# Evaluation of health programs for managing impaired nurses and midwives

## Report to the Nursing and Midwifery Board of Australia

## April 2012

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## Executive summary

AHPRA's *Annual Report 2010-11* indicates that, of 321,662 registered nurses and midwives 1,300 were notified to AHPRA. Less than a sixth of these notifications were for health reasons: the total number of notifications of nurses and midwives for health related reasons was 225:

**Numbers and percentages of all notifications of nurses and midwives by State and Territory**

| Jurisdiction | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | Totals |
|---|---|---|---|---|---|---|---|---|---|
| Registrants | 4,499 | 93,704 | 3,321 | 62,392 | 29,808 | 8,301 | 87,830 | 31,807 | 321,662 |
| Notifications - Nurses | 19 | 333 | 27 | 243 | 282 | 26 | 241 | 67 | 1,238 |
| Notifications - Midwives | 0 | 11 | 1 | 34 | 6 | 0 | 5 | 5 | 62 |
| Total notifications | 19 *(0.42%)* | 344 *(0.37%)* | 28 *(0.84%)* | 277 *(0.44%)* | 288 *(0.97%)* | 26 *(0.31%)* | 246 *(0.28%)* | 72 *(0.23%)* | 1,300 *(0.40%)* |
| **Health notifications** | **3** | **60** | **5** | **48** | **50** | **4** | **43** | **12** | **225** |
| % of all registrants | *0.07%* | *0.06%* | *0.15%* | *0.08%* | *0.17%* | *0.05%* | *0.05%* | *0.04%* | *0.07%* |

The AIHW estimates that 5% of adults use alcohol at a 'high risk' level and 15% 'at risk'; and that 20% of adults per year may have a mental health problem. It is unlikely that the profile of registrants differs greatly from the norm. In short, only a very small proportion of the nurses and midwives who may be absent from work, or perform below capacity, or leave the profession by reason of impairment come to the attention of regulatory authorities.

This report is drawn from interviews and written submissions from AHPHRA Chairs, Chief Nursing and Midwifery Officers, and ANF branches across the States and Territories in March 2012.

***Variation among the jurisdictions:*** State and Territory submissions indicate that the approach to managing impairment varies with the size of the nursing workforce. Processes in the smaller jurisdictions tend to be more informal and diversionary; the larger States are more formal, and nurses and midwives there are said to experience the notification process as punitive rather than remedial, which might cause those in difficulty to avoid attention rather than seek help.

Respondents described a range of other services available for help and treatment for AOD and mental health problems. All jurisdictions have Employee Assistance Programs [EAPs], but it is not clear that they are often used by impaired nurses and midwives. There is no reliable source of information in any jurisdiction for the numbers of impaired nurses and midwives using EAPs as employees, or using public or private sector services as individuals.

The only health program specifically for impaired nurses and midwives in Australia is the Nursing and Midwifery Health Program Victoria [NMHPV] which shares the confidence of AHPRA, the Health Department, and the ANF in assessing, planning and coordinating treatment and referrals, and offering support to employers. In 2010-2011, the NMHPV opened 159 episodes of care, and 128 episodes of care have been opened since then.

***Costs to AHPRA, registrants and employers:*** While few respondents had detailed information, they identified the following components:

*Costs to AHPRA: t*he costs of assessing a complaint, including medical assessments; in NSW, sitting fees of the Board's Panel process; Board members' fees; legal advice; the salaries of AHPRA staff who monitor compliance

*Component costs to nurse or midwife*: compliance with undertakings or conditions repeated cost of urine drug screening or Gas Chromatography-Mass Spectroscopy; treatment or counselling with psychiatrist, psychologist, counsellor or GP, or any ongoing therapeutic interventions imposed as conditions by the Board; independent medical assessments and reports required by imposed conditions; travel costs for non-metropolitan registrants; income lost if suspended, practising under conditions, or less employable while notified

*Component costs to employer:* EAP or support programs; salary and on-costs of occupational support staff or mentors; increased demand on resources when employing a nurse or midwife subject to

conditions; extra staffing costs if a registrant must be directly supervised by another practitioner or if additional training is required; supervision or reallocation to enable the registrant to remain in the workforce; replacement costs if a nurse is suspended with pay

***Productivity and loss of work:*** The ANF submitted an analysis of the cost of lost productivity for an impaired nurse or midwife who took time off work or worked under conditions, and estimated that the program represented a saving to the health sector of over $7million. (These figures were questioned by two other jurisdictions). The only available source of data for estimating how many impaired nurses or midwives have remained at work is a limited sample of NMHPV clients: roughly 60% had no time off work, and 40% had some time off work. 81% of all NMHPV clients were either supported to remain at work, returned to work, or planned to return to work in nursing.

***Nursing and Midwifery Health Programs for other States and Territories?*** There was complete agreement about the quality, effectiveness and value of the NMHPV's work. There are no other such Board-related health programs in other States and Territories. ANF branches were enthusiastic about the Victorian model, and argued that a similar program of support for and by impaired nurses and midwives was essential to retain a safe and competent workforce. Some jurisdictional contributors were also attracted to the model, but some had questions about a wider program. They felt the need was not so great as to require more than what EAPs and accessible public and private support services already provided. How it could operate in more dispersed States, and what would be the realistic cost of making it available to rural health services, district nurses, and aged care staff? Participants thought the costs of such an initiative and who should bear them required further exploration and agreement. Factors in calculating the cost of adopting the model are outlined.

***Notification***: Despite universal agreement that the central purpose of the legislation – protection of patient safety and health – is critically important, several participants thought mandatory notification rules were understood inconsistently. Their concern was that matters that could be dealt with informally by support or treatment sometimes became notifications even though the registrant had not "placed the public at risk of substantial harm". Some believed there was a need for greater consistency in the severity of the conditions imposed on registrants. In some places, the costs of compliance were clearly onerous, especially for those in rural and remote locations. There was also concern about the length of time a nurse or midwife spent in the process.

***Monitoring and evaluation:*** This project disclosed differences in how AHPRA's State and Territory boards operate. Program data is not collected consistently, and similar concerns are expressed by participants in several jurisdictions, for example about delays in the process, unintended consequences of how mandatory notification is interpreted, and financial and personal costs to registrants. A process of such importance in protecting patients and practitioners should adopt its own monitoring and evaluation framework in which these and other emerging issues may be addressed, including whether health programs for nurses and midwives would or would not advance the objectives of the Act.

***Recommendations for further work***

Based on the limited access to precise and consistent data available to this project, we offer the following suggestions for AHPRA's consideration.

AHPRA should seek agreements with State and Territory health departments, private and NGO providers on data capture and provision for this and other regulated health professionals.

A national minimum data set [NMDS], agreed by all State and Territory Boards under AHPRA's structure, will ensure consistent data across the regulated health professions.

As a matter of priority, AHPRA should design and implement a monitoring and evaluation framework for its regulatory activities, making use of these enhanced methods of data capture.

There is a need for enhanced communication of the guidelines on the exercise of mandatory reporting for all professions affected by regulation, and as they relate to nurses and midwives in particular.

To inform decisions about the future funding of the NMHPV and proposals to institute a national model, AHPRA could consider commissioning its own cost analysis of the NMHPV.

## Available health services by jurisdiction

| | | |
|---|---|---|
| **ACT** | Nurse & Midwife health program: | None |
| | Board mandated: | To a range of public and private AOD, psychologists, psychiatrists, university health services |
| | Jurisdictional: | Public sector-wide RED framework, contact officers; HR referral to free and anonymous EAP |
| | Self-referred: | "Not many opportunities in a small place like Canberra to admit oneself outside the local jurisdictional services." |
| **NSW** | Nurse & Midwife health program: | None |
| | Board mandated: | Referral to AA or voluntary or imposed treatment (at registrant's cost) |
| | Jurisdictional: | Employer is the local health service. HRM offers free access to EAP with psychologists or counsellors |
| | Self-referred: | GPs, psychologists, psychiatrists (fee for service) |
| **NT** | Nurse & Midwife health program: | None |
| | Board mandated: | Referral to Departmental AOD or Mental Health services. |
| | Jurisdictional: | Self-referral within the workplace. EAP "does not deal adequately with impairment" |
| | Self-referred: | Local GPs where available – few services outside main centres |
| **QLD** | Nurse & Midwife health program: | None |
| | Board mandated: | Board may require medical assessment (at Board expense) and impose monitoring (including screening at registrant's expense). Board cannot provide counselling sought by registrants |
| | Jurisdictional: | Most local area employers have OH&S and EAP programs, but QH central office "believes that the districts do not use EAPs for AOD or mental health impairments" |
| | Self-referred: | Improvements needed to facilitate self-referral – regarded as "not in a nurse's self interest" |
| **SA** | Nurse & Midwife health program: | None |
| | Board mandated: | Mutually agreed undertakings to deal with impairment (imposed if non-compliant); periodic medical reports (at registrant's cost) |
| | Jurisdictional: | Healthy Employment Program, OH units in Local Health Units offer 3 EAS sessions |
| | Self-referred: | "Considerable volume of self-referral by nurses to the EAS". Families may participate. EAS may refer to appropriate service or therapist for treatment |
| **TAS** | Nurse & Midwife health program: | None |
| | Board mandated: | Health professional assesses (an AHPRA cost. If substantiated, monitored conditions may include blood testing, psychologist, psychiatrist, GP (at registrant's expense) |
| | Jurisdictional: | Occupational health and safety nurse in each Area Health Service; Occupational physician with monitoring rather than treating role. Access to EAP external to DHHS |
| | Self-referred: | Departmental AOD service, NGOs (including Salvation Army) |
| **VIC** | Nurse & Midwife health program: | Nursing and Midwifery Health Program Victoria |
| | Board mandated: | Medical assessment at Board cost. Board strongly supports NMHPV as avenue of referral and assessment. Existing treatment arrangements are preserved (with annual report), or a treating GP, psychologist or psychiatrist is identified, |
| | Jurisdictional: | Employers (88 individual health services) have accredited EAPs, but may give rise to perceived lack of confidentiality because provided by employer |
| | Self-referred: | Most self-referral is to NMHPV |
| **WA** | Nurse & Midwife health program: | None |
| | Board mandated: | After preliminary assessment by case manager; Notifications Committee may impose conditions, or require further assessment or report by a psychologist, psychiatrist, or GP. There are limited opportunities to refer for assessment in some narrow specialist fields |
| | Jurisdictional: | In larger centres, help is available from public sector OH&S or AOD agencies, and nurses may be referred to independent psychiatrists who deal in AOD dependencies. |
| | Self-referred: | "There is no special process to assist impaired nurses or midwives to self-refer ... Independent registrants and not-for-profit employers have few support mechanisms." |

