Evaluation of the pilot of the Mental Health Nurse Incentive Program in the Private Hospital Setting

ACCOMPANYING REPORT 1: SURVEY FINDINGS

presented to

The Department of Health and Ageing

by

The Australian Institute for Social Research

THE UNIVERSITY
OF ADELAIDE
AUSTRALIA

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1 EXECUTIVE SUMMARY

1.1 Introduction

The Australian Institute for Social Research (AISR) was commissioned by the Nursing Section of the Department of Health and Ageing, Canberra to evaluate the Piloting of the *Mental Health Nurse Incentive Program* (MHNIP) in private hospital settings. Specifically, the Department sought these four outcomes from the evaluation.

- o Development of an evaluation framework for Piloting the inclusion of private hospitals as eligible organisations under the Mental Health Nurse Incentive Program.
- o Development of data collection tools to undertake research.
- o Analysis of data collected across the Pilot sites including, but not limited to:
    - ⇨ Analysis of patient outcomes;
    - ⇨ Analysis of participant (ie. mental health nurses, general practitioners and psychiatrists) outcomes;
    - ⇨ Analysis of the views of Mental Health Nurses (ie. has the Pilot contributed to improvement in patient care).
- o Submission of a final report outlining the effectiveness of the Pilot and options for future program enhancements.

The review has focused on six of a possible seven Pilot sites. These are located in –
- • Adelaide
- • Perth
- • Taree
- • Toowong
- • Warrnambool
- • Essendon (their Mental Health Nurse began employment in the second half of March 2009. The evaluators have interviewed the psychiatrist attached to the Essendon Pilot site, and obtained *preliminary* data for the Review from the Mental Health Nurse, the psychiatrist and six clients).

The key components of the review methodology have involved:

- o Development of an Evaluation Framework to structure the review (see Section 2.1.1).
- o Design of a user-friendly data collection tool for sites to document service data (see Section 2.1.2).
- o Design of a Service Profile Matrix (see Section 2.1.4).
- o Visits to all participating sites by the project team. These visits were structured to familiarise the evaluators with the particular interpretation of the MHNIP model adopted by that site and the reasons underlying the design of that model, to obtain qualitative feedback about the program, challenges being faced and how these were being addressed, successes and the reasons for these, and other issues. Each team member was allocated specific responsibility for a particular site (s) to enable a positive working relationship to be developed between the evaluators and the sites, and

to support ongoing communication. All Mental Health Nurses and Coordinators (the latter have been appointed by two sites) were interviewed at length during these visits (see Section 2.1.3).

o   Analysis of Medicare data relating to MHNIP Pilot sites (see Section 2.1.5).

o   Design of three survey instruments to quantify feedback from Mental Health Nurses (and Coordinators, where these have been appointed), from referring Psychiatrists and GPs (although there were few of the latter involved in this Pilot), and from clients (see Section 2.1.6).

o   Analysis of all findings.

o   Reporting. A number of specific reports have been provided throughout the Review, including this report of Survey Findings. These are designed to be read as accompanying reports to the Final Report of all findings.

Findings from the three surveys are presented in detail in this Survey Report, showing separately findings from the survey with clients, the survey with referring psychiatrists and GPs, and the survey with Mental Health Nurses. A comparative and triangulated analysis of these individual findings is provided as a separate section *(Section 6)*. This Executive Summary presents findings thematically, and focuses on the triangulated findings.

1.2   Survey sample and response rates

As the table below shows, 16 out of 19 Mental Health Nurses and Coordinators have responded **(84.2%)**, and that 119 out of 226 clients contacted **(52.7%)** have completed a survey together with 24 out of 70 **(34.3%)** referring psychiatrists and GPs. **These are very positive response rates and the evaluators have confidence that a representative sample has been achieved.**

Sample by site and stakeholder group

Site	Mental Health Nurse / Coordinator Survey		Survey of Referring Psychiatrists and GPs		Survey of Clients		Total
	N	% of sample	N	% of sample	N	% of sample	N
Ramsay Health Care, Adelaide	3	18.8	6	25.0	28	23.5	37
Essendon Private Hospital	1	6.3	1	4.2	6	5.0	8
Perth Clinic	3	18.8	1	4.2	15	12.6	19
Mayo Private Hospital, Taree	2	12.5	3	12.5	14	11.8	19
Toowong Private Hospital	4	25.0	7	29.2	35	29.4	46
St John of God Hospital, Warrnambool	3	18.8	(Psych) 1	(Psych) 4.1	21	17.6	30
			(GPs) 5	(GPs) 20.8			
Total	16	100.0	24	100.0	119	100.0	159

Note. St John of God Hospital was the only site to provide responses from GPs. These are shown separately in the Table. Results of the surveys for Psychiatrists and GPs were analysed as a group as there were too few GP surveys for separate analysis.

When interpreting the results from these surveys, note that the experiences of sites with a larger scale MHNIP operation will be better represented in the results than the experiences of smaller sites, simply as a consequence of the number of survey returns.

On a site basis, the highest response rates for Mental Health Nurses and Coordinators (100%) came from the Adelaide, Perth, Taree and Warrnambool sites. The highest response rates from Psychiatrist and GP surveys (100%) came from the Essendon and Taree sites, and the highest Client survey response rates came from the Adelaide site (90.3%) and from the Toowong site (70%).

St John of God Hospital in Warrnambool was the only site to distribute surveys to both Psychiatrists and GPs (all others only included Psychiatrists). Response rate was different between these two groups with one of two Psychiatrists returning the survey while only five of 23 GPs (21.7%) responded. However, it is suggested that the low GP response rate may be partially accounted for by the inclusion of GPs who had not yet participated in the Program.

1.3   The Project Model

A key part of the evaluation has involved an analysis of the Pilot Model – its appropriateness and effectiveness, strengths and weaknesses. During site visit interviews, **18** possible strengths and **7** possible weaknesses of the model were identified and these were used to structure a series of five point rating scales to quantify agreement or disagreement.

1.3.1   Strengths and Weaknesses of the Model

A guiding question for this Review has been whether or not the model represented by the MHNIP Pilot in the private mental health service setting is appropriate and effective, and related to this, which of its features represent strengths and which represent weaknesses or areas needing improvement.

> **Qualitative and quantitative feedback from the three main key stakeholder groups – clients, Mental Health Nurses and Coordinators, and referring psychiatrists and GPs – has identified strong endorsement of the model underpinning the MHNIP Pilot in private mental health settings. This is seen to benefit clients and their significant others as well as the private mental health system.**

Strengths

During site visit interviews, **18** possible strengths of the model were identified and these were used to structure a series of five point rating scales to quantify agreement or disagreement.

The key features of the Pilot model which have been identified strongly as Benefits and Strengths by Mental Health Nurses and Coordinators, and by referring psychiatrists and GPs, are summarised in the Figure below. The close agreement between both stakeholder groups is evident, with identical ratings on a number of dimensions, and very close ratings for the remaining dimensions. The features receiving the highest (more than '4') and most similar ratings were (in order of strength of ratings) –

   o   Provision of earlier and more effective crisis intervention
   o   MHNs fill a gap in the private mental health system
   o   Access for clients unable to access or rejected by the public mental health system
   o   Provision of support and continuity for clients in hospital for mental health issues
   o   Enabling of more holistic care

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- o   Provision of a free service to clients
- o   Provision of access for clients to an increased range of mental health services
- o   Enhanced access for clients through home-based service delivery
- o   Resource effectiveness achieved by the MHN substituting for psychiatrist or GP time
- o   Expected reduction in hospital admissions for mental health issues
- o   Flexible program guidelines support innovative service provision
- o   MHN role in medication monitoring reduces GPs' time spent on this
- o   MHN role in medication monitoring reduces psychiatrists' time spent on this
- o   Expected reduction in hospital stay length of stay for mental health issues.

The majority of Mental Health Nurses and Coordinators endorsed all 18 features of strength. Those that received the **lowest** ratings relate to the capacity of the MHNIP in private settings to enhance access to mental health services for people from **Indigenous** backgrounds (average rating **2.78**) or people from **diverse cultural** backgrounds (average rating 3.93). The capacity to **streamline access to psychiatrists** also received a relatively lower average rating (3.80).

> **From these findings, the evaluators conclude that there is agreement between Mental Health Nurses and Coordinators, and Psychiatrist and GPs about the strengths of the MHNIP model, and that that these relate to 17 out of 18 possible positive features.**

The following **strengths** were identified by more than one of 108 **(91%)** clients (the remaining 11 did not respond to this question) –

- o   The opportunity provided to discuss problems and issues with the Mental Health Nurse, and to receive constructive feedback about these (n = 55)

- o   The provision of regular, frequent and ongoing communication, support and monitoring (n = 16)

- o   The education provided to clients, including about medication and its managements (n = 13)

- o   The quality of the care provided and skills of the Mental Health Nurse (n = 11)

- o   The continuity of care provided (n = 10)

- o   Reduced social isolation (n = 10)

- o   The accessibility and responsiveness of the program, particularly due to the provision of home visits (n = 8)

- o   Reduced reliance on GPs and psychiatrists (n = 6)

- o   Reduced reliance on family and a consequent reduction in burden on families, together with the support provided to family members (n = 6)

- o   The client focus and tailoring of care to individual need (n = 3)

Ratings of the strength of the program in the private setting

■ MHN or Coordinator ■ Psychiatrist or GP

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An unexpected finding for the evaluators has been the Pilot's provision of access to services for those unable to or rejected by the public mental health system.

Less surprising has been confirmation of the gap being filled by Mental Health Nurses, the enhanced capacity for early and more effective crisis intervention, the provision of more holistic care and access to an increased range of services.

Weaknesses

Site visits also identified **7** weaknesses in the pilot model .The key Weaknesses associated with the Pilot model that were identified strongly by Mental Health Nurses and Coordinators, and referring psychiatrists and GPs, are summarised in the figure below

Comparative ratings of the MHNIP model's weaknesses

It can be seen that the strongest agreement about the main weaknesses of the MHNIP exists in relation to funding (rather than about the model itself) –

⇨ **Lack of Medicare funding for case management meetings and discussions between Mental Health Nurses and Psychiatrists**, closely followed by
⇨ **Reliance on the auspice's infrastructure due to a lack of dedicated funding for accommodation, cars and related supports.**

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Close agreement also exists about the following –

⇨ Insufficient and ineffective **promotion of the MHNIP to GPs**, resulting in them having under-developed understanding of the Program.
⇨ Insufficient and ineffective **promotion of the MHNIP to psychiatrists**.
⇨ **Lack of Medicare funding for Mental Health Nurses to undertake coordination or follow-up work** with clients.
⇨ **Rigidities in Medicare funding guidelines** that require servicing of two clients within one half day session – presenting particular difficulties for those in rural areas travelling to and from clients' homes.

The widest gap in average ratings related to the **temporary and unpredictable status of being a Pilot** (making planning and recruitment difficult). This was rated as being more of a problem by Mental Health Nurses, than by psychiatrists and GPs as being a key defect.

> The weaknesses endorsed by Psychiatrists and GPs are not associated with the design of the Pilot model, but with its funding which is seen as limited and unrealistic, and with the uncertainties associated with pilot status. By contrast, the strengths identified lend significant support to the model itself, its positive impact on clients and the gap being filled in the private mental health system. These findings are also reflected in the feedback provided by Clients.

If the Pilot receives ongoing funding, the issue of Medicare funding will need to be addressed. At present, this is not reflecting all of the roles of the Mental Health Nurse that have been identified by the three groups of stakeholders consulted – for example, case management, communication with psychiatrists and GPs The issue of funding to cover infrastructure support will also need to be addressed.

It can be reasonably expected that abandonment of Pilot status will see more effort being put into promoting the MHNIP to GPs and psychiatrists, including promoting the fact that it is no longer a Pilot. At this stage, significant promotion would have been inappropriate because it could raise expectations without ongoing provision of the Program's services.

The lowest assessment of capacity has been for the Pilot filling a gap in mental health services for Indigenous people. However, there has been no Indigenous-specific provision made so this finding is not surprising. Similarly, capacity to enhance access for people from culturally and linguistically diverse backgrounds has received a relatively low rating. Without specific provision designed for these target groups, the model is unlikely to achieve this outcome.

Two main **weaknesses** were identified by more than one of 35 **(29%)** clients -

o The need for the program to be **better resourced** (n = 14)

o Accessibility, including the need for the program to offer services **outside of normal hours**, and for some clients, the distance between home and the clinic (n = 11).

> The evaluators have concluded that clients regard the MHNIP model as having more strengths than weaknesses, and improvements suggested actually support the existing model by seeking increased resourcing to continue it, with minor modifications to service delivery.

> It is clear that on balance, there are far more strengths than weaknesses identified, and where weaknesses exist, they relate primarily to *resourcing* and not to the design of the Pilot model or service delivery issues.

1.3.2   Responsiveness and Flexibility

When initially referred, **63.0%** of clients saw the Mental Health Nurse **within one week**, including 13 (10.9%) seen on the day of their referral and 62 (52.1%) who waited up to a week. Some clients (16.8%) were unable to indicate how long they waited, while 20.2% stated that they had waited for more than one week – see Figure below.

These rates indicate a responsive service, providing significantly shorter waiting times than would occur in relation to seeing a psychiatrist.

Waiting time to see MHN for first time
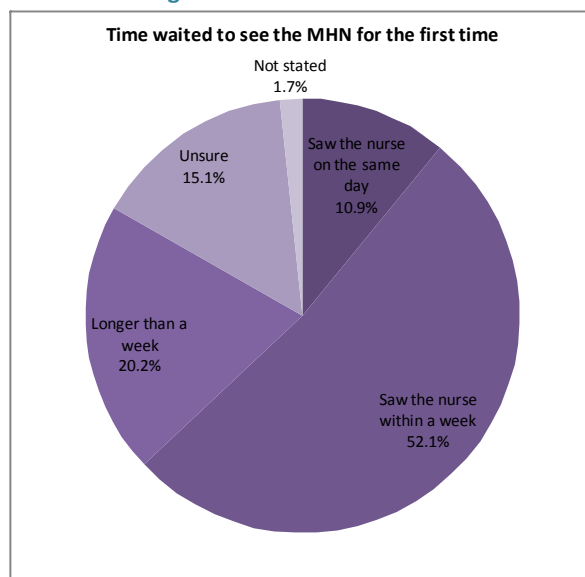
Time waited to see the MHN for the first time

In addition, clients were receiving a **significant amount of telephone based support** from the Mental Health Nurse. This varied from once a week (13.4%), to once a fortnight (18.5%), once a month (25.2%) and less than once a month (21.0%). A further 16.0% had never had telephone contact with the Mental Health Nurse.

Feedback from psychiatrists and GPs showed agreement about the MHNIP providing clients with continuity of support and holistic care – as the two following Figures illustrate.
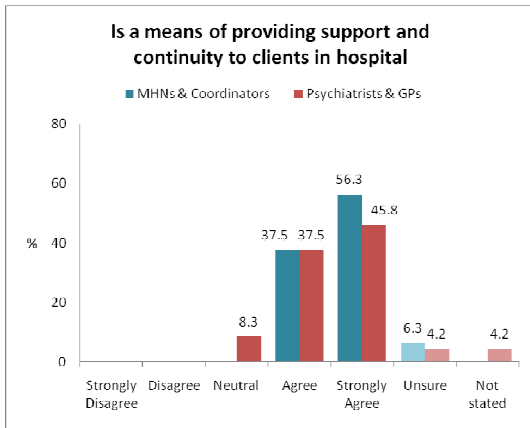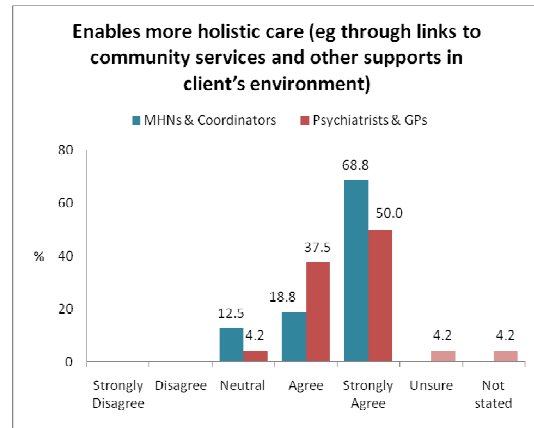
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Provides continuity of support

Is a means of providing support and continuity to clients in hospital

Enables holistic care

Enables more holistic care (eg through links to community services and other supports in client's environment)

These findings indicate that the MHNIP services have been very responsive and supportive to their clients, providing significantly shorter waiting times than would occur in relation to seeing a psychiatrist.

1.3.3 Accessibility

The provision of home visits separates the MHNIP model from usual private mental health services, especially those provided by psychiatrists and other mental health specialists. **Home visits** from the Mental Health Nurse were being received by **64.7%** of these clients. This was occurring once a week for 13.4%, once a fortnight for 28.6%, once a month for nearly 14.3% and less than once a month for nearly 7.6%. **This finding suggests that the MHNIP model offers significant *accessibility* and *flexibility* in its mode of delivery.**

Feedback from psychiatrists and GPs showed agreement about the MHNIP providing clients with access to an increased range of services to enhanced access through home-based services and to a free service

Free service
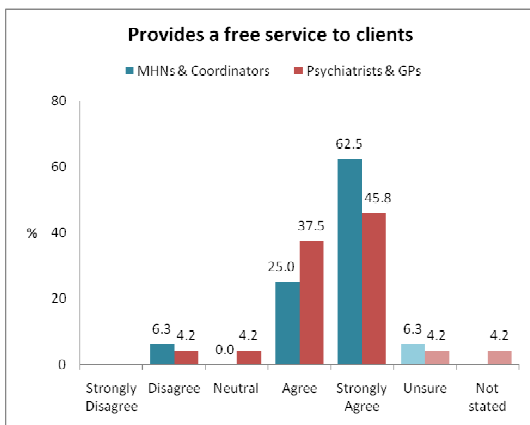
Provides a free service to clients

Increased range of services

Clients have access to an increased range of mental health services

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Accessibility is greatly enhanced through provision of home based service

■ MHNs & Coordinators   ■ Psychiatrists & GPs
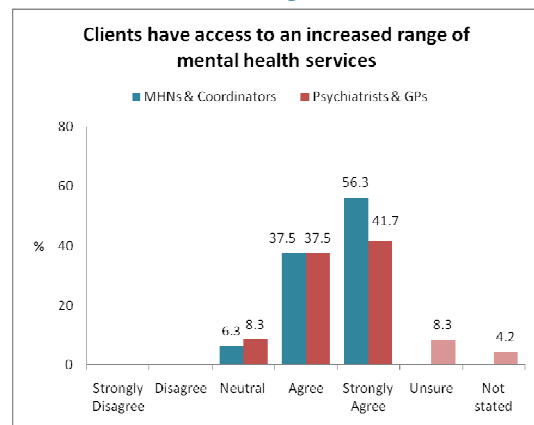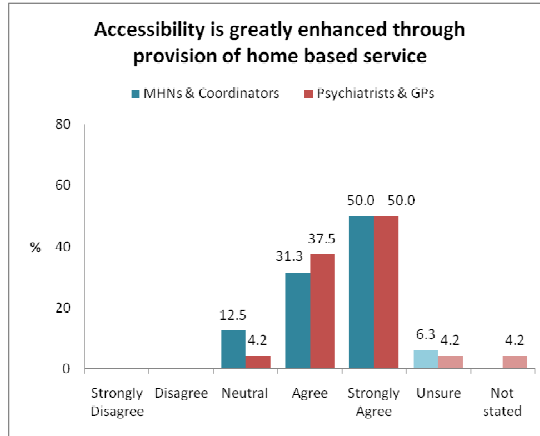
Feedback from Mental Health Nurses identified the following two key advantages of providing services in clients' homes are –

i. **increased accessibility for clients who find it difficult to visit clinics** (93.8%) – this was also supported by clients in their feedback - and

ii. the gaining of **additional, important information that assists in assessment and treatment** (93.8%).

However, this model brings **risks for Mental Health Nurses associated with travel and safety** which the clinic-based model avoids (81.3%) and is considered to be **less cost-effective than clinic-based delivery** (68.8%) due to time and costs associated with travel.

Advantages and disadvantages of a clinic versus home-visit based model of delivery
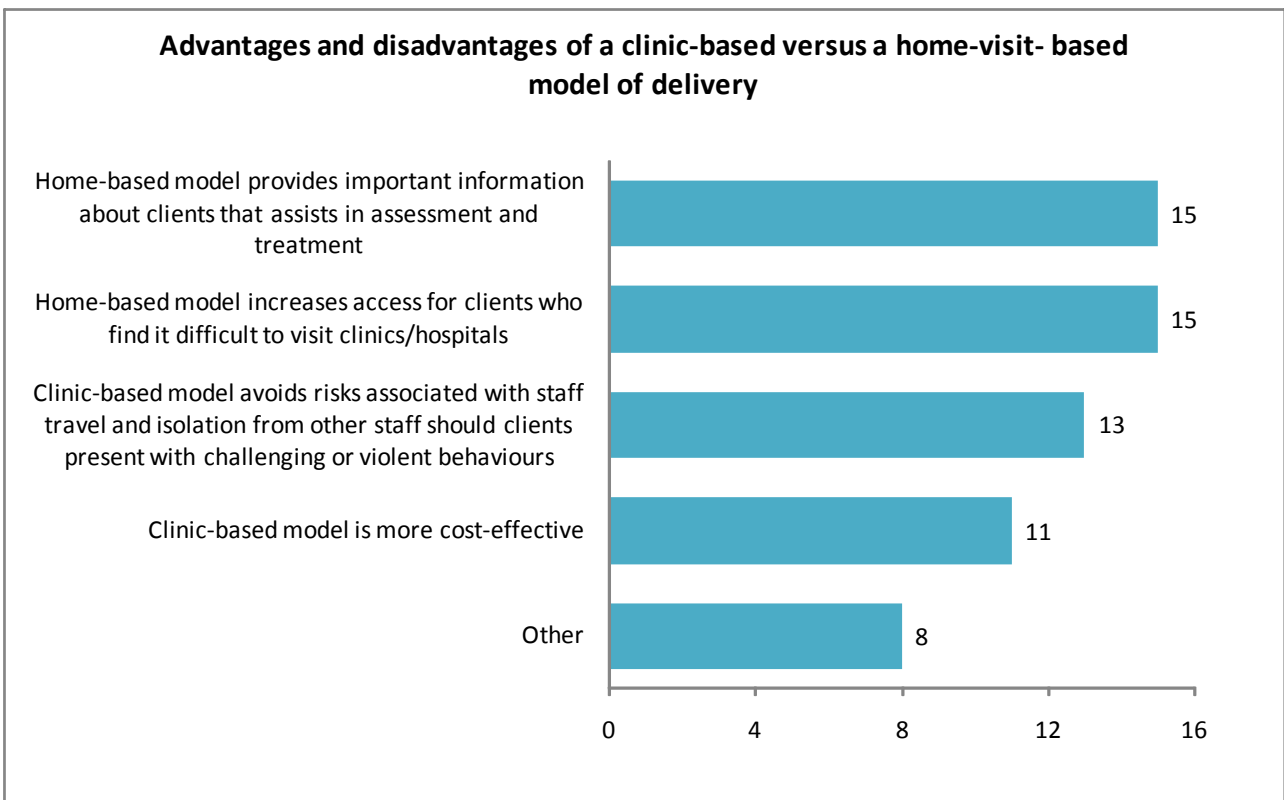
Advantages and disadvantages of a clinic-based versus a home-visit- based model of delivery

Home-based model provides important information about clients that assists in assessment and treatment — 15

Home-based model increases access for clients who find it difficult to visit clinics/hospitals — 15

Clinic-based model avoids risks associated with staff travel and isolation from other staff should clients present with challenging or violent behaviours — 13

Clinic-based model is more cost-effective — 11

Other — 8

Note. Multiple responses possible

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Clearly, most of the sites have adopted a **hybrid model** to maximise the advantages and minimise the disadvantages, with the exception of the Perth site which has provided most of its services to date in the clinic setting. Sites vary in relation to the **proportion** of home visits to clinic visits made by Mental Health Nurses.

1.3.4   Appropriateness

Eighty-six clients **(72.3%)** stated they were receiving the appropriate amount of contact with the Mental Health Nurse, only one person wanted less contact, and 30 (25.2%) were seeking a greater amount of contact –see Figure below. Of the 30 clients seeking more contact, 14 wanted more home visits, 14 also wanted more telephone contact and 11 wanted more clinic based contact. **These findings indicate a high level of client satisfaction with the amount of contact being provided.**

Description of the amount of contact with MHN
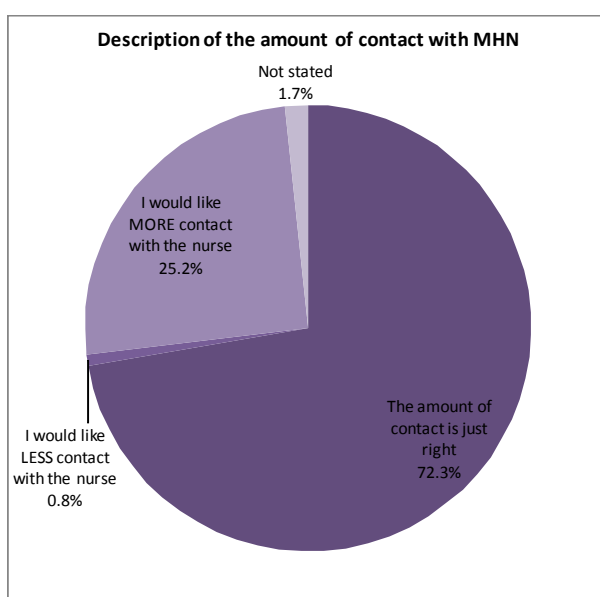
These findings indicate a high level of client satisfaction with the amount of contact being provided.

Feedback from psychiatrists and GPs, and from Mental Health Nurses, regarding the strengths of the MHNIP model, also endorses the model as being highly appropriate.

1.3.5   Effectiveness

Using a five-point Likert scale, clients were asked to rate the service they had been receiving on six of dimensions. None of the clients provided negative ratings ('Poor' or 'Very Poor') to any of the six dimensions explored, and the ratings applied have been very high – with approximately 97% of clients rating the Pilot as 'Very Good' to 'Excellent'. As the Figure below illustrates, the lowest mean rating was **4.4** and the highest **4.7**. As the detailed responses indicate, **extremely positive** ratings have been applied to all six (*see Figure 30 to 35*)–

➪ **Respect for the client as an individual** (68.1% rated this as Excellent and 26.9% as Very Good)
➪ **Overall quality of service received** (66.4% rated this as Excellent and 27.7% as Very Good)
➪ **Maintenance of client privacy** (63% rated this as Excellent and 29.4% as Very Good)
➪ **Accessibility** (57.1% rated this as Excellent and 35.3% as Very Good)
➪ **Responsiveness to client need** (54.6% rated this as Excellent and 37% as Very Good)
➪ **Flexibility in responding to changing client need** (50.4% rated this as Excellent and 37% as Very Good).

It is concluded from these findings that clients regard the MHNIP's service provision in the most positive terms.

Rating of services provided by the MHNIP
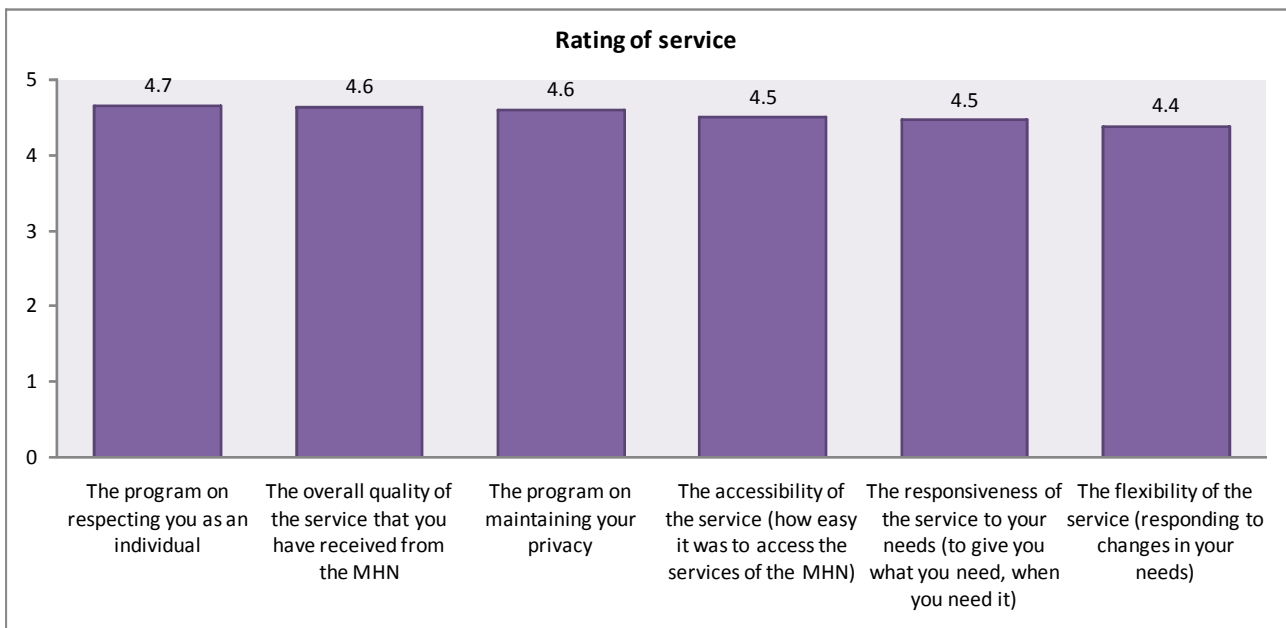
There were no statistically significant differences (ANOVA) for any of these variables between sites (anova) or based on gender (t-test).

It is concluded from these findings that clients regard the MHNIP's service delivery as effective, accessible, flexible, responsive and appropriate.

Feedback from psychiatrists and GPs, and from Mental Health Nurses, regarding the strengths of the MHNIP model, also endorses the model as being highly effective.

1.4 Outcomes and Impact

1.4.1 Overview of findings on outcomes and impact

Qualitative and quantitative feedback from the three main key stakeholder groups – clients, Mental Health Nurses and Coordinators, and referring psychiatrists and GPs – has identified strong endorsement of the model underpinning the MHNIP Pilot in private mental health settings. This is seen to benefit clients and their significant others as well as the private mental health system. The Mental Health Nurse role has been found to fill a gap in the private health system, and to have had an extremely positive impact on clients and to have brought a number of benefits to referring psychiatrists and GPs. This positive impact is seen by all three groups of stakeholders as able to be extended through resourcing improvements.

1.4.2 Impact on clients

In relation to the perceived impact of the MHNIP on clients, Mental Health Nurses and Psychiatrists and GPs show their strongest agreement about the Program's capacity to –

- o Assist clients to make more effective use of health care, social and community services and resources.
- o Improve quality of life (eg due to broader improved focus on psychosocial issues, linkages made to other services).
- o Increase compliance with medication.
- o Reduce symptoms.
- o Reduce length of inpatient stay.
- o Reduce frequency of sessions with psychiatrists.
- o Reduce need for psychiatric review.
- o Reduce hospital admissions and readmissions.
- o Reduce burden of care for clients' families and significant others (which was also identified by clients).
- o Improve general functioning in everyday life.

The remaining six features of impact are not marked, as is evident from the following Figure.

The evaluators conclude that there is a high level of agreement between Mental Health Nurses and Psychiatrists and GPs about the positive impact of MHNIP services on clients, which in turn supports the underpinning model.

Impact on clients of the engagement of a MHN
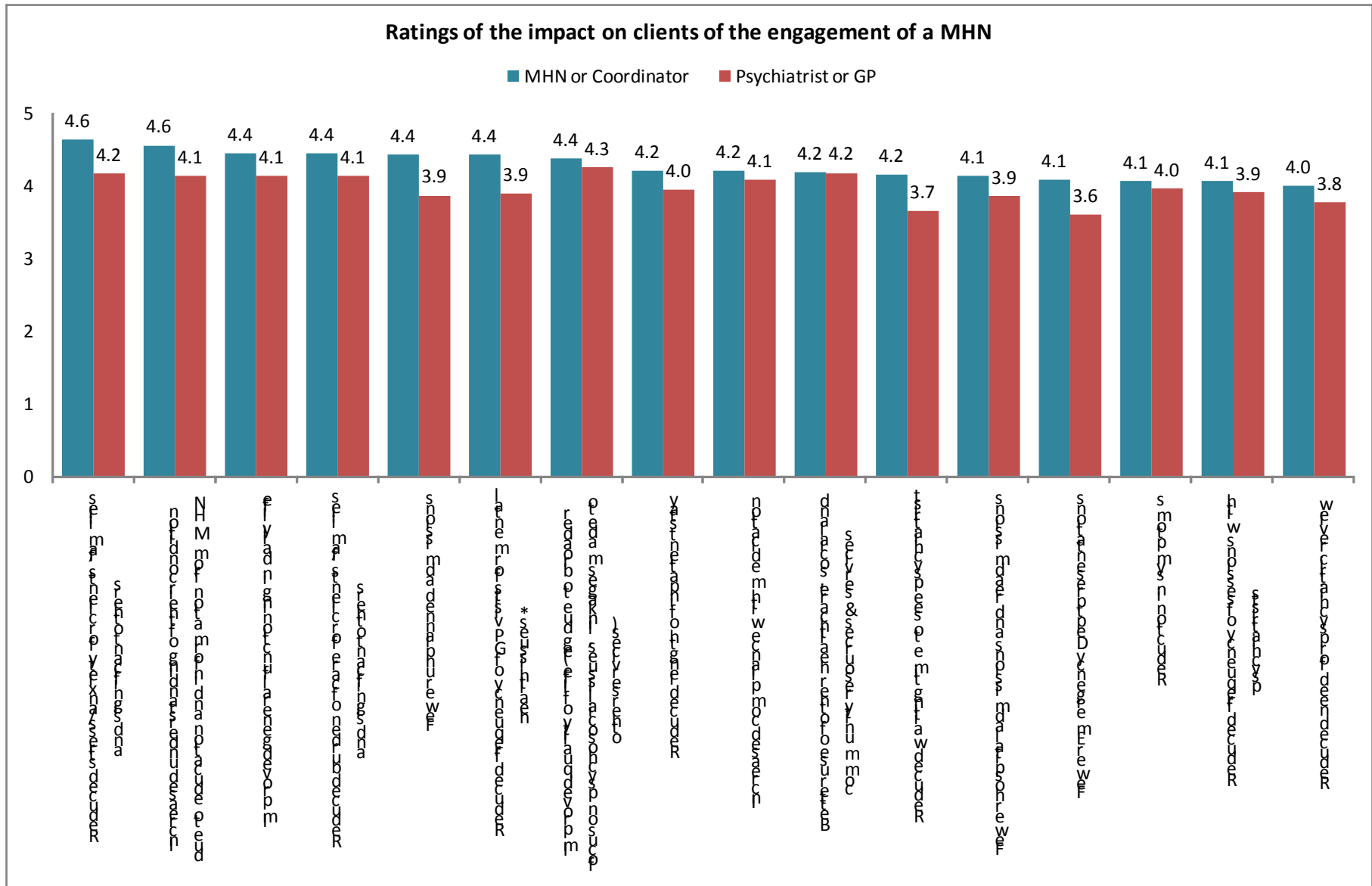
Ratings of the impact on clients of the engagement of a MHN

■ MHN or Coordinator   ■ Psychiatrist or GP

Category	MHN or Coordinator	Psychiatrist or GP
1	4.6	4.2
2	4.6	4.1
3	4.4	4.1
4	4.4	4.1
5	4.4	3.9
6	4.4	3.9
7	4.4	4.3
8	4.2	4.0
9	4.2	4.1
10	4.2	4.2
11	4.2	3.7
12	4.1	3.9
13	4.1	3.6
14	4.1	4.0
15	4.1	3.9
16	4.0	3.8

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Clients concurred with the assessments of Mental Health Nurses and Psychiatrists and GPs about the value of the program with 84.0% agreeing that the program improved general daily life functioning, and 79.0% agreeing that their quality of life improved because of the program. Their views concurred more closely with those of the GPs and psychiatrists than with the Mental Health Nurses, and findings include the following (see Figure below). When the views of all three stakeholder groups are analysed -

o   There is a high degree of congruence regarding **symptom reduction** for all three groups (62.5% psychiatrist or GP, 68.1% Mental Health Nurse, 68.8% client).

o   Over three-quarters of all three groups perceive an **improvement in both daily functioning and overall quality of life.**

o   Over 55% of all three groups specified a **reduction in hospital admissions** as an outcome.

o   Approximately 60% of all clients and doctors specified reduced frequency of visits to psychiatrists and GPs, with Mental Health Nurses reporting the highest impact in this area.

o   The least agreement related to reduced length of stay - 75% of Mental Health Nurses, 58% of GPs and psychiatrists but only 26% of Clients (however 44% of clients specified 'unsure'.)

