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

FINAL REPORT

presented to

The Department of Health and Ageing, Nursing Section

by

The Australian Institute for Social Research



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Table of Contents

1	EXECUTIVE SUMMARY	1
1.1	INTRODUCTION	1
1.1.1	<i>Survey sample and response rates.....</i>	<i>2</i>
1.1.2	<i>Medicare data analysis.....</i>	<i>3</i>
1.1.3	<i>Site data analysis.....</i>	<i>3</i>
1.1.4	<i>Comparing Medicare and Site Data.....</i>	<i>4</i>
1.2	CLIENT AND SERVICE PROFILE INFORMATION.....	4
1.2.1	<i>Medicare data.....</i>	<i>4</i>
1.2.2	<i>Site data client numbers.....</i>	<i>5</i>
1.2.3	<i>Average time spent in the Program – based on Site data.....</i>	<i>5</i>
1.2.4	<i>Demographic profile of consumers.....</i>	<i>5</i>
1.3	SERVICES PROVIDED	6
1.4	ELIGIBILITY ISSUES.....	7
1.5	INTEGRITY OF THE PROJECT MODEL.....	7
1.5.1	<i>Strengths and Weaknesses of the Model.....</i>	<i>8</i>
1.5.2	<i>Responsiveness and Flexibility.....</i>	<i>12</i>
1.5.3	<i>Home-based visits versus clinic-based service delivery.....</i>	<i>13</i>
1.6	EMPLOYMENT OF MENTAL HEALTH NURSES UNDER THE MHNIP.....	14
1.6.1	<i>Quantifying the role of the Mental Health Nurse.....</i>	<i>14</i>
1.6.2	<i>Rating the credentialing requirement for Mental Health Nurse employment.....</i>	<i>15</i>
1.6.3	<i>Job satisfaction and conditions of employment.....</i>	<i>15</i>
1.7	IMPACT ON THE PRIVATE MENTAL HEALTH SERVICE SYSTEM.....	16
1.7.1	<i>Caseloads.....</i>	<i>16</i>
1.7.2	<i>Barriers to expanding current caseloads.....</i>	<i>17</i>
1.8	IMPACT AND OUTCOMES ACHIEVED FOR CLIENTS.....	17
1.8.1	<i>Overview of findings on outcomes and impact – survey and interview feedback.....</i>	<i>17</i>
1.8.2	<i>Impact on clients – survey feedback.....</i>	<i>17</i>
1.8.3	<i>Outcomes for clients – based on HoNOS scores.....</i>	<i>19</i>
1.8.4	<i>Change in HoNOS between entry and exit.....</i>	<i>20</i>
1.8.5	<i>Clients who left the MHNIP.....</i>	<i>20</i>
1.9	RESOURCING.....	21
1.10	SUMMARY OF RECOMMENDATIONS.....	21
2	INTRODUCTION.....	23
2.1	OVERVIEW OF METHODOLOGY.....	24
2.1.1	<i>The Evaluation Framework.....</i>	<i>24</i>
2.1.2	<i>Data collection tool.....</i>	<i>27</i>
2.1.3	<i>Site interviews.....</i>	<i>27</i>
2.1.4	<i>Service Profile Matrix.....</i>	<i>27</i>
2.1.5	<i>Medicare data analysis.....</i>	<i>28</i>
2.1.6	<i>Surveys with the three main stakeholder groups.....</i>	<i>29</i>
2.1.7	<i>Representativeness of the client survey sample.....</i>	<i>30</i>
2.1.8	<i>Site data.....</i>	<i>30</i>
3	CLIENT AND SERVICE DATA	32
3.1	EXPLANATORY INFORMATION ON DIFFERENCES IN THE MEDICARE AND SITE DATA.....	32
3.2	OVERALL PROFILE OF CLIENT NUMBERS AND SERVICE PROVISION.....	32
3.2.1	<i>Medicare data.....</i>	<i>32</i>

3.2.2	<i>Site data client numbers</i>	33
3.2.3	<i>Average time spent in the Program – based on Site data</i>	34
3.2.4	<i>Time spent in Program – Medicare data</i>	35
3.2.5	<i>Time spent in program – Clients who appear to have Exited the program</i>	36
3.3	DEMOGRAPHIC PROFILE OF CONSUMERS	37
3.3.1	<i>Gender</i>	37
3.3.2	<i>Age</i>	38
3.3.3	<i>Marital Status</i>	38
3.3.4	<i>Country of Birth</i>	38
3.3.5	<i>Language spoken at home</i>	39
3.3.6	<i>Indigenous Status</i>	39
3.3.7	<i>Remoteness</i>	39
3.3.8	<i>Private Health Insurance</i>	39
3.4	CLIENTS SEEN	40
3.4.1	<i>Clients seen</i>	40
3.5	SERVICES PROVIDED	42
3.5.1	<i>MHN Sessions provided – Medicare data</i>	42
3.5.2	<i>MHN Consults provided – Medicare data</i>	44
3.5.3	<i>Consults within sessions – Medicare data</i>	46
3.5.4	<i>Number of face to face and non face to face consults within sessions – Medicare data</i>	46
3.5.5	<i>Number of face to face consults per client - site data</i>	47
3.5.6	<i>Frequency of service (number of face to face consults per client per month) – site data</i>	47
3.5.7	<i>Frequency of service by type of consult – site data</i>	49
3.5.8	<i>Summary of sessions, consults and clients seen by Site – Medicare data</i>	49
4	INTEGRITY OF THE MHNIP MODEL AND ITS PLACE IN THE PRIVATE MENTAL HEALTH SERVICE SYSTEM	51
4.1	STRENGTHS OF THE MHNIP PILOT MODEL	51
4.1.1	<i>The service provider perspective</i>	51
4.1.2	<i>The client perspective</i>	53
4.1.3	<i>Conclusions: Strengths of the MHNIP model</i>	55
4.2	WEAKNESSES OF THE MHNIP PILOT MODEL	56
4.2.1	<i>Conclusions – weaknesses of the Model</i>	57
4.2.2	<i>Program responsiveness</i>	58
4.3	ELIGIBILITY ISSUES	58
4.4	HOME-BASED VISITS VERSUS CLINIC-BASED SERVICE DELIVERY	60
4.4.1	<i>Conclusions: Home-based vs Clinic-based service delivery</i>	61
4.5	QUANTIFYING THE ROLE OF THE MENTAL HEALTH NURSE	62
4.5.1	<i>Conclusions: Role of the Mental Health Nurse</i>	63
4.6	RATING THE CREDENTIALING REQUIREMENT FOR MENTAL HEALTH NURSE EMPLOYMENT	64
4.6.1	<i>Conclusions: Mental Health Nurse credentialing</i>	65
4.7	JOB SATISFACTION AND CONDITIONS OF EMPLOYMENT	65
4.8	RATING CONDITIONS OF EMPLOYMENT	65
4.8.1	<i>Conclusions: Mental Health Nurse working conditions under the MHNIP model</i>	66
4.9	IMPACT ON THE PRIVATE MENTAL HEALTH SERVICE SYSTEM	66
4.9.1	<i>Impact of the MHNIP on workload</i>	66
4.9.2	<i>Advantages and disadvantages of mental health nurse role in private sector</i>	67
4.9.3	<i>Conclusions: Impact on the private mental health system</i>	68
5	OUTCOMES ACHIEVED FOR CLIENTS	69
5.1	IMPACT OF MHNIP PILOT ON CLIENTS: COMPARATIVE ANALYSIS OF SURVEY FINDINGS	69

5.1.1	<i>Impact of MHNIP on clients: comparative analysis of provider response</i>	69
5.1.2	<i>Impact of MHNIP on clients: comparative analysis of all three survey groups</i>	71
5.2	IMPACT OF THE PROGRAM ON CLIENTS – BASED ON ANALYSIS OF SITE DATA	72
5.2.1	<i>Clients who have not yet exited</i>	73
5.2.2	<i>Clients who had exited the Program</i>	74
5.2.3	<i>Exited clients who had become well/functional</i>	75
5.2.4	<i>Relationship between HoNOS score at entry and exit from the Program</i>	75
5.2.5	<i>Reason for exit</i>	76
5.2.6	<i>Exit destination</i>	77
5.2.7	<i>HoNOS scores at exit</i>	77
5.2.8	<i>Change in HoNOS between entry and exit</i>	79
5.2.9	<i>Change in HoNOS between entry and exit for clients who became well/functional</i>	80
5.3	CONCLUSIONS – IMPACT OF THE PROGRAM ON CLIENTS	82
6	OUTCOMES ACHIEVED FOR SERVICE PROVIDER PARTICIPANTS	84
6.1	RESOURCING ISSUES	84
6.1.1	<i>Caseload patterns – Medicare data</i>	84
6.1.2	<i>Quantifying maximum caseloads – survey data</i>	85
6.1.3	<i>Barriers to expanding current case loads</i>	86
6.1.4	<i>Reliance on auspicing organisations’ contribution to resourcing</i>	86
7	FUTURE ENHANCEMENTS RECOMMENDED FOR THE MHNIP	88
7.1	IMPROVING THE MHNIP IN PRIVATE SETTING	88
7.2	ISSUES FOR CONSIDERATION AND CHANGE	89
7.2.1	<i>Funding to achieve positive client and service system outcomes</i>	89
7.2.2	<i>Credentialing of Mental Health Nurses</i>	89
7.2.3	<i>Mental Health Nurse working conditions under the MHNIP model</i>	90
7.2.4	<i>Capacity to manage cultural diversity</i>	90
7.2.5	<i>Accountability requirements associated with Medicare funding</i>	91
7.2.6	<i>Future Monitoring and Evaluation</i>	91
7.3	RECOMMENDATIONS	91

List of Figures

FIGURE 1:	OUTCOMES HIERARCHY STRUCTURING THE EVALUATION FRAMEWORK	25
FIGURE 2	EVALUATION FRAMEWORK: OVERVIEW	26
FIGURE 3:	SURVEY RESPONSE RATES BY SITE AND STAKEHOLDER GROUP	30
FIGURE 4:	CLIENTS, CONSULTS AND SESSIONS IN THE MEDICARE DATASET – AND DEFINITION OF TERMS	33
FIGURE 5:	NUMBER OF CLIENTS WHO ENTERED THE PROGRAM, BY SITE	34
FIGURE 6:	PERCENTAGE OF CLIENTS WHO EXITED THE PROGRAM, BY SITE	34
FIGURE 7:	AVERAGE AND MEDIAN NUMBER OF MONTHS SPENT IN PROGRAM, BY SITE	35
FIGURE 8:	AVERAGE AND MEDIAN LENGTH OF TIME (MONTHS) CLIENTS SPENT IN THE PROGRAM, BY SITE: CLIENTS WHO HAD SPENT AT LEAST ONE MONTH IN THE PROGRAM (N=289)	36
FIGURE 9:	AVERAGE AND MEDIAN LENGTH OF TIME (MONTHS) THAT CLIENTS SPENT IN THE PROGRAM, BY SITE: CLIENTS WHO APPEAR TO HAVE EXITED THE PROGRAM	37
FIGURE 10:	AGE PROFILE BY SITE (SITE DATA)	38
FIGURE 11:	COUNTRY OF BIRTH BY SITE (SITE DATA)	39
FIGURE 12:	PRIVATE HEALTH INSURANCE BY SITE (SITE DATA)	40
FIGURE 13:	NO OF CLIENTS SEEN PER MONTH	41

FIGURE 14: NO OF SESSIONS AND NO OF CLIENTS SEEN PER MONTH – MEDICARE DATA	41
FIGURE 15: NO OF CLIENTS SEEN PER MONTH, BY SITE – MEDICARE DATA.....	42
FIGURE 16: NUMBER OF SESSIONS FUNDED, BY SITE, SINCE PROGRAM INCEPTION	43
FIGURE 17: NUMBER OF SESSIONS FUNDED PER MONTH SINCE PROGRAM INCEPTION	43
FIGURE 18: NO OF SESSIONS FUNDED PER MONTH, BY SITE	44
FIGURE 19: NUMBER OF CONSULTS, BY SITE, SINCE PROGRAM INCEPTION – MEDICARE DATA.....	44
FIGURE 20: NUMBER OF CONSULTS PER MONTH SINCE PROGRAM INCEPTION – MEDICARE DATA	45
FIGURE 21: NO OF CONSULTS PER MONTH BY SITE – MEDICARE DATA.....	45
FIGURE 22: AVERAGE NUMBER OF CONSULTS PER SESSION, PER SITE – MEDICARE DATA	46
FIGURE 23: AVERAGE NO OF FACE TO FACE AND NON FACE TO FACE CONSULTS, PER SESSION, PER SITE	46
FIGURE 24: AVERAGE AND MEDIAN NUMBER OF FACE TO FACE CONSULTS PER CLIENT, BY SITE - SITE DATA	47
FIGURE 25: FREQUENCY OF SERVICE - AVERAGE NUMBER OF FACE TO FACE AND NON FACE TO FACE CONSULTS – SITE DATA	49
FIGURE 26: PROPORTION OF MHNIP SESSIONS, CONSULTS AND CLIENTS SEEN, BY SITE – MEDICARE DATA	50
FIGURE 27: STRENGTH OF THE PROGRAM IN A PRIVATE SETTING	52
FIGURE 28: CLIENTS’ RATING OF FEATURES OF THE MHNIP MODEL	55
FIGURE 29: COMPARATIVE RATINGS OF THE MHNIP MODEL’S WEAKNESSES.....	56
FIGURE 30: PATHWAYS FROM REFERRAL TO ENTRY.....	59
FIGURE 31: PERCENTAGE OF CLIENTS NOT MEETING ENTRANCE CRITERIA	59
FIGURE 32: TYPE OF CONTACT BY SITE – SITE DATA	60
FIGURE 33: ADVANTAGES AND DISADVANTAGES OF A CLINIC VERSUS HOME-VISIT BASED MODEL OF DELIVERY.....	61
FIGURE 34: IMPORTANCE OF MHN/ COORDINATOR ROLES	63
FIGURE 35: IMPORTANCE OF MHN/ COORDINATOR ACCREDITATION	64
FIGURE 36: MHN JOB SATISFACTION	65
FIGURE 37: AVERAGE RATINGS OF KEY FEATURES OF MHN WORKING CONDITIONS.....	66
FIGURE 38: IMPACT ON CLIENTS OF THE ENGAGEMENT OF A MHN.....	70
FIGURE 39: PROVIDER AND CLIENT ASSESSMENT OF IMPACT OF MHNIP	71
FIGURE 40: IMPACT ON CLIENT OF REFERRAL TO MHNIP	72
FIGURE 41: AVERAGE HONOS SCORES AT ENTRY AND REVIEWS: CLIENTS WHO HAD NOT YET EXITED.....	74
FIGURE 42: CHANGE IN AVERAGE HONOS SCORES OVER TIME	74
FIGURE 43: AVERAGE HONOS SCORES AT ENTRY AND REVIEWS: CLIENTS WHO BECAME WELL/ FUNCTIONAL.....	75
FIGURE 44: DISTRIBUTION OF HONOS SCORES REPORTED UNDER THE MHNOC FOR VOLUNTARY ADULT CLIENTS AT EXIT FROM AN AMBULATORY SERVICE IN 2006-7	78
FIGURE 45: AVERAGE AND MEDIAN HONOS SCORE AT EXIT, BY SITE.....	79
FIGURE 46: CHANGE IN HONOS BETWEEN ENTRY AND EXIT	80
FIGURE 47: CHANGE IN HONOS BETWEEN ENTRY AND EXIT: CLIENTS WHO BECAME WELL/ FUNCTIONAL.....	81
FIGURE 48: AVERAGE CASELOAD (NO OF CLIENTS SEEN PER FTE MHN, AVERAGED OVER 3 MONTHS), FOR EACH QUARTER SINCE PROGRAM INCEPTION	85
FIGURE 49: CASELOAD (NO OF CLIENTS SEEN PER FTE MHN) AVERAGED OVER ENTIRE PERIOD OF OPERATION, BY SITE.....	85
FIGURE 50: MAXIMUM CASELOAD PER FTE MHN.....	85
FIGURE 51: BARRIERS TO EXPANDING CASE LOAD.....	86
FIGURE 52: RESOURCES PROVIDED TO SUPPORT THE EMPLOYMENT OF A MHN	87

List of Tables

TABLE 1: SUMMARY OF CHANGES IN HONOS SCORES OVER TIME	19
TABLE 2: COMMENCEMENT DATES OF MHNIP SITES.....	24
TABLE 3: APPLICATIONS OF THE MHNIP MODEL	28
TABLE 4: SURVEY SAMPLE BY SITE AND STAKEHOLDER GROUP	29
TABLE 5: DIFFERENCES BETWEEN THE CHARACTERISTICS OF CLIENTS INCLUDED IN MEDICARE, SITE OR SURVEY DATA	30
TABLE 6: PERIOD OF TIME FOR WHICH SITE DATA WERE PROVIDED	31
TABLE 7: CLIENT GENDER - MEDICARE AND SITE DATA COMPARISON	37
TABLE 8: CLIENT AGE - MEDICARE AND SITE DATA COMPARISON	38
TABLE 9: CLIENT LOCATION - MEDICARE AND SITE DATA COMPARISON	39
TABLE 10: NUMBER OF MONTHS BETWEEN ENTRY AND MOST RECENT SERVICE, AND NUMBER OF FACE TO FACE CONSULTS PER CLIENT PER MONTH: SITE DATA STATISTICS	48
TABLE 11: AVERAGE FACE TO FACE SERVICES PER CLIENT PER MONTH BY LEVEL OF CARE REQUIRED – SITE DATA.....	48
TABLE 12: ADVANTAGES AND DISADVANTAGES OF UNDERTAKING THE MHNIP ROLE IN THE PRIVATE SECTOR.....	68
TABLE 13: AVERAGE HONOS SCORE AT EACH TIME POINT.....	77
TABLE 14: SUMMARY OF CHANGES IN HONOS SCORES OVER TIME	82
TABLE 15: COMPARISON OF IMPROVEMENTS RECOMMENDED TO THE MHNIP	88

List of Boxes

BOX 1: ENTRANCE CRITERIA FROM THE MHNIP PROGRAM GUIDELINES.....	58
BOX 2: PROGRAM GUIDELINES RELATING TO THE ROLE OF THE MENTAL HEALTH NURSE.....	62
BOX 3: INTERPRETING CHANGE IN HONOS SCORES	73
BOX 4: EXIT CRITERIA ACCORDING TO MHNIP PROGRAM GUIDELINES.....	76

1 EXECUTIVE SUMMARY

The *Final Report* draws together and interprets the key elements detailed in the *Survey, Medicare and Site Data Analysis Reports*. These companion reports contain comprehensive analyses of data from the different sources, and should be read in conjunction with this *Final Report*.

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.

- Development of an evaluation framework for Piloting the inclusion of private hospitals as eligible organisations under the Mental Health Nurse Incentive Program.
- Development of data collection tools to undertake research.
- 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).
- 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:

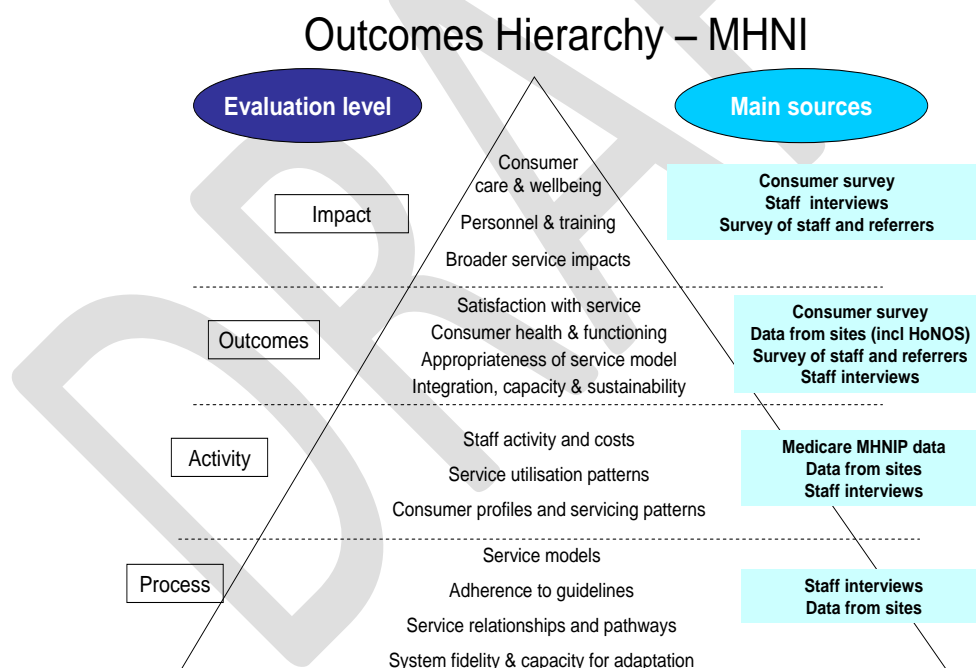
- Development of an Evaluation Framework to structure the review (see Section 2.1.1, and below).
- Design of a user-friendly data collection tool for sites to document service data (see Section 2.1.2).
- Design of a Service Profile Matrix (see Section 2.1.4).
- Visits to all participating sites by the 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).

- Analysis of Medicare data relating to MHNIP Pilot sites (see Section 2.1.5).
- 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).
- Analysis of all findings.
- 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.

The diagram below summarises the program logic Outcomes Hierarchy (Process⇒ Activity⇒ Outcomes⇒ Impact) underpinning the Evaluation Framework. This has also structured the reporting provided in this Final Report.

Outcomes Hierarchy structuring the Evaluation Framework



1.1.1 Survey sample and response rates

As the table below shows, 16 out of 19 Mental Health Nurses and Coordinators have responded to the survey (**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.

1.1.2 Medicare data analysis

The specifications for Medicare data extract were designed in consultation with Medicare Australia, with access arranged for the evaluators by the Department of Health and Ageing. The Medicare data were 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:

- MHNIP claims processed **from Program inception through to end of January 2009** (extracted end of February 2009)
- MHNIP claims processed **from January 2009 to end of March 2009** (extracted end of April 2009).

The datasets comprised information from the MHNIP claim forms submitted to Medicare by each site, and contained confidentialised client identifiers which enabled the evaluators to undertake comprehensive analysis without compromising confidentiality. A complete dataset containing data for all sites and all available months was constructed and analysed using SPSS V15.0 and SPSS V17.0.

1.1.3 Site data analysis

The sites compiled data from their administrative systems using a data collection tool designed for this evaluation by the AISR evaluation team. In designing the data collection tool, 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 Excel, Word or on paper by printing copies of the Word document. Details are provided in *Accompanying Report 2*. 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.

A complete dataset containing data from all sites was constructed in Microsoft Access. Validation checks, recoding and the majority of the basic analysis was then undertaken using Microsoft Access and Microsoft Excel. More complex analysis including statistical testing was undertaken using SPSS V15.0 and SPSS V17.0.

Data were provided to the evaluators by the following sites:

- Ramsay Health Care, Adelaide
- Perth Clinic
- Mayo Private Hospital, Taree
- Toowong Private Hospital
- St John of God Hospital, Warrnambool.

Essendon Private Hospital commenced operation subsequent to this data collection, therefore their service is not represented in this analysis. The five sites provided data on a total of **277** client referrals to the MHNIP.

1.1.4 Comparing Medicare and Site Data

In analysing data collected by the sites for the evaluation, and data provided by the sites to Medicare, the evaluators recognise that some differences emerge when both are presented comparatively. It is for this reason that separate and detailed reports of each have been provided – see *Accompanying Reports 2 and 3*.

The major difference between the two sources is that *fewer clients* were recorded in the Site Data than the Medicare data (271 versus 407), despite the Site Data being reported for a longer time period.

In addition, clients who spent only a *short time* in the program (less than one month) are strongly represented in the Medicare data (37% of all clients) but not in the Site Data (6% of all clients).

1.2 Client and Service Profile information

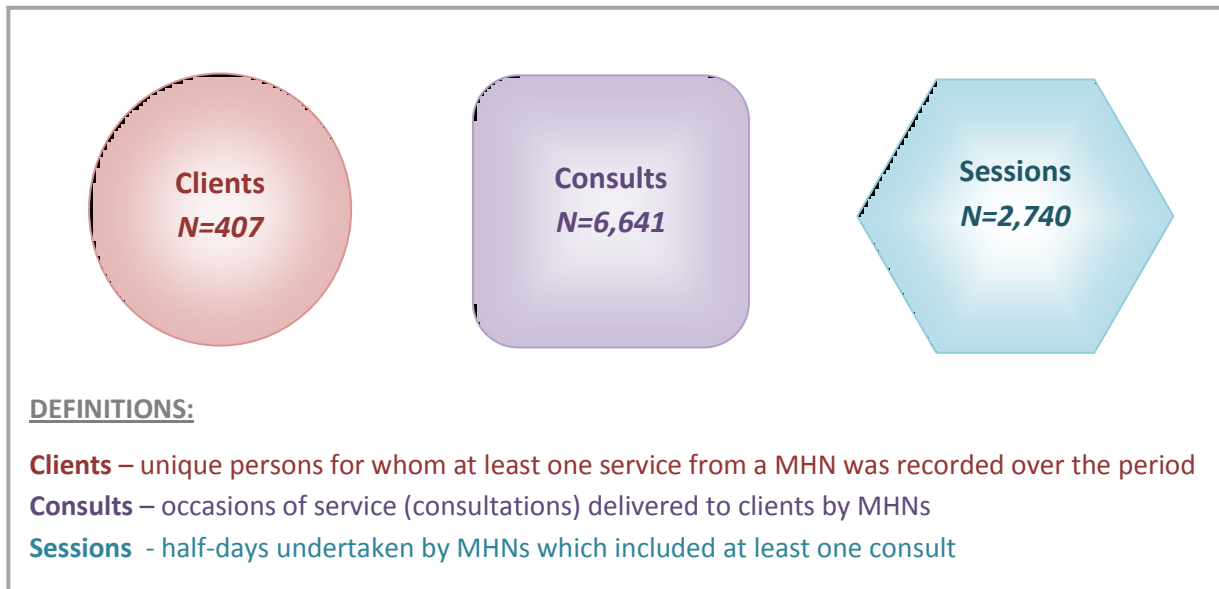
1.2.1 Medicare data

According to the data provided by Medicare in relation to Program inception to Jan/Feb 2009 –

- ⇒ A total of **2,740** Mental Health Nurse sessions (ie. half-days) had been funded.
- ⇒ **More than 6,600** consults had been provided.
- ⇒ A total of **407** clients had received a service.

