. The National Strategy and other state and territories should look to Victoria as an example to efficiently adapt similar reforms.

Against Objective 5 within the Draft Strategy; 'the mental health workforce is retained in the sector', the ANMF raises the issue of the need for robust publicly funded mental health services. The Strategy will not be able to be implemented if there is not a commitment to publicly fund and resource mental health services so that consumers have equitable access. Many of the NGOs and private providers are not affordable to those most at risk. While the Strategy includes mention of funding, there is no commitment to ensure there is adequate public resourcing. Inequalities exist in the Australian health system and are felt the hardest by the most vulnerable members of the population including those experiencing mental ill-health. These inequalities have likely been intensified by the impact of the COVID-19 pandemic on many facets of everyday life including healthcare and social services. The Australian public health system has proven itself to be among the very best in the world, a well-resourced, publicly owned and operated health system is key to ensuring the health and wellbeing of the community. This extends to accessing public mental health services which over time has seen a significant de-investment in community mental health and in the acute sector leading to fragmented care for consumers. The ANMF recommends an action under Priority Area 5.1 'Promote funding reform to provide more secure employment arrangements'; develop and fund workforce renewal schemes that are aimed at regenerating the workforce by staggering the projected retirement of a substantial number of nurses and midwives over the next five years.

5. The draft Strategy provides a high-level roadmap to improve the attractiveness of careers in mental health, with implementation approaches differing across occupations and locations. To what extent does the draft Strategy provide a useful approach to addressing issues that impact on the attractiveness of the sector?

Workplace Mental Health and Wellbeing

The Strategy does engage briefly with the importance of addressing workplace mental health, but this could be integrated more thoroughly to ensure optimal attractiveness of the sector to new staff. Changing cultural practices to equip education facilities and workplaces to be mentally healthy will assist in reducing stigma of working in mental health and will assist in improving the attractiveness of the sector. This work must include health practitioners themselves. One of the unexpected effects of the COVID-19 pandemic is the exposure of, and a shift in, the cultural expectation that health practitioners attend work unless they are too sick to practice safely. Equally problematic but less obvious is the negative culture surrounding the lack of support for health practitioners' mental health. Remodelling this culture is vital to ensure all health care staff have safe and supportive workplaces in which to deliver care to others. It is also essential workplaces have support mechanisms that recognise and mitigate vicarious trauma for those working in health systems, as both recipients and providers of care.

Nurses and other staff working in mental health cope with significant mental and physical challenges, including exposure to verbal and physical violence. Nurses who work in mental health environments have a 20 times higher rate of physical violence than those working in public health units. In addition to the measures described above, the ANMF also calls for the national adoption of the ANMF Victorian Branch's 10-point plan to end violence and aggression in workplaces (cited above),[20] and for the incorporation of these requirements into the model Work Health and Safety Regulations.

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

6. A key issue for the mental health workforce is maintaining existing highly qualified and experienced workers. To what extent does the draft Strategy capture the key actions to improve retention?

While the Draft Strategy acknowledges several key factors important to retention of the existing mental health workforce such as a need to ensure staff are supported to access continuing professional development, it could consider more broadly the role of nurses and midwives within the listed action items. As the largest body of health professionals, and one of the most geographically dispersed and cost-effective sources of expertise for combined management of mental health and care coordination, nurses and midwives are a frequent point of contact for those accessing mental health services, particularly as rurality increases. The need to retain the broader nursing and midwifery workforce throughout the mental health sector should not be understated and the ANMF considers this has not yet been sufficiently acknowledged in the Draft Strategy. The objective of careers in mental health are, and are recognised as, attractive – is sound and will required several priorities for action to achieve this. The ANMF advocates that improved partnerships with universities and registered training organisations should be developed to enhance perceptions that mental health as attractive, where currently, and historically, lecturers often encourage students interested in mental health to – consolidate their skills in an acute setting first. Further, mental health nurses need to be better embedded into academic staffing profiles, as opposed to the current practice of reliance on casual academics to deliver this education.