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**Abbreviations used in this report**

| | |
|---|---|
| ADIN | Australian Drug Information Network |
| AHPRA | Australian Health Practitioner Regulation Agency |
| ANF | Australian Nurses Federation |
| ANMFSA | Australian Nurses and Midwives Federation of South Australia |
| AOD | Alcohol and other drugs |
| ATODS | Alcohol, Tobacco and Other Drugs |
| D&A | Drug and Alcohol |
| EAP | Employee Assistance Program |
| GCMS | Gas Chromatography-Mass Spectroscopy |
| HADS | Herston Alcohol Drug Service |
| HCCC | Health Care Complaints Commission |
| HR or HRM | Human Resource Management |
| IAC | Immediate Action Committee |
| NMBA | Nursing and Midwifery Board of Australia |
| NMDS | National Minimum Data Set |
| NMHPV | Nurses and Midwives Health Program Victoria |
| NSWNA | NSW Nurses Association |
| RED | R Respect, Equity, Diversity Framework ACT Health |
| QNU | Queensland Nurses Union |
| SHAW | Safety Health and Wellbeing |
| UDS | Urine Drug Screening |

# Introduction

## The scope of the project

The Australian Health Practitioner Regulation Authority [AHPRA], through the Nurses and Midwives Board of Australia [NMBA], engaged Siggins Miller to undertake a gap analysis between services provided to support impaired nurses and midwives in Victoria, through both AHPRA and the Nurses and Midwives Health Program Victoria [NMHPV], and those services offered in other jurisdictions.

This analysis is a broad assessment of health services offered both as a result of notifications, and where nurses and midwives are able to self-refer voluntarily. It briefly describes the processes for managing impaired nurses and midwives from notification to outcome from a regulatory perspective in each jurisdiction, and the numbers of nurses and midwives who are involved in Board related impairment programs in each jurisdiction.

It canvasses the views of the State and Territory Board Chairs, Chief Nursing and Midwifery Officers of Health Departments, and the branches of the Australian Nurses Federation [ANF] on the advantages and disadvantages of each process, potential changes or improvements, and where possible the component costs associated with managing impaired nurses and midwives.

This account includes processes for impaired nurses and midwives to self refer for assistance in each jurisdiction. For those who notify themselves to AHPRA, the process is the same as for third-party notifications. Other options for seeking assistance are outlined, but there are no reliable sources of information about the numbers of nurses and midwives who use them.

A second part of the report briefly summarises issues arising from the processes, gaps and inconsistencies in the management of impaired nurses and midwives across the jurisdictions. It reports on component costs, and reactions to proposal to adapt the Victorian health program model in other Australian jurisdictions. It also suggests ways to enhance monitoring and evaluation of AHPRA's regulatory activities in dealing with health related notifications.

## Terms of Reference

The Terms of Reference call for this analysis to be undertaken in two parts. The first part is a broad assessment of services offered both as a result of notifications and where nurses and midwives are able to voluntarily self refer. The Board requires the following two questions to be asked of each jurisdiction and relevant professional bodies in each jurisdiction.

Question 1-what are the processes for managing impaired nurses and midwives from notification to outcome from a regulatory perspective in each jurisdiction?

- What are the advantages and disadvantages in this model?
- What elements would you wish to retain?
- What improvements would you identify?

Question 2- what processes are available for impaired nurses and midwives to self refer for assistance in each jurisdiction?

- What are the advantages and disadvantages in this model?
- What elements would you wish to retain?
- What improvements would you identify?

The second part is to ascertain where possible the costs associated with managing impaired nurses and midwives and also to obtain data on the scope of the undertaking in each jurisdiction. This project will include where possible information on the following:

- Numbers of nurses and midwives who are involved in Board related impairment programs in each jurisdiction
- Percentage of nurses and midwives per jurisdiction who are involved in Board related impairment programs
- Number of episodes of care opened in the 2010/2011 financial year

- Any information that is available relating to the length of time nurses and midwives are involved in impairment programs in each jurisdiction
- Any information that is available on component costs for both NMBA and registrants
- Percentage of nurses and midwives involved in impairment programs who are currently working
- Any information that is available on advice and pathways of support for employers who are managing nurses and midwives with impairment
- Classifications, names and number of agencies, professionals and AHPRA staff involved the management of nurses and midwives involved in impairment programs
- Geographical implications of the impairment programs for each jurisdiction
- Percentage of impairment cases from rural and remote areas for the 2010/2011 financial year
- Identification of gaps and inconsistencies in the management of impaired nurses and midwives across the jurisdictions.

A brief is to be presented as to the Ministerial Council with a tabular presentation across the jurisdictions of services available and component costs, and containing a broad costing of the implications of moving to a national model based on the NMHPV model.

Background information required above must be provided to the PC as a report but will not form part of the brief to the Ministerial Council.

### Method

Within a three week timeframe, Siggins Miller sent an emailed letter of invitation to every State and Territory Board Chair, the Chief Nursing and Midwifery Officers or Principal Nurse Advisors of all jurisdictional Health Departments, and the state and federal branches of the ANF (28 potential informants in all).

The letter included a list of the survey questions posed by the NMBA, and invited the recipients to reply either in writing or by telephone interview within the short timeframe. Follow up calls were made to each recipient within two days of their receiving the invitation. Follow up calls were also made daily to those who had not yet made contact, or had not made a response. Follow up email reminders were also sent.

In response, 25 recipients or their nominees provided a written response or took part in a telephone interview. In three cases, the principal respondent was accompanied by other officers. One recipient felt they could not contribute, one was overseas, and no response was received from a third.

It was also suggested that it might be possible to quantify nurses' and midwives' use of Alcohol and Other Drugs [AOD] services and Employee Assistance Programs [EAPs]. However, mapping of national alcohol and drug treatment capacity for ANCD took over 18 months to compile and verify, and identified over 1,100 services (reflected in the ADIN website). All rigorously preserve patient confidentiality. The demographic data they collect may not include details of clients' occupations. Ethical clearance would be needed to enquire about any available information.

All ACHS-accredited services have EAPs, but in practice the delivery of employee assistance is multi-layered – that is, hospitals and health services contract commercial or NGO agencies that provide EAP services, and they in turn subcontract psychologists, social workers, counsellors and the like to deal with individual clients. It would be a costly, protracted, and probably unproductive task to seek figures from these sources on attendances by nurses and midwives, and in particular whether those attendances concerned self-referred impairments.

## Part 1: State and Territory processes

### Australian Capital Territory

#### *AHPRA ACT Board process*

The ACT Board manages notifications and self-referrals through a range of both public and private AOD services, psychologists and psychiatrists, or university health services who can help nurses or midwives with an addiction or a mental health problem.

Notification may be by another practitioner, or by a member of the public, and the Board has a working relationship with the Health Services Commissioner who may receive a patient complaint that discloses a professional issue. About two-thirds of the notifications are from another party, and one third are self-notifications.

The Board does not intervene immediately, but refers for exploration – sometimes to a health panel, or to a specialist psychiatrist, and self-referred nurses may come with their existing therapists' advice.

There are 4,499 practising nurses and midwives in the ACT. In this small jurisdiction, the volume of notifications is small – the Board probably places five or six nurses a year on a condition that requires regular reporting of rehabilitation to the Board (there were three for health-related notifications in 2010-11). Conditions are imposed in a manner that preserves the confidentiality of the nurses' treatment. While the Board is committed to its legislative duty to protect public safety, and could in principle cancel a registration, in practice its process is very supportive. In one recent case, a nurse found the reporting process "very hard at first", but after six month told the Board it was the "best thing she'd done".

#### *ACT Health Directorate*

The ACT Health Directorate has an established process for referring impaired nurses to the Board. This process is overseen by the Human Resource Management Branch [HR], which manages the nurse from notification through to outcome. The former Territory Board would review each individual case and then notify the HR department and chief nurse of the outcome. A "very small percentage" of the approximately 3,900 nurses and midwives practising in the ACT are involved in Board-related impairment programs.

An alternative opportunity for ongoing management of impairment is available in the Directorate's Employee Assistance Program which is largely unlimited in access, and available 24-hours a day, 7 days a week.[1] The EAP is free and anonymous, and is well known throughout the health service as a good service. Individuals can access it by self-referral, and managers may seek assistance from the EAP on a staff member's behalf or seek help from the EAP in managing that person. The EAP can refer people to private psychologists. The cost of this program is borne by the ACT Government under a RED (**R**espect, **E**quity, **D**iversity) Framework rolled out across the whole ACT public sector. The HR department can also refer impaired nurses to private psychologists.

In Health in particular, the new RED Framework comprises a network of nearly a hundred contact officers working across the Directorate who have been trained in listening to people's concerns about matters such as bullying, racism, or harassment, and who can offer support and advice on options available to address such issues. This framework hopes to create a positive culture that reflects equity and diversity and assures staff that their concerns will be addressed. Nurses and midwives suffering an impairment can seek out a contact officer to talk to them about their concerns. The service is completely anonymous and confidential. However, one disadvantage of this service is that, since some managers offer to be contact officers, there is potential blurring between the role of managers and the role of contact officers. The cost of this program is significant, but not enough to deter the Department from continuing it. It is funded by the Health Directorate and has the backing of

[1] An informant from the ANF believed the separate EAP contractors to Canberra Hospital and Calvary Hospital offered three free consultations, sometimes extended to six sessions, which provided help confidentially, but as they as staffed by social workers and some psychologists, this informant believed that they might not be fully appropriate to deal with serious addictions or mental illness.

ministers. The Directorate also seeks to provide a strong management program available to all managers that provides them with the skills needed to manage difficult behaviour and impairment.

The Health Directorate response raised the issue of how mandatory reporting was interpreted, on the grounds that it might not give enough opportunity to look at the context of an impairment. They believe there are occasionally extenuating circumstances where reporting someone may not be in their or the health organisation's best interests. An example was a situation where a nurse had voluntarily admitted herself to the mental health unit for an alcohol problem. She had never missed a day off work as a result of her condition, and had used her holidays to admit herself. The staff in the unit felt obligated to report this nurse, and the nurse was sent to the Impaired Practitioners Tribunal as a result. This was regarded as an unfortunate way to deal with the issue, given that the nurse had control over her problem, had never breached her duty of care, and was voluntarily doing something about the issue. There were not many opportunities in a small place like Canberra to admit oneself outside the local jurisdictional services. However, other notifications were certainly warranted in other cases. The Directorate considers an authority such as the Registration Board should ensure that the application of standards is linked consistently to maintaining high quality professional practice.

