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Values and valuing mental health nursing in primary care: what is wrong with the 'before and on behalf of' model?

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Accessible summary

- The present model of employment specified in the Mental Health Nurse Incentive Program (MHNIP) is closely aligned to a traditional practice nurse model whereby the nurse is employed to assist and extend medical practice.
- Mental health nurses working within MHNIP typically possess post graduate qualifications and a breadth of experience characteristic of a specialist and advanced practitioner in mental health.
- Mental health nurses ought to enjoy the same status, level of remuneration, professional esteem and accountability of other health professionals.

Abstract

The Mental Health Nurse Incentive Programme (MHNIP) provides funding to organizations to enable mental health nurses (MHNs) to provide care to people with complex needs in primary care settings in Australia. The programme is based on a 'for and on-behalf of' practice nursing model whereby the MHN is presumed to have no specialist knowledge, skills or professional autonomy, and rather extends the reach of medicine. This paper provides a profile of MHNs working in the MHNIP derived from an online survey. A content analysis of responses establishes that nurses who work within MHNIP are highly experienced, and have extensive postgraduate qualifications particularly in psychotherapy. Nurses have negotiated a range of complex employment and contractual arrangements with organizations and pushed the boundaries of the programme to realize good outcomes. The 'practice nurse model' of employment and the underpinning assumptions about MHNs and their skill set relative to other professions is critically examined. Changes to the programme funding mechanism and programme specifications are recommended.

The Mental Health Nurse Incentive Programme (MHNIP) is funded by the Australian Federal Government to enable credentialed mental health nurses (MHNs) to work in primary care settings with people at high risk of hospitalization. As the name suggests, it provides 'incentives' for eligible organizations to engage MHNs to work with people diagnosed with 'severe' mental illness and presenting with complex needs. Incentives include an establishment grant of $AU5000 and payments of $AU240 to the eligible organization for a session of three and a half hours (up to a maximum of 10 per week). A higher rate is paid for people working in remote settings. The MHN must see an average of two people face to face during a given session and has the flexibility to see them for as many occasions of service as is needed. An eligible organization must be community based and have the services of a general practitioner (GP) or psychiatrist with a provider number allocated by Medicare. Such organizations can include general practices, private psychiatry practices, Aboriginal and Torres Strait Islander Services and organizations called Medicare

locals (which can contract out the services of nurses). Medicare is Australia's universal health insurance scheme (introduced in 1984), and most health professionals are reimbursed by Medicare for services provided. The MHNIP is not funded in this manner.

MHNs in Australia have traditionally been employed by public state-funded mental health services or private psychiatric hospitals, although they have long been involved in the provision of community mental health, intensive case management and increasingly in consultation liaison roles. The MHNIP has provided new employment opportunities for nurses and ways to provide highly specialized services to people with quite specific and complex needs not otherwise served in many communities. A recent evaluation of the MHNIP concluded that the programme does appear to be meeting the needs of the target population with over 40 000 people having received a service (Health Management Advisors 2012). MHNIP service users have been found to have symptom severity greater than those engaged in other mental health programmes in primary care (Meehan & Robertson 2013a). An examination of a sample of clinical profiles of MHNIP service users found significant reductions in symptom severity as measured by Health of the Nations Outcome Scale over the course of a service episode (Lakeman & Bradbury 2013). It appears well regarded by service users (Happell & Palmer 2010, Happell *et al*. 2010) and other stakeholders such as GPs (Hurley *et al*. 2013, Meehan & Robertson 2013b), and MHNs have reported that many service users experience improved social and occupational functioning (e.g. they maintain employment, experience improved relationships and participate more fully in their communities) (Lakeman 2013). The MHNIP does appear to be delivering good outcomes and meeting the needs of many service users, although it is unclear what the critical ingredients of the programme are that have contributed to its success.

While the MHNIP appears to be successful in many ways, there are elements of the programme specifications that are problematic in that they appear to devalue nursing, dilute the perceived importance of the nurses contribution to positive outcomes and reinforce an image of nurses as non-specialist, poorly educated non-professionals. This paper critically examines how the programme is specified, funded and what is assumed of nurses. An online survey of MHNs was undertaken that explored the features of those who have taken up the opportunity to work within MHNIP to date, their experience, qualifications and how they have been engaged by eligible organizations. The findings from this survey establish the MHNIP nurse as a highly educated, experienced specialist practitioner. Finally, how nurses with this particular skill set ought to be recognized and what model of funding MHNs in primary care is considered.