Provider and client assessment of impact of MHNIP

It is evident that all three groups, representing the key stakeholders in the MHNIP, have positive views about the impact of the program on client outcomes. This is despite the difficulties associated with implementing the program as a pilot.

1.4.3   Impact on referring psychiatrists and GPs

Psychiatrists and GPs were asked to quantify the outcomes resulting from referring clients to the MHNIP Pilot. Most of those surveyed believe that the Pilot has had a number of positive outcomes, specifically, in relation to:

⇨   Increased **capacity to deal with complex cases** for **79.2%** (but no impact for 16.7%).

⇨   More **timely response to acute or emergency presentations** for **66.7%** (but no impact for 29.2%).

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⇨ Increased **liaison with others involved in client's care** for **62.5%** (but no impact for 20.8% and a reduced impact for 12.5%).

There were a number of effects that have been positive for some but not for others. These involve:

⇨ Increased capacity to see new clients for 50.0% but no impact for 50.0%.[1]
⇨ Time spent in case conferences and similar meetings has increased for 50.0%, decreased for 12.5% and had no impact for the remaining 37.5%. (While this may be seen as additional time, it can also be seen as time well spent in terms of coordination of care and client outcomes.)

There were also a number of aspects of MHNIP related service provision for which **no impact** had occurred for the majority of those surveyed. These involve –

⇨ Extent of contact with clients' families (66.7%) – with a decrease for 20.8% and an increase for 12.5%.
⇨ Time spent in case planning (50.0%) – with an increase for 37.5% and a decrease for 12.5%.
⇨ Amount of paperwork (50.0%) – but an increase for nearly 37.5% and a reduction for 8.3%.

These differences in impact appear to be site based and may also reflect individual approaches to service delivery.

> **It is concluded that the MHNIP model has had benefits for referring GPs and psychiatrists that involve an increased capacity to deal with complex cases, more timely response to acute or emergency presentations, and increased liaison with others involved in clients' care. No impact was discernible on contact with clients' families, time spent in case planning and amount of paperwork. There were also differences in impact from one site to another.**

1.5   Role of the Mental Health Nurse

The Pilot is trialling the provision of Mental Health Nurses in private mental health settings, and because this is an innovative strategy, the evaluation has been designed to quantify the dimensions of that role. All three stakeholder groups surveyed provided information about their perceptions of that role.

Clients were asked to indicate (from a standardised response list) which activities and services they were receiving from the Mental Health Nurse. (The surveys with Mental Health Nurses and referring Psychiatrists and GPs also asked this question to enable comparative analysis across the three stakeholder groups.) Of the nine roles possible, the three most commonly identified were –

o **Provision of information and advice to assist in self-management of mental health issues (97.5%).**
o **Provision of support not elsewhere received (88.2%).**
o **Help with understanding and managing medication (70.6%).**

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[1] In hindsight, the evaluators consider that the question should have specified impact on current caseload not workload generally, and this may account for the split in responses, with different interpretations made.
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As indicated in the Figure below, Mental Health Nurses and Coordinators have assigned a high degree of importance (average rating of '4' or higher) to 13 of the 15 roles identified, but with the most consistently high levels of importance assigned to the following –

- **Monitoring** clients' mental health and wellbeing (5.0).
- **Face to face** sessions with clients (4.9).
- **Client education**, including in medication and socialisation (4.8).
- **Advice and general information** provision to clients (4.8).
- Meetings and information **exchange with psychiatrists** (4.8).
- Post-discharge **follow up** of clients (4.8).
- **Administration** relating to the MHNIP (4.7).
- **Support and education** to clients and their families (4.6).
- **Referral/linkage** of clients to other services in the community (4.5).
- **Telephone contact** with clients (4.5).

1.6 Mental Health Nurses and Credentialing

MHNIP guidelines require the employment of Mental Health Nurses who hold appropriate credentials, recognised by the Australian College of Mental Health Nurses. Some of the sites have identified the limited supply of these nurses as the key factor for their delayed implementation, and this has been compounded by

the pilot status of the MHNIP in the private mental health setting. A significant proportion of available Mental Health Nurses are in secure employment and unwilling to exchange this for a lack of guaranteed employment – especially if they are in older age groups. However, credentialing is an important quality control mechanism, and a means of formal recognition of the expertise required of Mental Health Nurses.

Mental Health Nurses and Coordinators gave their highest average rating on this issue **(4.3)** to **'This requirement is an important mechanism for quality control'**, and to **'Experience as a MHN is as important as formal accreditation and should be part of MHNIP requirements'**. In other words, while formal qualifications are seen as important, Mental Health Nurses do not want experience to be overlooked in recognising their competency.

They believe that experience can be formally acknowledged through **Recognition of Prior Learning** mechanisms (4.0) and that their **employers should support them to achieve the required qualifications** (4.1).

The sample was divided about whether or not the current shortage of credentialed Mental Health Nurses will decrease over time (average rating 2.7), about whether the current supply of Mental Health Nurses makes this MHNIP requirement difficult to fulfil (3.3) and about whether the time and commitment involved in gaining the required credentials makes it difficult to fulfil (3.2).

1.7   Mental Health Nurses and Employment Conditions

None of the Mental Health Nurses and Coordinators surveyed indicated dissatisfaction with their work. Only one person is neither satisfied nor dissatisfied, **56.3%** are 'Quite Satisfied' and **37.5%** are 'Very Satisfied.

MHN job satisfaction

MHN job satisfaction with role

Neither satisfied nor dissatisfied 6.3%

Very satisfied 37.5%

Quite satisfied 56.3%

Additional open-ended responses, provided by 16 individuals, identified a number of trends in identifying the **most rewarding** aspects of the Mental Health Nurse role. These involve –

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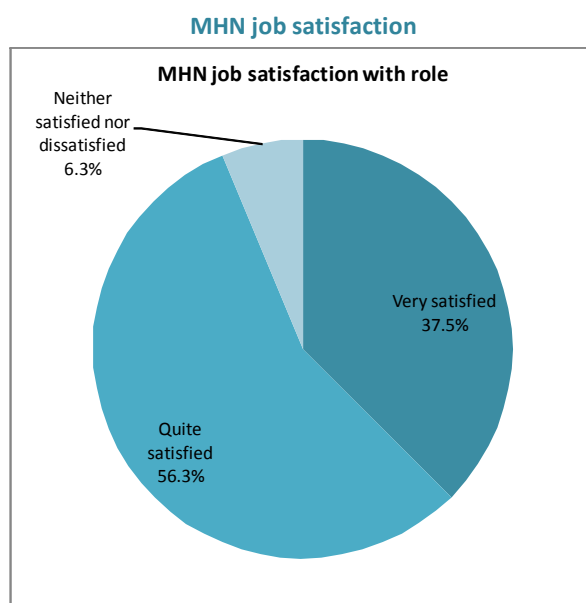
- The positive impact made on clients' health and well being (n = 5)
- The autonomy associated with the work role (n = 4)
- The focus on and contact with clients (n = 3)
- The flexibility associated with the delivery model (n = 3)
- The model itself, including the capacity for innovation, delivery in the home and linkage to the community (n = 3)
- The supportive work environment and respect received from colleagues (n = 3).

Most of the features of the Mental Health Nurse's role that are seen as rewarding arise from the MHNIP model itself. By contrast, the most challenging aspects of this role arise less from the model and more from conditions of employment, and resource limitations.

With regard to working conditions, the Figure below indicates –

- The **lowest** average rating **(3.1)** was applied to **'Opportunities for further training and development',** followed by **'Security of employment'** and **'Salary and financial benefits' (3.2),** and an average of **3.3** to **'Opportunities to develop specialised skills and knowledge on-the-job'**.

- The **highest** ratings were applied to **'Impact on your career' (4.1)** and **'Working conditions' (4.1).**

Average ratings of key features of MHN working conditions

Ratings of conditions associated with role

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> **The evaluators have concluded from these findings that attracting Mental Health Nurses to the private sector requires attention to opportunities for further professional development, job security (which stands in contrast to that of the public sector), and salary and financial benefits.**

It must be remembered that (apart from the currently limited supply of appropriately accredited nurses) many Mental Health Nurses in the public sector are aged in the normal pre-retirement years, and are unlikely to surrender hard earned security and associated employment benefits. For nurses to move to a program like the MHNIP, these conditions and the opportunity to acquire increased skills and knowledge, is a recruitment factor that crosses all age groups.

> **The evaluators have concluded that the Program has scope to build on its existing strengths of providing a valuable career development opportunity together with working conditions (such as, autonomy, flexibility, innovative service delivery) in attracting its workforce.**

1.8   Resourcing

Earlier interviews undertaken by the evaluators found that auspicing organisations were providing significant resources that are of critical importance to the Pilot. The survey with Mental Health Nurses and Coordinators was designed to quantify those resources, and as the Figure below indicates, these confirm the qualitative findings and involve –

- o   Office accommodation (n=16, 84.2%)
- o   Office overheads, such as, phone, fax, computer (n=15, 93.8%)
- o   Administrative services (n=11, 68.8%)
- o   Vehicle/s (n=11, 68.8%)
- o   Access to other services provided by the organisation (n=10, 62.5%)
- o   In-kind support (12.5%)
- o   Other support (12.5%).

Resources provided to support the employment of a MHN

Organisational resources provided to support employment of MHN

Resource	Value
Office accommodation	16
Office overheads (phone, fax, computer etc)	15
Vehicle(s)	11
Administrative services	11
Access to other organisational services	10
In-kind support	2
Other support	2

Note. Multiple responses possible

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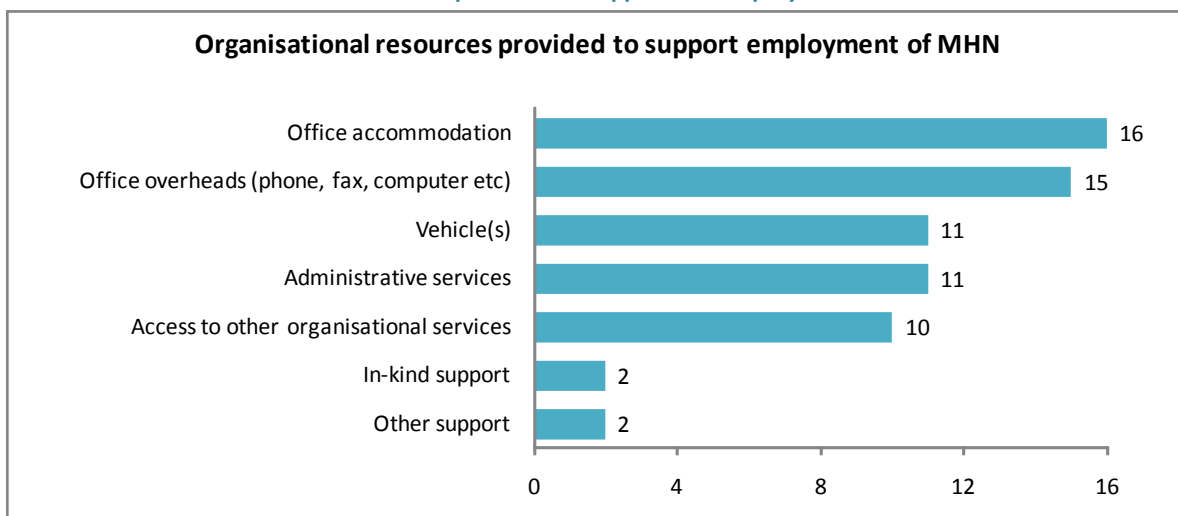
Our site interviews also identified the importance of the auspicing service for **achieving service synergies**, **exchange of resources** and **effective subsidisation** of the MHNIP. Many of those interviewed stated that the MHNIP does not receive sufficient funding to be a stand-alone service. This has been confirmed by survey findings with Mental Health Nurses and Coordinators – see Figure below.
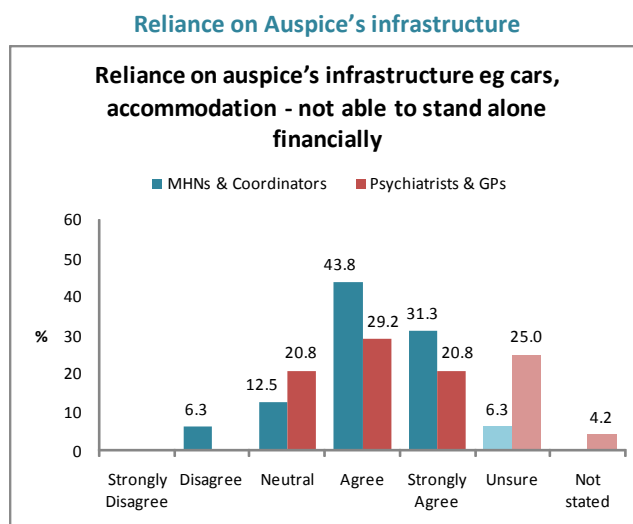
Reliance on Auspice's infrastructure

Acknowledging that case loads can vary with the mix of clients and their needs, Mental Health Nurses and Coordinators were asked to identify the maximum manageable caseload (that is, the maximum number of active clients) of one FTE Mental Health Nurse, averaged over a three month period. The majority (75.0%) have quantified this at between **20** clients (31.3%) and **25** clients (43.8%). They were also asked if they had waiting lists, and the majority (81.3%) do not. The main barriers to expanding the current case load were described as involving –

- o Lack of infrastructure – such as, accommodation, cars (n=11, 68.8%).
- o Time and distance involved in providing home visits to clients (n=9, 56.3%).
- o Difficulties in recruiting accredited Mental Health Nurses (n=8, 50.0%).
- o Administrative and coordination load (n=6, 31.3%).

1.9 Future directions suggested by the survey findings

Survey findings indicate the need to address a number of issues. These foreshadow recommendations that are made in the Final Report for the evaluation and concern –

- o The discrepancy between Medicare funding being provided and what is considered to be the essential roles and responsibilities of Mental Health Nurses in achieving positive outcomes for clients, and for the service system as a whole. The reliance on auspicing organisations to fill gaps in the funding provided.
- o The use of credentialing of Mental Health Nurses as a means of ensuring quality control in service delivery and how this should be supported.

- Difficulties in recruitment of appropriately credentialed Mental Health Nurses and the need for specific strategies to enhance recruitment. The relationship between recruitment capacity and work conditions offered to MHNIP funded Mental Health Nurses.
- The capacity of the MHNIP to manage cultural diversity.
- Promotion of the MHNIP to psychiatrists and GPs.
- Accountability requirements associated with Medicare funding.

1.9.1 Funding issues

Qualitative feedback from the sites indicates that funding limitations mean that, at best, Pilot sites will break even, but when the contribution by auspicing organisations is taken into account, current funding does not cover the actual costs of service delivery. Survey findings have been clear in identifying the reliance on auspicing organisations to fill funding gaps, particularly in relation to infrastructure costs (for example, those associated with motor vehicles which are essential to a home-based delivery model).

There will always be important service synergies between the auspicing organisation and the MHNIP, some of which will be in-kind and difficult to measure, and some of which will involve a mutually beneficial exchange of resources and subsidisation of MHNIP. At present, organisations engaging a Mental Health Nurse receive a once-off payment of $10,000 to cover the upfront costs involved, with one payment available per organisation, not per nurse engaged. However, under the current funding model, the MHNIP in private mental health settings is not a self sufficient service and is heavily reliant on the goodwill of its auspicing organisation. Qualitative feedback indicates that these are motivated by the provision of better services for clients and enabling psychiatrists and GPs to focus on their core skills. This cannot be expected to continue beyond the life of the Pilot.

Should the MHNIP become an ongoing component of the private mental health system, it will be important that its resourcing is less reliant on goodwill and altruism and more reliant on funding that acknowledges the range of inputs required.

The Review has quantified the various roles that Mental Health Nurses need to undertake in order to achieve positive outcomes for the clients, and which have a positive effect on the service system. Current Medicare funding does not recognise all of those roles (especially those that do not involve face-to-face work with clients – such as, case management and coordination), and does not support the infrastructure costs associated with service provision by Mental Health Nurses. Furthermore, delivery in rural areas, and where significant distance and travel is involved, is not supported by the current funding model's requirement of servicing two clients in a half day session.

This indicates the need for future program guidelines and funding to recognise the range of roles and responsibilities undertaken by Mental Health Nurses, and the additional resources needed for those in rural and remote locations. Specifically, this will require funding (beyond what is currently provided) that supports the following –

- ⇨ **Case management of clients, including case conferencing between Mental Health Nurses and psychiatrists and GPs.**
- ⇨ **Coordination of care relating to clients.**

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⇨ **Infrastructure costs, including office accommodation and operating costs, and the purchase and maintenance of vehicles.**

⇨ **Loading for rural and remote based services to reflect the additional costs associated with distance.**

⇨ **Greater flexibility in Medicare guidelines relating to the number of sessions undertaken – so that services are not financially disadvantaged when clients do not turn up for appointments and when travel to and from clients' homes (as occurs in rural and remote settings) consumes a considerable component of what is currently regarded as 'session' time.**

1.9.2   *Credentialing of Mental Health Nurses*

It can be argued that the success of the MHNIP is highly dependent on the quality, competence and experience of the Mental Health Nurse. Current guidelines require the employment of Mental Health Nurses credentialed with (or being in the process of obtaining this by working towards qualifications in mental health and with three years' recent experience in mental health nursing) the Australian College of Mental Health Nurses (ACMHN), and this indicator of quality has been endorsed in the Review by key stakeholders.

However, there has also been strong support for **also** providing recognition of experience for those without ACMHN recognised credentials, and two mechanisms exist for achieving this, without compromising standards of qualification. One involves providing enhanced access for Mental Health Nurses to Recognition of Prior Learning (and raising awareness about this mechanism which does not appear to be widely understood), which will acknowledge that experience will lead applicants to achieving their qualification. The other involves support from employers (for example, in providing study time and/or payment of fees) to achieve the required qualifications. (The evaluators acknowledge the support also provided through the 1,000 mental health nursing scholarships provided under the national Mental Health Nurse and Psychologist Scholarships subsidy scheme designed to address workforce shortages in these areas.)

The evaluation findings support the employment of Mental Health Nurses whose qualifications meet ACMHN requirements. However, to make this attainment more accessible for nurses, and to enhance the ability of MHNIP services to attract these nurses, it is important that provision is made for –

a) **Increasing awareness about Recognition of Prior Learning and how to obtain this.**
b) **Provision of financial support by employers to undergo a Recognition of Prior Learning assessment.**
c) **Provision of financial support and paid study leave by employers to enable Mental Health Nurses to complete their qualifications while working for the MHNIP.**
d) **Increasing awareness about the national Mental Health Nurse scholarship subsidy scheme.**

1.9.3   *Recruitment and retention of Mental Health Nurses*

The pilots have reported difficulties in recruiting appropriately qualified Mental Health Nurses – the sites in Canberra and Essendon both attribute delays in starting to this issue, and some of the other sites also identified this as having been a challenge for them.

Apart from the fact that supply will increase over time, the issue has been compounded by the uncertainty associated with the Pilot and whether or not it will become an ongoing program. Mental Health Nurses, particularly those in secure public sector jobs, and particularly those who are of mature age, are unwilling to exchange permanent for temporary employment.

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However, in addition to the changes suggested in the main report, recruitment and retention can be enhanced by promoting positive work conditions currently associated with the MHNIP Mental Health Nurse role, and by providing other conditions that will add to its attraction (based on survey feedback). Some sites have found that including as a condition of employment, support to achieve the required credential, has assisted them significantly in the recruitment process. Conditions that have emerged as attraction factors are the capacity to work autonomously, flexibly and innovatively and these can be promoted as part of a recruitment strategy. In addition, work conditions that offer job security (which will be possible if the MHNIP continues beyond its Pilot phase) and salaries that reflect the ACMHN benchmarks will act as positive recruitment and retention factors.

1.9.4   Capacity to manage cultural diversity

The lowest assessment of capacity has been for the Pilot filling a gap in mental health services for Indigenous people. As there has been no Indigenous-specific provision made to date, this finding is not surprising. Similarly, capacity to enhance access for people from culturally and linguistically diverse backgrounds (CLD) has received a relatively low rating. Again, without specific provision designed for this target group, the model cannot be expected to achieve this outcome.

Future directions for the MHNIP could include the development of Indigenous-specific and CLD-specific service offerings – either within existing services or as specialist services. This would require the development of partnerships with appropriate Indigenous and CLD mental health service providers to design and deliver inclusive services to both target groups. The supply of Mental Health Nurses from either of these backgrounds is not known, but specific recruitment could be undertaken for this purpose.

1.9.5   Promotion issues

The evaluators recognise the difficulties associated with promoting a Pilot initiative as most service providers will not engage with a program that may be short lived. However, if the MHNIP continues beyond the pilot phase, it will be critical for specific promotional strategies to be developed that target psychiatrists and GPs, using appropriate networks (for example, Divisions of General Practice) and communication methods.

1.9.6   Accountability issues

Feedback from Mental Health Nurses and psychiatrists and GPs has been negative in relation to the amount of time being spent on completing what is described by them as lengthy and repetitive reporting. The evaluators believe that existing reporting should be redesigned to be as concise as possible, and offered in electronic format.

2   INTRODUCTION

The Australian Institute for Social Research (AISR) was commissioned by the Nursing Section of the Department of Health and Ageing, Canberra to evaluate the Piloting of the *Mental Health Nurse Incentive Program* (MHNIP) in private hospital settings. Specifically, the Department sought these four outcomes from the evaluation.

- o   Development of an evaluation framework for Piloting the inclusion of private hospitals as eligible organisations under the Mental Health Nurse Incentive Program.
- o   Development of data collection tools to undertake research.
- o   Analysis of data collected across the Pilot sites including, but not limited to:
    - ⇨   Analysis of patient outcomes;
    - ⇨   Analysis of participant (ie. mental health nurses, general practitioners and psychiatrists) outcomes;
    - ⇨   Analysis of the views of Mental Health Nurses (ie. has the Pilot contributed to improvement in patient care).
- o   Submission of a final report outlining the effectiveness of the Pilot and options for future program enhancements.

The review has focused on six of a possible seven Pilot sites. These are located in –
- •   Adelaide
- •   Perth
- •   Taree
- •   Toowong
- •   Warrnambool
- •   Essendon (their Mental Health Nurse began employment in the second half of March 2009. The evaluators have interviewed the psychiatrist attached to the Essendon Pilot site, and obtained *preliminary* data for the Review from the Mental Health Nurse, the psychiatrist and six clients).

Canberra, like the Essendon site, experienced significant difficulty in engaging an appropriately accredited Mental Health Nurse, and although the evaluators visited the site for preliminary interviewing purposes, were not able to include the site due to lack of commencement in the timeframe of the Review.

The Chart below shows that the Pilots are at different stages of implementation, having commenced at different times. This has been taken into consideration in the analysis of findings. Not surprisingly, there is significant variation in the quality of data held by the sites. This ranges from non-existent data in sites like Canberra, to minimal data at the Essendon site through to very comprehensive data at other sites.

Commencement dates of MHNIP sites

Site	2007							2008				2009	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-Dec	Jan	Mar
Taree	▓												
Toowong									▓				
Perth									▓				
Warrnambool									▓				
Adelaide										▓			
Essendon													▓

2.1 Overview of Methodology

The key components of the review methodology have involved:

- o Development of an Evaluation Framework to structure the review (see *Section 2.1.1*).
- o Design of a user-friendly data collection tool for sites to document service data (see *Section 2.1.2*).
- o Design of a Service Profile Matrix (see *Section 2.1.4*).
- o Visits to all participating sites by the project team. These visits were structured to familiarise the evaluators with the particular interpretation of the MHNIP model adopted by that site and the reasons underlying the design of that model, to obtain qualitative feedback about the program, challenges being faced and how these were being addressed, successes and the reasons for these, and other issues. Each team member was allocated specific responsibility for a particular site (s) to enable a positive working relationship to be developed between the evaluators and the sites, and to support ongoing communication. All Mental Health Nurses and Coordinators (the latter have been appointed by two sites) were interviewed at length during these visits (see *Section 2.1.3*).
- o Analysis of Medicare data relating to MHNIP Pilot sites (see *Section 2.1.5*).
- o Design of three survey instruments to quantify feedback from Mental Health Nurses (and Coordinators, where these have been appointed), from referring Psychiatrists and GPs (although there were few of the latter involved in this Pilot), and from clients (see *Section 2.1.6*).
- o Analysis of all findings.
- o Reporting – this has been provided throughout the Review at regular intervals and at the completion of the Review.

The team has been impressed by the level of commitment evident by site representatives towards the Pilot and to this review. We have received full cooperation and the enthusiasm to participate in the evaluation, as a learning process, has made our work much smoother than is normally the case in large scale evaluations.

2.1.1 The Evaluation Framework

Reflecting the purpose of the evaluation, the Framework components follow a hierarchy ranging upwards from Process, to Activity, to Outcomes and to Impact, based against 11 evaluation Domains each with their own areas of enquiry. The detail of the Framework is reflected in those areas of enquiry, for which the evaluation team designed a series of survey tools and other mechanisms of data collection.

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The Evaluation Framework is presented in detail in **Attachment 1**. The chart below summarises the Outcomes Hierarchy (Process⇨Activity⇨Outcomes⇨Impact) underpinning that Framework. This is followed by a diagrammatic summary of the key elements of the Evaluation Framework which is in matrix form – the four levels of the hierarchy of outcomes plotted against Evaluation Domain and Areas of Enquiry.

OUTCOMES HIERARCHY STRUCTURING THE EVALUATION FRAMEWORK

Outcomes Hierarchy – MHNI

Evaluation level

Main sources

Impact

Consumer care & wellbeing

Personnel & training

Broader service impacts

Consumer survey
Staff interviews
Survey of staff and referrers

Outcomes

Satisfaction with service
Consumer health & functioning
Appropriateness of service model
Integration, capacity & sustainability

Consumer survey
Data from sites (incl HoNOS)
Survey of staff and referrers
Staff interviews

Activity

Staff activity and costs

Service utilisation patterns

Consumer profiles and servicing patterns

Medicare MHNIP data
Data from sites
Staff interviews

Process

Service models

Adherence to guidelines

Service relationships and pathways

System fidelity & capacity for adaptation

Staff interviews
Data from sites

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EVALUATION FRAMEWORK: OVERVIEW

EVALUATION LEVEL	EVALUATION DOMAIN	AREAS OF ENQUIRY

Impact

- **Consumers** — Consumer wellbeing (mental, physical, social); Timeliness of service delivery; Coordination of care
- **Staff** — Longer term supply and demand; Provision of training & credentials
- **Services** — Change in use of other health services (quantitative & qualitative changes)
- **Government** — Policy and program development

Outcomes

- **Consumers** — Accessibility of mental health services; Satisfaction with MHNIP service; Improved health & functioning
- **Staff** — Skills & career development; Job satisfaction
- **Service** — Appropriateness of service model; Service integration; Service capacity and sustainability
- **Government** — Discovery of unmet need; Cost-consequence analysis; Recommendations for continuation

Activity

- **Service utilisation** — Profile of consumers; Profile of activity within & across sites
- **Staff activity** — Staffing and associated costs; Case loads and case mix; Breadth and balance of activities

Process

- **Service models** — Descriptive service profiles; Comparison of service models; Adherence to guidelines
- **Service integration** — Relationships between providers; Inter-agency coordination of services; Typical service pathways
- **Service adaptation** — Perceived strengths, weaknesses, achievements & challenges; System fidelity & capacity for adaptation

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2.1.2   Data collection tool

In designing data collection tools for the Review, the evaluators sought consistency with measurement instruments being used in the sector (for example, HONOS, LSP, BASIS or K10) and to minimise the burden of data collection for sites participating in the Pilot. An overview was also made during site visits of existing data collection processes and instruments to determine how these could be synthesised with the evaluation framework and its associated instruments.

The data collection tool was designed to be completed in either Word or Excel. Details are provided in **Attachment 2,** and the key information captured related to –

- ⇨ Referral
- ⇨ Entry related information, including diagnosis and initial HONOS score
- ⇨ Client profile (including age, gender, location, cultural background, and health insurance cover)
- ⇨ HONOS and other assessment scores at each review
- ⇨ Services provided by the Mental Health Nurse
- ⇨ Exit related information, including final HONOS score, date and reason for exit, destination (eg referral to psychiatrist) and any follow up data collected.

2.1.3   Site interviews

Semi-structured interviews were held at all Pilot sites with Mental Health Nurses, and in the case of Adelaide, Warrnambool and Essendon, with several psychiatrists to scope key issues and to inform the design of questionnaires. General Practitioners (GPs) were also interviewed at Warrnambool. A representative of the Australian College of Mental Health Nurses has also been interviewed and provided important background and other information for the evaluation.

2.1.4   Service Profile Matrix

As part of the site visits, a service profile was developed to map the key features of each service and its interpretation of the Pilot model. This documented information about –

- ⇨ Structure (eg psychiatrists located at same site as MHN/Coordinator or at private clinics)
- ⇨ Staffing (no of FTE Mental Health Nurses)
- ⇨ Client numbers (referred, and active)
- ⇨ Service delivery (home visit only, clinic/hospital only, or combination)
- ⇨ Communication processes (eg between MHNs and Psychiatrists)
- ⇨ Assessment tools used (HONOS, others eg LSP16).

The chart below summarises the service profile developed at the time of site visits (late 2008 to first quarter of 2009). *Shaded cells indicate that a feature exists for a particular site, and where more specific information applied, this is provided in word or figure form.* It can be seen that –

- o Few referrals are from GPs, and most are from psychiatrists.
- o Sites vary in their ratio of home visits to clinic based delivery, but most are providing home visits.
- o All are reliant on the auspicing hospital to subsidise program funding (for example, by providing cars, use of other services provided by the hospital).
- o None are charging a gap fee.

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o All provide a range of mental health services on a single site.

Features of Model	MHNIP Site					
	Adelaide %	Perth %	Taree %	Toowng %	Essendn %	Wrrnmb %
Referrals from GPs as well as psychiatrists					(plan to)	(50:50)
Referrals from psychiatrists only						
Emphasis on home visits	35.0	5.0	95.0	95.0	n/a	70.0
Emphasis on clinic based delivery	65.0	95.0	5.0	5.0	n/a	30.0
Reliance on auspice's services to subsidise MHN funding						
Provision of a Coordinator						
No gap fee charged						
No geographic boundaries set for service provision						
Delivery on a single site, integrating range of mental health services						
Accompanying outreach program/ links to auspice's own community program		Not at 09/08				

2.1.5 Medicare data analysis

A formal request was made via the Department to obtain an extract of MHNIP related Medicare data for the purpose of analysing MHN staffing and client activity. The specifications for this extract were designed in consultation with a contact in Medicare recommended by the Department.

The Medicare data was provided to the evaluators in two portions, to allow analysis to be trialled on a subset of the data. The two portions of data were:

o MHNIP claims processed from program inception through to end of January 2009 (extracted end of February 2009)
o MHNIP claims processed from January 2009 to end of March 2009 (extracted end of April 2009).

The data provided contained confidentialised client identifiers which enabled the evaluators to undertake detailed analysis without compromising confidentiality.

2.1.6 Surveys with the three main stakeholder groups

Three survey instruments were designed, one each for Clients, Mental Health Nurses and Coordinators, and referring Psychiatrists and GPs. Copies of these can be found in **Attachments 3A, 3B and 3C.**

The survey design drew on the qualitative information obtained from the on-site interviews, for example, in identifying the strengths and weaknesses of the MHNIP, and the features of the role being played by Mental Health Nurses and its relationship to the broader mental health service system. All three survey instruments were linked by a common core set of questions which has enabled triangulation of findings.

The process by which surveys were completed (hard copy or online via email with an embedded link to the AISR website to complete the survey) varied from one site to another and by different stakeholder groups (eg clients were most likely to use hard copy, as were many psychiatrists). The process was tailored to address different needs and preferences. Mental Health Nurses distributed hard copies of the survey to their clients, explaining to them its purpose, confidentiality, complaint process and that it was a voluntary exercise.[2] Those completing the survey electronically were sent an email with an embedded link to the AISR website taking them to the MHNIP Review survey.

Table 1 shows the composition of the MHN/Coordinator, Psychiatrist/GP and Client samples. When interpreting the results from these surveys, note that the experiences of sites with a larger scale MHNIP operation will be better represented in the results than the experiences of smaller sites, simply as a consequence of the number of survey returns.

Table 1: Sample by site and stakeholder group

Site	Mental Health Nurse / Coordinator Survey		Survey of Referring Psychiatrists and GPs		Survey of Clients		Total
	N	% of sample	N	% of sample	N	% of sample	N
Ramsay Health Care, Adelaide	3	18.8	6	25.0	28	23.5	37
Essendon Private Hospital	1	6.3	1	4.2	6	5.0	8
Perth Clinic	3	18.8	1	4.2	15	12.6	19
Mayo Private Hospital, Taree	2	12.5	3	12.5	14	11.8	19
Toowong Private Hospital	4	25.0	7	29.2	35	29.4	46
St John of God Hospital, Warrnambool	3	18.8	(Psych) 1 (GPs) 5	(Psych) 4.1 (GPs) 20.8	21	17.6	30
Total	16	100.0	24	100.0	119	100.0	159

Note. St John of God Hospital was the only site to provide responses from GPs. These are shown separately in the Table. Results of the surveys for Psychiatrists and GPs were analysed as a group as there were too few GP surveys for separate analysis.

