ACIL ALLEN CONSULTING

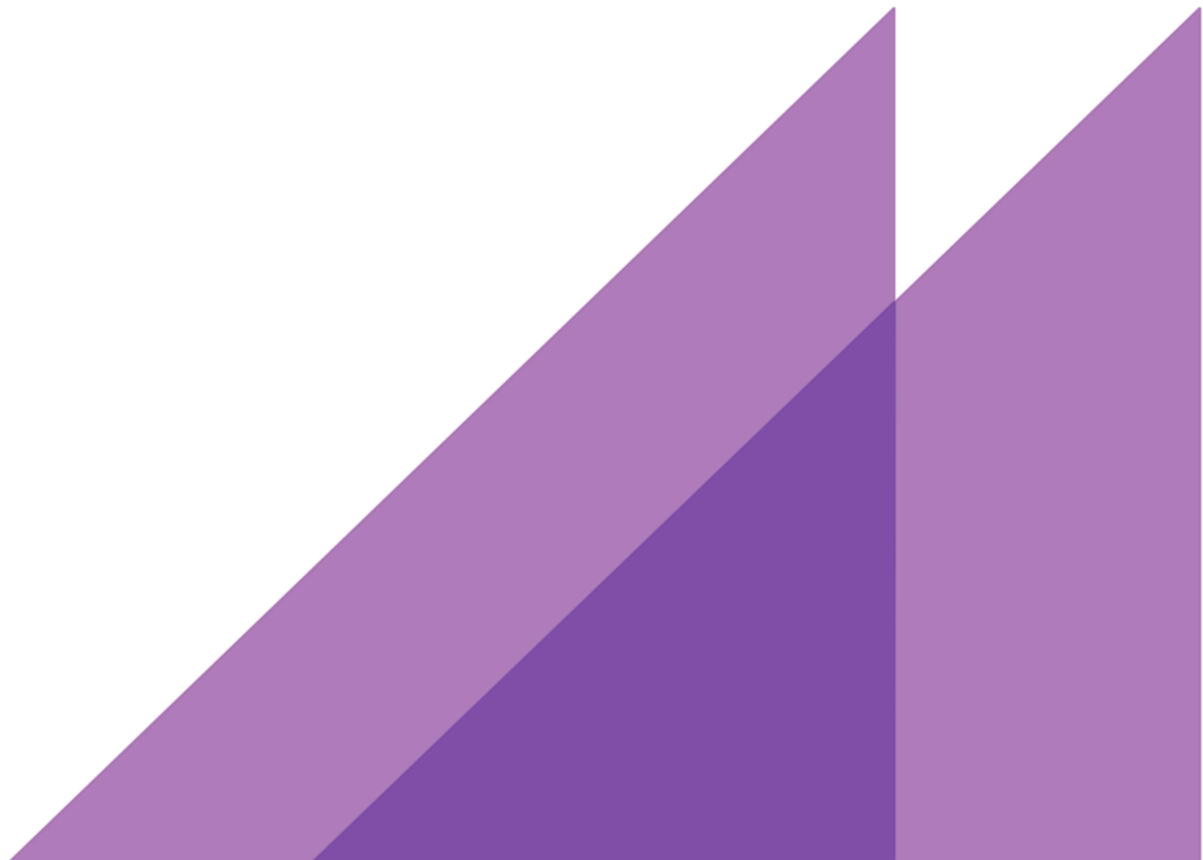
REPORT TO
NURSING AND MIDWIFERY BOARD OF AUSTRALIA

MAY 2015

NATIONAL HEALTH IMPAIRMENT

REFERRAL, TREATMENT AND REHABILITATION SERVICES FOR REGULATED HEALTH PRACTITIONERS WITH AN IMPAIRMENT

FINAL REPORT



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Executive Summary

Impairment amongst health practitioners

Health impairment is defined by the *Health Practitioner Regulation National Law Act 2009* (National Law) (section 5) as a person who has a 'physical or mental impairment, disability, condition or disorder that detrimentally affects or is likely to detrimentally affect the persons capacity to practise the profession'. In this context, there is an important distinction between 'impairment' and 'illness' as the diagnosis of an illness does not necessarily signify an impairment as defined under the National Law.

Evidence has shown that nurses and midwives face work-related conditions that lead to health issues and illnesses that if left untreated can progress to impairment and result in heightened risks for the public, themselves and their profession. The literature consistently highlights the stressful nature associated with nursing and to a lesser extent midwifery and indicates that nurses and midwives are particularly susceptible to health impairment, when compared to the wider health practitioner population.

This review

The Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Nursing and Midwifery Board of Australia (NMBA) commissioned ACIL Allen Consulting to review:

— referral/notification, assessment, treatment, monitoring and rehabilitation for health practitioners with a health impairment (the management and support process)

— the role the regulator may play in supporting national health programs giving consideration to the National Law as in force in each state and territory.

The National Law states that the National Board, at its discretion, can provide financial or other support for health programs for registered health practitioners and students. In this context a health program is considered:

> A program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence.
>
> *Section 5 Health Practitioner Regulation National Law Act 2009*

The review has investigated available academic and grey literature on practitioner impairment, and specifically, Australian and international models of referral, treatment and rehabilitation programs for practitioners with a health related impairment.

It has also undertaken broad consultations with stakeholders regarding management and support models for practitioners with a health impairment, good practice principles in supporting practitioners with a health impairment, and the role the regulator may play in such arrangements. This included an online survey of

nurses and midwives (with over 9,000 respondents) as well as focus groups with nurses and midwives.

Two other supporting reports have been produced and should be read in conjunction with this report:

— A *Literature Review* outlining the types of health programs and program models found in Australia and internationally (Attachment A).
— A *Stakeholder Report* outlining current management and support arrangements for health practitioners with a health impairment in Australia and overseas, as well as a summary of stakeholder feedback.

Key review findings

Prevalence

The review consultations confirm the literature review findings that impairment in nurses and midwives is a significant issue, even if not sufficiently serious to meet the criteria for notification to AHPRA. Sixty six (66) per cent of respondents of the Nursing and Midwifery Health Impairment Survey noted they had either witnessed or had themselves experienced a health impairment. Notwithstanding this, the majority of these cases would not have involved the regulator.

The relatively high incidence of health impairment in the workforce and the influence of nursing and midwifery practice on patient outcomes means that it is important to consider what support is required for this professional group, not just for the nurse or midwife themselves but to improve protection of the public and the reputation of the profession.

Awareness and understanding

It is evident that nurses and midwives do not have a clear understanding of the impairment process, including their obligations upon being notified as well as the broader role of the regulator. Nurses and midwives involved in the review consistently reported that they are uncertain about where and how to seek support when they self-identify they have an impairment, identify an impairment in their colleagues, or are notified that they have been reported as having an impairment. They also reported being unclear on mandatory notification thresholds, as evidenced in just under 70 per cent of all notifications requiring no further action in 2013-14.

In relation to available support services, encouragement of self-referral to a health support service and/or self-reporting (notification) to the regulator regarding a health impairment has been identified as a good practice principle, both in the literature and amongst review consultations. Self-referral to a health support service reflects practitioner acceptance, may increase the likelihood that a health impairment issue is identified earlier, and represents the lowest cost option, given it bypasses the costs associated with, for example, regulator investigation leading to referral.

Nurses and midwives expressed particular concern with the situation where the first communication regarding an impairment was through a formal notification from the regulator. This is often a distressing event, with no single well understood procedure or first point of call for the practitioner.

Current support services

The most common forms of support accessed were Employee Assistance Programs (EAPs), private health practitioners, government alcohol/drug/mental health services, and services provided by nursing and midwifery organisations (for example, the Australian Nursing and Midwifery Federation (ANMF)).

Perhaps the strongest feedback the review received was in relation to the consistency and effectiveness of these services, as well as insufficient awareness of and/or access to the range of available support services. Of the 9,000 nurses and midwives surveyed, only 22 per cent reported that current support services were adequately meeting their needs and only 30 per cent of respondents were aware of government mental health, and drug and alcohol services.

A particular issue raised was that employer assistance and EAPs were often found to focus on broader work environment issues, only provide limited support, and be highly variable dependent upon the workplace culture. Further, support arrangements were noted as varying widely across and within jurisdictions, especially between rural, regional and metropolitan settings. Examples of 'first points of support' include some branches of the ANMF and the Nursing and Midwifery Health Program in Victoria (NMHPV), however, access to greater guidance regarding example situations and responses would assist nurses and midwives to better understand the options available to them upon being notified.

Cost implications

The cost pressures placed on nurses and midwives under notification were frequently raised throughout the review, particularly in relation to the costs associated with monitoring strategies involving assessments and reports, compliance with treatment conditions on licence/registration such as counselling and urine or hair testing, travel costs, and legal advice, representation and court/tribunal costs. The combined effect of these costs could often be substantial, the impact further exacerbated when any conditions placed prevented the nurse or midwife from practising or limited their earning potential.

It was also raised that the high monitoring costs could also act as deterrent to seeking support at a sufficiently early stage, resulting in an escalation of the impairment and hence risk to the nurse or midwife and the public.

Areas for attention

The findings and themes from the literature review and stakeholder consultations suggest three key areas of focus for potential service enhancement.

The first involves additional *education and awareness programs* to better inform nurses and midwives of mandatory notification requirements, obligations to the regulator upon being notified, how to better identify health impairment among colleagues, as well as where and how to access appropriate support services. The second involves establishing a national *support service* for nurses and midwives that provides a range of advisory, counselling and referral services, either through a single national service, or through state-based services within a national framework. The third focusses on reducing the impact of *monitoring and testing costs*, so as to help encourage earlier self-referral and quicker rehabilitation and return to work.

Education programs

The importance of education was raised by stakeholders in many contexts but most tended to focus around the potential benefits these would bring in terms of, firstly increasing the awareness of nurses and midwives about the notification process, mandatory notification and dealing with impairment in general, and secondly encouraging greater awareness of available support services.

While the second of these is beyond the specific legislative focus of the NMBA, it is included here in view of its potential to encourage earlier self-referral and

thereby avoid or limit the extent of a notification, and/or to shorten the time for rehabilitation and return to work.

While there are some presentations and training sessions provided by AHPRA staff on behalf of some State and Territory Boards and AHPRA offices, the ANMF and employers, the review heard that there would be benefit from the establishment of a systemic approach to providing advice to nurses and midwives on how to deal with impairment in the workplace. At minimum, this would involve a suite of education programs that provide advice on respective obligations under mandatory notifications, where to seek help and what procedures should be followed when the impairment is considered to put the public at risk. These could also be extended to employers, other health practitioners and nursing and midwifery educators, explaining their obligations under National Law, and how they can get advice and assistance for impaired staff or students.

Such programs could be provided through jurisdiction specific face-to-face sessions to universities and/or major employers, as well as an online resource to cater in particular for nurses and midwives living in regional and remote areas of Australia. It was also considered important that the available support services are communicated and reinforced upon a nurse or midwife becoming notified.

Support services

In considering the issues raised in relation to having ready and consistent access to supportive health programs, the literature considers the following services as important components—phone support lines, referral and counselling service, case management and regulator management. Of these, there is strong evidence for case management given it is the most effective in improving outcomes in relation to rehabilitation and return to work.

There are a number of ways that such additional support services could be implemented nationally. They could involve a single organisation being contracted to deliver a single support service available across Australia. Alternatively, separate parties from each jurisdiction could be given responsibility for implementing these services within a national framework.

It would be important to carefully delineate the additional support services from generic support services, such as EAPs, which can also cater to varying severities of health impairment. The additional support services could be accessible only to those nurses and midwives who have been notified and assessed as having a health impairment. They could also be a point of referral for nurses and midwives who have been notified but whose case requires no further action given they do not pose a threat to public safety, or have early signs of an impairment, which has the potential to deteriorate and become notifiable if not adequately supported.

The NMHPV is discussed in the report as an illustrative example of an existing support service operating in Victoria. It is important to note, however, that the proposed service elements are not advocating the replication of the NMHPV *per se* across all states and territories. What the review has established is the need for consistent and effective national support services and that their design should draw on examples and good practice principles identified in the Literature Review. Another useful guide may be provided by the recently announced establishment of a national health program for doctors and medical students by the Australia Medical Board of Australia and the Australian Medical Association (AMA).

