Submission No 2

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: Australian College of Mental Health Nurses

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Mental Health Nursing Services in NSW: Submission to Select Committee on Remote, Rural and Regional Health 2024

Glossary

ACMHN: Australian College of Mental Health Nurses (ACMHN)

CMHN: Credentialed Mental Health Nurses - The Credential for Practice Program is an initiative of the ACMHN and has established the only national consistent recognition for specialist mental health nurses. Credentialing is a core component of clinical/professional governance or self-regulation where members of a profession set standards for practice and establish a minimum requirement for entry, continuing professional development, endorsement and recognition.

GPN: General Practice Nurses - A general practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by a general practice. The scope of practice of a general practice nurse typically covers a broad range of health areas (e.g. wound care, medication management), rather than specialist expertise in a particular area (e.g. mental health).

MHN: Mental Health Nurses – "A mental health nurse is a registered nurse who holds a recognised specialist qualification in mental health [nursing]. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual" (ACMHN, 2010, p.5).

HoNOS: Health of the Nation Outcome Scale

NMBA: Nursing and Midwifery Board of Australia

MHNIP: Mental Health Nurse Incentive Program

MHNP: Mental Health Nurse Practitioners are advanced practice clinical nurses educated at Master degree level who are regulated by the Australian Health Practitioner Regulation Agency (APHRA) and endorsed against the Nursing and Midwifery Board of Australia (NMBA) nurse practitioner standards for practice (2014), which took effect on 1 January 2014. (Refer to appendix for where to find information on the scope of practice for MHNPs)

PHN: Primary Health Network

NMHC: National Mental Health Commission

Aims

To provide readers with a clear understanding of the role of mental health nurses in primary mental health care and possible engagement options for the Primary Health Networks, by:

1. Outlining the scope of practice of mental health nurses and describing the Australian College of Mental Health Nurses (ACMHN) process of credentialing mental health nurses.
2. Demonstrating how Credentialed Mental Health Nurses (CMHN), Mental Health Nurse Practitioners (MHNP) and mental health nurses (MHN) more generally can provide part of an effective stepped care approach to mental health care in primary care settings, augmenting the services available through general practice.
3. Outlining some key points of the Mental Health Nurse Incentive Program (MHNIP), including the strong positive clinical outcomes associated with the program, as evidenced by general practitioners and clients across Australia reporting the value of closer engagement with MHN in effective primary mental health care.
4. Providing assistance to PHNs who would like ACMHN to help facilitate access to MHN in their region.

Our organisation

Australian College of Mental Health Nurses

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 of mental health nursing.

The College is recognised in Federal legislation across all jurisdictions and represents the interests of mental health nurses (MHN) nationally and internationally with the International Council of Nurses (ICN) and has done so for close to 50 years.

Universities offering MHN postgraduate study seek accreditation from ACMHN to ratify the training standards of MHN.

As a Peak nursing body, we sit on the Nursing and Midwifery Strategic Reference Group, we have legal standing on a variety of Boards at Director level including with the Mental Health Professional Network (MHPN) and to be finalised as one of the four organisations on the National Nurse and Midwife Health Service Advisory Group.

Recent findings

1. Various NSW Government, Opposition and cross-bench members are indicating support for the 'Fully Fund Mental Health in NSW' campaign. Media interest in and uptake of press has named ACMHN.

2. ACMHN is part of a mental health alliance in NSW with Psychiatrists, GPs and Psychologists where the government is encouraged to commit to a full-scale gap analysis of mental health services in NSW. To date the commitment has been for a limited gap analysis only (mainly community/primary care and youth mental health).

Contents

Scope of Practice of Mental Health Nurses

The practice of all nurses in Australia is framed by the regulatory requirements of the Nursing and Midwifery Board of Australia (NMBA), including adherence to relevant competency standards and decision-making frameworks, currency of practice and professional practice and development.

Guidance on the practice of all MHN in Australia is provided by the ACMHN Standards of Practice for Australian Mental Health Nurses 2010 and the ACMHN Scope of Practice of Mental Health Nurses in Australia 2013.

While any Registered Nurse may work in a mental health setting, the ACMHN defines MHN as a Registered Nurse who holds a recognised specialist qualification in mental health (nursing).

MHN's perform a wide-range of roles, functions and activities, from promoting optimal mental health, preventing physical and mental ill health, and providing therapeutic interventions. Taking a holistic approach, guided by evidence, the MHN works in collaboration with people who are experiencing mental ill health, their family and community, towards recovery as defined by the individual.

The scope of practice of MHN in Australia 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;
- centred around person-centred and client-focused therapeutic approaches to deliver specialised, recovery-oriented, evidence-based care to people across ages, cultures and settings;
- characterised by engagement and collaboration with clients, carers, families and other members of multidisciplinary teams; and
- underpinned by personal and professional reflection.

As with all Registered Nurses, the scope of practice of individual MHNs will change as their experience and expertise develops, and is influenced by specific factors such as:

- Community context, including health preferences and needs of clients, carers, families, communities and specific populations; and geographical location.
- Professional context including employment conditions, practice setting, service setting and area of specialisation.
- Professional qualities including educational experience; level of competence; personal awareness, insights, background, life experiences and interests; personal nursing philosophy and theories; practice experiences; professional and practice development experiences; and lifelong learning.

Credentialed Mental Health Nurses

In Australia, the NMBA does not recognise or endorse specialty areas of nursing practice. As a result, the ACMHN has developed a specialist nurse professional credentialing program for mental health nurses. The ACMHN Credential for Practice Program is the only nationally consistent approach to identifying a specialist mental health nurse.

The Mental Health Nurse Credential recognises the qualifications, skills, expertise and experience of nurses who are practicing as specialist mental health nurses. It demonstrates to employers, colleagues, clients and carers that an individual nurse has achieved the professional standard for practice in mental health nursing. The Credential also increases awareness of the contribution MHN make to the mental health of the community.

To gain a Credential, applicants must demonstrate that they:

- Hold a current licence to practice as a registered nurse within Australia
- Hold a recognised specialist/post graduate mental health nursing qualification
- Have had at least 12 months experience since completing specialist/postgraduate qualification or have three years' experience as a registered nurse working in mental health
- Have been practicing within the last three years
- Have acquired minimum continuing professional development points for education and practice
- Are supported by two professional referees
- Have completed a professional declaration agreeing to uphold the standards of the profession.

Successful applicants are awarded a Credential that is valid for 3 years.