An additional Psychiatrist survey from the Perth Clinic was returned well after the closing of the survey and after findings had been calculated. However, the evaluators have taken into account qualitative information provided by the psychiatrist and noted that quantitative information followed the trend in responses given by other psychiatrists.

On a site basis, the highest response rates for Mental Health Nurses and Coordinators (100%) came from the Adelaide, Perth, Taree and Warrnambool sites. The highest response rates from Psychiatrist and GP
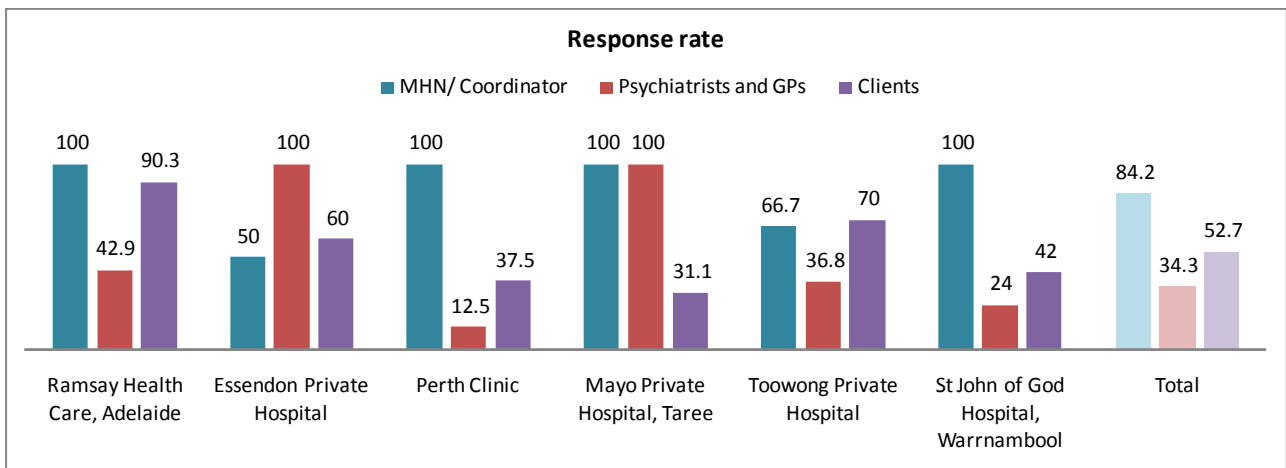
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[2] The AISR sought and obtained clearance from the University of Adelaide's Human Research Ethics Committee for this process.

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surveys (100%) came from the Essendon and Taree sites, and the highest Client survey response rates came from the Adelaide site (90.3%) and from the Toowong site (70%).

St John of God Hospital in Warrnambool was the only site to distribute surveys to both Psychiatrists and GPs (all others only included Psychiatrists). Response rate was different between these two groups with one of two Psychiatrists returning the survey while only five of 23 GPs (21.7%) responded. However, it is suggested that the low GP response rate may be partially accounted for by the inclusion of GPs who had not yet participated in the Program.

Response rates for all three stakeholder groups across the six sites from which feedback has been provided, are summarised in *Figure 1*. It can be seen that 16 out of 19 Mental Health Nurses and Coordinators have responded **(84.2%),** and that 119 out of 226 clients contacted **(52.7%)** have completed a survey together with 24 out of 70 **(34.3%)** referring psychiatrists and GPs. **These are very positive response rates and the evaluators have confidence that a representative sample has been achieved.**

**Figure 1: Response rates by site and stakeholder group**

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3 CLIENT SURVEY FINDINGS

3.1 Survey sample

A total of **119** clients, including 6 from the recently established Essendon pilot, have provided survey feedback. The highest numbers have been received from the Toowong (35) and Adelaide (28) sites.

Figure 2: Private hospital client received services from
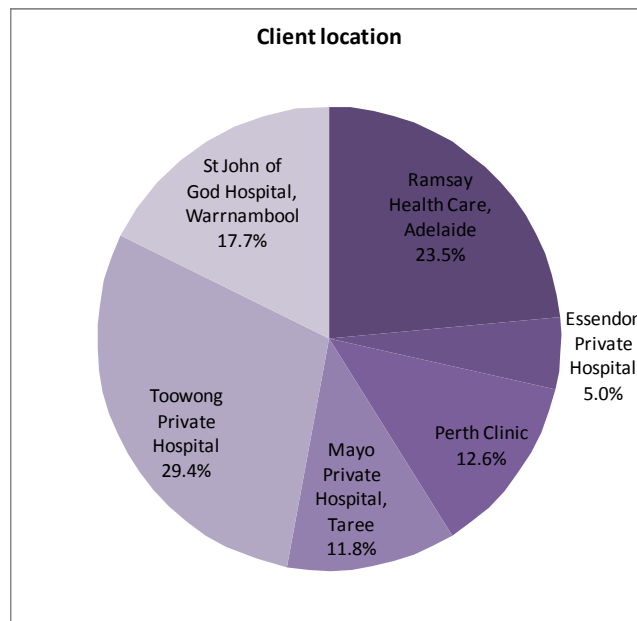
In terms of demographic profile –

- o 73 (61.3%) of the sample are **female**.
- o One identified as being of **Aboriginal or Torres Strait Islander** origin.
- o Six (5.0%) reported speaking a language other than English as their first **language**:
  - ⇨ With 4 speaking a southern European language, one Mandarin and one not specifying.
- o The average **age** of the clients is **47.8 years** with some variations by site:
  - ⇨ Clients from the Mayo Private Hospital in Taree (average age - 62.4 years) were statistically significantly older than those from the Perth Clinic (average 36.0 years) and Toowong Private Hospital (average 42.6 years).

When this is compared with client profile extracted from the AISR team's separate analysis of site data (detailed in Report 2), the survey sample is representative of the entire client group by age, gender and Indigenous background, as illustrated in Table 2. However, there is a discrepancy between those identifying as having a language other than English for their first language – the survey includes six individuals identifying as such while site data records no individuals, which questions the sites' identification of this client characteristic.

Table 2: Differences between the characteristics of clients included in Medicare, site or survey data

Client Characteristic	Medicare Data Profile	Site Data Profile	Survey Profile
Gender – female	63%	61%	61%
Aboriginal or Torres Strait Islander origin	*Not available*	1 person	1 person
First Language is other than English	*Not available*	none	6 individuals
Age – average	44.4 years	45.8 years	47.8 years

In terms of employment and income *(see Figure 3 and 4)* –

- o The majority (53.8%) are **not in paid work** and are **not looking for work**;
- o 19.3% are employed part time and a further 10.9% are employed full time;
- o 13.4% are looking for paid employment;
- o 41.2% are receiving the **Disability Pension**;
- o 17.6% are receiving a wage or salary and 5.9% are self-employed;
- o 2.0% are receiving Unemployment Benefits.
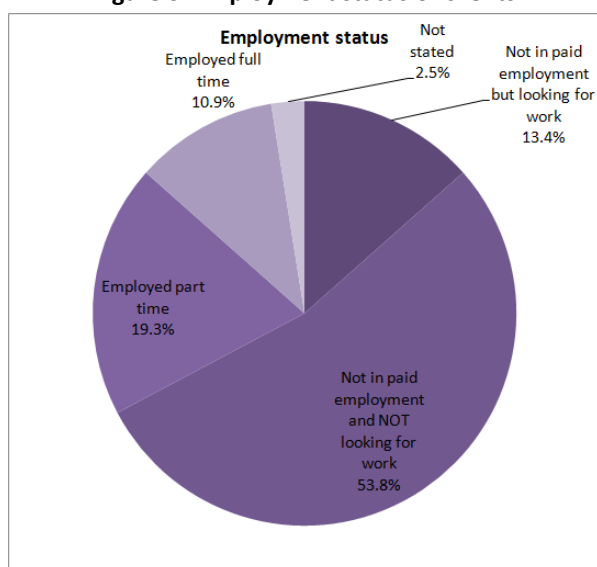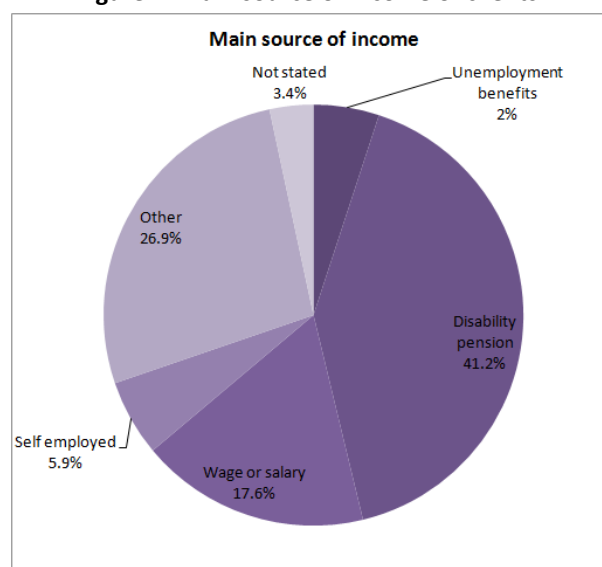
Figure 3: Employment status of clients

Figure 4: Main source of income of clients

3.2   Referral source

The majority of clients **(76.5%)** were referred to the Mental Health Nurse by a **psychiatrist** and a further 6.7% by their GP. Another nurse had referred 4.2%. Figure 5 provides these details.

Of those identifying an 'other' referral source, two had been referred by a psychologist, two by a relative, four by professionals employed at the private hospital concerned, one by a physician, one was self-referred and one did not specify.

First contact with the Mental Health Nurse had occurred within the last year for almost three quarters of clients (72.3%), with the highest proportion (28.6%) having first seen the Mental Health Nurse between six

20

and twelve months ago. Twenty-eight clients (23.5%) had first contact with the Mental Health Nurse more than a year ago. All clients from Essendon Private Hospital had their first contact with the Mental Health Nurse less than three months previously, while clients from Ramsay Health Care were statistically most likely to have had their first contact with the Mental Health Nurse between 6 and 12 months ago – *see Figure 6*.

It is interesting to note that referral sources have been wider than simply GPs and psychiatrists (as set out in the Program Guidelines). As this is a Pilot program, this indicates the need for Guidelines to set out a number of possible and acceptable sources of referral to the MHNIP.
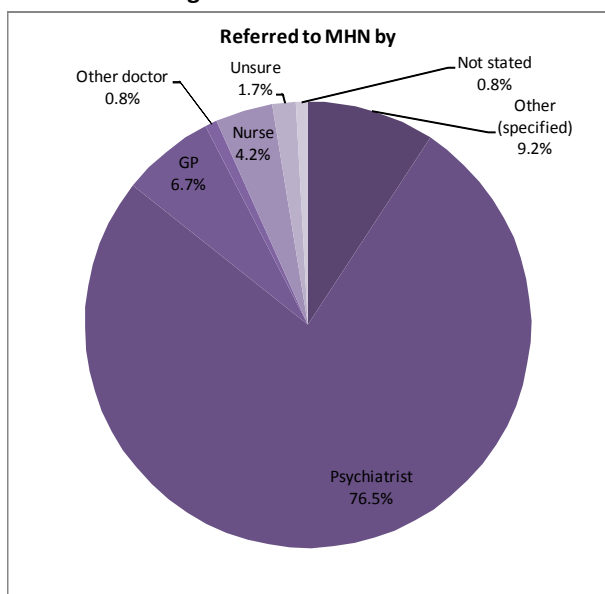
Figure 5: Referral source

Figure 6: First contact with the MHN
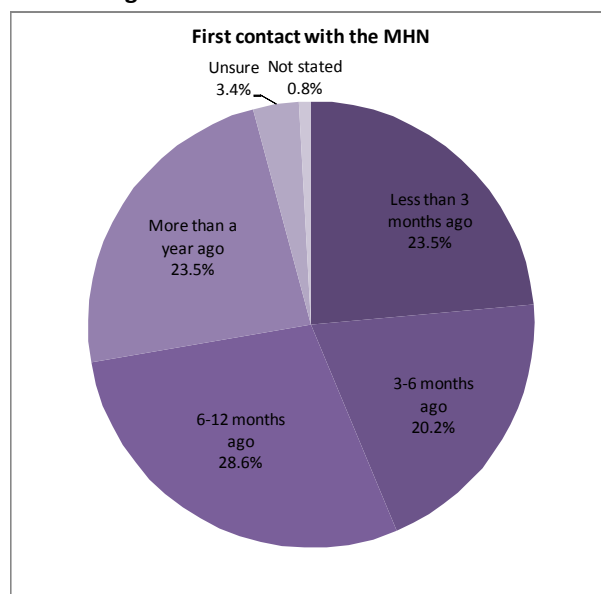
3.3   Service responsiveness

When initially referred, **63.0%** of clients saw the Mental Health Nurse **within one week**, including 13 (10.9%) seen on the day of their referral and 62 (52.1%) who waited up to a week. Some clients (16.8%) were unable to indicate how long they waited, while 20.2% stated that they had waited for more than one week – *see Figure 7*.

These rates indicate a responsive service, providing significantly shorter waiting times than would occur in relation to seeing a psychiatrist. The majority (92.4%) were still receiving a service from the Mental Health Nurse at the time of the survey. Of the eight clients who reported they were no longer in the program, four had been in the program for less than 3 months, three for 6-12 months and one for over a year.

Figure 7: Waiting time to see MHN for first time

Time waited to see the MHN for the first time

Not stated
1.7%

Saw the nurse on the same day
10.9%

Unsure
15.1%

Longer than a week
20.2%

Saw the nurse within a week
52.1%
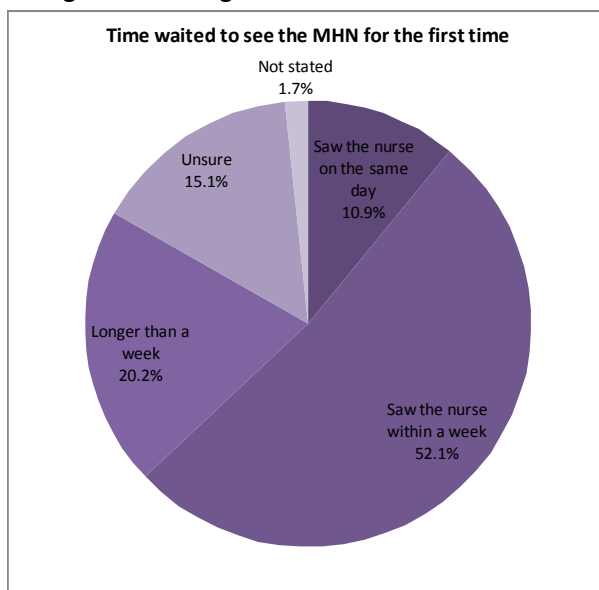
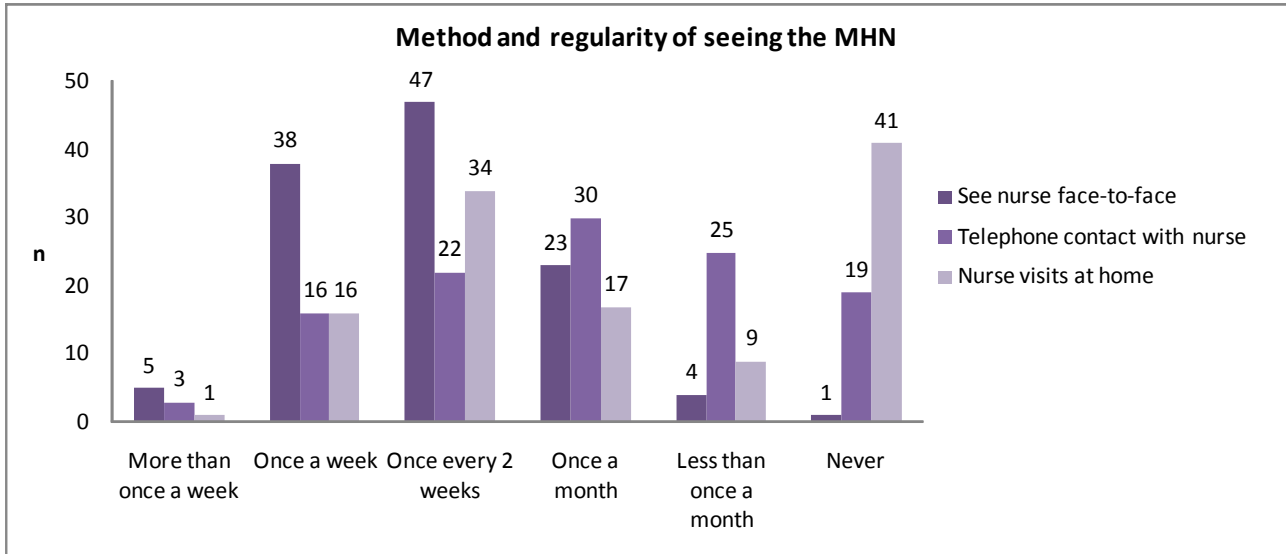The amount of face-to-face contact with the Mental Health Nurse varied from more than once a week (4.2%) to once a week (31.9%), to once a fortnight (39.5%) for most of these clients (*see Figure 8*). Given the variation in levels and types of need, such differences can be expected. **But the trend was for most to be receiving regular face-to-face support, between one and two weeks.**

In addition, clients were receiving a **significant amount of telephone based support** from the Mental Health Nurse. This varied from once a week (13.4%), to once a fortnight (18.5%), once a month (25.2%) and less than once a month (21.0%). A further 16.0% had never had telephone contact with the Mental Health Nurse.

The provision of home visits separates the MHNIP model from usual private mental health services, especially those provided by psychiatrists and other mental health specialists. **Home visits** from the Mental Health Nurse were being received by **64.7%** of these clients. This was occurring once a week for 13.4%, once a fortnight for 28.6%, once a month for nearly 14.3% and less than once a month for nearly 7.6%. **This finding suggests that the MHNIP model offers significant *accessibility* and *flexibility* in its mode of delivery.**

All but three clients reported they had some level of contact with the Mental Health Nurse (face-to-face, telephone and/or in the home) at least once a month, while 80.7% reported some contact at least every 2 weeks. **These findings indicate that the MHNIP services have been very *responsive* and *supportive* to their clients.**

Figure 8: Method and regularity of seeing the MHN

Method and regularity of seeing the MHN

Eighty-six clients **(72.3%)** stated they were receiving the appropriate amount of contact with the Mental Health Nurse, only one person wanted less contact, and 30 (25.2%) were seeking a greater amount of contact – *see Figure 9*. Of the 30 clients seeking more contact, 14 wanted more home visits, 14 also wanted more telephone contact and 11 wanted more clinic based contact. This included seven who would like more contact in two or more of the listed ways – *see Figure 10*. **These findings indicate a high level of client satisfaction with the amount of contact being provided.**
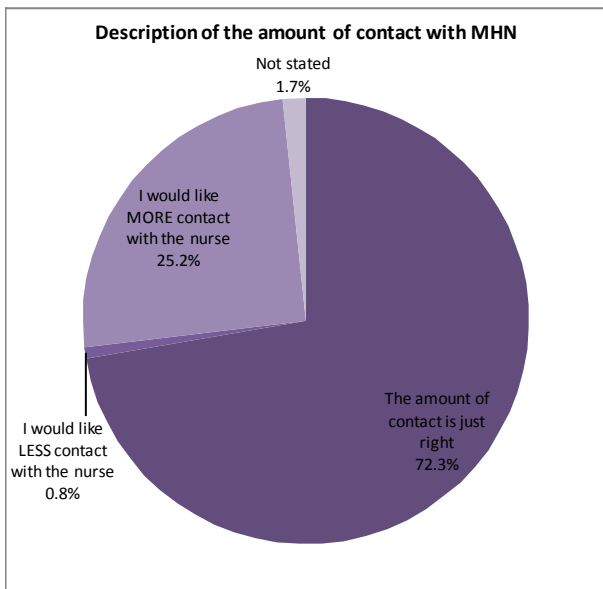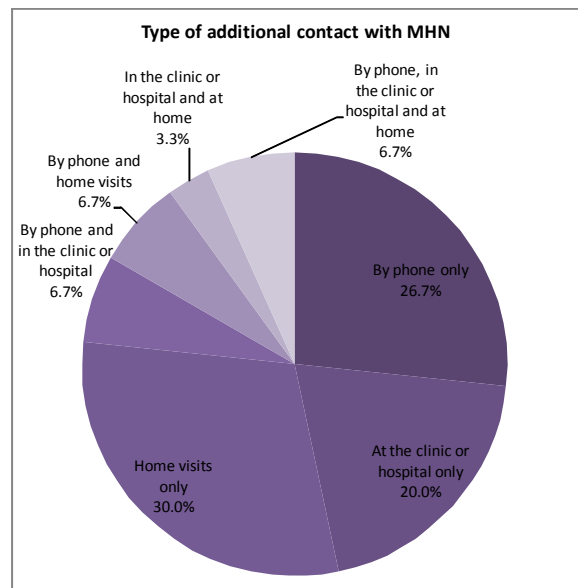
Figure 9: Amount of contact with MHN

Description of the amount of contact with MHN

Figure 10: Type of additional contact (n=30)

Type of additional contact with MHN

3.4 Delineating the role of the Mental Health Nurse

Clients were asked to indicate (from a standardised response list) which activities and services they were receiving from the Mental Health Nurse. (The surveys with Mental Health Nurses and referring Psychiatrists and GPs also asked this question to enable comparative analysis across the three stakeholder groups.) Of the nine roles possible, the three most commonly identified were –

- o **Provision of information and advice to assist in self-management of mental health issues (97.5%).**
- o **Provision of support not elsewhere received (88.2%).**
- o **Help with understanding and managing medication (70.6%).**

There were no statistically significant differences (base on chi square analysis) for any of these variables between sites, or based on gender, income or employment.

Interestingly, clients were divided in their perception of the Mental Health Nurse role of linking them to other medical services *(Figure 16)* and non-medical services *(Figure 17)*, provision of support to clients' significant others *(Figure 15 and Figure 19)* and hospital visiting *(Figure 14)* suggesting different interpretations of the MHNIP model across sites.

Figure 11 to *19* depict client perceptions of the different roles of the Mental Health Nurse.

Figure 11: MHN helps understand and manage my condition
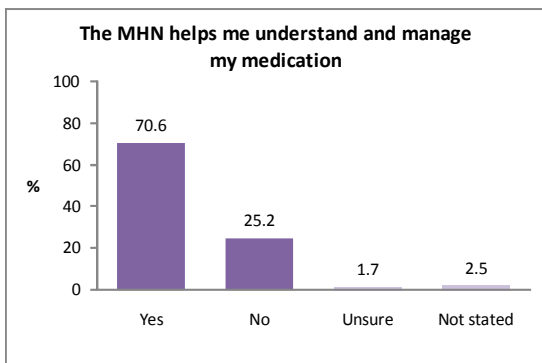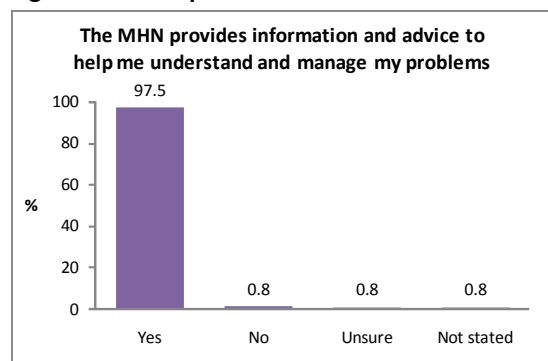

Figure 12: MHN provides information & advice
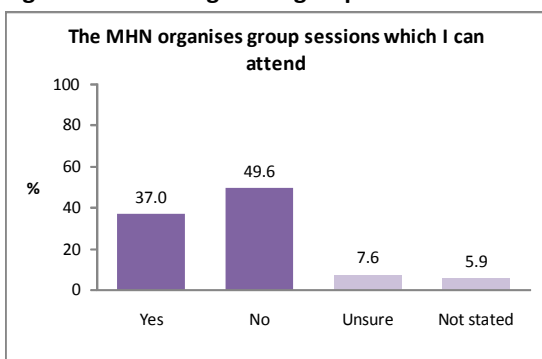

Figure 13: MHN organises group sessions
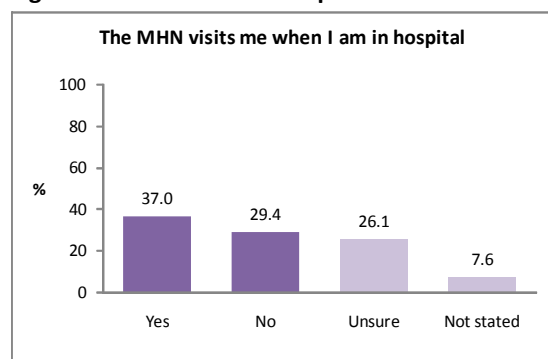

Figure 14: MHN visits in hospital

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Figure 15: MHN supports family & others

The MHN provides support to my family and other people close to me

	Yes	No	Unsure	Not stated
%	41.2	41.2	11.8	5.9
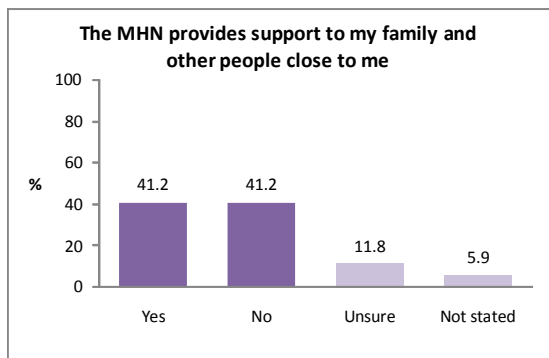
Figure 16: MHN organises medical services

The MHN helps me to organise and use other medical services that I need (eg doctors or clinics)

	Yes	No	Unsure	Not stated
%	49.6	42.9	4.2	3.4
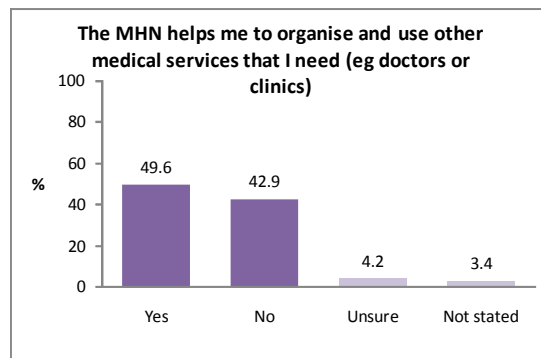
Figure 17: MHN organises non-medical services

The MHN helps me to organise or use other non-medical services (eg for housing or work)

	Yes	No	Unsure	Not stated
%	42.9	44.5	6.7	5.9
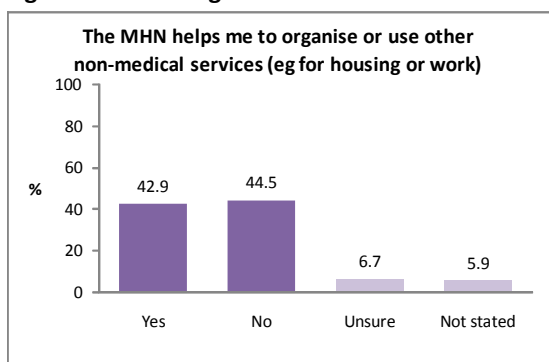
Figure 18: MHN provides new support

The MHN provides me with support that I did not have before

	Yes	No	Unsure	Not stated
%	88.2	5.9	1.7	4.2
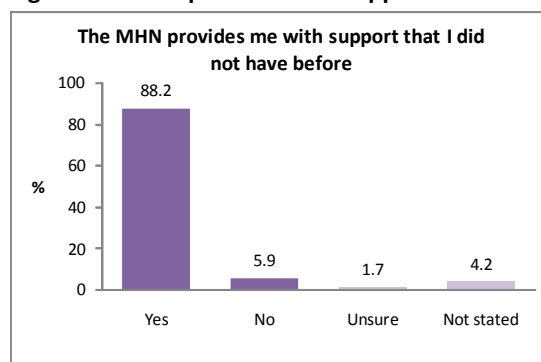
Figure 19: MHN helps in other ways

The MHN helps me or my family in other ways

	Yes	No	Unsure	Not stated
%	42.0	18.5	5.9	33.6
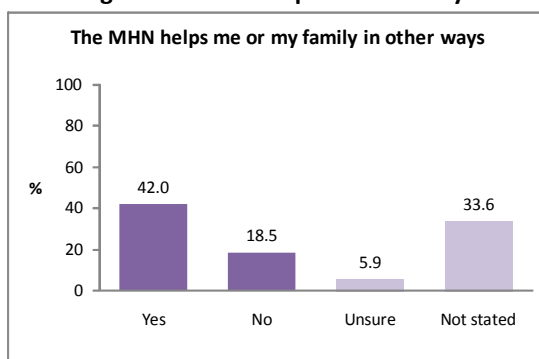
In their own words, a total of 46 clients provided **additional comments or examples of ways in which the Mental Health Nurse had assisted them.** There were clear trends in their responses which can be categorised into three main groups, all of which reflect the issues identified in the figures above. These are described below, to illustrate the information provided in the preceding Figures.

1) Provision of personal support and organisation of daily activities

➢ *Provides personal support and encourages me to get going and make an effort.*

➢ *Always within phone contact when feeling very down.*

➢ *Monitors my progress with goals by actively encouraging and reminding me.*

➢ *Makes himself available on short notice.*

➢ *Listens to my ups and downs - asks relevant questions of me.*

> *Helps me to talk through personal issues.*

> *Helps me understand more on what I am going through and help reduce the pressures.*

> *Gives me suggestions and strategies of how to deal with managing my day to day life.*

> *Gives me advice on how I can be more involved in day activities around the house.*

2) Family support, education of family members about the client's illness, and linkage to services to support the family

> *Someone the family can talk to and help understand my illness.*

> *Helps me deal with my problems and issues so I don't have to dump on my husband. Marital relationship has improved as a result.*

> *The nurse talked to my children to explain and reassure them as to what I was going through. Offered this service to anyone I needed it for.*

> *Talks to my mother and sister to help them be more patient with me.*

> *Helps both husband and myself communicate better.*

> *Gives my husband moral support and helps him understand my illness.*

> *Helps family manage my mental health crises.*

3) Linkage to other services - financial, recreational, income support, employment and career development

> *Assisted me with applying for mobility allowance and vital call system.*

> *Arranges other community services to help family. Attends Centrelink interviews. Attends interviews in workplace.*

3.5 Delineating the perceived impact on health and wellbeing of the support received

From a possible nine options, all but one (relating to reduced length of stay if hospitalised) was identified as an outcome which these clients believed had been achieved for them. The most commonly identified indicate benefits for the client and the private mental health system, and involve –

- ⇨ Improved **ability to cope** with problems (89.9%).
- ⇨ Maintenance or restoration of **health** (86.6%).
- ⇨ Improved **general functioning** in daily life (84.0%).
- ⇨ Improved **quality of life** (79.0%).
- ⇨ Reduction in **symptoms** (68.1%).
- ⇨ **Less visits** to psychiatrist (64.7%).
- ⇨ **Less visits** to GP (58.8%).
- ⇨ Reduced **hospitalisation** (56.3%).
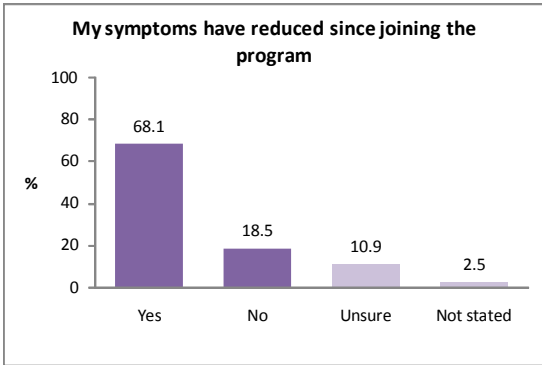
Figure 20: Symptoms have reduced

My symptoms have reduced since joining the program

	Yes	No	Unsure	Not stated
%	68.1	18.5	10.9	2.5

Figure 21: Helps maintain/restore health

The program helps me maintain or restore my health

	Yes	No	Unsure	Not stated
%	86.6	2.5	8.4	2.5
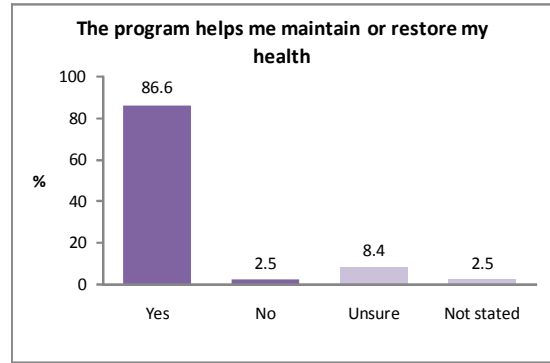
Figure 22: Helps me cope better

The program helps me cope better with my problems

	Yes	No	Unsure	Not stated
%	89.9	4.2	3.4	2.5
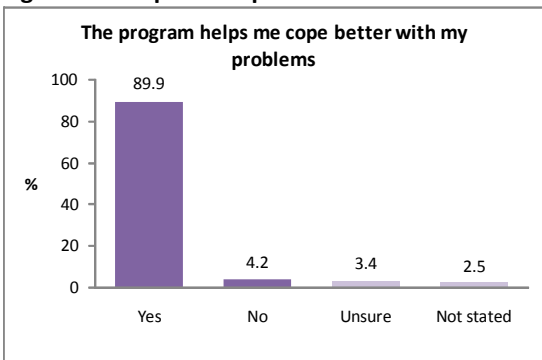
Figure 23: Helps improve general functioning

The program helps improve my general functioning in daily life

	Yes	No	Unsure	Not stated
%	84.0	6.7	7.6	1.7
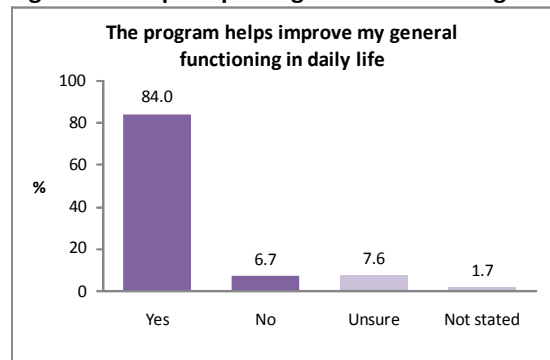
Figure 24: Go to hospital less often

I don't need to go to hospital as often

	Yes	No	Unsure	Not stated
%	56.3	13.4	25.2	5.0
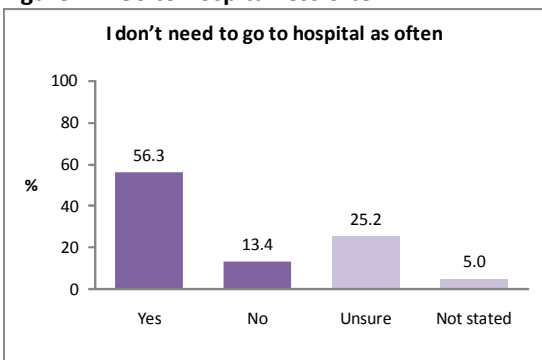
Figure 25: Less time in hospital

If I do have to go to hospital, I don't have to stay as long

	Yes	No	Unsure	Not stated
%	26.1	21.8	43.7	8.4
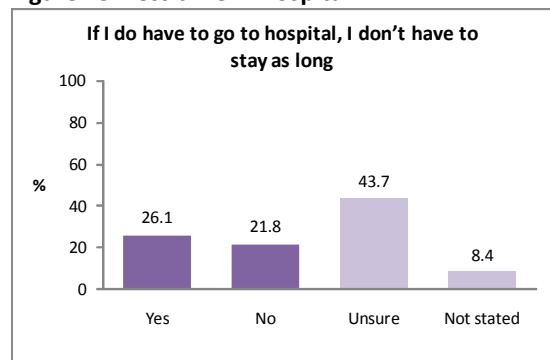
Figure 26: Visit psychiatrist less

The program means that I can visit my psychiatrist less often

	Yes	No	Unsure	Not stated
%	64.7	21.8	8.4	5.0

Figure 27: Visit GP less

The program means that I can visit my GP less often

	Yes	No	Unsure	Not stated
%	58.8	24.4	10.9	5.9
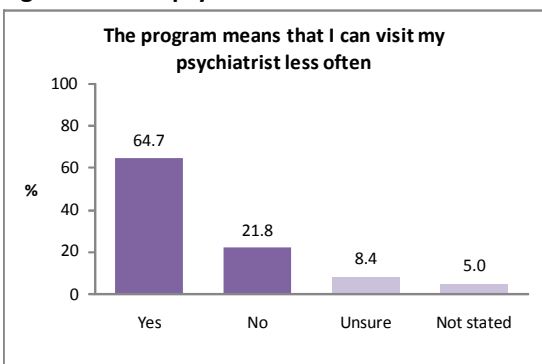
Figure 28: Quality of life improved

My quality of life has improved because of the program

(bar chart: Yes 79.0, No 5.9, Unsure 11.8, Not stated 3.4; y-axis labelled %)

3.5.1 Site-based differences

All clients from the Taree site reported *less* visits to their psychiatrists, whereas only half of the clients from Toowong reported the program meant *less* visits to their psychiatrists. Both of these results showed statistical significance.