Monitoring costs

There are various costs associated with monitoring nurses and midwives with a health impairment. Most significant are the costs of regular drug tests, which are

incurred by the individual nurse or midwife. It is understood that cost effective sourcing of appropriate laboratories to perform the monitoring tests required is currently under consideration, including the establishment of formal working relationships and discounted drug tests for notified health practitioners.

In Australia there may also be the potential for some monitoring costs to be reduced as a result of access to universal healthcare, for example through gaining a Medicare contribution for visits to a treating practitioner. Indeed, one of the elements of the support services discussed above could be to provide advice on cost effective means for accessing appropriate treatment and testing services whilst on a monitoring regime.

Financial assessment of the identified enhancements

There are a range of financial benefits available through addressing the areas identified, resulting in the main from avoided or reduced costs in relation to notification processes, testing and treatment, productivity losses and adverse events. While broad estimates have been made to indicate the scale of costs and benefits involved, these should be interpreted with care as they are based on high level assumptions which have not been market tested.

For *education programs*, cost savings could result from nurses and midwives being better informed about impairment, seeking help earlier, and fewer nurses and midwives having a serious impairment, with financial benefits estimated to be in the order of $5 million per annum, as per details provided in **Error! Reference source not found.** 4.4. The costs involved in providing additional education services would include the salary of a coordinator, travel and accommodation for AHPRA staff undertaking education activities across eight states/territories, development of the website and educational materials such as brochures and posters. Total costs as are estimated to be in the order of $0.5 million per annum.

For national *support services*, cost savings would result from more nurses and midwives seeking early help, fewer nurses and midwives requiring notification, and a reduction in post-notification costs (tests and treatment) and are estimated to be in the order of $26 million per annum. The costs of operating enhanced national support services for impaired nurses and midwives relate to staffing, property and utility services, information and communications technology, travel, consumables and marketing, and are estimated to be in the order of $2.5 million per annum in the case of a single national program, and $2.6 million per annum in the case of jurisdictionally implemented programs within a national framework.

In relation to lowering *monitoring costs*, financial benefits would accrue if more nurses and midwives seek help earlier, resulting in a reduction in overall monitoring costs to health practitioners and the regulator, as well as in the monitoring period itself. The estimated combined savings to health practitioners and the regulator are in the order of $5.8 million per annum. While it would require a separate and specific study to identify the optimal level of subsidy in terms of the shifts in complexity achieved, the review’s modelling has assumed a 50 per cent subsidy (that is, halving the costs for the practitioner), which would amount at an estimated national cost of $2.3 million per annum.

Implementation considerations

In considering appropriate organisations able to take responsibility for implementing the education, support and monitoring enhancements, there are a number of potential stakeholder bodies with varying degrees of roles and/or interests in the proposed service elements. They include educators, employers, insurers, governments, professional colleges and associations, and regulators.

An analysis of which of these bodies could have a primary or contributory role, or whether they have an 'interest' in the success of the service, is provided in Figure ES1 on the next page.

As the regulator, NMBA has an interest in the outcomes of all service elements as a result of its mandate to protect the public. It has a primary role in ensuring that all stakeholders are informed regarding the notification process. While having no direct responsibility in the provision of education regarding support services or funding monitoring costs, it has a strong interest in ensuring that these are not preventing early identification of potential impairment or elongating the monitoring process, resulting in increased risk to the public.

Notably, there is no identified single stakeholder with a primary responsibility for sponsoring nationally accessible support services, though it is clear that employers, professional associations and governments were seen as bodies who could play a contributory role. While health insurers were not explicitly raised, it is possible that such services could also be to their benefit and therefore warrant some role.

Also relevant is that the potential benefits of the suggested service enhancements have multiple beneficiaries, extending beyond avoided regulatory cost savings to non-cost benefits, such as avoided adverse events to the public and productivity losses to employers. Realising these benefits will therefore require a national dialogue amongst all relevant stakeholders to progress the service enhancements.

Potential models that could be considered are:

- The NMBA working to provide additional education and awareness programs regarding impairment and the notification process. Employers, whether public or private, would also provide important channels for such programs.
- AHPRA exploring strategies to reduce the costs of monitoring for a nurse or midwife with an impairment. In the case of students, this would also need to involve the educational institutions.
- The NMBA working with government and professional colleges and associations to facilitate the establishment of a national support service for nurses and midwives either suspected or found to have a health impairment. These services would also need to involve employers to ensure a clear delineation between more general employee assistance programs (EAPs).

A key question is what could or should the regulator's role be in progressing these discussions, given they involve issues beyond the review's objective in advising the regulator on its specific regulatory roles and responsibilities. The fact that the regulatory system is impacted by these areas adjacent to its direct regulatory responsibilities, an effective support service being a case in point, provides some rationale for the NMBA to encourage or facilitate such discussions.

Figure ES 1 **Areas of attention and potential primary and contributory roles for key bodies**

Key themes from the review	Resulting areas identified for attention	Potential stakeholder roles					
		Educators (Students)	Employers	Medical indemnity insurers	Professional Colleges and Associations	Government	Regulator
	Education services						
Many nurses and midwives reported a lack of knowledge about the notification process, mandatory notification and dealing with impairment in general	Education to nurses and midwives regarding the notification process	○	●	○	○	○	●
Self-referral to the regulator often leads to better outcomes for health impaired practitioners	Education to nurses and midwives about available support services	○	●	●	●	●	○
Nurses and midwives are at greater risk of health impairment when compared to the general population and other health professions Access to and awareness of support services to nurses and midwives is variable across Australian jurisdictions Current support arrangements are considered to be not providing adequate support for nurses and midwives Good practice support for health impaired practitioners increasingly involves case management Support services are increasingly focussing on early intervention and prevention	**Support services** Additional support services to nurses and midwives with a health impairment	○	◑	○	◑	◑	○
High monitoring costs associated with regulator enforced conditions can deter practitioners from seeking support for a health impairment	**Monitoring services** Subsidisation of monitoring costs incurred by nurses and/or midwives	○	◑	○	○	◑	◑

Source: Key: ● Primary: the stakeholder could play a leading role in implementing additional services; ◑ Contributory: the stakeholder could play an assisting role in implementing additional services: ○ Interest. the stakeholder has an interest in the outcomes of the service.

Allied to the question of implementation responsibility is that of funding. The most likely potential contributing sources include government(s), professional associations, employers and registration fees as collected by the regulator.

While a levy through registration fees could be a single and nationally comprehensive funding option, there are issues to be considered with regulator funded services, particularly in relation to the provision of *support services*. Most prominent is the concern that these may not be perceived as sufficiently independent from the legislated and largely disciplinary functions of the regulator, which could make nurses and midwives reluctant to access such services.

There is also the risk that support services funded by way of health practitioner registrant fees may divert away from regulatory oversight cases where nurses and midwives have a severe health impairment, and whose conduct would otherwise result in notification and subsequent investigation by the regulator. If registration fees were found to be the most appropriate mechanism for funding the support service enhancements, strong independent governance arrangements and processes would need to be implemented to ensure escalation to the regulator of impairment issues that posed a risk to the public under the provisions of the National Law.

1 Introduction

This chapter provides an overview of the review including its objectives, context and outputs to date. It also outlines primary sources of data collection and the methodology employed.

1.1 The review

The Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Nursing and Midwifery Board of Australia (NMBA) has commissioned ACIL Allen Consulting to review:

- The referral, assessment, treatment, and monitoring services for health practitioners with a health impairment, involving the identification and review of existing approaches and/or healthcare programs for nurses, midwives and students.
- The role the regulator may play in supporting national health programs giving consideration to the *Health Practitioner Regulation National Law Act 2009* (National Law) as in force in each state and territory.

Specifically, this review has investigated and analysed the evidence relating to national and international health program models and other health support approaches available for regulated health practitioners to inform the NMBA in determining:

- the role of a health practitioner regulator in supporting independent national referral, support/treatment, monitoring and rehabilitation services for regulated health practitioners in Australia
- the most appropriate and cost effective means of service delivery for regulated health practitioners
- the most appropriate resourcing for such services.

To date, two other supporting reports have been produced and should be read in conjunction with this report:

- A *Literature Review* outlining the types of health programs and program models found in Australia and internationally, with a focus on the role of the regulator in these models and the interactions and interfaces between regulators and the programs in their jurisdictions (Attachment A).
- A *Stakeholder Report* outlining current management and support arrangements for health practitioners with a health impairment in Australia and overseas, and a summary and analysis of stakeholder feedback, and identification of common themes that emerged from the consultations.

1.2 Project methodology

The review method has comprised:

— *Stage One:* a literature review

— *Stage Two:* stakeholder consultations including face-to-face and telephone interviews, an online survey, focus groups and public submissions

— *Stage Three:* identification of areas for further attention, with analysis of associated costs and benefits.

The methodologies adopted for stages 1 and 2 are outlined below. The evidence gathered from these sources is drawn together in this report as part of the stage 3 analysis.

Literature review

The literature review was based on a search strategy that identified a set of key research questions regarding regulation, referral, assessment, treatment, and rehabilitation and outcomes. Appropriate search terms were derived from these questions and an initial search undertaken to confirm appropriate national and international search targets.

The search targets included:

— Electronic data bases to enable a broad and comprehensive search of published, peer-reviewed literature across all key areas relevant to health care models for impaired health practitioners.

— Websites to capture existing roles of regulation agencies in managing and supporting health impaired practitioners and to identify current health care models that provide support to health impaired practitioners.

— Monographs as identified through searching of electronic databases and website.

Stakeholder consultations

Stakeholder consultations were conducted in three ways:

— Interviews with relevant Australian and international stakeholders not including nurses and midwives.

— Focus groups involving nurse and midwives.

— Public online survey targeted at nurses and midwives.

Interviews

These were conducted between August 2014 and March 2015 and included:

— health practitioner regulatory bodies at both a state/territory and Commonwealth level

— support service providers for nursing and midwifery and health practitioners more broadly

— state/territory and Commonwealth health departments

— health complaint entities involved in complaints against health practitioners

— health professional associations

— AHPRA staff involved in notifications.

Overall, a total of 46 interviews were undertaken, either face-to-face or by phone, and three written submissions were received. A list of stakeholder organisations and representatives is provided at Appendix A.

Survey for nurses and midwives

Feedback from registered nurses and midwives was obtained through an online survey and two focus groups.

The survey was open for nurses and midwives between 28 January 2015 and 13 February 2015 (17 days). A total of 9,117 nurses and midwives completed the online survey, which represents some 2.5 per cent of all registered nurses and midwives. As an absolute response rate it indicates strong interest in the issue of impairment and provides a sound basis for analysis.

Given the survey was made available on the NMBA website, it is possible that other interested parties provided responses. However, the vast majority of respondents (98 per cent) indicated that they were a nurse and/or midwife.

Focus groups for nurses and midwives

Two focus groups were also scheduled to gather feedback from nurses and midwives. New South Wales (Sydney) was selected both for its size and the fact that it is a jurisdiction with co-regulatory arrangements. South Australia (Adelaide) was the second location selected because of its centrality and the fact that it is a jurisdiction with arrangements that are representative of 'standard' application of the National Law.

A total of 18 nurses and midwives participated the focus groups, nine in Adelaide and nine in Sydney.

1.3 This report

This report synthesises the key findings from the previous Literature Review and Stakeholder Report and identifies areas for attention in relation to the management and support processes for nurses and midwives with a health impairment. It also considers potential stakeholder roles in effecting these enhancements.

Analysis of the associated costs and benefits has been undertaken, drawing upon a range of sources to inform the modelling assumptions.

The report structure for the remainder of this document is as follows:

- Chapter 2 summarises current regulatory arrangements
- Chapter 3 outlines current arrangements for, and issues with, managing and supporting nurses and midwives with a health impairment
- Chapter 4 identifies and discusses potential enhancements within the management and support process, potential stakeholder roles as well as any financial considerations
- Chapter 5 concludes with an overall summary of review findings.

2 The regulatory context

This chapter sets out the regulatory context within which the NMBA operates, it also defines the key functions of the NMBA in relation to nurses and midwives with a health impairment.

2.1 The National Scheme

In July 2010 registration of health practitioners in Australia moved from a complex localised scheme of regulation to the National Regulation and Accreditation Scheme (the National Scheme). Under the National Scheme, National Boards for each of the 14 health professions were established, which represented a consolidation of over 80 boards and their associated structures.