A Mental Health Nurse Credential was identified by the Commonwealth Government as the entry criteria for nurses working under the Mental Health Nurse Incentive Program (MHNIP), as this is the only mechanism by which specialist mental health nurse can be identified. The qualifications and experience of these nurses has been integral to the excellent outcomes achieved through the MHNIP (see evidence provided later). The MHNIP has provided an opportunity for CMHN to show the positive outcomes that CMHN can deliver, offering professional high quality specialist mental health care as part of a high performing, multi-disciplinary team.

A Mental Health Nurse Credential provides clients, the community and PHNs with some certainty around the expertise and qualifications of the MHN and the quality of services they can expect when engaging or commissioning a CMHN. There are currently over 1100 CMHNs working across Australia. The ACMHN is transitioning to an online credentialing system at the end of 2022, streamlining the process for nurses and reviewers, while maintaining the same strong emphasis on quality and standards.

Further information about the credentialing process and how to find a Credentialed Mental Health Nurse is available on the College website http://www.acmhn.org/credentialing/what-is-credentialing

Attract

With the stigma of mental health issues one of the challenges is to attract RNs to the field. Providing both recognition of their role, and clear expectation for staff in mental health wards, will assist in this process.

Financial barriers for MHN and particularly Credentialed Mental Health Nurses (CMHN) are as widespread as every other part of our sector. The item numbers are out of date, and there is a need to increase a fee from over a decade ago to be brought up to current financing.

The current situation sees GPs at more updated fees being still regarded as the first point of call (rightly), but given the normal process of referrals to Psychiatrists there is a significant wait list and public cost.

If nurses are improved from the appalling $54.60 for a 40 min consult, this basically means MHN are not used nor called upon by GPs, Psychiatrists, and so on as there is literally no viable funding for MHN.

Comparison of CMHN & NP-MH authorizations and Mental Health services across professional groups

Nurse Practitioner MH SOP (NP-MH)	Better Access (MHTP) NB: excludes MH Nurses	PHN Step Care MH Services	Chronic Disease Management Plan (CDMP)	Pregnancy Support Counselling (PSC)	General Practitioner providing FPS	General Practitioner Standard Consult	Consultant Psychiatrist	Pediatrician
MBS 82215 40+ mins **$54.60** **Average MH consult is 60 – 90 minutes**	At least 50+ mins Clinical Psychologist **$136.35** Psychologist **$116.65** Allied Health**$105.55**	At least 50 mins **$180.00 unit cost** **Psychologist** **CMHN only direct employ models with subcontracted org**	At least 20 mins **$58.00** Psychology MH-OT, MH-SW & MHN +	MBS 81000 - 81010 At least 30 mins **$68.10** Psychology MH-OT, MH-SW & MHN	MBS 2717 - MHTP 40+ mins **$146.90** MBS 2725 - FPS 40+ mins **$145.35** **Not limited to these items**	Level D 40+ min **$117.40** Not limited to this item	MBS items 291 45+ mins **$427.75** MBS 296 45+ mins **$246.00**	MBS 135 45+ **$249.40**
unlimited	10 sessions	12 sessions	5 sessions	3 sessions	10 sessions	unlimited	unlimited	Unlimited

	Clinical Psychologist	Psychologist MH Social Worker MH Occupational Therapist	Credentialed Mental Health Nurse	Nurse Practitioner – MH SOP	General Practitioner	Adult Psychiatrist	Child Psychiatrist	Paediatrician Developmental and Behavioural
Referral is ***not*** required for a client to initiate service = direct booking ie. walk in clinic				✓	✓	Referral from GP or NP	Referral from GP or NP	Referral from GP or NP
Assessment								
Biological systems			✓	✓	✓	✓	✓	✓
Social	✓	✓	✓	✓	✓	✓	✓	✓
Psychopathology	✓	✓*	✓	✓	✓*	✓	✓	
Physical health clinical investigations & pathology			Screening & Mx	✓	✓	✓	✓	✓
Outcome measures	✓	✓	✓	✓	✓	✓	✓	✓
Diagnosis ADHD	✓*	Screening	Screening	✓*	Screening	✓*	✓	✓
Treatment								
Advance psychotherapeutic skills	✓*	✓*	✓*	✓*		✓*	✓	
Focused psychological strategies (FPS)	✓*	✓*	✓	✓*	✓*	✓*	✓	
MH Counselling	✓	✓	✓	✓	✓	✓	✓	
Psychometric testing	✓		Administer & Mx	✓	✓	✓	✓	
Prescribe stimulant medication				✓ letter from Med Specialist	✓Letter from Med Specialist	✓	✓	✓
Referral to medical specialist				✓	✓			
Write sick certificates				✓	✓	✓	✓	✓
Admission rights				✓	✓	✓	✓	✓
Number of sessions	10 BA 12 PHN	5 CDMP 10 BA 12 PHN 3 PSC	5 CDMP	Unlimited	Unlimited (limited FPS 12 sessions)	291 x1 annually 296 unlimited	291 x1 annually 296 unlimited	Unlimited

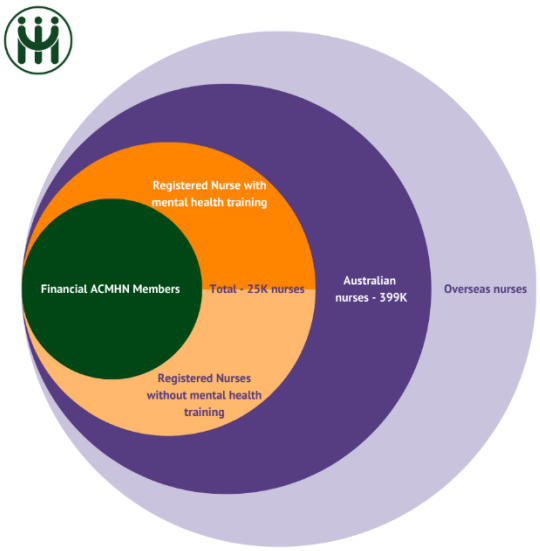
*Note: Health Care Professional can provide ADHD service with specialised training. Only Child Psychiatrists and Paediatricians are fully qualified to assess, diagnose and treat without further education and training for ADHD. GP requires post graduate qualifications in MH and further specialised training in ADHD. NP-MH have Master in MHN/NP therefore can do CPD skills training for ADHD ie. 2 day course.
In 2010 the MBS items and PBS authorisations were established for NP. Both require integration across all health systems and funding to allow full implementation of NP authorisations outlined in legislation.