Background

In 2011–2012, 529 nurses were active in the MHNIP, working with 283 GPs and 90 psychiatrists (Senate Community Affairs Committee 2012). They provided 114 573 sessions at a cost of $AU35.6 million channelled through 444 eligible organizations (Senate Community Affairs Committee 2012). At the Federal budget in 2012, it was announced that the programme would be frozen at existing funding levels pending an evaluation of the programme. The report (Health Management Advisors 2012) was released on Christmas eve 2012 with no publicity and at the time of publication the programme remains frozen. New nurses or organizations have been prevented from joining the programme, and organizations have been instructed to ensure that 'their nurses' not claim more than the allocated number of sessions. This had wide reaching ramifications for MHNs, many of whom have been forced to leave or anticipate not being able to continue their work as the number of sessions they have been allocated has fallen short of their projected workload. This provides some clue as to the value placed on MHNs by the government. The evaluation process also provided some other clues with the commissioned evaluators, 'Healthcare Management Advisors' offering an incentive for people to complete a survey of $AU100 to the first 50 medical doctors and $AU50 to the first 100 MHNs. The relative value of the MHNs' time was seen as half that of medical colleagues, which is probably generous compared with potential incomes. GPs can earn between $AU150 000 and $AU800 000 in Australia based on what they bill Medicare (Beatmedical 2012).

These highly symbolic gestures of the relative value of mental health nursing crystalize our attention to the issue of how the work of occupational groups come to be valued. The sessional payment is capped and expected to meet all associated costs of the MHNIP, including providing a profit to medical practices. Unlike other Medicare items, the provision of nursing is mandated to be at little or no cost to the service user (Australian Government Medicare Australia 2012); therefore, there is little capacity to charge a fee for service even if the target group could afford it. Thus, the MHN's potential earnings are capped. There has been no increase in the sessional payment since the programme's conception, and it is not indexed like many other subsidies. At the same time, medical doctors have typically increased their part charges to become the highest remunerated occupations in Australia (Corderoy 2013).

Unlike other Medicare fee for service items (which professionals can claim directly and offset with part charges), the MHNIP payments are made directly to eligible organizations. The clear intent is for practices to employ people, and establishment grants will only be paid to eligible

organizations that employ nurses. The MHN can only work with doctors employed by the eligible organization, and should that doctor leave or the patient move elsewhere service must cease. Furthermore, should the person exercise their choice to change doctors, the MHN can no longer work with them. Indeed, their ongoing involvement with the person is entirely contingent on the person's continuing relationship with the medical doctor, and if the person can no longer afford to see that doctor the nurse must cease their relationship. This dependent relationship is unlike most other professional service relationships whereby a referral is typically made by a medical doctor (who will generally be reimbursed for making that referral) and then the professional will report back as required or collaborate further as needed.

Autonomy and discourse

Professions tend to have a number of characteristics including a body of specialist knowledge, and professionals undergo specialist education and training (Funder 2010). Autonomy in a sphere of practice is a key feature of professional groups. Medicine, the archetypal profession enjoys protected, state subsidized monopolies in areas of practice (Starr 1984). In Australia, general practice and private psychiatry are generally 'for-profit' businesses, with income derived largely from Medicare rebates, patient part charges, insurance payments and government subsidies and incentives. Most subsidized health services (including mental health) can only be obtained via a medical referral.

Nurses on the other hand tend to have severely limited professional autonomy. Traditionally, there have been no mechanisms by which nurses can generate income to enable them to work in primary care except as practice nurses. The employment of practices nurses has often been subsidized and they have added value through facilitating the efficient running of the practice, undertaking basic assessment tasks, carrying out delegated therapeutic procedures and undertaking administrative functions to increase the number of patients (Patterson & McMurray 2003). This public face of nursing in primary care has traditionally been seen to be non-specialist, the nurses poorly educated and the role constrained to helping doctors with menial tasks and managing the practice (Halcomb *et al*. 2006). A limited number of Medicare item numbers have made practice nurses marginally more valuable to practices as they can receive reimbursement for some delegated medical procedures (Halcomb *et al*. 2006). These commentators note that the 'small business' structure of Australian General Practice has greatly constrained the role development of practice nurses whose scope of practice is almost entirely determined by GPs and what is required to improve their income (Halcomb *et al*. 2006).