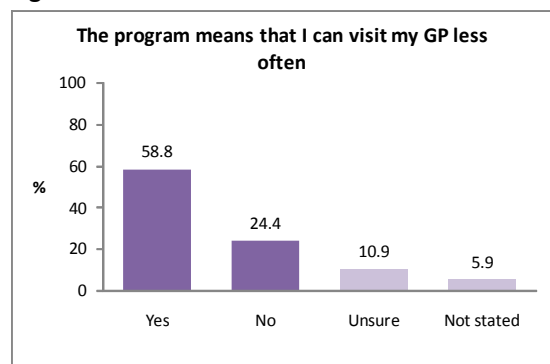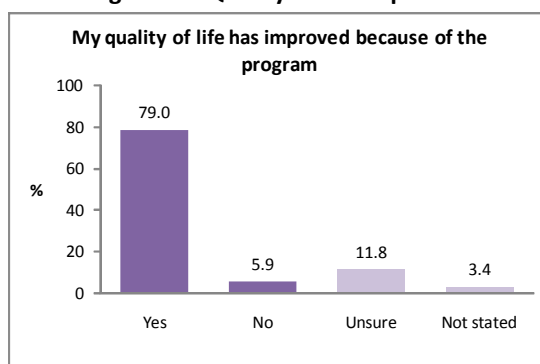Adelaide site clients were significantly more likely to agree that the program meant a reduced need to visit their GP (87.0% stated they visited their GP *less*), whereas around half of Essendon and Toowong clients disagreed stating they *did not* visit their GP less).

3.5.2 Differences based on clients' employment status

Clients who were employed part-time were also significantly more likely to agree that they were able to visit their GPs less often (95.0%), whereas clients not in paid employment but looking for work were most likely to disagree (58.3% reported they *did not* visit their GP less).

Several clients also identified these positive outcomes resulting from MHNIP services.

➢ *The best thing has been the restoring of my health and confidence.*

➢ *The program picked me up after my husband had been in the hospital with depression. They held me together when I was not only at my worst personally but for my entire family. The home visits also lowered the anxiety of having to take time to visit them.*

➢ *The service provided saved my life. I had been misdiagnosed by my GP and without referral to a mental health nurse would have ended badly.*

It is concluded that from the clients' perspective, the MHNIP model has been extremely successful in improving their health and well-being and quality of life, has reduced their reliance on GP and psychiatrist services, and reduced hospitalisation for slightly more than half of them.

## 3.6 Rating the MHNIP Pilot

Using a five-point Likert scale, clients were asked to rate the service they had been receiving on six of dimensions. None of the clients provided negative ratings ('Poor' or 'Very Poor') to any of the six dimensions explored, and the ratings applied have been very high – with approximately 97% of clients

rating the Pilot as 'Very Good' to 'Excellent'. As *Figure 29* illustrates, the lowest mean rating was **4.4** and the highest **4.7**. As the detailed responses indicate, **extremely positive** ratings have been applied to all six (*see Figure 30* to *35*)–

⇨ **Respect for the client as an individual** (68.1% rated this as Excellent and 26.9% as Very Good)
⇨ **Overall quality of service received** (66.4% rated this as Excellent and 27.7% as Very Good)
⇨ **Maintenance of client privacy** (63% rated this as Excellent and 29.4% as Very Good)
⇨ **Accessibility** (57.1% rated this as Excellent and 35.3% as Very Good)
⇨ **Responsiveness to client need** (54.6% rated this as Excellent and 37% as Very Good)
⇨ **Flexibility in responding to changing client need** (50.4% rated this as Excellent and 37% as Very Good).

It is concluded from these findings that clients regard the MHNIP's service provision in the most positive terms.

Figure 29: Rating of services provided by the MHNIP
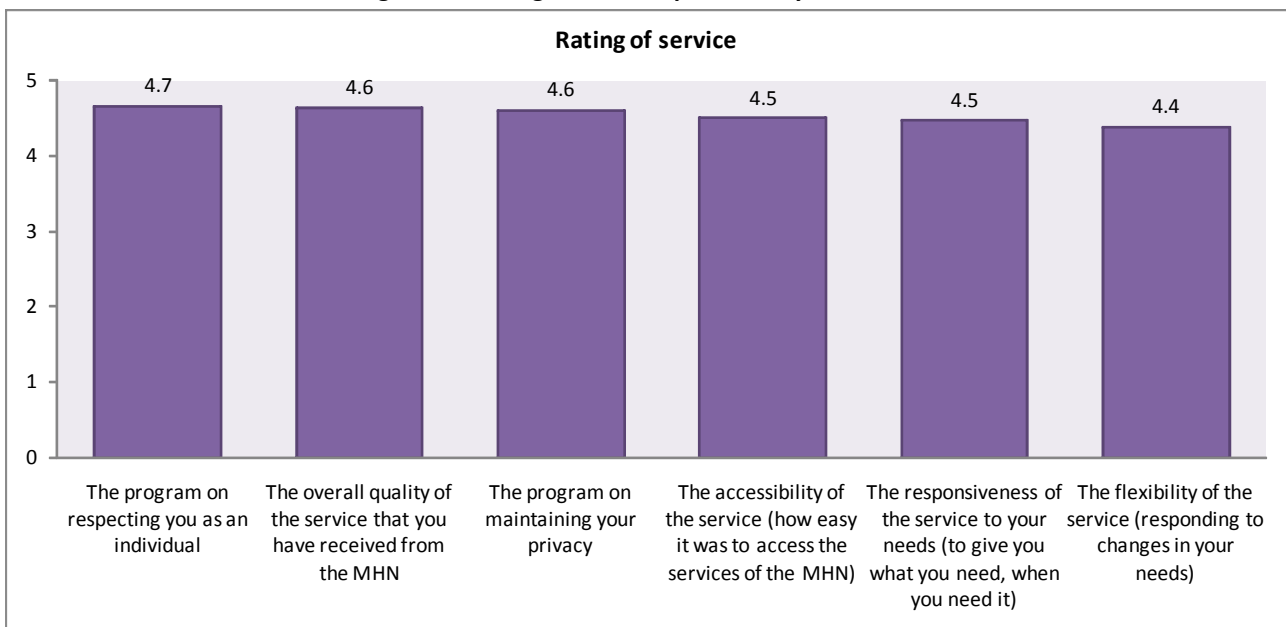
There were no statistically significant differences (ANOVA) for any of these variables between sites (anova) or based on gender (t-test).
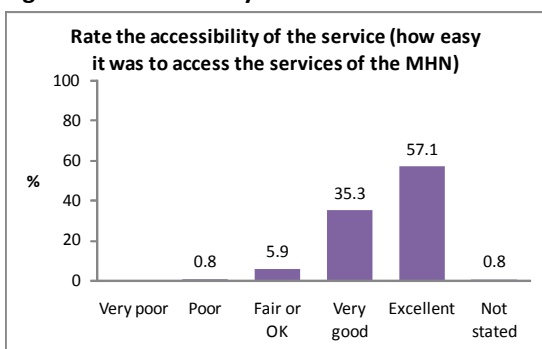
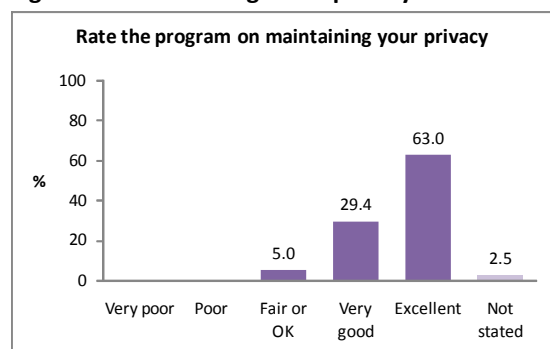**Figure 30: Accessibility of the service**

Figure 31: Maintaining client privacy
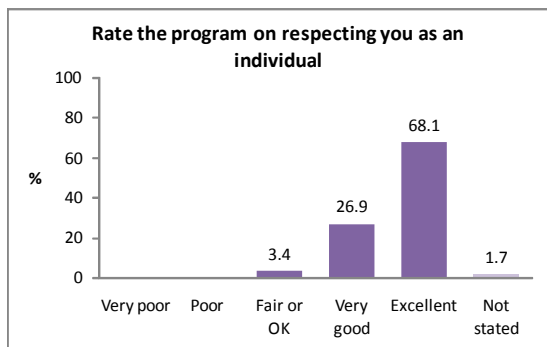
Figure 32: Respecting the client's individuality

Rate the program on respecting you as an individual

Very poor	Poor	Fair or OK	Very good	Excellent	Not stated
		3.4	26.9	68.1	1.7

Figure 33: Responsiveness of the service

Rate the responsiveness of the service to your needs (to give you what you need, when you need it)

Very poor	Poor	Fair or OK	Very good	Excellent	Not stated
	0.8	6.7	37.0	54.6	0.8
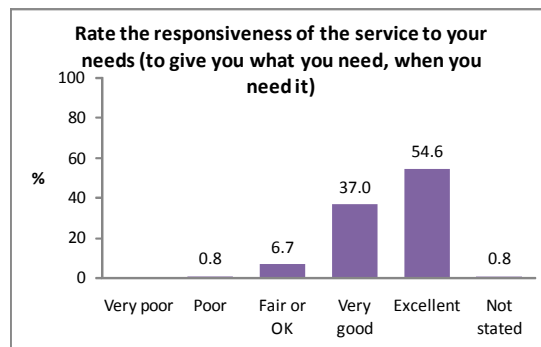
Figure 34: Flexibility of the service

Rate the flexibility of the service (responding to changes in your needs)

Very poor	Poor	Fair or OK	Very good	Excellent	Not stated
0.8		10.1	37.0	50.4	1.7
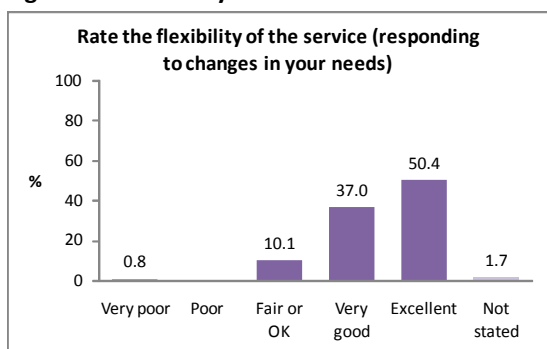
Figure 35: Overall quality of the service

Rate the overall quality of the service that you have received from the MHN

Very poor	Poor	Fair or OK	Very good	Excellent	Not stated
		4.2	27.7	66.4	1.7
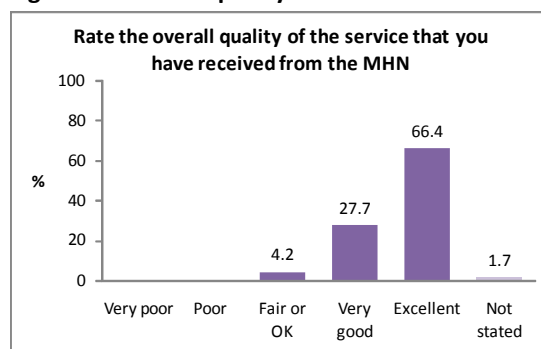
3.6.1 Differences based on clients' employment status

Although the clients invariably rated the responsiveness of the service to their needs (i.e. to give them what they need, when they need it) in the **very good to excellent** range (with an overall average of 4.5), the clients who were in **paid employment** rated significantly **higher** than clients who were not in paid employment but were looking for work (4.9 compared to 4.1). These clients were also more positive about the overall quality of service received from the Mental Health Nurse (clients who were not in paid employment but were looking for work, 4.3, and clients in paid employment, 5.0).

Clients who were not in paid employment but looking for work also rated the flexibility of the service to respond to changes in their needs (3.9) significantly lower than either clients who were not in paid employment and *not* looking for work (4.5) or those who were employed full time (4.7). (In reviewing these data it needs to be remembered that those not in employment represented some 80% of the sample compared with only about 20% being in employment.)

3.6.2 Perceived strengths and weaknesses of the MHNIP

In three open-ended questions, clients were asked to describe the **strengths** and **weaknesses** of the MHNIP, and to suggest **improvements** that could be made. Clients identified a wide range of strengths, very few weaknesses and identified only a few improvements that they felt could be made to the program. These findings are presented below, with the clients' own words used to illustrate the points made.

The following **strengths** were identified by more than one of 108 **(91%)** clients (the remaining 11 did not respond to this question) –

- o **The opportunity provided to discuss problems and issues with the Mental Health Nurse, and to receive constructive feedback about these (n = 55)**

  - ➤ *Being able to come to terms with my afflictions and the follow up of my problems.*

  - ➤ *Being able to talk about my illness and learn strategies to deal with problems related to my mental health e.g. relaxation techniques.*

  - ➤ *Gave understanding and strategies to improve my mental health; complimented other services and was very accessible/available.*

  - ➤ *Having someone come and see if I'm alright and talking about how I'm feeling and any problems arising.*

  - ➤ *Having someone to talk to without judgement.*

  - ➤ *I have support I didn't have before   Can discuss my problems confidently.*

  - ➤ *Having the opportunity to liaise with the community nurse discussing treatment and discuss my progress at work; family and life in general. Minimising my stress and lessening the need for medications/treatment and consultations with my psychiatrist.*

  - ➤ *The personal contact with the nurse… the ability to lead conversations and contribute to. Clear and concise conversations. Open communication. I would have been in a real mess if left by myself especially after hospitalisation.*

  - ➤ *The face-to-face friendly and caring contact. The good advice on things like medication management and some life issues and life stressors.*

- o **The provision of regular, frequent and ongoing communication, support and monitoring (n = 16)**

  - ➤ *Having regular weekly contact which has enabled me to function without loneliness; with now good structure and get out of bed for a reason.*

  - ➤ *Relying on her weekly visit; I look forward to it.*

  - ➤ *Knowing I'll be contacted regularly by someone I trust.*

  - ➤ *The ability to talk to somebody on a weekly basis.*

- o **The education provided to clients, including about medication and its managements (n = 13)**

  - ➤ *Explanation of drugs and the effects in layman's terms. Learning about problems of other members of the group and the nurse explaining the importance of them taking their medication i.e blood pressure medication and why.*

  - ➤ *Learning things I never knew existed (education).*

  - ➤ *Learning more about my illness.*

- o **The quality of the care provided and skills of the Mental Health Nurse (n = 11)**

  - ➢ *That I can have someone trained and qualified to listen to me regularly and knows how to deal with it.*

  - ➢ *The nurse is very knowledgeable not only in mental health but also in other areas of health. Her experience in a number of different fields in nursing helps to have the full picture about a lot of health issues that we have discussed.*

  - ➢ *The holistic approach that the MHN takes which helps me to address all aspects of my life.*

- o **The continuity of care provided (n = 10)**

  - ➢ *Having support after discharge from hospital.*

  - ➢ *Good follow up in hospital.*

  - ➢ *The connection (interaction) between patients, nurse and psychiatrists.*

  - ➢ *Continuity of care - same person seeing me the whole time – so can build trust and she can observe changes in me over a period of time I may not have seen myself and she can report back to my psychiatrist.*

- o **Reduced social isolation (n = 10)**

  - ➢ *I don't feel so alone and anxious.*

  - ➢ *Someone to talk to and extra contact with the outside world.*

- o **The accessibility and responsiveness of the program, particularly due to the provision of home visits (n = 8)**

  - ➢ *Having a mental health professional talk to me in my home environment to understand me better.*

  - ➢ *Having the home visits … found it very hard to get out.*

  - ➢ *Excellent communication with MHN and accessibility at short notice. e.g. usually same day at a time to suit both MHN and patient.*

  - ➢ *The willingness and availability of staff to act promptly.*

- o **Reduced reliance on GPs and psychiatrists (n = 6)**

  - ➢ *I have had someone to talk to when my doctor has been unavailable.*

  - ➢ *My [Mental Health Nurse] is more accessible then my psychiatrist.*

  - ➢ *It has been easier to talk to the mental health nurse than the psychiatrist and on a more regular basis.*

- o **Reduced reliance on family and a consequent reduction in burden on families, together with the support provided to family members (n = 6)**

  - ➢ *A friendly ear without relying on family for support.*

  - ➢ *Great support for family. Help organising family life to cope at home.*

  - ➢ *Having support outside of my family. Also, having my family know the nurse and that they or I can contact him if needed.*

  - ➢ *Someone for mum to talk to, now she can understand me better.*

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- o **The client focus and tailoring of care to individual need (n = 3)**

  Greater individuality of treatment and the less formal structure.

The following **weaknesses** were identified by more than one of 35 **(29%)** clients (the remainder did not respond to this question, or stated that they could not find fault with the program, or identified issues that were beyond the control of the program, such as, clients not wanting to make appointments with the nurse, clients feeling guilty that they needed the program, or issues relating to their particular condition) –

- o **The need for the program to be better resourced (n = 14)**
  - ➢ *Sometimes the program wasn't accessible under time constraints.*
  - ➢ *The MHN is only available 3 days per week.*
  - ➢ *Lack of equipment at the hospital to help pass time and reduce my stress levels.*
  - ➢ *When the nurse is on holiday or ill.*
  - ➢ *Due to overload of clients; weekly contacts are split between 2 nurses ie. one-week one nurse.*
  - ➢ *Sometimes my nurse is busy and can't come.*
  - ➢ *High demand for appointments.*
  - ➢ *Would like to be seen once a week in my home to make me feel safe and secure mentally and increase well being.*

- o **Accessibility, including the need for the program to offer services outside of normal hours, and for some clients, the distance between home and the clinic (n = 11)**
  - ➢ *When you build such a bond with the team of nurses in this program; not having an around the clock access is difficult when your disease is extreme. I knew I could always ring them but also they needed time out as well. More staff needed!!*
  - ➢ *Not having someone to talk to outside office hours.*
  - ➢ *Scheduling the appointments whilst working full-time … night duty shifts can be challenging on the occasion; due to business of program. Generally manage by pre-scheduling appointments weeks in advance.*
  - ➢ *No visits over Christmas or Easter.*

- o **Insufficient flexibility and responsiveness of the program (n = 2)**
  - ➢ *Sometimes the program did not have the flexibility of time I required.*
  - ➢ *Her need to ring me and change appt. times due to unexpected emergency or fitting in a new client.*

3.6.3 Improvements sought by clients

There were trends in the improvements suggested by the **82** clients (69%) responding to this open-ended question. Their feedback suggests the following two changes -

- o **Increased funding and resourcing to the program, generally, or to support specific changes – particularly out of hours service delivery, more time with the Mental Health Nurse or assistance with transport to the clinic**

  - ➢ *More funds - greater flexibility and accessibility.*

  - ➢ *More pay to pay nurses so they can work more than 3 days - if they want to.*

  - ➢ *More staff; 24 hour emergency access which again needs more staff.*

  - ➢ *Perhaps an improvement would come from greater resources and in my case a further education program to recognise the symptoms earlier.*

  - ➢ *Provide more nurses to cope with demands of the workload.*

  - ➢ *After hours contact via telephone would be good to help with problems.*

  - ➢ *More access out of hours times.*

  - ➢ *Weekend and holiday service.*

- o **Modifications to current service delivery features**

  - ➢ *Meet together outside the hospital setting. Have a list of activities for the year typed up rather than trying to think what we will do on the day. Bring in some guest speakers. eg. Nutritionist; Podiatrist; Pharmacist to speak about different areas of health.*

  - ➢ *May I suggest a courtesy pick-up coach.*

  - ➢ *More variation … [in options provided].*

  - ➢ *Organise face to face contact-home visits for regional residents.*

  - ➢ *Regular appointments on the same day of the week for people who need weekly appointments when your brains going funny it's a strangely big stress having different times dates and days each time.*

  - ➢ *The nurse really shouldn't double up on talk therapy whilst some issues are being looked at with the psychiatrist. This created some confusion and mixed messages.*

The evaluators have concluded that clients regard the MHNIP model as having more strengths than weaknesses, and improvements suggested actually support the existing model by seeking increased resourcing to continue it, with minor modifications to service delivery.

4 MENTAL HEALTH NURSE/COORDINATOR FINDINGS

4.1 Survey sample

A total of **16** Mental Health Nurses or Coordinators participated in the survey. Five of these are employed as Coordinators – either in a full time capacity with a focus on administration (2 individuals), or in a combined Mental Health Nurse/Coordinator role (*see Figure 37*). Between one and four MHN/Coordinators came from each of the six sites (the distribution can be seen in *Figure 36*).

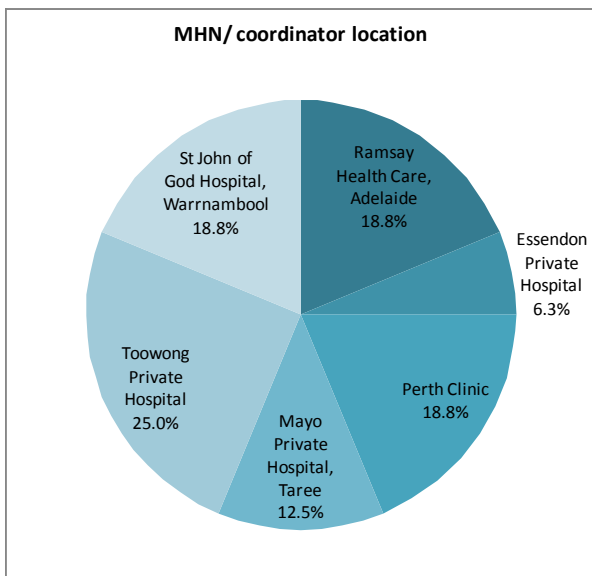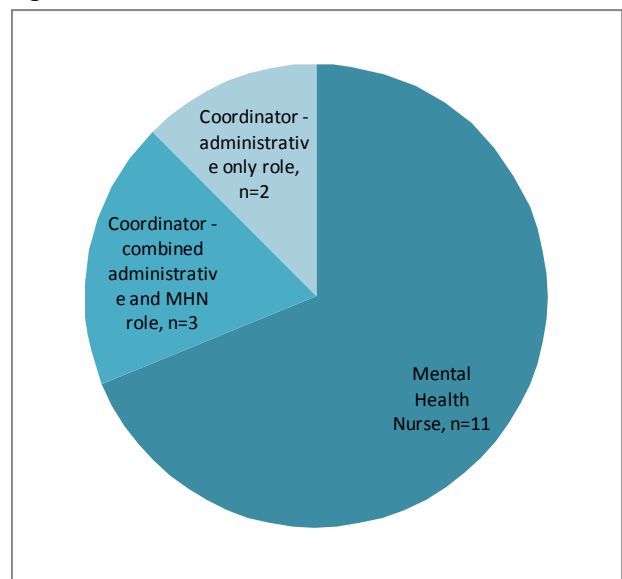**Figure 36: MHN/Coordinator's location**

Figure 37: MHN/ Coordinator's role within MHNIP

4.2 Delineating the role of the Mental Health Nurse

Based on site visit interviews with Mental Health Nurses, Coordinators and psychiatrists, the range of possible roles played by Mental Health Nurses in the private mental health setting were identified. These were used to structure a question where the relative importance of these different roles was rated on a five point scale ranging from Not Important to Very Important, or Not Performed. *Figure 39* to *53 provide details about ratings for each of these roles.*

As indicated in *Figure 38,* Mental Health Nurses and Coordinators have assigned a high degree of importance (average rating of '4' or higher) to 13 of the 15 roles identified, but with the most consistently high levels of importance assigned to the following –

- **Monitoring** clients' mental health and wellbeing (5.0).
- **Face to face** sessions with clients (4.9).
- **Client education**, including in medication and socialisation (4.8).
- **Advice and general information** provision to clients (4.8).

- Meetings and information **exchange with psychiatrists** (4.8).
- Post-discharge **follow up** of clients (4.8).
- **Administration** relating to the MHNIP (4.7).
- **Support and education** to clients and their families (4.6).
- **Referral/linkage** of clients to other services in the community (4.5).
- **Telephone contact** with clients (4.5).
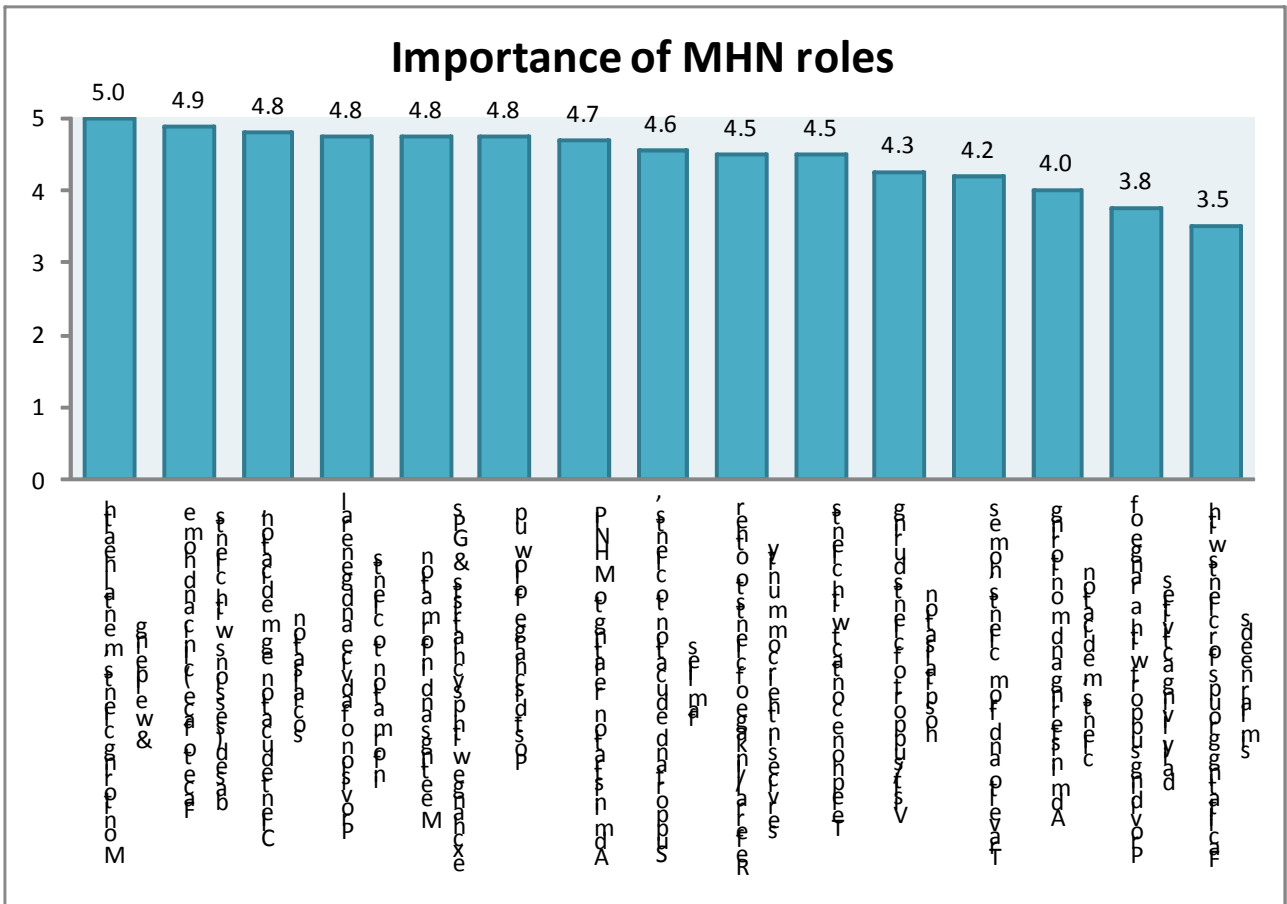
Figure 38: Importance of MHN/ Coordinator roles
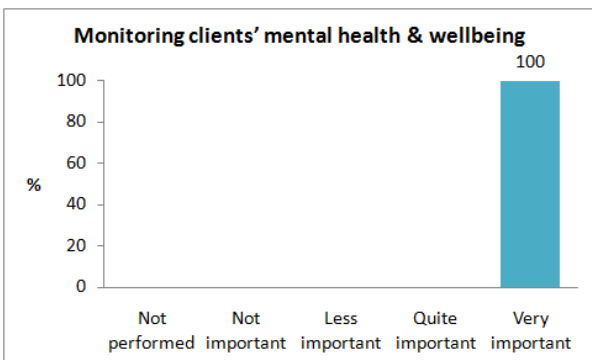

Figure 39: Monitoring mental health and wellbeing
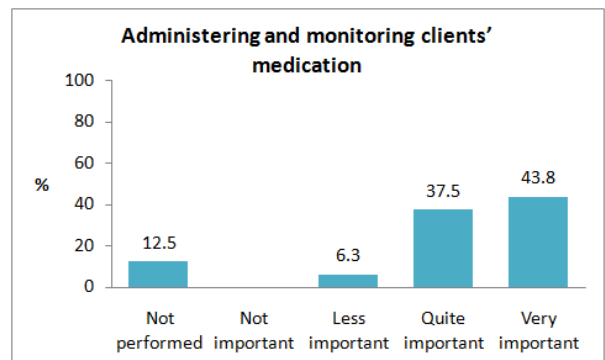

Figure 40: Administering and monitoring medication
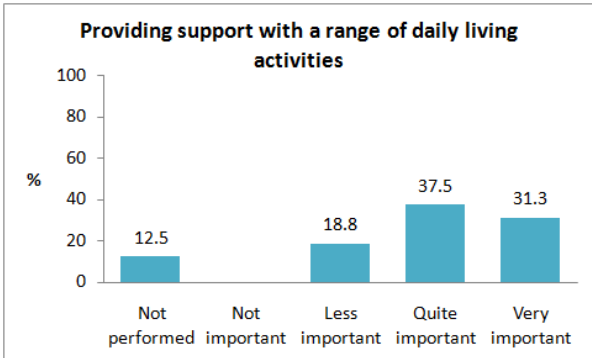
Figure 41: Support with activities of daily living

Providing support with a range of daily living activities

- Not performed: 12.5
- Not important:
- Less important: 18.8
- Quite important: 37.5
- Very important: 31.3

Figure 42: Referral to other community services

Referral/linkage of clients to other services in their community

- Not performed:
- Not important:
- Less important: 6.3
- Quite important: 37.5
- Very important: 56.3
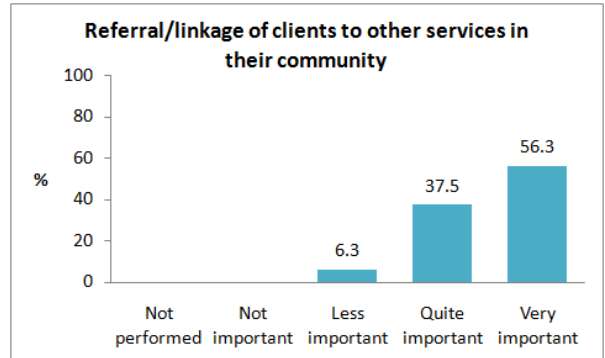
Figure 43:Face to face sessions

Face to face (clinic and home based) sessions with clients

- Not performed:
- Not important:
- Less important:
- Quite important: 12.5
- Very important: 87.5
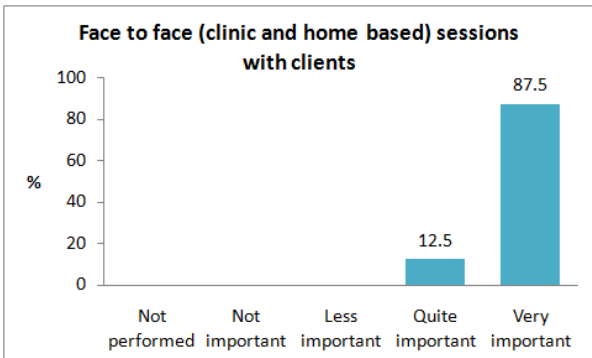
Figure 44: Telephone contact

Telephone contact with clients

- Not performed:
- Not important:
- Less important:
- Quite important: 50.0
- Very important: 50.0

Figure 45: Travel

Travel to and from clients' homes

- Not performed:
- Not important: 12.5
- Less important: 18.8
- Quite important: 6.3
- Very important: 62.5
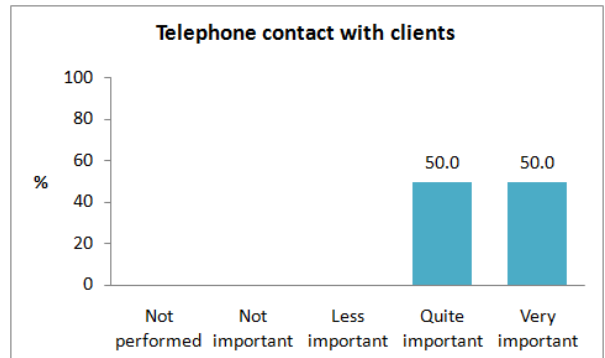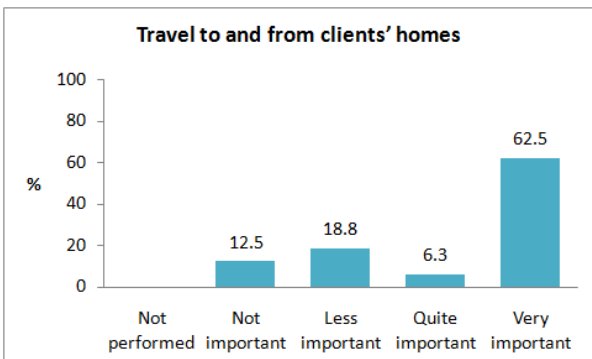
Figure 46: Facilitating groups