Addressing workplace violence

Our members working in mental health tell us they leave jobs they love because of high stress, inadequate staffing, and unsafe work environments. Workplace violence is one of the most critical issues for nursing staff, and it is not clear how this is addressed in the strategy beyond investment in infrastructure.

Nurses and other staff working in mental health cope with significant mental and physical challenges, including exposure to verbal and physical violence. Nurses who work in mental health environments have a 20 times higher rate of physical violence than those working in public health units.[21] In previous submissions on mental health workforce, the ANMF has called for the national adoption of the ANMF Victorian Branch's 10 point plan to end violence and aggression in workplaces, and for the incorporation of these requirements into the model for Work Health and Safety Regulations. Actions such as this provide a clear legislative framework to support the management of workplace violence and its implementation would assist all stakeholders.

Funding uncertainty

The ANMF agrees that current cycles of funding contribute to mental health service fragmentation, affecting access, uptake, and optimal health outcomes. As proposed, extending the length of funding cycles and guaranteeing continuity of mental health supports would create better certainty for both providers and consumers of mental health services. However, the priority areas discussed in the Draft Strategy do not consider the wider need for funding certainty beyond employment security of the specified professions.

Funding uncertainty places many pressures on the mental health workforce and contributes to workforce attrition and shortages. For example, when highly effective programs end, specialised and experienced health practitioners in mental health can no longer deliver these services. Members of the ANMF have reported that when funding changes resulted in the closure of, or altered, admission criteria to these programs, they felt as though they were abandoning consumers with whom they had trusted therapeutic relationships. This not only negatively affects the person seeking care, who must find a new practitioner and repeat work previously done, but also reduces the health practitioner's sense of job satisfaction. This in turn leads to a greater risk of the health practitioner leaving their role or the sector entirely due to low job satisfaction, sense of accomplishment, and frustration with ongoing funding uncertainty in the sector.

This uncertainty could be resolved by guaranteeing longer periods of dedicated funding, and reinstating initiatives such as the Mental Health Nurse Incentive Program. This program allowed mental health nurses to provide cost effective community-based mental health care, and despite demonstrable improvements in clients' overall mental health and social functioning, and correlated reductions in hospital admissions alongside increased levels of employment, funding for this successful program was frozen. This funding was then diverted into a general flexible funding pool and is no longer quarantined for the provision of effective, efficient care by qualified mental health nurses.

Access to appropriate supervision

The ANMF welcomes the proposed action item to ensure the establishment of appropriate supervision and support for nurses and other staff working in mental health care. Necessary to support retention at all

levels, supervision provided by experienced registered nurses and other staff are critical elements of a well-supported workplace. It is essential that clinical supervisors promote a positive learning culture, understand the importance of reflective practice and are able to provide appropriate constructive feedback from a profession specific perspective. With an increased need to grow the mental health workforce will come an increased demand for high-quality supervision. It is also vital these senior members of staff are recognised and rewarded for the time and work they contribute to training and supervision.

Improve career paths within the mental health sector

While the ANMF supports efforts to improve career paths for nurses throughout the mental health care sector, we highlight that we do not support any recommendation to develop a three-year direct entry mental health nurse bachelor qualification. There is currently no pathway for registration of mental health nurses under the National law. The costly and arduous process of implementing such a recommendation presents a barrier to building an effective mental health nursing workforce and is a poor use of resources with no guarantee of successfully addressing shortages.

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

To support career paths for nurses within the mental health sector, the ANMF recommends the implementation of strategies focusing on attraction, retention, and progression such as providing:

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

Ensuring appropriate staffing levels

In all settings, adequate staffing levels and skills mix are required to ensure safe and quality care can be delivered. The Draft Strategy does not appear to provide any provision to address sectors of health care where the provision of mental health care is provided, but where safe staffing levels cannot be assured e.g., aged care. Safe staffing levels means, amongst other things, ensuring workers have time to deliver person centred care and complete administrative tasks in paid work time. By ensuring appropriate staffing and skills mix across mental health, issues of retention can be addressed by alleviating pressures related to interfaces with the

wider health and social services sectors, handover to other health professionals, provision of individualised person-centred care, and engagement with family members and loved ones. Further, appropriate staffing improves the capacity of services to offer better quality clinical placement positions for students, and supports better occupational health and safety and workplace conditions, and ease demands and stress resulting from expectations to meet unfeasible workloads. To further expand on what constitutes safe staffing, legislation should mandate adequate breaks between shifts (including when on-call), mandated adequate breaks in shifts (i.e., meal breaks to be taken or automatically paid), and a percentage or set number of days of personal leave to be accessible without documentation (e.g. medical certificate) to allow for leave for mental health.

7. The Productivity Commission and other inquiries have identified the importance of improving integration of care, and supporting multidisciplinary approaches. How can the Strategy best support this objective?

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

Structural weaknesses in healthcare

A crucial weakness in the Australian healthcare system arises from a lack of coordination of mental healthcare across providers. Enrolled Nurses are underutilised in this co-ordination role and we contend that they would provide a cost-effective solution in improving care co-ordination and stopping people from falling through the gaps. The present inquiry has the opportunity to address issues with fragmented, uncoordinated care in mental health.

An important step toward addressing deficiencies in the current system is to enable the nursing and midwifery workforce to work to their full scope of practice. Mental health services in Australia should make greater use of the skills and scope of practice of the nurse, nurse practitioner, and midwife workforce by ensuing greater involvement of the professions in acute and primary care (including in general practice, schools, and community) as well as residential aged care. A shift away from generic 'case-management' models that have the potential to de-skill highly qualified health practitioners is an imperative. Nurse, midwife, and nurse practitioner-led models of care in mental health should be trialled and expanded.

Along with ensuring that nurses and midwives are supported to work to their full scope of practice, greater acknowledgment from multidisciplinary healthcare professionals, policy makers, and the wider community would assist in growing a broader and clearer understanding of the importance and value of nurse and midwife work in the area of mental health.

In Victoria, there has been a dilution of nurses in community mental health teams due to the generic case management model. The Royal Commission has identified that; 'the generic case management model of care does not allow clinicians from different disciplines (for example, consultant psychiatrists and psychiatry registrars, nurses, psychologists, occupational therapists and social workers) to deliver evidence-based interventions related to their specific disciplines and qualifications.' This points to the need for a clearer definition of multi-disciplinary care with the Strategy.[22]

8. There are recognised shortages across the mental health workforce, including maldistribution across metropolitan/regional locations and settings. To what extent does the Strategy address the issues and supports required to improve workforce distribution?

Strengthen local mental health service planning, alignment of workforce planning and development

The ANMF welcomes the Draft Strategy's acknowledgment of the maldistribution of the mental health workforce across metropolitan/ regional locations and settings, and note the important role played by nurses in the delivery of mental health care in increasingly rural and remote settings.

There is ample research evidence focused on interventions to improve attraction and retention of care and support workers in rural and under-severed areas including a recent systematic review of systematic reviews.[23] Unfortunately however, included studies found little evidence to demonstrate the effectiveness of the included interventions. Key findings showed that various regulatory measures were able to attract health workers to rural and underserved areas, especially when obligations were attached to incentives. Health workers were likely to relocate from these areas once their obligations were completed, however. This means that further attention must be focused on ensuring rural, regional, and remote communities, health and support services are attractive and rewarding places to live and work.

Recruiting rural students and rural placements improved attraction and retention although most studies were without control groups, which made conclusions on effectiveness difficult. This highlights one of the ANMF's key areas of focus in advocating for further support for regional universities and vocational training that must incentivise quality rather than allowing the sector to accept a less or standard. Overall, cost-effective utilisation of limited resources and the adoption and implementation of evidence-based health workforce policies and interventions that are tailored to meet local health system contexts and needs are essential.