The MHNIP treats the MHN in much the same way as a traditional practice nurse and provides funding accordingly. The assumption is that medical diagnosis and treatment is the reason for involvement, and the medical doctor could undertake all of the necessary care but delegates some technical tasks to the nurse. The official specifications of the MHNIP tend to support the view of the MHN as a medical practitioner substitute as they state that the role of the MHN is to review people's mental state, monitor and manage medication, provide information on physical health care and arrange access to other health professionals (Australian Government Department of Health and Ageing 2012). In contrast to the MHNIP, another programme called Better Access (which provides funding to enable people with high prevalence problems to access 'focused psychological strategies') does not assume that providers are simply substituting for a medical practitioner. As King (2013) notes, the scheme has allowed private psychology clinics to flourish. Nevertheless, King (2013) is critical of this programme for encroaching on the professional autonomy of practitioners by prescribing the kinds of interventions that can be provided. That is, treating psychotherapy like a drug or some other medical intervention. He also strongly argues that there is no sound basis for restricting providers to particular professional groups, and asserts that nurses and other appropriately trained groups can deliver psychological interventions.

However, nurses are still perceived to have a duty to carry out doctor's orders (a powerful symbol) and intelligently observe and assess patients and support the work of medical practitioners, deferring to their judgment or at least appearing to do so. Many nurses are highly skilled practitioners and have a long history of practicing in indirect ways in order to influence the clinical and bureaucratic setting (Traynor *et al*. 2010). The notion of the 'doctor nurse game' (Radcliffe 2000) is well understood as a dynamic between doctors and nurses in which the interactions are carefully choreographed so as not to disturb hierarchical relationships. Nurses make recommendations as long as they are made to look as if they were initiated by medical doctors and thus it is with the MHNIP. In day-to-day work in the public sector, this tends to pose no great problem, nor in the myriad of mutually respectful and collegial relationships that nurses actually enjoy. However, nurses have colluded in constructing a discourse that positions nursing as subservient to medicine.

Discourse has frequently been acknowledged as a powerful factor influencing the pace and direction of reconstructing professional roles (Gergen 1999; Zeeman & Simons 2011). Discourses highlighting traditional views are frequently forwarded by those holding influential and powerful positions, resisting competing but less powerful

discourses advocating change (Gergen 1999, 2001). The Australian discourse around mental health remains largely biomedical. Nursing is traditionally seen as complementary but subservient to medicine. Thus, it seems that the natural order of things that nurses should help with medical treatment and not claim that their work is therapeutic. Indeed, nurses have been very ambivalent about claiming to work therapeutically even when having advanced training in psychotherapy (see Barker 1989). Indeed, to date no professional nursing bodies in Australia have been publically critical of the model of engagement embedded in the MHNIP nor like King (2013), a psychologist, have they argued for MHNs to have access to other Medicare items.

Assumptions about what MHNs do are derived from a distinctly biomedical discourse of mental ill health. Queensland Health (2012) identifies MHNs as monitors of biological mental illness, watchers of patients' behaviours and dispensers of medications. Government of Western Australia, Mental Health Commission (2012) states that MHNs are capable of medication and mental state monitoring and add that they are capable of linking the care performed by other disciplines. Other organizations attribute greater capabilities to MHNs. Allied Health Professionals Australia (2012) acknowledge that nurses can offer general counselling and psychological interventions, as well as undertaking biological and collaborating care roles. However in contrast, mental health social workers and psychologists are assumed to be actively solving service users' problems with specified models of psychotherapy. These assumptions about the capabilities and preparation of nurses may go some way to explain why a practice nurse model of engagement of MHNs in MHNIP was adopted as nurses are not seen as possessing psychotherapeutic skills. Rather, they are seen as having a good enough grasp of biomedical concepts to extend the reach of medicine.