The above chart shows an ADHD example where CMHN and MH-NP are compared to other providers showing SOP and costings.

Thus to attract more nurses to assist in the one area of ADHD as an example, we need to make CMHN and NP with a MHN training as a viable option and this will attract them to this service.

Train

With close to half of the 25,000 MHN not trained in mental health, there is an urgent need for identification of skilled versus unskilled nurses in our sector. ACMHN has already implemented a standard called Provisional Credentialed Mental Health Nurse (PCMHN) that helps identify the skills most Directors of Nursing (DON) and Nurse Unit Managers (NUM) are seeking to help with improvement in HR and training of MHN. (See point 2 PCMHN).



The estimates for current RNs not trained in MHN are as follows:

Industry average churn rate of RNs is 15.1% whereas with untrained RNs who work in mental health the churn is closer to 20%. The resulting loss of 2,500 RNs annually or conservatively is $250,000,000 nationally. For NSW this means an estimated $72,000,000 in lost skills and trained nurses which can be slowed with proper training of RNs. The recommendation from our College is the Government invest $5 Million over three years or $1.6 million annually in tertiary education for RNs to train to become MHN.

Retain

The above Attract and Train elements will contribute to retention.

In addition the College encourages the consideration of a Mental Health Nursing Incentive Program (MHNIP) similar to previous programs but with caps on funding.

Bullying prevention is critical to retention of MHN and all nurses and midwives. The College cannot put a price on the initiative that NSW Health needs to place on continuing work in this area.

The Mental Health Nurse Incentive Program (MHNIP)

The Mental Health Nurse Incentive Program (MHNIP) was established in 2007 and designed to provide clients with severe mental illness access to mental health nursing care, through primary care GPs, psychiatrists and Aboriginal Medical Centres.

The ACMHN commissioned and reported on a number of surveys of MHNIP providers[1] and in 2012 the then Department of Health and Ageing undertook an evaluation of MHNIP[2].

The outcomes were overwhelmingly positive and findings included:

- The benefits created by a model of care which involved credentialed mental health nurses working with eligible medical practitioners received strong endorsement from clients, carers, medical practitioners and relevant peak bodies.
- Improved outcomes for clients receiving treatment and support under MHNIP as a result of improved levels of care through increased continuity, follow-up and service coordination, access to support and compliance with treatment plans.
- An overall reduction in average hospital admission rates and lengths of stay in hospital where admission occurred; increased levels of employment; improved family and community connections; and positive impacts on GP workloads.
- Costs analyses showing savings on hospital admissions on average at approximately $2,600 per patient per annum, which was about equivalent to the average direct subsidy levels of providing MHNIP.[3]

It is possible that the positive outcomes of MHNIP could be attributable to the fact the program required MHN to be credentialed, and therefore the workforce had extensive experience as MHN. Nurses with no formal education in mental health and without significant experience as a mental health nurse may not be able to achieve the positive outcomes that have been reported through all the evaluations of the MHNIP.

Appendix 1 provides a number of descriptions of how mental health nurses worked under the MHNIP, including demonstrations of improved client outcomes and significant cost savings.

The MHNIP evaluation report is available at - http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-e-evalnurs

Funding allocated to MHNIP was transitioned from the Department of Health to PHNs from 1 July 2022. Under this funding agreement, PHNs must ensure the continuity of care to MHNIP clients throughout this transition, and are required to engage previous MHNIP providers, where possible, in 2022-23 to achieve this. If the PHN has not provided MHN services before, does not currently have MHNs providing services in their region, or needs to fill a MHN position that has become vacant to ensure service continuity for existing clients, ACMHN is happy to be contacted and can help to facilitate access to MHN as required.

From 2023-18, PHNs will have the flexibility to decide the best way to ensure the availability of mental health nursing services to those in need across their region.

[1] http://www.acmhn.org/career-resources/mhnip/mhnip-review
[2] HMA (201), Evaluation of the Mental Health Nurse Incentive Program, Final Report. Department of Health and Ageing.
[3] Ibid. (2)

Key Elements and Future Enhancements for a mental health nurse service

The various reviews and reports on MHNIP have identified elements that should be considered for the ongoing success and operation of MHN in primary care settings, including:

1. Building a strong relationship, undertaking a thorough collaborative assessment and working intensively at the time of referral and/or crisis is required for best outcome.

   Key Element: MHN/CMHNs should be able to work with the client for as long as the client meets eligibility criteria, at the level of intensity the person requires and in line with what is possible within the reasonable MHN/CMHN workload.

2. Nurses who have expertise and qualifications in mental health deliver more positive outcomes for clients and their families.
   Key Element: Where possible, PHNs should engage CMHNS, given the outcomes CMHNs have achieved to date and the opportunities they present for the delivery of mental health services into the future.

3. In supporting people with mental illness, MHN/CMHNs utilise a range of strategies and approaches.
   Key Element: Funding approaches need to consider the range of contact media that MHN/CMHNs engage in to deliver a service including, but not limited to, face-to-face sessions, phone, video, skype, carer support/psycho education, report writing and telehealth service delivery.

4. Under the MHNIP, access to CMHN was constrained by CMHN services needing to occur through an 'Eligible Organisation'.
   Key Element: MHN/CMHN (as specialists) can now be registered providers of care, contracted/commissioned directly with PHNs, and to receive direct payment for the services they provide.
   Key Element: MHN/CMHNs should be able to work with clients from across multiple practices, this also ensures clients have choice and flexibility (for example, it ensures continuity if a client changes to another GP practice, but wants to continue seeing the MHN).

5. Under MHNIP, access to CMHN was constrained by the client referral criteria. CMHNs were not able to work to their full scope of practice.
   Key Element: Eligibility for referral to a MHN/CMHN be extended to any individual who is a client of a tertiary mental health service and who has a mental health care plan, as clinically indicated. This will encourage service integration between tertiary and primary mental health care and ensure better prevention and early intervention, instead of waiting for a MHN to be engaged as a "crisis response" only.

6. MHN/CMHNs have the skills and knowledge to undertake mental health assessment and care planning.
   Key Element: That the MHN/CMHN role in developing a Mental Health Treatment Plan be acknowledged and included as a paid service as part of the session.

Mental Health Nurses as a part of PHN Clinical Governance

CMHN and MHN can play a central role in the PHN Clinical Councils given their experience and expertise in delivering mental health care across a broad spectrum of clinical settings in collaboration with many other health professionals, and are already working in a stepped care approach of service delivery. Nurses are very familiar with coordinated care, as well as the need for integration and collaboration.