***ANF ACT Branch***

Over the past five years the ACT branch of the ANF has helped support a relatively small number of nurses and midwives with an AOD or mental health problem. Some have been nurses who have been the subject of a report to the Board, and the ANF has then supported them in their dealing with the Board. In other cases, the ANF has facilitated the process where a workplace is preparing a report to the Board.

The ANF in its professional standing understands the requirements of legislative process, and sees its role as making the notification process as painless as possible, and finding the right balance between its punitive and remedial aspects, and seeking care and support for people with an AOD or mental health problem.

*Costs to registrants and employers*

Apart from the cost of the RED program to the public sector employers, and the costs to individual nurses or midwives referred to private practitioners, no other information about costs was received from ACT informants.

## New South Wales

There are about 93,704 nurses and midwives practising in NSW. At the moment, 93 nurses and midwives are within the processes of the Nursing and Midwifery Council,[2] of whom approximately 60 are in the health notification stream. 77 Impaired Registrants Panels for nurses or midwives were completed in 2010-11.[3]

### *The Nursing Council*

Notifications come to the Nursing and Midwifery Council from AHPRA, employers, the Health Care Complaints Commission [HCCC] which also has a regulatory function, [4] and a small number of self-referrals. The Council tends to receive notification of the more serious cases of impairment – milder conditions that do not raise an issue of public safety are more likely to be handled locally by the employer or health district.

The Council's first step is to refer the registrant for assessment by a Council appointed psychiatrist or clinical psychologist. The Council considers the assessment report, and may take one of several actions.

It may require the registrant to attend an Impaired Registrants Panel comprising a medical practitioner and at least two other health professionals (including nurses) with expertise in the area. The registrant attends the panel to talk through their situation. The Panel discusses with the nurse their situation including work, support systems and current treatment. After a brief private consultation among the members, the Panel considers what restrictions on practice or treatment the registrant may need, and seeks to gain the registrant's agreement to these recommendations. Voluntary conditions usually relate to receiving continuing treatment, and occasionally work under the supervision of another nurse, or any other condition the Panel deems appropriate. The nurse can accept these conditions and sign consent to their being placed on their registration or other record. If a nurse disagrees with a proposed condition, the Council has the power to impose the condition if it deems it necessary.

Observance of imposed conditions is monitored by the staff of the Council, and may include supervision, reporting requirements, restrictions of shifts or hours of work, limitations on scope of practice, and compliance with a regimen of treatment. In the case of AOD problems, conditions may include attending AA, limits on amounts consumed, total abstinence, or in a few cases urine drug screening [UDS]. The Council may review a notification at intervals of 3 months, 6 months, or a year. In mental health cases, the review may be done on paper and considered by a supervising committee.

The Council tries to maintain a clear separation between the assessment and treatment stages of the process, so that the registrant is assured of an unbiased therapeutic relationship during rehabilitation.

In practice, many impairment problems are dealt with locally at health service level For example, an alcohol problem may be dealt with as human resource management [HRM] issue, with assessment by the employer in the local health service. All employees of NSW Health have access to Employee Assistance Programs which offer a certain number of free consultations with psychologists or counsellors either in person or over the phone. People may self-refer to GPs, psychologists, psychiatrists, drug and alcohol counsellors, medical centres and professional associations. Depending on the severity of the impairment, a nurse may be notified to the Board. The NSW Nurses Association [NSWNA] provides support to its members who participate in Board processes. However, a member may not seek NSWNA assistance if they are not comfortable disclosing their impairment issues.

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[2] When the National Registration and Accreditation Scheme began on 1 July 2010, the Nursing and Midwifery Council of New South Wales was established and the Nurses and Midwives Board of New South Wales ceased to operate.

[3] Nursing and Midwifery Council of NSW, *Annual Report 2010-11*, page 7

[4] According to complaints listed in the 2011 Annual Report of the HCCC, 13 nurses were deregistered in 2010–11, and one nurse was suspended. Others had conditions imposed on their registration. However, the HCCC does not disaggregate impairment related complaints from professional conduct complaints about nurses and midwives.

*Perceived advantages and disadvantages*

The perceived advantages of this model are that nurses can maintain their registration, and often their employment, by placing conditions on their registration; consultation with the nurse about voluntary conditions; and follow up consultations with the Panel to review the conditions in place.

The disadvantages of this model are that consultations are sporadic, and it now takes a long time for an impaired nurse to come before the Panel. Partly because of difficulty in convening panels, it may take up to 5 months from receipt of a notification until the process is fully under way. During that initial period, the Council will consult the HCCC. At present, the average (not median) time a nurse or midwife is in the process is 1.4 years.

The Council is presently reviewing aspects of the Panel process – in particular, it is considering reducing the number of Panels, partly because it is increasingly difficult to recruit doctors to sit on them. It has considered advertising for panellists, or reviewing the fee structure. At present, the sitting fee for a medical practitioner on a panel is from $625 for a half day to $1,000 for a full day. For nurses on panels, the fees are $218 for a half day to $436 for a full day, but this is under upward pressure as nursing salaries increase. The Council may in future use panels only where issues of public safety or fitness to practice arise.

***The NSW Nurses Association***

The Council bears the cost of the assessment and supervision of a registrant, but the cost of treatment of a condition is borne by the registrant. This arrangement has little financial impact on a nurse if he or she lives in the Sydney Metropolitan area. However, if they live rurally, nurses must travel to Sydney to participate in the Panel, which according to the NSWNA can place a severe financial burden on a low income rural family. If the nurse is required to see a Board appointed specialist who is not in their local area, that will also incur travel costs If urine drug screening [UDS] is required as a condition of their registration, this too may have a financial impact on a nurse, particularly as an impaired nurse may be more likely to work reduced hours as a result of an impairment. If the nurse is participating in *random* UDS, it reduces their capacity to work, since they are not able to plan when they must attend for a test.

These costs differ depending on the location and circumstances of each nurse. The cost of UDS also varies and there are a limited number of Medicare subsidies available. In 2011 an NSWNA member reported that UDS was costing $165 per week. The NSWNA believes the process could be improved by ensuring more regular and consistent follow up, and by cost subsidies for travel and UDS.

If the nurse is not employed, these conditions can be onerous and interfere with the ability of a nurse to obtain employment. If the nurse is employed and the employer is supportive, this support can be very beneficial to the nurse, and will often ensure that the nurse is not placed in a high stress working environment.

*Potential improvement*

A potential improvement to the model proposed by the NSWNA is adoption of a more appropriate notification form. The single existing AHPRA form is called a "Complaint". It makes no provision for someone to make a self-referral. The NSWNA suggests replacing the existing form with a form entitled "Notification" rather than "Complaint", and amending the form so that it allows for self-referrals for impairment and professional conduct issues. An alternative would be separate forms depending on the subject-matter - a form for complaints, a form for people to make an impairment notification or self referral; and a form for a nurse who wants to self report for any reason in order that professional conduct can be managed effectively.

## Northern Territory

There are about 3,321 nurses and midwives practising in the Northern Territory. The number of notifications is very small – 28 Nurses and midwives in the 2010-11 year, of whom probably five were in the health notification stream.

### *AHPRA NT Board process*

The Board is likely to get a communication from a medical officer or a GP that a nurse or midwife is impaired, and the Board then refers the case for investigation, and potentially could place conditions on the nurse's practice. Its standard method is to refer a notified nurse or midwife to the relevant service (AOD or mental health) of the NT Department of Health & Families for investigation. This is a completely confidential referral – there is no report back to the Board, The nurse will be assessed by a medical officer and a case manager appointed. The feedback has been that this method has worked well for this small number of nurses.

### *Department of Health & Families*

Less formally, a nurse may seek help from appropriate services at the workplace, but that carries the possibility that a notification may follow. There is no record of how many self-referrals have taken place to Departmental services.

Counselling is available through EASA Inc, a not for profit, non-government NT Association with offices in Darwin, Alice Springs, and Katherine. It offers programs for management, support and guidance, but does not adequately deal with impairment.

The main concentrations of nurses and midwives are in Darwin, Katherine, Alice Springs, Gove, and Tennant Creek. Apart from Darwin, everywhere else in the Territory is classified as rural or remote. The Department has procedures in place to help employing services with replacements for nurses who have to take time off work or be away from their usual location (their isolation may well be a causal element in their impairment). It may try to relocate someone or stretch existing resources.

### *ANF NT Branch*

There are no Board-related treatment programs in the NT, and no formal pathways for self-referral. If nurses have a problem, they go to their own doctor, but their problems are often managed poorly. The ANF says it sees "a lot" of nurses and midwives experiencing difficulties in their occupation because of a lack of support, and a number of them have left as a result. Some avoid seeking assistance for fear that if they seek support they may end up with restrictions from the Board on their practice.

*Costs to registrants and employers*

No information about costs was received from NT informants.

## Queensland

There are approximately 62,092 nurses and midwives registered in Queensland. There were 277 notifications of nurses and midwives in the 2010-11 year, of which an estimated 48 were in the health notification stream.

***AHPRA processes in Queensland.***

The Queensland Board says it takes a rehabilitative approach to managing practitioners who have come to its attention as a result of an impairment. The Board first assesses the risk to the public of the impairment or potential impairment. It then considers information detailing the extent of any such impairment and how it will affect the registrant's ability to practise in their profession. The Board may request information from a registrant's treating practitioners to inform the extent of the impairment, and may also require a registrant to undergo a health assessment by a medical practitioner or psychologist (dependent on the nature of the identified impairment).

Once the Board has the information is needs to make an informed decision whether or not the registrant's impairment will detrimentally affect their ability to practise or is likely to do so. It may accept undertakings from a registrant, impose conditions on their registration, or if necessary suspend their registration. The nature of the identified impairment influences the types of action taken by the Board. While instituted as a means of protecting the public while the nurse or midwife continues to practise, these conditions also provide a framework for rehabilitation from the impairment, if appropriate to do so.

From the Board's point of view, the advantages in this model is that a nurse or midwife is supported by the regulatory authority in a model designed to improve their health and wellbeing, which in turn decreases the risk to the public from the impairment.