The number of sessions, clients and consults identified by this method are shown below, together with definition of key terms. *These definitions have been applied in this and other reports prepared for the evaluation.*

Clients, Consults and Sessions in the Medicare dataset – and definition of terms



1.2.2 Site data client numbers

Five sites reported data on a total of **277** client referrals to the MHNIP, of whom **271** (97.8%) met Program eligibility criteria (see Section 4.3). Almost all clients who were referred to the MHNIP entered the Program (271 clients, **97.8%**), and **30.3%** of those who entered had exited the Program by the date on which the data were compiled.

1.2.3 Average time spent in the Program – based on Site data

Of the 78 clients who exited the Program and for whom entry and exit dates were provided, the number of months spent in the MHNIP ranged from less than one month to 18 months. On average clients spent **5.7 months** in the Program before exiting, and this was quite consistent across sites, ranging from an average of 4.8 months at Ramsay Health Care Adelaide to 6.1 months at Toowong Private Hospital. *Note that these averages may be influenced by the number of months that each site has been operating.*

1.2.4 Demographic profile of consumers

Using information derived from the analyses of Medicare data (based on 407 clients) and site data (based on 271 clients), it was evident that the majority of clients were **female**, aged in their **mid forties**, and living in a major **city** (but with strong representation from **rural** areas.) Site data identify under-representations of people from culturally and linguistic diverse backgrounds, and from Indigenous backgrounds. They also show that **57.0%** of clients had private health insurance.

1.3 Services provided

Data about services provided are differentiated on the basis of -

- a. **Consults** – occasions of service (consultations) delivered to clients by MHNs
- b. **Sessions** - half-days undertaken by MHNs which included at least one consult.

Medicare data show that a total of **2,740** Mental Health Nurse sessions (ie. half-days) had been funded since Program inception to Jan/Feb 2009. The largest MHNIP operation at that time was at Toowong Private Hospital site, which had 1,119 sessions funded, representing 41% of all MHNIP sessions funded to Jan/Feb 2009.

More than 6,600 consults had been provided under the MHNIP to Jan/Feb 2009, ranging from 481 consults at Ramsay Health Care Adelaide (a small operation with one Mental Health Nurse, and which commenced in March 2008), to 2,984 consults at Toowong Private Hospital (a large operation employing several Mental Health Nurses). The number of consults per month is primarily dependent on the number of Mental Health Nurse sessions per month.

The **average** number of consults per session across all sites was **2.4**, ranging from 1.9 at Mayo Private Hospital to 2.7 at Toowong. The **median** number of consults across every site was **2.0**.

The amount of service provided conforms with the MHNIP Guideline of at least two individual patients (with a severe mental health disorder) per session.

In terms of *types of consult*, site data show that the number of **face to face** consults per client per month averaged **2.0 for all sites** combined, and non face to face consults per client per month **averaged 1.5**.

The total number of face-to-face services provided to a client will naturally vary depending on the length of time they are engaged with the service, potentially confounding apparent differences between sites. Therefore, the number of face-to-face consults *per month* was calculated for clients who had been in the MHNIP for at least one month. **This showed that clients had received an average of 2 face to face consults per month, over an average time span of 7.1 months of activity.**

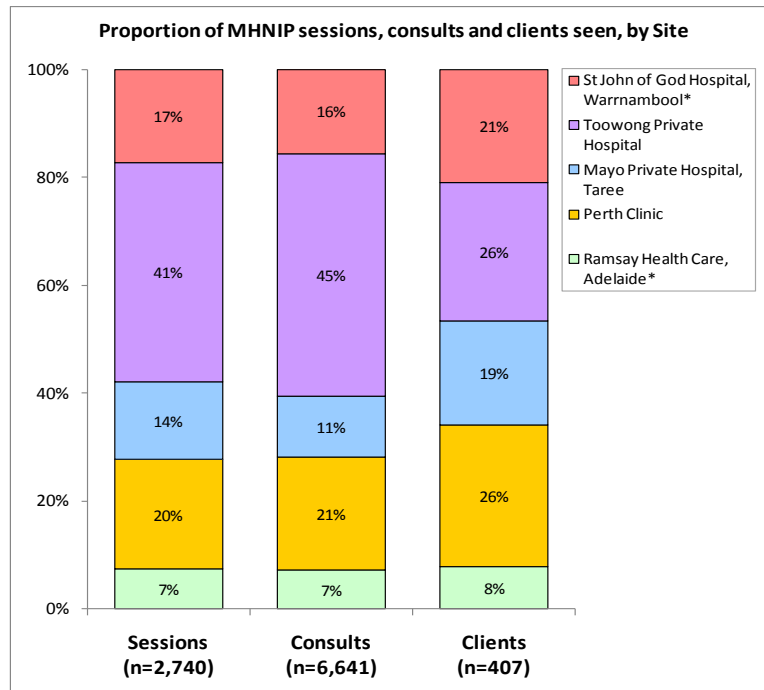
The average of 2 face to face consults per month remained fairly consistent regardless of clients' primary diagnosis, but altered when different **levels of client need for care** were taken into account, as would be expected. As the table below indicates, consults average **1.4** services per month for low, **1.9** for medium, and **2.6** for high care needs.

Average face to face services per client per month by Level of Care Required – site data

Level of Care Required	No. of Clients	Average	SD	Median	Minimum	Maximum
Low	66	1.4	0.8	1.1	0.3	4.0
Medium	81	1.9	1.1	1.8	0.2	6.5
High	109	2.6	1.5	2.4	0.0	11.0

Analysis of the number of sessions, consults and clients highlights operational differences between sites. The site with the largest proportion of consults (45%) and sessions (41%) is Toowong Private Hospital, and shares with the Perth Clinic, the highest proportion of clients (26%) across the Program as a whole. The smallest proportion of consults, sessions and clients is held by the Adelaide site.

Proportion of MHNIP sessions, consults and clients seen, by site – Medicare data



* Information not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09, therefore numbers for those sites are underestimates.

1.4 Eligibility issues

Of the **271** clients entered into the MHNIP, 59 clients (22%) were reported to have failed to meet one or more entrance criteria and were therefore technically ineligible according to Program guidelines. In other words, 59 people were accepted into the Program despite failing one or more eligibility criteria.

The six clients who *did not enter the Program* failed to meet one or more of the eligibility criteria on assessment. All six clients failed to meet Criterion 6 (Consent to treatment from a Mental Health Nurse), and four of the six clients also failed to meet Criterion 4 (Expected to require continuing treatment over the next two years).

These findings may indicate the need to review Program Guidelines, possibly with a view to changing the number of criteria that must be met to achieve eligibility.

1.5 Integrity of 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.

1.5.1 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) –

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

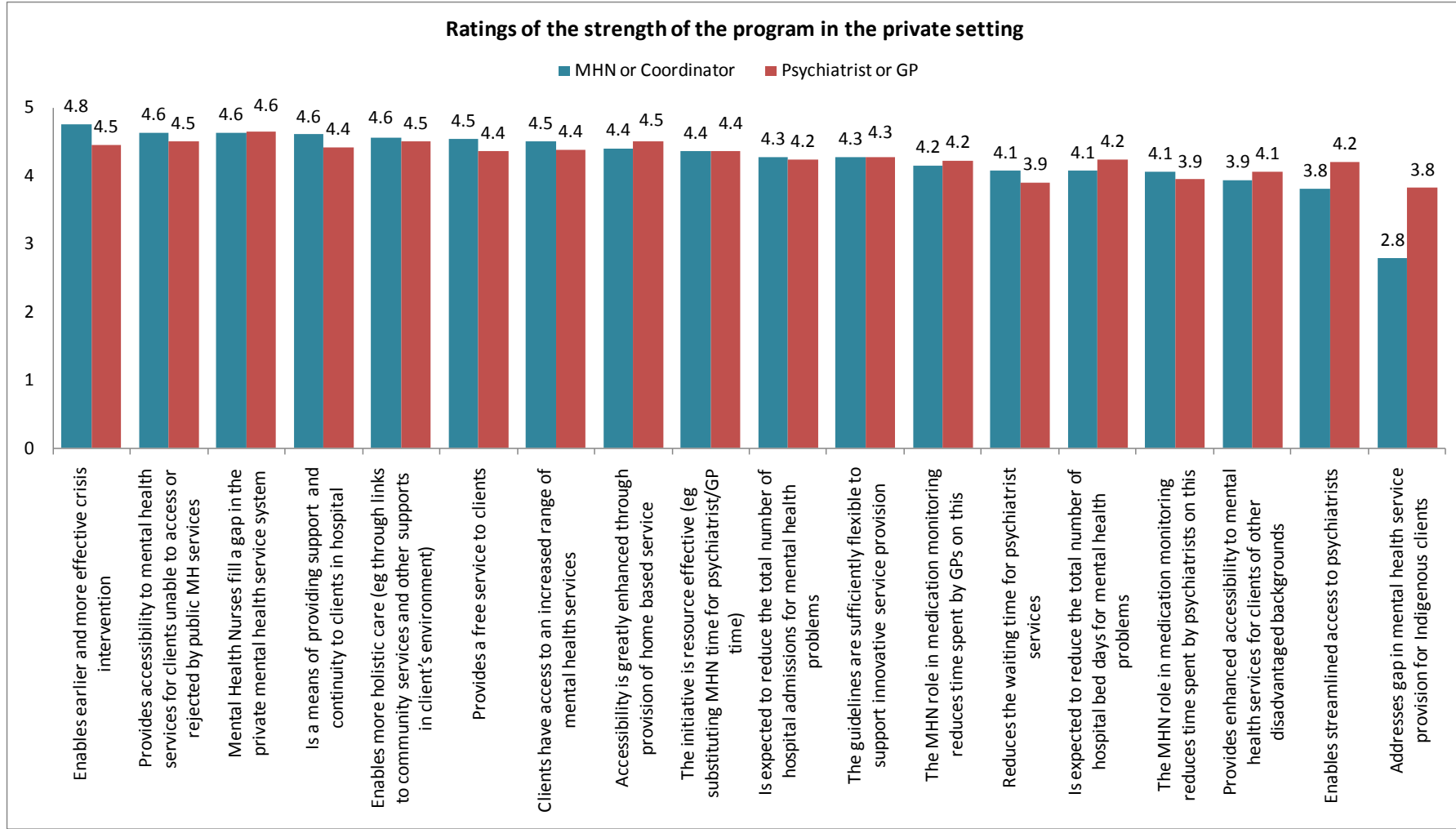
The following **strengths** were identified by more than one of 108 (**91%**) clients (the remaining 11 did not respond to this question) –

- 1) The opportunity provided to discuss problems and issues with the Mental Health Nurse, and to receive constructive feedback about these (n = 55)
- 2) The provision of regular, frequent and ongoing communication, support and monitoring (n = 16)
- 3) The education provided to clients, including about medication and its managements (n = 13)
- 4) The quality of the care provided and skills of the Mental Health Nurse (n = 11)
- 5) The continuity of care provided (n = 10)
- 6) Reduced social isolation (n = 10)
- 7) The accessibility and responsiveness of the Program, particularly due to the provision of home visits (n = 8)
- 8) Reduced reliance on GPs and psychiatrists (n = 6)
- 9) Reduced reliance on family and a consequent reduction in burden on families, together with the support provided to family members (n = 6)
- 10) The client focus and tailoring of care to individual need (n = 3).

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.

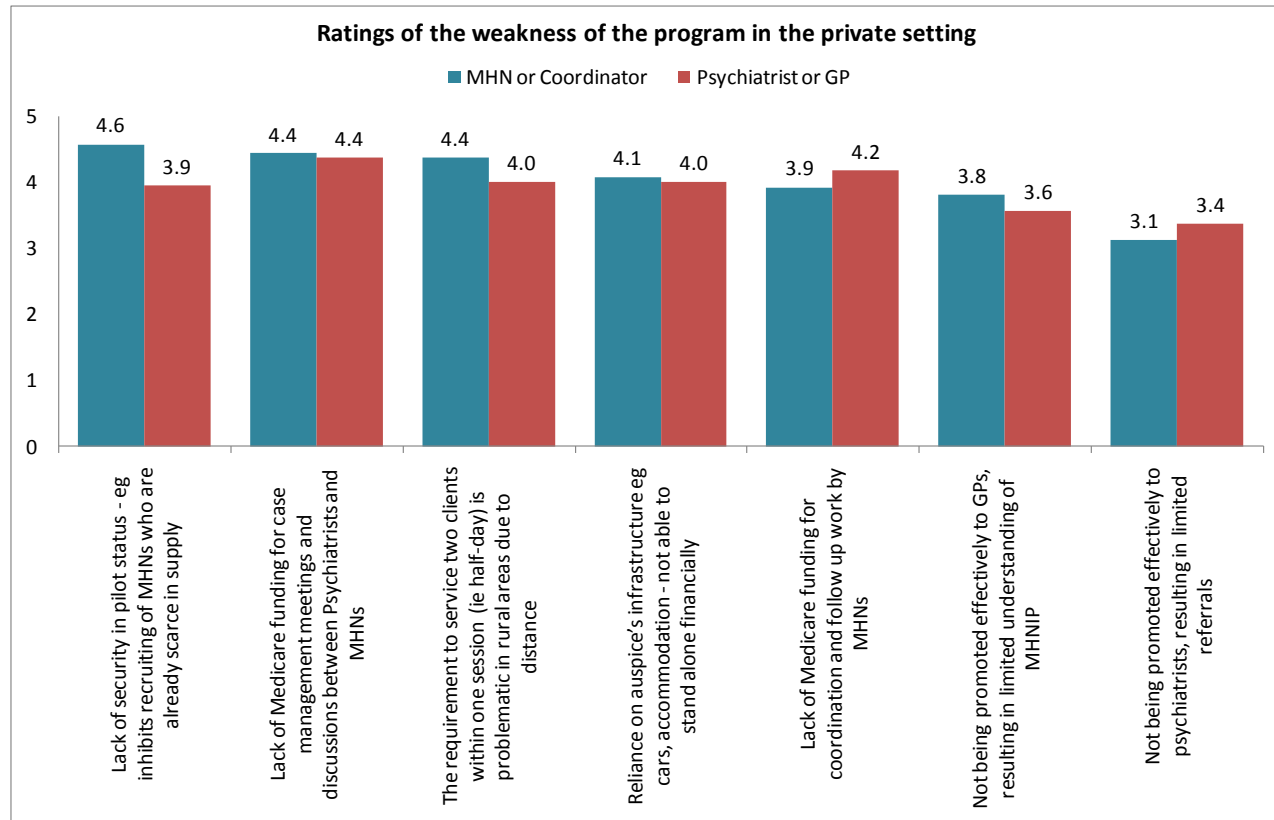
Strength of the Program in a private setting



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.**

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 funding for infrastructure will 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 -

- 11) The need for the program to be **better resourced** (n = 14)
- 12) 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.

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

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.

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.

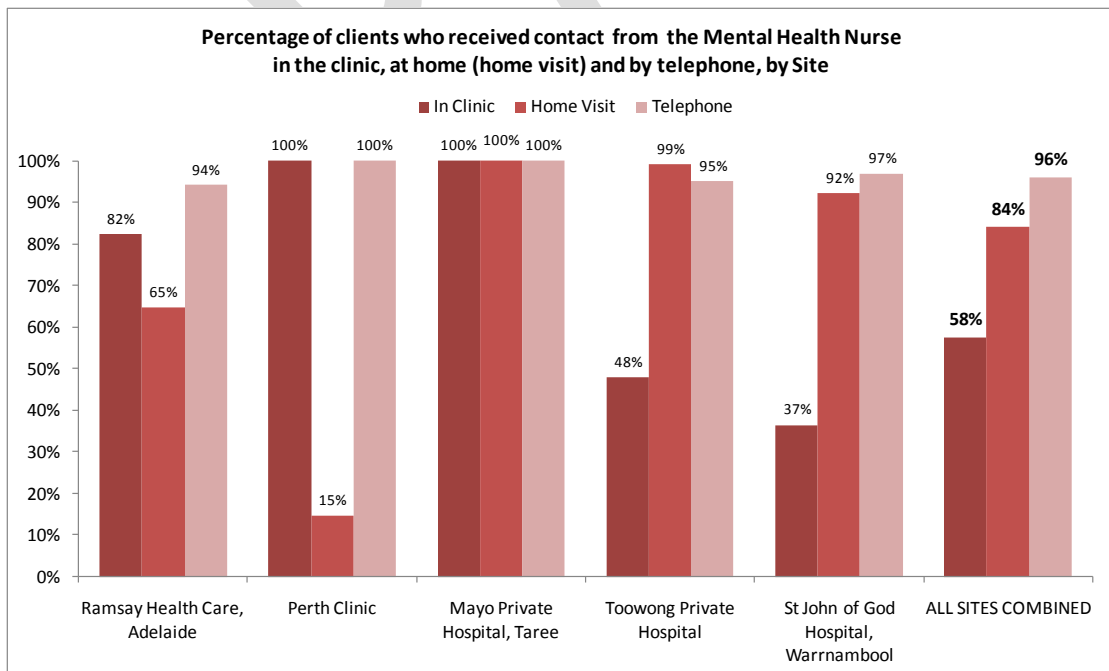
1.5.3 Home-based visits versus clinic-based service delivery

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. However, the degree to which home-based service delivery has been adopted varies across the sites.

The figure below shows the percentage of clients at each site who received one of three types of contact – *in clinic*, *home visit* or *telephone* contact. Across all sites, 96.0% of clients were contacted at least once by telephone, 84.0% received at least one home visit and 58.0% were seen at least once in the clinic.

Sites differed as to their use of each type of contact. For example, every client from the Taree site received in clinic services, home visits and telephone contact, whereas only 15.0% of clients at the Perth site received home visits.

Type of contact by Site – site data



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.

Survey results found that where home-based visits are being provided, the MHNIP model offers significant accessibility and flexibility in its mode of delivery for clients. From a clinical perspective, the opportunity to increase service providers' understanding of clients' home environments is also provided.

However, home-based delivery does bring increased risks for Mental Health Nurses, associated with travel and with safety in relation to some clients. The time and costs associated with home-based delivery make it more expensive than a clinic based delivery mode, but these issues need to be balanced against enhanced information about client needs, and increased accessibility and flexibility for clients.

1.6 Employment of Mental Health Nurses under the MHNIP

1.6.1 Quantifying the role of the Mental Health Nurse

The Mental Health Nurse is central to the MHNIP model, and for this reason, the evaluation has sought to quantify the different aspects of the Mental Health Nurse role. This also has implications for Medicare funding and the scope of services provided as part of the Mental Health Nurse role.

Mental Health Nurses and Coordinators 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 these roles:

- **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).

Clients surveyed were asked to indicate (from a standardised response list) which activities and services they were receiving from the Mental Health Nurse. Of the nine roles possible, the three most commonly identified were:

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

The range of 15 roles being undertaken by Mental Health Nurses employed under the MHNIP Program has been validated by survey and interview feedback and it is important that Medicare funding is available to support all of those roles.

1.6.2 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 (ACMHN). 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 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.

The evaluators agree that the current Program requirement regarding recognition by the ACMHN is an important quality control mechanism, and a means of formal recognition of the expertise required of Mental Health Nurses. At the same time, it is important to recognise previous experience and MHNIP nurses should have ready and affordable access to Recognition of Prior Learning assessment processes.

1.6.3 Job satisfaction and conditions of employment

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'.

In rating (on a five point scale with '5' equating to most positive feedback) work conditions were assessed as follows -

- 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**).

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.

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). Nor has it diminished their very high levels of job satisfaction.

1.7 Impact on the private mental health service system

Psychiatrists and GPs surveyed were asked to quantify the outcomes resulting from referring clients to the MHNIP Pilot.

The majority of participating psychiatrists and GPs believe that the MHNIP has made a positive impact in a number of ways, but in particular, in relation to their capacity to deal with complex cases, increased involvement with others involved in client's care, and the achievement of a more timely response to acute or emergency presentations.

Mental Health Nurses, in their interviews with the evaluation team and in survey feedback, see the MHNIP as filling a gap in the system, and providing greater flexibility, accessibility and responsiveness of care. Many of the strengths identified for the model are also indicators of a positive impact on the private mental health system as a whole. In particular -

- Provision of earlier and more effective crisis intervention
- MHNs fill a gap in the private mental health system
- Resource effectiveness achieved by the MHN substituting for psychiatrist or GP time
- Expected reduction in hospital admissions for mental health issues
- MHN role in medication monitoring reduces GPs' time spent on this
- MHN role in medication monitoring reduces psychiatrists' time spent on this
- Expected reduction in hospital stay length of stay for mental health issues.

1.7.1 Caseloads

MHNIP Guidelines require a **current** minimum case load of 20 individual patients with a severe mental disorder per week, averaged over three months, and an expected **annual** caseload per FTE Mental Health Nurse of **35** clients with a severe mental disorder, most of whom being expected to require ongoing care over the course of the year.

On this basis, the Adelaide, Perth, and Taree sites have met or exceeded the Guideline, the Warrnambool site is just below at 34.3 (and is a relatively newly established site) while Toowong is well below at 28.1.

Site data show that the average caseload (number of clients seen per FTE Mental Health Nurse, averaged over 3 months) tends to remain within the range of **30 to 35 clients** per FTE Mental Health Nurse, when data from all sites are combined.

Average caseloads vary between sites, from **28.1 clients** per FTE Mental Health Nurse at Toowong Private Hospital (whose operation is characterized by home visits) to **37.9 clients** per FTE Mental Health Nurse at Ramsay Health Care Adelaide.

Caseloads tend to vary over time, across phases of operation and as different procedures and staffing profiles are introduced at each site.

The caseload averaged across all sites and the entire period of MHNIP was **32.8 clients** per FTE Mental Health Nurse. Note that this average for all sites is strongly influenced and lowered by the data from Toowong Private Hospital, as Toowong's operation comprises 41% of all MHNIP sessions.

Of course, variations in case load capacity will occur depending on factors such as –

- a) Severity or complexity of the client's condition
- b) Client's location and travel time required for home visits (which doesn't apply to those using a clinic based delivery only).
- c) Service location – those in rural and remote areas having greater distances to travel.

1.7.2 Barriers to expanding current caseloads

Survey and interview feedback identified that the main barriers to expanding the current case load were –

- **Lack of infrastructure** – such as, accommodation, cars
- **Time and distance involved in providing home visits** to clients
- **Difficulties in recruiting accredited Mental Health Nurses**
- **Administrative and coordination load.**

1.8 Impact and Outcomes achieved for clients

Outcomes achieved for clients have been assessed using three mechanisms –

- I. Analysis of site data, including psychological tests prior to and following intervention
- II. Analysis of Medicare data
- III. Surveys with Mental Health Nurses, Psychiatrists and GPs, and Clients with questions relating to outcomes and impact triangulated across the three groups of stakeholders.

1.8.1 Overview of findings on outcomes and impact – survey and interview feedback

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.

1.8.2 Impact on clients – survey feedback

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 –

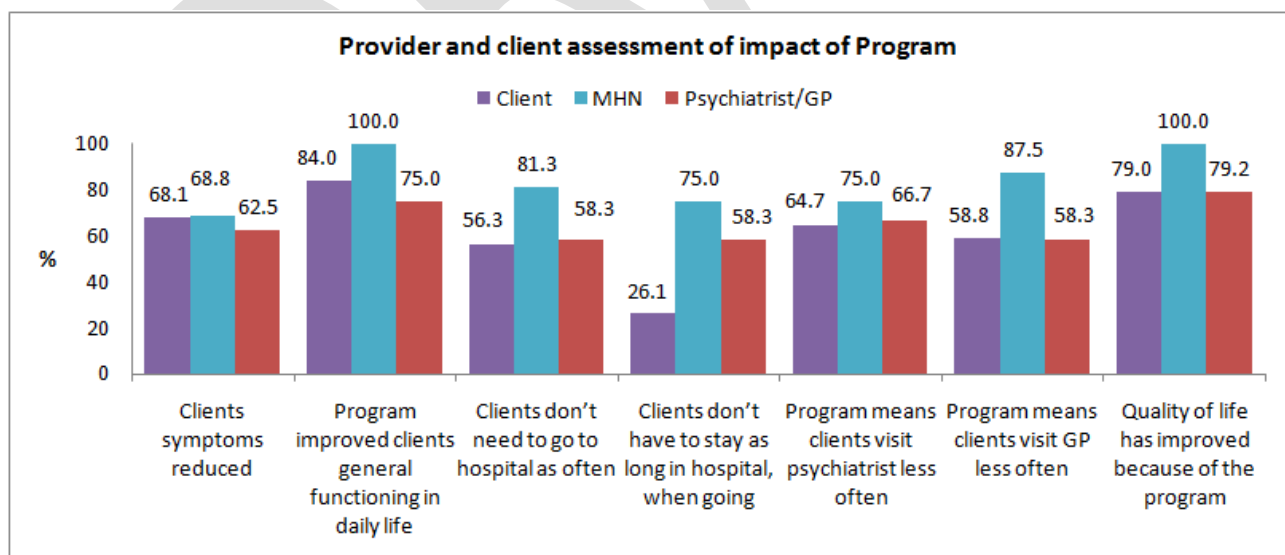
- Assist clients to make more effective use of health care, social and community services and resources.