The strategies which the ANMF considers can aid capacity building for the rural and remote mental health workforce, include:

- Structured clinical placement opportunities in rural and remote health care facilities, for nursing and midwifery students, to promote the integration of physical and mental health, as well as showcase the benefits of country living.
- Improving support for newly graduated nurses and midwives in rural and remote health facilities to aid retention; as well as assisting rural and remote nurse and midwife managers in their role as preceptors of beginning registered practitioners.
- Mental health specific continuing professional development of registered nurses, enrolled nurses and midwives working in rural and remote locations, facilitated by managers (both time release and funding assistance).
- De-escalation education for all nurses and midwives practising in rural and remote centres, in the management of people with mental illness.
- Encouragement of registered nurses and midwives to undertake post graduate mental health programs, with the flexibility of distance education modules.
- Targeted quarantined scholarship funding for nurses and midwives to undertake post graduate level studies in mental health, to work in rural and remote areas.
- Targeted quarantined scholarship funding for mental health nurse practitioners to work in rural and remote areas.
- Provision of scholarships for education and professional development specifically in dementia care for all nursing staff and care workers in rural aged care.
- Provision of positions in rural and remote locations for mental health Nurse Practitioner

Enhance use of integrated and flexible workforce models, reflecting community strengths and needs.

The ANMF draws attention to the integral role in the healthcare system that nurses and midwives play, and that this is inclusive of the delivery of mental health care, particularly in rural and remote communities. Nurses and midwives can effectively be responsible for the integration of flexible workforce models of care in a variety of settings, nurse practitioners and mental health nurses in particular have substantial experience in delivering effective nurse-led models of care.[24] Whilst the term 'nurse-led model of care' has no strict definition, it typically is applied where nurses take leadership, coordinate, or provide a supervisory role or practise without the direct supervision of another health professional in delivering care.[25] This may occur where the nature of the treatment is particularly amenable to nursing care, e.g. in situations where regular monitoring or treatment is required, where a treatment cannot be administered by the individual or their carer, or perhaps, where the individual requires frequent holistic reassessment. This is appropriate in the context of rural and remote locations where there is a lack of availability of other health staff and/or limited resourcing of health services.[26]

Increase availability and appropriate utilisation of telehealth

The ANMF supports increasing access to mental health services in rural and remote locations through the use of telehealth technology. Telehealth mental health services can be used to link a person requiring mental health care with mental health experts in major centres, such as a mental health Nurse Practitioner, and/or medical mental health specialists. Telehealth interventions have also proven extremely useful in the context of the COVID-19 pandemic which has limited people's access to face to face care.

Greater utilisation of telehealth for mental health care provides several benefits, including: convenience for the person seeking care and their families by not having to travel long distances, incurring travel and accommodation costs; less disruption to family life for the individual by being able to remain in their community; ability for family or friends to more easily accompany the person to their consultation; ability for the nurse or midwife involved in the person's care to participate in the consultation, if agreeable by all parties; easy access to expert advice and treatment discussions; better range of choice in health professional/s involved in care; educative opportunities for nurses and midwives in rural and remote locations; and, the opportunity for better integration of services and collaborative practice for health professionals.

The ANMF support and recommend that MBS benefits for teleconferencing and mental health plans be extended to primary and community health nurse practitioners and to mental health nurse practitioners as providers. Widening access to these services allows faster implementation of the actions arising from the strategy, and facilitates equity of access for geographically and socioeconomically distanced populations.

9. Adopting a broad definition of the mental health workforce provides a platform for innovation to ensure all occupations are able to work effectively. How can the Strategy encourage innovation in service delivery models and workforce optimisation approaches?

Removing Restrictions on Nurse and Midwife Scope of Practice

As noted above, nurses, including specially trained mental health nurses, represent the largest proportion of professionals working in the Australian mental health system and provide care to individuals and communities throughout Australia from metropolitan locations to regional and remote sites. Nurses are well positioned to understand the complex interrelationship between physical and mental health and to respond to the high premature mortality/ morbidity rates of individuals being treated for mental health issues caused by physical illnesses, such as cardiac disease, diabetes, and metabolic related orders.