Facilitating groups for clients with similar needs

- Not performed: 6.3
- Not important: 6.3
- Less important: 37.5
- Quite important: 31.3
- Very important: 18.8
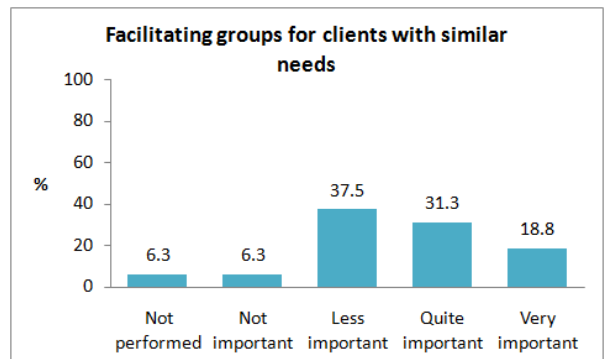
Figure 47: Advice and general information

Provision of advice and general information to clients

- Not performed:
- Not important:
- Less important:
- Quite important: 25.0
- Very important: 75.0

Figure 48: Education

Client education eg medication, socialisation

- Not performed:
- Not important:
- Less important:
- Quite important: 18.8
- Very important: 81.3
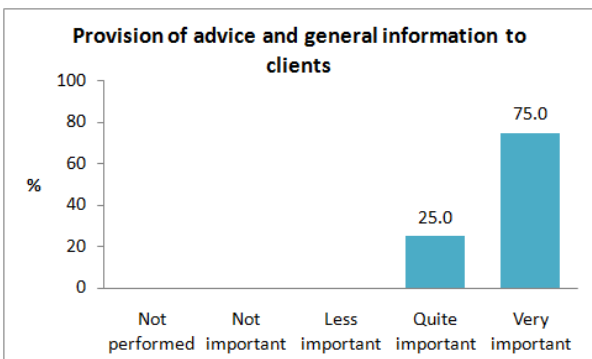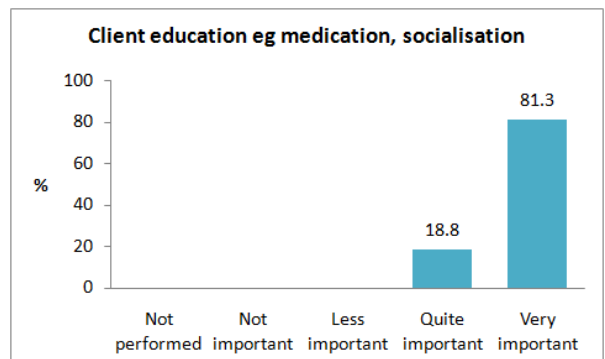
Figure 49: Support during hospitalisation

Visit/support of clients during hospitalisation
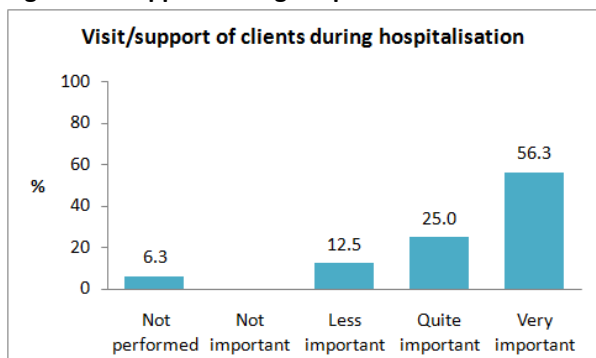
Figure 50: Support to families

Support and education to clients' families

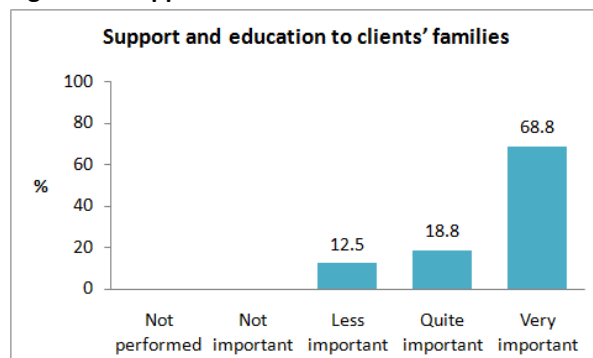**Figure 51: Meetings with psychiatrist and GPs**

Meetings and information exchange/liaison with psychiatrists and GPs
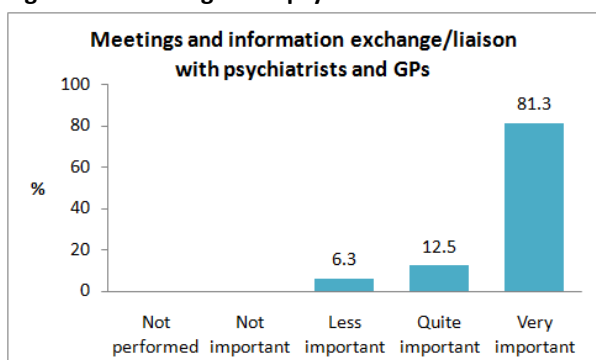
Figure 52: Post-discharge follow-up

Post-discharge follow up
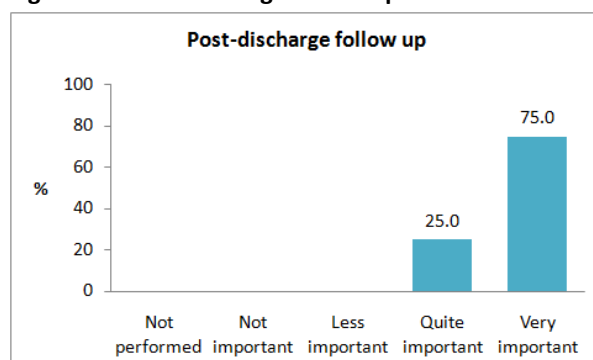
Figure 53: MHNIP administration

Administration relating to MHNIP
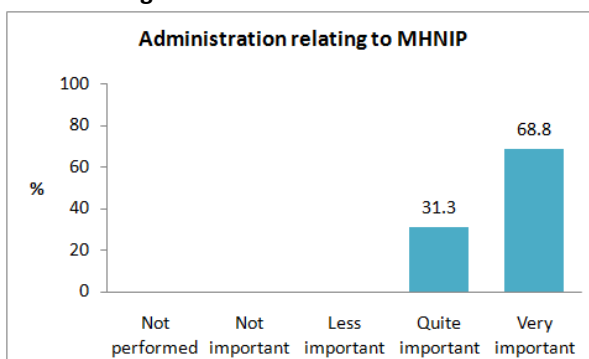
A number of **other roles and activities** were identified in open-ended format, and rated using the same scale. The following were nominated as *'Very important'* –

⇨ Referral to specialist services eg. mother and baby unit, crisis support team.
⇨ Physical health/metabolic screening and organizing this screening
⇨ Liaising with other members of the extended Mental Health team.
⇨ Support of staff in aged care facilities.
⇨ Transfer to acute care when high risk.
⇨ Monitoring side effects of new medications (although this would be encompassed in the recognized role of medication monitoring).
⇨ Psychosocial and interpersonal counselling (again, this would be encompassed within existing recognized roles of the MHN).

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⇨ Facilitating re admission to hospital if required.
⇨ Facilitating carer support group.

These three activities were rated as being *'Quite Important'* –

⇨ Peer supervision.
⇨ Out of hours phone calls – weekends.
⇨ Promoting clients' 'social engagement'.

4.3   Rating the credentialing requirement for Mental Health Nurse employment

MHNIP guidelines require the employment of Mental Health Nurses who hold appropriate credentials, recognised by the Australian College of Mental Health Nurses. Some of the sites have identified the limited supply of these nurses as the key factor for their delayed implementation, and this has been compounded by the pilot status of the MHNIP in the private mental health setting. During the site interviews comment was made that significant proportion of available Mental Health Nurses are in secure employment and unwilling to exchange this for a lack of guaranteed employment – especially if they are in older age groups. However, credentialing is an important quality control mechanism, and a means of formal recognition of the expertise required of Mental Health Nurses.

Figure 54 summarises average ratings, and detailed responses to each issue appear in *Figure 55* to *61.* It can be seen that Mental Health Nurses and Coordinators gave their highest average rating on this issue **(4.3)** to **'This requirement is an important mechanism for quality control'**, and to **'Experience as a MHN is as important as formal accreditation and should be part of MHNIP requirements'**. In other words, while formal qualifications are seen as important, Mental Health Nurses do not want experience to be overlooked in recognising their competency.

They believe that experience can be formally acknowledged through **Recognition of Prior Learning** mechanisms (4.0) and that their **employers should support them to achieve the required qualifications** (4.1).

The sample was divided about whether or not the current shortage of credentialed Mental Health Nurses will decrease over time (average rating 2.7), about whether the current supply of Mental Health Nurses makes this MHNIP requirement difficult to fulfil (3.3) and about whether the time and commitment involved in gaining the required credentials makes it difficult to fulfil (3.2).

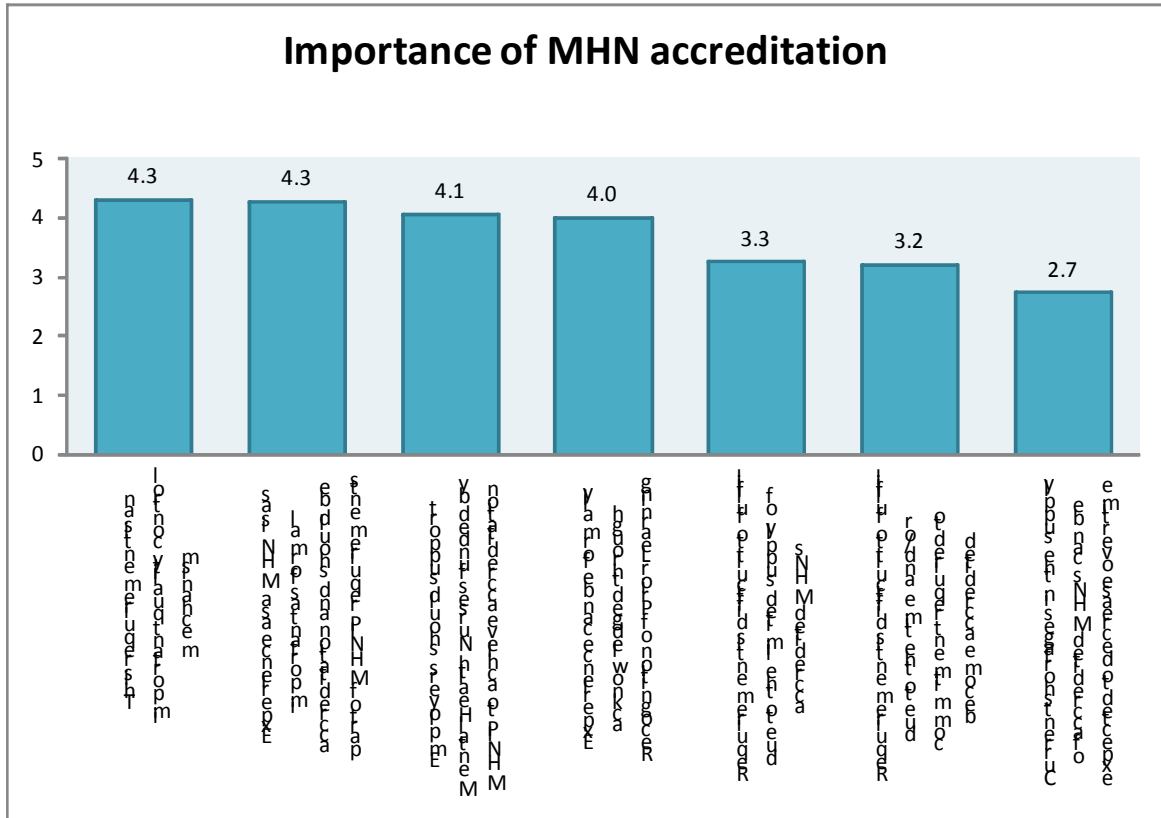**Figure 54: Importance of MHN/ Coordinator accreditation**

Importance of MHN accreditation

(Bar chart values: 4.3, 4.3, 4.1, 4.0, 3.3, 3.2, 2.7)

Figure 55: Limited supply of accredited MHNs

Requirement is difficult to fulfil due to the limited supply of accredited MHNs

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
12.5	18.8	18.8	31.3	18.8
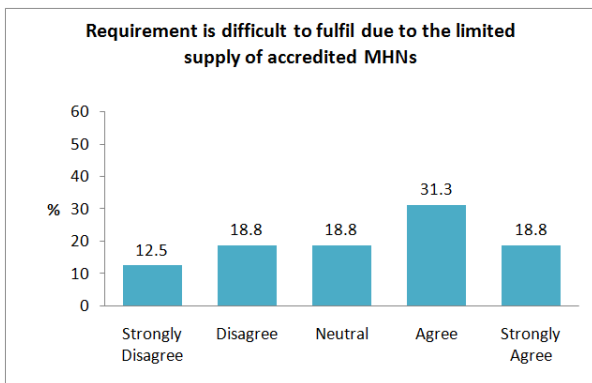
Figure 56: Time required to become accredited

Requirement is difficult to fulfil due to the time and/or commitment required to become accredited

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
12.5	31.3	6.3	25.0	25.0
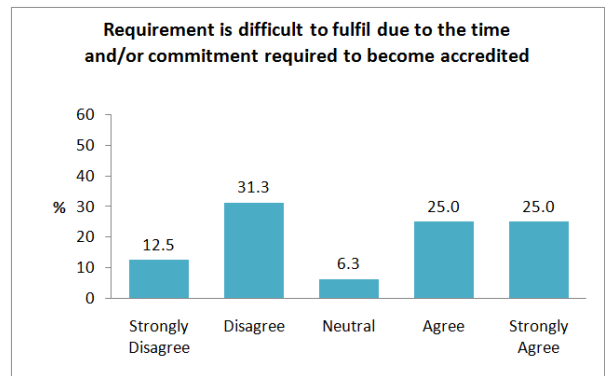
Figure 57: Important quality control mechanism

This requirement is an important quality control mechanism

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
	6.3	6.3	37.5	50.0
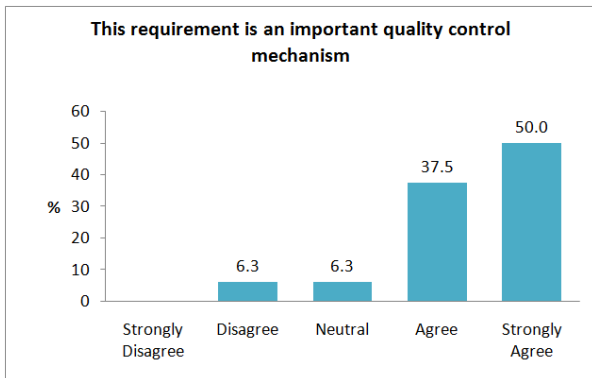
Figure 58: Experience is as important

Experience as a MHN is as important as formal accreditation and should be part of MHNIP requirements

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unsure
		6.3	56.3	31.3	6.3
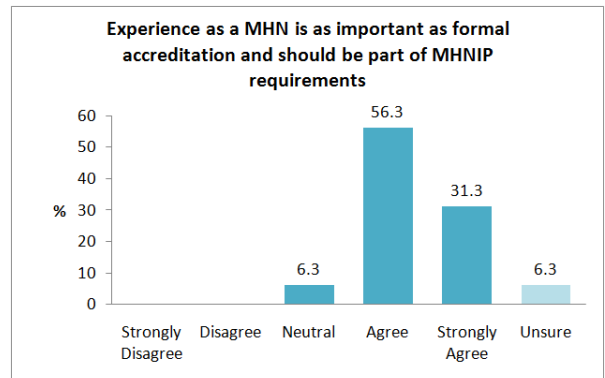
Figure 59: Recognition of Prior Learning

Experience can be formally acknowledged through Recognition of Prior Learning

- Strongly Disagree: 6.3
- Disagree: (none)
- Neutral: 6.3
- Agree: 56.3
- Strongly Agree: 25.0
- Unsure: 6.3
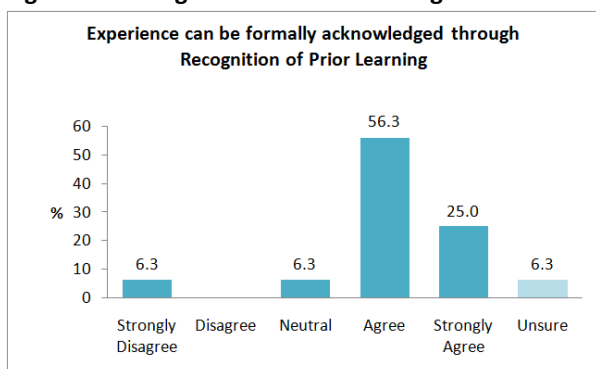
Figure 60: Employer support

Employers should support Mental Health Nurses funded by MHNIP to achieve accreditation

- Strongly Disagree: 6.3
- Disagree: (none)
- Neutral: 18.8
- Agree: 25.0
- Strongly Agree: 43.8
- Unsure: 6.3

Figure 61: Shortages to decrease

Current shortages in the supply of accredited MHNs can be expected to decrease over time

- Strongly Disagree: 31.3
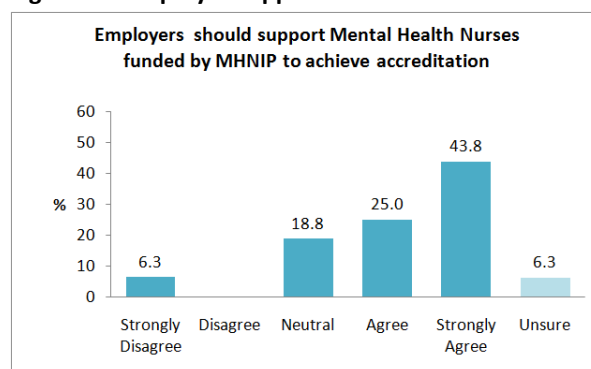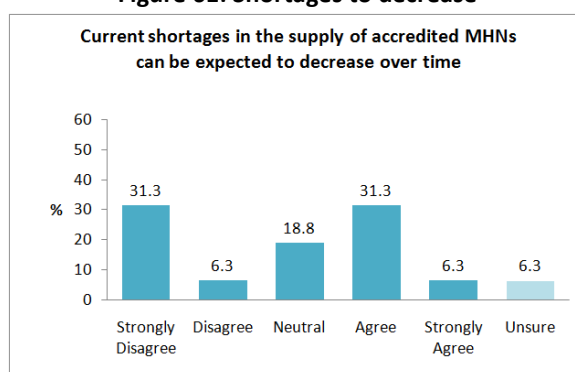- Disagree: 6.3
- Neutral: 18.8
- Agree: 31.3
- Strongly Agree: 6.3
- Unsure: 6.3

Five people provided additional comments on the issue of accreditation, and four of these supported accreditation, while the fifth commented on insufficient attention being given to mental health issues in undergraduate nursing training.

> ➢ *For myself, this organisation has supported my application for credentialing, this was however only possible because of my experience and commitment to maintaining my level of education. This is fueled by a belief that to be an effective member of the treating team it is important for us as individuals to be educated and current. It is my belief that there is not enough being done to foster the development of a mental health workforce into the future. More needs to be done to make this an attractive option for new grads. We need to have a career structure that acknowledges that we don't all practice in a ward setting, movement from RN to CNS to CNC and NP should be a defined path with defined responsibilities.*

> ➢ *Accreditation should return financial benefits for the nurse.*

> ➢ *The credentialing process is time consuming in the initial credential but is less so when you apply for re-credentialing. No points are given to the nurse for the actual amount of time they spend in clinical contact hours with clients/others which I believe is missing.*

> ➢ *Mental Health Nurses working in this program require extensive experience and knowledge in a broad range of mental health issues. In many instances they are seeing patients in place of the psychiatrist. I recommend Clinical supervision with a psychiatrist as a necessity.*

> ➢ *Accreditation to be upheld due to nature of work.*

4.4 Resourcing issues

4.4.1 Quantifying maximum caseloads

Acknowledging that case loads can vary with the mix of clients and their needs, Mental Health Nurses and Coordinators were asked to identify the maximum manageable caseload (that is, the maximum number of active clients) of one FTE Mental Health Nurse, averaged over a three month period. As *Figure 62* indicates, the majority (75.0%) have quantified this at between **20** clients (31.3%) and **25** clients (43.8%). They were also asked if they had waiting lists, and the majority (81.3%) do not – *see Figure 63*.

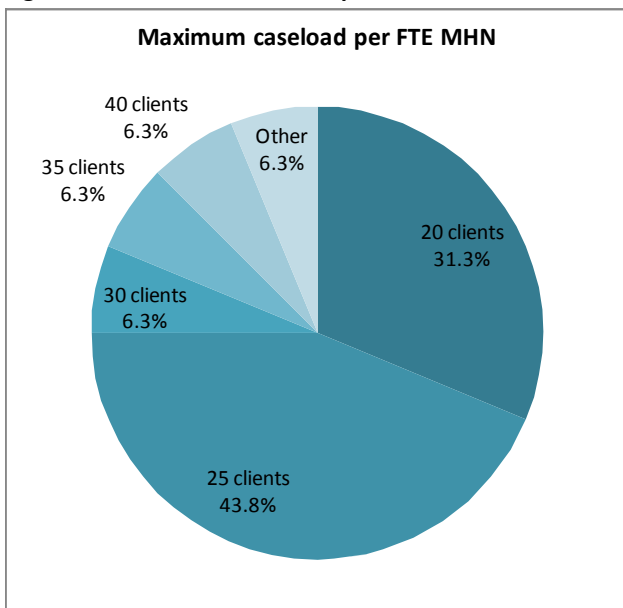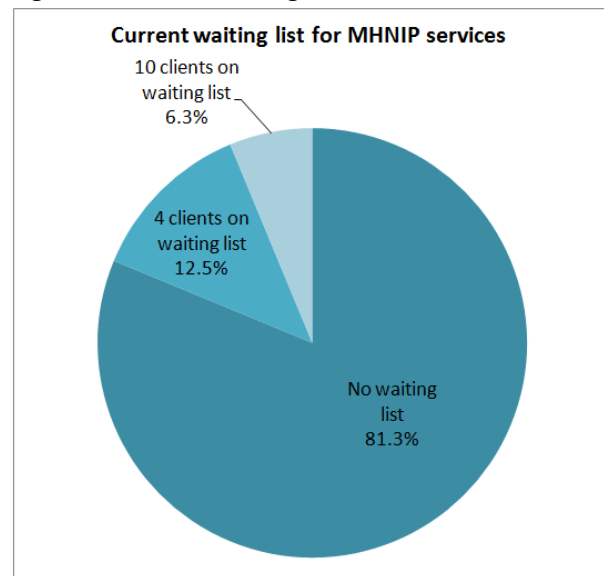**Figure 62: Maximum caseload per FTE MHN**

Figure 63: Current waiting time for services

Additional comments on the quantifying of case load appear below. Basically these point out that a 'one size fits all' approach is not appropriate because of varying client need, location and model applied.

> ➢ *Depending on the level of severity of illness. If you have all low care needs people you could take on more than 30. Travel time is also a major factor depending on your catchment area.*

> ➢ *For us to travel is time consuming. Clients in isolated areas often unable to attend the hospital. This travel time narrows patient contact time.*

> ➢ *Depending on what model and practice i.e. if 'outreach' is the core component and role. Consider travel time. If 'centre-based service' i.e. client attends clinic appointment, caseload can be higher in number.*

> ➢ *The number of clients depends on the travelling distance to see them. I have to travel an hour to see one client who I visit fortnightly.*

> ➢ *This depends on complexity severity of symptoms. Also it can depend greatly on if they have had a relapse or admission.*

> ➢ *As we are working with particularly unwell patients, there needs to be time available to respond to crisis.*

Two people also commented on the amount of administration required as affecting caseload.

> *Having come from the public system with its emphasis on MH-OAT I am amazed that I am able to case manage the group I am able to manage, currently 43 people, because I don't have that cumbersome instrument to complete.*

> *Hopefully post evaluation some of the paper work will decrease and more time will be able to be spent in patient management.*

4.4.2 Barriers to expanding current case loads

The main barriers to expanding the current case load were described as involving *(Figure 64)* –

- o **Lack of infrastructure** – such as, accommodation, cars (n=11, 68.8%).
- o **Time and distance involved in providing home visits** to clients (n=9, 56.3%).
- o **Difficulties in recruiting accredited Mental Health Nurses** (n=8, 50.0%).
- o **Administrative and coordination load** (n=5, 31.3%).
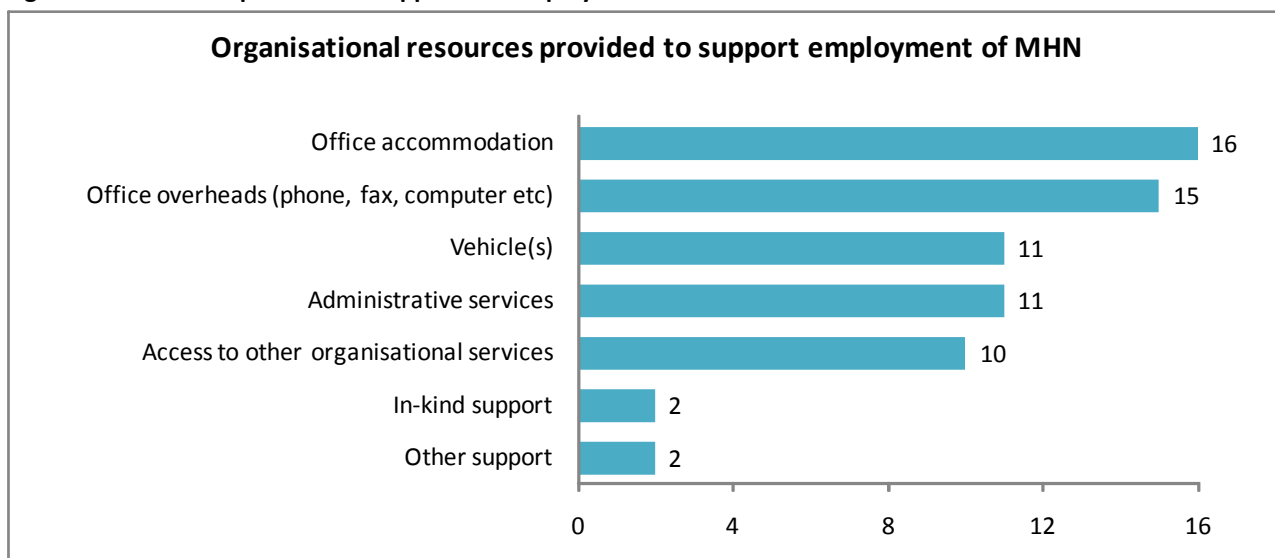
Figure 64: Barriers to expanding case load
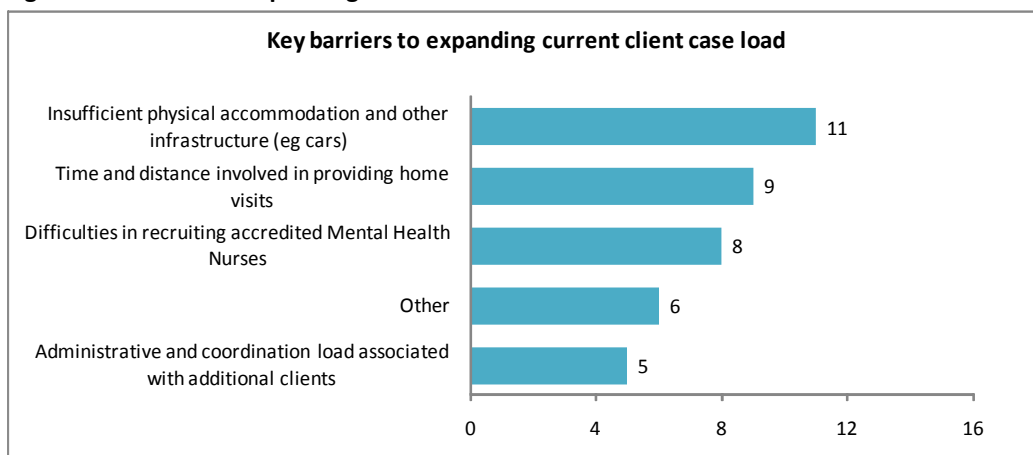
Note. Multiple responses possible

4.4.3 Reliance on auspicing organisations' contribution to resourcing

Earlier interviews undertaken by the evaluators found that auspicing organisations were providing significant resources that are of critical importance to the Pilot. The survey was designed to quantify those resources, and as *Figure 65* indicates, these confirm the qualitative findings and involve –

- o Office accommodation (n=16, 100.0%)
- o Office overheads, such as, phone, fax, computer (n=15, 93.8%)
- o Administrative services (n=11, 68.8%)
- o Vehicle/s (n=11, 68.8%)
- o Access to other services provided by the organisation (n=10, 62.5%)
- o In-kind support (12.5%)
- o Other support (12.5%).

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Figure 65: Resources provided to support the employment of a MHN

Organisational resources provided to support employment of MHN

Resource	Value
Office accommodation	16
Office overheads (phone, fax, computer etc)	15
Vehicle(s)	11
Administrative services	11
Access to other organisational services	10
In-kind support	2
Other support	2

Note. Multiple responses possible

In terms of 'other support' provided, the two respondents concerned described this as involving –

- o Clinical supervision provided and paid for by nurses themselves as a group meeting monthly.
- o In-house education and case reviews. Use of onsite psychologists, rehabilitation and other staff.

The evaluators' site interviews also identified the importance of the auspicing service for **achieving service synergies**, **exchange of resources** and **effective subsidisation** of the MHNIP. **Many of those interviewed stated that the MHNIP does not receive sufficient funding to be a stand-alone service.**

Only 2 respondents were able to estimate what this support equated to in dollars per year. The details are as follows –

1) $90,000, which included all types of support listed above.
2) $30,000, which included office accommodation, office overheads (phone, fax, computer etc), administrative services and vehicles.

The evaluators do not consider this information sufficiently useful for drawing conclusions about the dollar value of auspicing organisations' contribution to the MHNIP. However, for future costing of the program, this information should be obtained as part of program accountability requirements.

4.5   Home-based visits versus clinic-based service delivery

Mental Health Nurses and Coordinators were asked to quantify the advantages and disadvantages of delivering Mental Health Nurse services in clients' homes and in the hospital or clinic setting.

As *Figure 66* summarises, the two key advantages of providing services in clients' homes are –

iii.   **increased accessibility for clients who find it difficult to visit clinics** (93.8%) – this was also supported by clients in their feedback - and

44

iv.   the gaining of **additional, important information that assists in assessment and treatment** (93.8%).

However, this model brings **risks for Mental Health Nurses associated with travel and safety** which the clinic-based model avoids (81.3%) and is considered to be **less cost-effective than clinic-based delivery** (68.8%) due to time and costs associated with travel.

Clearly, most of the sites have adopted a **hybrid model** to maximise the advantages and minimise the disadvantages, with the exception of the Perth site which has provided most of its services to date in the clinic setting *(see Section 2.1.4).* Sites also vary in relation to the **proportion** of home visits to clinic visits made by Mental Health Nurses.

Figure 66: Advantages and disadvantages of a clinic versus home-visit based model of delivery
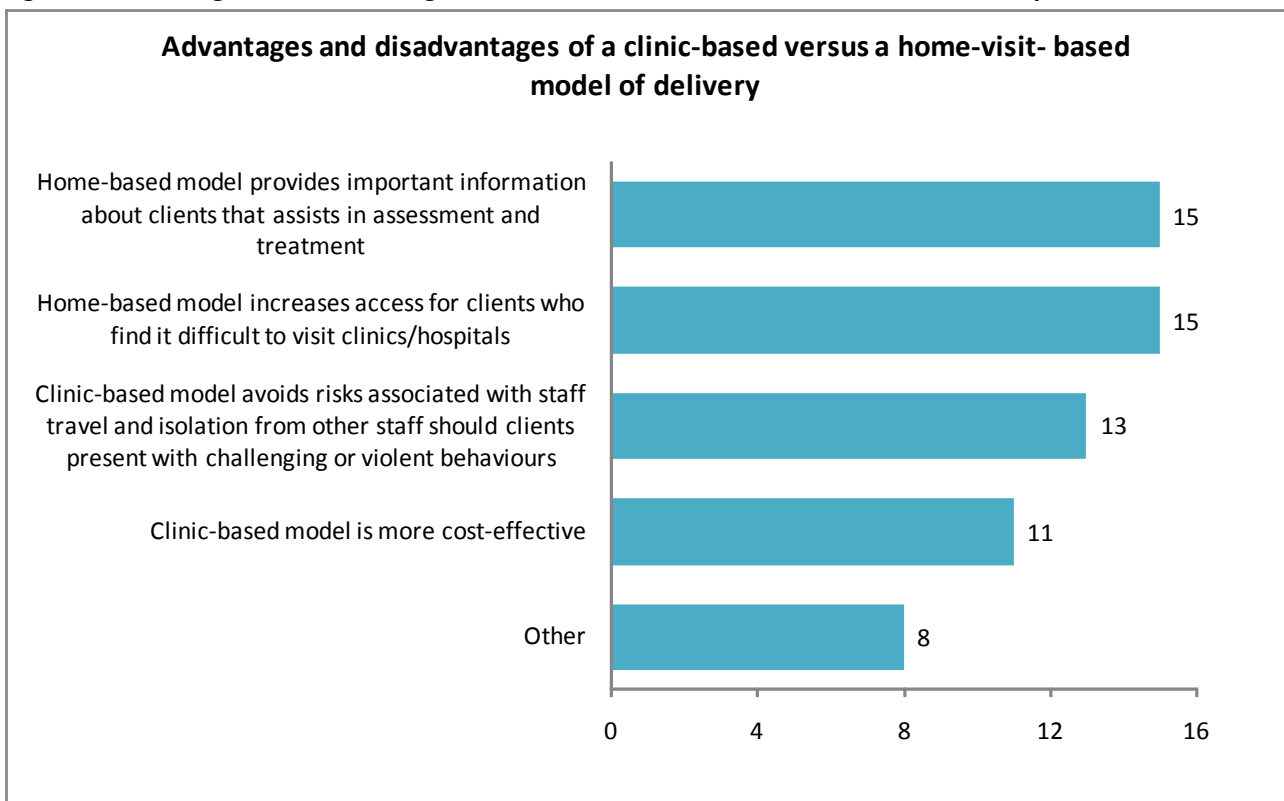
Note. Multiple responses possible

Additional, open-ended feedback appears below. This is separated according to advantages identified for each model.