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

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. When the views of all three stakeholder groups are analysed -

- 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).
- Over three-quarters of all three groups perceive an **improvement in both daily functioning and overall quality of life**.
- Over 55% of all three groups specified a **reduction in hospital admissions** as an outcome.
- 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.
- 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.

1.8.3 Outcomes for clients – based on HoNOS scores

Analysis of HoNOS scores reported over time (at each Review) was undertaken for -

- Clients who have *not yet exited* the service
- Clients who *have exited* the service
- Clients who exited the service because they *became well/functional* (according to their reason for exit).

HoNOS scores at entry were recorded for 65 (79.3%) of the 82 clients who exited the Program. The average HoNOS score at entry for these clients was **13.5**, and average HoNOS score at entry for clients who had *not yet exited* the program was **14.9**.

The Table below summarises changes in HoNOS scores over time, from entry and between review intervals, to exit from the Program. (Note that lower scores indicate less severe symptoms, therefore a decrease in HoNOS scores indicates improvement.)

Table 1: Summary of changes in HoNOS scores over time

Interval	No. clients with HoNOS at both time points	% of clients showing Improvement	% of clients showing No Change	% of clients showing Deterioration	Average Change
<i>Clients who had not yet exited the MHNIP (n=189)</i>					
Entry to 1 st Review	158	64%	11%	25%	3.3 HoNOS points improvement*
1 st to 2 nd Review	57	48%	9%	44%	0.6 HoNOS points improvement
2 nd to 3 rd Review	40	52.5%	5%	42.5%	0.2 HoNOS points deterioration
3 rd to 4 th Review	16	50%	19%	31%	1.8 HoNOS points improvement
<i>Clients who had exited the MHNIP (n=82)</i>					
Entry to 1 st Review	41	66%	5%	29%	2.5 HoNOS points improvement
Entry to Exit	46	67%	7%	26%	4.0 HoNOS points improvement**
<i>Clients who had exited the MHNIP due to becoming well or functional (n=41)</i>					
Entry to 1 st Review	28	71%	4%	25%	2.8 HoNOS points improvement
Entry to Exit	29	83%	3%	14%	5.7 HoNOS points improvement***

*A statistically significant change occurred between **Entry and 1st Review** (p<.01) and also **Entry and 4th Review** (p<.01, not shown).

**Statistically significant change (p<.01).

***Statistically significant change (p<.001).

The number of months that clients spent in the Program before exiting was significantly related to their HoNOS score at entry, with higher (worse) scores on entry mildly associated with a longer period of time before exit (Pearson correlation, r=.252 p<.05), as would be expected.

A statistical analysis of the entry HoNOS scores for Exited and Non-Exited clients was undertaken to determine whether these groups differed significantly on their scores at entry. This test identified a statistically significant difference (Mann-Whitney U test, $p < .05$), suggesting that **clients with lower (better) HoNOS scores at entry were more likely to exit the Program, whereas clients with higher (worse) HoNOS scores at entry are likely to remain in the Program, as would be desired.**

1.8.4 Change in HoNOS between entry and exit

Testing identified a **statistically significant difference** between HoNOS at entry and exit for the **46 clients** with a HoNOS score at both time points (Wilcoxon test for paired samples, $p < .01$), **confirming that clients recorded a significantly lower HoNOS score (and therefore, improvement) on exit from the Program.** Of these 46 clients with HoNOS recorded at both entry and exit –

- ⇒ 67.0% recorded an **improvement** based on their HoNOS score,
- ⇒ 7.0% of clients recorded **no change** in HoNOS score, and
- ⇒ 26.0 % of clients recorded a **deterioration** based on their HoNOS score.

When the group of exiting clients is separated based on the 29 clients who *became well/functional*, the average HoNOS score on Entry for these 29 clients was **12.2** and their average HoNOS score on Exit was **6.6**.

Statistical testing identified a **highly significant difference** between HoNOS at entry and exit (Wilcoxon test for paired samples, $p < .001$), **confirming that clients who became well/functional recorded a significantly lower HoNOS on exit from the Program.**

1.8.5 Clients who left the MHNIP

Exit destination was reported for approximately 80.0% of Exited clients. According to the data provided to the evaluators by each site, **slightly more than half** of the 79 clients for whom an Exit Reason was recorded had left the Program because they *became well/functional*.

Clients who exited because they *refused or failed to engage with MHN services*, or who had *disengaged or withdrawn* from the service represented some 6.0% of all clients who entered the Program ($n=271$), **indicating a relatively low level of difficulty in engaging clients with the Program.**

Of the **65** Exited clients for whom exit destination was reported, more than 60.0% exited to a *psychiatrist*, and more than one quarter exited to a *general practitioner*.

The evaluators conclude that the MHNIP has had a positive impact on the health and well-being of most of its clients, based on statistically significant changes in HoNOS scores following entry to the Program, and based on the interview and survey feedback of MHNs, clients, and psychiatrists and GPs.

1.9 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 these involve –

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

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.

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.

1.10 Summary of Recommendations

Findings to date indicate the need to address a number of issues that are reflected in the Recommendations:

- The reliance on auspicing organisations to fill gaps in the funding provided.
- The capacity of the MHNIP to manage cultural diversity.
- Promotion of the MHNIP to psychiatrists and GPs.
- Accountability requirements associated with Medicare funding.
- Issues relating to future monitoring and evaluation of the MHNIP should it be given ongoing Program status.

Recommendation 1:

It is recommended that the MHNIP in private hospital settings be implemented as an ongoing Program.

Recommendation 2:

It is recommended that funding (beyond what is currently provided) supports infrastructure costs, including office accommodation and operating costs, and the purchase and maintenance of vehicles.

Recommendation 3:

It is recommended that greater flexibility be applied to Medicare guidelines relating to the number of sessions undertaken so that services are not financially disadvantaged when clients do not turn up for appointments.

Recommendation 4:

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 recommended 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.

Recommendation 5:

It is recommended that the MHNIP in the private sector provide opportunities for further professional development, job security and salary and financial benefits to make it competitive with public sector conditions, thereby increasing its capacity to attract appropriately credentialed and experienced Mental Health Nurses.

Recommendation 6:

It is recommended that the cultural accessibility of the MHNIP be enhanced through the development of Indigenous-specific and CALD-specific service offerings – either within existing services or as specialist services. This would require the development of partnerships with appropriate Indigenous and CALD mental health service providers to design and deliver inclusive services to both target groups.

Recommendation 7:

It is recommended that existing reporting for Medicare be redesigned to be as concise as possible, and offered in electronic format.

Recommendation 8:

In light of the number of clients being admitted to the Program who do not meet current eligibility criteria, it is recommended that Program Guidelines be reviewed, possibly with a view to changing the number of criteria that must be met to achieve eligibility.

Recommendation 9:

It is recommended that if the MHNIP pilot in the private hospital setting is given ongoing program status that monitoring and evaluation processes incorporate the data collections systems developed for this evaluation, and that consideration be given to –

- a) Tracking clients over time to analyse the Program's long term impact.
- b) Examining the interface between public and private Program services.
- c) Using the longer term data available to incorporate cost-comparison or cost-effectiveness analysis
- d) Exploring additional funding models, for example, utilising private health insurance.

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.

- Development of an evaluation framework for Piloting the inclusion of private hospitals as eligible organisations under the Mental Health Nurse Incentive Program.
- Development of data collection tools to undertake research.
- 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).
- 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.

Table 2 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.

Table 2: 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:

- Development of an Evaluation Framework to structure the review (see *Section 2.1.1*).
- Design of a user-friendly data collection tool for sites to document service data (see *Section 2.1.2*).
- Design of a Service Profile Matrix (see *Section 2.1.4*).
- 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*).
- Analysis of Medicare data relating to MHNIP Pilot sites (see *Section 2.1.5*).
- 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*).
- Analysis of all findings.
- 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.

Figure 1 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 - see Figure 2.

Figure 1: Outcomes Hierarchy structuring the Evaluation Framework

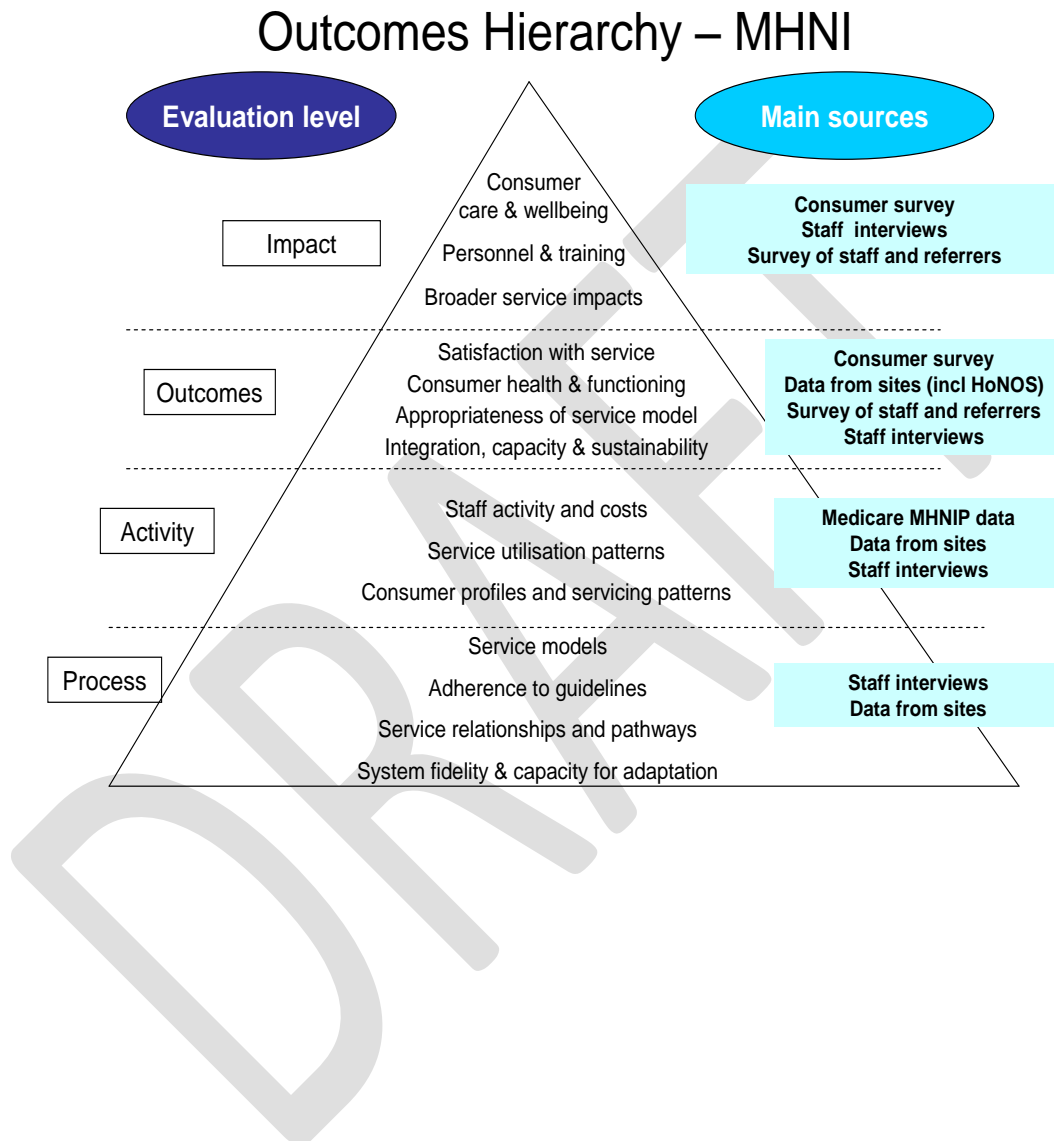
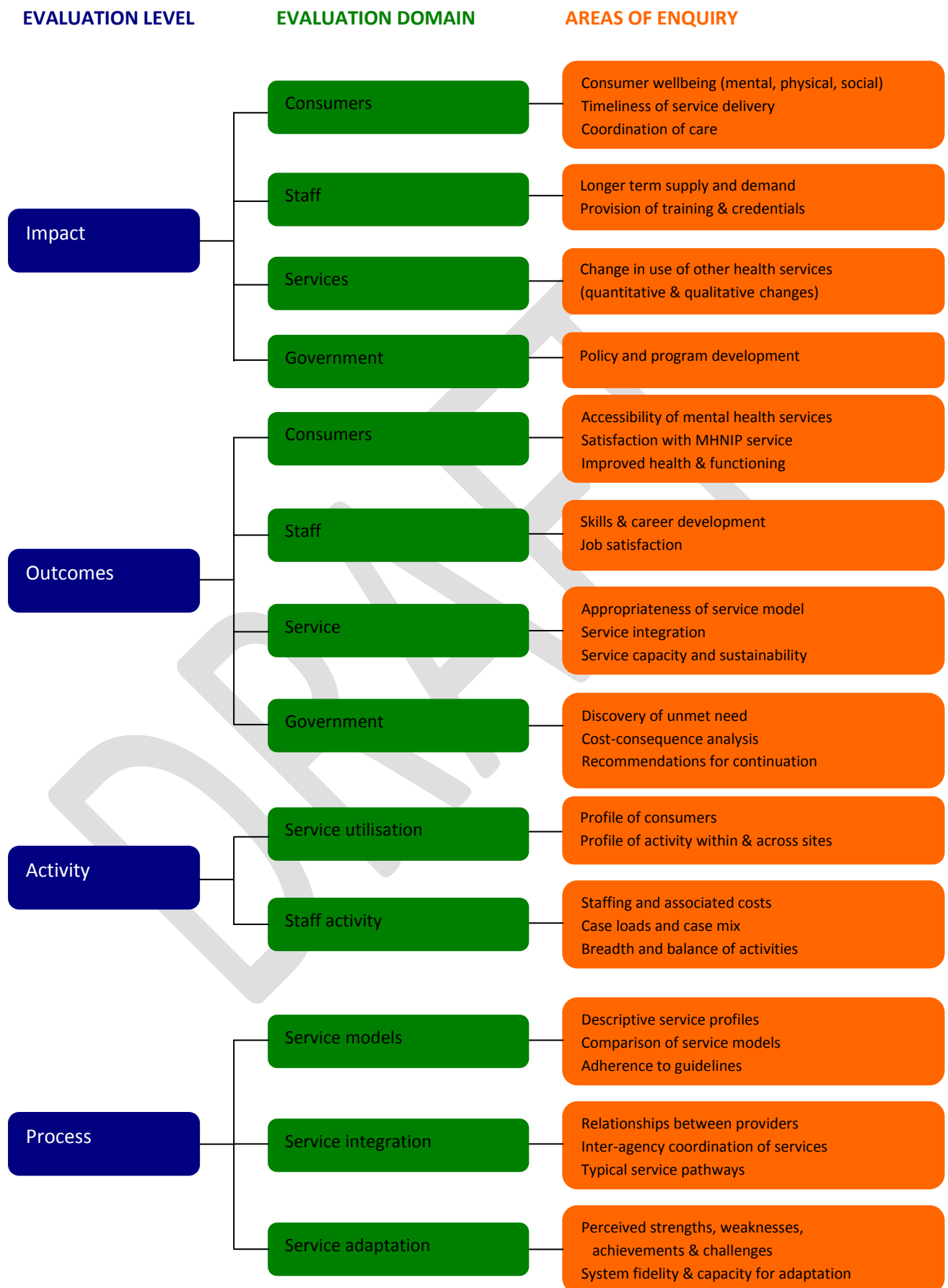


Figure 2 Evaluation Framework: Overview



2.1.2 Data collection tool

The sites compiled data from their administrative systems using a data collection tool designed for this evaluation by the AISR evaluation team. In designing the data collection tool, 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 Excel, Word or on paper by printing copies of the Word document. Details are provided in *Accompanying Report 2*. 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.

A complete dataset containing data from all sites was constructed in Microsoft Access. Validation checks, recoding and the majority of the basic analysis was then undertaken using Microsoft Access and Microsoft Excel. More complex analysis including statistical testing was undertaken using SPSS V15.0 and SPSS V17.0.

Sites varied in terms of the information that they were able to provide. Therefore analysis was restricted to items which were available from most sites. Most sites provided their data electronically. For those who submitted hardcopies, the data were entered into Excel by administrative staff at AISR.

2.1.3 Site interviews

Semi-structured interviews were held at all Pilot sites (including Canberra) with service managers/coordinators, 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 and Coordinators)
- ⇒ 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).

Table 3 summarises the service profile developed at the time of site visits (late 2008 to first quarter of 2009). It can be seen that –

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

Table 3: Applications of the MHNIP model

Features of Model	MHNIP Site					
	Adelaide %	Perth %	Taree %	Toowong %	Essendon %	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				

Note. 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.

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 Medicare data extract were designed in consultation with Medicare Australia, with access arranged for the evaluators by the Department of Health and Ageing.

The Medicare data were 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:

- MHNIP claims processed **from Program inception through to end of January 2009** (extracted end of February 2009)
- MHNIP claims processed **from January 2009 to end of March 2009** (extracted end of April 2009).

The datasets comprised information from the MHNIP claim forms submitted to Medicare by each site, and contained confidentialised client identifiers which enabled the evaluators to undertake comprehensive analysis without compromising confidentiality.

A complete dataset containing data for all sites and all available months was constructed and analysed using SPSS V15.0 and SPSS V17.0.

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 of Accompanying Report 1 to this Final Report..*

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.

Table 4 shows the composition of the MHN/Coordinator, Psychiatrist/GP and Client survey samples.

Table 4: Survey 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

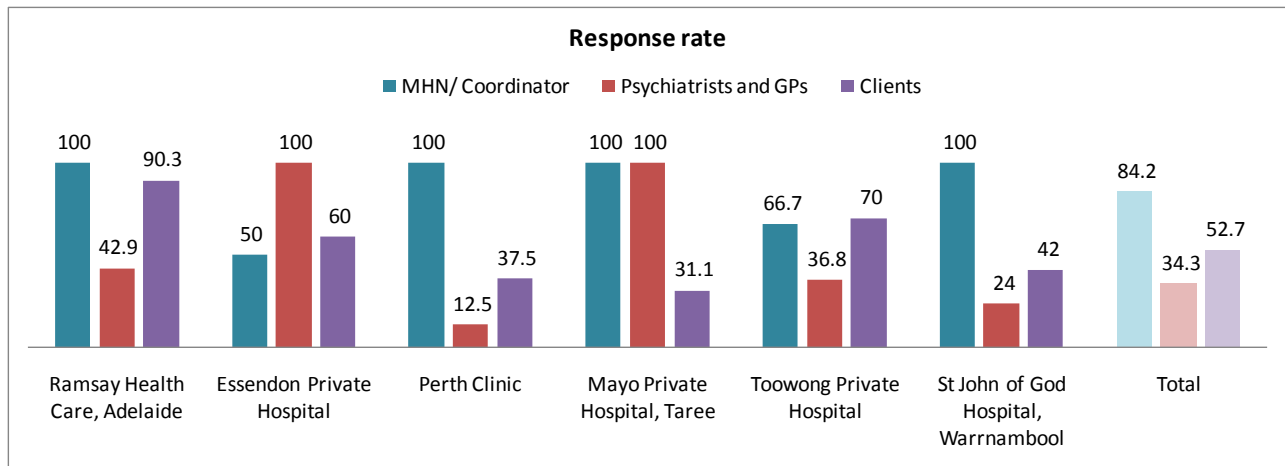
Note. St John of God Hospital was the only site to provide responses from GPs. These are shown separately in the Table. Results of the surveys for Psychiatrists and GPs were analysed as a group as there were too few GP surveys for separate analysis.

Survey response rates for all three stakeholder groups across the six sites from which feedback has been provided, are summarised in *Figure 3*. It can be seen that –

- ⇒ 16 out of 19 Mental Health Nurses and Coordinators have responded (**84.2%**),
- ⇒ 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 survey sample was achieved.

Figure 3: Survey response rates by site and stakeholder group



2.1.7 Representativeness of the client survey sample

The survey of clients was based on voluntary participation, and as *Table 5* indicates, the sample obtained is reasonably representative in terms of gender, age and Indigenous background. None of the sites had recorded having clients who first language was not English but six survey participants identified as having this characteristic.

Table 5: 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

2.1.8 Site data

Data were provided to the evaluators by the following sites:

- Ramsay Health Care, Adelaide
- Perth Clinic
- Mayo Private Hospital, Taree
- Toowong Private Hospital
- St John of God Hospital, Warrnambool.

Essendon Private Hospital commenced operation subsequent to this data collection, therefore their service is not represented in this analysis. *Table 6* shows the period of time for which each site provided data.

Table 6: Period of time for which Site Data were provided

Site	Referral Date		Date Entered Program		Approx. no. of months for which data was provided
	Earliest	Latest	Earliest	Latest	
Ramsay Health Care, Adelaide	16/03/2008	31/03/2009	19/03/2008	31/03/2009	12.5
Perth Clinic	18/03/2008	19/05/2009	19/03/2008	20/05/2009	14
Mayo Private Hospital, Taree	7/10/2007	12/06/2009	7/10/2007	9/04/2009	20
Toowong Private Hospital	14/02/2008	13/03/2009	14/02/2008	13/03/2009	13
St John of God Hospital, Warrnambool	22/01/2008	13/02/2009	29/02/2008	13/02/2009	13
Total	7/10/2007	12/06/2009	7/10/2007	20/05/2009	21

The five sites provided data on a total of **277** client referrals to the MHNIP.

3 CLIENT AND SERVICE DATA

3.1 Explanatory information on differences in the Medicare and Site Data

In analysing data collected by the sites for the evaluation, and data provided by the sites to Medicare, the evaluators recognise that some differences emerge when both are presented comparatively. It is for this reason that separate and detailed reports of each have been provided – see *Accompanying Reports 2 and 3*.

The major difference between the two sources is that *fewer clients* were recorded in the Site Data than the Medicare data (271 versus 407), despite the Site Data being reported for a longer time period.

In addition, clients who spent only a *short time* in the program (less than one month) are strongly represented in the Medicare data (37% of all clients) but not in the Site Data (6% of all clients).

This in turn influences the **average number of months in the Program (5.7 months** according to the Site Data, **2.2 months** according to the Medicare data). However, when clients who spent less than a month in the program are excluded from the Medicare data, the average number of months in program rises to an *average of 6.2 months*, consistent with the results from the Site Data analysis. See *Section 3.2.3* and *Section 3.2.4* for detailed discussion of time spent in the MHNIP by clients.

Another possible explanation for those apparent differences in the results from the Medicare Data and the Site Data involves the data gathering procedures for the Site Data. Sites were asked to compile data for the evaluation on as many clients as possible; some sites may have chosen to focus on providing information about clients for whom change over time could be assessed, as that was a major reason for collecting the data. Clients who were not successfully engaged by a service, but who did receive a brief period of service/contact initially, may have been excluded from the data provided to the evaluators by some sites. *Examination of client identifiers and associated demographic data in the Medicare dataset was checked thoroughly by the evaluators to exclude the alternative possibility that clients may have been represented by more than one identifier in the Medicare data.*

Another consequence of the greater representation in the Site Data of clients who spent less than one month in the program was the inflation of the figure for average number of face to face services per client (Site Data 13.9 services, Medicare data 10.1 services). However, when the number of months spent in the Program is taken into account, the two sources were consistent in demonstrating **an average of 2.0 face to face services per client per month**. See *Section 3.5* for discussion on services provided.

3.2 Overall profile of client numbers and service provision

3.2.1 Medicare data

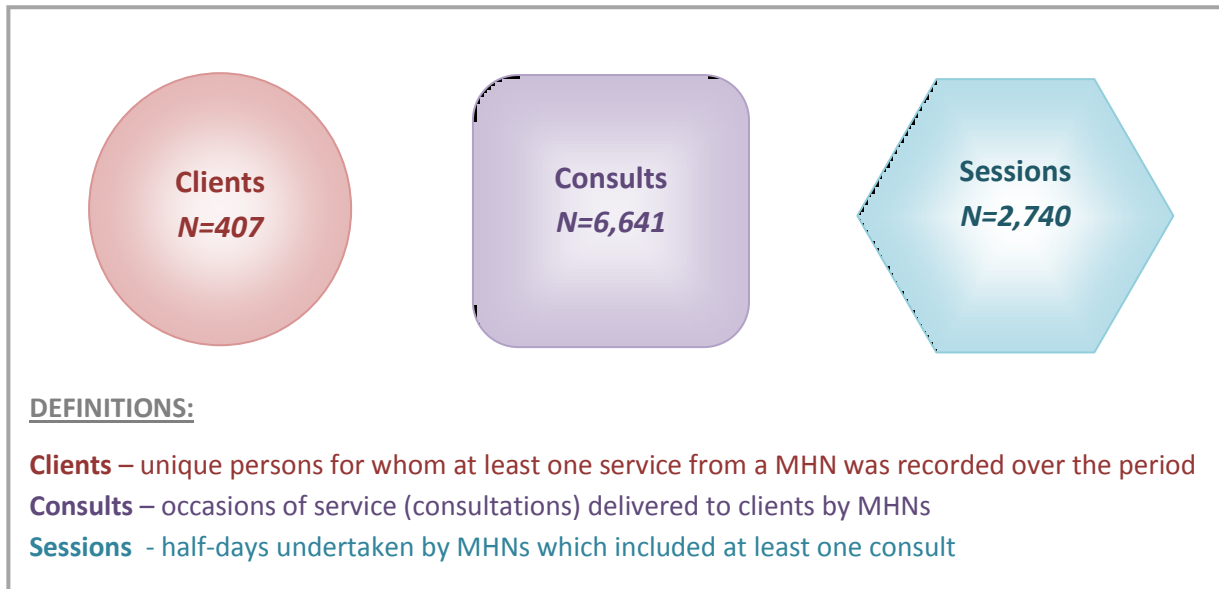
According to the data provided by Medicare in relation to Program inception to Jan/Feb 2009 –

- ⇒ A total of **2,740** Mental Health Nurse sessions (ie. half-days) had been funded.
- ⇒ **More than 6,600** consults had been provided.