Mental health nurses represent the largest mental health workforce in Australia and work in all contexts of care. MHN can therefore provide insights and advice about mental health care services

and delivery from across the continuum, providing a valuable contribution to developing and progressing mental health strategies or other related health reforms. MHN are often the only mental health professional providing care in some areas, in particular regional and rural areas of Australia.

Nurses are leaders in Australia's' health care system. They make significant contributions to the delivery of health care across a range of settings, professions and locations, and are experts in providing collaborative and client-centred models of care. Nurses have a breadth of knowledge on the delivery of health from clinical, administrative, educational and research perspectives.

There is a significant amount of health reform occurring across Australia which will guide and impact how health is delivered into the long term, this includes reforms in primary care, mental health, and managing chronic disease – three of the largest areas impacting the health system. Each of these areas also directly or indirectly relates to mental health, and the role of mental health nurses, as people living with mental ill health often have increased chronic disease comorbidity and are significant users of primary health care.

The mental health nursing perspective of health care delivery, improvement and reform can greatly contribute to these deliberations. Mental health nurses, and nurses more broadly, are the profession that are managing health care services 24/7 365 days a year, across the country.

Engaging mental health nurses: Maximising service delivery outcomes in the primary health setting

Prior to the transition of the program to the Primary Health Networks from 1 July 2022, the Mental Health Nurse Incentive Program (MHNIP) provided non-MBS incentive payments to eligible community based general practices, private psychiatry services and other appropriate organisations (such as PHNs and Aboriginal Medical Services) who engage mental health nurses to coordinate treatment and care for people with serious mental illness requiring clinical intervention and complex care coordination. This funding model was unique since payment did not involve claiming via an MBS item number. It is for this reason that careful consideration should be given to how best to ensure the elements of MHNIP that helped make it so successful are not lost during the transition, and that other areas of the MHNIP service delivery model are improved and expanded upon.

Evidence of the effectiveness of this model of service delivery has been well-documented by a number of reviews.4 Clients receiving treatment and support under MHNIP experienced improved outcomes through increased continuity of care – including through home visits, follow-up and care coordination, access to support and greater compliance with their treatment plans.
There was evidence of an overall reduction in average hospital admission rates and lengths of stay in hospital where admission occurred; increased levels of employment; improved family and community connections; and positive impacts on GP workloads.

Additionally, cost analyses showed savings on hospital admissions on average at approximately $2,600 per patient per annum, which was about equivalent to the average direct subsidy levels of providing MHNIP.

There are a number of foundational elements of this unique primary MHN service delivery model that were crucial to the overall success of MHNIP and positive outcomes for clients. To achieve and – ideally – exceed these outcomes through the commissioning of these services by the PHNs, it is recommended these elements form the basis of PHNs model for commissioning these MHN services:

[4] HMA (2022), Evaluation of the Mental Health Nurse Incentive Program, Final Report. Department of Health and Ageing.

- **Recognition of need for flexibility in service delivery:** CMHN/MHNs need to adjust their service delivery in response to their clients' individual needs. Their ability to continue delivering positive outcomes for their clients based on individual needs hinges on their contractual, payment and reporting arrangements recognising this need for flexibility. For example, the length of time spent face to face with each client may vary depending on what individual clients need or can manage at a given point in time. Sometimes more coordination of care (such as phone calls, working with the family to develop their ability to support the client etc.) will be required in addition to face to face clinical intervention with the client. Similarly, a session with a client may include psychosocial support and that may involve the mental health nurse meeting with the person in their home, or accompanying them so they can go to the shops to buy their groceries. Psychosocial support for people with complex mental illness is highly important.

- **Recognition of travel time and care coordination if a client fails to attend:** Remuneration recognising travel time of the CMHN/MHN is necessary to allow MHN the flexibility to conduct home visits, or to meet the needs of those whose experience of mental illness impacts on their capacity to attend. There may be a number of reasons that people with mental illness do not keep appointments, such as apathy, anhedonia, reduced social drive, loss of motivation, lack of social interest, and inattention to social or cognitive input. Enabling MHN the flexibility to pursue clients who have not attended in this way, also decreases the likelihood that there will be a deterioration in the person's mental state as a result of dropping out of treatment. Remuneration also needs to acknowledge the care coordination role the CHMN/MHN typically engages in to follow up with a client if they miss an appointment, and that for people with mental illness, care-coordination, including liaising with a person's family, other health practitioners and support services, can take a significant amount of time.

- **Recognition of continued professional development (CPD) and clinical supervision:** CMHN/MHNs also require a portion of paid time to allow for continued professional development (CPD) and clinical supervision. Both clinical supervision and lifelong learning are core elements of the *Standards of Practice for Mental Health Nurses in Australia* (ACMHN 2010). They are crucial to ensuring the CMHN/MHN workforce remains highly skilled and up-to-date with developments in best practice so they can continue to deliver positive outcomes for people with severe and persistent mental illness.

- **Clinical decisions:** The decision to discharge a client from the CMHN/MHN service is a clinical one requiring close knowledge of the individual's clinical history and should be made by the CMHN/MHN in collaboration with the client's GP and/or psychiatrist. Standard discharge criteria can act as a guide, but also need to be applied in the context of each client's own circumstances. While some clients may appear to be doing well (for example, from a low HONOS score), their illness may be quite episodic and monthly contact with a CMHN/MHN may be the key driver behind their ability to manage their illness in the community and stay out of hospital. Flexibility regarding client engagement is critical to support effective client care.
- **Reporting:** CMHN/MHN are keen to provide information that may help to improve outcomes for people with severe mental illness and address service gaps. However, current reporting requirements appear to lend themselves more to a straight fee-for-service model, rather than the variable, highly individualised clinical and coordination role of the CMHN/MHN formerly delivering services under MHNIP. This is therefore also time that must be taken into account in the remuneration structure of the MHNs given the level and frequency of reporting the CMHN/MHN are currently required to engage in.

The foundations underpinning the MHNIP provide an opportunity for PHNs to develop a service model for CMHN/MHN that continues to achieve positive outcomes for people with severe and persistent mental illness. They also provide the necessary platform on which to harness the opportunities created through the PHNs to address the geographical inequities identified in past

reviews of MHNIP and to expand on this very successful primary mental health care model to better meet the mental health needs of the community.