Mental health nursing in primary care has been constructed based on a biomedical discourse that sees people with serious mental illness as having biomedical problems, and the most pressing need is for coordinating biomedical treatment. A practice nurse model based on stereotypical ideas about the nurse–medical doctor relationship whereby the nurse acts for and on behalf of the time-pressed doctor has been the proposed solution. Similar to practice nurses (Patterson & McMurray 2003), no matter how well regarded they are at a local level, MHNs as a group are presumed to be poorly educated, lacking in specialist skills and requiring the direction of a medical practitioner. To date, there has been a paucity of research that describe the actual capabilities and experience of MHNs who work in the MHNIP to challenge the assumptions that underpin MHNIP and the discriminatory way that nursing is deployed in primary care relative to other professions.

Methods

An online survey of MHNs working in the MHNIP was commissioned by the Australian College of Mental Health Nurses (ACMHN). The intention was to ask predominantly open-ended questions so as to capture the richness and diversity of experience of working in the MHNIP as this breadth had been absent in previous surveys. A suite of questions were developed about aspects of the programme and trialled with a small cohort of MHNs. After obtaining ethical approval from the Southern Cross University institutional ethics committee, the ACMHN emailed all credentialed MHNs (approximately 1000 at the time) and invited those who had worked under the MHNIP (529 in 2011) to undertake an online survey. The survey included demographic questions and a range of open questions relating to how the programme operates and achievements to date. Nurses were also invited to contribute brief case profiles and outcome data. The survey was deployed using Qualtrics Survey Software (Qualtrics Labs Inc. 2009). This enabled aggregated data to be downloaded in a spreadsheet format. Responses to qualitative questions were analysed using thematic content analysis as outlined by Braun & Clarke (2006), with the intention of capturing all the variation of responses in themes derived inductively from the data (see also Lakeman 2013). Demographic details and responses to the questions relating to the education and experience that was useful in their roles and how the MHN engages with the eligible organization are reported in this paper. This serves to present a typical profile of a nurse working in the programme.

Findings

Demographic characteristics

Two hundred eighty-eight responses to the survey were received, of which 238 were complete and included in the analysis. The average age of respondents was 50.7 years [standard deviation (SD) = 10, range 27–68], with 88% over the age of 40. Seventy-two per cent of respondents ($n = 171$) were female. The majority were living in Victoria (45%, $n = 105$), New South Wales (23%, $n = 53$) or Queensland (21%, $n = 49$). A little over half worked primarily in metropolitan or inner city areas (53%, $n = 123$). Most (85%, $n = 201$) had been working in the MHNIP for over a year (mean = 2.6, SD = 1.5).

Employment relationships

A considerable diversity and complexity of employment relationships were revealed with a little over half of respondents (n = 132, 55%), stating that they were in an employment relationship with an eligible organization. Some people were 'engaged' in different ways, with several organizations describing themselves as contractors (n = 75, 31%) and/or independent sole traders (n = 58, 24%). Most people undertook more than one session per week. Thirty-one per cent stated that they undertook 10 sessions per week (the maximum allowable), and 22% worked five or less per week. The average number of face-to-face consultations each week was 16 (SD = 9) or 2.1 people face to face consultations each session (SD = 0.83).

Some respondents (n = 58) stated that they received a wage from an eligible organization, with that organization handling billing Medicare and providing basic resources, e.g.

> I am employed permanently by a family medical centre, It has 2 principals and numerous doctors working there. I am employed to do 10 sessions a week and payed on an hourly rate with annual leave etc and a study allowance provided.

This appeared to work well for some nurses but appeared highly dependent on the ethos of the organization. As one nurse who had worked for three different organizations and who stated that she earned the same as a graduate (first year) nurse stated,

> If a GP clinic employs a CMHN (in my experience) they request that clinicians do things which bring more money into the clinic, such as GP Mental Health Care Plans for people who are not even involved in the MHNIP. This option I found was very money targeting and my expertise and benefits to patients were disregarded. On my resignation the Director of the medical clinic even stated that the MHNIP was not making enough profit for them to continue . . .

Others received funding from a number of sources for their position or had mixed roles, e.g. working at university health clinics, at private hospitals or providing a variety of consultancy services.