⇒ A total of **407** clients had received a service.

The number of sessions, clients and consults identified by this method are shown in **Error! Reference source not found.** together with definition of key terms. *These definitions have been applied in this and other reports prepared for the evaluation.*

Figure 4: Clients, Consults and Sessions in the Medicare dataset – and definition of terms



3.2.2 Site data client numbers

Five sites reported data on a total of **277** client referrals to the MHNIP, of whom **271** (97.8%) met Program eligibility criteria (see Section 4.3). Almost all clients who were referred to the MHNIP entered the Program (271 clients, **97.8%**), and **30.3%** of those who entered had exited the Program by the date on which the data were compiled.

The number of clients who **entered** the Program at each Site, according to the data provided to the evaluators, is shown in Figure 5. Nearly one third of clients who entered the Program (82 clients, **30%**) had **exited** by the date on which the data were compiled. The exit rate at each Site is shown in Figure 6.

Figure 5: Number of clients who entered the Program, by site

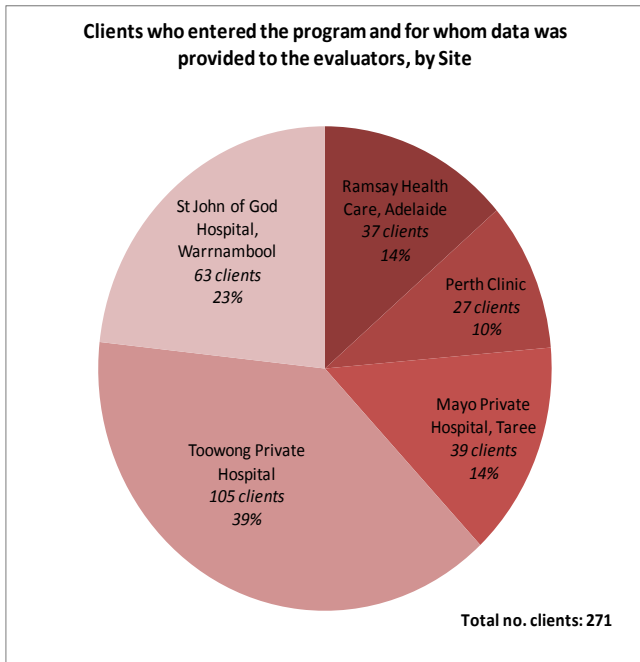
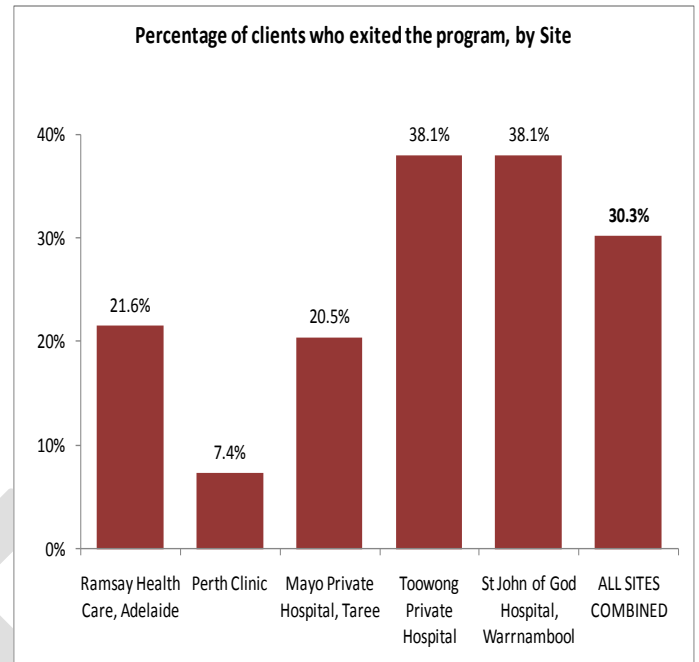


Figure 6: Percentage of clients who exited the program, by Site

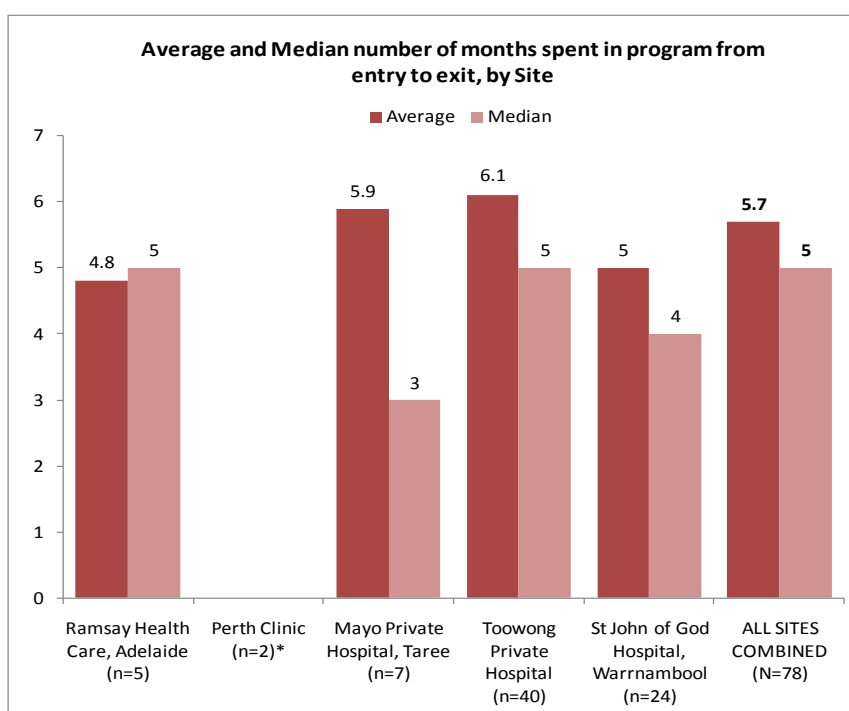


3.2.3 Average time spent in the Program – based on Site data

Of the 78 clients who exited the Program and for whom entry and exit dates were provided, the number of months spent in the MHNIP ranged from less than one month to 18 months. On average clients spent **5.7 months** in the Program before exiting, and this was quite consistent across sites, ranging from an average of 4.8 months at Ramsay Health Care Adelaide to 6.1 months at Toowong Private Hospital (see

Figure 7). Note that these averages may be influenced by the number of months that each site has been operating.

Figure 7: Average and median number of months spent in program, by site



* Data not shown for sites where n<5, in order to protect client confidentiality and to avoid unreliable estimates.

3.2.4 Time spent in Program – Medicare data

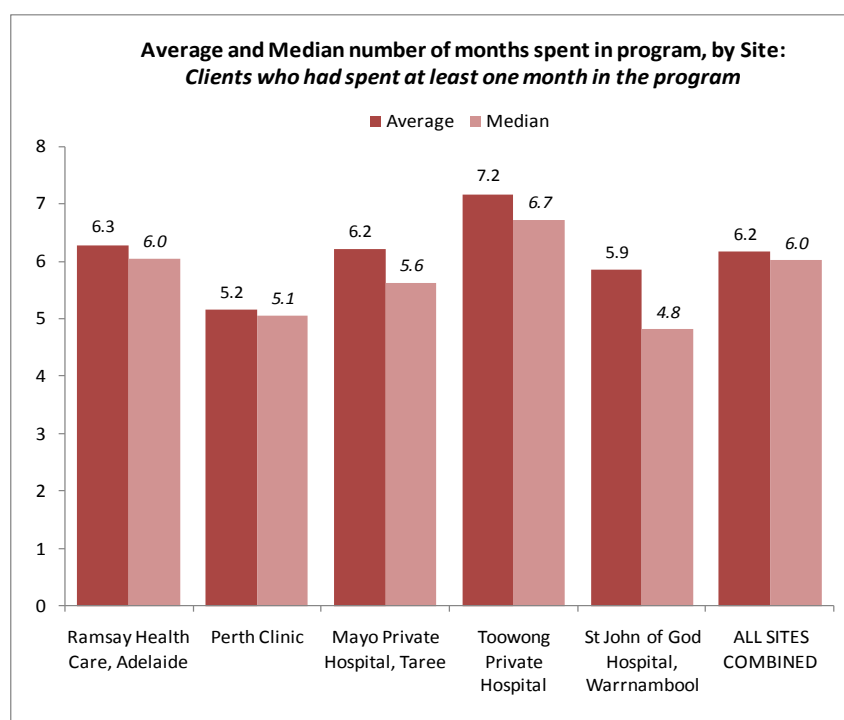
Medicare data indicate that the average number of months that **all** clients had spent in the Program to date was **4.5 months** (SD 3.9 months, **Median** 3.7 months). *Note that this includes clients who are still receiving a service as well as clients who have exited the Program.*

However, this includes nearly **one-third** of all clients who appeared to spend **less than a month** in the Program, perhaps indicating difficulties in engaging some clients. The percentage of clients who had spent less than one month in the Program varies quite substantially between some sites, and this will influence the statistics (average and median). Excluding clients who may not have engaged with the service (ie clients who spent less than a month in the Program) from the analysis produces more reliable results for average number of months spent in the program, as shown in *Figure 8* below.

- ⇒ At the time of analysis, a total of **289** clients had been in the Program for *more than one month*.
- ⇒ **Across all sites, this group of clients had been receiving MHNIP services for an average of 6.2 months and a median of 6 months. This figure is equivalent to that derived from site data.**
- ⇒ This ranged from a low of 5.2 average (and 5.1 median) months at the Perth site, to a high of 7.2 average (and 6.6 median) months at the Toowong site.

*Note however that many of these clients would be continuing in the Program beyond the scope of the Medicare data provided, and therefore the statistics on time spent in the Program are likely to be **underestimates** at this stage.*

**Figure 8: Average and Median length of time (months) clients spent in the Program, by site:
Clients who had spent at least one month in the program (N=289)**



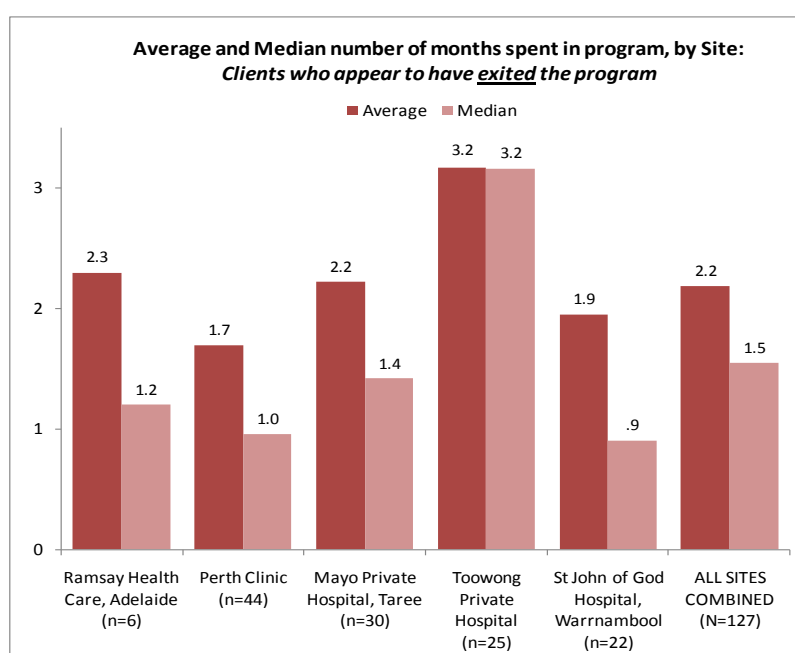
3.2.5 Time spent in program – Clients who appear to have Exited the program

The Medicare data do not capture whether or not clients have exited the Program. As a proxy measure the evaluators identified those clients who *appeared to have exited* the MHNIP by examining their last date of service.

Using information from the analysis of Site Data (*Accompanying Report 3 to the Final Report of the evaluation*) regarding the proportion of clients who exited the service (30%), a cutoff for the last date of service was set as 31st October 2008, which classified **31%** of the client group (127 clients) as having exited the program.

- ⇒ The **average length of time spent in the Program** between first service and last service for the clients who appear to have exited the service is **2.2 months (median 1.5 months)** – see *Figure 9*.
- ⇒ If the MHNIP continues and longer-term clients exit the service, the average length of time spent in program is expected to increase.
- ⇒ *Almost a quarter* of clients who appear to have exited the Program had spent *less than one week* in the Program, and a further *20.5%* spent *between one week and one month* in the Program.

Figure 9: Average and median length of time (months) that clients spent in the Program, by Site:
Clients who appear to have exited the Program



3.3 Demographic profile of consumers

This section describes the main demographic characteristics of the clients who entered the MHNI Program. It brings together information derived from the analyses of Medicare data (based on 407 clients) and site data (based on 271 clients).

Both sets of information yielded a very similar demographic profile. Comparative information is provided in *Table 7*, *Table 8* and *Table 9*. These show that the majority of clients were **female**, aged in their **mid forties**, and living in a major **city** (but with strong representation from **rural** areas.)

Site data identify under-representations of people from culturally and linguistic diverse backgrounds, and from Indigenous backgrounds. They also show that **57.0%** of clients had private health insurance.

3.3.1 Gender

Table 7: Client Gender - Medicare and Site data comparison

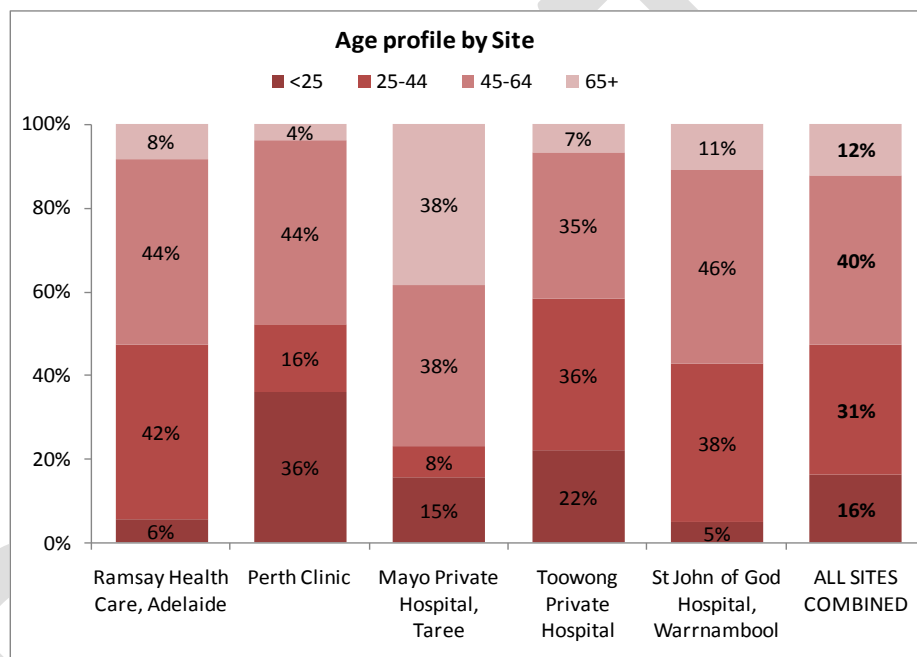
Site data (based on 271 clients)	Medicare data (based on 407 clients)
61.0% were female.	63.0% were female.
The gender profile was similar across most sites, ranging from 61.0% females at Toowong Private Hospital to 67.0% females at Perth Clinic. The exception was Mayo Private Hospital at Taree, where only 49.0% of clients were female.	The gender profile was similar across sites, ranging from 59% females at Ramsay Health Care Adelaide to 68% females at Perth Clinic.

3.3.2 Age

Table 8: Client Age - Medicare and Site data comparison

Site data (based on 271 clients)	Medicare data (based on 407 clients)
The majority of MHNIP clients were aged between 15 and 64 years, with an average age of 46 years .	The average age for the entire client group was 44 years .
The sites with the youngest age profile were Perth Clinic and Toowong Private Hospital (average age 38 years and 41 years respectively), followed by Ramsay Health Care Adelaide (48 years) and Warrnambool (49 years), with Mayo Private Hospital showing the oldest age profile (average age 57 years). See <i>Figure 10</i> below.	The average age of clients at each site ranged from 40 years at Perth Clinic and Toowong to 53 years at Mayo Private Hospital.

Figure 10: Age profile by Site (site data)



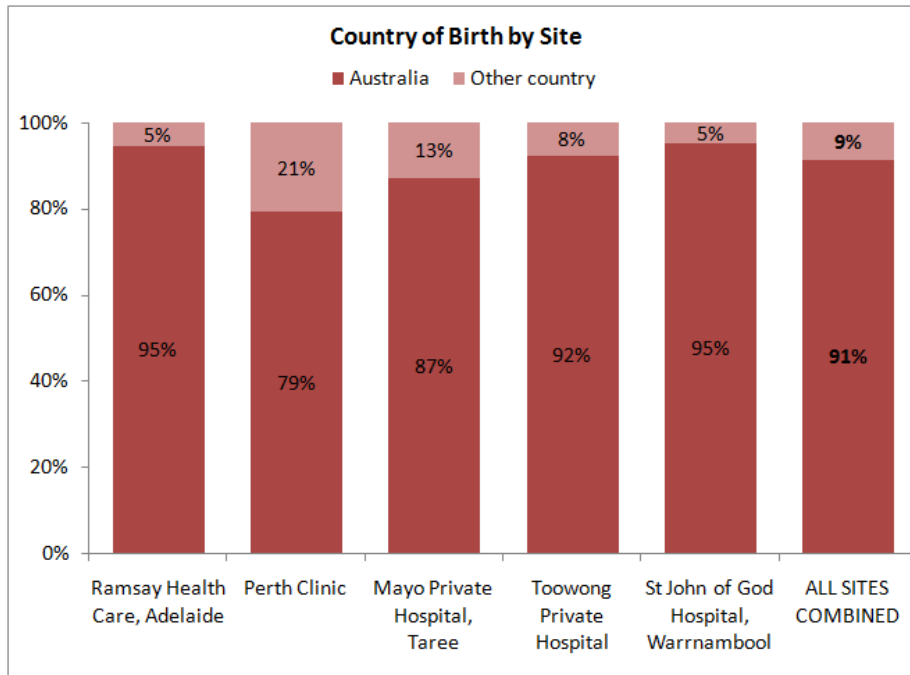
3.3.3 Marital Status

Approximately one third of the client group were Married/Defacto and a further third were Single/Never married. The remaining clients were separated, divorced or widowed. Differences across sites appear to be related to the age profile of clients at each site.

3.3.4 Country of Birth

Site data report that over ninety percent of clients were born in Australia, however there were some site-specific differences in the proportion of overseas-born clients (see *Figure 11*).

Figure 11: Country of Birth by Site (site data)



3.3.5 Language spoken at home

Site data indicate that all clients use English as the main language spoken at home.

3.3.6 Indigenous Status

Site data identify only **one** client as being of Indigenous Status.

3.3.7 Remoteness

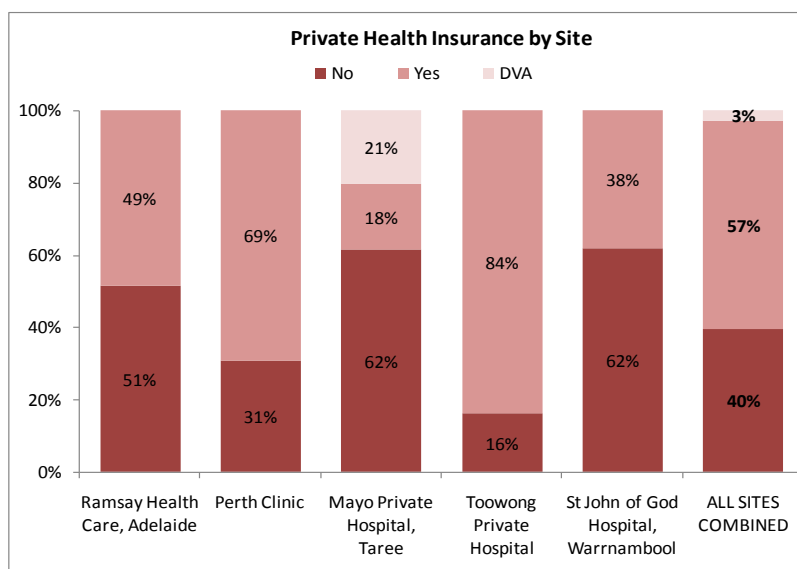
Table 9: Client Location - Medicare and Site data comparison

Site data (based on 271 clients)	Medicare data (based on 407 clients)
Inner Regional areas were well-represented in the client group (34.0% of clients).	Inner Regional areas are well-represented in the client group (36% of clients).
A further 5.0% of clients were living in postcodes classified as Outer Regional .	A further 5% of clients were living in postcodes classified as Outer Regional .
The remaining 61.0% of clients were living in a major city .	The remaining 58% of clients were living in a major city .

3.3.8 Private Health Insurance

Analysis of site data shows that across all sites, **57.0%** of clients were reported as having private health insurance. However, this proportion varied greatly across sites from 18% at Mayo Private Hospital Taree (which also had the highest representation of Department of Veterans’ Affairs clients – 21%) to 84% at Toowong Private Hospital (see Figure 12).

Figure 12: Private Health Insurance by Site (site data)



3.4 Clients seen

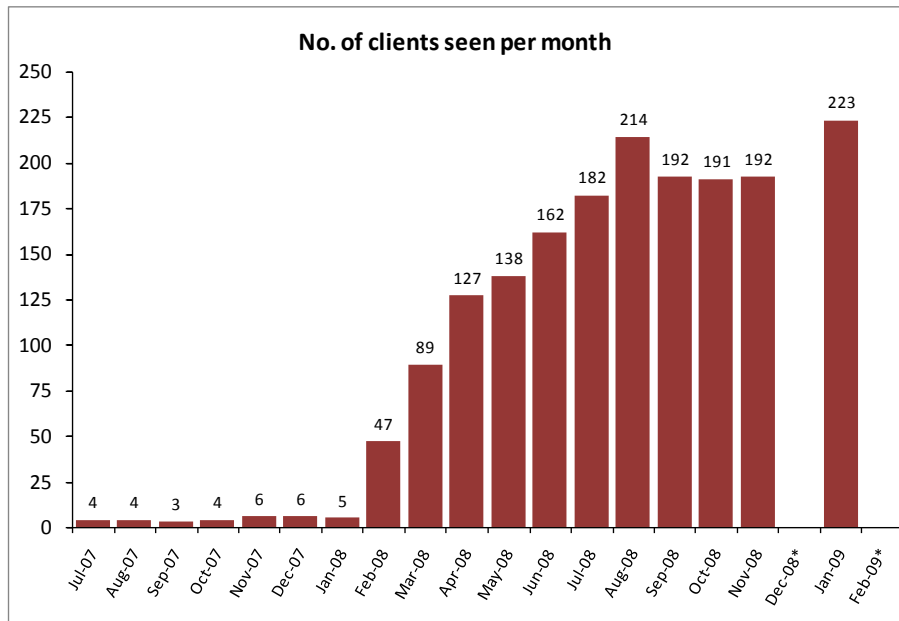
3.4.1 Clients seen

Medicare data record a total of **407** clients had received a service under the MHNIP since its inception. Perth Clinic and Toowong Private Hospital each provided a service to over 100 clients, closely followed by Warrnambool (85 clients) and Mayo Private Hospital (78 clients). Ramsay Health Care (Adelaide), being the smallest MHNIP operation with only one Mental Health Nurse employed, had seen 32 clients.

As would be expected, the number of clients seen *per month* (see *Figure 13*) **increased** over time. This is linked to the number of Mental Health Nurse sessions per month (that is, half-days undertaken by Mental Health Nurses which included at least one consult), and these have increased with the growth of the Program, as illustrated in *Figure 14*.¹

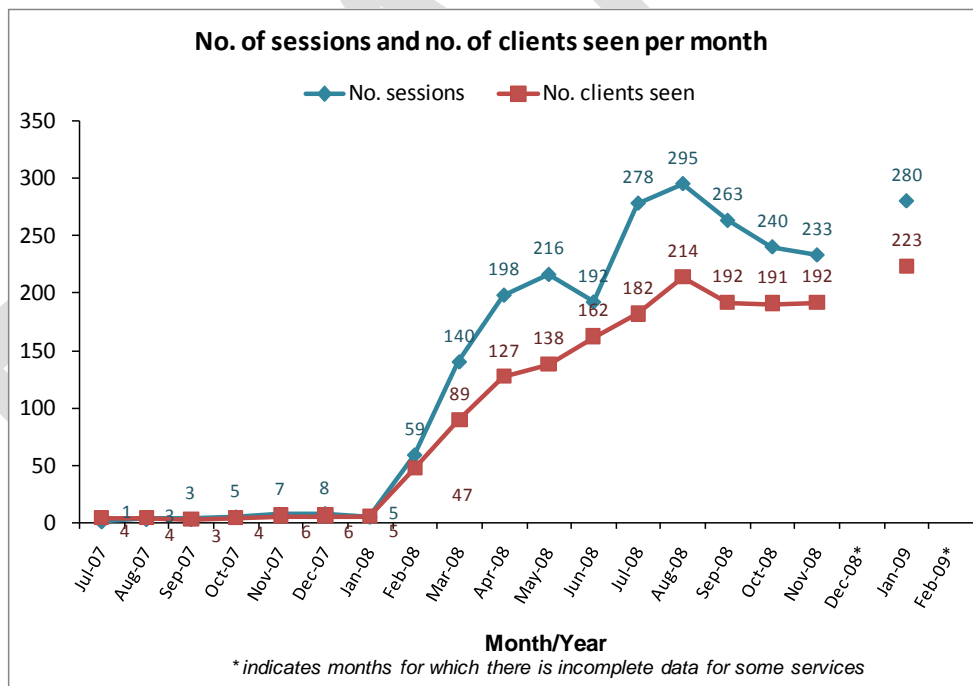
¹ For definitions of the terms: clients, consults and sessions see ***Error! Reference source not found.***

Figure 13: No of clients seen per month



* The total number of clients seen in December 2008 and February 2009 has been excluded because no information was available for Ramsay Health Care and St John of God Hospital for those months.