The 2022-23 Transition Period

The ACMHN recognises that for 2022-23 PHNs are expected to commission CMHN/MHN services via the current network of MHNIP providers with the primary objective of ensuring continuity of care. From 2023-18, PHNs will be able to determine the best way to make mental health nursing services available where required.

Funding available for mental health nursing services in 2022-23 will be generally commensurate with 2015-16 funding, and additional funding will be allocated in regions that currently have service levels that are less than the weighted national average.

To manage the transition period, issues that will need to be considered by the PHNs include:

- Managing existing contracts with bodies who were 'eligible organisations', namely GPs and psychiatrists, either practices or individuals in their own practice.
- Recognising some CMHN/MHN were engaged directly by the previous Medicare Locals or PHNs.
- Recognising some CMHN/MHN were engaged through contractual arrangements and some were directly employed.
- Acknowledging that the previous payment or claim mechanism was through Medicare, which will now be through PHNs.
- The previous MHNIP payment was $240 per session, which hadn't increased for 9 years, and that the level of actual payments to CMHN varied, based on employment/engagement relationship with the eligible organisations and/or the individual negotiations.
- Recognising that CMHN/MHN also spend a considerable amount of time engaging in other tasks that do not involve clinical face to face contact, including person centred care coordination, travel time, CPD and reporting that are still important for delivering a quality service that is responsive to individual needs.

The ACMHN recommends that for the 2022-23 period, including for those PHNs who will receive funding for mental health nursing services for the first time, that the following claim and payment process will be the most workable in the short-term:

- PHNs manage and maintain existing contracts with GP or psychiatry practices
- CMHN/MHN submit their claim forms directly to the PHNs. If necessary, the GP or psychiatry practice could sign the form before it is submitted.
- CMHN/MHN submit claim forms based on a timeframe that bests suits their work schedule, and there are minimum mandatory payment timeframes for the PHNs in which to make the payments.
- CMHN/MHN currently employed directly by PHNs continue to be so until the end of 2022-23 when new processes/arrangements may be established by PHNs.
- Previous workplace or contractual arrangements between CMHN and Eligible Organisations (including where PHNs were 'Eligible Organisations') should remain in place (i.e. honoured by the PHN) until end of 2022-23.
- The sessional payment needs to increase to reflect the actual costs associated with the provision of mental health nursing services and increases in costs and should be calculated on the basis of CPI as a minimum.

APPENDIX 1: How mental health nurses work in different settings

The report *Achieving through collaboration, creativity and compromise*[5] highlights how CMHN have kept many people out of hospital and helped them back into the workforce or other meaningful social lives – leading not only to benefits for the individual, their family and community, but the overall economy. It demonstrates how CMHN have been able to practice autonomously – using and adapting their extensive knowledge, skills and experience according to client's needs. The report also identifies case studies for CMHN working across different settings and population groups.

The practice examples that follow are written by CMHN describing their different approaches and ways of working within primary care settings in Australia.

Achieving social justice, reducing stigma and collaborating across the community sector

Practice Setting: A CMHN working in Kings Cross, NSW in collaboration with an addiction specialist GP.

Clients: Clients who were living with chronic mental and physical ill health, usually including severe alcohol and drug dependence. A significant number of the clients were street homeless or living in unstable situations; had experienced childhood trauma and incarceration; and had not seen a doctor for many years. Addressing physical health needs, in particular long-standing conditions, was prioritised, supporting access to treatment - and new problems were then identified.

Collaborations: The CMHN established a close relationship with the Salvation Army and Centrelink – two agencies providing assistance to long-term unemployed people. The Salvation Army Employment Plus scheme identified 90 clients on Newstart Allowance who were living with chronic mental and physical ill health. In consultation with Centrelink, social support needs were reassessed, with many people transferred to the Disability Support Pension and provided with priority housing.

CMHN Focus of Care: The CMHN was able to spend quality time with clients, using a narrative approach to determine the underlying cause of their many and varied problems. This usually involved spending an hour with each person to build trust and then develop a plan to address the current and underlying symptoms of their illness. Addressing the significant social and physical health needs was the first step in supporting clients to address mental health issues and other issues within their life, leading to significantly improved health and wellbeing outcomes.

'Walking together': providing continuity and consistency for Aboriginal community members

Practice Setting: A private hospital in Warrnambool use a team of CMHNs to work across a large geographic area, with most contact occurring in the client's own environment.

Clients: Many clients had not received specialist treatment opportunities at public mental health services, due to increasing referrals and demand. The uniqueness of the service is the flexibility that it allows CMHNs to deliver care on an as needed approach and work directly with GPs to address their specific concerns about clients.

Collaborations: A multidisciplinary case management approach to providing clinical and social care was adopted, whereby the CMHN engaged with clients, other health professionals and clinical service providers where appropriate. The service engages with the local Aboriginal community,

[5] ACMHN 2017 Mental Health Nurse Incentive Program: Achieving through collaboration, creativity and compromise.

including addressing longer term disability. There are multiple and complex health problems and some services could not work with them over a longer period. Gaining trust and rapport with the community was vital to address unhealthy lifestyles, provide coping skills and increase resilience.

Outcomes: Due to the ability to meet clients in their own homes, there was a noticeable reduction in hospital admissions. In the 2008 financial year there were 33 in-patient admissions from 77 clients; which reduced in the 2009 financial year to 24 admissions from 134 clients; and in 2010 had reduced further to 8 admissions from 180 clients.

Community feedback raised concerns that existing mainstream services often react to crisis events only and did not progress any further with social and emotional wellbeing and physical situations. In this case one person was able to work with the community and connect them to services.

A Women's Wellbeing Group was also developed and facilitated by CMHNs, with the goal to promote social inclusion and healthy lifestyles and build self-esteem. The flexibility of the service to encompass such a program, provided services to women who would not otherwise be able to access specialist mental health care.

Evidence of outcomes and savings of over $20,000 per client

Practice Setting: Those CMHN who was a private practitioner, was contracted by a private psychiatrist under MHNIP.

Contractual Arrangements: A framework for conducting the service was developed which provided structure and clear guidelines for the provision of care for clients, role clarity between the CMHN and other health care providers, continuity of care through implementation of weekly clinical meetings, and the offer of three monthly case reviews between the CMHN, the psychiatrist, clients and their significant others.

Focus of Care: Services were to be conducted primarily in clients homes (dependent on risk assessment), as this would provide a more accurate assessment and greater understanding of the individual's problems, concerns, issues and lifestyle. It also allowed for greater engagement with families.