Mental health services are increasingly delivered in the community by primary health care providers, however nurses and mental health nurses are underfunded which limits community access to these vital services and the ability of nurses to provide necessary care and preventive interventions. Further, a shortage of mental health nurses is expected to be the largest sector in the overall nursing workforce shortage of at least 19,000 nurses by 2030. The Strategy must embed the need to significantly increase the number of nurses and mental health nurses around the country, particularly in high needs areas.

Workforce planning is vital to ensuring that the supply of healthcare professionals, including nurses and midwives, is enough to meet the demands of Australia's growing and aging population. Some states have commenced effective action plans to mitigate against these Health Workforce Australia (HWA) workforce projections including:

- promoting mental health nursing as a career of choice;
- providing scholarships to contribute towards the postgraduate course fees;
- Improving the safety for everyone in mental health wards and clinics;
- Introducing clinical supervision and resilience building programs within workplaces;
- Regulating workload to ensure that nurses are able to provide people/patients with the time they deserve; and
- Reducing insecure work practices.

The nursing workforce, like the Australian population in general, is ageing. The mental health nursing workforce may be additionally stretched in the future by the fact that mental health nursing is not a priority career pathway for many junior nurses. Early prevention, early diagnosis, and identifying suicide risk in the treatment and management of mental health problems are essential in achieving positive outcomes for individuals. Often a first point of contact for people in the community, nurses are, on many occasions, best placed to ensure these critical interventions occur through timely referral and care. This is especially vital in rural, regional, and remote areas where access to specialised mental health services and general practice is more limited and can also be true for disadvantaged metropolitan populations in the community (e.g. socially, culturally, and linguistically diverse and/or disadvantaged people) and in aged care.

Better choice and more accessible mental health care could be provided to people through different models of care, such as mental health nurse-led models, including mental health nurse practitioner-led models; an increase in school nurse positions in the public school sector (for early intervention); and, quarantining of the Mental Health Nurse Incentive Payment (MHNIP) funding within Primary Health Networks to enable reinstitution of the excellent work that had been undertaken by mental health nurses in keeping people well and living in their community.

Mental health nurses, nurse practitioners, and skilled registered nurses are also well positioned to provide necessary care to residents in aged care facilities and people receiving aged care and/or disability support in the community. Providing positions for mental health nurse practitioners with funding models which broaden access for people seeking mental health care and which facilitate viable and sustainable practice operation would be one way to address the access issues faced by Australian consumers. Mental health services must also be appropriately tailored, and accessible to provide effective, safe, and meaningful care to the diverse Australian population. Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people (including asylum seekers, new migrants, and refugees), socially disadvantaged, and sexually and gender diverse people all face barriers to accessing safe, quality care that meets their specific needs and preferences.

The ANMF advocates that all people experiencing mental health conditions should have access to effective, quality mental health care that acknowledges their particular needs and preferences for culturally safe and appropriate care particularly for Aboriginal and Torres Strait Islander people, and those from socially, culturally and linguistically diverse and/or disadvantaged backgrounds including asylum seekers, new migrants, and refugees, and sexually and gender diverse people.

As a workforce development strategy, the ANMF considers initiatives need to be developed and incentives need to be in place to retain the experienced mental health nursing workforce and recruit and mentor nurses new to mental health, to help grow the mental health nursing workforce. This includes transition to practice programs to equip both newly qualified and experienced registered nurses and midwives with the specialist skills required in mental health nursing.

Nurse-led models of care

Better choice and more accessible mental health care could be provided to people in rural and remote areas through different models of care, such as mental health nurse-led models, including mental health nurse practitioner-led models. This would enable people to remain in their rural, regional, or remote communities, obviously a more ideal option than the dislocation of travelling to a regional or metropolitan centre, for their mental health care.

As a workforce development strategy, the ANMF believes initiatives need to be developed and incentives need to be in place to retain the experienced mental health nursing workforce to mentor nurses new to mental health, to help grow the mental health nursing workforce. Mental health nursing requires a sound theoretical base upon which experiential mentoring can establish the necessary interpersonal and competency skills needed for safe practice. Rural and remote health facilities can, and should, encourage nurse and midwife employees to undertake post graduate studies in mental health by providing time release and funding assistance. This, in addition to providing opportunities for continuing professional development in mental health, will act as an incentive to remain in rural and remote locations.