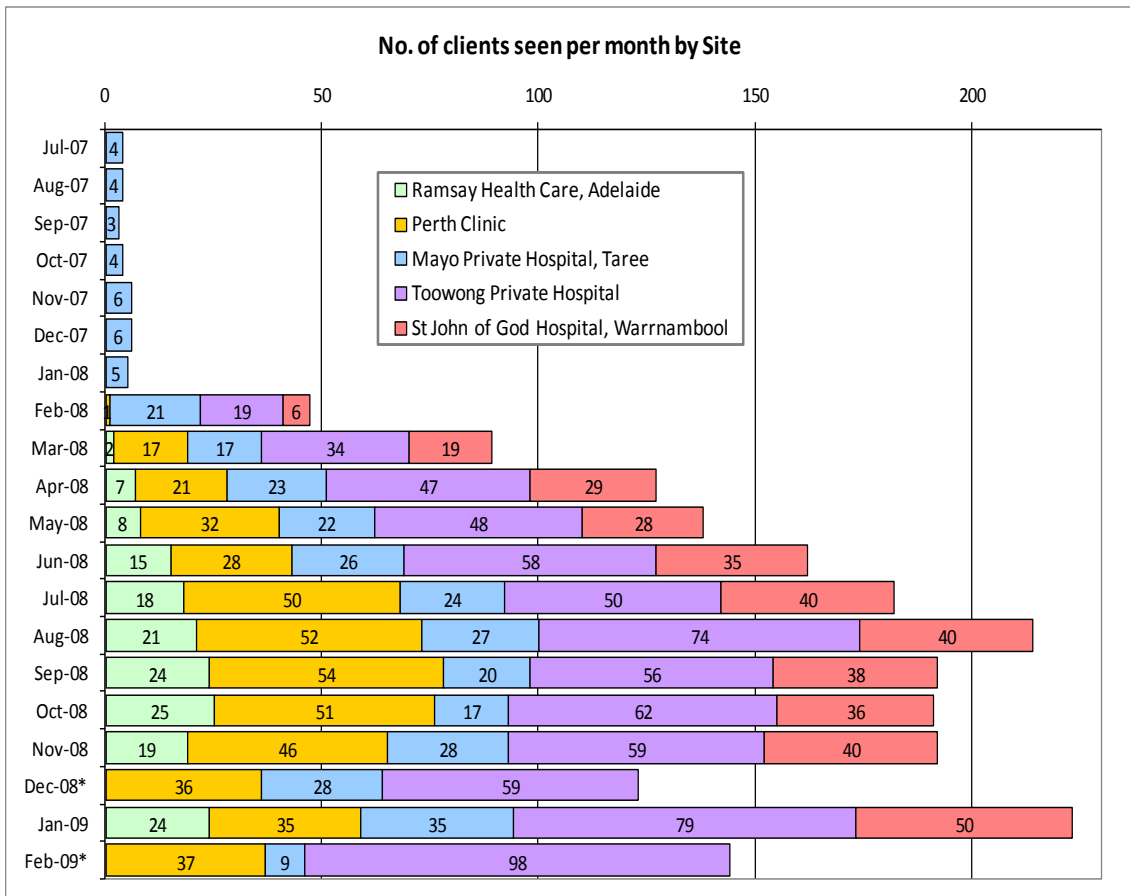
Figure 14: No of sessions and no of clients seen per month – Medicare data



* The total number of sessions and clients seen in December 2008 and February 2009 have been excluded because no information was available for Ramsay Health Care and St John of God Hospital for those months.

The number of clients seen per month at each site is shown in *Figure 15* below. Month-by-month variations in client load may also reflect site-specific factors such as periods of peak referral due to local promotion of the service, and periods of leave or training undertaken by staff.

Figure 15: No of clients seen per month, by site – Medicare data



* Information not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09.

3.5 Services provided

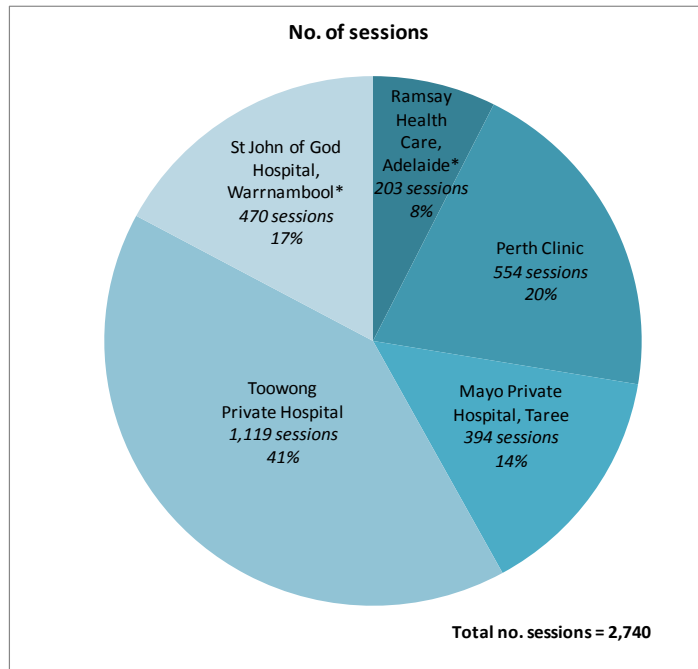
As outlined in *Error! Reference source not found.*, data about services provided are differentiated on the basis of -

- c. **Consults** – occasions of service (consultations) delivered to clients by MHNs
- d. **Sessions** - half-days undertaken by MHNs which included at least one consult.

3.5.1 MHN Sessions provided – Medicare data

According to the data provided by Medicare in relation to Program inception to Jan/Feb 2009, a total of **2,740** Mental Health Nurse sessions (ie. half-days) had been funded. The largest MHNIP operation at that time was at Toowong Private Hospital site, which had 1,119 sessions funded, representing 41% of all MHNIP sessions funded to Jan/Feb 2009. Figure 16 provides details.

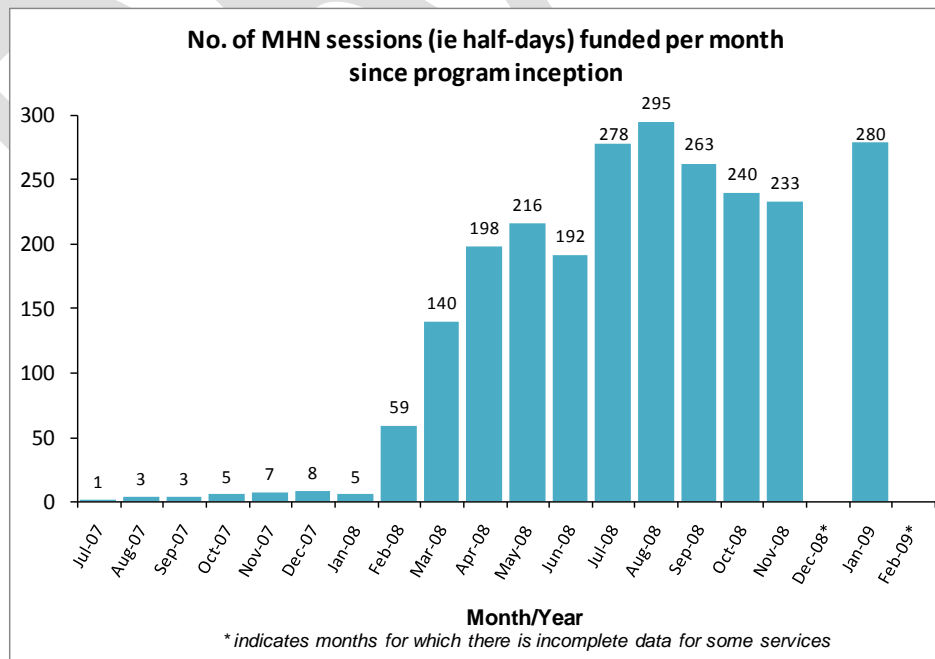
Figure 16: Number of sessions funded, by site, since Program inception



* Information was not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09, therefore numbers for those sites are underestimates.

Month-to-month variations in number of sessions across the first year of implementation reflect the commencement and growth of the MHNIP across the five sites. The small variations across the last 6 months shown (ie after most sites have reached their capacity) are mostly reflected in the particular number of working days in each calendar month. The implementation of the MHNIP over time in terms of funded sessions is shown in *Figure 17*.

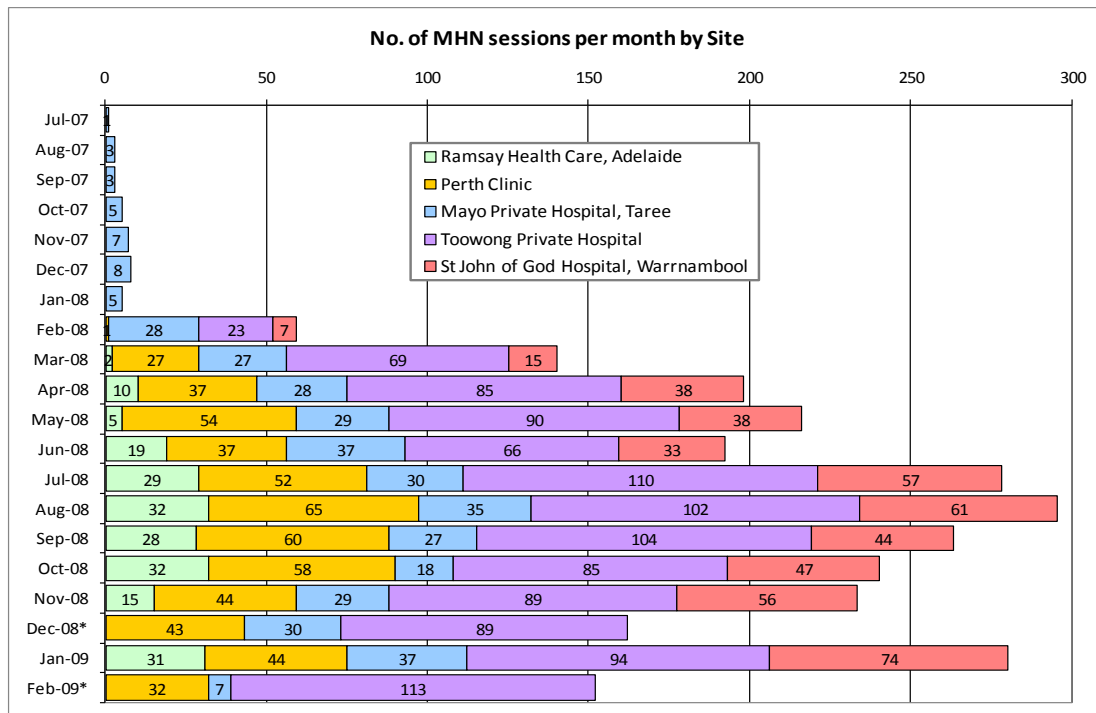
Figure 17: Number of sessions funded per month since Program inception



* The total number of sessions for December 2008 and for February 2009 has been excluded because no information was available for Ramsay Health Care and St John of God Hospital for those months.

Each site's contribution to the number of sessions per month is shown in *Figure 18*.

Figure 18: No of sessions funded per month, by site

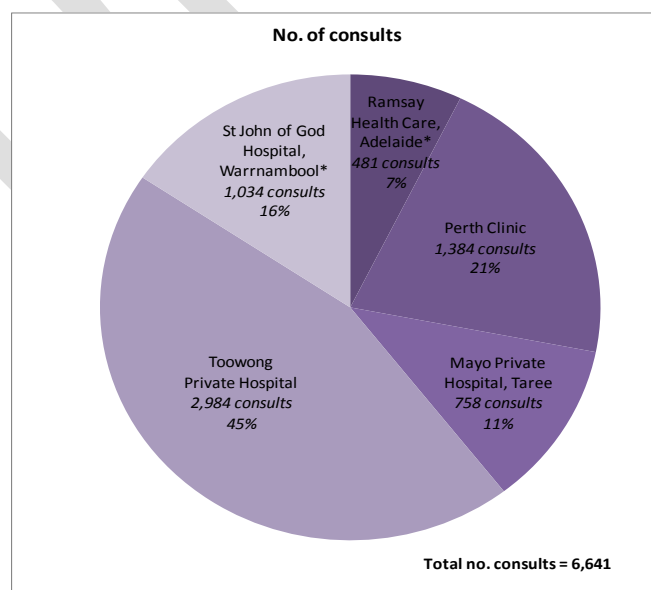


* Information not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09.

3.5.2 MHN Consults provided – Medicare data

More than 6,600 consults had been provided under the MHNIP to Jan/Feb 2009, ranging from 481 consults at Ramsay Health Care Adelaide (a small operation with one Mental Health Nurse, and which commenced in March 2008), to 2,984 consults at Toowong Private Hospital (a large operation employing several Mental Health Nurses). *Figure 19* provides details.

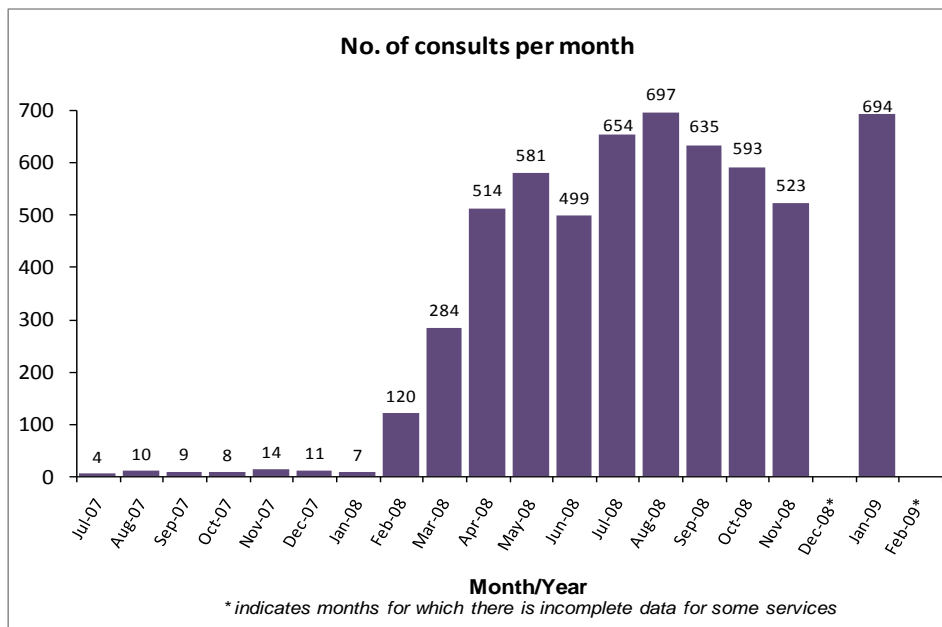
Figure 19: Number of consults, by site, since Program inception – Medicare data



* Information was not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09, therefore numbers for those sites are underestimates.

The total number of consultations per month is shown in *Figure 20*. The number of consultations per month is primarily dependent on the number of Mental Health Nurse sessions per month.

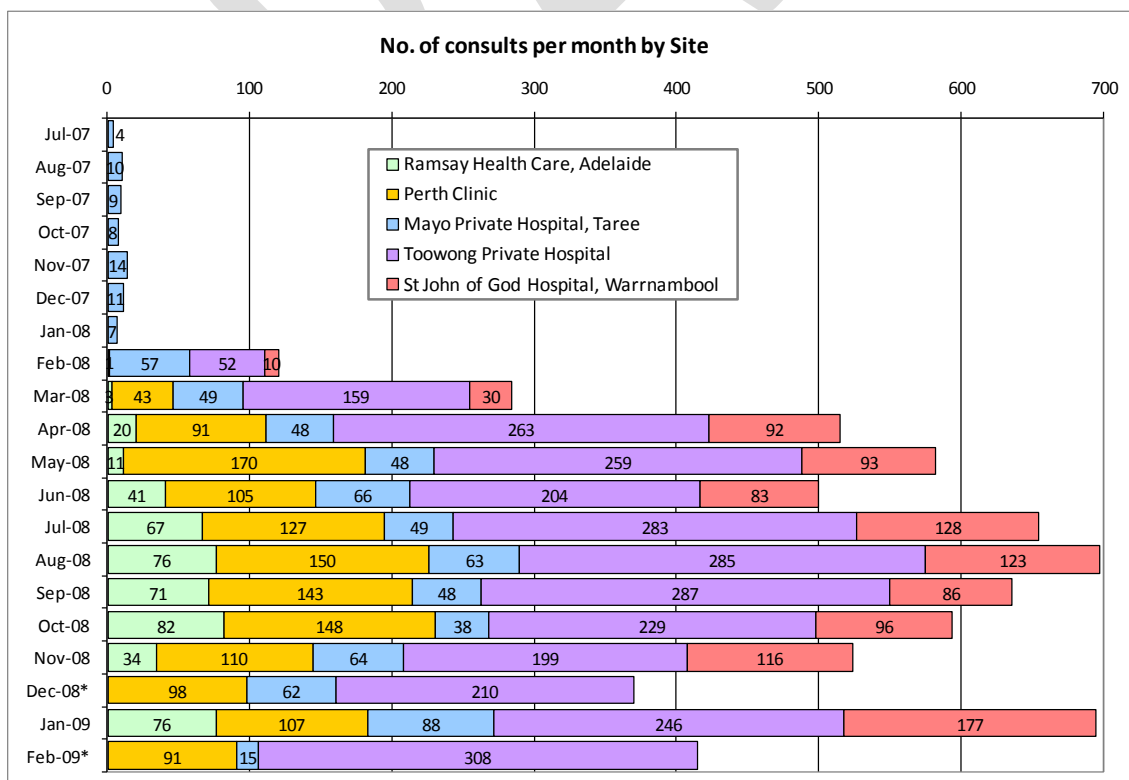
Figure 20: Number of consultations per month since Program inception – Medicare data



* The total number of consultations for December 2008 and for February 2009 has been excluded because no information was available for Ramsay Health Care and St John of God Hospital for those months.

Each site's contribution to the number of consultations per month is shown in *Figure 21*.

Figure 21: No of consultations per month by site – Medicare data



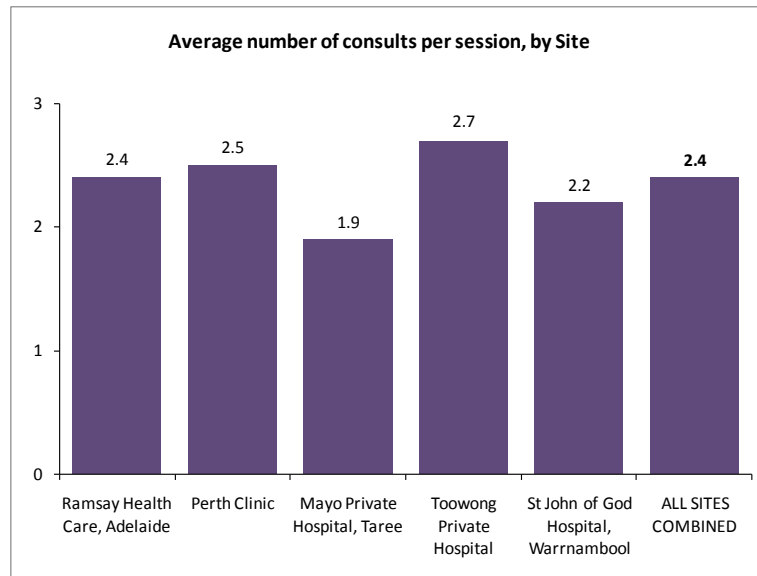
* Information not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09.

3.5.3 Consults within sessions – Medicare data

As Figure 22 indicates, the **average** number of consults per session across all sites was **2.4**, ranging from 1.9 at Mayo Private Hospital to 2.7 at Toowong. The **median** number of consults across every site was **2.0**.

The amount of service provided conforms with the MHNIP Guideline of at least two individual patients (with a severe mental health disorder) per session.

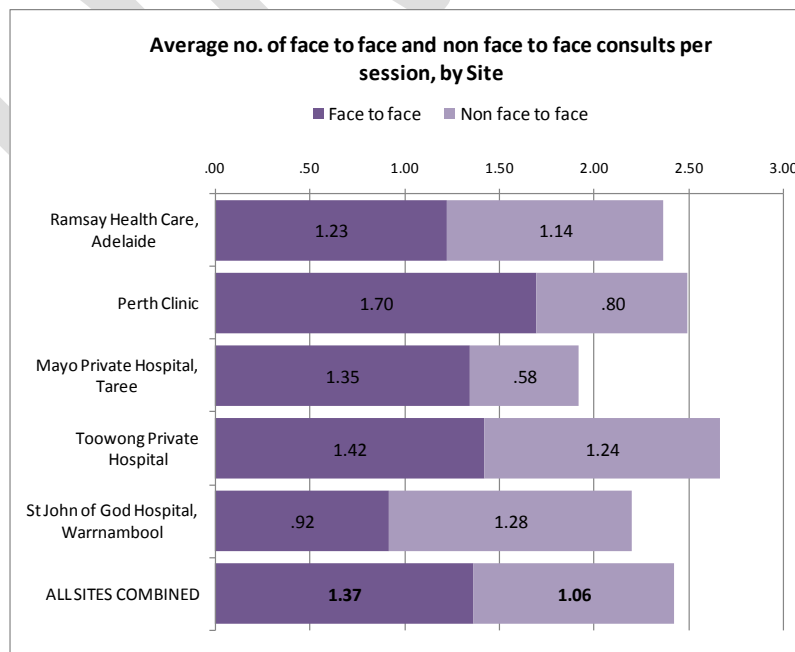
Figure 22: Average number of consults per session, per site – Medicare data



3.5.4 Number of face to face and non face to face consults within sessions – Medicare data

The **average** number of face to face consults and non face to face consults per session further reveals differences in the conduct of the Program across sites – see Figure 23.

Figure 23: Average no of face to face and non face to face consults, per session, per site



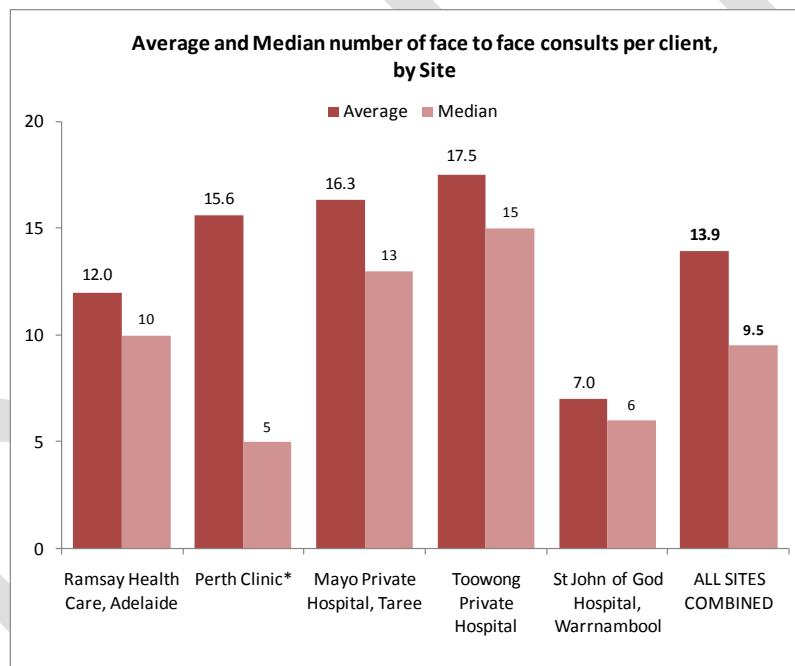
The **median** number of face to face consults per session was **1.0**, as was the median number of non face to face consults per session.

3.5.5 Number of face to face consults per client - site data

The following analysis is based on the **266** clients for whom the *number of face to face consults received to date under the MHNIP* had been reported in site data collections, regardless of how long each client had been in the Program and whether or not they had exited the Program.

Across all sites, clients had received an average of around **14 face-to-face consults** each – see *Figure 24*. The average number of face-to-face consults per client varied **across sites** from a low of 7.0 at the Warrnambool site to a high of 17.5 at the Toowong site. Wide variations within sites were also evident. For example, Toowong site data reported one client with zero face to face consults and another client with 81 face to face consults. Wide variations such as these are at least partly due to variations in the length of time that each client had spent in the Program.

Figure 24: Average and median number of face to face consults per client, by Site - site data



3.5.6 Frequency of service (number of face to face consults per client per month) – site data

The total number of face-to-face services provided to a client will naturally vary depending on the length of time they are engaged with the service, potentially confounding apparent differences between sites. Therefore, the number of face-to-face consults *per month* was calculated for clients who had been in the MHNIP for at least one month.

The length of time that a client had spent in the Program was determined from their entry date and the date of their most recent service. The number of face to face consults per month could be calculated for **256** of the 266 clients for whom face-to-face consults were reported – *clients with either a missing date of*

most recent service or who had been in the Program for less than one month were excluded from the analysis.

Table 10 presents statistics on the number of months between entry and most recent service received, and the number of face to face consults per month. **To date, clients had received an average of 2 face to face consults per month, over an average time span of 7.1 months of activity.**

Table 10: Number of months between entry and most recent service, and number of face to face consults per client per month: Site data Statistics

	Adelaide	Perth	Taree	Toowong	Warrnambool	Total
No. of Clients	34	23	37	100	62	256
Months between Entry & Most Recent Service						
Average	7.4	5.9	9.8	7.2	5.7	7.1
Standard Deviation	4.0	4.4	5.5	4.2	3.6	4.4
Median	9.0	5.0	10.0	6.5	5.0	6.5
Minimum	1	1	1	1	1	1
Maximum	14	14	18	14	14	18
Number of face to face consults per client per month						
Average	1.8	2.8	2.2	2.2	1.5	2.0
Standard Deviation	1.0	1.6	1.9	1.1	1.0	1.3
Median	1.6	2.0	1.8	2.2	1.3	1.8
Minimum	0.0	0.4	0.3	0.0	0.3	0.0
Maximum	4.0	5.4	11.0	6.8	6.5	11.0

The average of 2 face to face consults per month remained fairly consistent regardless of clients' primary diagnosis, but altered when different levels of client need for care were taken into account, as would be expected.