AHPRA supports the work of the 14 National Boards (some with state and territory Boards and committees), which have the following objectives:

- protection of public safety
- facilitation of workforce mobility and high quality education and training
- promotion of access to health services
- development of a flexible responsive and sustainable workforce.

2.2 Functions of the NMBA

The National Law as in force in each state and territory provides the legislative framework for the National Scheme and the 14 health practitioner National Boards.

The National Law sets out the objectives of the National Scheme (Section 3), which include:

> *To provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.*

The National Law also sets out guiding principles for the National Scheme as follows:

> *(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;*
>
> *(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;*
>
> *(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.*

In exercising its functions under the National Law, the Nursing and Midwifery Board of Australia (NMBA) is required to exercise those functions having regard

to the objectives and guiding principles of the National Scheme set out in Section 4 of the Act.

Section 35(1) of National Law sets out the functions of the Board, which include, but are not limited to the following:

- registering suitably qualified and competent persons in the health profession and, if necessary, to impose conditions on registration of persons in the profession
- deciding the requirements for registration or endorsement of registration in the health profession
- developing or approving standards, codes and guidelines for the health profession
- where necessary, conducting panel hearings and referring serious matters to Tribunal hearings.

The National Law establishes a range of registration categories under which health practitioners can practise in Australia. The NMBA can grant student registration to nurses and midwives undertaking an approved program of study. It also has powers to check an applicant's identity, criminal history and investigate an applicant. The NMBA may refuse, suspend or impose conditions on registration and accept undertakings from registrants.

2.3 Regulatory role in relation to impairment

In performing its regulatory functions under National Law, the health practitioner regulatory boards are required to take into account impairment or other health issues affecting health practitioners. Impairment is defined in Section 5 of National Law as follows:

> ***Impairment***, *in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect—*
>
> *(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or*
>
> *(b) for a student, the student's capacity to undertake clinical training—*
>
> *(i) as part of the approved program of study in which the student is enrolled; or*
>
> *(ii) arranged by an education provider.*

The term impairment, as outlined above, is distinct from 'incompetence' and unprofessional misconduct. Incompetence is lacking the requisite skills, knowledge and qualities to perform effectively within the scope of one's professional practice, whereas professional misconduct is conduct that fails to conform to moral standards or policies (Kay and Izenour 2008). While the terms are distinct, practitioners with a health impairment can on occasion display incompetent or professional misconduct.

Specific details of the NMBA's role in health impairment issues are outlined below:

— The NMBA may decide an individual is not a suitable person to be registered as a nurse or midwife if, in its opinion, "the individual has an impairment that would detrimentally affect the individual's capacity to practise the profession to such an extent that it would or may place the safety of the public at risk" (Section 55).

— A registered nurse or midwife who applies to renew his or her registration must complete a statement that includes a declaration that he or she does not have an impairment (Section 109).

— AHPRA on behalf of the NMBA may investigate a registered nurse or midwife if it decides it is necessary or appropriate because the NMBA has received a health impairment notification or for any reason believes the practitioner or student has, or may have, an impairment (Section 160).

— The NMBA may take immediate action in relation to a nurse or midwife's registration if it reasonably believes that a nurse or midwife's performance, health, conduct or impairment poses a serious risk to public health or safety (Section 156).

2.4 Mandatory notification

The National Board's regulatory role is supported by mandatory notification provisions in the National Law, requiring all registered health practitioners to report a health practitioner who in their 'reasonable belief' poses a risk to the public. Health practitioners must notify AHPRA as soon as practical after forming a reasonable belief in the course of practising their profession that a registered health practitioner or student has exhibited conduct and/or demonstrated an impairment that in the course of undertaking clinical practice or training may place the public at substantial risk of harm (Section 141).

Notifiable conduct is defined as follows (Section 5):

> ***Notifiable conduct**, in relation to a registered health practitioner, means the practitioner has—*
>
> *(a) practised the practitioner's profession while intoxicated by alcohol or drugs; or [...]*
>
> *(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment.*

Division 3 of Part 8 also establishes provisions for voluntary notification on the grounds that a registered nurse or midwife has, or may have, an impairment. This Division does not require the notifier to form a reasonable belief that the public may be at risk of harm.

Western Australian health practitioners are not required to make a mandatory notification of suspected impairment but still have a professional duty to protect and promote public health and safety.

Registered health practitioners in all jurisdictions are also exempt from the requirement to make a mandatory notification in certain circumstances, as listed in Section 141 of the National Law (for example, if the health practitioner is employed by a medical indemnity insurer).

2.5 Regulatory role in delivery national health services

The terms of reference for this review seek an examination of “the role the regulator may play in supporting national health programs … and … in supporting independent national referral, treatment and rehabilitation services for regulated health professionals in Australia”. The National Board's functions under section 35(2) include:

> *- at the Board's discretion, to provide financial or other support for health programs for registered health practitioners and students.*

A *health program* is defined in the National Law to mean:

> *a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence.*

The National Board's functions in respect of health programs for nurses and midwives are therefore defined by the National Law and, if exercised, must have regard to the objectives and guiding principles set out above. In particular, involvement in support services for nurses and midwives requires careful consideration of the NMBA’s legislated functions in relation to its paramount guiding principle under section 3A:

> *The main principle for administering this Act is that the health and safety of the public are paramount.*

Therefore while there is provision under National Law for the NMBA to provide financial or other support for health programs that may assist a registered nurse or midwife with an impairment, it is important that any such regulator involvement does not inadvertently place increased risk to the public. An example of this could be where practitioners or students delay seeking support for a health impairment if they perceive the support to be not sufficiently independent from the regulator.

3 Current arrangements

This chapter outlines current arrangements for managing and supporting nurses and midwives with an impairment, and the key issues identified through the review.

3.1 Management of impairment

While the implementation of the National Scheme has increased regulatory consistency, there is still some significant variation between states and territories in the approaches to managing impaired practitioners.

The largest of the variations are in New South Wales, and more recently Queensland, both of which are 'co-regulatory jurisdictions' as defined in the National Law and, as such, have different processes for notifications and complaints to those of the other states and territories.

An overview of the broad arrangements of managing nurses and midwives with an impairment is provided in Table 1.

Table 1 **Management and support process for all Australian jurisdictions**

Process	All states/territories excluding NSW and Qld	New South Wales	Queensland
Referral	Nurses and midwives may be referred to a health support service by other health practitioners, employers, family or friends. Alternatively they may choose to self-refer.		
Notification	Nurses and midwives with a notifiable impairment are reported to AHPRA, who inform the relevant state/territory National Board. All jurisdictions have implemented mandatory notifications as specified in the National Law, however, WA practitioners are exempt from mandatory notification.	Nurses and midwives with a notifiable impairment are reported to the NSW Health Care Complaints Commission, but may also be reported to AHPRA and the Nursing and Midwifery Council.	Nurses and midwives with a notifiable impairment are reported to the Queensland Office of Health Ombudsman who may refer the complaint to the National Board. Notifications may also be reported to the NMBA and AHPRA.
Assessment	If a notified nurse or midwife is suspected of having a health impairment, the NMBA may refer the registrant to a medical practitioner and/or psychologist to undertake a health assessment. Findings from the health assessment are provided to AHPRA and the NMBA and the health practitioner. If the assessment reveals that the practitioner poses an immediate risk to the public, the Board will take action to suspend or place conditions on their registration.	The NSW Nursing and Midwifery Council may refer a health practitioner or student for a health assessment by a Council-appointed practitioner. The appointed assessor will produce report for a Council. The Council will consider the Health Assessment report and may decide to refer the matter to an Impaired Registrants Panel (IRP) for further inquiry.	See all other states/territories
Support	Nurses and midwives in all states/territories may have access to a range of support services such as EAPs, private practitioners and government funded services. In Victoria only, in addition to other services, nurses and midwives have access to NMHPV, which offer counselling, referrals and case management services.	Nurses and midwives have access to a range of services including EAPs, private practitioners and government funded services.	See New South Wales
Treatment	Nurses and midwives are responsible for seeking their own treatment and payment of treatment.	See all other states/territories	See all other states/territories
Monitoring	If a nurse or midwife has an impairment, and conditions are placed on this person's registration, the NMBA will decide a review period for the conditions. Monitoring conditions may include testing, which is largely for those with an alcohol and/or substance abuse problem.	The Council monitors the nurse or midwife for a period of time that is negotiated between the health practitioner and the IRP.	See all other states/territories The OHO receive three-monthly reports on cases referred to AHPRA and is provided with additional reports upon request.

Source: *Health Practitioner Regulation National Law Act* (2009); NMHPV 2014; OHO 2013; AMA Queensland 2013; HCCC 2014; Health Professionals Council Authority (HPCA) 2012; Wardell 2009; NMCNSW 2014

Adding to the challenges of developing a consistent approach is that there is a range of other entities who can play a role in managing and supporting health practitioners with an impairment—including education providers, employers, health services, professional associations and colleges, and insurers.

3.1.1 Referral and notification

The first stage in the treatment and rehabilitation of nurses and midwives with a health impairment is the identification of those practitioners who may be at risk of impairment, followed by referral to a support service or notification to the regulator.

There is a difference between reporting ('notification' in the Australian context) and referral. Reporting means raising a concern about a potentially impaired practitioner with a regulator, on the understanding that investigation and potential regulatory action may follow. Referral means suggesting or directing that a practitioner engage with a service for impaired practitioners.

Many possible points of referral with self-referral considered the ideal

The literature review and feedback from stakeholder consultations highlight that there are a range of referral and reporting sources in Australia, as is the case internationally as well. Prominent sources are employers, treating practitioners, family/friends, universities, colleagues as well as self-referral/reporting. Self-referral is widely viewed as the ideal method of referral to practitioner support services as it is considered to demonstrate reduced stigma, practitioner acceptance that they have a problem and need help, motivation to change and faith in the quality and suitability of the service (Kay and Izenour 2008; CRNBC 2012; Hamilton and Duncan 2012). Self-referral may also pick up problems earlier, better protecting patients and the practitioner. It is also a lower-cost option, as it bypasses the costs associated with, for example, regulator investigation leading to referral (Dunn 2005; CRNBC 2012).

That self-referral and early identification of a health impairment may reduce the likelihood or severity of the condition impacting upon performance and therefore may in turn decrease the number of notifications and potential risk to the public.

Reluctance to identify or acknowledge impairment

Nurses and midwives who participated in the review consistently highlighted a lack of knowledge about where and how to seek support when they self-identify they have an impairment, identify an impairment in their colleagues, or are notified that they have been reported as having an impairment.

> As someone who has gone through a health impairment and had no support at the time I felt very let down by the system….I do believe first & foremost that encouragement to access advice and support should be step one in the long recovery process for all Nurses & Midwives with a Health Impairment.
>
> *Nursing and Midwifery Health Impairment Survey 2015*

> I feel there is little or no support for health impaired nurses. Having suffered a mental health issue that took over 12 months to overcome I am now looking at a future without nursing.
>
> *Nursing and Midwifery Health Impairment Survey 2015*

Difficulties in identifying impairment are not unique to nurses and midwives in Australia. As discussed in the literature review, identification of health impairment among health practitioners can be extremely difficult when compared with the general population, given health concerns in practitioners are often picked relatively late when the problem is already severe and entrenched. This has been attributed to denial and minimisation of the problem, stigma and shame, fear of

consequences, and doubts about the quality of care that would be provided (Ponech 2000; Clode 2004; Dunn 2005).

Stages within the notification process are not well known

Nurses and midwives also expressed concern with the situation where the first communication regarding an impairment may have been through a formal notification from the regulator. This can be a distressing event in itself, which may be exacerbated by there being a lack of awareness or understanding of the processes to follow or first point of call for the practitioner.

Discussions with AHPRA Notification Directors and State Managers reinforced these issues by confirming the apparent limited knowledge nurses and midwives have in regard to the notification process and their responsibilities upon being notified.

Mandatory notification is often misunderstood

Misunderstanding regarding the application of mandatory reporting is also an issue for nurses and midwives. They reported being unclear on mandatory notification thresholds, which can lead to the reporting of practitioners whose impairment does not place the public at risk. This may help explain why, for nurses and midwives, just under 70 per cent of all notifications, of which a proportion are related to impairment, require no further action (AHPRA 2015).