Outcomes/Assessment Data
The impact of the MHNIP on the following was assessed:

- Clinical symptoms
- Percentage of families involved in the treatment and care of the person
- Collaboration and coordination of care
- Rates of hospitalisation
- The health care dollar

Data was collected over a period of 15 months and found the following outcomes:

- Decrease in severity of symptoms - average admission Health of the Nation Outcome Scale (HoNOS) score was 23 and the average discharge HoNOS score was 6.
- 72% of families had involvement in the treatment and care of the individual. The others were not involved either because the client refused or, in a very small percentage, decided not to be involved.
- During the period of the study we liaised with and referred clients to over 40 different agencies, organizations or professional bodies.
- Hospitalisations were reduced – there were only a small number of clients (15) for which data could be produced that reflected their episodes of hospitalisation 12 months prior to entry and

12 months after entry into the MHNIP. Prior to care, admissions (including day client admissions) totalled 230. Twelve months after care under MHNIP admissions had decreased to 138.

The savings identified for each client were estimated to be in excess of $20,000 per client over the study period.

In this case, a privately practicing CMHN was able to work with a private psychiatry practice to deliver the following:

- Continuity of care
- Access to support on a psychological and practical level
- Closer monitoring of clients who were acutely unwell and support continued outpatient treatment
- Support objective observations in the homes of clients facilitating better quality information
- Increased emotional support for the client which enhances their response to treatment

Further web material regarding CMHN.

Apply for credentialing (acmhn.org)

If you have any questions, or would like to discuss any of the information contained in this document, including to discuss or obtain ideas regarding commissioning or service delivery models for the delivery of mental health nursing services, please contact ACMHN on 02 6285 1078 or via email at enquiries@acmhn.org.

APPENDIX 2: Number of mental health nurses nationally and hours worked

Australian College of Mental Health Nurses

Report – Mental Health Nurses

Source AIHW 2022 data

Geospatial type	State/ territory	Geospatial division[b]	# of MHN[c]	Average hours worked / week	Average clinical hrs worked / week	FTE	Clinical FTE	MHN per 100,000 population[d]	FTE per 100,000 population[d]	Clinical FTE per 100,000 population[d]
State or territory	NSW	New South Wales	7,213	37	34	6,981	6,447	89	86	80
State or territory	Vic	Victoria	6,965	36	33	6,534	6,025	106	100	92
State or territory	Qld	Queensland	4,941	36	34	4,710	4,402	95	90	84
State or territory	WA	Western Australia	2,947	37	34	2,849	2,671	107	104	97
State or territory	SA	South Australia	1,753	36	34	1,677	1,553	97	93	86
State or territory	Tas	Tasmania	558	35	32	513	472	98	90	83
State or territory	ACT	Australian Capital Territory	415	38	35	419	377	91	92	83
State or territory	NT	Northern Territory	189	41	37	202	182	76	81	73
State or territory	OT	Other Territories	22	35	35	21	20	454	423	413
State or territory	Total[e]	Total[e]	25,003	36	34	23,906	22,149	97	93	86
Remoteness area	NSW	Major cities	5,602	37	34	5,427	5,032	92	89	83
Remoteness area	NSW	Inner regional	1,450	37	33	1,395	1,271	94	91	82
Remoteness area	NSW	Outer regional	155	38	34	154	139	35	34	31
Remoteness area	NSW	Remote	6	36	31	6	5	22	20	18
Remoteness area	NSW	Very remote	—	—	—	—	—	—	—	—
Remoteness area	Vic	Major cities	5,584	36	33	5,226	4,834	111	104	96
Remoteness area	Vic	Inner regional	1,267	36	33	1,206	1,098	101	96	88
Remoteness area	Vic	Outer regional	114	34	31	102	94	45	40	37
Remoteness area	Vic	Remote	—	—	—	—	—	—	—	—
Remoteness area	Qld	Major cities	3,476	36	33	3,256	3,050	103	97	91
Remoteness area	Qld	Inner regional	831	37	35	814	769	81	79	75
Remoteness area	Qld	Outer regional	588	38	35	592	542	84	84	77
Remoteness area	Qld	Remote	19	40	37	20	18	26	27	25
Remoteness area	Qld	Very remote	27	39	31	28	22	50	51	41
Remoteness area	WA	Major cities	2,558	37	34	2,461	2,317	118	114	107
Remoteness area	WA	Inner regional	152	36	34	143	136	63	60	57
Remoteness area	WA	Outer regional	138	38	35	139	126	72	72	66
Remoteness area	WA	Remote	76	41	36	83	72	84	92	80