The Board also consider the disadvantages of the model are that:

- Many practitioners find that the actions taken by the Board are punitive rather than rehabilitative. However these practitioners are often found to lack insight into their impairment.
- Treating practitioners often find it difficult to report on their patient's health and improvement to the Board, stating that it is a breach of trust to the therapeutic relationship.
- Some undertakings or conditions are onerous (the cost of UDS may seem prohibitive; the registrant may be inconvenienced by having to undergo testing before attending work).
- Registrants living in rural and remote areas have difficulty in accessing services. This is not unlike the disparity the general public face when accessing health care services in those areas.
- The Board and AHPRA take every opportunity to assess what information is published on the public register, but while those with health related conditions are not detailed, some registrants still feel that having to disclose undertakings or conditions to an employer is to their disadvantage, particularly when they are looking for employment.

Registrants often find that they want support from AHPRA staff in complying with conditions or undertakings, almost to the point of an expectation that counselling is provided. While AHPRA will work with an individual to help them meet compliance with monitoring, a counselling service cannot be provided because AHPRA's responsibility to protect the public. In the Board's experience, notified registrants who have the support of a third party (such as legal or union representation) have reduced expectations of AHPRA support. It would improve the process if the Board had the capacity to provide additional services and supports to the registrant who is undergoing monitoring for their impairment.

*Component costs*

In Queensland, the Board has accepted protocols in line with various standards and therapeutic indicators to monitor drug or alcohol use via hair, urine, blood and breathalyser testing, as ways to manage a registrant who is required to undergo screening as part of demonstrating abstinence from illicit, prescribed, or alcohol. The cost of UDS to the registrant could be considered prohibitive depending on the frequency of testing. Even with exemption from the pathology provider, the tests

cost $60 (reduced from $260) and may increase should Gas Chromatography-Mass Spectroscopy [GCMS] testing of the sample be required. The registrants are also responsible for paying for treatment, therapy, or counselling with their own psychiatrist, psychologist, counsellor or GP.

An employer may also experience an increase in demand on resources when employing a nurse or midwife who is subject to conditions and undertakings. They may include increased staffing costs if the registrant under monitoring must be directly supervised by another practitioner.

The costs to AHPRA while the registrant is undergoing monitoring are minimal, except for the salaries of the AHPRA staff who review and monitor the file.

In some instances, a decision by a tribunal will also require a person who is looking to return to the register to undergo similar pathology testing regimes or treatment with a professional such as a psychiatrist. These costs are borne by the former registrant. Similarly, someone who applies for registration in accordance with the National Law may be required to undergo a health assessment as a means of assessing the application — particularly if a declaration of impairment is made at that time. The applicant bears the cost of the assessment at this stage.

*Processes available for impaired nurses and midwives to self refer for assistance*

The Board knows of no established bodies providing assistance specifically to impaired nurses or midwives who self refer. Nurses and midwives may use organisations established for use by the general public. The Queensland Nurses' Union has sometimes encouraged self-referral, as have various employers, but no formal process is in place. If a nurse or midwife contacted AHPRA staff, support and encouragement would be provided for full self-referral/disclosure.

Providers that nurses and midwives may access as a result of conditions or undertakings include Queensland Medical Laboratories (for the required pathology testing), private hospital services (including the Damascus Unit at Brisbane Private Hospital, Belmont Private Hospital and Toowong Private Hospital, the Currumbin Clinic and New Farm Clinics), and specialised public services (including ATODS and HADS at the Royal Brisbane and Women's Hospital).

*Nurses and midwives involved in Board related impairment programs*

In Queensland there are 70 nurses and midwives who have open notifications raised against them indicating health impairment and are in the assessment phase (preliminary assessment or awaiting the outcomes of a Board required health assessment). 129 nurses or midwives have monitoring of conditions or undertakings on registration as a result of health impairment. That is, as a proportion of the 54,770 nurses and midwives practising in Queensland, 0.13% are currently in assessment, and 0.24% are being monitored for health related conditions and undertakings. The Board is unable to ascertain how many episodes of care were opened in 2010/2011 using the current data capture.

Nurses and midwives experience various amounts of time in monitoring for health impairments in Queensland - anywhere from six months to seven years (the oldest file currently being managed). On average, the length of monitoring is approximately two years. Length of time is influenced by the nature of the impairment, risk to the public and the registrant's rehabilitation.

The majority of those nurses undergoing assessment or monitoring are still working (an exact percentage cannot be ascertained, but the indication is that it is about 90%, apart from the 19 registrants subject to suspensions or 15 with undertakings not to practise).

Current data capture does not record whether the nurses or midwives are in rural or remotes areas, but those who live in these areas do experience a higher level of difficulty in maintaining compliance with conditions, particularly when it comes to undergoing treatment, urine drug testing, and practising under supervision. While this may influence the Board's decision making based on individual issues, ultimately the Board must ensure the protection of the public as its first priority.

*Advice and support for employers managing nurses and midwives with impairments*

AHPRA staff are happy to provide as much support as possible to employers when they employ a nurse or midwife who has conditions associated with their registration. There is no specialised service should an employer seek an opinion if they have suspicions about an employee's impairment.

However, most employers have an EAP or a more specialised service (such as the Safety Health and Wellbeing [SHAW] Unit for employees at the Mater Health Service, Brisbane). The Nursing and Midwifery Board of Australia has released *Guidelines for mandatory notifications*[5] *to* provide direction to registered health practitioners, employers of practitioners and education providers about the requirements for mandatory notifications under the National Law.

***Queensland Health***

Queensland Health is developing a nursing and midwifery supported practice framework to support nurses and midwives who have performance issues. Once this is made available to all staff, it will be an avenue for self-referring as part of the employee annual performance appraisal and development process. It is a process where the individual takes responsibility for his or her own practice and actions.

For Queensland Health, senior nursing and midwifery leaders have estimated anecdotally that there would be at least 300 nurses and midwives with an impairment which would affect their performance. The Department does not monitor or collect the number of nurses and midwives involved in Board related impairment programs, as this is a facility/district process.

Queensland Health nurses and midwives are notified to the Board on the AHPRA Notification Form. The information on the form is managed confidentially by the District Directors of Nursing and Midwifery, with support from the Department's Human Resource services at local and corporate levels.

Processes are available for impaired nurses and midwives to self-refer as part of the registration process. A registrant can self-refer their impairment by writing to the Board, but are usually directed to make the notification to AHPRA completing the form "Notification – Complaint".

There are also opportunities for self referral to Occupational Health and Safety officers, and through Workers' Compensation for impaired nurses and midwives in the health services. However, there is reluctance to self refer owing to fear of loss of employment.

While the Department's Employee Assistance brochure says EAPs are a potential source of support for emotional stress and depression or drug and alcohol problems, the central office believes that health districts do not use EAPs for AOD or mental health impairments, but mainly for dealing with workplace behaviour or with physical impairments.

There are costs to the health services in supporting people with impairment during the process after a complaint has been lodged. The HR, workplace relations, nursing and midwifery management resources are considerable. Internal Queensland Health corporate and district policies on performance improvement plans and development management are available for employers who are managing nurses and midwives with impairments.

***Queensland Nurses Union***

The main advantage of the model is that highly-impaired registrants will not place the public at a substantial risk of harm by continuing to practise while the impairment versus risk issue is resolved.

A nationally consistent approach is a potential advantage, in that over time there may be opportunity for de identified data to be available to nursing and midwifery leaders to support any changes needed to maintain professional standards, professional development and education and training.

Improvements to facilitate self referral would be the best outcome.

A disadvantage is that there seems to be no clear path for a complaint regarding professional conduct and ethics from one professional to another. A complaint is rightly centred on patients, but there may be misconduct in putting another professional at risk, and Question 15 on the Notification form *(Are you reporting notifiable conduct about a health practitioner or a student?)* could have a point added to cover this possibility.

[5] http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx

The title of the form *Notification: Complaint* should be improved. In content, it would be helpful for the form to give a brief description of the process and desired outcomes in lay terms, explaining why it is so important. It is important to highlight the confidentiality of this information up front. It would also be good to gather feedback on the process from complainants.

Disadvantages perceived by the QNU include:

- un clear guidelines for mandatory notifications, leading to little understanding of the relationship between the degree of impairment and risk to the public, or what degree of impairment places the public at a substantial risk of harm.
- poor understanding of the meaning of "substantial harm", leading to unnecessary notifications.
- no widespread promulgation of the guidelines on mandatory notification published in 2011 in a fourth-level webpage of the AHPRA website, while it could have been emailed to every registrant and employer with an email address at very little cost.
- no health services for impaired registrants other than those available to the general public
- the costs of complying with undertakings or conditions.

Poor understanding of the mandatory reporting requirement means that many issues are notified that should have been dealt with directly and simply in the workplace. There are variations among the health districts in this respect: in some places, a nurse may be referred for a medical assessment, for example by a psychiatrist, before a decision is made to notify.

The QNU represents nurses in notification processes, and considers that the Board's methods are not rehabilitative but punitive, and impose burdensome conditions. For example, nurses with an addiction problem may be subjected to repeated urine screening every two days at the cost of $60 each; or breath analysis may be required before the nurse begins the day's work. It may be one to two years before conditions are reviewed (the Board specifies the period). These methods have direct effects on whether the nurse retains his or her employment. Nurses or midwives with conditions imposed upon their registration find it very difficult to maintain or obtain employment, often leading to exacerbation of their health condition rather than rehabilitation. Some nurses have resigned their registration rather than comply with the conditions placed on their practice, with substantial impacts on recruitment, running directly counter to current attempts to expand the workforce.

The fact that there are no rehabilitative health services specifically targeted to impaired registrants leads to reluctance on the part of registrants to engage in treatment and rehabilitation, in light of the fear of being reported to AHPRA by a colleague or treating team.

For all these reasons, it is often not in a person's interest to self-refer. There is no incentive for nurses or midwives to self-refer to AHPRA regarding impairment, given the only outcome will be restrictive undertakings or conditions, not referral to any rehabilitative processes.

*Costs to registrants and employers*

Compliance with undertakings or conditions to maintain registration is often difficult and expensive.

Nurses or midwives in rural and remote areas of Queensland are particularly affected as a result of a notification, owing to the nature of small communities where most inhabitants are familiar with each other. There is an additional financial burden of travelling long distances to comply with undertakings or conditions.

The cost of UDS at $60 per test is prohibitive for most nurses or midwives, especially when, as sometime happens, testing can be required every second day (or $900 a month). Currently, Queensland Medical Laboratories say the fee for UDS cannot be rebated by Medicare on the basis that the test is related to employment, for which a rebate is prohibited by legislation. A counter argument is that the test is related not to employment, but to an impairment that affects the registration of the health practitioner, and while employment is one potential benefit of registration, it is not a consequence of it.

