Submission No 42

PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

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Submission to the NSW Parliamentary Committee on Children and Young People

Inquiry into the current approaches aimed at preventing youth suicide in NSW

Australian College of Mental Health Nurses

the Australian College of Mental Health Nurses inc.

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The Australian College of Mental Health Nurses (ACMHN) welcomes the opportunity to provide a submission to the NSW Parliamentary Inquiry into the current approaches aimed at preventing youth suicide in New South Wales.

the Australian College of Mental Health Nurses inc.

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1. Our Organisation

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The ACMHN also sets standards of practice for the profession and promotes best practice in mental health nursing.

As the peak professional organisation for mental health nurses in Australia, the ACMHN is currently involved in a range of activities relating to youth suicide prevention and suicide prevention more broadly, including:

- Ministerial PHN Evaluation Advisory Panel
- National Eating Disorders Collaboration (Executive Committee)
- Suicide Prevention Advisory Group
- Private Mental Health Consumer and Carer Network
- PHN Evaluation Advisory Group

2. Introduction

The ACMHN acknowledges the Terms of Reference (TOR) for the NSW Parliamentary Inquiry into the current approaches aimed at preventing youth suicide in New South Wales. The ACMHN sought input from its members in NSW in relation to the Inquiry Terms of Reference and has prepared a response with a particular focus on the:

- Gaps in the coordination and integration of suicide prevention activities and programs (particularly between Commonwealth and state-funded services; and people with moderate-severe episodic mental illness)
- Governance arrangements and accountabilities for suicide prevention
- Role of the MHN workforce in improving the provision of services in regional and rural communities
- Provision of services to vulnerable and at risk groups (specifically young people experiencing eating disorders and Aboriginal and Torres Strait Islander youth)
- Data collection about the incidence of youth suicide and attempted suicide
- Provision of high quality information and training to service providers

3. Gaps in the coordination and integration of suicide prevention activities and programs

It is the position of the ACMHN that people of all ages who are in need of mental health care, including young people at risk of suicide, should be:

- Engaged in their own care and provided with extensive opportunity to direct their care and influence their integrated mental and physical health care plan.
- Able to access the service they need, when they need it. This should not require people to be at imminent risk of suicide in order to receive the specialist mental health care and support they need.
- Able to access timely psychological treatment based on sound evidence
- Discharged from the mental health service when their clinician deems that their individual circumstances indicate they are ready to be discharged

Unfortunately, structural limitations of service models, barriers to accessing specialist care (for mental health and more expert care relating to a particular diagnosis) and poor governance and evaluation continue to create unnecessary gaps in care (see section 6 for more discussion on governance and evaluation).

> *"The MHNIP / PMHC-N program has enabled this practice to offer early intervention, support and education, monitoring of at-risk consumers, and support to families in the aftermath of a death from suicide. Unfortunately we are not confident that funding will be ongoing for us as a provider."* – *ACMHN member*

Examples of gaps in service coordination and integration that ACMHN has become aware of include:

- Funding being awarded to larger organisations to reduce the administration of managing multiple contracts, leaving many sole clinicians and smaller local organisations inaccessible aside from the capped sessions available under the MBS (which are very limited for MHN services since MHNs remain unable to claim for their services under Better Access and high out of pocket fees make care inaccessible for many).
- In some PHN regions, mental health nurses in primary care (who may or may not be able to access the funding for the severe and complex model of care), are specifically being excluded from other relevant pools of funding, such as suicide prevention funding, despite having demonstrated experience of achieving positive outcomes in this area.
- Models of care and funding models that prevent people whose level of need has changed from continuing to see the same clinician, despite still needing the same type of treatment that the clinician can provide (e.g. ATAPs level of care VS 'severe and complex' MH care).
- In public community services, access is often available only to those who have highly complex circumstances or who are in crisis, which leaves very little room for prevention and early intervention (to prevent people from reaching crisis in the first place). People discharged from acute mental health settings are at greater risk of engaging in self-harm or suicide attempts in the period following discharge (National Children's Commissioner, 2014); making timely access to evidence based mental health services in the community not merely important, but potentially lifesaving.
- The majority of services are often capped or time limited and are intended to be 'brief', meaning that regardless of the individual presentation, people will be exited from the service until their needs increase again to the point of crisis. This has adverse consequences for many, particularly those with moderate-severe episodic mental illness, as the premature withdrawal of treatment may result in more frequent (and potentially severe) episodes of relapse.