The review found that health impairment cases among health practitioners often do not require attention from the regulator. This includes the nursing population where 10 per cent of the profession have a substance abuse disorder, but only 6 per cent have a condition severe enough to interfere with their immediate ability to practise (Ponech 2000 & Brown *et al* 2002). Victoria's Nursing and Midwifery Health Program (NMHPV) noted that the majority of their cases are stress-related and approximately only 5 per cent involve the NMBA. Similar statistics were found for British Columbia's Early Intervention Program (Canada) and New South Wales' Medical Benevolent Association. What these figures show is that many health practitioners, including nurses and midwives, can practise safely with an illness and/or a disability.

Few formal referral agreements between regulators and health programs/services

In relation to referral to health services, national and international literature identified four broad models of referral and reporting between health programs/services and regulators. These take into account the presence or absence of (a) a formal public agreement, (b) mandatory notification and (c) 'shielding' of clients.

The most common model in Australia is mandatory notification without any formal agreement, as seen, for example, in the operation of the various Doctors Health Advisory phone support lines (except WA), and services offered by Medical Benevolent Associations and EAPs. Under this model, clinicians working within the program or service are bound by mandatory notification requirements with respect to program clients, without a formal agreement with the regulator to guide them. This was reported as resulting in service operators, staff, clients, potential clients, external treating practitioners, reporters and potential reporters being uncertain about the role reporting to the regulator plays. Inconsistent application and interpretation of reporting requirements have been reported, with some practitioners considering program compliance to negate the need to report, while others do not (Whelan 2009).

The contract between the NMHPV and the NMBA is a form of formal agreement with shielding, containing some references to operational issues, including referral and reporting. However, unlike equivalent arrangements in North American

programs, the details of the arrangement are not publicly available. The website for NMHPV and the associated publications make no mention of mandatory reporting, or how it interacts with the program (NMHPV 2014). This may contribute to uncertainty about the program and, in turn, prevent nurses and midwives from seeking its help.

3.1.2 Assessment

After referral to a support service or reporting to a regulator, the next stage is assessment to determine the nature of impairment (if any) and possible treatment options.

There are two broad types of assessment that are relevant to evaluating health practitioners who are suspected of having a health impairment—health assessments and performance assessments.

Health assessments may include cognitive testing, psychiatric evaluation, psychological profiling, and physical examination and/or medical tests. These can establish the existence of a health issue, but do not necessarily establish the existence of an impairment of professional performance, as many practitioners with disabilities or health issues can practise safely, with or without adjustments to their work practice.

Unclear whether appropriate links are being made between performance and health issues

Although there are well established separate assessments to determine the existence of health issues and performance issues, techniques and standards for identifying whether health impairment issues may be causing or contributing to a performance problem are more contentious. Further, methods for whether a confirmed health issue impacts, or has a significant pressing potential to impact, on professional practice or performance are less standardised than those for detecting the presence of health issues. They tend to focus on competence or communication concerns rather than the impact of an impairment on clinical performance *per se*. More literature is needed to improve clarity in this area (Humphrey 2010; Thompson *et al* 2009).

Support services may employ clinical staff such as mental health and/or addiction nurses, general practitioners or psychologists to undertake assessments. Others refer potential clients to external practitioners for assessments. Ideally, the specialty of the assessor is aligned with the nature of the practitioner’s impairment, though practitioners who present with one concern are often found to have other less obvious issues.

The NMBA may require a nurse or midwife or nursing/midwifery student who has been notified to undergo an initial health assessment if the NMBA reasonably believes that the practitioner/student has, or may have, an impairment (section 169 National Law). The assessment involves either a medical, physical, psychiatric or psychological examination. In all jurisdictions, with the exception of the Northern Territory, the state/territory National Board is responsible for appointing a health practitioner to undertake the assessment. Generally this involves a medical practitioner or psychologist, who is not a member of the National Board.

Overall, stakeholders considered that the current regulatory assessment process in each state and territory works reasonably well and should be maintained. One area, however, frequently raised was in relation to concerns related to information sharing between health support services and AHPRA/NMBA.

Regulator access to support service information varies

Regulators, both nationally and internationally, can potentially receive selected information about the findings of an assessment undertaken by a support service. While the frequency and depth of such information sharing vary substantially, typically they fall into the following four groups:

— *Universal initial access:* where the regulator administers case management programs, or uses a regulator management approach (see section 3.1.3). In these cases, full information on the outcome of the assessment is available to the regulator and is used to determine next steps in the process.

— *Access upon infringement:* where there is provision within the formal agreement with the regulator that certain information about the client, including assessment findings, may be shared with the regulator if the client breaks the terms of their contract (i.e. is 'non-compliant'). This model is most common among case management programs in North America which utilise treatment and/or management contracts to formalise their expectations of clients.

— *Access where mandated:* where rules regarding information-sharing vary based on the entry path of the client into the program. In these circumstances, access about the assessment outcomes of clients is automatically accessible to the regulator in cases where the clients' participation was mandated by an order of that regulator.

— *Access in case of public risk:* where the program reserves the right (of which clients are clearly informed) to report clients who are believed to pose a serious risk to public and/or patient safety. This type of access reflects information-sharing protocols between Australian support services (with the exception of WA) and the regulator, as a result of mandatory notification.

3.1.3 Support and treatment

Nurse and midwives with a health impairment may be referred to a support service and/or treatment for assistance.

While not a primary responsibility of the regulator, support and treatment services are an important component in the rehabilitation of a nurse or midwife with a health impairment.

The range of current support services are not well understood or are not adequately meeting nursing and midwifery needs

Australian nurses and midwives do have access to a range of support services including EAPs, government drug/mental health services, private health practitioners and other employer-related services. Victoria has a specific support service providing an initial point of contact, referral and case management support for the nursing and midwifery profession, known as the NMHPV. The NMHPV also provides a range of online resources for nurses and midwives (such as the NMHP model of care, and assessments undertaken by the program) and employers (including guidelines for supporting an employee with a health impairment). There is no specific nursing and midwifery service in other jurisdictions, although the ANMF have reported that the state and territory branches do field a number of initial enquiries from members and employers in regard to health impairment in the nursing and midwifery profession.

Consultations with Australian nurses and midwives consistently highlighted, however, that many are either not aware of available support services or feel that the available services are not adequate to meet their needs (examined further in section 3.2). The services they considered 'essential' to be delivered well were:

referral to other health practitioners; assistance in re-entering the workforce; and education (or prevention) services to raise awareness of health impairment issues.

The literature highlights four broad categories of support services:

- *Phone support line:* 'Hotlines' which affected practitioners and/or concerned others can ring for support, information and referral. Calls are typically anonymous.
- *Referral and counselling servic*e: whereby affected practitioner have voluntary, brief contact with the service, which offers referral and occasionally limited therapeutic services such as counselling.
- *Case management:* Specialised services which manage and coordinate the practitioner's longer term involvement in an intensive, formal program of assessment, treatment and rehabilitation, monitoring and often agreed restrictions on practice. Typically these services may have a formal relationship with regulators.
- *Regulator management:* Where affected practitioners who come to the regulator's attention are directly assisted to access assessment, treatment, rehabilitation and monitoring. This service is linked to the regulator and can be offered as an alternative to discipline.

Case management is considered a highly effective form of support

Of the four main categories of support services listed above, case management is viewed as the most effective form of support as evidenced in the literature. This has been attributed to its intensity, which includes extensive assessment and individualisation, high continuity of care, long-term monitoring and follow-up and intensive support, treatment and rehabilitation, including crisis and inpatient options. It also promotes public protection through putting agreed and/or voluntary work restrictions in place, enabling regulator action in cases of serious risk and having formal agreements with the regulator (Gray 2006).

While details vary between case management services, typical treatment-related roles include:

- using assessment findings to develop a management and treatment plan
- creating an agreement or contract with the client, based on the treatment plan
- assisting the client to arrange and coordinate the treatment plan including referrals to appropriate treatment services, and monitoring compliance with treatment and management programs
- developing and implementing response plans when relapse or other significant negative events occur
- negotiating alterations to treatment and management plans as appropriate
- arranging re-assessment of clients reaching the end of service participation
- facilitating return-to-work efforts.

These service elements are considered to align with best practice principles in managing practitioners with a health impairment, which are 'managing risk in a proportionate manner', 'protect[ing] the public from harm', and 'evidence-based and tailored to the needs of health practitioners' (Fletcher 2001; Medical Council of New Zealand 2011; CRNBC 2012; General Medical Council 2014).

Support services typically exclude treatment

The literature indicates that support services generally do not provide clinical treatment for nurses and midwives with a health impairment, with the exception of in-house counselling. Rather they provide coordination, referral service to other

health professionals or specialist services and administrative and monitoring assistance. In addition, the services tend to specialise according to:

— *Geographic area*: In the US, Canada and the Australia, state or province-based programs are the norm. The literature provides little comment on the relative merits of a state-based or national approach.
— *Impairment type*: Many support services limit the scope of impairments they cover, however, substance misuse was specifically covered by all services identified in the Literature Review.
— *Profession*: All support services reviewed with the literature were, to some extent, specific to health practitioners. Some were specific to one or two health professions, while others were open to those working in a range of health-related occupations.

Meaningful outcomes data on service participation are limited

The literature is sparse in relation to measurable outcomes of health services for clients but does discuss the following as the key outcome indicators:

— *Recovery:* total (without relapse); total (with relapse); no longer a risk to patients, abstinence from substance abuse; non-recovery; and death.
— *Registration:* kept (without restrictions); kept (with restrictions); revoked or suspended; surrendered; and converted to non-practising.
— *Program completion:* program completed; failure to complete (voluntary exit); failure to complete (involuntary discharge); failure to engage at beginning.
— *Work status:* remained in work; returned to work; able to return to work, planning to return; able to return to work, not planning to return; and unable to return to work.

In particular, clients with substance use disorders in practitioner health programs recover at much higher rates than members of the general population undergoing substance use disorder treatment (as defined by abstinence at five years).

Optimistic estimates of recovery rate in the general population undergoing treatment generally range from 40 per cent to 60 per cent yet, for example, the average recovery rate for the US practitioner health programs (PHP's) is 88 per cent at five years. Similarly, the three-year recovery rate for UK-PHP is 79 per cent. The risk of relapse was also found to be lower in practitioners (Page 40, Literature Review).

In contrast, recovery from mental health issues, physical illness, cognitive impairment, ageing and disability was more difficult to define or in some cases not medically possible.

3.1.4 Monitoring and rehabilitation

Nurses and midwives who have been notified and had conditions placed upon their registration are typically monitored over a specific period of time. Nurses and midwives who have not come to the attention of the regulator but who are accessing a support service may also be monitored by that service.

Monitoring strategies used by regulators and the services available from health programs/support services can overlap in areas such as regular drug testing, treating practitioner feedback, medical monitoring and personal progress reports by clients.

In Australia, regulators are responsible for determining a monitoring period for nurses and midwives who have been notified and had conditions placed upon their registration. The costs associated with meeting monitoring requirements are the responsibility of the affected nurse or midwife. In other countries, such as the United States and the United Kingdom, health insurers and health professional unions may also contribute to these costs.

Monitoring costs can place significant financial pressure on the nurse or midwife

It was widely acknowledged throughout the review consultations that the high costs associated with meeting monitoring requirements can place significant financial pressure on the nurse or midwife. Costs to clients can include the following:

- assessments and reports
- compliance with treatment conditions on licence/registration (e.g. counselling)
- compliance with monitoring conditions on licence/registration (e.g. urine testing)
- travel costs to comply with conditions
- income loss
- legal advice, representation and court/tribunal costs.

Private sessions with a medical practitioner can range between $75-$300 per session (without a Medicare subsidy), while drug tests can cost up to $500 per test.