The decision on UDS frequency appears to the QNU to be an arbitrary process, devoid of therapeutic or scientific criteria. The ability of nurses or midwives to access leave from UDS appears to be dependent on the level of rapport the nurse has with their AHPRA case manager. Some nurses or midwives consider surrendering their registration owing to the financial burden UDS would impose.

Costs to employers include recruitment costs associated with the loss of employment of an impaired nurse or midwife. The majority of impaired nurses or midwives who retain employment create down-time costs for the employer in requirements for on-site testing (such as breath analysis) or providing mandated supervision.

## South Australia

Of the 29,808 registrants in SA, approximately 15,000 work in the public system, and the others in the private hospital or aged care sectors. In the 2010-11 year, the Board received 288 notifications, including about 50 in the health notification stream. In more severe impairments where fitness to practise or public safety is an issue, in accordance with the legislation the manager of an Occupational Health unit, or a treating psychologist or psychiatrist will notify AHPRA of a declared impairment that raises questions for the Board of the person's capacity to practice, or for the need for *pro tem* limitations on practice, or restrictions on placement.

### *AHPRA South Australian Board processes*

When the Board receives a notification, including a self-referral, a member of staff designated as investigator interviews the nurse or midwife, and gives a report to the Notifications Committee. Independent clinical advice may be obtained, and an informal meeting is held with the registrant to go through it. The results that may flow from this meeting may be that the registrant accepts mutually agreed undertakings to deal with the impairment (the usual outcome), but if the person is non-compliant, conditions may be imposed. There has not yet been a cause to convene a panel hearing.

The new process is effective, efficient and very timely – delays occur only if the nurse for some reason causes a delay. Conditions (either agreed or imposed) are generally in force for a year, but a nurse or midwife may apply to have them lifted in a shorter time on the basis of a report from a treating practitioner that the person has complied. (In two such recent applications, the Board refused one, and modified the conditions in the other.)

The majority of nurses and midwives who have dealings with the Board because of impairment have remained at work. Reflecting the distribution of the State's population, probably 98% of these notifications have been in the metropolitan area.

*Perceived advantages and disadvantages*

This process has very many advantages over what used to happen in South Australia. Registrants were then represented by lawyers, and the Board was also legally represented before a full panel hearing. This was an unfortunate and protracted approach, and especially disturbing in dealing with instances of mental health or AOD impairments.

There are no specific processes available in SA for impaired nurses and midwives to seek assistance, even though there was such a service perhaps twenty years ago. In the Board's view, the Victorian program seems to be a very good scheme.

While there is no specific process to advise or support employers managing nurses and midwives with impairment, members of the Board's team have been visiting hospitals to make presentations about the regulatory system and the Board's functions.

It remains the case, however, that many of the complaints to the Board in both the conduct and health streams are about conduct that could have been dealt with directly at the workplace - for example, a nurse with a good record was notified for a one-off medication error.

### *SA Department of Health*

The previous Nursing Board did not have a program for managing impaired nurses. The Health Department has occupational health policies and a Healthy Employment Program (including an Employee Assistant System [EAS] which anyone can access) that are used in managing most cases of impairment. A nurse with a manageable addiction or anxiety, depression or the effects of personal events may be referred or may self-refer to the EAS. There is a considerable volume of self-referral by nurses to the EAS. This process takes place in Local Health Units with the support of the local OH unit rather than centrally. Families may also participate, and anonymity is preserved. The EAS may refer someone to an appropriate service or therapist for treatment.

Where the individual is under the care of a doctor or other health professional, management of their impairment will occur in a holistic manner only if that health professional drives and coordinates any such case management of the impairment. In most instances however, it is up to the individual nurse,

midwife or student to manage the impairment themselves. This would generally involve coordination of the health management, as well as any impact on their ongoing employment.

The only formal process in SA for the management of impaired nurses, midwives, or students is a notification to AHPRA, when the standard AHPRA directed process for investigating and dealing with the notification applies as described in the AHPRA *Notification Process*.

***Australian Nurses and Midwives Federation of South Australia***

The role of the ANMFSA [Australian Nurses and Midwives Federation of South Australia] within this process is to advocate on the individual's behalf, provide information and support to the member in responding to the notification, ascertaining the person's own support evidence and documentation (such as medical reports at an individual person's cost), and if conditions are proposed to be imposed, if appropriate drive the negotiation process around the proposed conditions. ANMFSA was engaged in ten cases related to impaired nurses and midwives in 2011.

ANMFSA officers often advocate strongly to influence the assessment process if it appears that independent investigations are inappropriate or are conducted without seeking important background information from the registrant. There have been occasions where the ANMF officer has been able to present evidence in Board meetings that has resulted in successful negotiation of a change to the proposed conditions to the benefit of the registrant without detriment to the public interest. Informal face to face meetings between AHPRA, a member of the SA notifications committee, the registrant, and the ANMFSA Officer as their advocate creates an opportunity to have a productive dialogue about future management of the matter.

There are no impairment programs for nurses in SA (similar to the Doctors' Health Advisory Service).

*Perceived advantages*

An advantage of the current process is its readiness to deal with the majority of matters informally without the need for a formal legal process, and the passage from notification to outcome is quicker compared to the previous state-based model. The method of dealing with impairment notifications is differentiated from notifications related to conduct: unlike the previous state system, there are no financial penalties. However, there are instances where the matter may be construed as a 'conduct' or 'performance' issue, but the precursor to the conduct or performance was health related (for example theft by a person with a history of depressive illness), and in this situation penalties do apply.

There is now a more informal process of open communication and regular opportunities to meet with an investigator or case manager to discuss any reports with the nurse, midwife, or student. These interviews are not recorded and there is no formal questioning, and often result in the case manager setting out the draft conditions they propose to recommend to the Board. The ANMFSA supports and represents its members through this process, acknowledging that sometimes there are clear grounds for notification to AHPRA.

*Perceived disadvantages*

The ANMFSA considers these features of the model to be its disadvantages:

- *In the case of notifications by health practitioners:*
  - Placing a mandatory requirement on the treating practitioner to notify APHRA about the impaired practitioner discourages nurses in need of support for their impaired health from seeking treatment, especially early intervention, for fear of being notified, and the possible impact on their ongoing capacity to practice and earn an income
  - Many health practitioners are still not clear about when mandatory notification is required
  - The model does not provide a flexible, discretionary approach involving referral to a supportive and understanding profession-specific health program.
  - It is not a support and recovery focussed model.

- *In the case of notifications by employers*
  - Mandatory notification compels the employer to notify staff without first considering alternate referral options and self-management.
  - Many employers still not clear about when mandatory notification is required.
  - There is no consistency among employers about *when* they notify AHPRA (some notify at the outset of their own investigation, while others notify only at the end of their own investigation and have concluded there is an impairment that affects the person's capacity to practise the profession.
  - The guidelines for employers provide no scope to use their discretion on a case by case basis to engage in a voluntary alternative to notification with impairment cases (for example, by using Employee Assistance Programs, or working closely with the employee's treating health practitioners to manage the impairment.
- *For the individual*
  - Regulatory requirements drive the management of condition. There is no process for early intervention or a recovery focussed approach.
  - A nurse is unlikely to seek early intervention or disclose a problem to an employer or treating health professional owing to strong possibility that they will then be subject to mandatory notification by these parties.
  - The therapeutic relationship between a treating professional and the nurse changes when the treating professional is required to provide regular updates to AHPRA.
  - The process of investigation can be protracted if the is matter is complex and multi-faceted.
  - If immediate action conditions are imposed, this may have a significant effect on the nurse's capacity to continue to work and earn an income, or even remain in the profession.
  - Parts of the process lack transparency: the submission of investigator or case manager to the Notifications Committee is usually not disclosed to the registrant, who is not present at the Notifications Committee meeting when a decision is made, and reasons for a decision (such as relevant minutes of the meeting) are not usually disclosed to the registrant.
  - Where the nurse or midwife consents, a supportive employer could be involved in the negotiation of proposed conditions - for example, agreeing to take various responsibilities in ongoing management of impairment, and providing this undertaking to AHPRA.

Self- referral mechanisms for treatment are available to nurses, midwives and students as members of the general public to Drug and Alcohol Services and Mental Health Support, and as employees to Employee Assistance Programs for three sessions (or more with employer support). However, in each of these options, registrants may fear that an impairment of this nature would be reported to AHPRA by any heath professional they saw owing to mandatory reporting requirements. This fear may be a barrier to seeking care, treatment and support. Even in the case of, EAP, the provider may be a registered psychologist, and again this might trigger a mandatory report.

*Costs to AHPRA and registrants*

The Board bears the cost of assessing a complaint, but the registrant bears the cost of independent medical assessments, ongoing treatment, and reports required by imposed conditions.

In the now superseded process, the registrant paid the costs of defending a Board action or conditions, and the legal costs if it proceeded to a hearing (both their own costs, and usually the Board's legal costs as well).

No other information about costs was received from SA informants.

## Tasmania

There are about 5,300 registered nurses and midwives in Tasmania. The Board received 26 notifications in the 2010-11 year, of whom probably four were in the health notification stream.

### *AHPRA Tasmanian Board process*

AHPRA receives a notification from an employer, another health practitioner, or a member of the public. After a preliminary assessment, the notifier and registrant are contacted. The preliminary assessment is presented to the Board, which decides whether to make either a health or a performance assessment. Nurses and midwives may self refer. At present, a notification form is required to begin the process; and the pathway (health and/or performance) is determined by the information contained in the notification.

Arrangements made with an appropriate health professional to conduct an assessment and provide a report to AHPRA (the cost of the assessment is invoiced to AHPRA). A copy of the report is given to the registrant for comment before the Board receives it, and the report - together with the registrant's submissions - go to the Board for decision.

The Board may impose conditions on registration if impairment is substantiated. The registrant is advised of the decision, and the matter is referred to the compliance staff. AHPRA undertakes the monitoring of the conditions imposed, which may include blood testing, attendance at a psychologist or psychiatrist or general practitioner. The registrant is subject to the costs of monitoring, and is responsible for facilitating reports if and when the Board requires them. The length of the reporting period is 12 months at present, after which the matter is reviewed, or before if there is a material change.

There is no specific impairment program available as a stand-alone service in Tasmania for nurses or midwives.

There are about 7,560 nurses and midwives practising in Tasmania, none are currently involved in Board related impairment programs, and no episodes of care for nurses and midwives were opened in the 2010/2011 financial year While there is no specific program, nurses or midwives often access various health related programs, the Department's Alcohol and Drugs Service, or not for profit programs such as the Salvation Army alcohol program. Most of those using such services are still working.