Twenty-five per cent of the nurses who responded to the survey were employed by or had contracts with a Medicare local or division of general practice (full time, casually or part time). This arrangement allowed for the greatest degree of flexibility with respect to receiving referrals from different GPs and also enabled a form of 'shared care' with other division nurses that was not possible with other employment models. Fifteen nurses stated that they had a shared employment relationship with State mental health services which had released them to work with a Medicare local.

Fifty-five per cent of respondents stated that they were independent contractors, sole traders or self-employed. On the basis of their descriptions, these terms appeared synonymous. It meant that the nurse contracted with one or more eligible organization to provide sessions, and the sessional payment was either paid directly to the nurse or to the organization. If the organization provided rooms or administrative support, the sessional payment was garnished between 12.5% and 30%.

Closely related to form of employment/engagement were the relationships that people had with practices. Many nurses perceived that they were seen as solely as an instrument to make money. Nurses provided examples of how they completed tasks such as writing or updating mental health care plans, which generated additional income for the practice or individual GPs but were paid a fraction of the income they generated. That the MHN is unable to readily communicate directly with Medicare and correspondence typically goes to the eligible organization rather than the nurse has contributed to ill-feeling for some people. In one instance, a nurse was not paid for 8 months.

> I work independently in the sense that I rent my own rooms (as a percentage of my income), pay my own indemnity insurance and so forth. The doctor refers to me but took the entire establishment payment and this caused a little bit of ill-feeling as I met all the establishment costs. I don't receive the Medicare summaries directly despite being a contact person but nevertheless pay rent on what I bill at the end of each month. I don't get to see the reconciliation for months (if at all) but I usually receive less than what I bill for various reasons so end up being out of pocket. I love the work I do and I've never been more effective at putting my years of professional education into practice but will likely cease my practice when my insurance is up for renewal.

Being tied to an eligible organization and relying on one person to make referrals creates a tenuous employment relationship. One person was forced to find work elsewhere when the GP in a practice became unwell.

> The head GP insisted on charging for my service against my wishes and those of the other 4 GPs in the practice. As predicted my face to face contacts quickly fell from an average of 24 over 5 sessions a week to 12 over 3 sessions a week making the job unsustainable.

While in many instances doctors were willing to refer people to the nurse, not being able to refer people except via the medical doctor within the eligible organization posed problems. For example, a highly specialized child and youth nurse and family therapist was unable to directly receive referrals from a paediatrician or a consultant psychiatrist in the public sector. While some of these problems could be accommodated, others such as not being able to

continue seeing a person if they chose to exercise the choice to change GPs or attend a different medical practice could not be easily addressed.

Qualifications and experience

Nurses were asked to outline the qualifications held or training undertaken that was most helpful in their role. It appeared that most respondents had started or completed their postgraduate education prior to commencing work in the MHNIP, and several said that they could not afford to further their education on the low wages they currently received. However, the majority of respondents appeared to hold multiple postgraduate qualifications. Several had attained doctoral qualifications, and others were studying towards doctoral degrees. Thirty-two per cent acknowledged holding at least one master's degree in mental health care or mental health nursing ($n = 37$), a specific school of psychotherapy ($n = 16$) or other related field such as psychology, social work or addiction studies ($n = 9$). Eleven people had attained or were working towards a further master's degree, leading to accreditation as a nurse practitioner. Approximately 20% ($n = 46$) had a first degree, diploma or initial preparation as a psychiatric/MHN, which they stated was useful.

By far the most commonly cited useful skill set and area of education was in the field of psychotherapy, with 71% ($n = 161$) citing particular training in one or more forms of psychotherapy as being useful.

> . . . systems theory and family therapy – this has been most useful to date as almost every client has relational issues as causative or contributing factor to identified problems

Twenty-three per cent of people ($n = 52$) acknowledged having degree level or higher qualifications in some form of counselling or psychotherapy, and a further 48% ($n = 109$) had attended short courses or had attained certificate- or diploma-level qualifications. This probably understates the amount of experience and expertise in psychotherapy as others simply listed higher degrees in mental health that are likely to include some psychotherapeutic skill development. Figure 1 outlines the percentage of people who explicitly mentioned particular training or education in specific forms of psychotherapy or practice. Most people also mentioned a range of training in numerous modalities. The following was fairly typical of the responses received:

> Initially I had a psychiatric nursing certificate. I have since completed a graduate diploma in health services management, a Masters of Nursing (advanced practice majoring in mental health) and a Masters of Nursing (Nurse practitioner). I have a certificate in adolescent mental health . . . I have attended training and advanced training in Interpersonal psychotherapy, and parent child interactional therapy. I have attended many workshops on working with sexually abused children and adults. I have trained in somatic body work, psychotherapy and Jungian psychotherapy in work place training. I have also trained in the Adult Attachment Interview . . . and attended individual and group clinical supervision training.