As Table 11 indicates, consults average **1.4** services per month for low, **1.9** for medium, and **2.6** for high care needs.

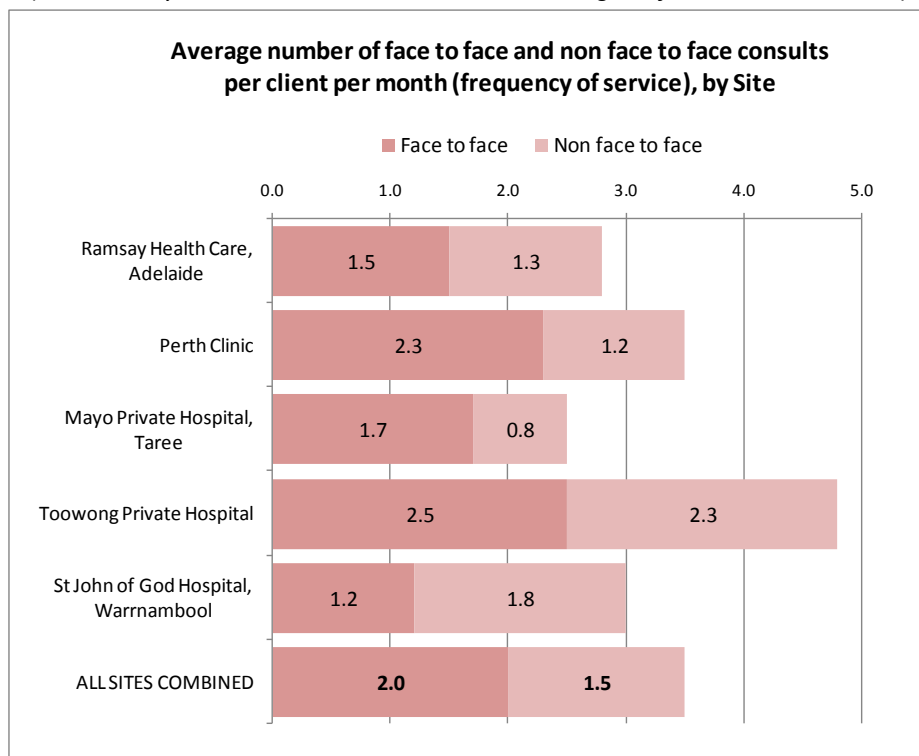
Table 11: Average face to face services per client per month by Level of Care Required – site data

Level of Care Required	No. of					
	Clients	Average	SD	Median	Minimum	Maximum
Low	66	1.4	0.8	1.1	0.3	4.0
Medium	81	1.9	1.1	1.8	0.2	6.5
High	109	2.6	1.5	2.4	0.0	11.0

3.5.7 Frequency of service by type of consult – site data

In terms of *types of consult*, site data show that the number of **face to face** consults per client per month averaged **2.0 for all sites** combined, and non face to face consults per client per month **averaged 1.5** – see *Figure 25*.

Figure 25: Frequency of service - average number of face to face and non face to face consults – site data
(includes only those clients who have been in the Program for at least one month)



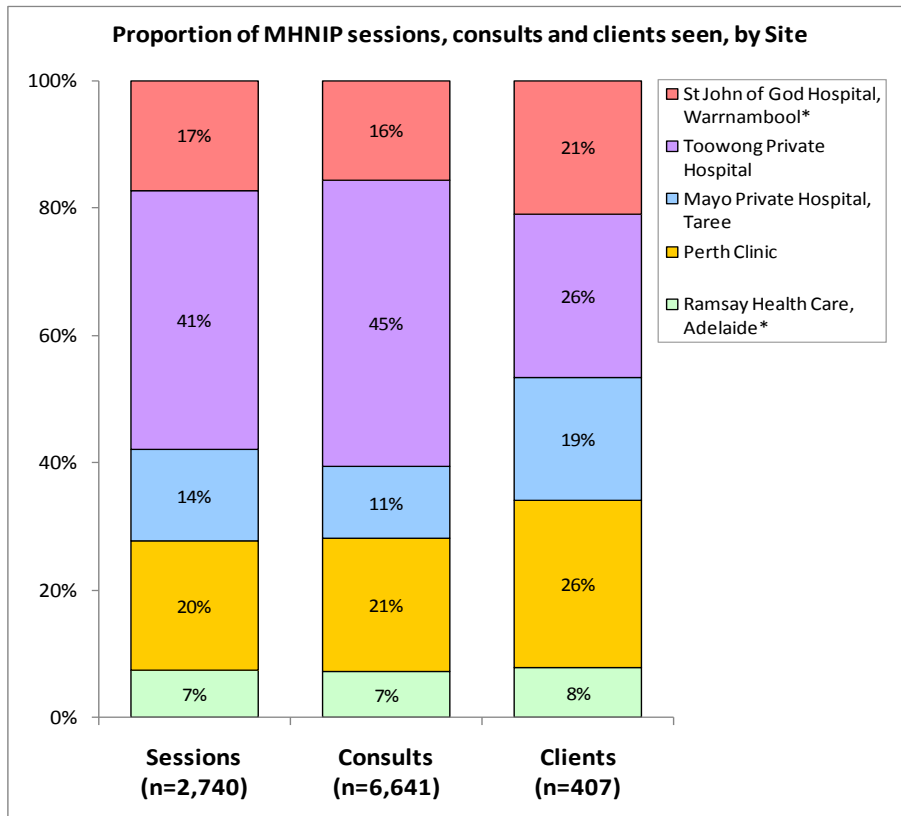
Over 40% of clients had **at least two face to face** consults per month, and around 30% of clients had **at least two non face to face** consults per month.

3.5.8 Summary of sessions, consults and clients seen by Site – Medicare data

Analysis of the number of sessions, consults and clients (see *Figure 26*) highlights operational differences between sites.

The site with the largest proportion of consults (45%) and sessions (41%) is Toowong Private Hospital, and shares with the Perth Clinic, the highest proportion of clients (26%) across the Program as a whole. The smallest proportion of consults, sessions and clients is held by the Adelaide site.

Figure 26: Proportion of MHNIP sessions, consults and clients seen, by site – Medicare data



* Information not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09, therefore numbers for those sites are underestimates.

DRAFT

4 INTEGRITY OF THE MHNIP MODEL AND ITS PLACE IN THE PRIVATE MENTAL HEALTH SERVICE SYSTEM

A guiding question for this evaluation 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).

4.1 Strengths of the MHNIP Pilot model

4.1.1 *The service provider perspective*

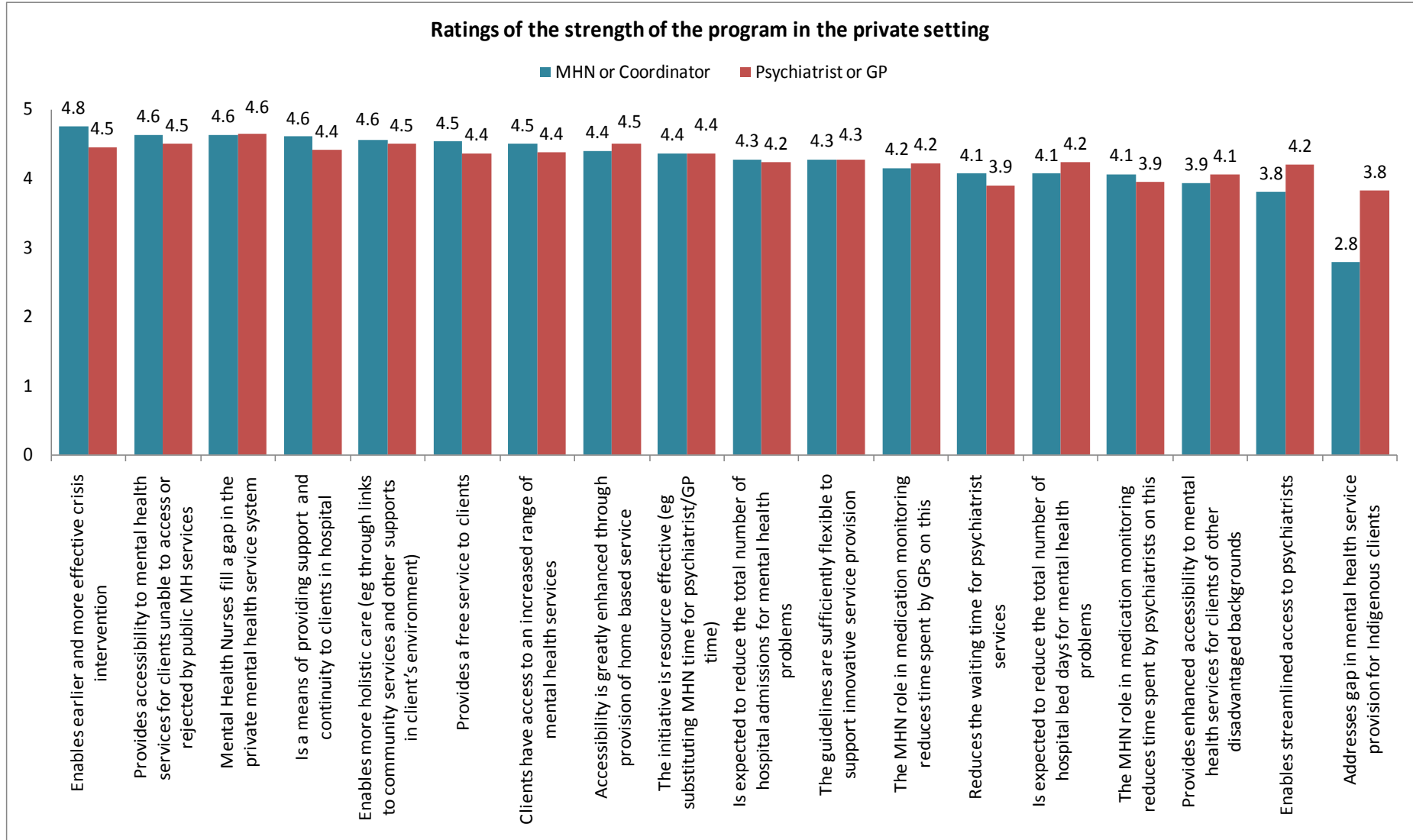
During site visit interviews, **18** possible strengths of the model were identified and these were used to structure a series of five point rating scales to quantify agreement or disagreement in the surveys with Mental Health Nurses and with Psychiatrists and GPs.

The **key features** of the Pilot model have been confirmed strongly as Benefits and Strengths by Mental Health Nurses and Coordinators, and by referring psychiatrists and GPs. 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' out of a possible five) and most similar ratings were (in order of strength of ratings) –

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

Figure 27 provides a comparative depiction of these findings. More detailed information on the model's strengths are provided in *Accompanying Report I – Survey Findings Report*.

Figure 27: Strength of the program in a private setting



4.1.2 The client perspective

In three open-ended survey 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 only a few improvements that they felt could be made to the Program. These findings are presented below, with some of the clients' own words used to illustrate the points made. (More complete descriptions are provided in *Accompanying Report I – Survey Findings Report*.)

The following **10 strengths** were identified by more than one of 108 (**91%**) clients –

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

This was clearly the most frequently cited strength of the Program from the consumer's perspective.

14) 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.*
- *Knowing I'll be contacted regularly by someone I trust.*

15) 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 more about my illness.*

16) 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.*

17) The continuity of care provided (n = 10)

- *Having support after discharge from 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.*

18) Reduced social isolation (n = 10)

- *I don't feel so alone and anxious.*
- *Someone to talk to and extra contact with the outside world.*

19) 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.*

20) Reduced reliance on GPs and psychiatrists (n = 6)

- *I have had someone to talk to when my doctor has been unavailable.*
- *It has been easier to talk to the mental health nurse than the psychiatrist and on a more regular basis.*

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

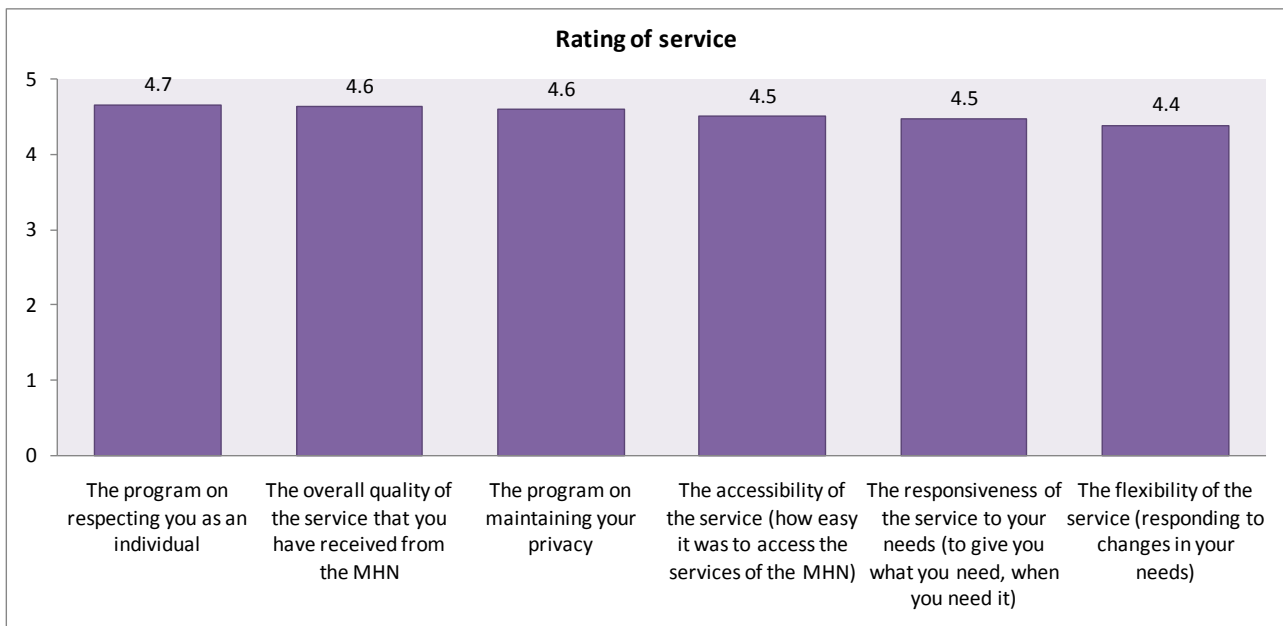
- *A friendly ear without relying on family for support.*
- *Someone for mum to talk to, now she can understand me better.*

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

- *Greater individuality of treatment and the less formal structure.*

Using a five-point Likert scale, clients surveyed were asked to rate the service they had been receiving across six 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 28* illustrates, the lowest mean rating was **4.4** and the highest **4.7**.

Figure 28: Clients' rating of features of the MHNIP model



It is concluded from these findings that clients regard the MHNIP model in the most positive terms.

4.1.3 Conclusions: Strengths of the MHNIP model

These findings confirm qualitative feedback received in the course of the evaluation – through structured interviews and ongoing communication with the MHNIP sites. It is clear that the model has strong support from all three groups of stakeholders, and is filling a gap in mental health services. As such, it is making a valuable contribution to the private mental health system – and it is likely that the impact is being felt in the public health system.

An unexpected finding for the evaluators has been the Pilot's provision of access to services for those unable to enter 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 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 (CALD) backgrounds has received a relatively low rating. Again, without specific provision designed for this target group, for example, through a partnership approach with Indigenous service providers, and with CALD specific service providers, the model cannot be expected to achieve this outcome.

It is evident that clients regard the MHNIP model as having many more strengths than weaknesses, and improvements suggested by them actually support the existing model by seeking increased resourcing to continue it, with minor modifications to service delivery.

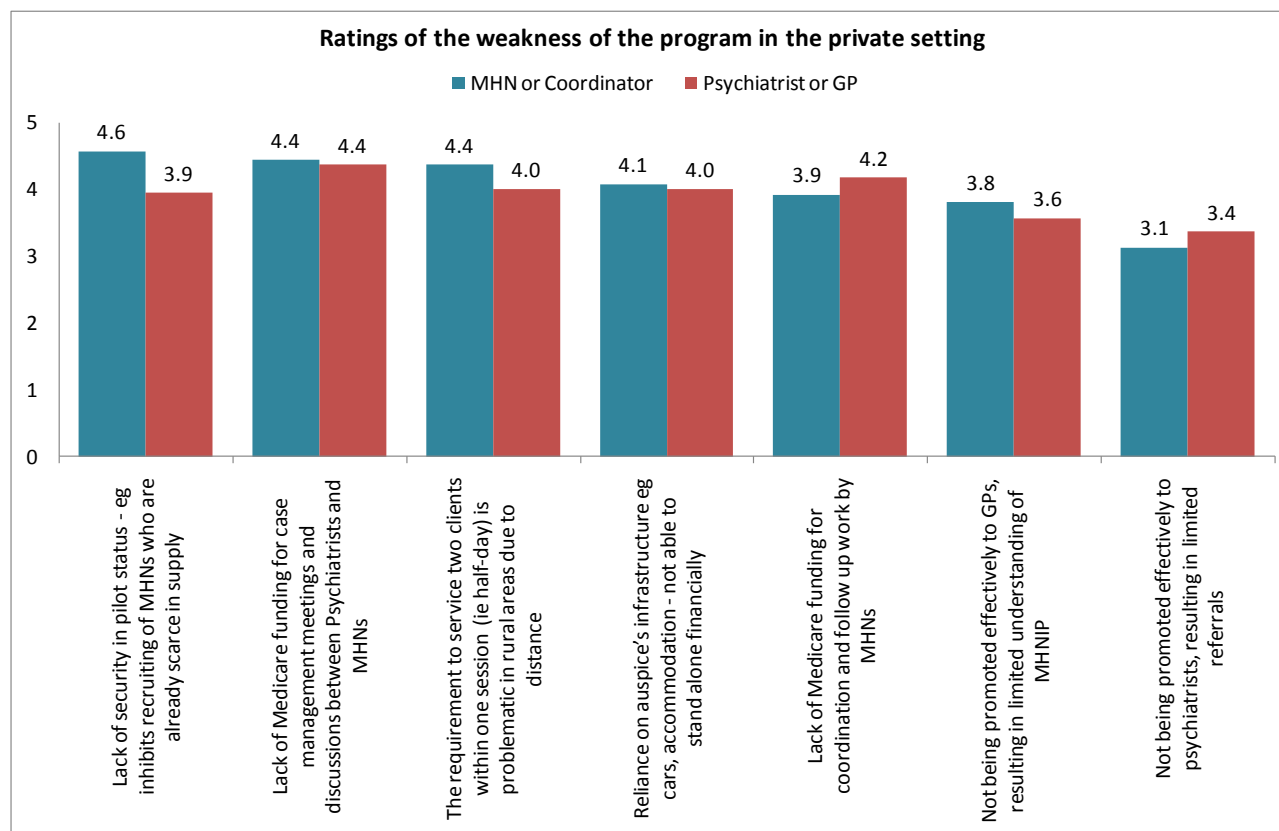
From these findings, the evaluators conclude that there is agreement between Mental Health Nurses and Coordinators, and Psychiatrist and GPs about the strengths of the MHNIP model, and that that these relate

to 17 out of 18 possible positive features. The strengths identified by clients reinforce these findings and reflect a high level of satisfaction with the model.

4.2 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 29*.

Figure 29: 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.**

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 deficiency in the Program.

The following **three weaknesses** were identified by more than one of 35 (**29%**) clients surveyed –

- 1. The need for the program to be better resourced (n = 14)**
 - *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!!*
 - *Sometimes my nurse is busy and can't come.*
- 2. 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)**
 - *Not having someone to talk to outside office hours.*
 - *No visits over Christmas or Easter.*
- 3. Insufficient flexibility and responsiveness of the program (n = 2)**
 - *Sometimes the program did not have the flexibility of time I required.*

More detailed information on the model's weaknesses is provided in *Accompanying Report I – Survey Findings Report*.

4.2.1 Conclusions – weaknesses of the Model

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 who identified the need for more resourcing of the program, which also affects accessibility in terms of operating outside of normal business hours. The MHNIP's position as a non-crisis service must also be acknowledged in this context. That is, in its current design, it is not able to deliver an on-call service.

It can be reasonably expected that promotion of a program that has Pilot status does not represent a wise use of limited resources, and could raise expectations without the certainty of ongoing provision of the

Program's services. **Therefore, at this stage of the Program's implementation, the evaluators do not consider that its promotion is an issue.**

4.2.2 Program responsiveness

The majority (70%) of clients entered the Program on the date they were referred – indicating a high degree of Program responsiveness.

The remaining clients entered between 1 and 72 days after referral.

4.3 Eligibility issues

Of the 271 clients entered into Program, 59 clients (22%) were reported to have failed to meet one or more entrance criteria and were therefore technically ineligible according to Program guidelines. In other words, 59 people were accepted into the Program despite failing one or more eligibility criteria.

The entrance criteria for the Program as specified in the Program Guidelines are summarised in Box 1 below. **All** criteria must be met for clients to be considered eligible for entry to the Program.

Box 1: Entrance criteria from the MHNIP Program Guidelines

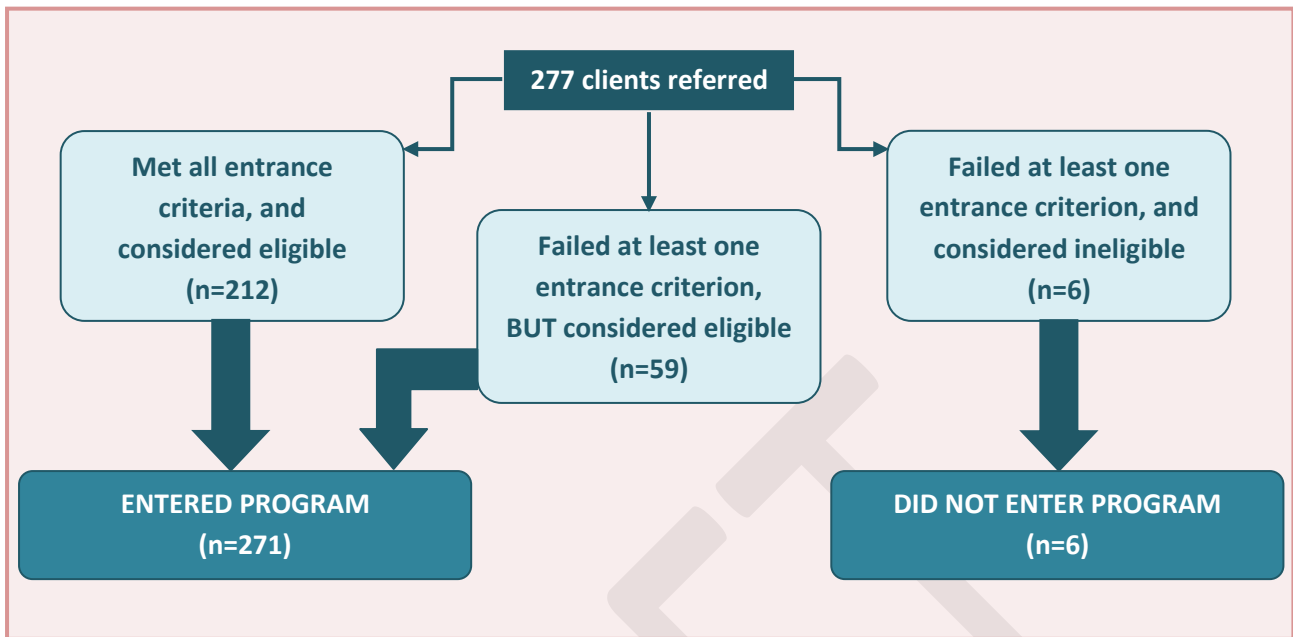
MHNIP Program Guidelines: Entrance Criteria

1. The patient has a diagnosis of mental disorder according to the criteria defined in the *World Health Organisation Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD 10 Chapter V Primary Care Version*, or the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV)*.
2. The disorder causes significant disablement to the patient's social, personal and occupational functioning.
3. The patient has experienced at least one episode of hospitalisation for treatment of their mental disorder, or is at risk of requiring hospitalisation in the future if appropriate treatment and care is not provided.
4. The patient is expected to require continuing treatment and management of their mental disorder over the next two years.
5. The general practitioner or psychiatrist is principally responsible for the patient's clinical mental health care.
6. The patient provides consent to treatment from a mental health nurse.

The six clients who *did not enter the Program* after referral failed to meet one or more of the eligibility criteria on assessment. All six clients failed to meet Criterion 6 (Consent to treatment from a Mental Health Nurse), and four of the six clients also failed to meet Criterion 4 (Expected to require continuing treatment over the next two years).

