Nursing Revolution in Australian Primary Mental Health

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ABSTRACT: *Objectives: To demonstrate how specialist mental health nurses, as adjuncts to general medical practitioners, are set to revolutionise primary psychiatric care in Australia. Conclusions: Mental health nurses, in association with psychiatrists could become the lynchpin of primary psychiatric care.*

Key words: Nurse specialist, General practitioner, Primary psychiatric care

INTRODUCTION

In Australia, a revolution is in the offing in primary psychiatric service delivery. Mental health nurse specialists are moving out from crisis and community-care teams attached to the public hospitals and community psychiatric clinics. To-date, three levels of psychiatric nursing have evolved: traditional basic mental health nursing; novel advanced nursing; and, advanced nursing with prescribing rights (Keltner & Folks, 1999; Talley & Brooke, 1992). The advanced forms are partnering with primary care physicians in private practice (Fisher, 2005; Hurley et al., 2014). Psychiatrists are beginning to link up with these nurse specialists, at the GP clinics. They are their natural, professional partners, sharing roles and responsibilities (Elsom, Happell, Manias & Lambert, 2007) This article argues for the benefits of models of primary psychiatric care in which the psychiatric nurse is the lynchpin of service delivery.

HISTORICAL SURVEY

The requirement for specialist, mental health nurses is based in two historical developments: mid-twentieth century deinstitutionalisation of the mentally ill; and, millennial commercialisation of medical care, most notably via managed care (Krauss, 1995). One might add that devolution of the mentally ill was not only to the community, but in designated forensic cases, to the prisons. That is another domain, locally and globally, massively under-resourced vis-à-vis psychiatric service provision, in which the specialist psychiatric nurse is set to make a significant difference (About Psychiatric-Mental Health Nurses; Hucker, 2004).

In the pre-modern period the mentally ill were triaged by primary care physicians, and then managed by alienists in the lunatic asylums. This system of mental health 'warehousing' was most comprehensively critiqued by Michel Foucault (Foucault, 1965). Outpatient psychiatry did not become prevalent until ambulatory psychological and physical therapies were developed, most notably, psychopharmacology, from the mid-twentieth century. The health dollar did not follow the psychiatric patient into the community. Community psychiatry failed to meet the treatment needs of all but the most psychiatrically impaired: chronic psychosis, substance abuse and severe personality disorder. Today, community-based mental health services are still focused largely on those with chronic and persisting illness. Services are clustered around acute care hospitals, homelessness shelters and gaols. By far and away the major part of psychiatric illness, however, is managed in general medical practice, in primary care.

Between 1960 and 1990, nurses began to specialise in psychiatry, first in the USA, and then in the rest of the developed world, including Australia. There had always been a small number of nursing doctoral candidates, headed for academe, and a similarly small number doing MBAs, headed for managerial roles. With congressional passage of the Health Maintenance Organisation Act, 1973, in the USA, and the consequent massive introduction of managed care, the number of nursing, shared-care programs, and of articles either describing or evaluating them, grew exponentially. Reiss-Brennan, a medical anthropologist and psychiatric nurse practitioner at Intermountain Healthcare, in Utah, was one of the first to examine mental health integration of nurses and psychologists in the primary care setting (Reiss-Brennan, 2006; Reiss-Brennan, Briot, Cannon & James, 2006; Reiss-Brennan, Van Uitert & Atkin, 2007).

Nurse specialists have cost-effectively (Baradell, 1994; NACNS, 2013; Kilpatrick et al., 2014) relieved the burden of pressure on primary medical care. They are set to make their mark in primary psychiatric practice. The most comprehensive review of research studies of nurse specialists overall was recently carried out by Donald et al. (2014) She and her co-workers surveyed 43, post-1980, randomised controlled trials (RCTs), evaluating the cost-effectiveness of US nurse practitioner (NP) and clinical nurse specialist (CNS) roles. The former prescribe medications, the latter mostly not. The survey covered outpatient, transition, and inpatient care. It found "fair-to-high quality evidence" for improvement of health system utilization (length of stay, re-hospitalization, costs of healthcare eg hospital, professional, and family costs), health resource use (eg diagnostic tests and prescriptions), and for positive patient outcomes (eg mortality, morbidity, quality of life, and satisfaction with care) and provider outcomes (quality of care and job satisfaction).

In this article, we suggest that nurse specialists add matchless clinical and fiscal value to general medical practice. This is because GPs attract by far and away the greatest burden of responsibility for psychiatric care, but are insufficiently qualified and resourced to fulfil this remit. In short, nurse specialists are set to step into the breach.