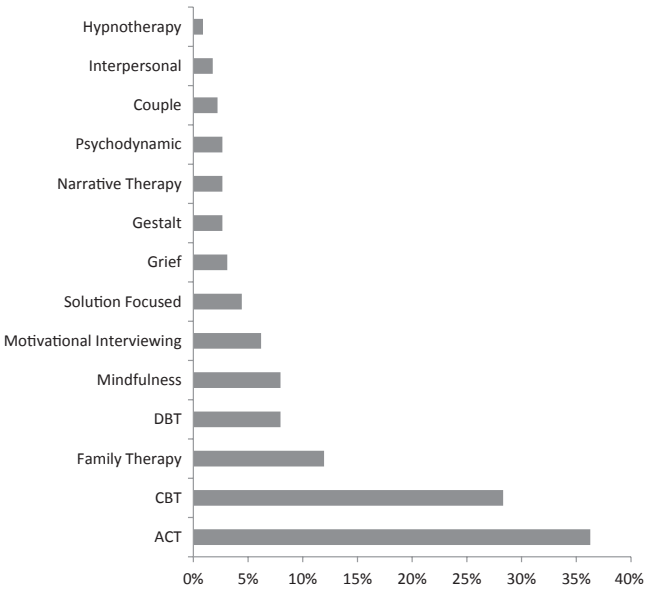

Figure 1
The percentage of respondents who mentioned having received formal training in a form of psychotherapeutic practice. ACT, acceptance and commitment therapy; CBT, cognitive behavioural therapy; DBT, dialectical behaviour therapy

Twenty-seven per cent ($n = 60$) had received some qualification in alcohol and drug work or addiction studies. Most people acknowledged a commitment to ongoing education and cited useful workshops they had attended ($n = 24$) such as hearing voices workshops, cultural awareness training, outcomes training, responding to trauma, sexual abuse, diabetes education, suicide prevention training, opiate prescriber accreditation courses and so forth.

Twenty six per cent of people ($n = 60$) spoke of their extensive experience working in the mental health sector (sometimes decades) and knowledge of the local community and how to get things done.

> [I have] experience in public sector; experience working on intensive mobile support team; experience as crisis team worker for several years . . . knowledge of local services . . . [the] . . . disability sector (first trained as Mental Retardation Nurse). . . . Many short courses undertaken over years . . . CBT training, strengths focused models, [the] recovery model, collaborative therapy, trauma focused counselling . . . experience

working at . . . Youth Health, of using assessment tools, and evidence based interventions.

Discussion

Close to 50% of MHNs who had worked in the MHNIP responded to this survey. It would be fair to suggest that this sample is representative of those practicing within MHNIP, and the age and sex profile as well as the geographic distribution is similar to that found by others (e.g. Health Management Advisors 2012). A limitation inherent in asking open-ended questions is a loss of precision. For example, relying on respondents to volunteer which qualifications they found useful means that it is likely that underestimates of qualifications will occur. Similarly, people were not asked to volunteer what their remuneration actually was. A further limitation may be associated with the timing of the survey administration, which occurred after the freeze of the MHNIP was announced. Thus, some MHNs may have been demoralized, and this may have affected their responses, although there is no clear evidence of such a bias as the problems that people mentioned often appeared to have occurred sometime in the past.