AHPRA has provided education sessions to employers, and managers of agencies on their role when a practitioner has declared an impairment or the employer or manager forms the reasonable belief a practitioner may be suffering an impairment. It also provides telephone support for employers on the process and legislative provisions relating to reporting of impairments.

### *Department of Health and Human Services*

A health and wellbeing area has been established in the Department of Health and Human Services which provides the services of occupational physicians to nurses and midwives on a self-referral basis. This was set up because no such program had existed beforehand. Supervisors can suggest that nurses see an occupational physician, but cannot force them to do so. If the issue is impairing the nurse's performance, the supervisor has to follow another pathway.

An occupational health and safety nurse is available in each of the three area health services in Tasmania. Very few impaired nurses and midwives access the occupational physician service. This could be either because they feel they will not be protected, or they are already self-referring to their own GPs. They often are not detected in the workplace unless something dramatic happens.

The occupational physician says she has seen very few impaired nurses as the result of disciplinary action, and has acted in a monitoring role. Her role is to support and monitor, not to treat. She helps people return to the workplace by seeing how they can be accommodated, and offers ongoing monitoring. She says there is little support for impaired nurses and midwives. Communication between the health organisations and the impaired services needs to be much better managed.

There is an Employee Assistance Program external to the organisation, and a workers' compensation section that refers nurses and midwives to treatment if their impairment was incurred at work.

*Perceived disadvantages and potential improvements*

The Department says the process can be protracted, given that the pathway is premised on the notification process, and is not specific to impairment.

The notification form, should a practitioner self refer, contains irrelevant sections, and is most appropriately suited to a notification that wishes to report performance or conduct issues that may manifest an underlying impairment. Given the focus of the current notification form, information relevant to the impairment must often be collected by direct discussion with the notifier or practitioner. This can significantly delay the process and concurrent risk assessment.

Potential improvements would be an additional form that registrants or employers' can complete that is specific to impairment, and contains questions relevant to that impairment as it relates to the practice of the profession.

*Costs to AHPRA, registrants and employers*

A health provider conducting an initial assessment on receipt of a notification invoices AHPRA for the costs of the consultation. The registrant bears the cost of any ongoing therapeutic interventions imposed as conditions by the Board, such as urine and or blood testing, counselling, psychology services, etc.

Costs accrue to employers in supervision arrangements, or reallocation to enable the registrant to remain within the workforce. The Department provides the salary on on-costs of the occupational physician and the OH&S nurses in the three area health services.

## Victoria

There are about 87,830 registered nurses and midwives in Victoria. In the 2010-11 year, the Board received 246 notifications, of which approximately 43 were in the health notification stream.

***AHPRA Victorian Board processes***

Notifications are preliminarily assessed and referred to the Notifications Assessment Committee (NAC) for initiation. If the matter is related to health impairment of a nurse or midwife, a health assessment by a Board approved medical practitioner is commissioned at Board cost. The assessment's recommendations are then discussed with the registrant by Board staff (or provided to the registrant by their GP when the assessor requests).

The matter is referred back to the Notifications Assessment Committee to finalise the outcome. Conditions are considered for their relevance to enabling the nurse or midwife to practise and keep the public safe. Requirements placed on registrants by way of conditions, or undertakings monitored by AHPRA compliance staff.

In its first correspondence with the nurse or midwife, the Board identifies the NMHPV as a resource. In essence the Board is a strong supporter of the NMHPV as an avenue for nurses to refer without fear of recrimination or adverse outcomes, and we trust the program to make notifications when necessary. The program keeps the Board apprised of initiatives and outcomes, and current evaluation programs under way are very promising.

In the event that a nurse or midwife is engaged with health providers who are suitable for the purpose of monitoring and treating the impairment, it is the Board's preference to not interfere with these arrangements, but we may request a 12-month independent assessment. If the registrant has no such prior engagement, we seek confirmation of the GP, psychologist or psychiatrist with whom the registrant does engage. The Board will not name a service provider specifically unless the registrant indicates an ongoing commitment to a provider such as a particular AOD counselling program or psychologist. Most often, however, this has already begun when the outcomes are finalised – particularly engagement with the NMHPV. The Board seeks to encourage practitioners to engage fully with the process.

Self referral for assistance related to impairment takes a number of forms, but the processes are not well articulated. The exception is the NMHPV, set up specifically to cater to the nurse or midwife in need of assistance, and proven to be most valuable in this regard, with rapidly growing self referrals.

All employers will have Employee Assistance Programs. Nurses and midwives also self-refer privately to the full range of health services available to the community. It is not possible to assess the number of practitioners resisting doing so owing to the risk of disclosure to their practice status.

The NMHPV is confidential and supportive of nurses and midwives in need of assistance for impairment. The relationship between the program and the Board is very good, and it takes a collaborative approach to assisting nurses and midwives. The Board strongly advocates for the continuation of the NMHPV to provide profession specific, confidential services.

*Perceived advantages*

The Board considers this model works well. The approach is non-punitive, supportive, and ensures the balance between protecting the public and the dignity and ability of the nurse to practise. The Board sees no cause to dispense with any element.

*Potential improvements*

Assessment may take some time to complete owing to the demand for services. Some assessors have been found to provide inadequate assessments and are no longer used. The list of initial assessors is likely to need reviewing for currency and capacity to provide services, guide decisions, and ensure commitment.

The program has limited ability to cater fully for regional and rural practitioners. Comprehensive services in regional centres could expand.

***Victorian Department of Health***

The Department of Health has no state-wide process. Because of the devolved structure of health services in Victoria all 88 Health Services are independent authorities. The Health Services are the employers, not the Department of Health. Impairment issues are managed locally by the Health Services, and the Department does not collect information about them centrally.

Most of the Health Services are ACHS-accredited against EQuIP4, which requires the Employee Assistance Programs outlined in Criterion B2.2.5. All the Services have EAPs of some sort which they may use in these circumstances, but typically they use the evaluated NMHPV. The advantage of this model is that the employer supports the employee, and issues are kept contained and local. The NMHPV is a local supplement we would wish to retain.

***ANF Victorian Branch***

*Nursing and Midwifery Health Program Victoria*

The ANF Victorian Branch was one of the founders of the Nursing and Midwifery Health Program Victoria (NMHPV) program, and gave this description of its operation.

The NMHPV was established in 2006 as a confidential, independent and profession-specific support service available to nurses, midwives and students to help them remain at work throughout an episode of care, or return to work when they return to health. It also offers supports and advice to employers about impaired or at-risk nursing and midwifery staff.

The NMHPV conducts assessments, develops individual management plans, and coordinates treatment, including the arrangement of appropriate referrals. It manages the supervision of those needing aftercare and follow up, and works with the client's employer to help them re-enter work.

It is based in Melbourne, and offers services from three regional locations, and facilitates support in other rural and regional settings on request. Where a participant is located in a remote location, NMHPV uses telephones and Skype to deliver support.

The program is funded by Victorian nurse registration through the former Nursing Board of Victoria (AHPRA now administers these funds). The ANF calculates that, with 87,830 nurses and midwives registered in Victoria, the funding equates to $5.69 per registrant annually, and affords every nurse and midwife in Victoria access to free support from the NMHPV. Students do not contribute to the funding of the Program. It is also offered to non-practising nurses and midwives.

An impaired nurse or midwife can enter the program through self-referral, an employer assisted referral, or referral by AHPRA. Once referred, an impaired nurse or midwife is assessed by NMHPV, allocated a case manager, provided with an individual care plan and referred for treatment. The program also offers regular treatment reviews, ongoing support, nurse counselling, relapse management, support for work re-entry (if deemed appropriate) and liaison with employers if required.

Since it started in August 2006, the NMHPV has facilitated 709 individual episodes of care, provided additional telephone support between appointments to about 245 individual nurses and midwives, run a weekly peer-support program attended by about 140 people, and assisted around 100 employers.

The ANF says that of the 709 participants who completed an episode of care in the program, 89% entered a positive therapeutic relationship, 66% showed significant behavioural changes that led to improved health status, and 81% were supported to remain at work, return to work, or planned to return to work.

*Perceived advantages*

The ANF says the chief advantage of this process is that nurses and midwives are advised by the investigative authority of the availability of a free, confidential and independent support service to restore health and focus on returning to work to practise safely and competently. The AHPRA Victorian Office ensures that individuals who are notified to them are advised of the existence of the NMHPV, its role and scope, and will receive the brochure for the program at the time of their interviews with AHPRA staff.

The program is delivered by nurses to ensure professional and cultural sensitivity towards discipline-specific nuances and to offer a supportive environment to reduce any fear, shame and guilt that could prevent individuals from seeking help. As the service is endorsed by AHPRA and the ANF, it helps overcome barriers to seeking help and recovery.

Self-referral for nurses, midwives and students is the most common way for them to access the program, and is strongly encouraged. All stakeholders have confidence in recommending that individuals access the health program independently, as the service maintains the principles of confidentiality, trust, respect and professional accountability.

Clients benefit from the expertise and experience among the NMHPV staff, who sometimes accompanied nurses or midwives during their interactions with the regulators, or negotiated on their behalf on specific issues of conduct, precedents, policies, regulations, the impact for patient care and the sanctions that may apply. The effectiveness of these negotiations is enhanced by mutual relationships between NMHPV team and the staff of the regulatory bodies – a relationship not provided by generic employee support services.

*Perceived disadvantages and potential improvements*

The ANF says that management of impaired nurses and midwives from notification to outcome is often a very lengthy process. Timeframes for access to the Program sometimes depend on the length of time a notification to AHPRA can take to be finalised. In circumstances where there may be ongoing conditions for 12 months or more on an individual's registration, this protracted period may accentuate stress and anxiety levels and lengthen time in the Program. The period of service may range from a single session to over a year. Most episodes of engagement average between three and six months. Currently 27% of the nurses using the service are from rural locations.

An improvement would be to ensure that notified registrants aware of the support available as early as possible. This has improved as the program has established and entrenched itself in the industry.

It can be difficult for nurses and midwives to explain absences from employment and to broach the existence of regulatory conditions and undertakings particularly when they may still be feeling devalued and lacking in confidence. When this process is managed, practitioners are more likely to continue working rather than leave the profession.

Many health services have employee assistance programs available for employees. However, these programs give rise to a perception of lack of confidentiality because it is provided directly by the employer. According to the ANF, many nurses and midwives also believe that EAP counsellors who are not nurses themselves lack an understanding of their profession and specific situation.

*Costs to AHPRA, registrants and employers*

At present, the Nursing and Midwifery Board administers the funds that support the NMHPV.