It is important that youth suicide prevention activities seek not only seek to target those at imminent risk of suicide, or who have made a suicide attempt (although these are clearly two groups of people of primary concern). As a community, we cannot expect to reduce the suicide rate if we continue to focus the majority of resources on the crisis/acute end. This includes actively building and promoting local community resilience and wellbeing and re-engineering structures that represent barriers to accessing timely care. Consideration must also be given to gaps in support for carers, as well as the role of the family unit in promoting the mental health and wellbeing of youth and the possible elevated risk associated with a family unit that is not cohesive or functioning effectively. There must be an integrated longer term plan across all levels of government that shows how Australia will

transition towards a mental health system that genuinely commits to preventing the need for crisis care wherever possible.

ACMHN recommendation: Review and amend service model guidance for primary and public mental health services that is creating unnecessary barriers to people accessing care and develop and implement a framework that considers the level and type of support people may need that reflects their individual circumstances in order to maintain recovery and prevent future relapse.

ACMHN recommendation: Increase funding for community mental health teams across NSW (for children/youth and adults), as this has longer term flow on effects for the rest of the mental health system, as well as other systems (families, employment, education, justice etc).

ACMHN recommendation: Increase access to evidence based support for carers of young people at risk of suicide, as well as funding family therapy where clinically indicated and seeking to address social factors that may be contributing to a maladaptive home environment, where this is evident.

ACMHN recommendation: Take proactive steps to build community resilience at a local level and promote mental wellbeing and suicide awareness (such as through schools and tertiary institutions; sporting, music and other youth community groups). This may include empowering peers with skills on what to do if they are worried about a friend or fellow student. In relation to young people transitioning to the tertiary education sector, one member suggested: *"Providing a support link such as a MH Peer Education Mentor that assists young people to acclimatise to the tertiary environment, and help navigate new systems and social groups, increases the likelihood of successful study and employment. It also provides those with lived experience of the education and MH issues supporting their peers."*

ACMHN recommendation: The ACMHN recommends that the NSW Government:

- develop and fund an evidence based program for building resilience and promoting emotional wellbeing among young people of school age (include those under 12), as well as school leavers and young adults; and
- identify opportunities to build and support pathways to specialist mental health care for youth who are identified as being at increased risk of suicide, or who have symptoms of an underlying mental illness requiring treatment.

Addressing the existing and predicted critical shortages in the mental health nursing workforce will help to reduce gaps in care

Suicide risk is particularly increased around key transitions points (e.g. across age groups, primary/high school, tertiary institutions, adolescent/adult); and also in response to changes in individual need (e.g. youth in crisis, being discharged from acute care etc), as identified in the NSW *LifeSpan approach* to suicide prevention (Black Dog Institute, 2016). It is the position of the ACMHN that programs which aim to promote resilience and emotional wellbeing will provide a solid foundation for reducing the youth suicide rate, as well as assisting with the identification of young people who are at greater risk of suicide and are in need of more intensive support.

Nurses in general are more geographically dispersed than other health professionals, which creates enormous potential for increasing access to mental health services in different settings across Australia, including in regional, rural and remote locations. The mental health nursing profession is well placed to deliver outreach services for at-risk youth, as evidence by the outcomes reported

under the Mental Health Nurse Incentive Program, which included mental health nurses targeting hard-to-reach and at-risk groups, including young people (HWA, 2012).

ACMHN recommendation: As the most geographically distributed workforce with a presence stretching across a diverse range of service settings, the NSW Government should give consideration to how the mental health nursing workforce could be developed to fill gaps in youth suicide prevention and mental health care.

4. Governance arrangements and accountabilities for suicide prevention

Service integration and defined roles and responsibilities between Commonwealth, state and territory funded mental health and suicide prevention services are currently very unclear and patchy. This becomes particularly evident when young people and the broader population with a mental health concern experience a change in their level of need.