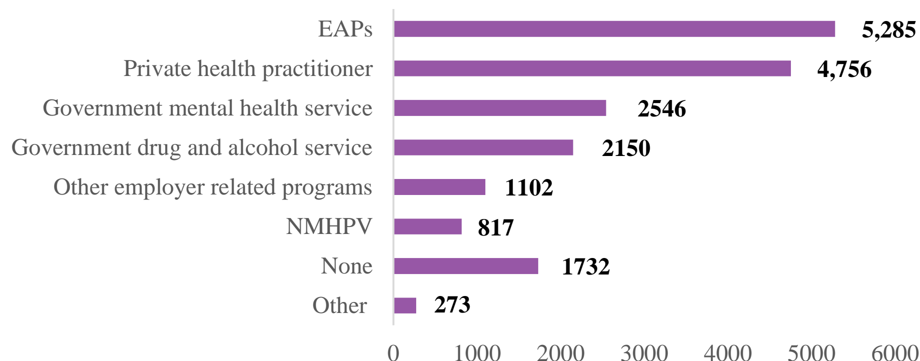
High costs, such as these, can have an adverse impact on both the levels of early self-referral as well as the length of the rehabilitation or recovery process, potentially resulting in an escalation of the impairment and hence risk to the nurse or midwife and the public.

3.2 Supporting impairment

As discussed earlier in section 3.1.3, one of the strongest themes raised in the review has been in relation to the awareness and adequacy of current support services available to nurses and midwives with a health impairment.

Commonly used services were identified in the Nursing and Midwifery Health Impairment Survey and are provided in Figure 1 below.

Figure 1 **Which services are you currently aware of that nurses and midwives with a health impairment access in your jurisdiction? (n=9,019)**



Note: Responses are greater than 9,019 as respondents could choose more than one response.
Source: Nursing and Midwifery Health Impairment Survey

EAPs are the most recognised source of support across the country with 28 per cent of respondents indicating knowledge of this form of support followed by treating health practitioners (25 per cent). Government mental health, and drug and alcohol services, are to a lesser extent also considered as sources of support (page 66, Stakeholder Report).

While positive feedback was received in relation to a range of support services, such as government services, EAPs, as well as services provided by the NMHPV, overall there was significant dissatisfaction expressed with current arrangements. For example, in relation to EAPs, feedback from stakeholders consulted suggests that the programs have a broad focus and, in general, do not provide specialised personnel to address the particular needs of health impaired nurses and midwives. Moreover, as EAPs are generally employer financed, some employees indicated a reluctance to use them given concerns about confidentiality. In relation to private treating health practitioners, nurses and midwives indicated that this source of support was limited due to the high costs involved.

As there is limited publicly available information regarding these services, the assessments outlined above reflect specific stakeholder perspectives and need to be considered in the context of other broader observations as discussed below.

Support arrangements vary across jurisdictions

Support arrangements can vary widely across and within jurisdictions, especially between rural, regional and metropolitan settings. In addition to individual treating practitioners, some branches of the ANMF are considered to provide an effective ‘first point of support’, as does the NMHPV for those who were aware of it, but access to greater guidance in the form of example situations and responses would assist nurses and midwives to better understand the options available to them.

The variability of experience is supported by the Nursing and Midwifery Health Impairment Survey (n=9,117) which found that only 22 per cent of respondents are satisfied with current support arrangements. It is noted that contrary to the positive feedback received through direct consultations regarding the NMPHV, this figure did not statistically differ for Victorian respondents. This suggests that other factors were at play, such as the respondents’ awareness of the service or the nature of the services received. The existence of a state-wide support service was clearly not of

itself sufficient for this group. It is possible that improving awareness of this program may go some way to increasing satisfaction levels reported among Victorian respondents.

Variable workplace support

Nurses and midwives consulted also considered a supportive workplace environment to be critical, but that this can vary significantly across employers and individuals within the organisation. While nurses and midwives working in large private/public hospitals have access to services provided by the Human Resource Departments, it was reported that personnel may have varying knowledge of and experience in dealing with impairment. Feedback from stakeholders consulted indicated that mechanisms or policies to encourage greater consistency in workplace responses to health impairment, whether notifiable or not, would assist nurses and midwives manage their impairment from referral/reporting to rehabilitation. Ensuring clear systems and protocols for dealing with impairment is highlighted in the literature as vital to ensuring patient safety (Leape and Fromson 2006).

There was also a common view that the potential and significant career and cost implications for the practitioner with an impairment may discourage early workplace dialogue regarding the issue. This may in turn ultimately present a greater risk for the public if the impairment is not managed. As such, approaches by employers which are supportive and encourage earlier identification and management, could prevent escalation of the impairment to the point where notification under the National Law is required.

Importantly, the Nursing and Midwifery Health Impairment Survey responses strongly supported employer involvement in support services and monitoring strategies, with just under 90 per cent of respondents believing that the employer should either be ‘fully’ or ‘partially’ responsible for funding these services. There was a similar level of response for government involvement in funding these services, though it is unclear the extent to which this was due to government acting as the employer.

Lack of national consistency in regulatory decisions and outcomes

The issue of national consistency was also raised, but was considered to be more in relation to the regulatory decisions and outcomes. That is, it was more important that action taken against nurses or midwives who have been notified should be dealt with in a consistent manner, rather than in standardising the actual processes and governance of managing and supporting impairment *per se*. Notwithstanding, it was generally held that support services available should be broadly consistent and in line with the move to a national regulatory approach. The NMHPV in Victoria was commonly cited as an example of where current support services are not nationally consistent.

3.3 The specific needs of nurses and midwives

Like many comparatively socio-economically advantaged groups, health practitioners, in general, are healthier and tend to live longer on average than the general population according to measures of physical health (Shannafelt *et al* 2003 & Clode 2004; Frank *et al* 2000). However, they are not immune to physical illness and disabilities that may impact on their work, including degenerative conditions (Clode 2004; Kay and Izenour 2008). Prominent health conditions causing impairment among the health practitioner population are physical health and disability, ageing, mental health and substance use and addition.

Nurses and midwives are highly susceptible to a health impairment

The literature indicates that nurses and midwives are particularly susceptible to health impairment, when compared to the wider health practitioner population (Vecchio *et al* 2010; Mayhew 2000; American Nurses Association 2011; Adriaenssens *et al* 2012; Boyle 2011; Campbell 2013). In particular, the stressful nature associated with nursing and to a lesser extent midwifery is highlighted with a number of key characteristics described below.

Research undertaken by the Australian Safety and Compensation Council in 2008 for example, revealed that Australian nurses are exposed to a number of occupational hazards. The study noted that 50 per cent of respondents had sustained at least one work related injury or disease that required time off work (most common injuries/diseases were musculoskeletal, stress and bullying).

Vecchio *et al* (2010) noted that nurses are at high risk of work-related injury due to the physically demanding role in their work, which has a significant impact on the practitioner's health and wellbeing.

The American Nurses Association (2011) found nurses ranked fifth in the most number of work days missed due to occupational injuries and illnesses.

A report by Mayhew (2000) identified nursing as the occupation group at most risk of violence in the workplace in Australia. Further, O'Connell *et al* (2000) found that 95 per cent of nurses have experienced repeated episodes of verbal aggression as supported by comments in the project's *Nursing and Midwifery Health Impairment Survey*.

> It is a real problem within the workplace that bullying and harassment is rampant.
>
> *Nursing and Midwifery Health Impairment Survey 2015*

Adriaenssens *et al* 2012 found that nurses, and in particular emergency nurses, were confronted frequently with traumatic events (such as death or serious injury of a child/adolescent), which has meant approximately one-third of nurses met sub-clinical levels of anxiety, depression and somatic complaints and 8.5 per cent met clinical levels of post-traumatic stress disorder (PTSD).

> Too many nurses retiring from nursing traumatised and exhausted.
>
> *Nursing and Midwifery Health Impairment Survey 2015*

British and Canadian studies have shown that the level of PTSD among emergency nurses is around 20 per cent. This figure increases to 25-33 per cent in American studies (Helps 1997; Clohessy & Ehlers 1999; Laposa *et al* 2003; Gates *et al* 2011; Dominguez-Gomez & Rutledge 2009).

Shift work, complexity, moral distress and compassion fatigue

Shift work is frequently highlighted in the literature as a key factor impacting upon the performance of nurses. For example, research into the impact of shift work (and associated sleep deprivation) has shown numerous negative outcomes in physical, psychological and social areas (Admi *et al* 2008).

The extent and complexity of nursing and midwifery role responsibilities are broad, including ensuring hospitals meet compliance regulations (for example, risk management, and quality driving incident reporting). Additionally, the role as a front line service within the health profession, often requires managing parents, families and carers in traumatic circumstances (Roberts *et al* 2012).

Other factors raised in recent literature include moral distress and in particular 'compassion fatigue'. Compassion fatigue relates to when a nurse 'psychologically withdraws and becomes disengaged from the caring nature of the job' (Roberts *et al* 2012). The topic has garnered intense interest from researchers in recent years,

particularly during the Mid Staffordshire Trust Inquiry, which investigated the poor care delivered by the Stafford Hospital between January 2005 and March 2009 (Campbell 2013).

Nurses are particularly susceptible to compassion fatigue due to their role as first responders where they "become partners, rather than observers, in patients' health care journeys" (Boyle 2011). For example, a 2010 study found that approximately 82 per cent of emergency nurses had moderate to high levels of burnout, and nearly 86 per cent had moderate to high levels of compassion fatigue (Hooper *et al* 2010).

The above pressures and employment related stresses faced were also underlined in the Nursing and Midwifery Health Impairment Survey:

> Most nurses at some stage will have stressful events at work and will get sick without realising the link. Burnout is a real problem at work but is not seen as unusual as it happens so often it becomes the "norm".
>
> The workload of the nurses has increased dramatically and we are being forced to look after patients outside our specialty because beds are not available in their own units. This has had a huge effect on morale, sick leave and stress.
>
> I believe that due to the type of stress encountered in our field education on coping strategies and available support services which are confidential would be of benefit to many staff.
>
> There should be more focus on prevention and management of stress, especially in Aged Care. Nurses in Aged Care are very stressed and overworked.
>
> *Nursing and Midwifery Health Impairment Survey 2015*

The above evidence indicates that nurses and midwives face work-related conditions that, as outlined at the start of this chapter, lead to heightened risks of impairment for the public, themselves and their profession. As such, this places specific importance on having in place both effective support as well as management arrangements.

3.4 Regulatory considerations

There was a consistent view among all stakeholders that the regulator has an important role in relation to the notification, assessment, monitoring and rehabilitation of nurses and midwives with a health impairment from the perspective of its core function in protecting the public.

Independence from support services is paramount

With regard to support services for nurses and midwives with an impairment, results from the stakeholder consultations indicated it is important that any related support services be provided independently of the regulator. Respondents expressed the view that close association of the regulator with health impairment support services for nurses and midwives, may deter registrants/students from seeking such assistance, primarily due to fear of notification. As suggested earlier, this may prevent early identification and intervention in the treatment and management of health impairment, prior to there being any need to submit a notification in regard to the health practitioner's performance.

Regulatory linkages with support services do exist

Notwithstanding the identified need for regulator independence in the management of health practitioner impairment, the literature did identify five main types of possible regulator activity in support services. Specifically, these are, public

promotion and endorsement; cross-referral; funding; formal agreement; and program provision (CRNBC 2012; Department of Licensing and Regulatory Affairs 2014; Fletcher 2001; Bohigian *et al* 2002; Brown & Schneidman 2004; Fletcher & Ronis 2005; Smith 2013). Analysis of Australian and international models revealed varying combinations of the following activities:

- *Promotion and endorsement of programs and services:*
  - For example, the Department of Licensing and Regulatory Affairs of Michigan actively promotes the Michigan Health Professional Recovery Program on its website.
- *Referral of specific practitioners to programs and services:*
  - For example, the UK's General Medical Council and General Dental Council both have formal memorandums of understanding with the NHS Practitioner Health Programme, which encourages the Councils to discuss potentially impaired practitioners with program staff with a view to potential referral.
- *Funding part or all of programs and services:*
  - For example the Early Intervention Program for Nurses in British Columbia is funded by the College of Registered Nurses British Columbia (CRNBC).
- *Maintaining formal agreements with programs or services.* These agreements usually cover issues that include information-sharing and confidentiality:
  - For example, all US Physician Health Programs have formal agreements with relevant regulators that provide a degree of 'shielding' from reporting to the regulator and/or disciplinary action for compliant participants.
- *Providing part or all of programs and services:*
  - For example, the CRNBC's Early Intervention Program is provided by the nursing regulator.

Worldwide, support services have varying arrangements regarding information-sharing with the regulator. A distinguishing feature of the different models is whether a formal agreement is in place regarding information-sharing, reporting and referral. Furthermore, major differences are seen in the nature of such agreements, including provisions regarding mandatory notification, sharing of client information with the regulator, coercion and 'shielding' of practitioners.