The ANF and the NMHPV submitted a recent sponsored analysis of the economic benefits of the program. It calculated the cost of lost productivity for an impaired nurse with time off work to be between $52,000 and $70,000 (based on payroll information provided by the ANF).[6] Time off work ranged from two months to two years. For the 60% of impaired nurses who did not have time off, but worked under conditions, the cost to the system was calculated to be between $38,000 and $40,000. Using these figures, the analysis estimated that the program represented a saving to the health sector of $7.23 million. (These figures are questioned by departmental respondents in two other States).

[6] Lorgelly, P (2011). *Estimated economic benefits of the Nursing and Midwifery Health Program Victoria*. Melbourne:. University of Melbourne.

## Western Australia

Western Australia has about 31,800 registered nurses and midwives. The Board received 72 notifications about nurses and midwives in the 2010-11 year, including an estimated 12 in the health notification stream.

### *AHPRA Board WA*

Notification is received through a number of avenues – self-referral, official notification, or the Board's own motion. All incoming mail is scanned by a senior case manager to ensure urgency if a serious problem is identified.

All notifications are allocated a case manager by the manager or director. Case managers consist of people from the following professions – nursing (1), law (3), pharmacy (1) and ex-police with experience in investigating (3). Case managers make a preliminary assessment, and seek a response from the registrant by providing them with a copy of the claim. They may seek authorisation to release patient information where appropriate. The registrant's response is sent to the notifier for comment.

If the case manager considers the case is urgent, he or she contacts the State Chair to discuss and authorise whether an Immediate Action Committee [IAC] should be convened, or the case listed with the next Notifications Committee. The IAC is usually via urgent telephone conference, or face to face after a Notification Committee meeting.

If the case is listed for IAC and Notifications Committee, APHRA staff provide the members with the notification, the preliminary assessment, and any other associated documents. The IAC considers the case under s.156 of the Act. If they have a reasonable belief that the registrant is impaired, the following options may be used:

- impose conditions
- suspend the registrant
- accept the registrant's voluntary undertaking
- accept the registrant's surrender of registration
- require a health assessment
- request the APHRA staff to investigate.

In fifteen cases of nurses or midwives (8 from Perth and 7 from country areas), the Board has requested a health assessment. They may or may not have further assessment as a result of a decision made by the Committee or IAC.

When a health assessment report is received, a Board meeting or Notifications Committee nominates a member to have discussion with the registrant (and provides support if required). The face-to-face discussion is facilitated by a Board member with the case manager in attendance, to clarify process issues for the registrant, and explore options the registrant might agree to for further management. It humanises the process and often provides registrants with options they may not have considered.

Where impairment has been identified, the registrants are either requested to provide ongoing reports from a psychologist, psychiatrist or general practitioner. The Board member orally reports the content of the meeting to the Board for a decision on ongoing management. The decision and action are notified to the registrant, and conditions or undertakings are published on the website. All health matters have restricted content on the web (the APHRA statement may read: "conditions relating to health contact APHRA").

An Impairment Review Committee reviews the process of transition by continuing to work with registrants to maintain their progress in dealing with their impairment. Such registrants usually seek the assistance they require, and submit reports they have agreed to provide as part of an undertaking or the conditions on their registration.

There is no special process available in WA to assist impaired nurses or midwives to self refer. It is reliant on the case manager to fill this gap.

In the larger metropolitan hospitals, impaired practitioners may seek help from Occupational Health and Safety. Registrants may also seek help directly through public sector agencies that deal with drug and alcohol dependencies, such as NextStep, the Perth Clinic, Hollyoak, Cyrean House, and the Metropolitan Health Service D&A services. Nurses may also be referred to independent psychiatrists who deal in drug & alcohol dependency.

*Perceived advantages and disadvantages*

It is a positive step to have a preliminary assessment conducted before Board members review the case as this saves time and the need to reconvene as information comes to light. However, a negative consequence is that it may extend the time between notification and action, especially if the registrant fails to attend. ANF involvement may also extend the process.

One disadvantage is the lack of professional nurses or midwives who are available to act as case managers. If they were available, it would reduce the need for remedial education of case managers in handling nursing investigations and speed the process.

The issues of impairment and conduct are currently dealt with separately. The Board regards this as inefficient, extends the risk to public, and adds to registrant distress.

A potential improvement would be education resources for both registrants and service providers, as they still have poor understanding of performance issues and the other issues that need to be dealt with under the Act. It would help to have nationally agreed resources or education packages (sensitive to State differences) to draw upon.

Gaps in the system include the reality that independent registrants and not-for-profit employers often have no support mechanisms; and there are limited opportunities to refer registrants for assessment in narrow specialist fields, including medication and anger management.

*Costs to AHPRA, registrants and employers*

Component costs to AHPRA include legal advice, expert opinion, medical expenses, specific tests, urine screening, Board members' fees, costs associated with legal avenues such as the State Administrative Tribunal, performance assessments and return to work programs which may require long supervision.

Costs to employers include payment if a nurse is on suspension with pay, or if supervision or additional training required. This includes employers who are managing nurses or midwives on sponsored visas.

The registrant bears legal costs, medical expenses, and the tests required. Income is lost if nurses are suspended, practising under conditions, or become less employable while notified.

## Part 2: Findings and comments

***Incidence***

AHPRA's *Annual Report 2010-11* gives an initial indication of the scale of need for management of impaired nurses and midwives. Of the 321,662 nurses and midwives registered in that year throughout Australia, 1,300 were the subject of notification to AHPRA. Less than a sixth of these notifications were in the health stream: the total number of notifications of nurses and midwives for health related reasons received from the States and Territories was 225.

Respondents in all jurisdictions described the range of other services accessed by nurses and midwives for help and treatment for AOD and mental health problems. There is no reliable source of information in any jurisdiction for the numbers of nurses using EAPs as employees, or public or private sector services as individuals. The AIHW estimates that 5% of adults use alcohol at a 'high risk' level and 15% 'at risk'; and that 20% of adults per year may have a mental health problem. It is unlikely that the profile of registrants differs greatly from the norm.

In short, only a very small proportion of the nurses and midwives who may be absent from work, or perform below capacity, or leave the profession by reason of impairment come to the attention of regulatory authorities.

***Variation among the jurisdictions***

State and Territory submissions indicate that the approach to managing impairment varies with the size of the nursing workforce.

The processes in the smaller jurisdictions tend to be more informal and diversionary –in the ACT because of strong traditions of collegiality and familiarity, and in Tasmania and the NT because there are very few avenues of support and little communication between health organisations and other AOD or mental health services.

Methods in the larger States are more formal, given central regulatory mechanisms for widely dispersed management, workforce, and industrial structures. A consequence may be that the notification process may be perceived as punitive and adversarial rather than remedial and supportive, which in turn may cause people in difficulty to avoid attention rather than seek help.

Victoria is an exception in that its health program has the shared confidence of AHPRA, the Department of Health, and the ANF in conducting assessments, developing management plans, coordinating treatment and referrals, and offering support to both employers and employees. The Victorian office of AHPRA advises notified nurses, midwives, and students of the existence, role and scope of the NMHPV, and gives them its brochure.

In the 2010-2011 year, the NMHPV opened 159 episodes of care, and 128 episodes of care have been opened since July 2011. Currently 123 nurses, midwives, or students are receiving support from the service.

***Costs to AHPRA, registrants and employers***

Participants in the survey were asked if they had any available information on component costs of their existing practice for AHPRA, registrants, and employers. While few respondents had detailed information, they identified the following components:

*Component costs to AHPRA*

- The costs of assessing a complaint, including the costs of any medical assessments
- In NSW, sitting fees of the Board's Panel process (now under review) –medical practitioners $625 for a half day, $1,000 for a full day; nurses $218 for a half day, $436 for a full day
- Board members' fees, legal advice
- While a registrant is undergoing monitoring, performance assessments and the salaries of the AHPRA staff who review and monitor the file

*Component costs to nurse or midwife*

- Compliance with undertakings or conditions to maintain registration, such as urine and or blood testing, counselling, psychology services, etc, including the repeated cost of UDS or GCMS testing
- Treatment, therapy, or counselling with one's own psychiatrist, psychologist, counsellor or GP, or any ongoing therapeutic interventions imposed as conditions by the Board
- Independent medical assessments and reports required by imposed conditions
- Costs to non-metropolitan registrants of travelling to comply with conditions
- Income lost if nurse or midwife is suspended, practising under conditions, or less employable while notified

*Component costs to employer*

- Provision of EAP or similar support programs to public sector employees
- Salary and on-costs of occupational support staff or mentors
- Increased demand on resources when employing a nurse or midwife subject to conditions and undertakings, including extra staffing costs if the registrant under monitoring must be directly supervised by another practitioner or if additional training is required
- Supervision or reallocation to enable the registrant to remain in the workforce
- Recruiting or replacement costs if a nurse is on suspension with pay

***Productivity and loss of work***

On the issue of costs to the employer, the ANF submitted a recent sponsored analysis of the economic benefits of the Victorian program, which calculated the cost of lost productivity for an impaired nurse or midwife who took time off work or continued to work under conditions, and estimated that the program represented a saving to the health sector of over $7million.[7] (These figures were questioned by departmental respondents in two other jurisdictions).

The only available source of data for estimating how many impaired nurses or midwives have remained at work is the limited sample of NMHPV clients used in the sponsored analysis above. Roughly 60% had no time off work, and 40% had some time off work. NMHPV recently reported that, of all their clients, 81% of nurse and midwife participants were either supported to remain at work, returned to work, or planned to return to work in nursing.

***Nursing and Midwifery Health Programs for other States and Territories?***

Questions arising from this project include:

- What would be the costs if such a health program were to be adopted nationally?
- Would nurses object to a small rise in their levee or registration fee to support it?
- Would there be any unintended negative consequences for the smaller States and Territories?
- Are profession-specific services necessary?
- How can the gap in services be closed between regional, rural, remote, very remote and metropolitan nurses and midwives?

The branches of the ANF who contributed to this report spoke or wrote enthusiastically about the work of the NMHPV – especially the ANF Victorian Branch, which was one of the founders of the program and remains a close collaborator with it. It argues that nurses and midwives are an important investment in the health of the population, and there should be resources available to protect this investment and provide protection to patients in assuring the level and quality of care they receive, and this nurse-led, industry specific service is fundamental in doing so.

[7] Lorgelly, P (2011). *Estimated economic benefits of the Nursing and Midwifery Health Program Victoria*. Melbourne: University of Melbourne.