> *"Our local PHN and the Ministry of Health both had funding for suicide prevention and ran two separate tenders. It would have been much better if the tenders had been combined….Greater clarity about the role of the LHD would be very helpful."*
>
> *"One area or gap that I can see, is the link between MH government and NGO services that support individual recovery." – ACMHN member*

There is an expectation that people unable to access (or who have time limited access) to services in primary care will be able to access care through the public mental health system (e.g. CAMHS). Conversely, there is an expectation that primary mental health care will be accessible to those unable to access the public mental health system (even though clinicians across many regions are often prevented from accepting new clients due to inadequate funding). Youth and their families in this situation are left feeling incredibly helpless and fearful that their love one may come to harm.

There is also a need for greater emphasis on evaluation of funded services (and basing policy and funding decisions on evaluation outcomes). Services are being capped, defunded, continued or expanded, in a manner that is contradictory to what would be expected based on the outcomes of the relevant service evaluations. Opportunities to make improvements in suicide prevention and broader mental health care should not be prevented or delayed out of political fear of government being seen to 'get it wrong'. Communication with the public should encourage a community expectation that government activities, when announced, will be open to evaluation, the outcomes of which will be used to improve services and outcomes into the future.

Nursing and Midwifery Code of Conduct and ACMHN Standards for Mental Health Nursing

At a more organisational/individual service level, nurses are obligated to deliver the best care for their patients. As health professionals registered with AHPRA through the Nursing and Midwifery Board, mental health nurses are required to comply with the Nursing and Midwifery Code of Conduct and professional standards[i]. However, these are general standards applicable to all registered nurses, regardless of where they are employed.

Standards of Practice provide practical benchmarks to guide and measure how care is provided. They are concerned with the performance of mental health nurses across a range of clinical environments and include professional knowledge, skills and attitudes (attributes). The Australian College of Mental Health Nurses (ACMHN) Standards for Mental Health Nursing are standards developed

specifically to support mental health nursing practice[1]. The ACMHN Standards of Practice for Australian Mental Health Nurses 2010 specify the minimum level of performance required for a registered nurse practising in any mental health setting.

The ACMHN also wishes to note that good clinical governance, supported by government, must give priority to what is happening at a systemic, organisational and management level to support the mental health nursing and broader mental health workforce to implement government funded suicide prevention and mental health activities.

ACMHN recommendation: Develop a long term strategy with tangible actions and measurable outcomes that set out a transition plan for NSW mental health services to become less crisis-driven and more prevention focused.

ACMHN recommendation: Address integration between Commonwealth and State/Territory funded mental health services (e.g. primary care VS Community-based Child and Adolescent Mental Health Services and adult mental health services) and identify government roles and responsibilities, including who is responsible for identifying and addressing gaps.

ACMHN recommendation: Commit to a robust mental health service evaluation framework that independently draws on available evidence and utilises evaluation findings to inform future policy and funding decisions.

ACMHN Recommendation: Resource services to provide clinical education, clinical supervision[2] and peer and managerial support for the clinical mental health workforce as it works to implement suicide prevention policies for youth and the wider community.

5. Provision of services in local communities, particularly in regional and rural areas

Social determinants of mental health

Socioeconomic equality is widely reported as being strongly associated with elevated rates of suicide (Law et al, 2014; Taylor et al, 2005; Burnley, 1995). The World Health Organisation Social Determinants of Mental Health Report (WHO, 2014) called for a 'Health in all policies' approach to improve responses to addressing the risk and protective factors that exist outside of the tradition health sphere. Fisher et al (2016) conducted an analysis of Australian health policies and found that while there is a recognition in policy of the social determinants of health, strategies for improving health and wellbeing still focus predominantly on responses from the health care system and for the most part, overlooked opportunities to improve population health and wellbeing through collaboration and integration between other sectors and industries.

> *"Finding people with appropriate skills is extremely difficult in rural areas."*
> – Feedback from ACMHN member

Evidence suggests that rural towns in Australia with populations below 4000 people have experienced some of the largest increase in male youth suicide (Kõlves et al, 2012; Alston, 2010). The link between socioeconomic inequality and increased prevalence of suicide has been well documented and is more visible in regional, rural and remote locations (Law et al, 2014; McGrail and

[1] See: http://www.acmhn.org/publications/standards-of-practice [Accessed 19 July 2017]
[2] See the ACMHN Clinical Supervision Position Statement: http://www.acmhn.org/career-resources/clinical-supervision [Accessed 19 July 2017]

Humphreys, 2009). Increased alcohol and drug use, social isolation, financial hardship and people who are not in employment, education or training are common risk factors that can be compounded in rural areas (Patton et al, 2016; Kõlves, 2012).