General Practitioners

Psychiatric disorder is the principal cause of medical disability in Australia (Whiteford, 2010). However, it attracts only 4.9% of Australian, government, health expenditure (AU$906 million, out of AU$18.6 billion) (DHS, 2013). Most psychiatric disability is triaged by GPs in the community. (Lowinsky, 2014; Britt et al., 2014)Since the introduction of managed care, psychiatric patients have increasingly been retained in general practice. About one-third of GP consultations are primarily psychiatric (Wittchen, Muhlig & Beesdo, 2003). GPs were encouraged to pursue psychiatric care by the introduction of safer antidepressants (SSRIs), by positive

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expectations generated by patient (consumer) literacy, and by the stigma of psychiatric illness and psychiatrists.

To assist GPs, and offset costs of psychiatric care, GPs were mandated by Medicare to generate and implement psychiatric treatment plans, in conjunction with allied carers. Typically, GPs manage physical treatments; psychologists provide counselling, notably CBT, DBT, and mindfulness therapies. General practice was even provided with item numbers for longer psychological consultations. In busy practice, these could rarely be taken up. GPs were unprepared for this increased psychiatric workload both in terms of time or training (Leigh, Stewart & Mallios, 2006). They were plied with screening tools, structured assessments, checklists, guidelines and manuals, without palpable benefit. The adaptation of the DSM to primary care (DSM-IV-PC) had a very low rate of acceptance. Psychiatric liaison was trialled, but in the absence of third party funding, did not find a following (Creed & Marks, 1989)

Primary care remained under resourced and underfunded. GPs managed most of their mental health cases but attracted only 21.4% (AU$194 million out of AU$906 million) of the mental health budget. Psychiatrists fared a little better at 33.2% (AU$301 million). Australian psychologists, however, attracted a staggering 43.1%. By and large, they treat anxiety and depression. (Pirkis et al., 2006; Morley et al., 2007)They are anti-medical model, preferring individualised psychological therapies over either biological or social therapies. They are as costly as physicians, but narrower in the range of therapeutic options offered or conditions addressed. Nevertheless, as a powerful lobby group, they managed to convince Australian governments that via GP plans they could service primary mental health more effectively, clinically and fiscally, than psychiatrists. Psychologists however, are generally not able to address Serious Mental Illness (SMI) with complex comorbidity, notably substance abuse. Nor do they assist in the actual preparation of GP mental health treatment plans. These are the very areas of psychiatry which psychiatric nurses excel.

Nurses and General Practice

In the developed world, routine psychiatric nurse training is scaling down. It is briefer, and more integrated with general nursing training. By way of contrast, specialist mental health nursing is developing in Australia (The department of Health, 2012), and in the USA (AACN, 1993; Puskar, 1996; Roberts, Robinson, Stewart & Smith, 2009; Butler et al., 2008). Nonetheless, it is still an under-utilized resource. Today, the expectation is that those nurses intent on working in the mental health field will go the extra training 'yard.' A bachelor's degree is no longer sufficient. A master's degree or equivalent is expected. Psychiatrists, and latterly psychologists, have been reluctant to share their practice with specialist nurses. They argue that the latter are insufficiently prepared, and require supervision. They regard them as competitive, rather than collaborative. It is further asserted that clinical responsibility remains with the GP, and with the supervisor (Elsom, Happell, Manias & Lambert, 2007). The evidence does not support these assertions.

Specialist mental health nurses possess knowledge and skills to-date deficient at the primary, mental health coalface. Over and above all other allied mental health workers, nurses are best set to assist GPs in the generation and implementation of mental health care plans, and to take team-leadership roles (Pringle, 2009). They are well-qualified to assist GPs with the management of at-risk (Puskar & Bernardo, 2002), patient populations, in both urban, and rural and remote settings (Jameson & Blank, 2010). Specialist nurses are sensitive to the needs of the poor and unemployed, the young and the elderly, rural and remote populations (Odell, Kippenbrock, Buron & Narcisse, 2013), and refugees and immigrants.

Most importantly, specialist nurses are able to bridge the dual,

diagnostic and therapeutic gap between medicine and psychiatry (Blythe & White, 2012; Hardy & Thomas, 2012; McConnell, Inderbitzin & Pollard, 1992; Worley, Drago & Hadley, 1990). They are trained to manage both medical and psychiatric illness, reducing illness risk, and promoting health and wellbeing (Burman et al., 2009) especially in the long-term, physically and mentally ill (Vousden, Drago & Hadley, 1990; Smith, Allwright & O'Dowd, 2007). They have made inroads, for example, in the management of comorbid diabetes and depression (Astle, 2007; Ciechanowski, 2006 ; Katon et al., 2006; 2005). Nurses can assist with management of the metabolic syndrome that frequently accompanies long-term use of anti-psychotic medications. They can work towards smoking reduction, and are experienced in all aspects of the management of drug and alcohol abuse. Specialist nurses assist in the management of depression (Swindle, 2003),especially depression in the elderly (Skultety & Zeiss, 2006; Unutzer et al., 2008). They are familiar with the management of personality disorder and the functional psychoses, especially with complex psychiatric comorbidity. Nurses are able to work with veterans, forensic patients, and in matters of worker's compensation. They are effective at assessing and managing psychiatric emergencies and crises, especially where there is risk of harm to self and/or others. In the therapeutic arena specialist nurses are more flexible, and less school-bound. They can augment cognitive and behavioural therapies with treatments based in psychodynamics, family dynamics, and sociodynamics (Stein, 2012; Wheeler, 2013).