Advantages of the clinic based model

➢ *Clinic-based model much more time effective and reduces the stress of driving.*

➢ *Clinic based health care-can assist to minimise transferance issues with certain clients.*

➢ *Clinic sessions allow for a greater number of patients to be seen as time is not lost in travelling. Patients are required to take greater responsibility for their mental health care.*

- *Solo practitioners are at risk visiting some patients at home due to area/complex in which they live. Risk not necessary from patient referred. I have had to take a staff member from another unit with me on two occasions.*

- *Clinic based model puts emphasis on the patient's own motivation for treatment and therefore increases responsibility of patients. However it does also burden patients who have access issues - children, live a long way away, or are unwilling to use public transport.*

- *Time taken in travel is a major factor when considering case load assignment and coordinating your own visits. Clustering persons to visit in an area is ideal but unfortunately not always practical and achievable. Clients do want to reschedule appointments which makes the task even more difficult.*

Advantages of the home based model

- *Difficulties for us include isolation. In rural areas often needing home based visit.*

- *Home-based visits facilitate compliance with insightless or amotivated clients who would be unlikely to attend clinic appointments.*

- *Home based therapy works well if there is no risk issues identified. This can be done on the initial consultation and regular follow up.*

- *Home based model more accessible for amotivated clients who would be unlikely to attend appointments.*

- *There are assessments that are difficult to ascertain when one cannot travel to someone's house to see them.*

- *We are in a rural area travelling is an issue but worth it as we gather, assess more comprehensively.*

- *The great advantages of home based model from a service provision stand is the flexibility to be able to meet with the client in a setting they are comfortable with, where there are no restrictions to access because of the lack of public transport, cost of transport to a centre, the ability to spend more time should that be necessary. There could be safety concerns, these are mitigated in our service by the psychiatrist having seen the person before referral to outreach.*

- *… tend to have clients who book an appointment then not turn up or phone to request reschedule appointment at the last minute. Leads to clinics not being able to fulfill the 2-3 patient/session requirement (mostly book 1 hour per patient) - 7 patient/day. Sometimes only 4 turn up! The Department of Health and Ageing need to somehow make some concession for this problem because cancellation and appointment by clients at the last minute is not within our control!!*

4.6 Job satisfaction and conditions of employment

As *Figure 67* indicates, none of the Mental Health Nurses and Coordinators surveyed indicated dissatisfaction with their work. Only one person is neither satisfied nor dissatisfied, **56.3%** are 'Quite Satisfied' and **37.5%** are 'Very Satisfied.

Figure 67: MHN job satisfaction

MHN job satisfaction with role

- Neither satisfied nor dissatisfied 6.3%
- Very satisfied 37.5%
- Quite satisfied 56.3%
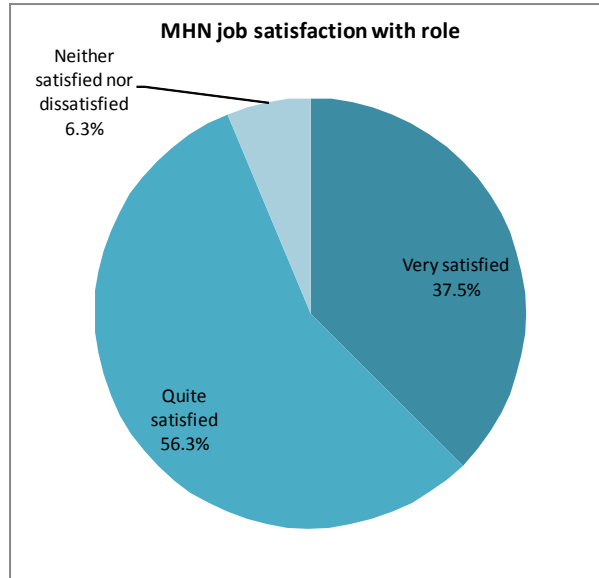
4.6.1 Most rewarding and challenging features of the MHN role

Additional open-ended responses, provided by 16 individuals, identified a number of trends in identifying the **most rewarding** aspects of the Mental Health Nurse role. These involve –

- The positive impact made on clients' health and well being (n = 5)

  I love the client contact, I feel that I make a difference in my client's quality of life.

- The autonomy associated with the work role (n = 4)

  Autonomy and ability to work innovatively.

  Continuity and autonomy of care with patients.

- The focus on and contact with clients (n = 3)

  I love the client contact and the fact that I have been able to discharge clients from the program due to improvements in their functioning.

- The flexibility associated with the delivery model (n = 3)

  The flexibility to provide a range of services to people who otherwise would not receive any service is very rewarding….

- The model itself, including the capacity for innovation, delivery in the home and linkage to the community (n = 3)

  Community focus and home visits, flexibility, autonomy and independence.

- The supportive work environment and respect received from colleagues (n = 3).

To be part of a range of services on offer within this health setting ....To be a valued member of a committed team.... To be able to apply skills and experience in a supported situation. To have the ability to readily communicate directly with treating psychiatrists.

Most of the features of the Mental Health Nurse's role that are seen as rewarding arise from the MHNIP model itself.

By contrast, the most challenging aspects of this role arise less from the model and more from conditions of employment, and resource limitations. However, it should be noted that some of those in rural locations identify the long distances travelled to clients' homes as a challenge (although acknowledging elsewhere that this is a positive feature of the model from the client's perspective). A total of 8 individuals provided feedback on this issue.

- The impact of limited resources, especially in periods of higher demand and heavier caseloads (n = 6)

  In acute need periods - time consuming and need for reorganisation of client load when resources limited.

- Driving long distances (n = 3)

  Long distances travelled (rural service).

- Difficulties in recruiting appropriately skilled and committed staff (n = 2)

  Recruitment of staff that have the skills and passion to make a difference ....

- Insufficient coordination and communication between Mental Health Nurses and psychiatrists (n = 2)
  Lack of co-ordination and communication between MHNIP nurses and psychiatrists.

- Lack of job security (n = 1)
- Lack of professional development (n = 1)
- The range and complexity of mental health issues involved (n = 1)
- Working in isolation (n = 1).

4.6.2   Advantages and disadvantages of mental health nurse role in private sector

Using open-ended responses, Mental Health Nurses were asked to nominate the advantages and disadvantages of undertaking their role in the private sector, as compared with the public sector. A total of 13 individuals provided feedback on the advantages and 8 provided feedback on the disadvantages.

Again, many of the disadvantages do not relate to the model, but to employment conditions and the way the model has been implemented. Those disadvantages that are too difficult to categorise, or don't appear to have answered the question, or reflect on systemic issues beyond the control of the MHNIP, are presented in *italics* – see *Table 3.*

Table 3: Advantages and disadvantages of undertaking the MHNIP role in the private sector

Advantages identified	Disadvantages identified
Greater flexibility of care delivery possible than in public setting (n =2)	Eligibility criteria are less flexible than in public sector (n = 1)
Greater accessibility through providing care in the home (n = 1)	*Sometimes difficult to access support for public patients from government agencies (n =1)*
Greater innovation possible (n =1)	*Support systems are more difficult to access as they are not structured to facilitate multi-disciplinary care (n =1)*
Greater responsiveness possible in care delivery (n =2)	*Poorer job security than in public sector (n = 1)* *MHNs paid less in private sector (n = 1)*
Increased access for clients to psychiatrists (n =1)	*Isolation from not being part of multi-disciplinary team (n = 1)*
Greater continuity of client care, especially in the provision of post-hospital follow up (n =2)	*Some procedures still not developed (n = 1)* *Insufficient inpatient follow up (n = 1)*
Enhanced collaboration between psychiatrists and mental health nurses (n =1)	*Employer/hospital management not understanding model due to 'hospital based thinking' (n = 1)*
Filling of a key gap in the mental health service system eg provision of support services that are normally too expensive in private sector (n =2)	*Resource sharing issues with rest of hospital (n = 1)* *Not seeing enough patients to claim Medicare payment and feeling pressure when this occurs (n = 1)*

4.7 Rating conditions of employment

As can be seen from *Figure 68* –

- o The **lowest** average rating **(3.1)** was applied to **'Opportunities for further training and development',** followed by **'Security of employment'** and **'Salary and financial benefits' (3.2),** and an average of **3.3** to **'Opportunities to develop specialised skills and knowledge on-the-job'**.

- o The **highest** ratings were applied to **'Impact on your career' (4.1)** and **'Working conditions' (4.1).**

Figure 69 to *74* provide details of the range of responses to different aspects of MHNIP nurses working conditions.

The evaluators have concluded from these findings that attracting Mental Health Nurses to the private sector requires attention to opportunities for further professional development, job security (which stands in contrast to that of the public sector), and salary and financial benefits.

It must be remembered that (apart from the currently limited supply of appropriately accredited nurses) many Mental Health Nurses in the public sector are aged in the normal pre-retirement years, and are unlikely to surrender hard earned security and associated employment benefits. For nurses to move to a program like the MHNIP, these conditions and the opportunity to acquire increased skills and knowledge, is a recruitment factor that crosses all age groups.

Setting aside these concerns, the Program can build on its existing strengths of providing a valuable career experience and development opportunity together with working conditions (such as, autonomy,

flexibility, innovative service delivery) in attracting its workforce. Despite Mental Health Nurses' negative assessment of their employment-related conditions, this has not affected the positive impact of their work on clients (as assessed by both service providers and clients).

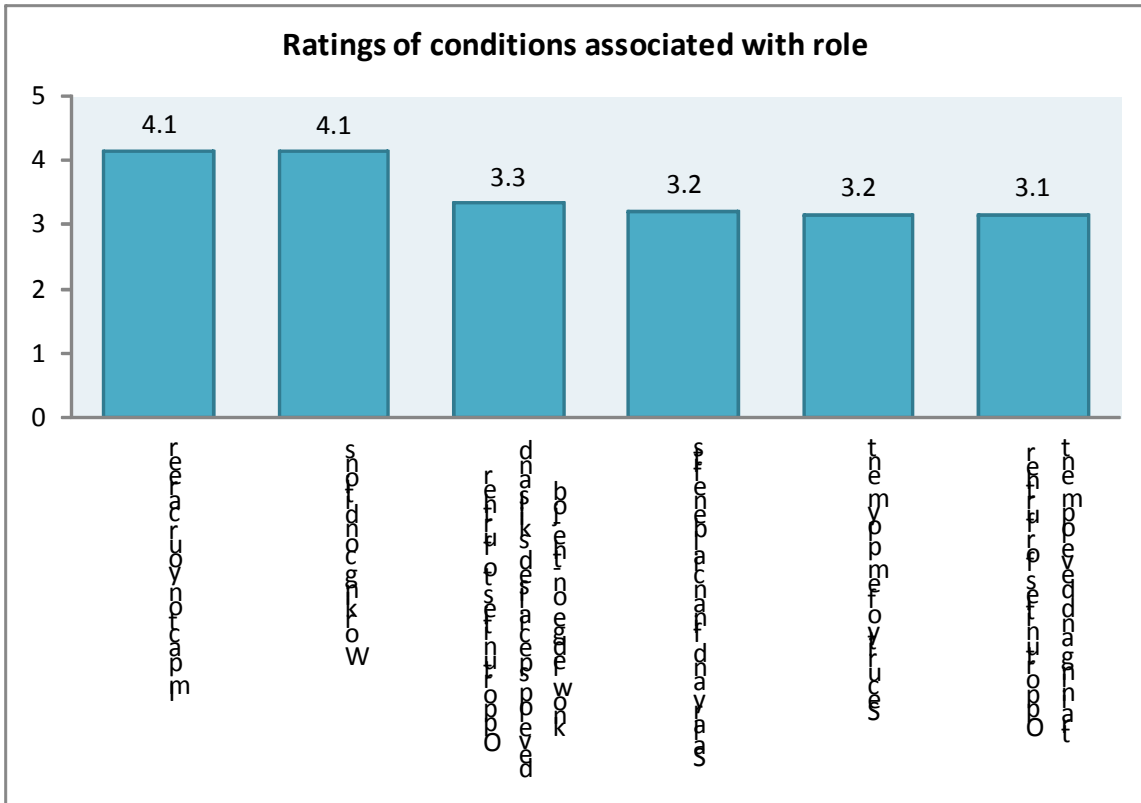**Figure 68: Average ratings of key features of MHN working conditions**

Ratings of conditions associated with role

Figure 69: Rating salary & financial benefits
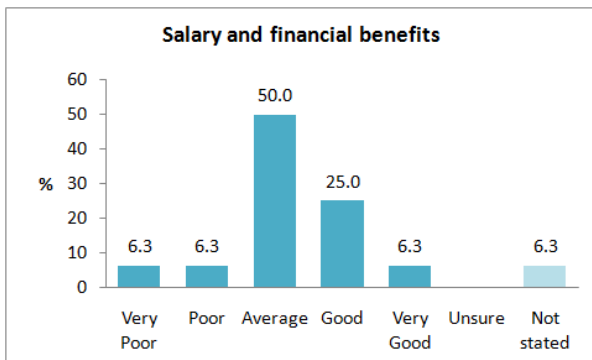
Figure 70: Rating overall working conditions
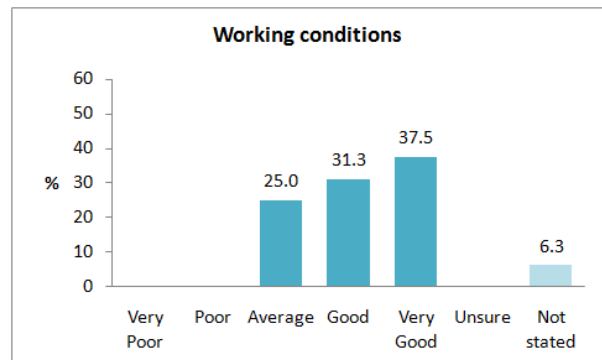
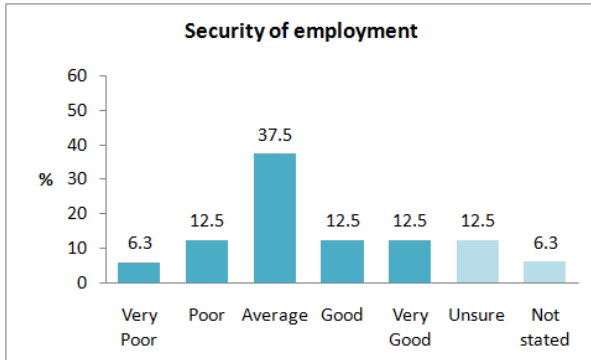**Figure 71: Rating security of employment**

Security of employment

Category	%
Very Poor	6.3
Poor	12.5
Average	37.5
Good	12.5
Very Good	12.5
Unsure	12.5
Not stated	6.3

Figure 72: Rating skill development opportunity

Opportunities to further develop specialised skills

Category	%
Very Poor	6.3
Poor	12.5
Average	31.3
Good	31.3
Very Good	12.5
Unsure	
Not stated	6.3
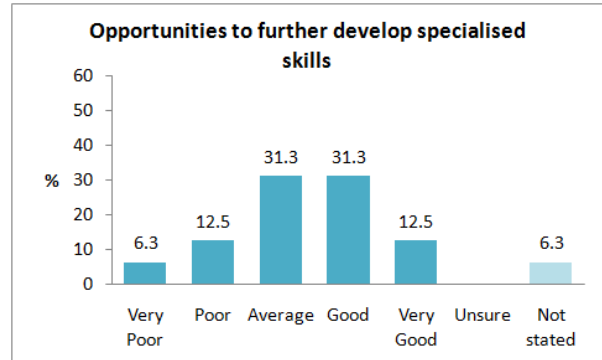
Figure 73: Rating professional devt opportunity

Opportunities for further training and development

Category	%
Very Poor	6.3
Poor	25.0
Average	18.8
Good	25.0
Very Good	12.5
Unsure	6.3
Not stated	6.3

Figure 74: Rating impact on career

Impact on your career

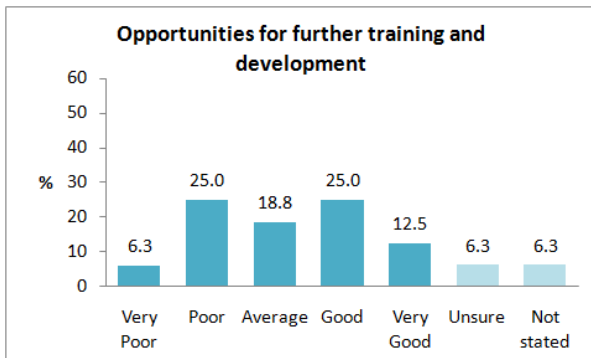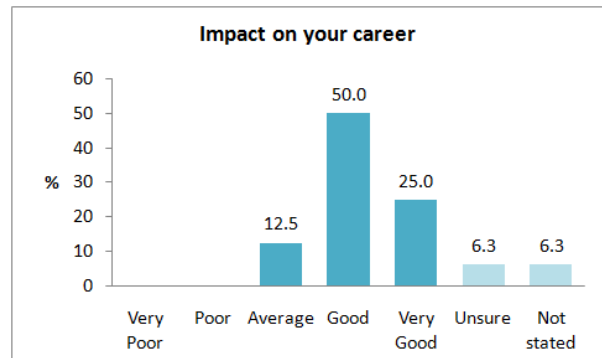| Category	%
Very Poor	
Poor	
Average	12.5
Good	50.0
Very Good	25.0
Unsure	6.3
Not stated	6.3

Mental Health Nurses and Coordinators were then asked to rate the impact of the Pilot on their clients in relation to 16 types of outcome. Details of these responses are presented alongside responses for Psychiatrists and GPs in *Section 6.1.*

5 REFERRING PSYCHIATRIST/GP SURVEY FINDINGS

5.1 Survey sample

At the time of writing, a total of **24** referring psychiatrists (19) and GPs (5, all from the Warrnambool site) had completed a survey – *see Figure 76*. Response rates were moderate at 34.3% overall, ranging from 12.5% to 42.9% (for more details see *Figure 1*). As *Figure 75* indicates, the highest number of responses were received from the Toowong site (29.2%), closely followed by the Adelaide and Warrnambool sites (25.0% each)**.** The newly established Essendon site contributed 4.2% of psychiatrist/GP responses as did the well established Perth site. Some psychiatrists or GPs have referred less than five clients (37.5%) while others have referred more than twenty (20.8%) – see Figure 77.
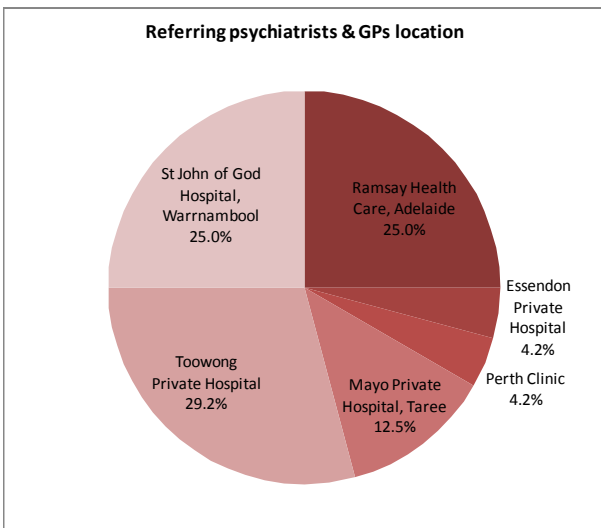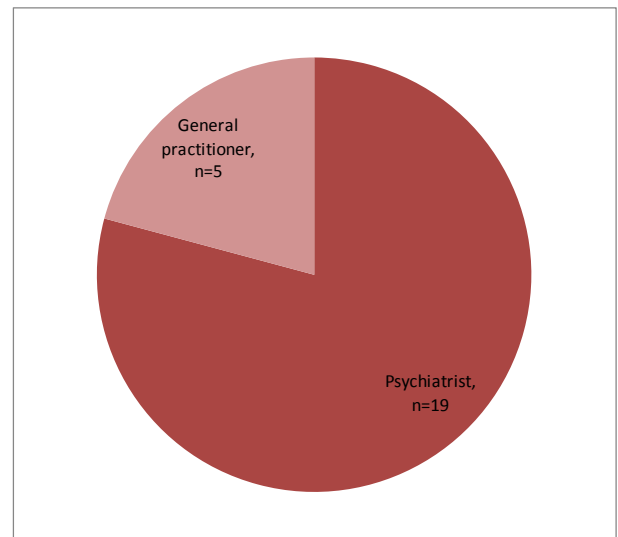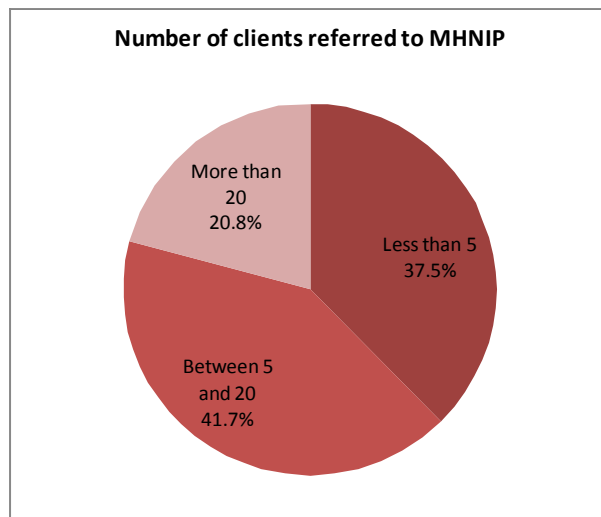
Figure 75: Referrer's location


Figure 76: Referrer's profession

Note. St John of God Hospital was the only site to provide responses from GPs (n=5). Results of the surveys for Psychiatrists and GPs were analysed as a group as there were too few GP surveys for separate analysis.

Figure 77: Number of clients referred to MHNIP

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The majority believe that they have received **sufficient information** about the MHNIP Pilot in private mental health settings regarding a) respective roles and responsibilities (nearly 92.0% feel sufficiently informed), b) eligibility criteria (83.3%) and information sharing requirements (87.5%). However, as indicated in *Section 6.3*, many also believe that the MHNIP needs better promotion to their colleagues.

Figure 78: Proportion of psychiatrists and GPs receiving sufficient information about the MHNIP
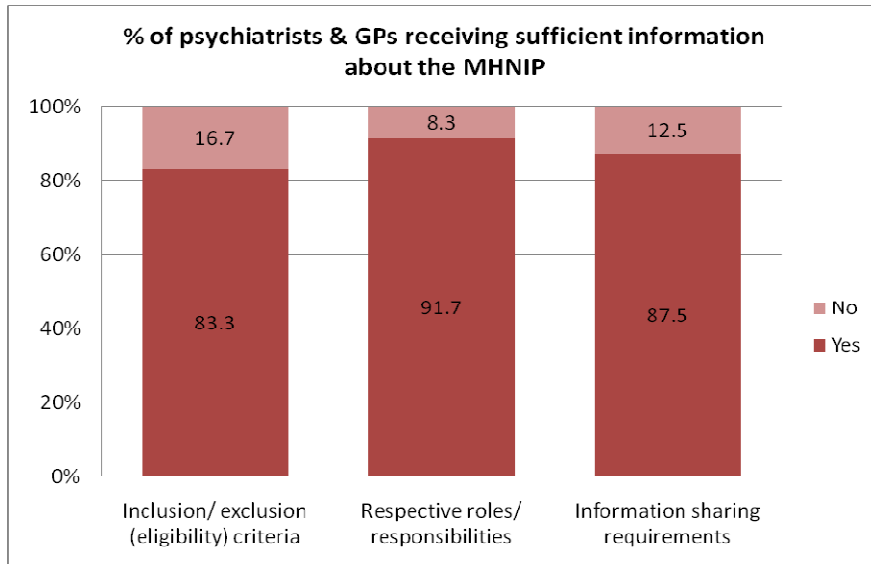
5.2   Impact of the MHNIP on workload

Psychiatrists and GPs were asked to quantify the outcomes resulting from referring clients to the MHNIP Pilot. As *Figure 79 to 87* indicate, most of those surveyed believe that the Pilot has had a number of positive outcomes, specifically, in relation to –

⇨ Increased **capacity to deal with complex cases** for **79.2%** (but no impact for 16.7%).
⇨ More **timely response to acute or emergency presentations** for **66.7%** (but no impact for 29.2%).
⇨ Increased **liaison with others involved in client's care** for **62.5%** (but no impact for 20.8% and a reduced impact for 12.5%).

There were a number of effects that have been positive for some but not for others. These involve:

⇨ Increased capacity to see new clients for 50.0% but no impact for 50.0%.[3]
⇨ Time spent in case conferences and similar meetings has increased for 50.0%, decreased for 12.5% and had no impact for the remaining 37.5%. (While this may be seen as additional time, it can also be seen as time well spent in terms of coordination of care and client outcomes.)

There were also a number of aspects of MHNIP related service provision for which **no impact** had occurred for the majority of those surveyed. These involve –

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[3] In hindsight, the evaluators consider that the question should have specified impact on current caseload not workload generally, and this may account for the split in responses, with different interpretations made.

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⇨ Extent of contact with clients' families (66.7%) – with a decrease for 20.8% and an increase for 12.5%.

⇨ Time spent in case planning (50.0%) – with an increase for 37.5% and a decrease for 12.5%.

⇨ Amount of paperwork (50.0%) – but an increase for nearly 37.5% and a reduction for 8.3%.

These differences in impact appear to be site based and may also reflect individual approaches to service delivery.

One psychiatrist offered this comment about the MHNIP impact on their workload –

Delighted to have more professional support in a very challenging structure, particularly appreciated a snapshot view of patient's home after a home visit.

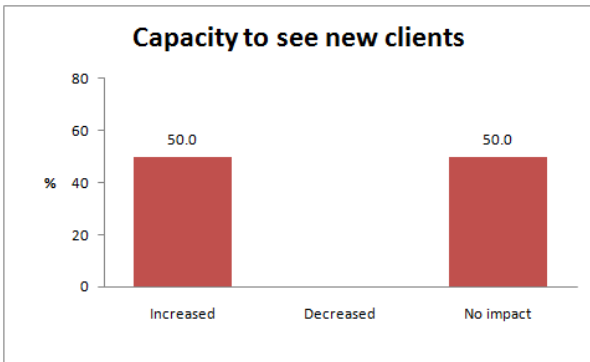**Figure 79: Capacity to see new clients**
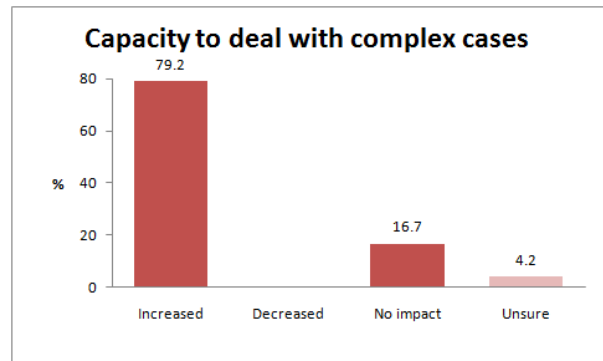

Figure 80: Capacity to deal with complex cases
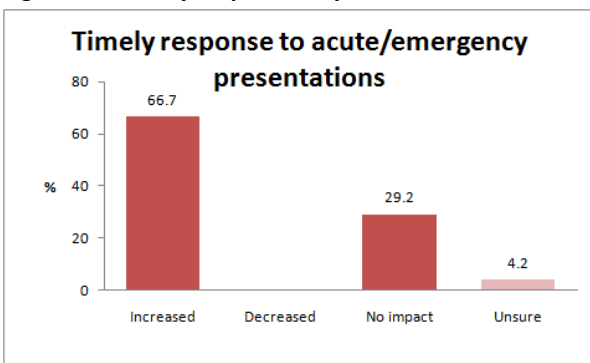

Figure 81: Timely response to presentations
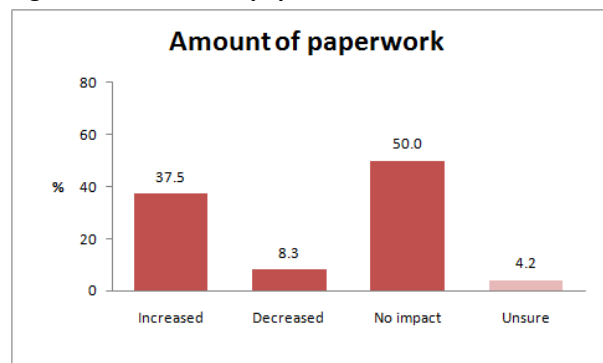

Figure 82: Amount of paperwork

Figure 83: Time spent in meetings

Time spent in meetings eg case conferences

	Increased	Decreased	No impact
%	50.0	12.5	37.5
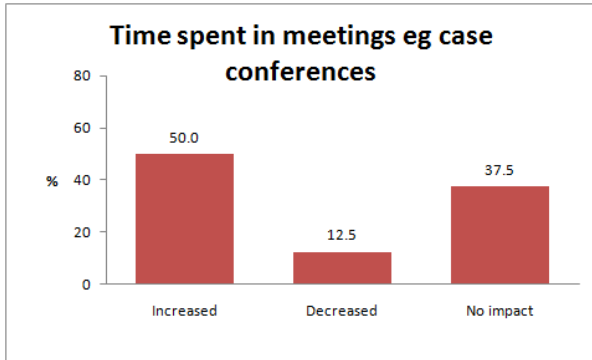
Figure 84: Time spent in case planning

Time spent in case planning

	Increased	Decreased	No impact
%	37.5	12.5	50.0
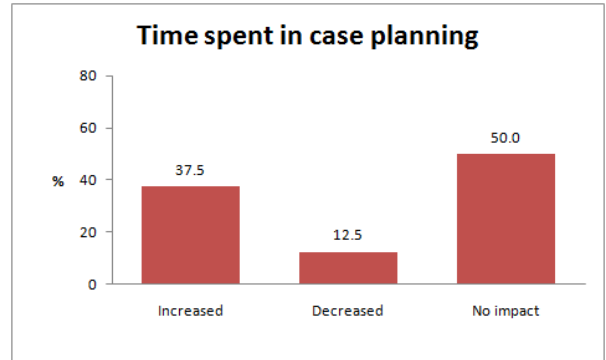
Figure 85: Extent of liaison with other staff

Extent of liaison with other staff involved in client's care

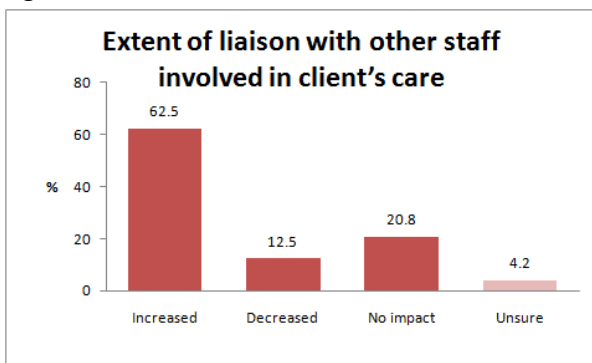|	Increased	Decreased	No impact	Unsure
%	62.5	12.5	20.8	4.2

Figure 86: Extent of contact with families

Extent of contact with clients' families etc

	Increased	Decreased	No impact
%	12.5	20.8	66.7
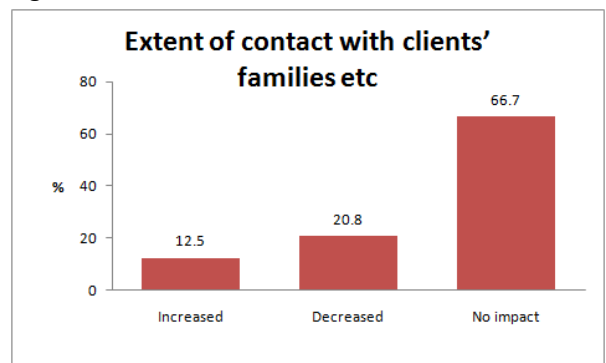
Figure 87: Extent of liaison with other services

Extent of liaison with other services

	Increased	Decreased	No impact
%	33.3	25.0	41.7

55
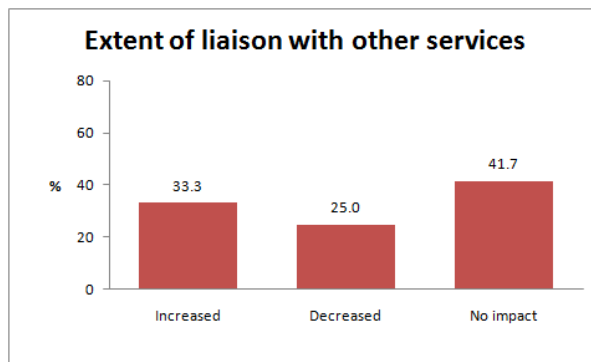
5.3 Impact of the MHNIP Pilot on clients

Those surveyed were asked to rate, using a five point Likert scale, the overall impact of the Pilot on their clients' mental health and wellbeing. As *Figure 88* indicates, **62.5%** believe that there has been a **significantly positive impact** and a further **20.8%** regard the impact as **moderately positive**. None have rated the impact as being negative.

Figure 88: Impact on client of referral to MHNIP
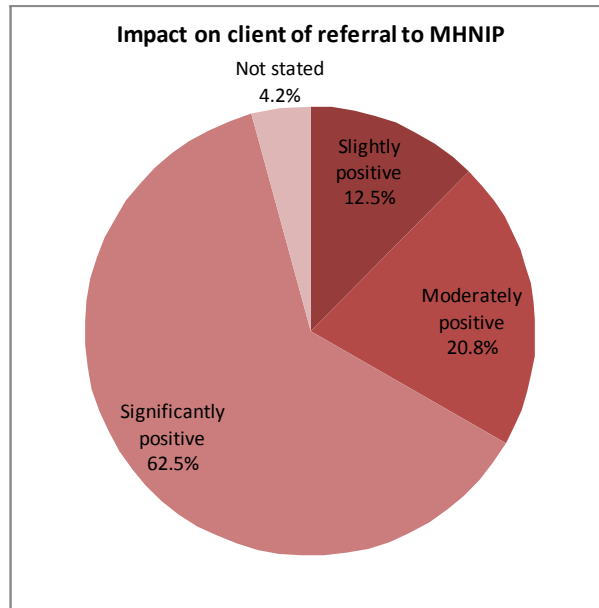
Referring psychiatrists and GPs were then asked to rate the impact of the Pilot on their clients in relation to 16 types of outcome. Details of these responses are presented alongside responses for Mental Health Nurses and Coordinators in *Section 6.1.*

6 QUANTIFYING OUTCOMES AND IMPACT OF THE PROGRAM

A guiding question for this Review has been whether or not the model represented by the MHNIP Pilot in the private mental health service setting is appropriate and effective, and related to this, which of its features represent strengths and which represent weaknesses or areas needing improvement. Other key questions involve whether or not Mental Health Nurses fill a gap in the private mental health system, and the impact of the MHNIP on clients, and key service providers (especially psychiatrists and GPs).

6.1 Impact of MHNIP Pilot on clients: comparative analysis

The surveys with Mental Health Nurses, Psychiatrists and GPs, and Clients were designed to enable triangulation of findings on a number of key issues. This section presents a comparison of those findings, identifying trends where agreement between different stakeholder groups was evident. The survey questions for the 2 provider groups in relation to perceived impact on clients were identical and are presented in *Section 6.1.1*. The related section for Clients had to be simplified of necessity to ensure client understanding and relevance. Consequently seven questions can be compared across the three groups and these are presented in *Section 6.1.2*.