Further to the discussion in section 3.1.1, the literature shows that it is common for health support services to have some limited contact with a regulator as long as the practitioner is compliant with treatment contracts and/or support service recommendations. In some models, this is formalised through a 'shielding' provision. In other cases, it occurs informally, through people choosing not to report health practitioners to the regulator if they are compliant with health support services.

4 Potential enhancements

This chapter outlines potential areas for attention in the management and support process for nurses and midwives with a health impairment. It also considers the roles that various stakeholders could undertake in the proposed service elements. Lastly, costs and benefits for each area for attention have been calculated, in order to determine whether the proposed service elements represent a value for money intervention.

4.1 Risks of impairment

Potential service enhancements to current national arrangements are all aimed at reducing the risk associated with impairment, specifically, the risk to patients, practitioners and the wider health profession.

Risks to the public

By definition, impaired practitioners pose a potential risk to their patients due to their inability to safely, competently and professionally practise (Fletcher 2001, Hamilton and Duncan 2012). The claim is made in much of the literature that impaired practitioners can and do cause direct harm to patients (Fletcher 2001; Dunn 2005; Hamilton and Duncan 2012).

There are high-profile legal and regulatory cases where impaired practitioners have harmed patients (Robinson 2014 & Russell 2014). Drawing on Australian examples, the harm in such cases includes major clinical errors and 'botched' procedures (Robinson 2014), infection of patients with blood-borne diseases via needle re-use (Russell 2014), and patients receiving saline or tap water instead of pain relief following theft of drugs for personal use. An Australian study also found that doctors with poor psychological support, were more likely to sexually abuse patients (Galletly 2004). Other than such court proceedings, however, there is little research that directly investigates impairment with breaches in safe practice by health practitioners.

Risks to the practitioner

The underlying health condition that commonly result in practitioner impairment, such as alcoholism and drug addiction, can lead to morbidity, disability and even death. They also place practitioners at risk of contact with the criminal justice system, strained workplace relationships and job loss, including the stress, financial and social losses associated with these (Frank *et al* 2000). When a health issue results in impairment, further risks to the practitioner include disciplinary action by employers or regulators, loss or restriction of practising licence/registration, legal action and loss of career. All of these impacts can generate knock-on problems for the practitioner in family and personal relationships, social standing, reputation, finances, and mental and physical health.

Risks to the profession

Damage to the public's trust in health practitioners, the healthcare system as a whole, and practitioner regulation, is a potential impact from mismanagement of impaired practitioners. In Australia, several high profile legal cases, investigations and reports regarding impaired practitioners have attracted negative public comment on complaints-handling and regulatory systems (for example, the HCCC's handling of the Suresh Nair case) (Sydney Morning Herald 2014; Sim &

Khong 2013). Furthermore, regardless of the gaps in academic literature and evidence, a UK study found that the public view addiction among practitioners as a significant threat to patient safety. Members of the public considered a dentist smelling of alcohol or a GP with depression to pose a medium risk, but a surgeon with an addiction problem to pose a high risk.

4.2 Areas for attention

In considering possible service elements for managing and supporting nurses and midwives with a health impairment, the findings and themes from the literature review and stakeholder consultations suggest three key areas of focus, namely *education and awareness programs*, *support services* and *monitoring costs* as outlined in more detail below.

Education programs

The importance of education and awareness was raised by stakeholders in many contexts but most tended to focus on the potential benefits these would bring in terms of (see section 3.1.1):

- Increasing nursing and midwifery awareness about the notification process, mandatory notification and dealing with impairment in general, all of which were highlighted as a key concern among this professional group.
- Encouraging greater rates of self-referral among nurses and midwives with an impairment, which has been identified as a good practice principle, both in the literature and amongst review consultations.

While it can be argued that the second of these is beyond the specific focus of the regulator, it is included here in view of its potential to either encourage earlier self-referral and thereby potentially avoid or limit the extent of a notification, and/or to shorten the time for rehabilitation and return to work,

While there are a range of components that additional education on the notification process could encompass, specific priority services that were commonly raised by nurses and midwives were: advice on respective obligations of the practitioner and the regulator under mandatory notification; where to seek help; and on the procedures to be followed when the impairment is considered to put the public at risk. Others included education for employers (managers) regarding their obligations under National Law, and where and how they can get further advice and assistance for staff with an impairment. Such information could be provided through ‘help-seeking portals’, which link health practitioners to important information and services (Health for Health Professionals 2010).

Education in relation to available support services could be provided through jurisdiction specific face-to-face workshops with universities and/or major employers, as well as an online resource, catering in particular for nurses and midwives living in regional and remote areas of Australia. It is also important that the available support services are reinforced upon a nurse or midwife becoming notified. Specific information considered important included:

- the jurisdiction in which the support service operates
- whether the support service is targeted towards a certain type of impairment (for example, physical or mental impairment)
- whether the service is targeted at nurses or midwives, health practitioners or society more broadly

— funder(s) of the support service
— expected costs incurred by the practitioner.

Support services

While nurses and midwives have access to a range of support services provided by government health services, EAPs and private treating health practitioners, issues were raised regarding the current situation in relation to:

— variability across workplace environments
— level of awareness of and/or access to the available support services
— adequacy of existing support services to meet nursing and midwifery needs (see section 3.2 for more detail).

The literature regarding major models of support for health practitioners with an impairment considers the following additional services as important components– phone support lines, referral and counselling service, case management and regulator management (as outlined in section 3.1.3).

Perhaps the best guide for maximising client outcomes is to ensure that any additional support services apply the principles of best practice in managing health practitioners with an impairment, as identified within the literature and reaffirmed by stakeholder feedback as part of this review (see Box 1).

Box 1 **Best practice principles**

1. Protect the public from harm
2. Maintain confidence in regulator and profession
3. Support timely access and response
(‘early intervention and prevention’ as identified by stakeholders)
4. Optimise recovery and rehabilitation
5. Manage risks in a proportionate manner
6. Assist practitioners to remain in/return to the workforce
7. Promote trust, honest, help-seeking
(‘trusted treatment’ as identified by stakeholders)
8. Ensure natural justice and fairness
9. Minimise regulatory costs and burden
(‘independence from the regulator’ as identified by stakeholders)
10. Evidence-based and tailored to the needs of health practitioners
(professionally led ‘staffing’ as identified by stakeholders)

Source: Fletcher 2001; Medical Council of New Zealand 2011; General Medical Council 2014 and Page 54 Stakeholder Report

It is important to note that there may be some tension between these principles, for example:

> *Encouraging help-seeking vs public protection:* Some measures intended to encourage help-seeking and program compliance can clash with the desire to protect patients and the public from impaired practitioners.
>
> *Encouraging compliance vs ethics of coercion*: Some programs shield practitioners from regulator reporting or related action while they are compliant with the program, but report them as a direct consequence of non-compliance. This ‘high stakes’ coercive arrangement is believed to be a major contributor to the high success rates of these programs, but raises ethical questions about natural justice, procedural fairness and the role of coercion in informed consent and treatment of clients.

> *Public protection vs workforce retention:* The tension between public protection and maintaining practitioners in the workforce is also a consideration. This is especially true given the significant cost to society of educating and training practitioners, and the costs of practitioner loss and early retirement.
>
> *Public protection vs discrimination*: With respect to managing impaired practitioners, there is tension between public protection, and anti-discrimination laws and principles…. Issues to consider include the potential for legal challenges to regulator mandates or actions, claims of workplace discrimination, maintaining workforce diversity, public safety, reasonable adjustments, and employer encumbrance.
>
> *Jenkins 2013; Bosch 2000; Gastfriend 2005; Sick Doctors Trust 2014; Darbro 2009; Boyd and Knight 2012; Swan 2005; Wohlsen 20007; Skipper and Dupont 2011; Hagan 2012; Morris and Turnbull 2007; Grainger 2008; Sin and Fong 2008*

It would be important to clearly delineate such additional support services from generic support services, which can also cater to varying severities of health impairment. That is, additional support services could initially apply only to those nurses and midwives who have been notified and assessed as having a health impairment or whose case requires no further action given they do not pose a threat to public safety. They could also be made available to those who are showing early signs of an impairment which has the potential to worsen and become notifiable, though this would require care to ensure that they are not inappropriately shielded from the regulatory oversight as required under the National Law.

There are a number of ways that the additional support services could be implemented nationally. They could involve a single organisation being contracted to deliver the support service across Australia. Alternatively, separate parties from each jurisdiction could be given responsibility for implementing these services within a national framework. The resourcing or funding for the additional services would also need to take into account differences in delivery cost profiles across jurisdictions.

It is important to note that the proposed service elements are not aimed at replicating the NMHPV across all states and territories. What the review has established is the need for consistent and effective national support services and while the NMHPV has been raised as an example of an existing health program, no in-depth evaluation of its efficacy, effectiveness or efficiency has been conducted as part of this review. Indeed, as raised earlier, the level of satisfaction with existing services was not materially different for the Victorian participants of the Nursing and Midwifery Health Impairment Survey to that from participants from other states and territories where no equivalent service was in place. As such, any additional support services should draw on the experience of the NMHPV alongside others identified in the Literature Review (for example, the Michigan Health Professional Recovery Program, CRNBC’s Early Intervention Program and the NHS Practitioner Health Programme), as well the best practice principles discussed above.

Another example may be the recently announced establishment of a national health program for doctors and medical students by the Australia Medical Board of Australia and the Australian Medical Association (AMA). The program will be funded through registration fees and a subsidiary company of the AMA, Doctors Health Services Pty Limited, is to provide nationally consistent services available to all doctors and medical students. The services will provide face-to-face health-

related triage, advice and referral with telephone help line and online tools and resources where appropriate, and may be expanded to include resilience training and early intervention. It is understood that a critical part of the design of the health program is for it to be at arm's length from the Board to ensure that doctors and medical students trust these services and use them at an early stage in their illness (AMA 2015).

Monitoring costs

The cost pressures placed on nurses and midwives under notification were frequently raised throughout the review, particularly in relation to the costs associated with monitoring strategies.

Stakeholders also indicated that high monitoring costs, together with an anxiety of being notified and having to fund these costs, may deter some nurses and midwives from seeking support at a sufficiently early stage, resulting in an escalation of the impairment to the detriment of both the nurse or midwife, and the public.

Some of the typical monitoring strategies identified in the Literature Review are:

- regular drug testing (for example, blood, breath and hair)
- treating practitioner feedback
- workplace feedback
- unannounced worksite visits (during transition back to work or if remaining in work)
- documentation of mutual aid or support group attendance
- medical monitoring
- personal progress reports by clients (Warhaft 2004; Carinci and Christo 2009; Skipper and Dupont 2011; Michigan Health Professional Recovery Program 2013).

The highest cost component is regular drug testing and it is understood that cost effective sourcing of appropriate laboratories to perform the monitoring tests required is currently under consideration, including the establishment of formal working relationships and discounted drug tests for notified health practitioners.

In Australia there may also be the potential for some monitoring costs to be reduced as a result of access to universal healthcare, for example through gaining a Medicare contribution for visits to a treating practitioner.

Indeed, one of the elements of the support services discussed in the previous section could be to provide advice on cost effective means for accessing appropriate treatment and testing services whilst on a monitoring regime.

4.3 Potential stakeholder roles

In thinking about implementation of the above elements, an important consideration is the role that various stakeholders and organisations can undertake. A logical starting point is to look at the existing, well established bodies that either currently do provide aspects of the services proposed or have the capacity and capability to do so. These are educators, employers, medical insurers, professional colleges and associations, governments, and regulators.

An overview of each of these bodies and whether they could have a ‘primary role’, ‘contributory role’, or whether they just have an ‘interest’ in the success of the service, is provided in Figure 2.

It is noted that as the scope of the review did not specifically involve interviews with all the stakeholder bodies referenced, the discussion is necessarily general and is provided as a potential starting point for further and more detailed discussion with these stakeholders.

Educators

In relation to *education* enhancements, it is typical for educational providers to include information about practitioner impairment including definition, prevention, causes, consequences recognition and responses within their training course. They also have a responsibility to report students to the regulator who are suspected of having a health impairment that poses a risk to the public. It has not been within the terms of reference of the review to identify the extent to which educational providers in Australia inform their students about the notification process and/or available support services to nurses and midwives with a health impairment.