The ANMF cautions against schemes which promote credentialling of post graduate qualification holders, as validation of acquired mental health knowledge. This separate and often expensive process is not required, as the post graduate qualification itself attests to the additional body of knowledge. Mental health nurses work effectively across health facilities and community care settings. However, their numbers decrease significantly as one moves into rural and remote areas so mental health care in rural areas is often fragmented and inconsistent. Mental health clients require regular services to manage care and prevent crisis situations and the lack of continuity in care in rural areas from visiting mental health clinicians compromises relationship building, so essential to optimal outcomes in mental health care. Integrated services in particular are the key to effective mental health care.

Primary Health Network funding and mental health nurse employment

With the development of the Primary Health Networks (PHNs), the Mental Health Nurse Incentive Payment (MHNIP) program was ceased and funding has been transferred to the PHN flexible funding pool. This transfer of funding has led to difficulties experienced by clients when some mental health nurses either have, or are facing, a loss of employment from their primary health care position. It places further burden on the public health system as often the people who were previously engaging with a mental health nurse have limited or no suitable alternatives and subsequently become very unwell and present in crisis to an emergency department or worse. The ANMF Victorian Branch has reported that this represents a significant loss for patients, many with complex, trauma-based mental illness, who relied on these mental health nurses.[27]

Providers of mental health nursing programs were advised by some Victorian PHNs that their tenders to continue had been unsuccessful and would cease from 1 July 2018. These programs, funded under the MHNIP, had been successful in supporting people in Victoria with severe and persistent mental illness. The MHNIP nurses coordinated patients' mental, physical and social care including acute interventions, and identified a comprehensive range of needs such as dental appointments, public housing or National Disability Insurance Scheme advocacy. This mental health nursing model, which kept people well and living in the community, was proven through evaluation to give greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans; with the outcome being improved mental and physical wellbeing and employment, and greater involvement in social and educational activities. Importantly, there was a decrease in acute hospital admissions, or, where these did occur, a reduction in the length of stay was demonstrated.

The Queensland Branch of the ANMF, the Queensland Nurses and Midwives Union (QNMU) has also reported that mental health nurse members in their state are uncertain as to future employment following transfer of the MHNIP funding, under which they worked, into the PHN. Negotiations are still in train between the mental health nurses concerned and the PHNs in their locality.

The uncertainty about the employment of mental health nurses within the PHNs is causing a disruption to the continuity of care for people with mental health illness. This situation must be speedily resolved with a reinstitution of therapeutic relationships for the mental health nurses and their patients, under the PHN funding, to avoid causing further distress to an already vulnerable group of people in our community.

Nurse Practitioners

While the Strategy rightly acknowledges nurse practitioners as one of the members of the mental health workforce, it is noted that 'Nurse Practitioner' is not specifically named in Figure 1.2 Consultation Draft Strategy – Mental health workforce definition. This should be amended. Nurse Practitioners should be utilised as lead health practitioners in mental health care management and referral pathways. In part, they are prevented from doing so by funding barriers and lack of recognition. For nurse practitioner-led models of care to be viable in rural and remote centres, these health professionals need to be recognised as being able to provide independent mental health services, and be appropriately remunerated under MBS item numbers. In fact, there should be changes to the Practice Nurse Incentive Payment (PNIP) and a substantial increase in the payment for MBS items for Nurse Practitioners in private primary health care settings for mental health, to enable them to establish viable and sustainable practices.