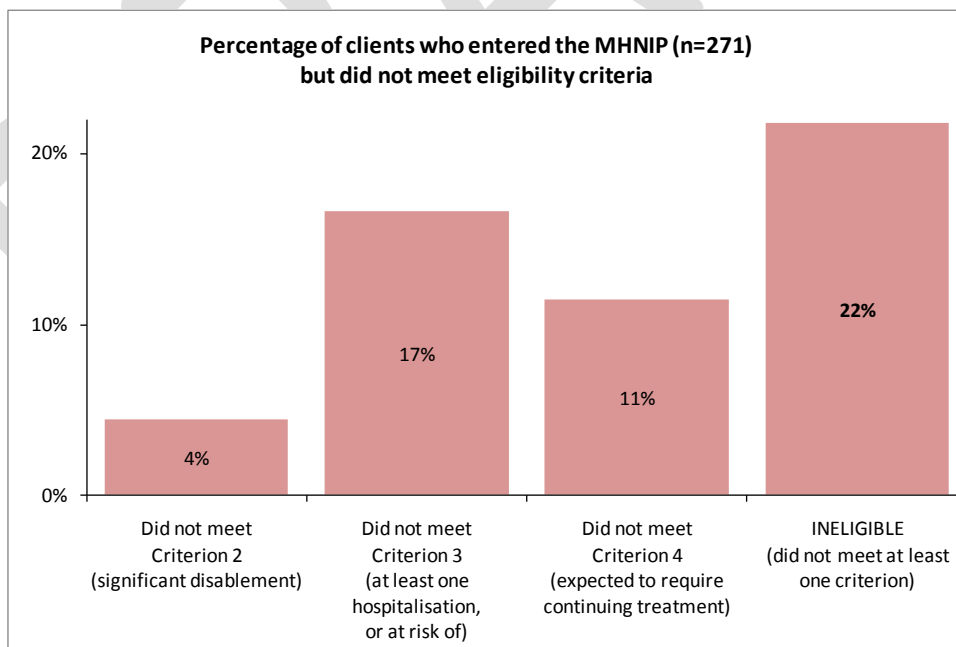
Figure 30 illustrates the pathway of clients from referral, to Program entry, in terms of eligibility, according to the data provided to the evaluators.

Figure 30: Pathways from referral to entry



The 59 clients who entered the Program but who were technically ineligible did not meet at least one of Criteria 2, 3 and 4. The percentage of clients who entered the Program without meeting these entry criteria is shown in Figure 31 below.

Figure 31: Percentage of clients not meeting entrance criteria



These findings may indicate the need to review Program Guidelines, possibly with a view to changing the number of criteria that must be met to achieve eligibility.

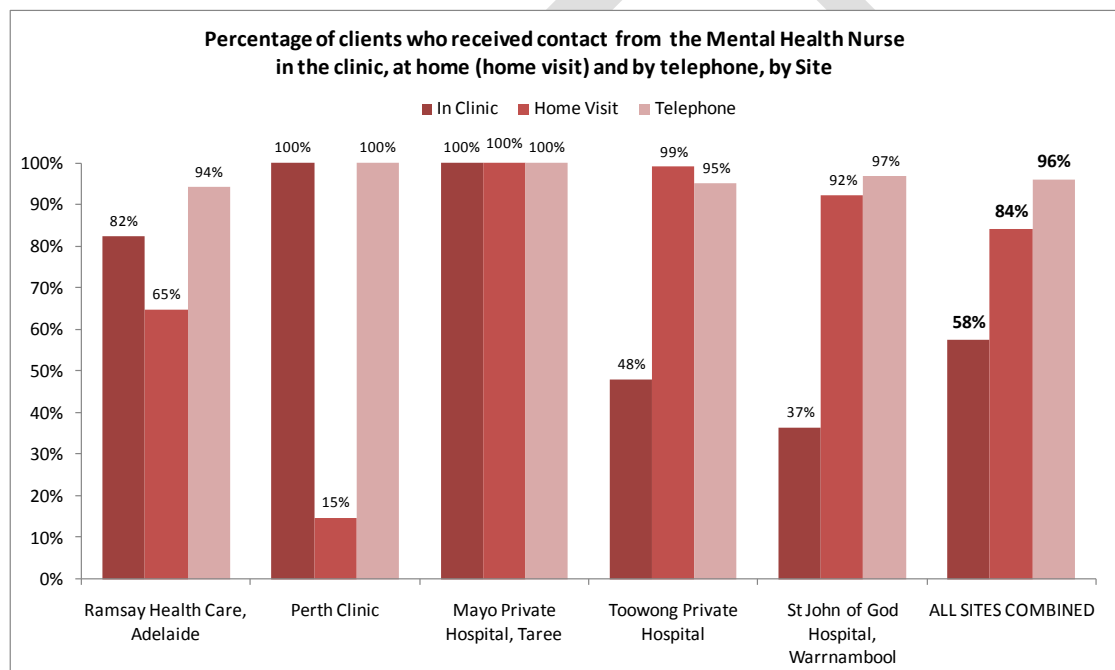
4.4 Home-based visits versus clinic-based service delivery

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. However, the degree to which home-based service delivery has been adopted varies across the sites.

Figure 32 shows the percentage of clients at each site who received one of three types of contact – *in clinic*, *home visit* or *telephone* contact. Across all sites, 96.0% of clients were contacted at least once by telephone, 84.0% received at least one home visit and 58.0% were seen at least once in the clinic.

Sites differed as to their use of each type of contact. For example, every client from the Taree site received in clinic services, home visits and telephone contact, whereas only 15.0% of clients at the Perth site received home visits.

Figure 32: Type of contact by Site – site data



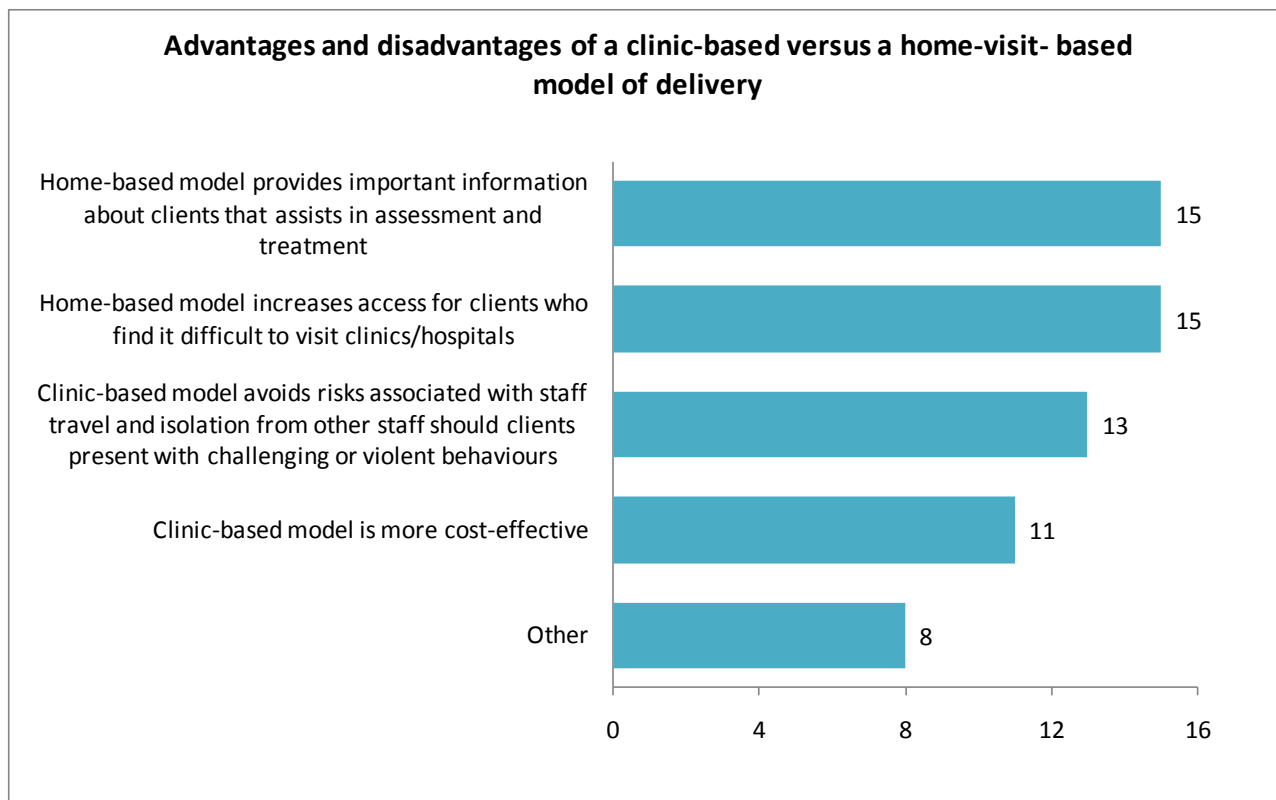
When surveyed, Mental Health Nurses and Coordinators were asked to quantify the advantages and disadvantages of delivering Mental Health Nurse services in clients' homes and in the hospital or clinic setting. As Figure 33 summarises, the two key advantages of providing services in clients' homes are –

- 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 **more expensive 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. Sites also vary in relation to the **proportion** of home visits to clinic visits made by Mental Health Nurses. *Figure 33* summarises the advantages and disadvantages of each delivery mode.

Figure 33: Advantages and disadvantages of a clinic versus home-visit based model of delivery



Note. Multiple responses possible

4.4.1 Conclusions: Home-based vs Clinic-based service delivery

Where home-based visits are being provided, the MHNIP model offers significant *accessibility* and *flexibility* in its mode of delivery for clients. From a clinical perspective, the opportunity to increase service providers' understanding of clients' home environments is also provided.

However, home-based delivery does bring increased risks for Mental Health Nurses, associated with travel and with safety in relation to some clients. The time and costs associated with home-based delivery make it more expensive than a clinic based delivery mode, but these issues need to be balanced against enhanced information about client needs, and increased accessibility and flexibility for clients.

The inherent flexibility of the Program, whereby providers may design their own service mix based on client need, catchment area and resource availability (eg vehicles, safety provisions etc), represents a significant strength.

4.5 Quantifying the role of the Mental Health Nurse

The Mental Health Nurse is central to the MHNIP model, and for this reason, the evaluation has sought to quantify the different aspects of the Mental Health Nurse role. This also has implications for Medicare funding and the scope of services provided as part of the Mental Health Nurse role.

Box 2: Program Guidelines relating to the role of the Mental Health Nurse

Current Guidelines for the Program describe the following roles for the Mental Health Nurse:

1. Provision of clinical nursing services for patients with severe mental disorders:

- a) *establishing a therapeutic relationship with the patient*
- b) *liaising closely with family and carers as appropriate*
- c) *regularly reviewing the patient's mental state*
- d) *administering, monitoring and ensuring compliance by patients with their medication*
- e) *providing information on physical health care to patients.*

2. Coordination of clinical services for patients with severe mental disorders:

- a) *maintaining links and undertaking case conferencing with general practitioners, psychiatrists, allied health workers, such as psychologists*
- b) *coordinating services for the patient in relation to GPs, psychiatrists and allied health workers, including arranging access to interventions from other health professionals as required*
- c) *contributing to the planning and care management of the patient*
- d) *liaison with mental health personal helpers and mentors, through establishing links with the Mental Health Personal Helpers and Mentors Program.*

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 in the stakeholder surveys 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. (*Accompanying Report I – Survey Findings Report provides details about ratings for each of these roles.*)

As indicated in *Figure 34*, 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 –

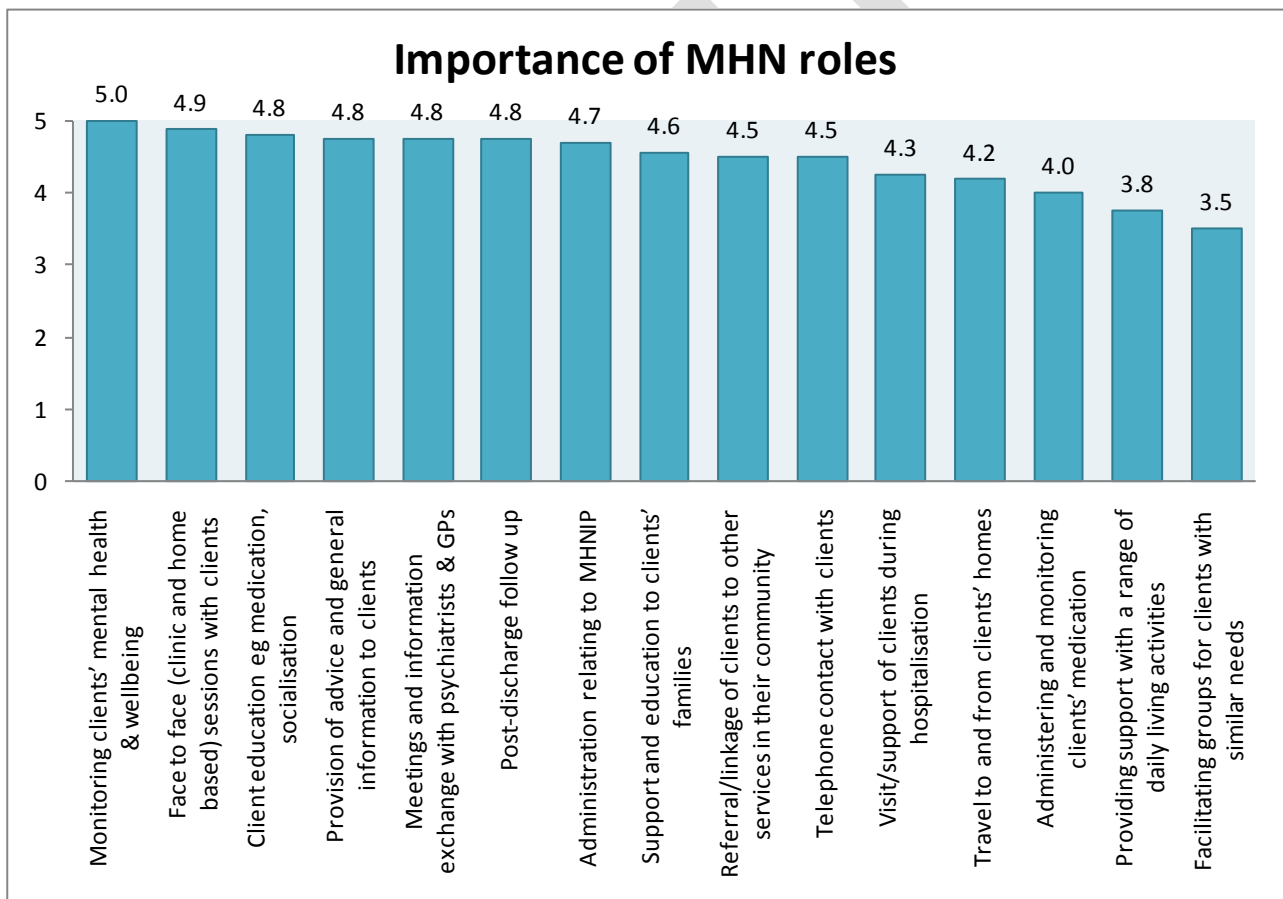
- **Monitoring** clients' mental health and wellbeing (5.0).
- **Face to face** sessions with clients (4.9).
- **Client education**, including in medication and socialisation (4.8).
- **Advice and general information** provision to clients (4.8).
- Meetings and information **exchange with psychiatrists**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

Clients surveyed were asked to indicate (from a standardised response list) which activities and services they were receiving from the Mental Health Nurse. Of the nine roles possible, the three most commonly identified were –

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

Interestingly, clients were divided in their perception of the Mental Health Nurse role of linking them to other medical services and non-medical services, provision of support to clients’ significant others and hospital visiting suggesting different interpretations of the MHNIP model across sites.

Figure 34: Importance of MHN/ Coordinator roles



4.5.1 Conclusions: Role of the Mental Health Nurse

The range of 15 roles being undertaken by Mental Health Nurses employed under the MHNIP Program has been validated by survey and interview feedback and it is important that Medicare funding is available to support all of those roles. Program features that enable this range of support should be retained, such as session-based funding, in-person and telephone consults and broad case management activities.

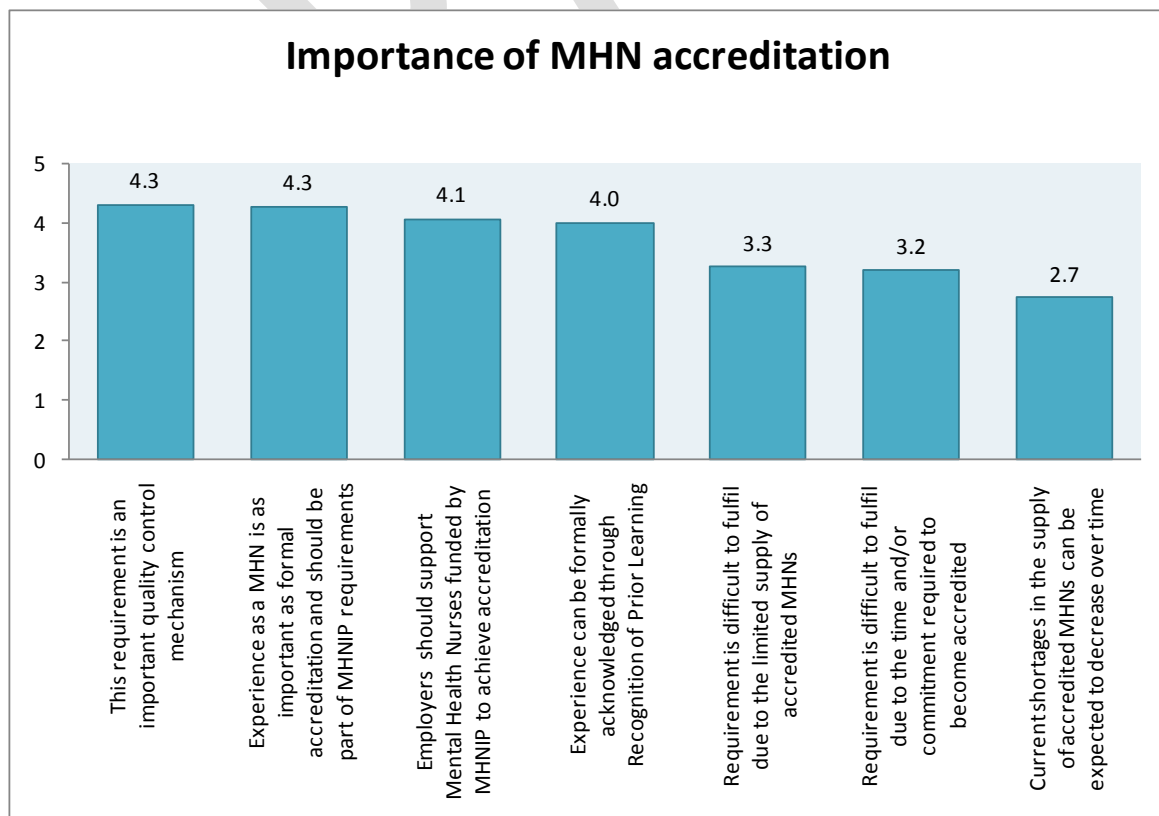
4.6 Rating the credentialing requirement for Mental Health Nurse employment

MHNIP guidelines require the employment of Mental Health Nurses who hold appropriate credentials, recognised by the Australian College of Mental Health Nurses (ACMHN). 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 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.

Figure 35 summarises average ratings. 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. However, 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 35: Importance of MHN/ Coordinator accreditation



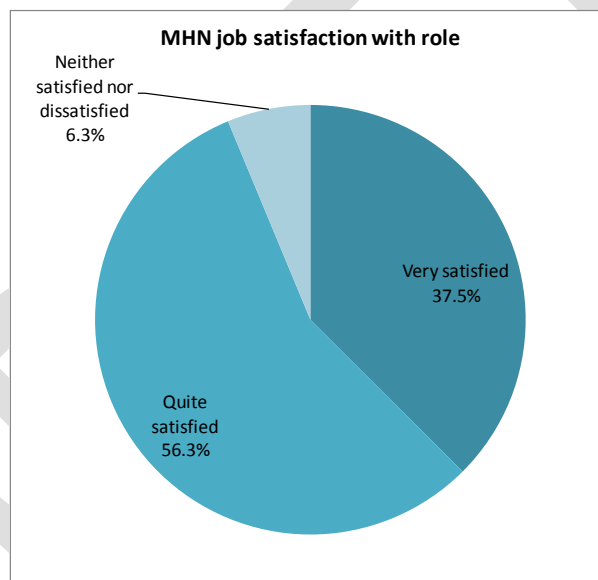
4.6.1 Conclusions: Mental Health Nurse credentialing

The evaluators agree that the current Program requirement regarding recognition by the ACMHN is an important quality control mechanism, and a means of formal recognition of the expertise required of Mental Health Nurses. At the same time, it is important to recognise previous experience and MHNIP nurses should have ready and affordable access to Recognition of Prior Learning assessment processes.

4.7 Job satisfaction and conditions of employment

As *Figure 36* indicates, none of the Mental Health Nurses and Coordinators surveyed (n=16) 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 36: MHN job satisfaction

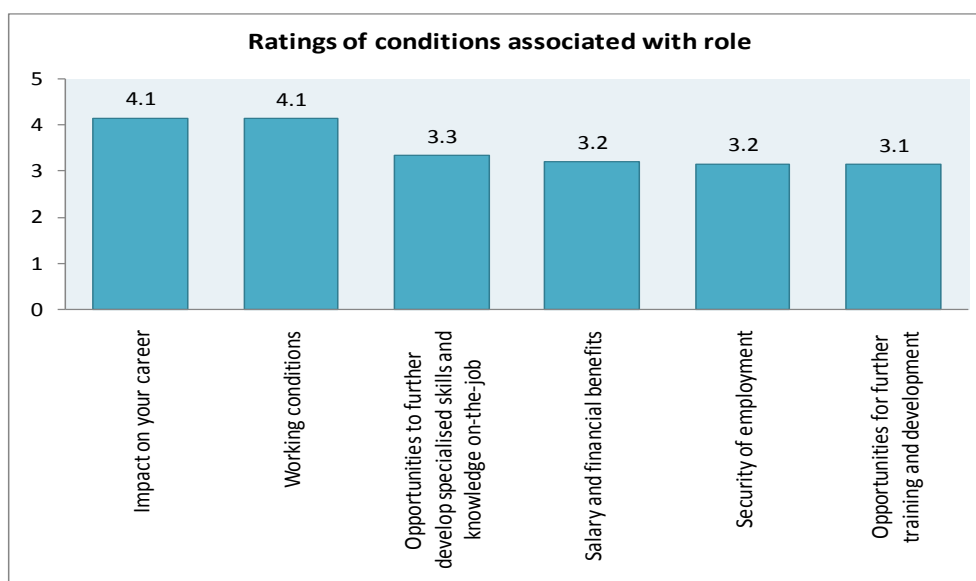


4.8 Rating conditions of employment

As can be seen from *Figure 37* –

- 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**).

Figure 37: Average ratings of key features of MHN working conditions



4.8.1 Conclusions: Mental Health Nurse working conditions under the MHNIP model

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). Nor has it diminished their very high levels of job satisfaction.

4.9 Impact on the private mental health service system

4.9.1 Impact of the MHNIP on workload

Psychiatrists and GPs surveyed (n=24) were asked to quantify the outcomes resulting from referring clients to the MHNIP Pilot. The majority 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%). (Refer to Accompanying Report 1).

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%.²
- ⇒ 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.

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

Using open-ended responses, Mental Health Nurses surveyed 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.

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 cannot be categorised, 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 12*.

² 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.

Table 12: 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)

4.9.3 Conclusions: Impact on the private mental health system

The majority of participating psychiatrists and GPs believe that the MHNIP has made a positive impact in a number of ways, but in particular, in relation to their capacity to deal with complex cases, increased involvement with others involved in client's care, and the achievement of a more timely response to acute or emergency presentations.

Mental Health Nurses, in their interviews with the evaluation team and in survey feedback, see the MHNIP as filling a gap in the system, and providing greater flexibility, accessibility and responsiveness of care. As *Section 4.1.1* indicated, many of the strengths identified for the model are also indicators of a positive impact on the private mental health system as a whole. In particular -

- Provision of earlier and more effective crisis intervention
- MHNs fill a gap in the private mental health system
- Resource effectiveness achieved by the MHN substituting for psychiatrist or GP time
- Expected reduction in hospital admissions for mental health issues
- MHN role in medication monitoring reduces GPs' time spent on this
- MHN role in medication monitoring reduces psychiatrists' time spent on this
- Expected reduction in hospital stay length of stay for mental health issues.

5 OUTCOMES ACHIEVED FOR CLIENTS

Outcomes achieved for clients have been assessed using three mechanisms –

- IV. Analysis of site data, including psychological tests prior to and following intervention
- V. Analysis of Medicare data
- VI. Surveys with Mental Health Nurses, Psychiatrists and GPs, and Clients with questions relating to outcomes and impact triangulated across the three groups of stakeholders.

5.1 Impact of MHNIP Pilot on clients: comparative analysis of survey findings

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.