There are university-wide *support* services available to educate and train students. Some of these are particularly relevant to the management of health impairment such as counselling services, chaplaincy, student welfare coordinators, health services and mentoring programs. As such, they may be well placed to contribute to, but have no direct responsibility to provide additional services to the wider nursing and midwifery workforce, other than through specific targeted and funded programs.

Employers

In relation to *education*, the literature review identified various employer-developed educational guides for employees in Australia, with referral or reporting to in-house support services as the ideal first step in managing colleague impairment. Some hospitals also have internal systems for managing potentially impaired practitioners, which focus on informing and referring practitioners to appropriate services. For example, the Royal Melbourne Hospital support program for ‘at-risk’ junior doctors has systems for identification, assessment, mentoring, referral, reporting, education and workplace management of distressed junior doctors (Dwyer *et al* 2011). The literature, however, does not identify the extent to which employers provide information on the notification process to practitioners, including their roles and responsibilities upon being notified. Employers appear well placed to do this given their direct ready access.

Employers play a significant role in providing *support* services to nurses and midwives with a health impairment, most commonly through EAPs. However, these services tend to cater for a wide range of staff issues and do not target the specific needs of health impairment. Additionally, most EAPs only make provision for a small number of sessions per employee.

Employers have a role in the monitoring stage given it is in their interest to maintain a productive workforce and limit employee time out of work due to impairment. Recovery of impaired staff requires employers to implement additional resources for monitoring purposes, such as extra supervision, observing work restrictions, managing confidentiality and interpersonal relationships, and reporting on progress.

As raised earlier, the over 90 per cent of Nursing and Midwifery Health Impairment Survey responses supported employer involvement in *support* services and *monitoring* strategies to the extent of being either be ‘fully’ or ‘partially’ responsible for funding these services.

Insurers

There is little evidence of insurer involvement in Australia in funding and/or providing *education, support* or *monitoring* services to practitioners with a health

impairment. Internationally there are some examples, such as in New Zealand, where a free, confidential counselling service for health practitioners is co-funded by the Medical Protection Society and the Medical Assurance Society. Limited to members of these insurance groups, the service is aimed at reducing stress-related and mental illness-related impairment in practitioners. The service includes referral to face-to-face treatment by other practitioners. There are also examples in the US of insurer involvement in funding monitoring services.

The willingness of insurers to contribute to the costs of additional services in Australia is unclear, given this group was not consulted as part of the review. However, similarly to employers, it could be argued that insurers may have a strong interest in limiting health impairment and its severity, due to the associated costs.

Professional colleges and associations

Professional Colleges currently provide some *education* regarding impairment and the management of impairment, in both self and others. This includes college publications such as newsletters, as well as continuing professional development programs, published resources for practitioners, and presentations at conferences and forums.

The ANMF also provide some *support* roles to nurses and midwives with a health impairment, for example, through in-house counselling and referring members to trusted treating practitioners.

While it is possible that professional colleges or associations may be able to assist their members to manage the costs associated with *monitoring*, neither the literature review nor stakeholder consultations identified instances where they have been directly involved in assisting with the monitoring costs incurred by their members.

Professional colleges and associations have an interest in ensuring their members are healthy and able to work, but there are factors that may restrict the impact that they can have. Most prominent here is the incomplete membership coverage, with over 30 per cent of registered nurses and midwives not being members of ANMF (AHPRA 2015)). Additionally, the respective roles of the ANMF and the separate colleges of nursing and midwifery would also need to be considered.

Government

State and territory governments provide a range of *support* services such as alcohol, drug and mental health services, with 25 per cent of respondents to the Nursing and Midwifery Health Impairment Survey being aware of these services. Survey feedback also indicated strong support for governments to fund *support* and *monitoring* services, with 90 per cent of respondents indicating that governments should either be 'fully' or 'partially' responsible for funding these services.

Governments have an interest in the potential outcomes from the provision of all the service enhancements, not only from a public policy and market failure perspective, but also because in some jurisdictions they are a significant employer of nurses and midwives.

As there remain significant differences in jurisdictional approaches, as evidenced in current implementation of mandatory notification and co-regulatory arrangements, a specific targeted review is likely to be required to reach national agreement for government involvement in progressing the service enhancements.

Figure 2 **Areas of attention and potential primary and contributory roles for key bodies**

Key themes from the review	Resulting areas identified for attention	Potential stakeholder roles					
		Educators (Students)	Employers	Medical indemnity insurers	Professional Colleges and Associations	Government	Regulator
	Education services						
Many nurses and midwives reported a lack of knowledge about the notification process, mandatory notification and dealing with impairment in general	Education to nurses and midwives regarding the notification process	○	●	○	○	○	●
Self-referral to the regulator often leads to better outcomes for health impaired practitioners	Education to nurses and midwives about available support services	○	●	●	●	●	○
Nurses and midwives are at greater risk of health impairment when compared to the general population and other health professions Access to and awareness of support services to nurses and midwives is variable across Australian jurisdictions Current support arrangements are considered to be not providing adequate support for nurses and midwives Good practice support for health impaired practitioners increasingly involves case management Support services are increasingly focussing on early intervention and prevention	**Support services** Additional support services to nurses and midwives with a health impairment	○	◑	○	◑	◑	○
High monitoring costs associated with regulator enforced conditions can deter practitioners from seeking support for a health impairment	**Monitoring services** Subsidisation of monitoring costs incurred by nurses and/or midwives	○	◑	○	○	◑	◑

Key: ● Primary: the stakeholder could play a leading role in implementing additional services; ◑ Contributory: the stakeholder could play an assisting role in implementing additional services: ○ Interest. the stakeholder has an interest in the outcomes of the service.

Source: ACIL Allen Consulting

Regulator

In relation to *education*, regulators internationally have a current role in the 'promotion and endorsement of programs and services'. In Australia, AHPRA communicates and informs nurses and midwives of available support services once they have been notified. AHPRA also provides online information regarding 'Who does what?' during the notification process as well as information on each stage such as lodgement, assessment, investigation, and panel and tribunal hearings (AHPRA 2015a).

As discussed in the Literature Review report, regulators can interact with a range of areas of activity in relation to *support* services for practitioners with a health impairment, such as 'funding part of all of programs and services' and 'providing part or all of programs and services' as is the case with the College of Registered Nurses of British Columbia Early Intervention Program (page 13, Literature Review).

Regulators have some interest in all the service enhancements, given the intent of these is to increase early access to appropriate support and thereby reduce instances and/or severity of health impairment among practitioners. As such, they have the potential to minimise costs associated with notifications, which are incurred by the regulator, as well as reducing risk to the public.

In relation to *education*, review feedback was broadly supportive of the role of the regulator in regards to the promotion of available *support* services. This is not to say that this was considered solely the role of the regulator, indeed there should be a degree of independence between the regulator and the strong promotion of support services, principally to avoid the deterrence effect that the disciplinary nature of the notification process can have.

In relation to *support* services, 65 per cent of Nursing and Midwifery Health Impairment Survey respondents indicated regulators should be either fully or partially responsible for funding. By comparison, approximately 90 per cent of respondents indicated that governments and/or employers should fund support services, with the same figure for individual practitioner being 65 per cent.

In relation to *monitoring,* it is understood that AHPRA is currently investigating cost effective options to perform the monitoring tests required. In support of this, 82 per cent of Nursing and Midwifery Health Impairment Survey respondents believe that there is a role for the regulator in assisting with the costs associated with monitoring services, albeit to a lesser extent than employers (88 per cent) and governments (90 per cent).

There are, however, significant factors to be considered regarding regulator involvement in service enhancements. Particularly in the provision of *support* services where, as discussed previously, the disciplinary focus of the regulatory role may deter nurses and/or midwives from self-referring or seeking support, or have the effect of diverting away from regulatory oversight of nurses and/or midwives with a notifiable health impairment.

A related role is funding, which necessitates a direct role in the provision of the services. Registration fees were seen by many nurses and midwives as a key source of funding for the enhancements, particularly the *support* services. The majority (57 per cent) of Nursing and Midwifery Health Impairment Survey respondents indicated that they would be willing to accept an increase in registration fees between $1-40 for the regulator to establish and provide health impairment services. Similarly, focus groups of nurses and midwives considered

that an increase in fees by $5-20 would represent good value for money. The comprehensive coverage of all registered nurses and midwives through registration fees addresses the equity issue raised earlier in relation to professional association membership fees, as well as reducing the per capita impact through the larger economies of scale.

If registration fees are to be used as a source of funding this raises an issue in relation to the separation of the regulatory role from the support role. Nurses and midwives consulted as part of this review indicated that this could lead to a perception that the support services would not be sufficiently independent of the regulator and, as such, could discourage or delay their effective use. To address this perception, robust governance arrangements and processes would be required to ensure appropriate shielding and escalation of notifiable matters to the regulator.

4.4 Financial considerations

In order to help assess the identified service enhancements, this section considers the nature and scale of the costs and benefits involved. The benefits, in particular, are typically a combination of avoided costs in:

- *Notification*: the costs associated with lodgement, assessment, health complaints entity consultation, investigation, health assessment immediate action, panel and tribunal hearings, and monitoring.
- *Testing and treatment*: required by the nurse or midwife to comply with the monitoring strategy.
- *Productivity losses*: the time taken out of the workforce as a result of an impairment, or reduced hours due to conditions and restrictions placed upon a nurse or midwife's registration.
- *Adverse events*: clinical incidents involving errors by health care practitioners can have serious health and quality of life consequences for patients.

Key results from the cost-benefit analysis are outlined below. They provide a broad indication of the scale of costs and benefits, but care should be taken when interpreting results as they reflect high-level estimates which have not yet been market tested.

In particular, a number of the benefits relate to avoided notification costs as result of assumed reductions in the complexity and/or severity of impairment cases, for which AHPRA has commenced collection and analysis of data on the respective notification costs. Accurate figures on the complexity/severity reduction require further and more detailed analysis.

Education programs

The annual cost of providing additional education programs for nurses and midwives has been estimated to be $0.5 million.

The benefits associated with additional education programs include nurses and midwives being better informed about impairment and seeking appropriate support services earlier, as well as reducing the number of those with a notifiable health impairment. For the purposes of the present estimates, it is assumed that the provision of additional education programs would reduce the proportion of impairment cases classified as highly complex. The resulting reduction in the number of notifications to AHPRA estimated to provide a cost saving of $2.5 million per annum.

Similarly, it is assumed that the proportion of nurses and midwives with a low degree of impairment will increase, and that the proportion with a medium or high degree of impairment will decrease, resulting in reduced testing and treatment costs in the order of $1.9 million per annum.

Avoided productivity losses result in earlier return to work are estimated to be in the order of $365,000**.** This adopts the same approach as in the work of Lorgelly (2014).

Annual cost savings associated with a reduction in the number of adverse events are in the order of $240,000**.** This draws on a range of benefit estimates in the literature together with conservative estimates of the proportion of avoidable adverse events caused by impaired health practitioners.

Support services

The costs of operating additional national support services relate to staffing, property and utility services, information and communications technology, travel, consumables and marketing.

The analysis has also adopted the 'lead jurisdiction' approach as proposed by DLA Piper (2014) for the provision of health services for doctors in Tasmania, the ACT and the Northern Territory. This approach involves servicing smaller jurisdictions from adjacent states—ACT from New South Wales, Tasmania from Victoria, and the Northern Territory from South Australia. Two support service models have been analysed—first, a national support services and second, a national support service implemented individually by states/territories.

The annual operating costs of a national service is estimated at $2.5 million, this figure increases to $2.6 million for a national service where jurisdictions are responsible for implementation.

The benefits include more nurses and midwives seeking help early, fewer nurses and midwives with notifiable impairments, and a reduction in post-notification costs.

In a similar way to as before, it is assumed that that additional support services will reduce the number of highly complex cases, which will decrease the cost associated with notifications by $6.2 million per annum.

National support services are also expected to have a significant impact on the severity of health impairment among nurses and midwives. The resulting reduction in the number of cases classified as either a medium or high impairment with the associated reduction in testing and treatment costs is estimated at $7.7 million per annum.

Avoided productivity losses associated with additional support services are estimated at $7.3 million per annum.

Cost savings due to a reduction in the number of adverse events are estimated at $4.8 million per annum.