Nurse Navigators

It is our view that the role of nurse navigator in mental health should be implemented nationally. There is a widely accepted view that the mental health care system is intricate, changeable, and often difficult to navigate for both affected people seeking help and those acting on their behalf, particularly for the 'missing middle' – people whose mental ill health is neither significantly acute or grave enough to require emergency mental health services, nor straight-forward and mild enough for low-level community support. Nurse navigators can help guide people through this complicated landscape of mental health provision to access services that best meet their needs. They support and work across system boundaries and in close partnership with multiple health specialists and health service stakeholders, to ensure consumers receive the appropriate and timely care needed. These registered nurses, experienced in mental health, are educationally prepared to undertake holistic assessment of the person. They have an intimate understanding of the care needs of consumers with complex mental health presentations, and have the knowledge to guide the person and their family through the difficult route of providing the right level and type of support for conditions that change unpredictably.

Nurses' broad preparation and skill-set, augmented with specialist mental health experience, positions them to holistically, adequately, and appropriately meet the biopsychosocial needs of people with complex mental health needs. Nurse navigator positions have been employed in the United States since the early 1990's, with increasing use of this role over recent years to improve care coordination and navigation of the healthcare system and access to services. In Australia, this model of care is used in varying ways across the

states and territories to coordinate care and is referred to by various titles, including nurse navigator. In 2015, Queensland Health introduced 400 nurse navigator positions to ensure appropriate care and coordination of services along a consumer's entire health care journey, helping them and their families/carers to navigate the healthcare system.

The advantages of registered nurse navigators, experienced in mental health care, are outlined below:

- Nurse navigators understand the roles of the other members of the multi-disciplinary team and can effectively refer on to, and collaborate with, the most appropriate health care professional or non-clinical provider to meet clinical and non-clinical needs;
- They work closely in care teams with other health care professionals such as the older person's General Practitioner (with a shared high level of health literacy, thus improved messaging of the person's care needs) and with the wider multi-disciplinary team members;
- The assurance of a qualified and regulated health care practitioner who practices under the governance of the Health Practitioner Regulation National Law Act (2009) and a risk mitigating Professional Practice Framework which includes standards, codes and guidelines;
- The ability to formulate a comprehensive picture of the consumer regarding all aspects of their physical and mental health;
- Nurse navigators present sound value for money.
- Nurses are accustomed to involving the person and their families/carers in understanding care needs, employing a person-centred approach to implementing care plans to ensure continuity of care through changing needs and levels of acuity; and
- When issues arise outside of their scope of practice, the nurse navigator is able to assess when referral might be required to another navigator, such as to a financial navigator.

The more rural or remote an area, the more likely it is that nurses will be the most prevalent qualified and regulated health practitioners available. They understand the unique challenges of rural and remote communities. It makes good economic and geographic sense, therefore, to use these health practitioners as the navigator for the mental health services. Rather than bringing in a health professional or other worker who is unknown to the older person or their family/carers, these nurses are already known and trusted by the local community, an aspect especially important in Aboriginal and Torres Strait Islander communities where nurses have established trusted relationships. In addition, nurses in these settings work collaboratively with Aboriginal and Torres Strait Islander health workers and their health practitioner or health professional colleagues, to provide culturally safe mental health care.

The nurse navigator role is ideally tailored to the scope of practice of registered nurses, due to the comprehensive nature of their assessment skills and knowledge of the mental health sector. Appropriate funding will be essential to ensure adequacy of staffing numbers to enable the nurse navigator to take the time required to work with the consumer and their support network. This funding should connect the nurse navigator to the consumer as part of the discharge team process in tertiary facilities or in primary care settings, such as general practices.

Aged care

Access to appropriately qualified staff in aged care facilities is an issue, with fewer registered nurses available to provide health care and insufficient staff overall. Access to good mental health care is limited. Mental health qualified nurses (both registered nurses and nurse practitioners) would be able to provide the services required if the appropriate structures were put in place. Many nurses have acquired formal qualifications in dementia care nursing to inform and enhance their practice in this area, whether this is a focus of their clinical role, such as in a residential aged care facility, or forms a part of a broader role, such as in community care (for example, mental health nurses). These studies should be encouraged and facilitated for nurses practising in rural areas.