6.1.1 Impact of MHNIP on clients: comparative analysis of provider response

Figure 89 compares the average ratings of Mental Health Nurses and Psychiatrists and GPs regarding the impact of the MHNIP on clients, while *Figure 90 to 105* show the detail of those responses. In relation to the perceived impact of the MHNIP on clients, Mental Health Nurses and Psychiatrists and GPs show their strongest agreement about the Program's capacity to –

- o Assist clients to make more effective use of health care, social and community services and resources.
- o Improve quality of life (eg due to broader improved focus on psychosocial issues, linkages made to other services).
- o Increase compliance with medication.
- o Reduce symptoms.
- o Reduce length of inpatient stay.
- o Reduce frequency of sessions with psychiatrists.
- o Reduce need for psychiatric review.
- o Reduce hospital admissions and readmissions.
- o Reduce burden of care for clients' families and significant others (which was also identified by clients).
- o Improve general functioning in everyday life.

The remaining six features of impact are not marked, as is evident from *Figure 89*.

The evaluators conclude that there is a high level of agreement between Mental Health Nurses and Psychiatrists and GPs about the positive impact of MHNIP services on clients, which in turn supports the underpinning model.

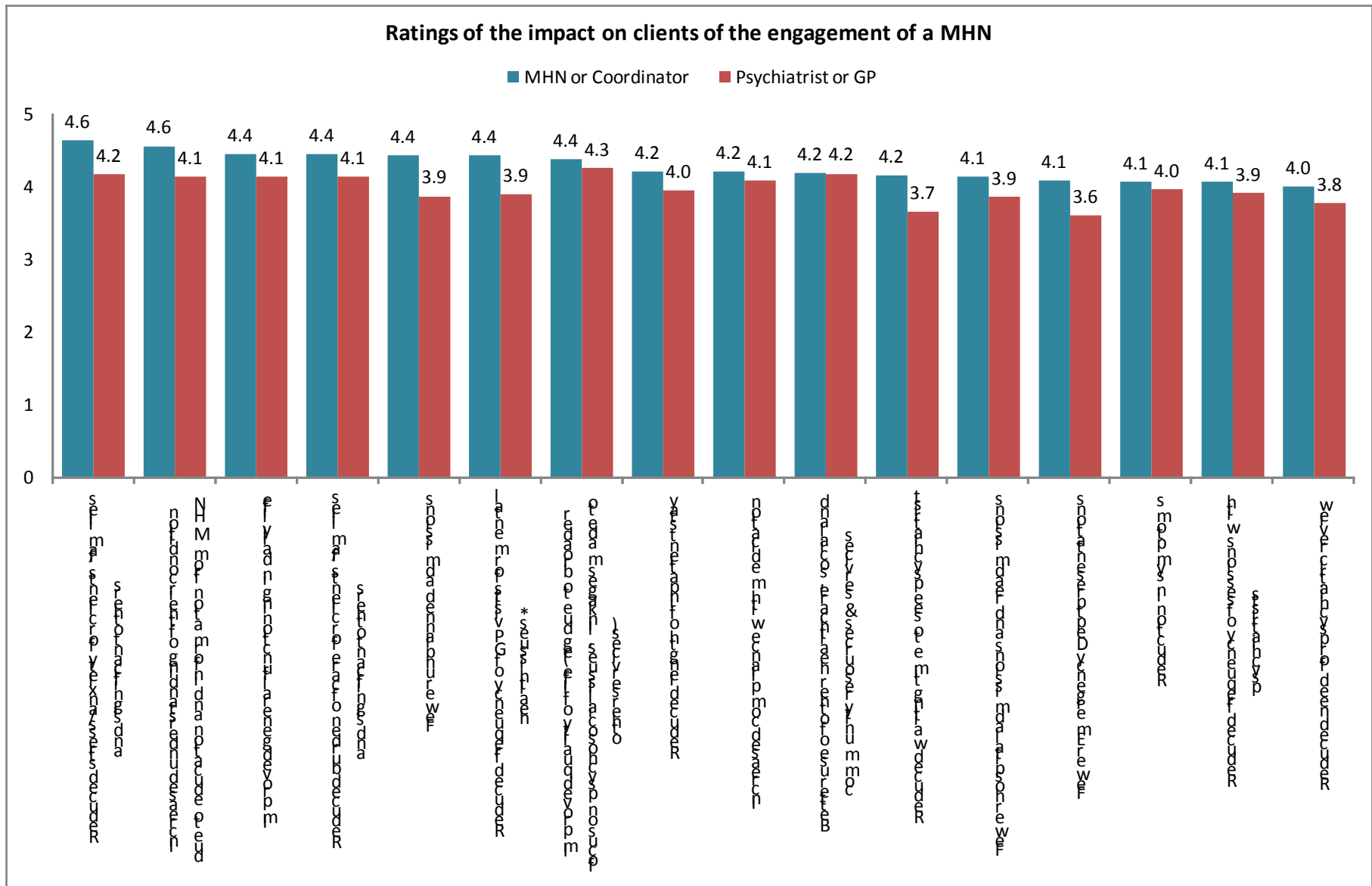**Figure 89: Impact on clients of the engagement of a MHN**

Ratings of the impact on clients of the engagement of a MHN

■ MHN or Coordinator ■ Psychiatrist or GP

MHN or Coordinator	Psychiatrist or GP
4.6	4.2
4.6	4.1
4.4	4.1
4.4	4.1
4.4	3.9
4.4	3.9
4.4	4.3
4.2	4.0
4.2	4.1
4.2	4.2
4.2	3.7
4.1	3.9
4.1	3.6
4.1	4.0
4.1	3.9
4.0	3.8

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Figure 90: Increased compliance with medication

Increased compliance with medication

MHNs & Coordinators / Psychiatrists & GPs

Strongly Disagree; Disagree 4.2; Neutral 6.3, 25.0; Agree 62.5, 25.0; Strongly Agree 25.0, 41.7; Unsure 6.3; Not stated 4.2
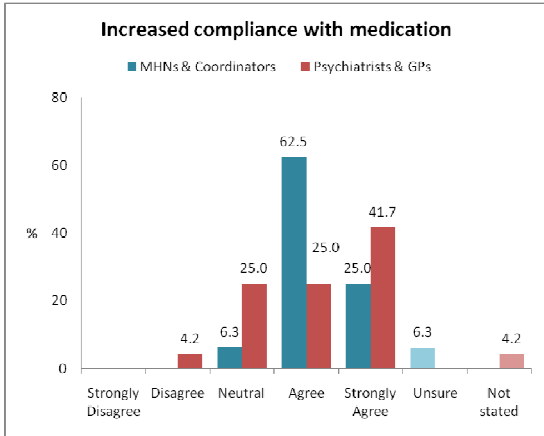
Figure 91: Increased understanding of condition

Increased understanding of their condition due to education and information from MHN

MHNs & Coordinators / Psychiatrists & GPs

Strongly Disagree; Disagree 4.2; Neutral 6.3, 12.5; Agree 31.3, 45.8; Strongly Agree 62.5, 33.3; Unsure; Not stated 4.2
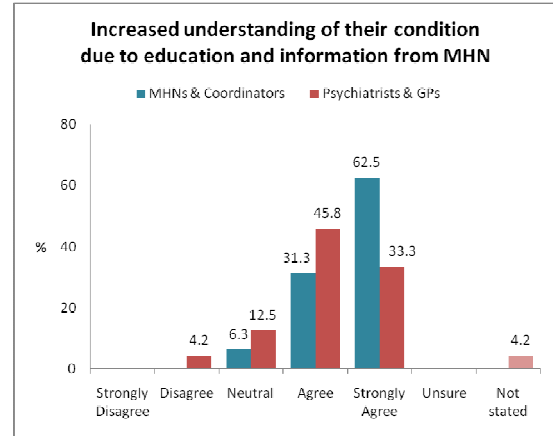
Figure 92: Reduction in symptoms

Reduction in symptoms

MHNs & Coordinators / Psychiatrists & GPs

Strongly Disagree; Disagree; Neutral 25.0, 33.3; Agree 37.5, 33.3; Strongly Agree 31.3, 29.2; Unsure 6.3; Not stated 4.2
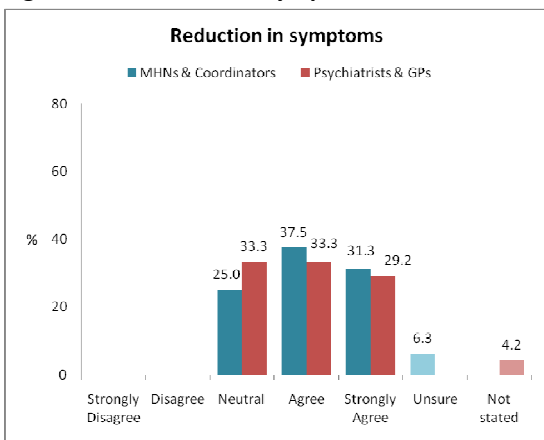
Figure 93: Improved general functioning

Improved general functioning in daily life

MHNs & Coordinators / Psychiatrists & GPs

Strongly Disagree 4.2; Neutral 16.7; 56.3, 37.5; Strongly Agree 43.8, 37.5; Not stated 4.2
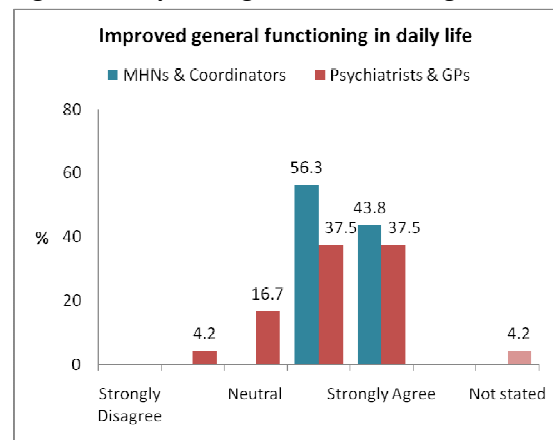
Figure 94: Improved quality of life

Improved quality of life (eg due to focus on psychosocial issues, service linkages)

MHNs & Coordinators / Psychiatrists & GPs

Strongly Disagree; Disagree 4.2; Neutral 12.5; Agree 62.5, 33.3; Strongly Agree 37.5, 45.8; Unsure; Not stated 4.2
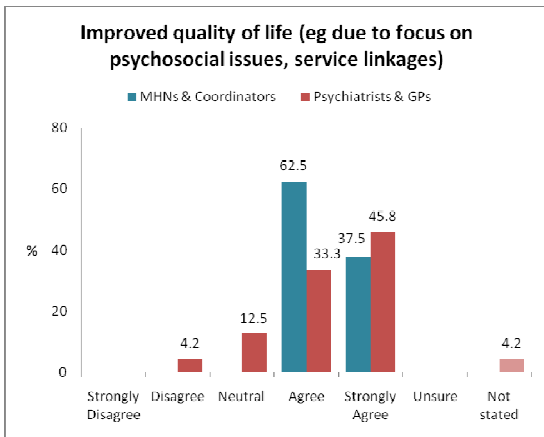
Figure 95: Better use of other resources

Better use of other healthcare, social and community resources & services

MHNs & Coordinators / Psychiatrists & GPs

Strongly Disagree; Disagree 4.2; Neutral 12.5, 16.7; Agree 56.3, 29.2; Strongly Agree 31.3, 41.7; Unsure 4.2; Not stated 4.2
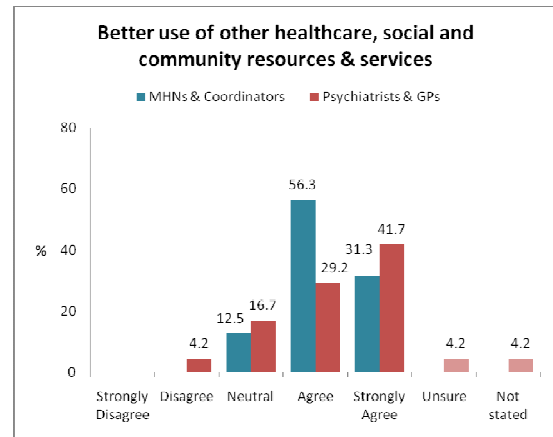
Figure 96: Reduced stress for families

Reduced stress/anxiety for clients' families and significant others
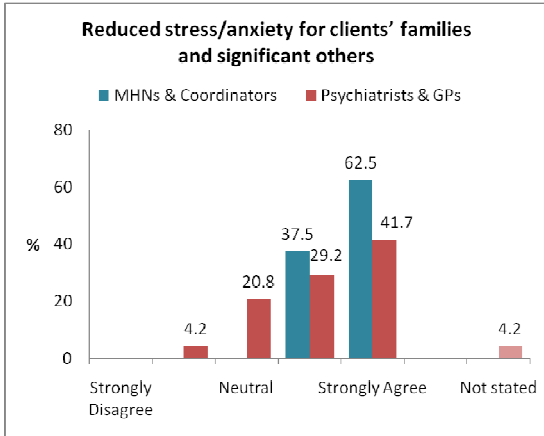
Figure 97: Reduced burden of care for families

Reduced burden of care for clients' families and significant others

Figure 98: Fewer hospital admissions
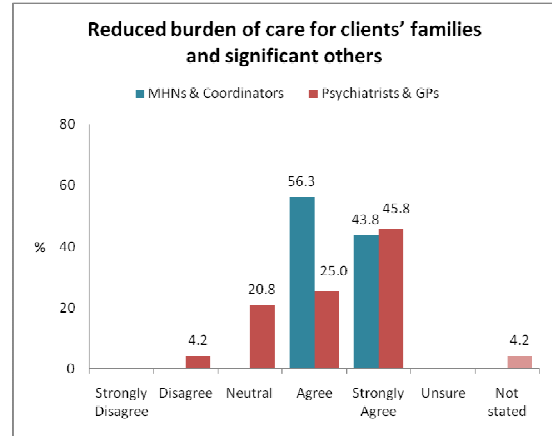

Fewer hospital admissions and readmissions
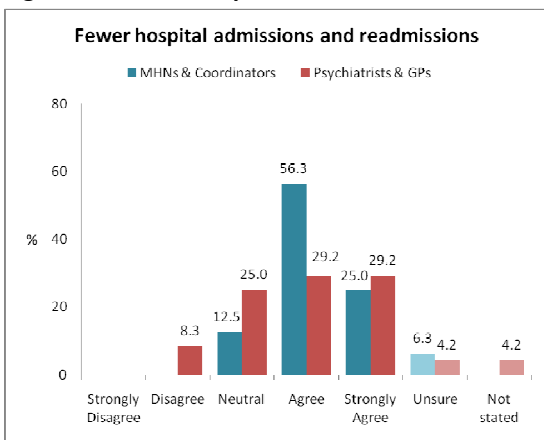
Figure 99: Fewer unplanned admissions

Fewer unplanned admissions
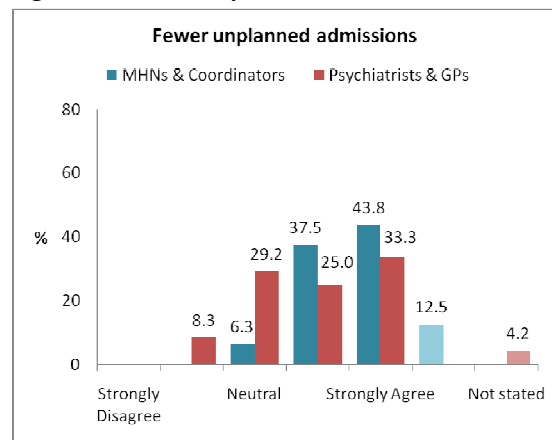
Figure 100: Reduced length of inpatient stay

Reduced length of inpatient stay
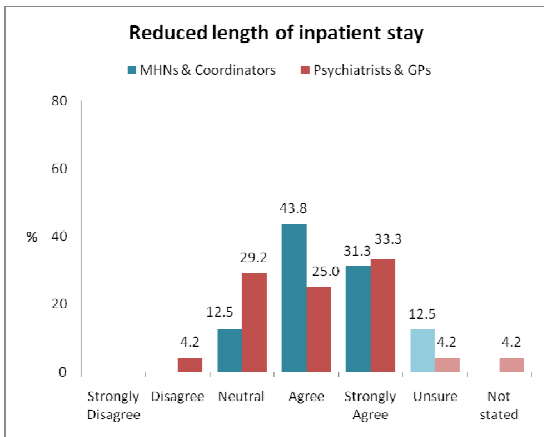
Figure 101: Fewer presentations to emergency

Fewer Emergency Dept presentations

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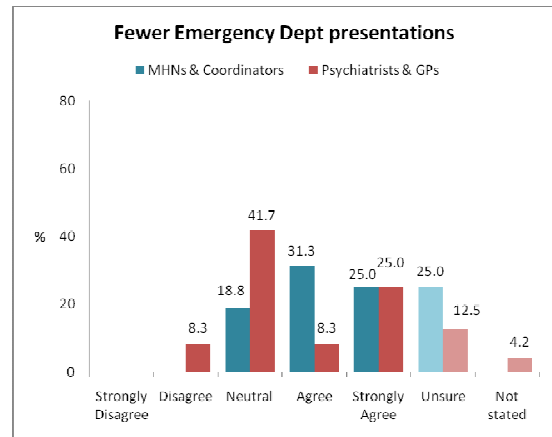
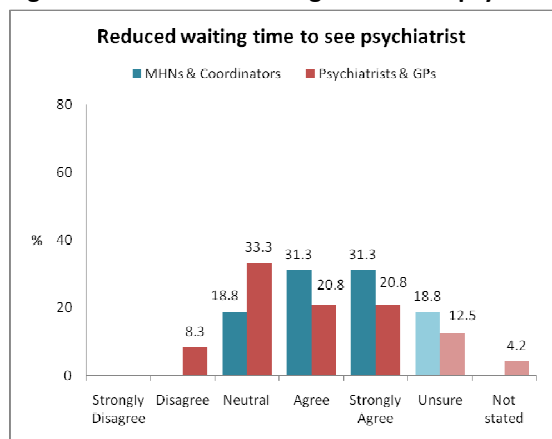**Figure 102: Reduced waiting time to see psychiatrist**

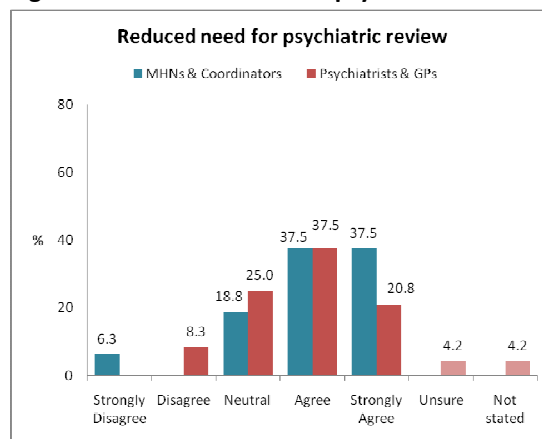**Figure 103:Reduced need for psychiatric review**

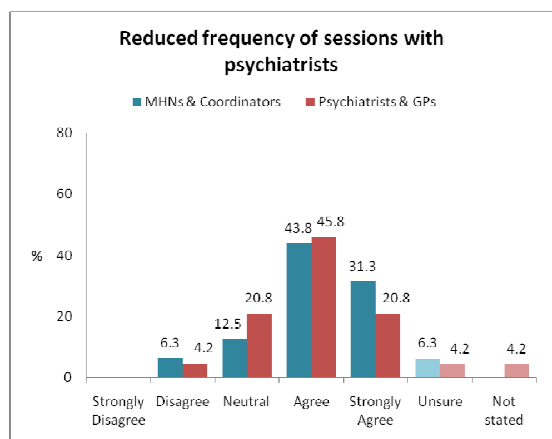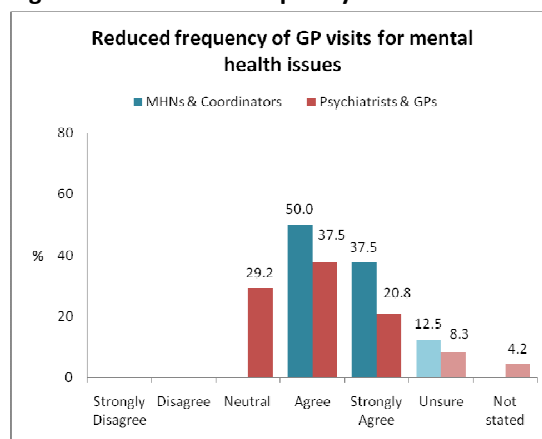**Figure 104: Reduced frequency of psychiatrist sessions**

Figure 105: Reduced frequency of GP visits

Other observations made by two psychiatrists were that the MHNIP enables them to manage unanticipated changes in clients' needs, and that there were less problems associated with 'countertransference' issues.

Four Mental Health Nurses made the following comments –

> *Although it is not really measurable - it is important to say that just having a level of community support and engagement between appointments with the doctor can greatly reduce the level of stress and chaos in a patient's perception and thus life.*

> *In particular one family report that as a result of our being able to assertively follow up their relative she has been more compliant with treatment than at any other time in her past, this is leading to an improvement in her mental state.*

> *Once rapport is established clients often reveal information not given to their psychiatrist. - MHNIP allocates more counselling time to clients.*

> *Patients report benefit from the continuity of care with one practitioner over a longer term period.*

One Coordinator commented –

Sometimes you feel as if you are not really doing a great deal of work with the clients but when you ask them or discuss this aspect with their doctor it is not true. In fact quite often the doctors have said that having the nurse taking an additional interest in the client makes the client feel better and able to manage better.

6.1.2   Impact of MHNIP on clients: comparative analysis of all three survey groups

Seven questions from the Client survey were designed to be comparable with responses from Mental Health Nurses, and Psychiatrists and GPs. However, clients were provided with three response categories (Yes, No and Unsure) rather than the 5 point likert scale used in the provider surveys. For these comparisons the 'Strongly Agree' and 'Agree' categories from the provider responses were combined and compared with the 'Yes' client category.

Detailed Client responses are shown in *Section 3.5.* Of note, clients concurred with the assessments of Mental Health Nurses and Psychiatrists and GPs about the value of the program with 84.0% agreeing that the program improved general daily life functioning, and 79.0% agreeing that their quality of life improved because of the program. Their views concurred more closely with those of the GPs and psychiatrists than with the Mental Health Nurses, and findings include the following (see *Figure 106*).

o   There is a high degree of congruence regarding **symptom reduction** for all three groups (62.5% psychiatrist or GP, 68.1% Mental Health Nurse, 68.8% client).
o   Over three-quarters of all three groups perceive an **improvement in both daily functioning and overall quality of life.**
o   Over 55% of all three groups specified a **reduction in hospital admissions** as an outcome.
o   Approximately 60% of all clients and doctors specified reduced frequency of visits to psychiatrists and GPs, with Mental Health Nurses reporting the highest impact in this area.
o   The least agreement related to reduced length of stay - 75% of Mental Health Nurses, 58% of GPs and psychiatrists but only 26% of Clients (however 44% of clients specified 'unsure'.)

Figure 106: Provider and client assessment of impact of MHNIP
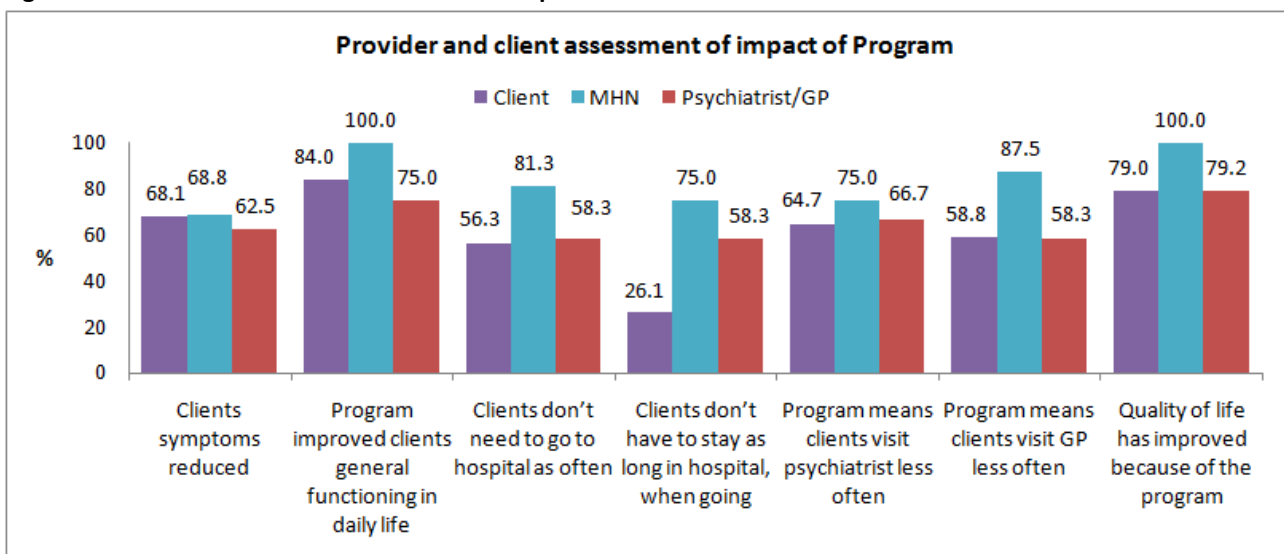
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It is evident that all three groups, representing the key stakeholders in the MHNIP, have positive views about the impact of the program on client outcomes. This is despite the difficulties associated with implementing the program as a pilot.

6.2   Strengths of the MHNIP Pilot model

During site visit interviews, **18** possible strengths of the model were identified and these were used to structure a series of five point rating scales to quantify agreement or disagreement.

The key features of the Pilot model which have been identified strongly as Benefits and Strengths by Mental Health Nurses and Coordinators, and by referring psychiatrists and GPs, are summarised in *Figure 107*. The close agreement between both stakeholder groups is evident, with identical ratings on a number of dimensions, and very close ratings for the remaining dimensions. The features receiving the highest (more than '4') and most similar ratings were (in order of strength of ratings) –

- o   Provision of earlier and more effective crisis intervention
- o   MHNs fill a gap in the private mental health system
- o   Access for clients unable to access or rejected by the public mental health system
- o   Provision of support and continuity for clients in hospital for mental health issues
- o   Enabling of more holistic care
- o   Provision of a free service to clients
- o   Provision of access for clients to an increased range of mental health services
- o   Enhanced access for clients through home-based service delivery
- o   Resource effectiveness achieved by the MHN substituting for psychiatrist or GP time
- o   Expected reduction in hospital admissions for mental health issues
- o   Flexible program guidelines support innovative service provision
- o   MHN role in medication monitoring reduces GPs' time spent on this
- o   MHN role in medication monitoring reduces psychiatrists' time spent on this
- o   Expected reduction in hospital stay length of stay for mental health issues.

An unexpected finding for the evaluators has been the Pilot's provision of access to services for those unable to or rejected by the public mental health system. Less surprising has been confirmation of the gap being filled by Mental Health Nurses, the enhanced capacity for early and more effective crisis intervention, the provision of more holistic care and access to an increased range of services.

The lowest assessment of capacity has been for the Pilot filling a gap in mental health services for Indigenous people. However, there has been no Indigenous-specific provision made so this finding is not surprising. Similarly, capacity to enhance access for people from culturally and linguistically diverse backgrounds has received a relatively low rating. Again, without specific provision designed for this target group, the model cannot be expected to achieve this outcome.

From these findings, the evaluators conclude that there is agreement between Mental Health Nurses and Coordinators, and Psychiatrist and GPs about the strengths of the MHNIP model, and that that these relate to 17 out of 18 possible positive features.

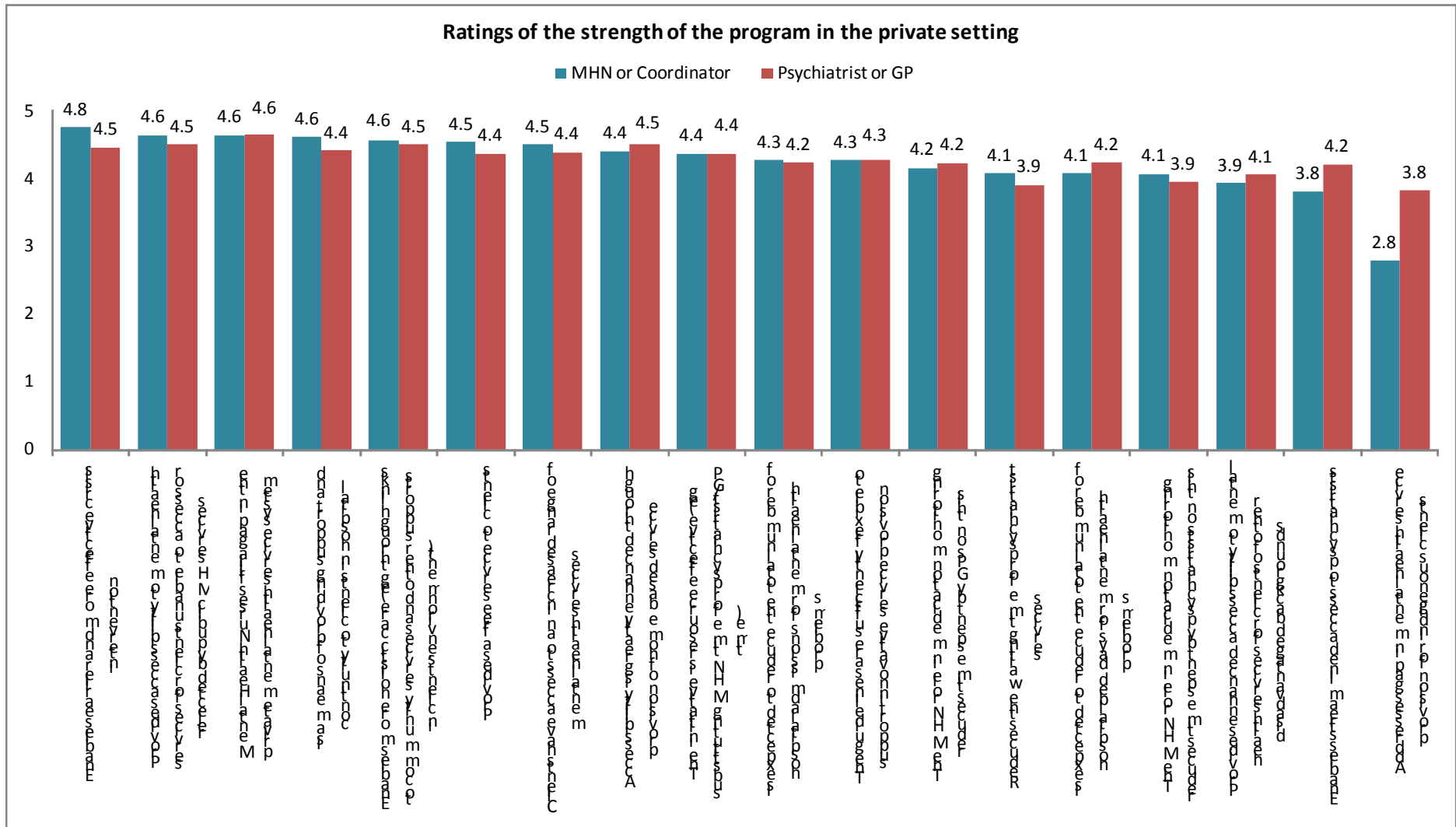**Figure 107: Strength of the program in a private setting**

Ratings of the strength of the program in the private setting

■ MHN or Coordinator   ■ Psychiatrist or GP

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Figure 108: Access when public services unavailable

Provides accessibility to mental health services for clients unable to access or rejected by public MH services
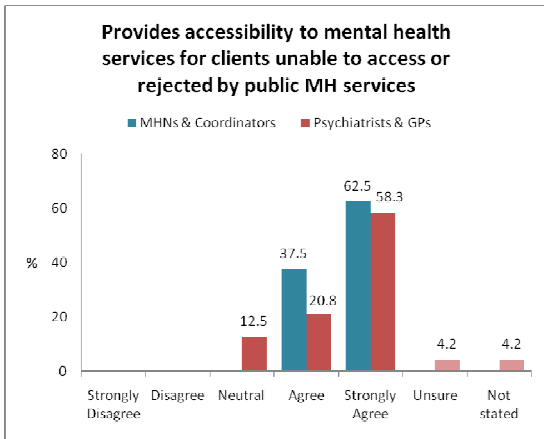
Figure 109: Addresses gaps for Indigenous clients

Addresses gap in mental health service provision for Indigenous clients
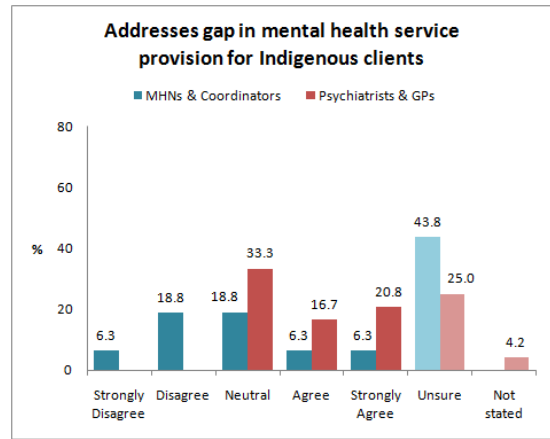
Figure 110: Enhanced access for disadvantaged

Provides enhanced accessibility to mental health services for clients of other disadvantaged backgrounds

Figure 111: Free service

Provides a free service to clients
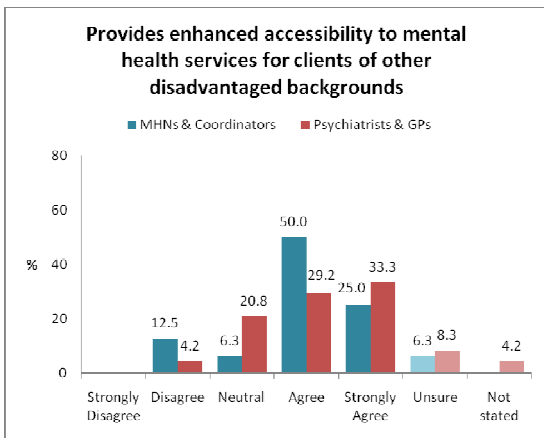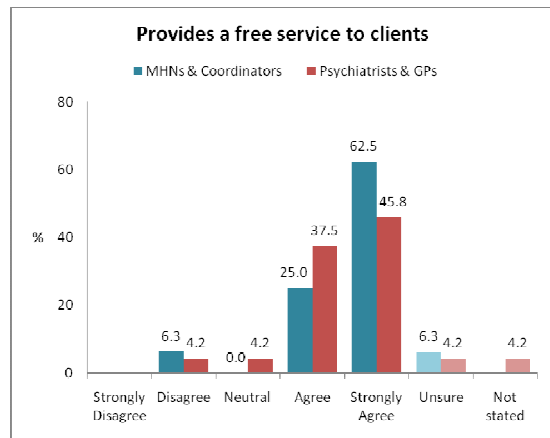
Figure 112: Increased range of services