Mental health nurses represent the most accessible mental health workforce in regional, rural and remote communities in Australia (AIHW, see NRHA factsheet, 2017). The scope of practice of a mental health nurse is provided within an holistic theoretical and clinical framework incorporating a range of factors affecting an individual or community; including cognitive, occupational, physical and social factors. Given their greater accessibility and holistic model of care, mental health nurses are well placed to deliver evidence based support to people in rural and remote communities, whether that be through one-to-one interventions, or family, group and community-based interventions.

Mental health nurse practitioners (MHNP) also offer an opportunity to increase access to mental health services in rural and remote locations, particularly where access to medical practitioners is limited or unavailable. The scope of practice of a MHNP means that they practice at an advanced level and are able to provide extensions on practice that include referral to specialists and prescribing of medications.

Through its various member representation activities, the ACMHN has developed a comprehensive understanding of the issues and policies affecting the delivery of mental health care and suicide prevention in rural and remote communities. GPs and psychiatrists, particularly from regional, rural and remote locations (including across NSW), regularly contact the College because they are specifically looking for mental health nurses for their community, or because they can see the role they believe mental health nurses should be playing to help to fill gaps in care.

ACMHN recommendation: All governments adopt a 'health in all policies' approach, which encompasses mental health and requires policy makers to consult the evidence surrounding the health impacts of what are typically considered 'non health related' policies (such as housing, employment, etc).

ACMHN recommendation: The ACMHN recommends that the NSW Government seek to grow the mental health nursing workforce (including CMHN and MHNP) as per the recommendations made by the National Mental Health Commission in its 2014 Review; and develop models of care and service delivery that facilitate the best utilisation of this workforce in regional, rural and remote communities.

6. Provision of services for vulnerable and at risk groups

"For this age group 12 to 25 one of the most potent killers is Eating Disorder (ED), most notably Anorexia Nervosa……In primary health care there is practically no specialist service for any eating disorder….We could improve the mortality and morbidity rate for ED (eating disorders) by having trained and supervised mental health nurses in primary care" - Feedback from ACMHN member, regional NSW

"Family therapy (in the treatment of eating disorders) is not routinely or regularly available on the North Coast."

For the purposes of this submission, the ACMHN will focus on the following two population groups:

- Young people with eating disorders, particularly anorexia nervosa
- Aboriginal and Torres Strait Islander youth

It is the position of the ACMHN that these particular groups are at significantly increased risk of suicide and should be specifically targeted for suicide prevention activities across all levels of government.

Developing evidence-based responses for young people experiencing eating disorders

Eating disorders frequently co-occur with other mental illnesses, particularly anxiety and comorbid depression. Anorexia nervosa in particular has the highest rate of suicide and morbidity, of any mental illness (APA, DSM-V, 2013). Of particular relevance to treatment of a person with an eating disorder is the concept of the multidisciplinary approach *(*RANZCP Clinical Practice Guideline, 2014). However, significant barriers to specialist evidence based care model exist and this is particularly evident in community based and primary care services. A real life example of these barriers is provided in Box 1 below.

Box 1: Real life example

A credentialed mental health nurse (CMHN) is working in private practice in a regional area of NSW. The area has a high rate of youth suicide and self-harm and has been targeted for additional suicide prevention funding. The CMHN specialises in the treatment of people with eating disorders, with particular interest in treating people experiencing anorexia nervosa - a mental illness known to have particularly high rates of co-occurring anxiety and depression, complex physical effects, as well as high risk of suicide and self-harm.

Some of the CMHN's referrals come from a child & adolescent psychiatrist in the area who shares the CMHN's interest in eating disorders and anorexia nervosa. However, the CMHN also receives referrals from local psychologists, paediatricians, dietitians and GPs, as well as direct referrals from families, who have all come to recognise their specialist expertise in the treatment of people with eating disorders. The CMHN is listed as a 'specialist' provider on the regional directories. The nearest specialist centre for eating disorders refers any enquiries they receive from the area to the CMHN.