In the relatively new profession of specialist mental health nursing, role definition is paramount for all parties: patients, physicians, psychiatrists, and third-party payers and policy makers. Most of all role clarity is essential for the practitioner themselves. Associated with this is titling, practice standards, models of collaboration, prescriptive authority etc. Partly this is externally defined by third parties. The USA is leading the way in specify the range and limits of specialist psychiatric nursing care (Oleck et al., 2011). In Australia regulation is covered by Federal and State legislation. Primary care is funded by Federal and private sources. Public facilities both inpatient and outpatient, are funded by combined Federal and State sources. Health, and especially mental health, often finds itself caught between these two stools, Federal and State (Rattan, 2012).

The field of training competencies was best systemised in the Dreyfus model of skill acquisition (Wikipedia, 2015). Their model proposed that a student passes through five stages: novice, competence, proficiency, expertise, and mastery. These have been applied conceptually to specialist nursing training (McHugh & Lake, 2010). The nursing novice with little or no specialist mental health experience needs extensive supervision; the beginner merely needs assistance; the competent practitioner is partially safe on their own; the proficient nurse has a high level of independence. The expert is able to show initiative and to pass on skills.

All professions and all professionals encounter barriers. Some barriers are extrinsic; some are intrinsic. Achieving targets, both personal and in collaborative, service delivery, precisely depends upon addressing and then overcoming these barriers. Hence it is essential to specify barriers as a prelude to advancing and sustaining service delivery. Corrections can then be made, outcomes evaluated, and services and their providers, improve (Blasinsky, Goldman & Unutzer, 2006; Lee et al., 2007).

Change in the service arena is a challenge both for the nursing practitioner and for the general physician, psychiatrist and other allied health workers. Nurses must match the role they were prepared for with the role expectations they encounter (Delaney, 2009). Barriers from fellow professionals come less from GPs, who relate to nurses as facilitators easing the burden, and more from psychiatrists, psychologists and others in allied health. Tensions can

be eased and collaboration fostered by regular peer review and joint training. Most important is transformative leadership from within the nursing professional and from without, in the primary practice arena.

Paradoxically, greater knowledge and experience with advanced nursing practice is accompanied by greater nursing, clinical uncertainty. Barriers to be overcome are both substantive and procedural. The former are usually specified; the latter, less commonly so. Substantive barriers are in the areas of training, maintenance of practice standards and quality assurance. The greatest attention must be paid to preparation, supervision and role clarity. In procedural terms, speciality nursing in primary care entails management of patient urgency, severity, and complexity. Nurses must think and act under time pressure. Logic must be accompanied by lateral thinking (Trimmer, 2013)

The community mental health hub

Most psychiatric nurse specialists in primary care work from GP offices. Psychologists are just as likely to work in their own rooms as those of the collaborating GP. Psychiatrists make practice visits, but generally do not provide clinical services outside their own clinics. The next step in primary health service delivery is to trial a community mental health hub. In this the core human resources constituency would be the psychiatric nurse specialist. They would be fed with patients by GPs, and would work collaboratively with psychiatrists and psychologists. They would engage in continuous service assessment, and would engage with tertiary academic centres to carry out empirical research. Ideally the service should be manualised so that it can be scaled.

There are two further potential tiers of psychiatric care: virtuality; and aides. To date, virtuality has mostly focused on off-site telemedicine for diagnosis, treatment and management. There has been very little use of internet virtuality. The potential for intra-nets to provide emergency and ongoing support and guidance has yet to be tested.

Mental health support workers could act as the go-betweens in the system. As culture carriers they would advocate for clients, help them with their complex financial, occupational, social and housing, inter-sectoral needs, promote health, and provide informal support and guidance eg with grief. A proportion would have had previous experience of mental illness. In the UK, MIND (http://www.mindaustralia.org.au/about-mind/community-education/mental-health-peer-work-5-day-training-program.html) operates a 5-day community mental health worker training programme. In Australia, training is more extensive. A tertiary certificate is offered to those with suitable life and work experience, who are looking for an opportunity to care for the mentally ill, without undergoing specialist professional training.

CONCLUSION

Blood pressure measurement was extended to nurses' scope of practice in the 1920s. Nearly a century later, Clozapine prescription is on the horizon in Australia and New Zealand (Edwards, 2013), The role of nurse mental health specialists is advancing rapidly. The next step in Australia is for specialist nurses to revolutionise primary psychiatric care, not only in diagnosis and treatment, but also in its leadership and organisation.

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