The NSW Nurses Association believes that the establishment of a national program of support for impaired nurses and midwives, provided by nurses and midwives, is essential to retain a safe and competent nursing and midwifery workforce into the future.

The Queensland Nurses Union says the NMHPV model has real attraction, and strongly recommend creation of a nurse or midwife health program funded by the NMBA or federal Government where impaired nurses or midwives have access to targeted health services with a rehabilitative focus based on a 'return to wellness' model.

The ANMF of South Australia believes it would enhance the process to introduce a confidential, profession-specific program for nurses and midwives that encourages early intervention (which it says is crucial in prevention and community protection. A supportive, health focussed service for nurses and midwives to obtain assistance for their impairment and support recovery could help individual nurses and midwives address their health concerns before they experience a personal or professional crisis that could pose a real or potential risk to the public.

The ACT Branch ANF is very supportive of a national service that assists nurses and midwives to overcome their impairment. It considers that the NMHPV offers many advantages over local methods: it is available to everyone, gives confidential support, emphasises performance not discipline, offers nurses and midwives professional care and support for AOD and mental health problems, and support on finding the right path through their difficulties. The Branch sometimes refers its members to the NMHPV for telephone counselling, since there is no similar program in the ACT.

There was complete agreement among the participants familiar with the Victorian program about the quality, effectiveness and value of the NMHPV's work. There are no other such board-related health programs in other States and Territories. However, some respondents had questions about the concept of a national program using this model.

People in two smaller jurisdictions wondered if it was needed. A Tasmanian official acknowledged that a national program would allow nurses and midwives to access health services with greater confidentially, but the need was not so great as to require something else over and above what already existed in Tasmania. Funding would have to be examined to ensure that State departments were not being asked to fund their own programs *and* contribute to resourcing a national program. Similarly in the ACT, a nurse practitioner had tried to set up a service that offered counselling to impaired nurses and midwives, but it did not continue because the EAP program was seen to be meeting the needs of staff. The NMHPV seemed to parallel what was already provided by EAPs, and a range of public and private support services was readily available.

A Queensland contributor, who strongly supported the model, nevertheless wondered how it could operate in a State so much larger and more dispersed than Victoria. The numbers cited by NMHPV might be convincing for a compact State like Victoria, but in widely dispersed populations and large geographical distances like Queensland or WA, what would be the realistic comparable cost of making such a health service available to rural health services, district nurses and midwives, and aged care staff?

Two respondents – one from the ACT and one from NSW – questioned the cost-effectiveness of a national program. A South Australian respondent believed that, to be convincing, NMHPV's argument for adopting its model in the other States and Territories would have to produce more evidence of its relative effectiveness. The data were not yet convincing, and the numbers were unreliable. "The question to be considered is the return on investment."

Similarly, a NSW respondent said that the NMHPV, despite its attraction, was relatively expensive, and raised the question of return on investment.

Participants canvassed options for meeting the cost of such a health program. The ANMF SA acknowledged that the cost of such an initiative and who may bear such costs required further exploration and agreement.

An ACT respondent said that, while the numbers of registered nurses and midwives differed widely from state to state, a national program would mean that the costs of managing a small proportion of nurses would be borne by the whole profession in higher registration fees.

The federal ANF was concerned that registration fees were likely to increase. The new national registration process had predicted economies of scale, but it was not yet clear that this would eventuate, and any further increase in nurses' registration fees to support a national health program would not be popular, even though they were not exorbitant and tax deductible. Other Branch contributors also said that, while nurses were now well paid, and the fee was smaller in some states than in others, any increase in fees "would be met with great resistance" or "would produce screams of objection".

A Victorian response had two elements: first, the large number of nurses and midwives in Australia meant that any increase to support the program would be relatively very small; and secondly, the potential savings to the health system in lost time, productivity, and replacement costs far outweighed the cost of subsidising the health program.

Queensland respondents also said there could be a case for Health Ministers to regard such a nursing and midwifery health program as a sensible cost of employment, given the numbers or registrants in public sector services, and aged care, and as a workforce benefit in recruitment and retention.

***Cost elements in adoption or adaptation of the NMHPV model in other jurisdictions***

The cost implications of adopting the Victorian model in other jurisdictions would vary with the numbers of nurses and midwives registered in each State or Territory. The calculation would be relatively straightforward in the more populated jurisdictions such as NSW, Queensland, South Australia and Western Australia, while smaller jurisdictions (NT, ACT & Tasmania) are likely to need a somewhat different service model to suit their registrant numbers.

The calculation would take account of the following elements:

- Number of registrants practising in a particular jurisdiction
- Estimated EFT staff needed to deliver health services to its impaired registrants
- Matching direct service costs (salaries, professional development &c)
- Estimated local on-costs (eg property rental, insurances, office equipment, vehicles &c)

The resulting budget would then be divided by the number of registrants to derive the *per capita* levy required to fund the health service. Given the large numbers of registered nurses and midwives, the tax deductable levy could be expected to be quite small. [8]

Other factors that could be taken into account include:

- the potential savings to the health system in reducing lost productivity
- additional infrastructure to serve nurses and midwives in regional and remote locations
- alternative options for a jurisdiction that does not wish to implement a model of this sort
- are profession-specific health services necessary, or would there be economies of scale for AHPRA in a model that encompassed all registered health professions?

***Notification***

Despite universal agreement that the central public purpose of the legislation – protection of patient safety and health – is of critical importance, several participants in this review were concerned that the mandatory notification rules were understood and applied inconsistently, and that the result was beneficial to neither the public nor the individual registrant.

The principals and expectations of the notification process are spelled out in detail in AHPRA documents and websites, but are not yet well understood throughout the sector. The concern is that matters that could be dealt with informally by support or treatment sometimes become notifications even though they do not meet the criterion that the nurse or midwife has "placed the public at risk of substantial harm in their practice because they have an impairment".

[8] Applied to the NMHPV, this calculation currently yields *a per capita* cost for each Victorian registrant of $5.85. The NMHPV estimates that 66% of its budget is used for direct service costs and 34% for administrative service costs.

Clearly, the small proportion of health steam notifications outlined above means that this does not happen very often, but it does give rise to unnecessary fear that to seek help or treatment from any registered health professional may give rise to a referral to AHPRA.

***Assessment and investigation***

These anxieties might be allayed if it were more widely understood that under s151 the Board may decide to take no further action if the notification is lacking in substance, or the issue is being dealt with, or has already been dealt with, adequately by another entity. In addition, after considering an initial investigation report, the Board under s167 may again decide to take no further action or refer the issue to another entity. It seems clear that in some jurisdictions Boards use these discretions to allow a registrant to deal with the health problem in therapy, but this is not consistently the case.

The Queensland Nurses Union proposed that this option be made explicit as a delegated power of state Boards, and a registrant's engagement in such a health program be recognised as an appropriate outcome of an impairment notification, without the need for any other undertakings or conditions, where there is no present risk of harm to patients or the registrant.

The use of initial assessment to divert notifications that pose no danger to the public or the registrant is consistent with the initial assessment screening provisions in health complaints laws.

A second area where some participants in this project believed there was a need for greater consistency was the severity of the conditions imposed on registrants. In one State in particular, nursing representatives regarded the imposed conditions as 'punitive' and claimed that nurses were treated more stringently than members of the other regulated health professions. In some places, the costs of compliance are clearly onerous, and in the absence of Board-related health programs, may lead to the surrender of a nurse's registration.

***Monitoring and evaluation***

The National Law is still in its early years. This project has disclosed noticeable differences among the States and Territories in how AHPRA's boards operate. Program data is not collected consistently, and concerns of similar kinds are expressed by participants in several jurisdictions, for example about delays in the process, unintended consequences of how mandatory notification is interpreted, and financial and personal costs to registrants. There is strong reason to believe that a process of such importance in protecting patients and practitioners should adopt its own monitoring and evaluation framework within which these and other emerging issues may be addressed – including whether health programs for nurses and midwives would or would not advance the objectives of the Act.

***Recommendations for further work***

Based on the limited access to precise and consistent data available to this project, we offer the following suggestions for AHPRA's consideration.

AHPRA should seek agreements with State and Territory health departments, private and NGO providers on data capture and provision for this and other regulated health professionals.

A national minimum data set [NMDS], agreed by all State and Territory Boards under AHPRA's structure, will ensure consistent data across the regulated health professions.

As a matter of priority, AHPRA should design and implement a monitoring and evaluation framework for its regulatory activities, making use of these enhanced methods of data capture.

There is a need for enhanced communication of the guidelines on the exercise of mandatory reporting for all professions affected by regulation, and as they relate to nurses and midwives in particular.

To inform decisions about the future funding of the NMHPV and proposals to institute a national model, AHPRA could consider commissioning its own cost analysis of the NMHPV.

## Appendix: Survey questions

**AHPRA survey: Assessment of health services offered to nurses and midwives both as a result of notifications and where they are able to voluntarily self refer**

**Question 1***:* What are the processes for managing impaired nurses and midwives from notification to outcome from a regulatory perspective in your State or Territory?

**1(a)** What are the advantages and disadvantages in this model?

**1(b)** What elements would you wish to retain?

**1(c)** What improvements would you identify?

**1(d)** Please supply any information you have on the component costs of these programs for employers, the registration board, and the registrants themselves

**Question 2:** What processes are available for impaired nurses and midwives to self refer for assistance in your State or Territory?

**2(a)** What are the advantages and disadvantages in this model?

**2(b)** What elements would you wish to retain?

**2(c)** What improvements would you identify?

**2(d)** Please supply any information you have on the component costs of these programs for employers, the registration board, and the registrants themselves

***Part 2***

In addition to the description of services in Questions 1 and 2, the National Board will be grateful to receive any information you may be able to contribute on the scope of programs for managing impaired nurses and midwives.

**Question 3:** How many nurses and midwives are involved in Board related impairment programs in your jurisdiction, *and* how many nurses and midwives are registered in your jurisdiction altogether?

**3(b)** How many episodes of care for nurses and midwives opened in the 2010/2011 financial year?

**3(c)** Do you have any information about the length of time nurses and midwives are involved in impairment programs in your jurisdiction?

**3(d)** Please describe the range of agencies, health professionals, and other services who help nurses and midwives with impairment (if possible in order of how frequently they are used).

**3(e)** How many of the nurses and midwives in impairment programs are currently working?

**3(f)** How many of the nurses and midwives in impairment programs were from rural and remote areas in the 2010/2011 financial year?

**3(g)** Do impairment programs in your jurisdiction have any geographical implications?

**3(h)** What advice and support are available for employers managing nurses and midwives with impairment?