Despite the CMHN being recognised as a specialist by other mental health professionals (including local psychologists and psychiatrists) and GPs:

- People with eating disorders referred to this CMHN by their psychiatrist, paediatrician, psychologist or GP (or those who self-refer) are unable to claim any MBS rebate for the CMHN's services under the Better Access scheme, despite the CMHN having a Masters in Couple & Family Therapy, training in CBT-E and Acceptance & Commitment Therapy, 20 years of experience working with this client group as a specialist provider, and acknowledgement by other health and mental health professionals as being an eating disorder and MH clinical specialist in the local area.
- The CMHN cannot access any of the funding for severe and complex services through the Primary Health Network, because severe and complex funding was provided to another mental health nurse in the town. This was despite the fact that the CMHN in question provides a specialist service to people with eating disorders (many of whom are children and youth), is a qualified

family therapist who can provide treatment to children, adolescents and adults, while the other MHN provides psychotherapy to adults with other mental health conditions (and does not provide specialist treatment to people with eating disorders).
- Despite many of the CMHN's patients being young people with anorexia who are at increased risk of suicide, the CMHN is also unable to access any of the suicide prevention funding to treat them.
- Even though the CMHN can provide services under the Chronic Disease Management Plan, a young person with an eating disorder requiring access to the specialist expertise this CMHN can provide and who has already used their five sessions for other services under the Chronic Disease Management plan (e.g. to see their dietitian), is entirely dependent on whether they (or their family) can cover the full cost of the specialist sessions with the CMHN themselves.
- Under the current arrangements, once those five shared chronic disease sessions run out, the CMHN is only able to provide specialist mental health nursing services to people with eating disorders in the regional area under private practice fee-based arrangements (funded by the clients themselves or their families).

As evidenced by the example above, while some progress has been made in some jurisdictions towards improving provision of eating disorder care and treatment in line with best practice, in general, this has been reflected in poor clinical leadership, inadequate care coordination and lack of adequate and accessible pathways to care (NSW Health, 2013, p3). Tragically, it has also been reflected in the youth suicide rate.

ACMHN recommendation: The ACMHN recommends an approach to the treatment of people with eating disorders that supports a multidisciplinary team approach and makes best use of the available clinical mental health workforce with demonstrated specialist expertise in the field (whether they be mental health nurses, psychologists, psychiatrists). Such an approach should be accessible in both community/outpatient and acute inpatient services and in line with the available evidence and treatment duration for specific diagnoses (e.g. anorexia nervosa).

Developing evidence-based responses for Aboriginal and Torres Strait Islander youth

The ACMHN sought input from the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives in relation to this section of the response and this input is provided below:

Aboriginal and Torres Strait Islander people suffer from mental health conditions at much higher rate than non-Indigenous people. This reflects a history of dispossession, racism, marginalisation, poverty, and inter-generational disadvantage, which have had a profound effect on the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples.

In 2008-2012 the suicide rate for Aboriginal people was almost twice that of non-Indigenous Australians, if we narrow that focus to 15-19 years olds the suicide rate becomes 5 times the rate of non-Indigenous Australians (AIHW, 2015). However, with recent cases of Aboriginal children as young as ten committing suicide, we do know that youth suicide statistics such as these don't give us a complete story.

Access to appropriate services is a major issue with Aboriginal and Torres Strait Islander young people being less likely to report diagnosed mental health conditions than their older counterparts, but much more likely to be hospitalised for intentional self-harm or end their life through suicide.

Aboriginal and Torres Strait Islander youth suicide has a unique demographic pattern that includes variances between states and territories, however a unique clustering effect that will tend to see

large peaks in suicide levels within Aboriginal communities at certain periods of time means that there can be large variances in suicide rates by location on a year by year basis.

Racism

The impact of both individual and systemic racism on Aboriginal and Torres Strait Islander mental health must be considered if we are to combat the alarming level of youth suicide levels.

A growing body of epidemiology indicates links between racism and poor health outcomes, including (but not limited to) poor mental health. This includes a recent study that found experiences of racism were associated with anxiety, depression, suicide risk and overall poor mental health for young Aboriginal people (Priest, Paradies, Gunthorpe, Cairney and Sayers, 2011).