Clients have access to an increased range of mental health services
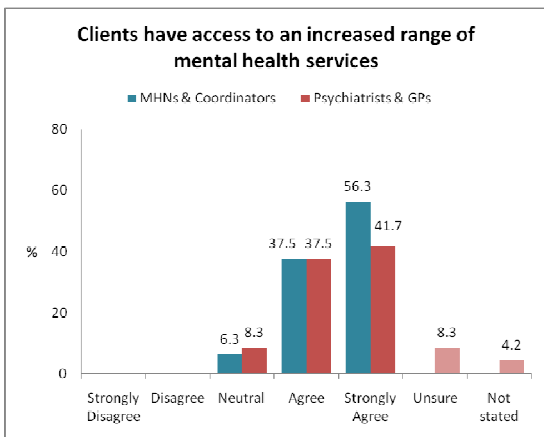
Figure 113: Access enhanced through home-based services

Accessibility is greatly enhanced through provision of home based service
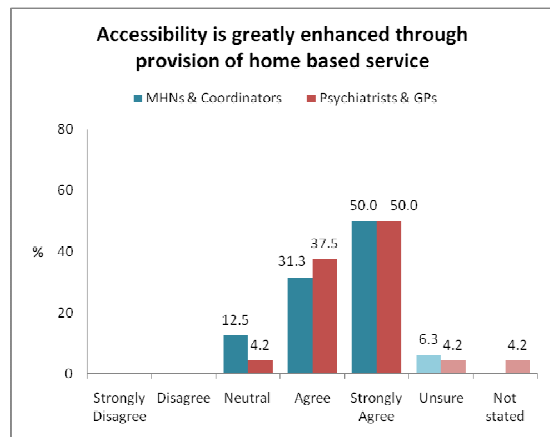
Figure 114: MHN fill gap in private system

Mental Health Nurses fill a gap in the private mental health service system
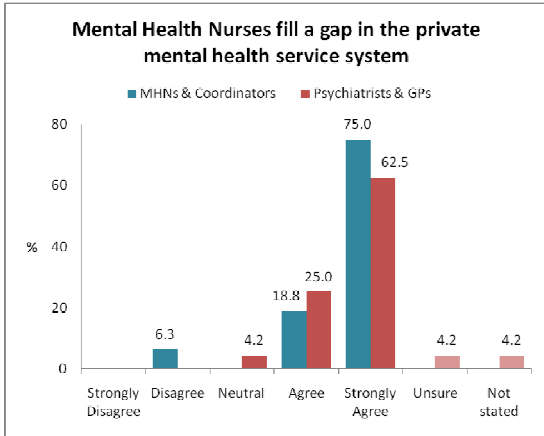
Figure 115: Reduces waiting time for psychiatrists

Reduces the waiting time for psychiatrist services
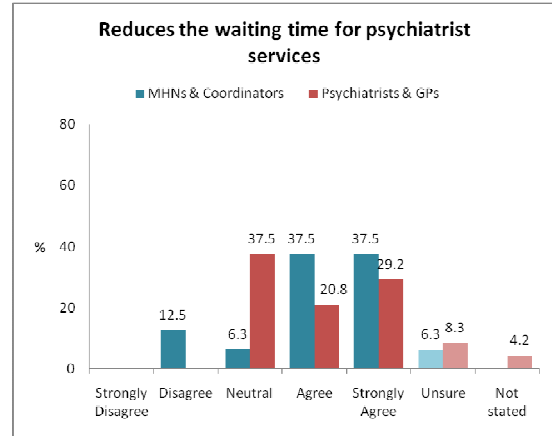
Figure 116: Streamlines access to psychiatrists

Enables streamlined access to psychiatrists
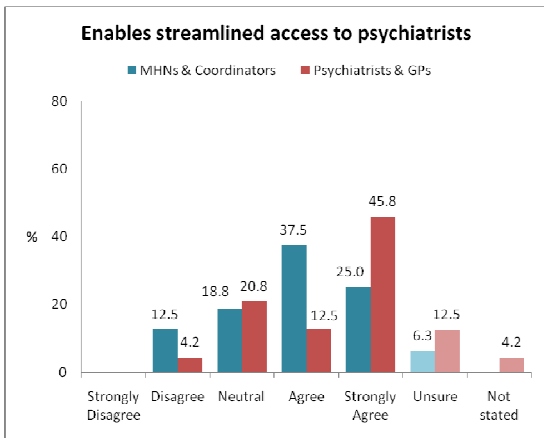
Figure 117: Reduces GP time on medication monitoring

The MHN role in medication monitoring reduces time spent by GPs on this
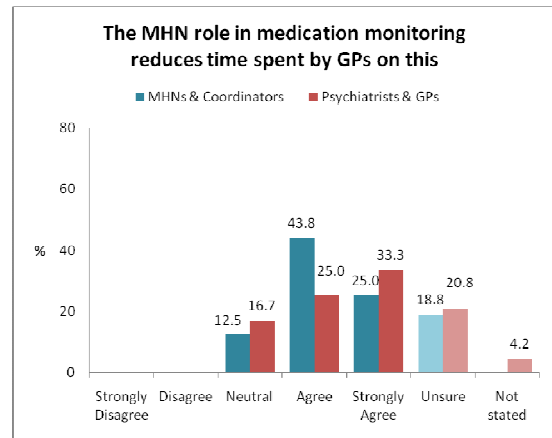
Figure 118: Reduces psychiatrist time on medication monitoring

The MHN role in medication monitoring reduces time spent by psychiatrists on this
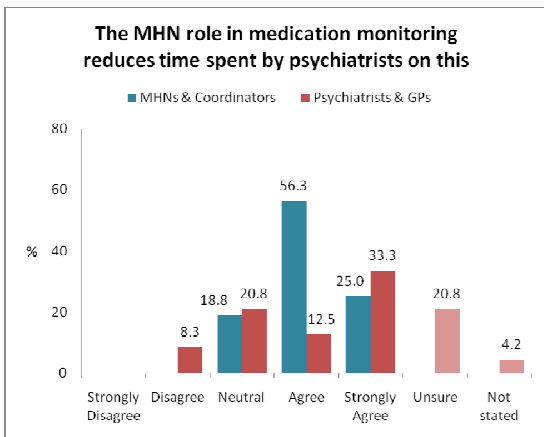
Figure 119: Enables earlier crisis intervention

Enables earlier and more effective crisis intervention
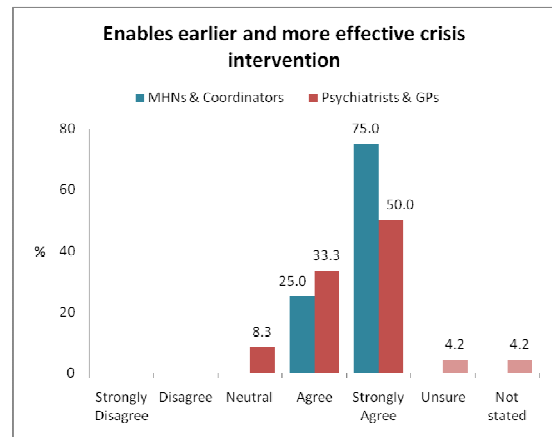
Figure 120: Reduces hospital admissions

Is expected to reduce the total number of hospital admissions for mental health problems

■ MHNs & Coordinators   ■ Psychiatrists & GPs
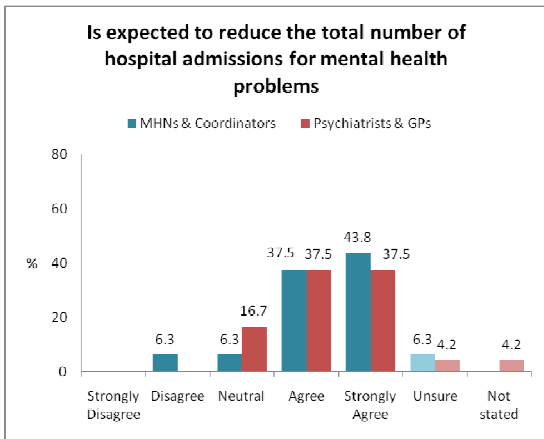
Figure 121: Reduces hospital bed days

Is expected to reduce the total number of hospital bed days for mental health problems

■ MHNs & Coordinators   ■ Psychiatrists & GPs
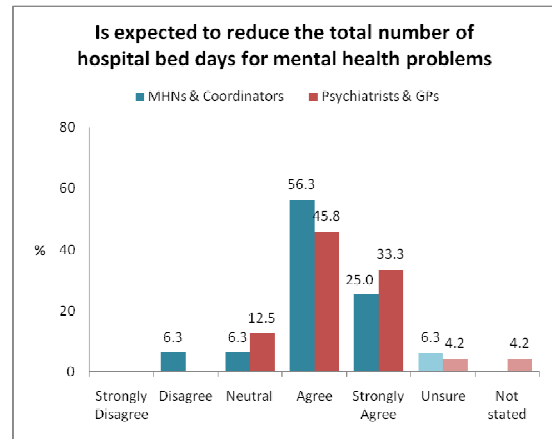
Figure 122: Provides continuity of support

Is a means of providing support and continuity to clients in hospital

■ MHNs & Coordinators   ■ Psychiatrists & GPs
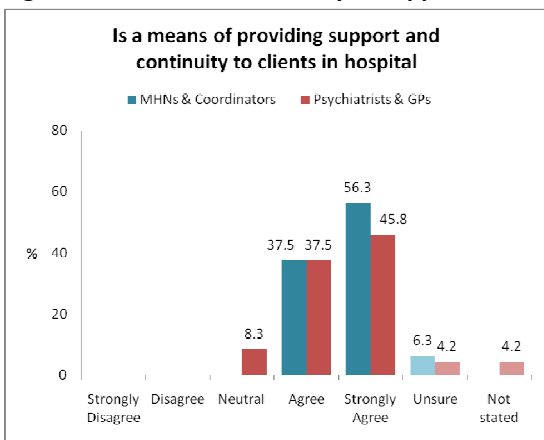
Figure 123: Enables holistic care

Enables more holistic care (eg through links to community services and other supports in client's environment)

■ MHNs & Coordinators   ■ Psychiatrists & GPs
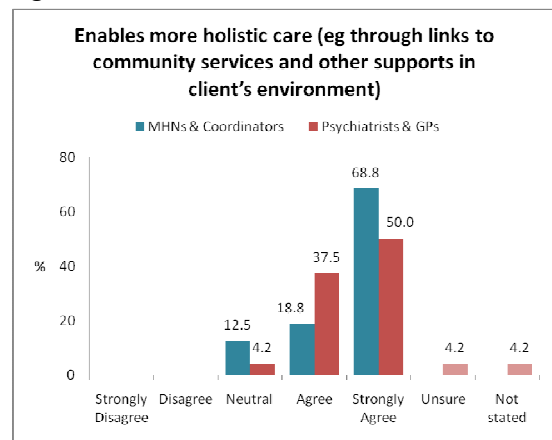
Figure 124: Guidelines are sufficiently flexible

The guidelines are sufficiently flexible to support innovative service provision

■ MHNs & Coordinators   ■ Psychiatrists & GPs
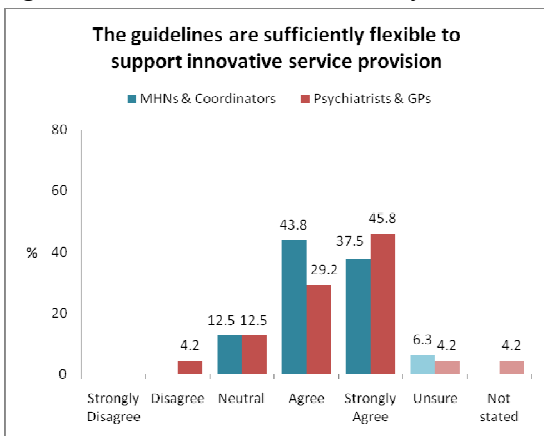
Figure 125: Initiative is resource effective

The initiative is resource effective (eg substituting MHN time for psychiatrist/ GP time)

■ MHNs & Coordinators   ■ Psychiatrists & GPs
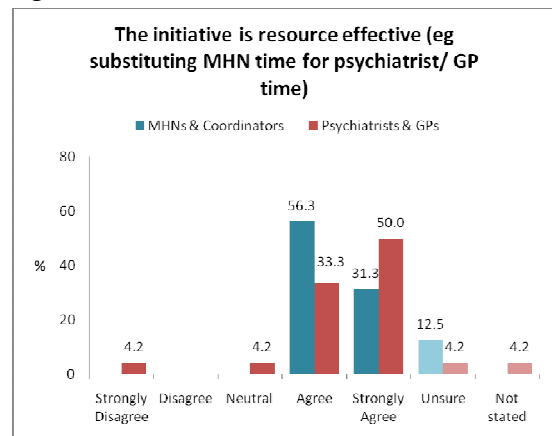
Additional comments made by two Mental Health Nurses about the MHNIP model's strengths -

> *The initiative provides for more flexible delivery of service to mentally ill people. On the question of whether the program will result in fewer admissions I think this is unlikely ho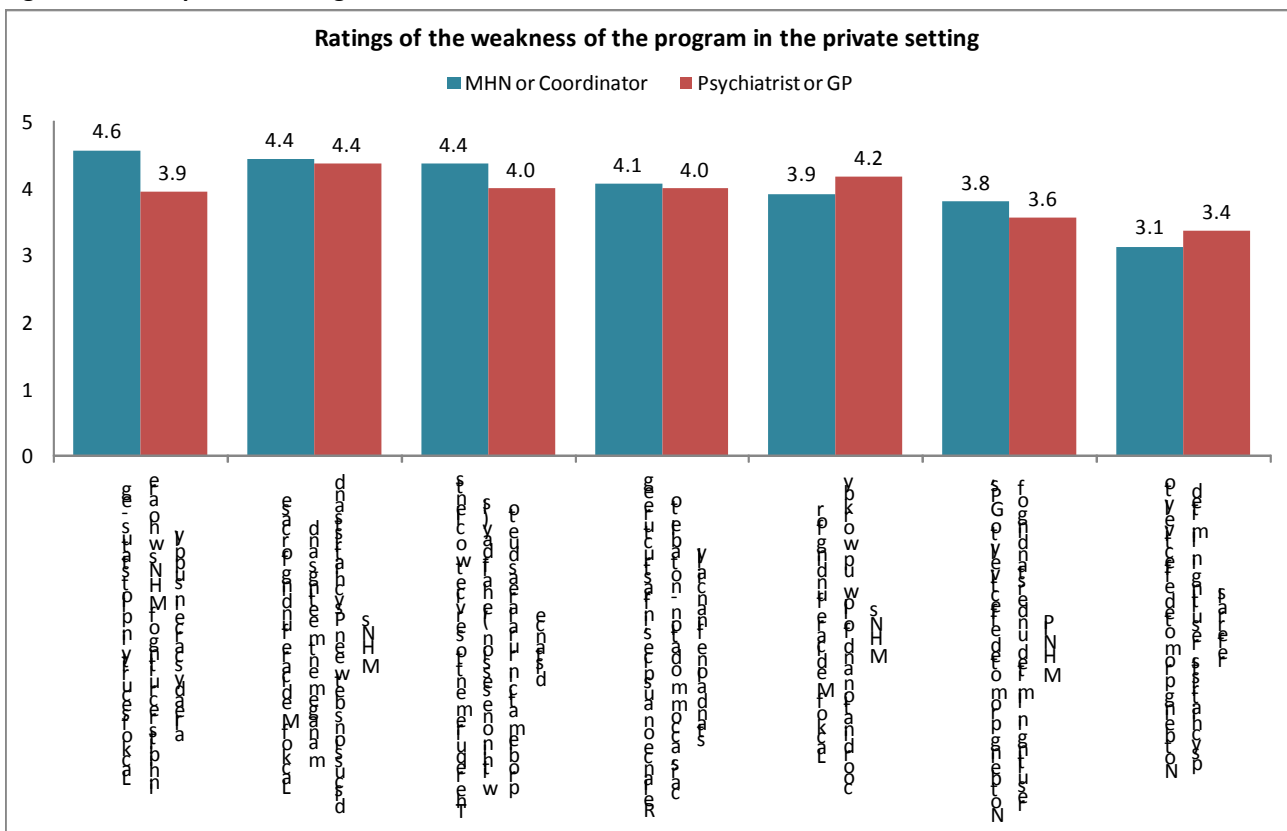wever I think it will lead to more timely admissions and therefore less disruption to family and carers, shorter stays in hospital and more effective use of services. Admitting people when they are becoming unwell rather than waiting for a catastrophe.*

> *Increased access to patients who wish to work long term on their mental health difficulties to increase quality of life and actually get out of mental health services.*

6.3   Weaknesses of the MHNIP Pilot Model

Site visits also identified **7** weaknesses in the pilot model .The key Weaknesses associated with the Pilot model that were identified strongly by Mental Health Nurses and Coordinators, and referring psychiatrists and GPs, are summarised in *Figure 126.*

Figure 126: Comparative ratings of the MHNIP model's weaknesses

It can be seen that the strongest agreement about the main weaknesses of the MHNIP exists in relation to funding (rather than about the model itself) –

⇨ **Lack of Medicare funding for case management meetings and discussions between Mental Health Nurses and Psychiatrists**, closely followed by

⇨ **Reliance on the auspice's infrastructure due to a lack of dedicated funding for accommodation, cars and related supports.**

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Close agreement also exists about the following –

⇨ Insufficient and ineffective **promotion of the MHNIP to GPs**, resulting in them having under-developed understanding of the Program.
⇨ Insufficient and ineffective **promotion of the MHNIP to psychiatrists**.
⇨ **Lack of Medicare funding for Mental Health Nurses to undertake coordination or follow-up work** with clients.
⇨ **Rigidities in Medicare funding guidelines** that require servicing of two clients within one half day session – presenting particular difficulties for those in rural areas travelling to and from clients' homes.

The widest gap in average ratings related to the **temporary and unpredictable status of being a Pilot** (making planning and recruitment difficult). This was rated as being more of a problem by Mental Health Nurses, than by psychiatrists and GPs as being a key defect.

The weaknesses endorsed by Psychiatrists and GPs are not associated with the design of the Pilot model, but with its funding which is seen as limited and unrealistic, and with the uncertainties associated with pilot status. By contrast, the strengths identified lend significant support to the model itself, its positive impact on clients and the gap being filled in the private mental health system. These findings are also reflected in the feedback provided by Clients.

If the Pilot receives ongoing funding, the issue of Medicare funding will need to be addressed. At present, this is not reflecting all of the roles of the Mental Health Nurse that have been identified by the three groups of stakeholders consulted – for example, case management, communication with psychiatrists and GPs The issue of funding to cover infrastructure support will also need to be addressed.

It can be reasonably expected that abandonment of Pilot status will see more effort being put into promoting the MHNIP to GPs and psychiatrists, including promoting the fact that it is no longer a Pilot. At this stage, significant promotion would have been inappropriate because it could raise expectations without ongoing provision of the Program's services.

Further details appear in Figure 127 to 133.

Figure 127: Reliance on auspice's infrastructure
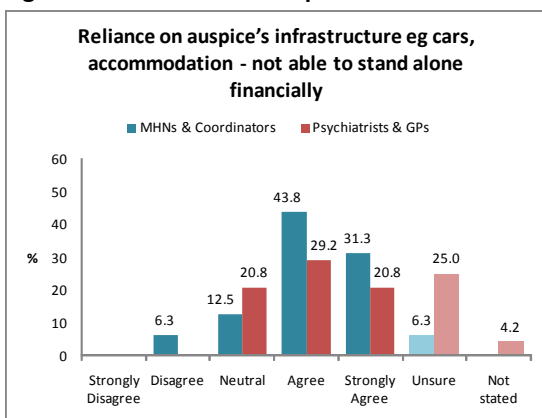
Figure 128: Lack of security in pilot status
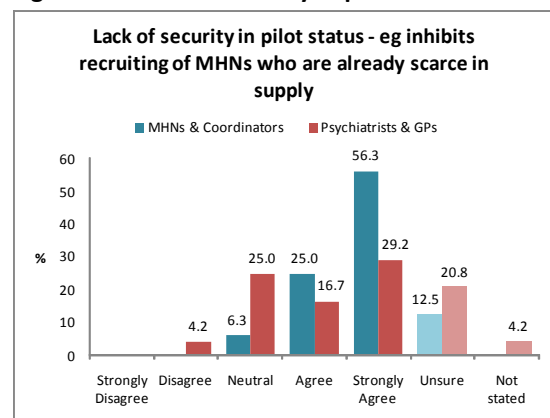
Figure 129: Lack of Medicare funding for coordination

Lack of Medicare funding for coordination and follow up work by MHNs
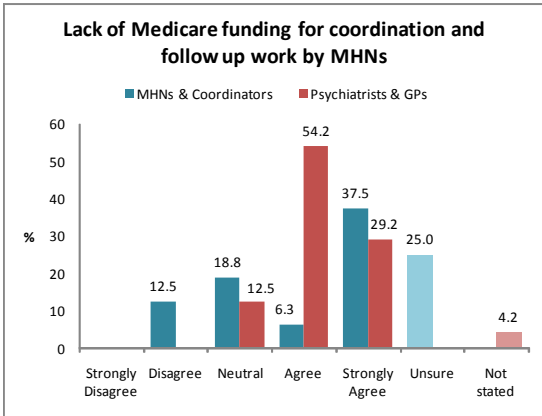
Figure 130: Minimum client numbers per session

The requirement to service two clients within one session (ie half-day) is problematic in rural areas due to distance
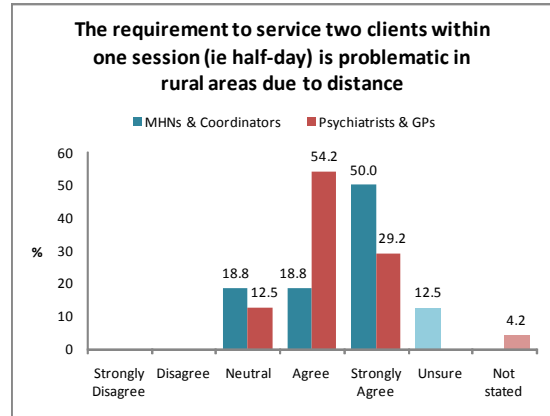
Figure 131: Not promoted effectively to psychiatrists

Not being promoted effectively to psychiatrists, resulting in limited referrals
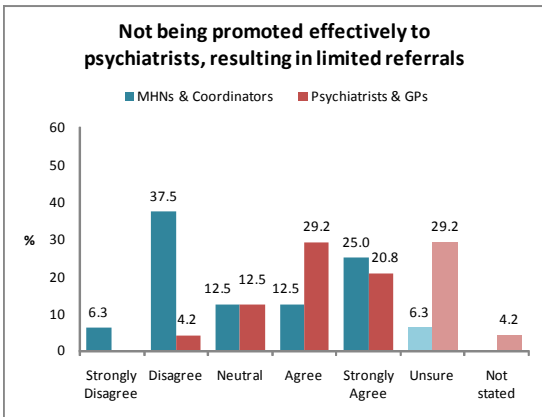
Figure 132: Not promoted effectively to GPs

Not being promoted effectively to GPs, resulting in limited understanding of MHNIP
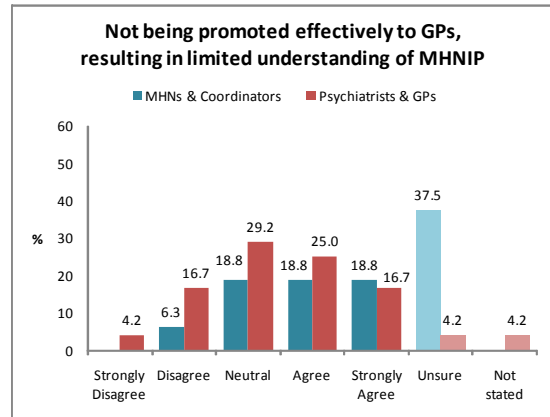
Figure 133: Lack of Medicare funding for care management

Lack of Medicare funding for case management meetings and discussions between Psychiatrists and MHNs
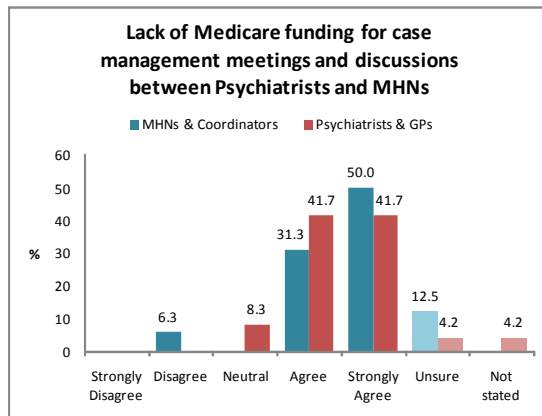
Additional comments made relate to the need for changes in Medicare funding guidelines –

> *Psychiatrists are reluctant to attend a case review as they are not paid to do so as part of a Medicare MBS item. There has to be 3 formal care providers present in order for them to claim. The MHN does claim the case review as part of a session. (Coordinator)*

> *There is no point in this if psychiatrists have to attend unremunerated meetings. I would rather be seeing another urgent case. (Psychiatrist)*

> *Lack of integration between psychiatrists and MHNIP nurses to update nurses on changes to treatment regime, crisis calls, admission to hospital, referrals to other professionals. (Mental Health Nurse)*

> *No funds for support services eg secretarial support to reduce time spent on paper work. (Mental Health Nurse).*

7 CONCLUSIONS: FUTURE DIRECTIONS FOR THE MHNIP

7.1 Improving the MHNIP in private setting

The survey provided scope for Mental Health Nurses and Psychiatrists and GPs to make three recommendations for improving the MHNIP. These are summarised comparatively in Table 4.

Table 4: Comparison of improvements recommended to the MHNIP

Improvement sought	Mental Health Nurses nominating	Psychiatrists nominating
Funding-related improvements		
Increased amount of session payment	2	4
Funding for provision of cars to facilitate home visiting	1	
Increased funding for establishment costs of the Program	1	1
Clearer guidelines about claimable and non-claimable items	1	
Funding for psychiatrists to undertake more comprehensive client review	1	
Additional 25% rural loading where nurses are travelling in excess of 20 kms or more to and from a client's home – to acknowledge time and cost	2	
Change requirement in funding guidelines regarding number of clients per session to acknowledge travel and distance, and clients who cancel their appointment at the last minute	1	
Provide funding for case management meetings and other non face-to-face client support	1	1
Review Medicare rebates for MHN or doctor time with families		1
MHN accreditation-related improvements		
Provisional registration for nurses working towards accreditation	2	
Automatic provision of Recognition of Prior Learning for accreditation	1	
MHN salary and associated conditions		
Payment of minimum remuneration as recommended by ACMHN	3	
Ensure that MHNIP salary matches other skilled nursing roles	3	
Ensure job security for MHNs		1
Administrative and accountability requirements		
Review the Medicare reporting requirements (lengthy and repetitive). Time taken on compiling this is not recognised by funding provided.	2	
Implement electronic claim forms		1
Design templates to facilitate current accountability requirements		1
Provide funding for administration assistance and support work that could be undertaken under the MHN's supervision, increasing time efficiencies	1	1
Operational processes		
More coordinated, team approach, to patient care between all parties involved.	1	
Formalise the provision of feedback from Psychiatrists following review	1	
Restrict the catchment area where the nurse travels to and from.	1	

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Improvement sought	Mental Health Nurses nominating	Psychiatrists nominating
Increase the formalisation of communication processes between MHNs, psychiatrists, GPs and other providers involved in MHNIP		1
Promotion of the MHNIP		
Increase usage of Program through better promotion to GPs	1	1
Other		
Access to shared care between private and public sector agencies.	1	1
Increased recognition on the role of the nurse counsellor.	1	

7.2 Issues for consideration and change

Findings to date indicate the need to address a number of issues. These foreshadow recommendations that are made in the Final Report for the evaluation and concern –

- o The discrepancy between Medicare funding being provided and what is considered to be the essential roles and responsibilities of Mental Health Nurses in achieving positive outcomes for clients, and for the service system as a whole. The reliance on auspicing organisations to fill gaps in the funding provided.
- o The use of credentialing of Mental Health Nurses as a means of ensuring quality control in service delivery and how this should be supported.
- o Difficulties in recruitment of appropriately credentialed Mental Health Nurses and the need for specific strategies to enhance recruitment. The relationship between recruitment capacity and work conditions offered to MHNIP funded Mental Health Nurses.
- o The capacity of the MHNIP to manage cultural diversity.
- o Promotion of the MHNIP to psychiatrists and GPs.
- o Accountability requirements associated with Medicare funding.

7.2.1 Funding to achieve positive client and service system outcomes

Qualitative feedback from the sites indicates that funding limitations mean that, at best, Pilot sites will break even, but when the contribution by auspicing organisations is taken into account, current funding does not cover the actual costs of service delivery. Survey findings have been clear in identifying the reliance on auspicing organisations to fill funding gaps, particularly in relation to infrastructure costs (for example, those associated with motor vehicles which are essential to a home-based delivery model).

There will always be important service synergies between the auspicing organisation and the MHNIP, some of which will be in-kind and difficult to measure, and some of which will involve a mutually beneficial exchange of resources and subsidisation of MHNIP. At present, organisations engaging a Mental Health Nurse receive a once-off payment of $10,000 to cover the upfront costs involved, with one payment available per organisation, not per nurse engaged. However, under the current funding model, the MHNIP in private mental health settings is not a self sufficient service and is heavily reliant on the goodwill of its auspicing organisation. Qualitative feedback indicates that these are motivated by the provision of better

services for clients and enabling psychiatrists and GPs to focus on their core skills. This cannot be expected to continue beyond the life of the Pilot.

Should the MHNIP become an ongoing component of the private mental health system, it will be important that its resourcing is less reliant on goodwill and altruism and more reliant on funding that acknowledges the range of inputs required.

The Review has quantified the various roles that Mental Health Nurses need to undertake in order to achieve positive outcomes for the clients, and which have a positive effect on the service system. Current Medicare funding does not recognise all of those roles (especially those that do not involve face-to-face work with clients – such as, case management and coordination), and does not support the infrastructure costs associated with service provision by Mental Health Nurses. Furthermore, delivery in rural areas, and where significant distance and travel is involved, is not supported by the current funding model's requirement of servicing two clients in a half day session.

This indicates the need for future program guidelines and funding to recognise the range of roles and responsibilities undertaken by Mental Health Nurses, and the additional resources needed for those in rural and remote locations. Specifically, this will require funding (beyond what is currently provided) that supports the following –

- ⇨ **Case management of clients, including case conferencing between Mental Health Nurses and psychiatrists and GPs.**
- ⇨ **Coordination of care relating to clients.**
- ⇨ **Infrastructure costs, including office accommodation and operating costs, and the purchase and maintenance of vehicles.**
- ⇨ **Loading for rural and remote based services to reflect the additional costs associated with distance.**
- ⇨ **Greater flexibility in Medicare guidelines relating to the number of sessions undertaken – so that services are not financially disadvantaged when clients do not turn up for appointments and when travel to and from clients' homes (as occurs in rural and remote settings) consumes a considerable component of what is currently regarded as 'session' time.**

7.2.2 *Credentialing of Mental Health Nurses*

It can be argued that the success of the MHNIP is highly dependent on the quality, competence and experience of the Mental Health Nurse. Current guidelines require the employment of Mental Health Nurses credentialed with (or being in the process of obtaining this by working towards qualifications in mental health and with three years' recent experience in mental health nursing) the Australian College of Mental Health Nurses (ACMHN), and this indicator of quality has been endorsed in the Review by key stakeholders.

However, there has also been strong support for **also** providing recognition of experience for those without ACMHN recognised credentials, and two mechanisms exist for achieving this, without compromising standards of qualification. One involves providing enhanced access for Mental Health Nurses to Recognition of Prior Learning (and raising awareness about this mechanism which does not appear to be widely

understood), which will acknowledge that experience will lead applicants to achieving their qualification. The other involves support from employers (for example, in providing study time and/or payment of fees) to achieve the required qualifications (The evaluators acknowledge the support also provided through the 1,000 mental health nursing scholarships provided under the national Mental Health Nurse and Psychologist Scholarships subsidy scheme designed to address workforce shortages in these areas.)

The evaluation findings support the employment of Mental Health Nurses whose qualifications meet ACMHN requirements. However, to make this attainment more accessible for nurses, and to enhance the ability of MHNIP services to attract these nurses, it is important that provision is made for –

- e) **Increasing awareness about Recognition of Prior Learning and how to obtain this.**
- f) **Provision of financial support by employers to undergo a Recognition of Prior Learning assessment.**
- g) **Provision of financial support and paid study leave by employers to enable Mental Health Nurses to complete their qualifications while working for the MHNIP.**
- h) **Increasing awareness about the national Mental Health Nurse scholarship subsidy scheme.**

7.2.3   Recruitment and Retention of Mental Health Nurses

The pilots have reported difficulties in recruiting appropriately qualified Mental Health Nurses – the sites in Canberra and Essendon both attribute delays in starting to this issue, and some of the other sites also identified this as having been a challenge for them.

Apart from the fact that supply will increase over time, the issue has been compounded by the uncertainty associated with the Pilot and whether or not it will become an ongoing program. Mental Health Nurses, particularly those in secure public sector jobs, and particularly those who are of mature age, are unwilling to exchange permanent for temporary employment.

However, in addition to the changes suggested in *Section 7.2.2*, recruitment and retention can be enhanced by promoting positive work conditions currently associated with the MHNIP Mental Health Nurse role, and by providing other conditions that will add to its attraction (based on survey feedback). Some sites have found that including as a condition of employment, support to achieve the required credential, has assisted them significantly in the recruitment process. Conditions that have emerged as attraction factors are the capacity to work autonomously, flexibly and innovatively and these can be promoted as part of a recruitment strategy. In addition, work conditions that offer job security (which will be possible if the MHNIP continues beyond its Pilot phase) and salaries that reflect the ACMHN benchmarks will act as positive recruitment and retention factors.

7.2.4   Capacity to manage cultural diversity

The lowest assessment of capacity has been for the Pilot filling a gap in mental health services for Indigenous people. As there has been no Indigenous-specific provision made to date, this finding is not surprising. Similarly, capacity to enhance access for people from culturally and linguistically diverse backgrounds (CLD) has received a relatively low rating. Again, without specific provision designed for this target group, the model cannot be expected to achieve this outcome.

AISR (2009) Evaluation of the MHNIP in the Private Hospital Setting, Acc Report 1: Survey Findings

Future directions for the MHNIP could include the development of Indigenous-specific and CLD-specific service offerings – either within existing services or as specialist services. This would require the development of partnerships with appropriate Indigenous and CLD mental health service providers to design and deliver inclusive services to both target groups. The supply of Mental Health Nurses from either of these backgrounds is not known, but specific recruitment could be undertaken for this purpose.

7.2.5   Enhanced promotion of the MHNIP

The evaluators recognise the difficulties associated with promoting a Pilot initiative as most service providers will not engage with a program that may be short lived. H**owever, if the MHNIP continues beyond the pilot phase, it will be critical for specific promotional strategies to be developed that target psychiatrists and GPs, using appropriate networks (for example, Divisions of General Practice) and communication methods.**

7.2.6   Accountability requirements associated with Medicare funding

Feedback from Mental Health Nurses and psychiatrists and GPs has been negative in relation to the amount of time being spent on completing what is described by them as lengthy and repetitive reporting. **The evaluators believe that existing reporting should be redesigned to be as concise as possible, and offered in electronic format.**