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Nursing Revolution in Australian Primary Mental Health

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ABSTRACT:

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 d

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.

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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

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

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 specifed; 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 offces. 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 fnancial, 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 certifcate 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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