Racism manifested in a systemic manner further compounds these ill effects through denial of access to the resources required for good mental health. This can mean differences in treatment regimens, funding inequity and cultural barriers to the use of healthcare services. Further systemic racism encourages a culture whereby biases are more readily expressed and acted upon.

We commend the vision of the Australian Government's National Aboriginal and Torres Strait Islander Health Plan for an 'Australian health system free of racism and inequality' that recognises the role of systemic racism in health inequality – and urge that all state and territory governments adopt and uphold this vision.

ACMHN recommendation: The ACMHN recommends that the NSW Government refer to the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Report (2016) and engage with local Aboriginal and Torres Strait Islander health services and communities to develop local, culturally safe solutions that reflect the unique needs of individuals and local communities.

ACMHN recommendation: Implement evidence based initiatives to actively grow the Social and Emotional Wellbeing Workforce, with the aim of reaching a target of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing workers that is proportionate to 3% of the Australian health workforce.

Embedding Cultural Safety CATSINAM Position Statement

The ACMHN supports the Cultural Safety Position Statement developed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. The Position Statement calls for government action in relation to the following areas:

- Ensuring culturally safe service delivery is one mechanism for addressing inequities in health services for Aboriginal and Torres Strait Islander young people.
- Aboriginal and Torres Strait Islander Australians are more likely to access health and wellbeing services that are respectful and culturally safe, and experience better outcomes from these services.
- Aboriginal and Torres Strait Islander nurses and health professionals have a unique practice that combines cultural and clinical knowledge and are critical for the delivery of culturally safe health services for Aboriginal and Torres Strait Islander people.
- We advocate for the systematic inclusion of Aboriginal and Torres Strait Islander communities and organisations in relevant health system governance structures and in key policy processes.

- Health professional standards must consistently support cultural safety: CATSINaM calls for the amendment of the Health Practitioner Regulation National Law Act 2009 to clearly identify cultural safety as a priority.

ACMHN recommendation: The ACMHN supports the position of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives to embed cultural safety into regulation and accreditation of health professionals and services, by making the necessary amendment to the National Law and providing funding to support the provision of accredited cultural safety training for all health professionals working in Commonwealth funded health services.

ACMHN recommendation: Implement evidence based initiatives to actively grow the Social and Emotional Wellbeing Workforce, with the aim of reaching a target of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing workers proportionate to 3% of the Australian health workforce.

ACMHN recommendation: Support policy and programme interventions that have a 'cultural determinant approach that places Aboriginal and Torres Strait Islander culture at the centre of health and wellbeing'.

7. Data collection about the incidence of youth suicide and attempted suicide

There is extensive evidence already available relating to the risk factors for youth suicide. While robust data is needed on actual suicide attempts and completed suicides, it is the position of the ACMHN that there is a lack of commitment from all governments to set meaningful and more importantly, measurable targets around suicide prevention, including youth suicide prevention. Data collection will be crucial for ensuring the targets are measurable and for identifying and funding tangible actions for achieving those targets.

The capacity for each organisation to auto-generate reports at the individual client and organisational level would also be an important tool for organisations to maintain progress and inform continuous service improvement. When used proactively, data can provide services with the information needed to reflect on their practice and to identify opportunities for continuous improvement.

ACMHN recommendation: That all State and Territory governments and relevant agencies seek to develop and agree:

a.) a framework to support the sharing and collation of data pertaining to completed suicide and suicide attempts
b.) measurable targets for reducing the suicide rate, across all age groups, including youth; and
c.) tangible, evidence-based actions for achieving those targets that are funded and implemented

8. Provision of high quality information and training to service providers

Maintaining specialist MH expertise and supporting evidence based clinical services

Recently, ACMHN members have generally shared a strong view that there is a shift toward staffing in mental health services that are inappropriately matched to the level of acuity, as well as increasing recruitment and rostering of staff without qualifications and training in mental health.

The reasons for this are multi-faceted. Firstly, there is no consistent, mandated approach to the qualifications, skills and experience of nurses being recruited into mental health settings. The delay in government action on the workforce shortage means there is increasing pressure on services to engage more people without specialist qualifications in mental health.