Remoteness area	WA	Very remote	23	39	33	24	20	35	36	30
Remoteness area	SA	Major cities	1,589	36	34	1,518	1,411	120	114	106
Remoteness area	SA	Inner regional	70	36	31	66	56	30	28	24
Remoteness area	SA	Outer regional	83	36	33	79	72	46	44	40
Remoteness area	SA	Remote	8	44	39	9	8	17	20	18
Remoteness area	SA	Very remote	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
Remoteness area	Tas	Inner regional	474	35	32	437	400	123	113	104
Remoteness area	Tas	Outer regional	83	35	33	76	72	49	45	42
Remoteness area	Tas	Remote	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
Remoteness area	Tas	Very remote	—	—	—	—	—	—	—	—
Remoteness area	ACT	Major cities	415	38	35	419	377	92	92	83
Remoteness area	ACT	Inner regional	—	—	—	—	—	—	—	—
Remoteness area	NT	Outer regional	121	40	36	129	115	81	86	77
Remoteness area	NT	Remote	55	41	38	59	55	110	117	109
Remoteness area	NT	Very remote	13	44	36	15	12	26	30	24
Remoteness area	OT	Inner regional	—	—	—	—	—	—	—	—
Remoteness area	OT	Very remote	—	—	—	—	—	—	—	—
Remoteness area	**Total[d]**	**Major cities**	**19,224**	**36**	**34**	**18,306**	**17,020**	**104**	**99**	**92**
Remoteness area	**Total[d]**	**Inner regional**	**4,244**	**36**	**33**	**4,061**	**3,731**	**91**	**87**	**80**
Remoteness area	**Total[d]**	**Outer regional**	**1,282**	**38**	**34**	**1,270**	**1,161**	**61**	**61**	**55**
Remoteness area	**Total[d]**	**Remote**	**165**	**41**	**37**	**177**	**159**	**55**	**59**	**53**
Remoteness area	**Total[d]**	**Very remote**	**66**	**41**	**34**	**72**	**59**	**34**	**37**	**30**
Primary Health Network	NSW	Central and Eastern Sydney	1,580	37	35	1,556	1,448	102	100	93
Primary Health Network	NSW	Northern Sydney	856	37	33	824	748	92	89	81
Primary Health Network	NSW	Western Sydney	790	38	36	799	745	75	75	70
Primary Health Network	NSW	Nepean Blue Mountains	328	36	34	315	289	85	82	75
Primary Health Network	NSW	South Western Sydney	623	38	35	619	576	59	58	54
Primary Health Network	NSW	South Eastern NSW	597	36	33	569	511	93	89	80
Primary Health Network	NSW	Western NSW	410	38	35	411	373	131	132	119
Primary Health Network	NSW	Hunter New England and Central Coast	1,238	35	33	1,142	1,077	95	87	82
Primary Health Network	NSW	North Coast	547	35	32	507	462	101	94	85
Primary Health Network	NSW	Murrumbidgee	156	37	34	151	139	63	61	56
Primary Health Network	Vic	North Western Melbourne	2,430	37	34	2,346	2,147	131	127	116
Primary Health Network	Vic	Eastern Melbourne	1,595	35	33	1,454	1,372	104	95	89
Primary Health Network	Vic	South Eastern Melbourne	1,248	35	33	1,153	1,068	78	72	67
Primary Health Network	Vic	Gippsland	290	35	32	268	246	97	89	82
Primary Health Network	Vic	Murray[f]	779	36	33	746	684	122	117	107
Primary Health Network	Vic	Western Victoria	711	35	32	656	589	103	95	85
Primary Health Network	Qld	Brisbane North	1,125	35	32	1,026	958	106	97	90
Primary Health Network	Qld	Brisbane South	1,104	37	35	1,070	1,010	91	88	83
Primary Health Network	Qld	Gold Coast	703	35	33	652	611	108	100	94
Primary Health Network	Qld	Darling Downs and West Moreton	621	37	35	607	570	102	100	94
Primary Health Network	Qld	Western Queensland	36	38	31	36	29	57	57	46

Primary Health Network	Qld	Central Queensland, Wide Bay, Sunshine Coast	715	36	34	675	630	79	74	69
Primary Health Network	Qld	Northern Queensland	637	38	35	644	594	89	90	83
Primary Health Network	WA	Perth North	1,634	36	34	1,545	1,454	144	136	128
Primary Health Network	WA	Perth South	929	38	36	920	867	87	86	81
Primary Health Network	WA	Country WA	384	38	35	384	350	69	70	63
Primary Health Network	SA	Adelaide	1,576	36	34	1,503	1,399	123	117	109
Primary Health Network	SA	Country SA	177	37	33	173	154	34	33	30
Primary Health Network	Tas	Tasmania	558	35	32	513	472	98	90	83
Primary Health Network	ACT	Australian Capital Territory	415	38	35	419	377	91	92	83
Primary Health Network	NT	Northern Territory	189	41	37	202	182	76	81	73
Statistical Area 4	NSW	Capital Region	209	37	33	201	182	88	84	76
Statistical Area 4	NSW	Central Coast	321	36	34	302	287	92	87	82
Statistical Area 4	NSW	Central West	329	37	34	324	296	154	152	139
Statistical Area 4	NSW	Coffs Harbour - Grafton	150	36	33	142	132	103	97	90
Statistical Area 4	NSW	Far West and Orana	82	41	36	88	79	70	75	67
Statistical Area 4	NSW	Hunter Valley exc Newcastle	105	33	31	92	86	36	31	29
Statistical Area 4	NSW	Illawarra	324	36	33	310	277	103	99	88
Statistical Area 4	NSW	Mid North Coast	176	38	33	174	154	77	76	67
Statistical Area 4	NSW	Murray	101	38	34	100	90	82	81	73
Statistical Area 4	NSW	New England and North West	122	37	34	119	110	65	64	59
Statistical Area 4	NSW	Newcastle and Lake Macquarie	626	34	32	564	534	160	144	137
Statistical Area 4	NSW	Richmond - Tweed	285	34	31	256	235	111	100	92
Statistical Area 4	NSW	Riverina	142	37	34	138	128	86	84	78
Statistical Area 4	NSW	Southern Highlands and Shoalhaven	87	34	30	77	68	54	48	42
Statistical Area 4	NSW	Sydney - Baulkham Hills and Hawkesbury	65	39	37	66	63	25	25	24
Statistical Area 4	NSW	Sydney - Blacktown	166	40	37	174	160	41	43	40
Statistical Area 4	NSW	Sydney - City and Inner South	397	38	35	392	363	118	117	108
Statistical Area 4	NSW	Sydney - Eastern Suburbs	507	39	37	514	487	192	195	185
Statistical Area 4	NSW	Sydney - Inner South West	269	37	34	261	241	44	43	40
Statistical Area 4	NSW	Sydney - Inner West	384	37	34	372	341	125	121	111
Statistical Area 4	NSW	Sydney - North Sydney and Hornsby	429	37	33	418	377	101	98	88
Statistical Area 4	NSW	Sydney - Northern Beaches	138	35	33	128	121	52	48	46
Statistical Area 4	NSW	Sydney - Outer South West	229	37	35	224	212	77	75	71
Statistical Area 4	NSW	Sydney - Outer West and Blue Mountains	316	36	33	301	277	95	90	83
Statistical Area 4	NSW	Sydney - Parramatta	574	38	36	577	538	116	116	108
Statistical Area 4	NSW	Sydney - Ryde	292	36	33	280	252	144	138	124