Monitoring costs

Subsidisation of monitoring costs is expected to encourage nurses and midwives to seek help earlier, reduce costs to the nurse or midwife as well as the regulator, and reduce the period over which the nurse or midwife is being monitored, thereby reducing the number of notifications and the net complexity of the cases being monitored.

While it would require a separate and specific study to identify the optimal level of subsidy in terms of the shifts in complexity achieved, a 50 per cent (that is, halving

the costs for the practitioner) has been used in the review's modelling. The estimated costs of the subsidy, at a national level, would be $2.3 million per annum. This figure would of course increase linearly with the subsidy rate.

In a similar fashion to that applied to education programs, such subsidisation of monitoring costs is expected to reduce the number of highly complex cases (and therefore notifications), with an associated saving of $2.5 million per annum.

The benefits expected through a reduced number of medium and high impairment cases, and consequent overall treatment and testing costs, are estimated at $2.7 million per annum.

The productivity benefits would only be comparatively small, estimated at $0.4 million per annum or around 5 per cent of the benefits when compared to additional support services.

Similarly, the benefits of avoided adverse-event related costs are estimated to be in the order of $240,000 per annum or 5 per cent of support services.

Summary of costs and benefits

A summary of the costs and benefits for education programs, support services and monitoring costs is provided in Table 2 below. All service enhancement areas have the potential provide good returns on the resources invested.

Table 2 **Summary of costs and benefits**

	Costs (p.a.)	Benefits (p.a.)			
Service enhancement		**Notification**	**Testing and treatment**	**Productivity**	**Adverse events**
Education programs	$0.5 million	$2.5 million	$1.9 million	$0.356 million	$0.240 million
Support services	$2.5 million	$6.2 million	$7.7 million	$7.3 million	$4.8 million
Monitoring costs	$2.3 million[a]	$2.5 million	$2.7 million	$0.4 million	$0.240 million

Note: [a] Assuming 50 per cent subsidy rate

Source: ACIL Allen Consulting

5 Conclusion

The need

Impairment can be a significant issue for health practitioners, employers and the public even if the impact is not sufficiently serious to meet the criteria for notification to the regulator. This is evidenced in the literature and reinforced through consultations with the range of stakeholders conducted as part of this review. Both lend support to the case for providing support to nurses and midwives, who are particularly susceptible to health impairment when compared to the wider health practitioner population.

The high incidence of health impairment in the nursing and midwifery workforce and the influence of nursing and midwifery practice on patient outcomes indicates that attention is required for this professional group, not just for the nurses and midwives themselves but to improve protection of the public.

While the overall role of the regulator in relation to assessment and monitoring is considered to work well in ensuring that nurses and midwives with a health impairment have appropriate restrictions placed upon their registration to protect the public, there are opportunities to increase practitioner awareness and understanding of impairment, mandatory notification and the processes and supports that are available.

The service enhancements

Three specific areas have been identified where there is potential to enhance the management and support of nurses and midwives with an impairment. The service elements within each of these areas have been drawn from broad consultation with stakeholders regarding management and support models for health practitioners with a health impairment, good practice principles in supporting health practitioners with a health impairment, and the role the regulator may play in such arrangements. They have also been informed by academic and grey literature on practitioner impairment, and specifically, Australian and international models of referral, treatment and rehabilitation programs for practitioners with a health related impairment.

The first involves additional *education and awareness programs* to better inform nurses and midwives of mandatory notification requirements, obligations to the regulator upon being notified, how to better identify health impairment among colleagues, as well as where and how to access appropriate support services. The second involves a establishing a national *support service* for nurses and midwives that provides a range of advisory, counselling and referral services, either through a single national service, or through state-based services within a national framework. The third focusses on reducing the impact of *monitoring and testing costs*, so as to help encourage earlier self-referral and quicker rehabilitation and return to work.

Implementation considerations

In considering appropriate organisations able to take responsibility for implementing these enhancements, a number of potential stakeholder bodies were identified as having varying degrees of roles and/or interests in the proposed service elements. In addition to the regulator, they include educators, employers, insurers, governments, and professional colleges and associations.

As the regulator, NMBA has an interest in the outcomes of all service elements as a result of its mandate to protect the public, however, it has a particular interest in ensuring that all stakeholders are informed regarding the notification process. While having no direct responsibility in the provision of education regarding support services or funding monitoring costs, it has a strong interest in ensuring that these are not preventing early identification of potential impairment or elongating the monitoring process, resulting in increased risk to the public.

Having said that, no single stakeholder was identified as having a primary responsibility for support service enhancements, with employers, professional associations, and governments all seen as bodies who could play a contributory role.

Moreover, as discussed above, the potential benefits of suggested service enhancements are significant and include avoided regulatory costs, avoided adverse events to the public and productivity gains to employers. The realisation of the identified benefits will require some party or parties to take a lead role in instigating a national dialogue amongst relevant stakeholders to progress service enhancements. Potential models that could be considered are:

- The NMBA working to provide additional education and awareness programs regarding impairment and the notification process, Employers, whether public or private, would also provide important channels for such programs.
- AHPRA exploring strategies to reduce the costs of monitoring for a nurse or midwife with an impairment. In the case of students, this would also need to involve the educational institutions.
- The NMBA working with government and professional colleges and associations to facilitate the establishment of a national support service for nurses and midwives either suspected or found to have a health impairment. These services would also need to involve employers to ensure a clear delineation between more general employee assistance programs (EAPs).

The role of the regulator

It is clear that implementing the proposed service elements will require national discussions with a range of key stakeholders. The realisation of the identified benefits will require some party or parties to take a lead role in instigating a national dialogue amongst relevant stakeholders regarding progressing the service enhancements

A key question therefore is what could or should the regulator's role be in progressing these discussions, given they involve issues beyond the review's objective in advising the regulator on its specific regulatory roles and responsibilities. The fact that the regulatory system is impacted by these areas adjacent to its direct regulatory responsibilities, an effective support program being a case in point, may provide a sufficient rationale for the NMBA to either lead or

facilitate such discussions. Additionally, there are significant potential benefits in relation to regulatory costs associated with the suite of enhancements identified here (for example, through reducing the severity of health impairment cases brought to the regulator's attention).

Tied to the question of implementation responsibility is that of funding. Potential contributing sources include government(s), professional colleges and association member's fees, employers and registration fees as collected by the regulator.

While a proportion of nursing and midwifery registration fees provide a single and national funding source that would cover all registrants, there are issues associated with regulator funded services, particularly in relation to the provision of support services. Most prominent is the concern that these may not be perceived as sufficiently independent from the legislated and largely disciplinary functions of the regulator, which could make nurses and midwives reluctant to access such services.

There is also the risk that regulator funded support services may divert attention away from regulatory oversight, which could lead to health impaired nurses midwives not practising safely. If it were decided that registration fees were the most appropriate source of funding for the support service enhancements, strong independent governance arrangements and processes would need to be put in place to ensure escalation to the regulator of impairment issues that posed a risk to the public under the provisions of the National Law.

The nature and ultimate level of regulatory involvement in implementing and/or funding additional services, and the benefits represented will also depend on the extent to which any systemic arrangements are able to be effected through government programs, employers and/or professional colleges and associations.

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Appendix A Stakeholder organisations interviewed

Table A1 **Stakeholder organisations**

Jurisdiction	Stakeholders
Australia	
Australia-wide	▪ Medical Radiation Board of Australia* ▪ Psychology Board of Australia ▪ Pharmacy Board of Australia ▪ Australian College of Nurses ▪ Australian College of Midwives ▪ Australian and Nursing Midwifery Federation* ▪ Royal Australian College of General Practitioners ▪ Australian Nursing and Midwifery Accreditation Council ▪ Commonwealth Chief Nursing and Midwifery Officer ▪ Commonwealth Department of Health ▪ Max Solutions ▪ AHPRA National Compliance Commissioner
Victoria	▪ Nursing and Midwifery Health Program Victoria ▪ Victorian Department of Health Chief Nursing and Midwifery officer ▪ Victorian Doctor's Health Program ▪ Australian Medical Association (AMA) Victoria ▪ Victorian Nursing and Midwifery Board of Australia ▪ AHPRA Victorian Manager of Health and Performance
New South Wales	▪ NSW Nursing and Midwifery Board of Australia ▪ Medical Benevolent Association (NSW) ▪ Impaired Registrant's Health Program (NSW) ▪ Health Care Complaints Commission ▪ NSW Nursing and Midwifery Council ▪ NSW Health: Hunter New England Local Health District – HNE Mental Health Service ▪ AHPRA NSW Director of Notifications
Western Australia	▪ WA Department of Health Chief Nursing and Midwifery officer ▪ Western Australian Nursing and Midwifery Board of Australia ▪ AHPRA Western Australia Director of Notifications
Australian Capital Territory	▪ ACT Department of Health Chief Nursing and Midwifery officer
South Australia	▪ South Australian Nursing and Midwifery Board of Australia ▪ South Australia's Doctor's Health Advisory Service ▪ South Australian Department of Health, Principle Nurse and Midwife Adviser ▪ AHPRA South Australia State Manager
Northern Territory	▪ Northern Territory Nursing and Midwifery Board of Australia ▪ AHPRA Northern Territory Director of Notifications
Tasmania	▪ Acting Chair of the Tasmanian NMBA ▪ AHPRA Tasmania Director of Notifications
Queensland	▪ Queensland Nursing and Midwifery Board of Australia ▪ Office of the Health Ombudsman ▪ AHPRA Queensland Director of Notifications
International	
All international stakeholders	▪ Canadian Medical Protective Association ▪ National Clinical Assessment Service (NCAS) (UK) ▪ Medical Protection Society (UK) ▪ Irish College of General Practitioners ▪ Medical Council of New Zealand ▪ Midwifery Council of New Zealand ▪ Dental Protection, London* ▪ British Columbia's Early Intervention Program (Canada) ▪ Minnesota's Health Professional Services Program (US)

Note: *Refers to submissions

Source: ACIL Allen Consulting

Appendix B Health support services

Provided in the table below is a list of health support services identified as part of this review.

Table B1 **National and international health support services**

Health program	Jurisdiction	Health profession	Services	Funding arrangements
		Australia		
Victorian NMHPV	Victoria	Nursing and midwifery	▪ Case management ▪ Referral to other health practitioners for treatment ▪ Helpline ▪ Nurse-led counselling ▪ Online information ▪ Prevention and education ▪ Research	NMBA under a transition legacy
Victorian Doctor's Health Program	Victoria	Doctors	See Victorian NMHPV	▪ Medical Practitioners Board of Australia ▪ Universities ▪ Medical Benevolent Associations
South Australian Doctor's Health Advisory Service	South Australia	Doctors	▪ GP led counselling (after hours) ▪ 24-hour phone service ▪ Online information ▪ Education and prevention ▪ Research	▪ Paid for by clients
Impaired Registrant's Health Program	New South Wales	Doctors	▪ Doctor-led counselling	▪ NSW Medical Council
Medical Benevolent Association	New South Wales	Doctors	▪ Counselling ▪ Financial assistance ▪ Recommendation to other health practitioners	▪ Donations
		International		
Irish College of General Practitioners - Health in Practice Programme	Ireland	General Practitioners	▪ Healthcare and mental health services ▪ Telephone helpline ▪ Information and advice ▪ Medical education ▪ Research	▪ Irish College of General Practitioners
Dentists Health Support Programme	London, UK	Dentists	▪ Counselling provided by dentists with previous health impairment issues	▪ Dentists Health Support Trust (independent of the Dental Association Committee)
Royal College of Nursing -Counselling	UK	Nurses	▪ Telephone service ▪ Face to face counselling by appointment ▪ Online information	▪ Royal College of Nursing membership fees
Health Professionals Services Program (HPSP)	Minnesota, US	18 professions and health departments including nursing	▪ Case management ▪ Face to face counselling ▪ Health assessments ▪ Education and promotion ▪ Monitoring	▪ 98 per cent of HPSP funding comes from health-licensing boards
Early Intervention Program	British Columbia, Canada	Nurses	▪ Medical assessment ▪ Referral to an appropriate medical practitioner ▪ Monitoring	▪ College of Registered Nurses of British Columbia

Source: NMHPV 2014; Irish College of General Practitioner's 2014; RCN 2014; HPSP 2012; CRNBC 2014, 2014a, 2014b, 2014c