Many people in the very early stages of dementia present to community health, General Practice clinics or mental health facilities, suffering from depression and/or anxiety. The recognition of these early symptoms would be enhanced by providing appropriate dementia education and training to nurses in general practice, mental health nurses and other nurses in the rural health workforce. Early recognition and timely intervention in the early stages of dementia can be critical to future care and quality of life. A primary health care and mental health workforce that is better equipped to see beyond the primary diagnosis and recognise the early signs of dementia will have a positive outcome both for the individual and their community.

The nurse practitioner role is growing within the aged care sector and their expertise in this field should be encouraged by opening up positions in rural aged care facilities. The expertise of these clinicians enables them to identify and diagnose early stage dementia, and to prescribe the appropriate treatment modalities. This also applies to nurse practitioners in the mental health field. The ANMF, therefore, requests that the Inquiry recommend the inclusion of funding mechanisms for nurse practitioners to work in rural locations.

10. Is there anything else you would like to add about the Consultation Draft (1,000 word limit)?

Funding arrangements

The ANMF endorses and advocates for a transition away from the current health and mental health system activity-based funding model, that can incentivise throughput and a lack of focus on improving consumer outcomes, to a value-based approach to health and mental health care. A value-based funding model aids in putting the consumer at the centre of care and is geared to driving improvements to prevention and wellbeing support, such as through mental health models that prioritise peoples' mental health rather than focussing solely on an illness/treatment-driven approach.

Value-based models of care encourage health systems to reward care approaches that help people to avoid becoming unwell in the first place, resulting in fewer necessary hospitalisations and treatments. This can result in considerable cost-savings as people are able to remain in the community rather than having to be treated as in-patients. Alongside value-based care that focusses upon optimising the experiences and outcomes of people who engage with the health and mental health system, there must also be strong data collection and reporting systems to allow measurement and monitoring of consumer-focussed outcomes. Moving to a value-based system must occur in tandem with necessary improvements in mental health data collection, reporting, and integration.

While a movement to an entirely value-based model of mental health care is unlikely to be able to occur instantly, there is a growing global understanding that transitioning gradually from activity-based health funding models to value-based and outcome-focussed models is feasible and achievable. Nurse or midwife-led services, and services that utilise a high level of nurse or midwife integration and involvement in care can aid meeting the growing needs and demands of mental health consumers. Supporting and funding employment of mental health nurse and nurse practitioner roles in primary health care and hospital emergency departments could be cost-effective approaches. Consumers who present at emergency departments for mental health issues experience generally longer waiting times than those with a similar severity of physical illness.

Another example of effective integration of nursing roles in mental health care is at the Gold Coast University Hospital (GCUH) where a rapid response triage trial has been designed to streamline appropriate care for mental health consumers who need rapid access to care.

These consumers are seen by a mental health nurse from the Mental Health, Alcohol and Other Drugs Service (AODS) and an emergency department physician. Preliminary results are positive, demonstrating receipt of targeted care plans from mental health nurses and earlier patient discharges.

Primary health network funding and mental health nursing

While nurses were once specifically funded to provide clinical therapeutic mental health care funding of the Mental Health Nurse Incentive Program (MHNIP) has been transferred to the Primary Health Networks (PHNs) where funding is now paid into the PHN flexible funding pool. Mental health services are now commissioned to local providers by PHNs which has resulted in increasing job uncertainty for mental health nurses due to reduced funding. The Australian Medical Association (AMA) has also reported that across over 200 general practitioner and psychiatry practices, patients are losing access to the mental health nursing workforce, and the treatment they provide, due to the change in funding model. The AMA has reported that by cutting salaries to mental health nurses by 40-50%, some PHNs are failing to attract or retain a viable mental health nursing workforce, resulting in the utilisation of a less qualified and appropriate workforce.

These PHN funding arrangements do not incentivise service providers to deliver optimal outcomes as PHNs do not have parameters around maintaining quality and ensuring the mental health services delivered are done so by qualified, appropriate health practitioners. Supporting the PHNs to deliver holistic mental health, including the necessary care provided by nurses, is imperative to ensuring the good mental health of communities. The ANMF recommends that assessment and evaluation of PHN funding decisions be undertaken to determine if the PHNs are improving or negatively impacting mental health care access and quality.

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