Policy decisions taken by government, higher education, professions and employers now will have a major impact on the scale of the projected workforce shortages and the flow-on effects to the quality of care delivered within the mental health system.

The ACMHN is also providing a submission to the NSW Review of Seclusion and Restraint, being undertaken by the NSW Chief Psychiatrist. Feedback received from many ACMHN members who responded to that particular issue highlighted the need for greater training for the general nursing workforce in mental health. One responder to the NSW Seclusion and restraint inquiry commented:

"More mandated mental health subjects in an undergraduate nursing degree is a good start. If it isn't mandated heads of schools won't do it. Our mental health nurses have gone from having 3 year or 18 month specialist training to – in some cases – none."

It is the position of the ACMHN that if we are to respond to the growing need in the community more broadly, as well as among youth, all nurses have must have adequate training and education in mental health – whether they work in the emergency department, a child and adolescent community health service or a specialist mental health unit. This is important for improving the quality of care provided to all people experiencing poor mental health and could prove life saving for someone who is at risk of suicide.

ACMHN recommendation: Develop a detailed mental health and suicide prevention workforce plan that aligns with the 5th National Mental health and Suicide Prevention Plan for the mental health workforce in NSW, which identifies the different qualifications, skills and experience that will be required to implement suicide prevention activities and broader mental health and wellbeing initiatives across the lifespan.

Credentialing[3]

Methods to recognise nurses with the qualifications, skills, expertise and experience to deliver high quality mental health care vary greatly across the mental health sector. A lack of government action on mental health nursing shortages means that general nurses with very limited or no specific qualifications/experience in mental health continue to be relied upon to staff acute mental health units. This will continue to have significant impacts on the quality of care provided unless the MH system recognises the need for specialist mental health nurses and adopts the mental health nurse credential to ensure recognition of qualifications and experience is standardised nationally. This is supported by feedback received from ACMHN members.

Recognition of mental health nurses through credentialing and the ACMHN Standards, together with the ongoing development of the ACMHN CPD Portal, represent one step for improving the quality of services. Since the tertiary system moved from specialist nursing degrees to a comprehensive nursing degree, the mental health nurse credential is now the only system in Australia that formally recognises nurses with post graduate qualifications, skills and experience in mental health. The Mental Health Nursing Credential demonstrates to employers, professional colleagues, consumers

[3] For more information, see: http://www.acmhn.org/credentialing/what-is-credentialing and also: https://www.c4n.com.au/ [Accessed 19 July 2017]

and carers that an individual nurse has achieved the professional standard for practice in mental health nursing.

As stated in the National Mental Health Commission Review (2014) under recommendation 21, more work is needed to address the mental health content and relevant clinical placements in the undergraduate nursing curriculum.

ACMHN recommendation: The ACMHN recommends that a pathway to credentialing be established in NSW to support the development of an appropriately qualified and skilled mental health nursing workforce that is capable of responding to the needs of at risk youth, as well as the needs of the broader community across the region.

Continuing Professional Development (CPD)

The ACMHN provides continuous professional development (CPD) and has developed various mental health elearning modules available to members and non-members which can be accessed through the ACMHN CPD portal. The ACMHN is currently reviewing and developing further on line CPD modules for both mental health nurses and general practice nurses. We would be very happy to discuss the development of a suicide prevention module targeting nurses in NSW.

Providers and organisations can apply for ACMHN endorsement of professional events, educational activities or products (e.g. online training and resources) via the College website.

The ACMHN has also been funded to conduct a project that will involve upskilling general practice nurses in mental health and developing a scope of practice for these nurses that articulates the role of general practice nurses in relation to mental health promotion and the identification and referral of people exhibiting symptoms of a mental health concern. It is expected this project will have the potential to be adapted for the broader health workforce (including for child and adolescent health clinicians who are not mental health specialists).

9. Conclusion

Mental health nurses work in mental health across a variety of settings across the mental health system in Australia and play an important role in the delivery of care to young people at risk of suicide, or who are recovering from a suicide attempt. They have the specialist skills, knowledge and experience required to be a part of the solution to reducing the rate of suicide in Australia and have the capacity and geographical distribution to address identified gaps in care.

If you require any further information regarding these comments or would like to discuss the College's workforce development activities, please contact the ACMHN.

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