These MHNs by and large appear exceptionally experienced and highly educated, holding at least the equivalent of a graduate diploma, but more often holding a relevant master's degree or combination of higher degrees. The majority had specific training in psychotherapy and most also held advanced qualifications in a specific form of psychotherapy. This profile is highly characteristic of a specialist professional amply capable of working autonomously and collaboratively. Their experience and qualification profile suggests expertise in working with people with complex mental health and social needs. Thus, the practice nurse or 'for and on behalf of model' of engagement appears inappropriate, although in practice many nurses are working as specialists despite the programme specifications. This poses a problem for programme evaluation research generally, that is determining what elements of the programme are pivotal to good outcomes. The good consumer outcomes demonstrated by MHNIP (Health Management Advisors 2012, Lakeman 2013, Lakeman & Bradbury 2013) may obscure the fact that there is something unsound about the model of delivery and that practitioners (both nurses and others) subvert the programme specifications in order to be able to deliver the best outcomes.

This is also borne out by the forms of engagement with eligible organizations in which roughly half of MHNs had negotiated a form of engagement that was different from a traditional employer–employee model. Problems with employment relationships typically centred around the fairness and adequacy of remuneration and dealing with 'eligible organizations'. Some nurses felt devalued by the process particularly being unable to deal with Medicare directly. Health Management Advisors (2012) stated that people were satisfied with the MHNIP model of service delivery. However, this survey suggests that this was by no means universal. There is little evidence that nurses want to be employed by organizations or that practices want to employ nurses, but nevertheless accommodations have been negotiated to make the programme work. Indeed, relative to their peers in public mental health services, MHNs in the MHNIP enjoyed lesser remuneration, poor conditions and insecure tenure.

The principle means of assigning a value to a profession or service in contemporary society is through policy that permits or constrains professional autonomy and sets a dollar value for the worth of that service. In the state public mental health system, this worth is in part expressed in salaries and conditions with a fairly standard formula that medical specialists are the most prized, and the regulated allied health professions and nurses are on a comparable footing. In primary care, the relative worth of professions is expressed through permitted autonomy and the dollar value of fees scheduled under the Medical Benefits Scheme (MBS). The first time that MHNs were named explicitly as an eligible provider group in the MBS was in 2004 with Enhanced Primary Care (EPC) items. This scheme allowed eligible providers to provide mental health interventions to citizens with a chronic mental illness. Access was based on referral by a GP and a care plan. All professions were remunerated equally and were seen as equally autonomous, in that reporting mechanisms back to the GP are standard (Australian Government Department of Health and Ageing 2012).

MHNs were shifted to the MHNIP when all of the other EPC mental health providers migrated to the Better Access scheme. The interest group strongly influencing this iteration was the Australian Medical Association. They asserted that nurses could not work independently because medical practitioners were ultimately legally responsible for the care delivered to patients. Although this was discovered not to be the case under Australian jurisprudence (Cashin *et al.* 2009), it nevertheless influenced policy. Nurses were viewed as instrumental in extending the care of medicine as opposed to carrying out focused psychological therapies. In terms of autonomy, nurses are viewed in the scheme as following protocols and adhering to plans formulated by medical practitioners. In terms of recognized autonomy, nurses were seen as protocol dependent, as less autonomous than under the EPC. For other groups, minimum reporting expectations of Medicare decreased to a letter

Table 1
Value as reflected in the medical benefit scheme

Profession	Eligible schemes	Rebate per session (longest duration) 85%	Qualifications required to participate
Credentialed mental health nurse	MBS primary care items MHNIP	$AU52.95 ($AU240 for 3.5 h session) $AU68.57/h	Credential by the Australian College of Mental Health Nurses in addition to AHPRA registration as a nurse. Graduate in diploma mental health/psychiatric nursing
Nurse practitioner	Nurse practitioner items	$AU49.80 (40 min plus)	AHPRA regulated Master's degree
Psychologist	MBS primary care items Better Access	$AU52.95 $AU84.80 (50 min plus)	General registration in psychology (undergrad)
Clinical psychologist	MBS primary care items Better Access	$AU52.95 $AU124.50 (50 min plus)	AHPRA regulated Master's degree
Social worker	MBS primary care items Better Access	$AU52.95 $AU74.80 (50 min plus)	Meet Australian Association Standards for a mental health social worker (no stipulated postgraduate study)
Occupational therapist	MBS primary care items Better Access	$AU52.95 $AU74.80 (50 min plus)	Undertake to observe the standards for occupational therapists in mental health by Occupational Therapy Australia (no stipulated postgraduate study)

Rates as per 1 November 2012.
AHPRA, Australian Health Practitioner Regulation Agency; MBS, Medical Benefits Scheme; MHNIP, Mental Health Nurse Incentive Programme.

posted to the GP (Australian Government Department of Health and Ageing 2012). Perceived autonomy, based on prescribed contact with the medical practitioner, for all groups other than nurses increased. This policy shift was based on rhetoric rather than evidence, but it cemented a view of nurses as medical practitioner helpers and faithful followers of the 'doctor's orders'.