Statistical Area 4	NSW	Sydney - South West	286	39	35	290	265	60	61	56
Statistical Area 4	NSW	Sydney - Sutherland	102	36	34	98	90	44	42	39
Statistical Area 4	Vic	Ballarat	237	37	33	231	208	137	133	120
Statistical Area 4	Vic	Bendigo	330	36	33	311	283	197	186	169
Statistical Area 4	Vic	Geelong	341	33	30	300	268	104	92	82
Statistical Area 4	Vic	Hume	163	35	33	150	141	89	81	77
Statistical Area 4	Vic	Latrobe - Gippsland	290	35	32	268	246	97	89	82
Statistical Area 4	Vic	Melbourne - Inner	1,542	36	32	1,455	1,310	246	232	209
Statistical Area 4	Vic	Melbourne - Inner East	502	35	32	459	426	133	121	113
Statistical Area 4	Vic	Melbourne - Inner South	178	34	31	161	147	42	38	34
Statistical Area 4	Vic	Melbourne - North East	604	35	33	558	529	111	102	97
Statistical Area 4	Vic	Melbourne - North West	169	38	36	169	162	39	39	38
Statistical Area 4	Vic	Melbourne - Outer East	355	34	32	314	302	68	60	58
Statistical Area 4	Vic	Melbourne - South East	791	36	34	745	702	91	86	81
Statistical Area 4	Vic	Melbourne - West	802	38	35	794	736	93	92	85
Statistical Area 4	Vic	Mornington Peninsula	330	34	32	299	275	106	96	88
Statistical Area 4	Vic	North West	95	35	32	88	81	61	56	52
Statistical Area 4	Vic	Shepparton	134	39	36	138	127	98	101	92
Statistical Area 4	Vic	Warrnambool and South West	102	36	32	96	85	80	75	66
Statistical Area 4	Qld	Brisbane - East	128	36	34	121	113	53	50	46
Statistical Area 4	Qld	Brisbane - North	256	36	34	240	229	112	105	100
Statistical Area 4	Qld	Brisbane - South	363	36	34	340	324	96	90	86
Statistical Area 4	Qld	Brisbane - West	26	35	30	24	20	14	13	11
Statistical Area 4	Qld	Brisbane Inner City	602	35	32	552	505	202	185	169
Statistical Area 4	Qld	Cairns	236	38	35	235	215	92	92	84
Statistical Area 4	Qld	Darling Downs - Maranoa	50	35	32	46	42	38	35	33
Statistical Area 4	Qld	Central Queensland	157	37	35	153	144	68	66	62
Statistical Area 4	Qld	Gold Coast	703	35	33	652	611	108	100	94
Statistical Area 4	Qld	Ipswich	455	38	36	452	428	122	121	114
Statistical Area 4	Qld	Logan - Beaudesert	263	37	35	257	243	72	70	66
Statistical Area 4	Qld	Mackay - Isaac - Whitsunday	89	39	38	92	90	49	50	49
Statistical Area 4	Qld	Moreton Bay - North	238	34	33	216	204	88	80	76
Statistical Area 4	Qld	Moreton Bay - South	96	34	31	86	79	43	39	36
Statistical Area 4	Qld	Queensland - Outback	43	39	33	44	37	53	54	45
Statistical Area 4	Qld	Sunshine Coast	381	35	32	349	321	94	86	80
Statistical Area 4	Qld	Toowoomba	379	38	36	376	354	231	229	216
Statistical Area 4	Qld	Townsville	294	38	35	297	272	124	125	114
Statistical Area 4	Qld	Wide Bay	182	37	36	179	170	59	58	55
Statistical Area 4	WA	Bunbury	123	36	34	117	111	63	60	57
Statistical Area 4	WA	Mandurah	28	38	36	28	26	25	25	24
Statistical Area 4	WA	Perth - Inner	1,121	36	34	1,069	1,001	594	566	530
Statistical Area 4	WA	Perth - North East	172	35	34	158	154	60	55	54
Statistical Area 4	WA	Perth - North West	332	36	33	310	292	56	52	49
Statistical Area 4	WA	Perth - South East	468	38	36	464	437	85	84	80

Statistical Area 4	WA	Perth - South West	442	38	35	437	412	96	95	90
Statistical Area 4	WA	Western Australia - Wheat Belt	106	37	34	104	95	75	73	67
Statistical Area 4	WA	Western Australia - Outback (North)	84	40	35	88	77	87	91	80
Statistical Area 4	WA	Western Australia - Outback (South)	71	40	36	75	66	57	61	54
Statistical Area 4	SA	Adelaide - Central and Hills	584	37	33	562	503	185	178	159
Statistical Area 4	SA	Adelaide - North	444	37	35	429	412	96	93	89
Statistical Area 4	SA	Adelaide - South	377	35	32	344	322	100	91	85
Statistical Area 4	SA	Adelaide - West	202	38	35	201	188	82	81	76
Statistical Area 4	SA	Barossa - Yorke - Mid North	20	34	32	18	17	17	15	14
Statistical Area 4	SA	South Australia - Outback	44	40	37	47	42	51	54	49
Statistical Area 4	SA	South Australia - South East	82	36	32	77	69	41	39	35
Statistical Area 4	Tas	Hobart	379	35	32	348	319	151	139	127
Statistical Area 4	Tas	Launceston and North East	91	35	32	84	76	59	54	49
Statistical Area 4	Tas	South East	—	—	—	—	—	—	—	—
Statistical Area 4	Tas	West and North West	88	35	33	81	77	74	68	64
Statistical Area 4	ACT	Australian Capital Territory	415	38	35	419	377	91	92	83
Statistical Area 4	NT	Darwin	121	40	36	129	115	81	86	77
Statistical Area 4	NT	Northern Territory - Outback	68	41	38	74	67	68	73	67
Statistical Area 4	OT	Other Territories	—	—	—	—	—	—	—	—

— Rounded to zero

n p not published

(a) Mental health nurses in this context refers to nurses who have indicated on the annual workforce survey that they primarily work in the job area of 'Mental health'
(b) Derived from location of main job where available; otherwise, remoteness area of principal practice is used as a proxy If location details unavailable, location of residence is used For records with no information on all three locations, they are coded to 'Not reported' The number of mental health nurses for each location may not sum to the total due to missing or not reported data Geospatial divisions were classified using the Australian Statistical Geography Standard (ASGS) See the online health-related classifications section for a description of the ASGS

(c) Data include mental health nurses who did not state or adequately describe their state or territory of principal practice, and mental health nursess who reside overseas

(d) Crude rate is based on the Australian estimated resident population as at 30 June 2021

(e) The number for each variable may not sum to the total and totals may differ due to the estimation process, rounding, not stated/missing data and/or confidentialisation

(f) PHN205 Murray lies partially in NSW, although the majority of residents in this PHN reside in Vic

Notes:

1 FTE for nurses and midwives is based on a 38-hour standard working week
2 Data were extracted using the Health Workforce Data Tool (HWDT) as at 12 April 2023 There may be some differences between the data here and that published elsewhere due to different calculation or estimation methodologies or extraction date The HWDT uses a randomisation technique to confidentialise small numbers This can result in differences between the column sum and total and small variations in numbers from one data extract to another

Source: National Health Workforce Data Set: nurses and midwives 2021.