Apart from recognized autonomy, the other element of value reflected in the MBS is the dollar value for the purchase of service. As reflected in Table 1, nurses receive the lowest scheduled fee. As has also been noted that, 'with the exception of participating optometrists, allied health professionals are free to determine their own fees for their professional service and charge fees in addition to Medicare subsidies (Australian Government Department of Health and Ageing 2012, p. 9). MHNs working in MHNIP are discouraged from charging for their services (Australian Government Medicare Australia 2012), although ironically as found in this survey, there is no limit to the fee a medical practitioner might charge and access to MHNIP can be curtailed by a simple change in practice policy whereby the charge to see the medical doctor is increased.

Nurses in Australia are presently highly remunerated relative to nurses in many other countries. However, it must be noted that because the MHNIP incentivizes employment of nurses by eligible organizations, most nurses only receive a fraction of the actual session fee, placing them at the lower end of remuneration relative to other health professionals. This paper argues that mental health nurses are specialists, and they ought to be treated fairly relative to other health professionals and remunerated according to their specialist status and experience (established in this survey). Most importantly, this ought to also be reflected in the way MHNs are described in the programme specifications.

The practice nurse model embodied in the MHNIP is morally flawed. Particularly morally repugnant is that the nurse is not seen as having a relationship of any independent value with the patient, except as mediated through the relationship with a medical doctor. In day-to-day practice, this instrumental relationship is made to work. Arguably, however, this is despite not because of the model of engagement promoted in the programme. It is sadly ironic that MHNs with decades of experience, postgraduate mental health qualifications and often advanced training in psychotherapy are excluded from billing under the Better Access scheme, whereas other allied health professionals with comparable and often lesser training can do so (and apparently provide focused psychological treatment). What the MHNs do tend to have in addition to such training is long experience working with people with the most complex of psychosocial problems. Thus MHNs appear well matched in terms of skill sets with the targeted population. Nurses are also, by dint of traditional organizational structures, the most team orientated of all health professions and thus do not need incentives to work collegially or engage key stakeholders as needed. The current complexity involving eligible organizations in the MHNIP and tying ongoing care to a particular medical practitioner serves no useful purpose, and indeed demeans those involved and creates sometimes untenable tensions that can undermine the good intent of the programme.

Influential commentators and participants in Australian mental health reform (Rosenberg *et al*. 2009) note that some of the interventions to date have failed to address the health problems of those most in need, and they call for a radical overhaul of the way services in primary care are funded away from a piecemeal fee for intervention model and towards providing integrated, targeted and collaborative services. The MHNIP has some promising elements in terms of sessional payments for particular groups at need rather than being tied to a capped number of sessions for a given patient (as in Better Access). In the absence of a radical change to funding formula, this sessional idea with appropriate accountability and reporting ought to be preserved. However, the professional autonomy of MHNs as specialists ought to be promoted through a referral for service structure and MBS item numbers for sessions reimbursed at a rate in keeping with their specialist status.

As with other specialist and generalists such as GPs, their employment arrangements can be negotiated separately and should not be mandated in programme specifications. While this might not undermine the predominant biomedical discourse that dominates mental health provision, it will go some way to modelling collegiality and respect for the different roles health professionals can play in health care provision. The findings of this study demonstrated that MHNs are highly prepared specialists who have the potential to practice autonomously and provide psychotherapeutic interventions to those with the most complex needs. This is borne out not only by their qualifications, but also by the actual outcomes of the programme (Health Management Advisors 2012, Lakeman 2013, Lakeman & Bradbury 2013). MHNs should not be seen as merely extenders of the medical profession or as brokers of care provided by others, and mental health programme specifications ought to recognize them as collaborating professionals and treat them accordingly.

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