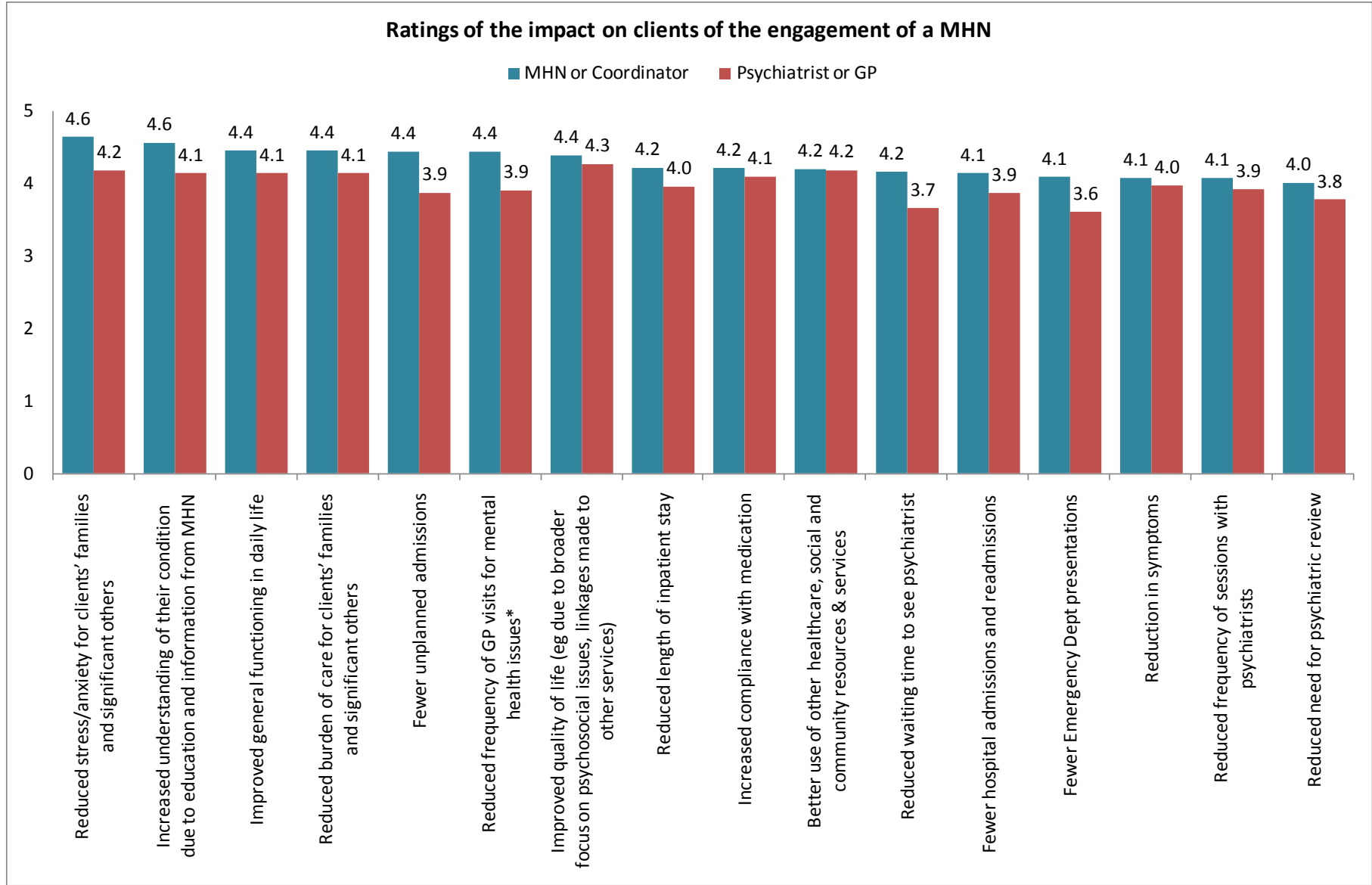
5.1.1 Impact of MHNIP on clients: comparative analysis of provider response

Figure 38 compares the average ratings of Mental Health Nurses and Psychiatrists and GPs regarding the impact of the MHNIP 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 –

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

The remaining six features of impact are not marked, as is evident from *Figure 38*.

Figure 38: Impact on clients of the engagement of a MHN



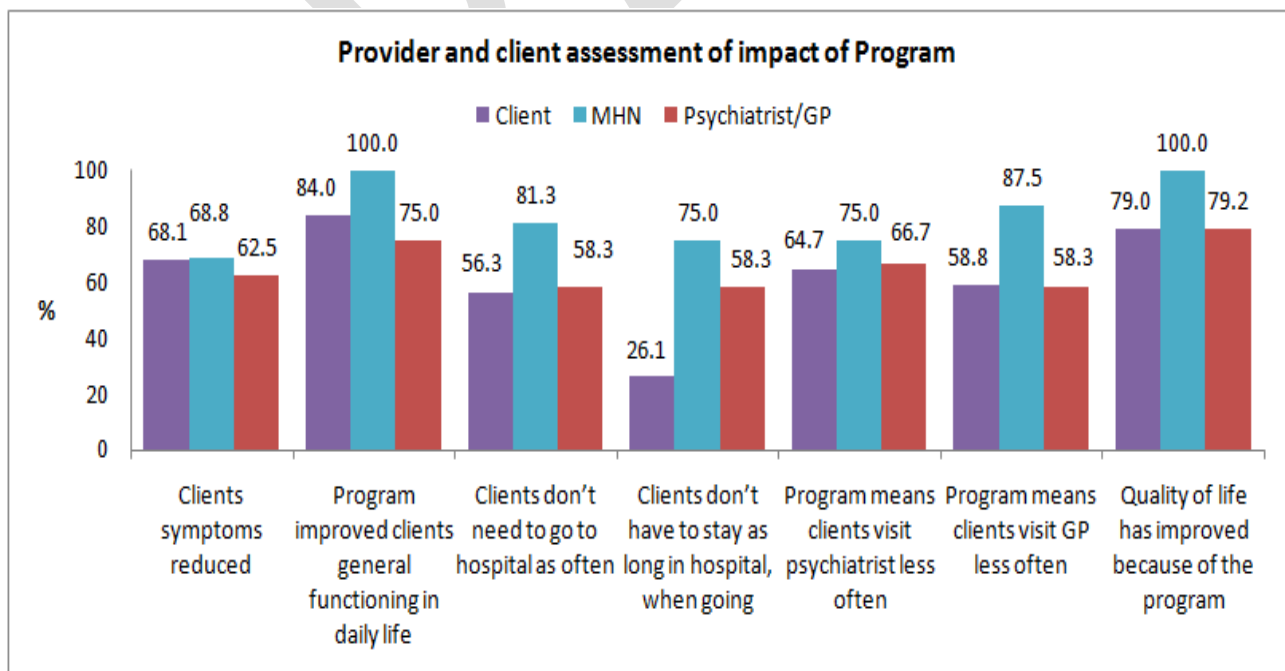
5.1.2 Impact of MHNIP on clients: comparative analysis of all three survey groups

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.

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 39).

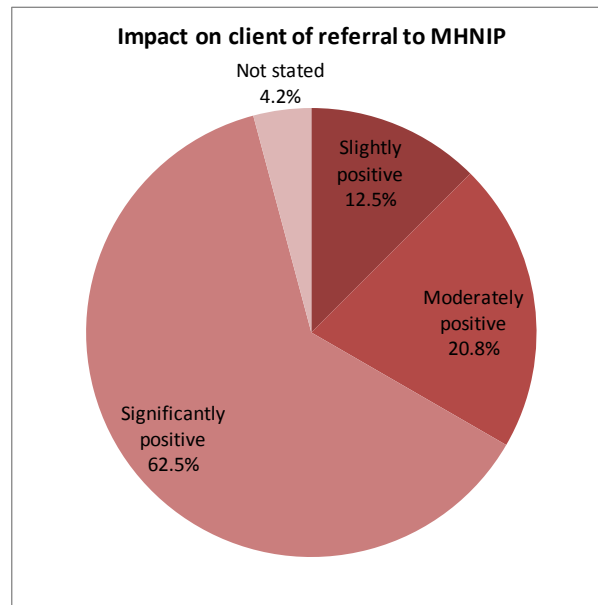
- There is a high degree of congruence regarding **symptom reduction** for all three groups (62.5% psychiatrist or GP, 68.1% Mental Health Nurse, 68.8% client).
- Over three-quarters of all three groups perceive an **improvement in both daily functioning and overall quality of life**.
- Over 55.0% of all three groups specified a **reduction in hospital admissions** as an outcome.
- Approximately 60.0% 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.
- The least agreement related to reduced length of stay – 75.0% of Mental Health Nurses, 58.0% of GPs and psychiatrists but only 26.0% of Clients (however 44.0% of clients specified ‘unsure’).

Figure 39: Provider and client assessment of impact of MHNIP



Participating Psychiatrists and GPs 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 40* 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 40: Impact on client of referral to 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 any difficulties associated with implementing the Program as a pilot.

5.2 Impact of the Program on clients – based on analysis of site data

This section presents analysis of HoNOS scores reported over time (at each Review) for the following subgroups of clients –

- Clients who have *not yet exited* the service
- Clients who *have exited* the service
- Clients who exited the service because they *became well/functional* (according to their reason for exit).

Note that lower scores indicate less severe symptoms, therefore a decrease in HoNOS scores indicates improvement (for further information on interpreting HoNOS scores, see Box 3 below).

Box 3: Interpreting change in HoNOS scores

Interpreting change in HoNOS scores

The information below outlines the terminology used in this Report to describe changes in HoNOS scores between reviews and between entry and exit. Refer to Box 2 for general information about the HoNOS.

How can change be measured?

The HoNOS is designed for use as a clinical outcome measure which can be used to quantify in broad terms how an intervention has affected a client's health and functioning. The HoNOS assessment is required to be undertaken by clinical staff at the client's entry to the service, at regular periods (eg. every 90 days) during the period of engagement/intervention, and again at exit.

Interpreting changes in HoNOS scores

Recalling that **higher HoNOS scores reflect a higher level of severity** (ie. more severe difficulties in health and functioning):

⇒ An **improvement** in a client's health and functioning would be represented by a **decrease in their HoNOS score** over time.

⇒ A **deterioration** in a client's health and functioning would be represented by an **increase in their HoNOS score** over time.

Limitations applicable to this analysis

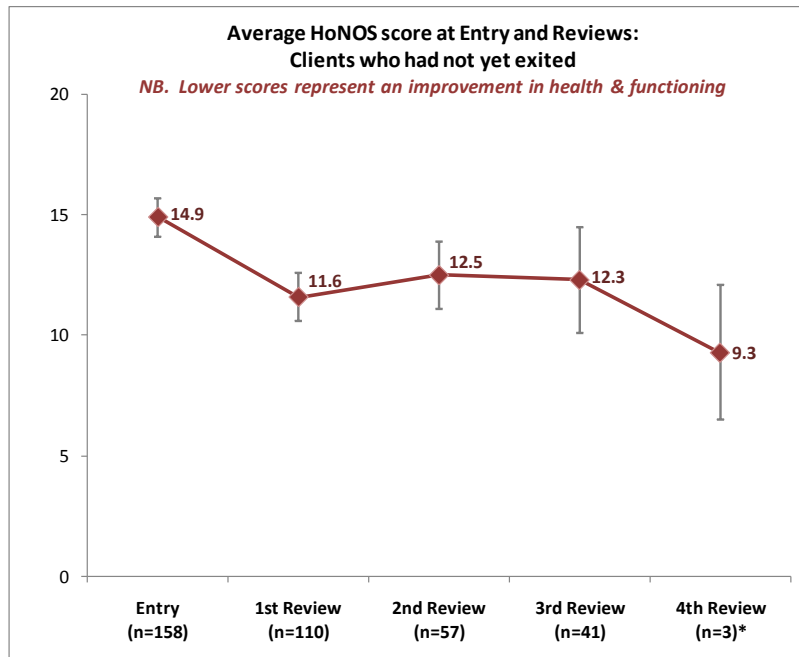
Improvements which are specific to one item (or a small number of items) within the 12 items comprising the HoNOS may be difficult to detect in the Total Score. Similarly, an improvement in some items may be obscured by deterioration in other items.

5.2.1 Clients who have not yet exited

The following analysis looks at changes in HoNOS scores across successive reviews for clients who had not yet exited the Program. The change in average HoNOS scores over time is illustrated in *Figure 41* below. Further details can be found in Accompanying Report 2, Table 7.

The overall change in clients' HoNOS scores over time was statistically significant (Repeated Measures ANOVA, $p < .01$). Post hoc testing (Tukey HSD) indicated that the significant differences occurred between **Entry and 1st Review ($p < .01$)** and **Entry and 4th Review ($p < .01$)**, however note that only three clients had a 4th Review.

Figure 41: Average HoNOS scores at Entry and Reviews: Clients who had not yet exited



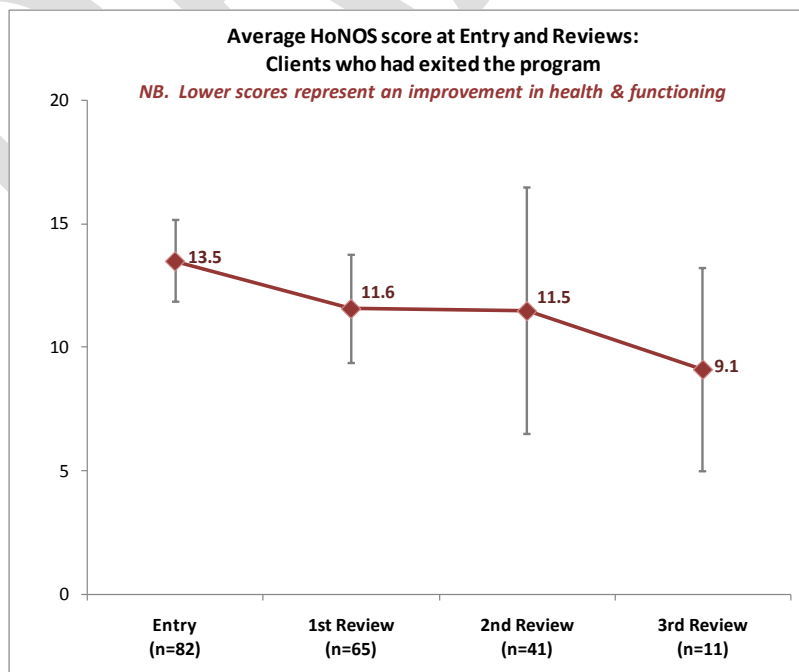
* Caution: Small sample size (n<5).

Note: Error bars show 95% confidence intervals. **The differences between Entry and 1st Review, and Entry and 4th Review are statistically significant (p<.01).**

5.2.2 Clients who had exited the Program

The following analysis looks at changes in HoNOS scores across successive reviews for clients who had exited the Program. The change in average HoNOS scores over time is illustrated in *Figure 42*, with statistics presented in Accompanying Report 2, Table 8.

Figure 42: Change in average HoNOS scores over time



Note: Error bars show 95% confidence intervals. No differences are statistically significant.

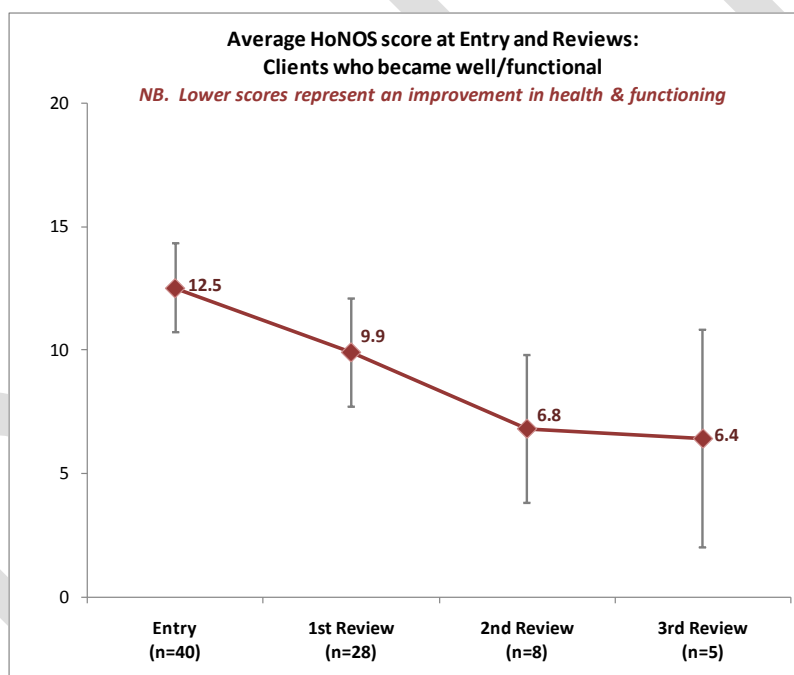
While the average HoNOS score appeared to decrease over time, due to high variability in the scores, neither the overall effect nor comparisons between Entry and Reviews were statistically significant.

This high variability is due to small sample sizes and also partly due to subgroups within the sample of Exited clients - some clients exited the Program after becoming well/functional, whereas others exited after becoming too unwell to continue in the Program. This produced subgroups with a) improving and b) declining HoNOS scores within the sample of Exited clients.

5.2.3 Exited clients who had become well/functional

There were **41** clients who exited the program as a consequence of becoming well/functional, according to the “reason for exit” recorded. The change in average HoNOS scores over time for these clients is illustrated in *Figure 43*, with statistics presented in Accompanying Report 2, Table 9.

Figure 43: Average HoNOS scores at Entry and Reviews: Clients who became well/ functional



Note: Error bars show 95% confidence intervals. Differences between time points are not statistically significant.

While the average HoNOS score appeared to decrease quite markedly over time, due to the small sample size neither the overall effect nor comparisons between Entry and Reviews reached statistical significance. As the MHNIP continues and more clients exit the Program, the sample size of “exited clients who became well/functional” will become large enough to detect significant differences in HoNOS scores over time.

5.2.4 Relationship between HoNOS score at entry and exit from the Program

HoNOS scores at entry were recorded for 65 (79.3%) of the 82 clients who exited the Program. The average HoNOS score at entry for these clients was **13.5**, and average HoNOS score at entry for clients who had *not yet exited* the program was **14.9**.

A statistical analysis of the entry HoNOS scores for Exited and Non-Exited clients was undertaken to determine whether these groups differed significantly on their scores at entry. This test identified a statistically significant difference (Mann-Whitney U test³, $p < .05$), suggesting that **clients with lower (better) HoNOS scores at entry were more likely to exit the Program, whereas clients with higher (worse) HoNOS scores at entry are likely to remain in the Program, as would be desired.**

The number of months that clients spent in the Program before exiting was significantly related to their HoNOS score at entry, with higher (worse) scores on entry mildly associated with a longer period of time before exit (Pearson correlation, $r = .252$ $p < .05$), as would be expected.

5.2.5 Reason for exit

The exit criteria for the Program are summarised in Box 4 below.

Box 4: Exit criteria according to MHNIP Program Guidelines

Exit criteria according to MHNIP Program Guidelines

The patient will no longer be eligible for services under this initiative when:

a) the mental disorder no longer causes significant disablement to the patient's social, personal and occupational functioning

OR

b) the patient no longer requires the clinical services of a mental health nurse

OR

c) the general practitioner or psychiatrist is no longer principally responsible for the patient's clinical mental health care.

According to the data provided to the evaluators by each site, **slightly more than half** of the 79 clients for whom an Exit Reason was recorded had left the Program because they *became well/functional* - analogous to criterion (a) above. ⁴

It is interesting to note that **10.0%** of clients exited because they *refused or failed to engage with MHN service*, and a further **11.0%** of exiting clients had *disengaged or withdrawn* from the service. **Overall,**

³ As the distribution of Entry HoNOS scores for Exited clients was significantly non-normal, a non-parametric test was used to analyse the difference in Entry HoNOS the two groups.

⁴ Note that the "exit reason" was collected as a free text field, which led to some variation in the interpretation made by sites when recording this information. Therefore reasons such as "referred to GP" may be a corollary of clients becoming well/functional, which may mean that the true proportion of clients who became functional may be underestimated in this analysis.

these clients represent around 6.0% of all clients who entered the Program (n=271), indicating a relatively low level of difficulty in engaging clients with the Program.

5.2.6 Exit destination

Exit destination was reported for approximately 80.0% of Exited clients.

Of the 65 Exited clients for whom exit destination was reported, more than 60.0% exited to a *psychiatrist*, and more than one quarter exited to a *general practitioner*.

5.2.7 HoNOS scores at exit

HoNOS scores at exit were recorded for only 46 (56.1%) of the 82 clients who exited the Program. The average HoNOS score on exit was 9.5 (median 8.0), with a standard deviation of 8.2 (see Table 13).

Table 13: Average HoNOS score at each time point

Time point	Not yet exited		Exited		Exited due to becoming well or functional	
	No. of clients with HoNOS	Average HoNOS	No. of clients with HoNOS	Average HoNOS	No. of clients with HoNOS	Average HoNOS
Entry	158	14.9	65	13.5	40	12.5
1st Review	110	11.6*	51	11.6	28	9.9
2nd Review	57	12.5	15	11.5	8	6.8
3rd Review	41	12.3	11	6.8	5	6.4
4th Review	3	9.3*	-	-	-	-
Exit	-	-	46	9.5**	29	6.6***

*Statistically significant difference between **Entry and 1st Review** (p<.01) and **Entry and 4th Review** (p<.01).

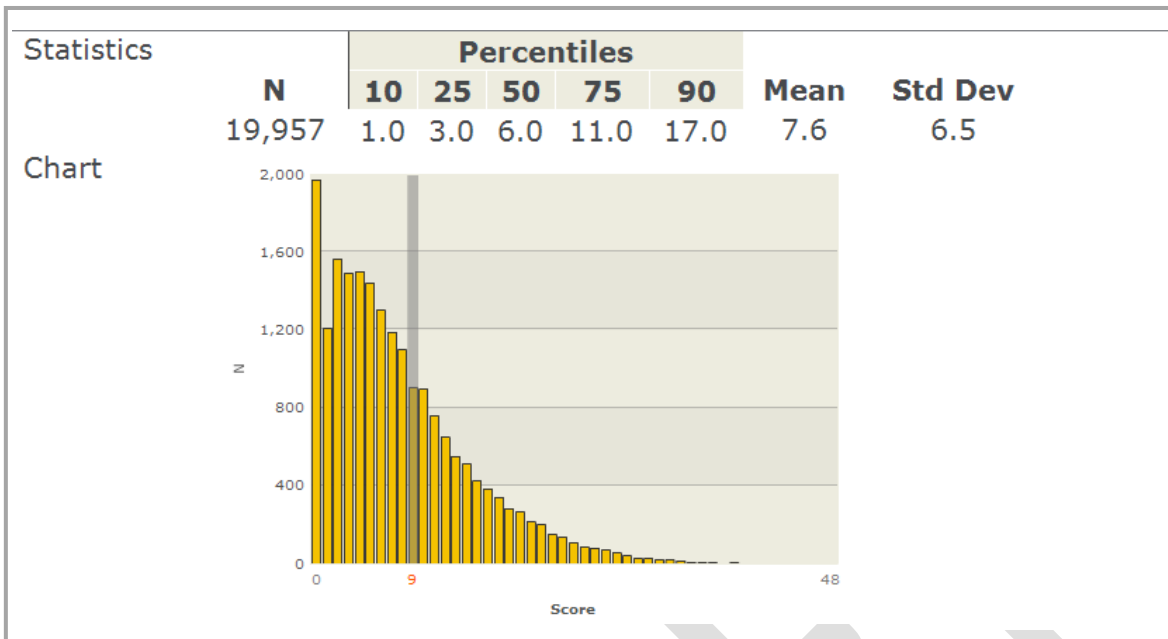
Statistically significant difference between **Entry and Exit (p<.01).

***Statistically significant difference between **Entry and Exit** (p<.001).

This is slightly higher than the average HoNOS score reported nationally under the MHNOCC⁵ for voluntary adult clients at exit from an ambulatory service in 2006-7 (the latest available), as shown in *Figure 44*.

⁵ Mental Health National Outcomes and Casemix Collection (Australia)

Figure 44: Distribution of HoNOS scores reported under the MHNOC for voluntary adult clients at exit from an ambulatory service in 2006-7



Extracted from the online AMHOCN⁶ Web Decision Support Tool, available at <http://wdst.mhnocc.org/>. Retrieved 14/8/2009. Query which produced the image above:

<http://wdst.mhnocc.org/query/jurisdiction=national/age-group=adult/measure=honos/view=htot12/level-of-analysis=collection-occasion/occasion=discharge/status-score=9/service-setting=ambulatory/financial-year=2006/legal-status=voluntary/>

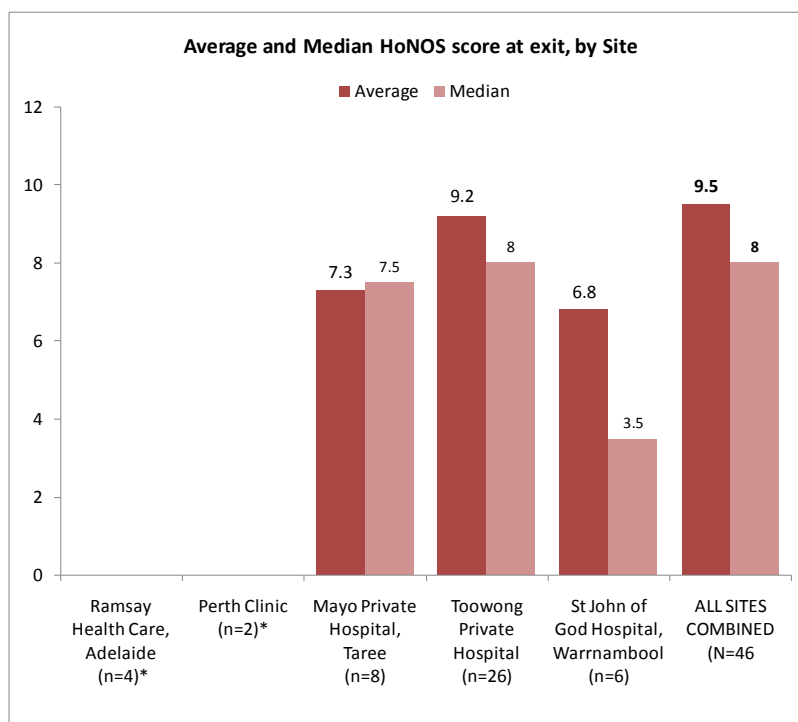
A mean HoNOS score of 9.5 (highlighted in *Figure 44* above) would lie around the 69th percentile of the national distribution of scores. **This suggests that while the overall severity of mental health related problems experienced by the MHNIP client group at exit may appear to be slightly higher on average than for clients of other community-based mental health services, the difference is unlikely to be statistically significant⁷.**

There was some variation between sites in the average HoNOS at Exit, as shown in *Figure 45* below. Note that the data for Adelaide and Perth are not shown due to very small sample sizes.

⁶ Australian Mental Health Outcomes and Classification Network

⁷ Due to the highly skewed nature of the HoNOS data, statistical comparison of the two means was inappropriate and likely to produce misleading results.

Figure 45: Average and Median HoNOS score at exit, by Site



* Data not shown for sites where n<5, in order to protect client confidentiality and to avoid unreliable estimates.

5.2.8 Change in HoNOS between entry and exit

Recalling that the average HoNOS score on **Entry** for clients who exited the Program was **13.5** and the average **Exit** HoNOS score was **9.5**, statistical testing was carried out to determine whether the difference was statistically significant.

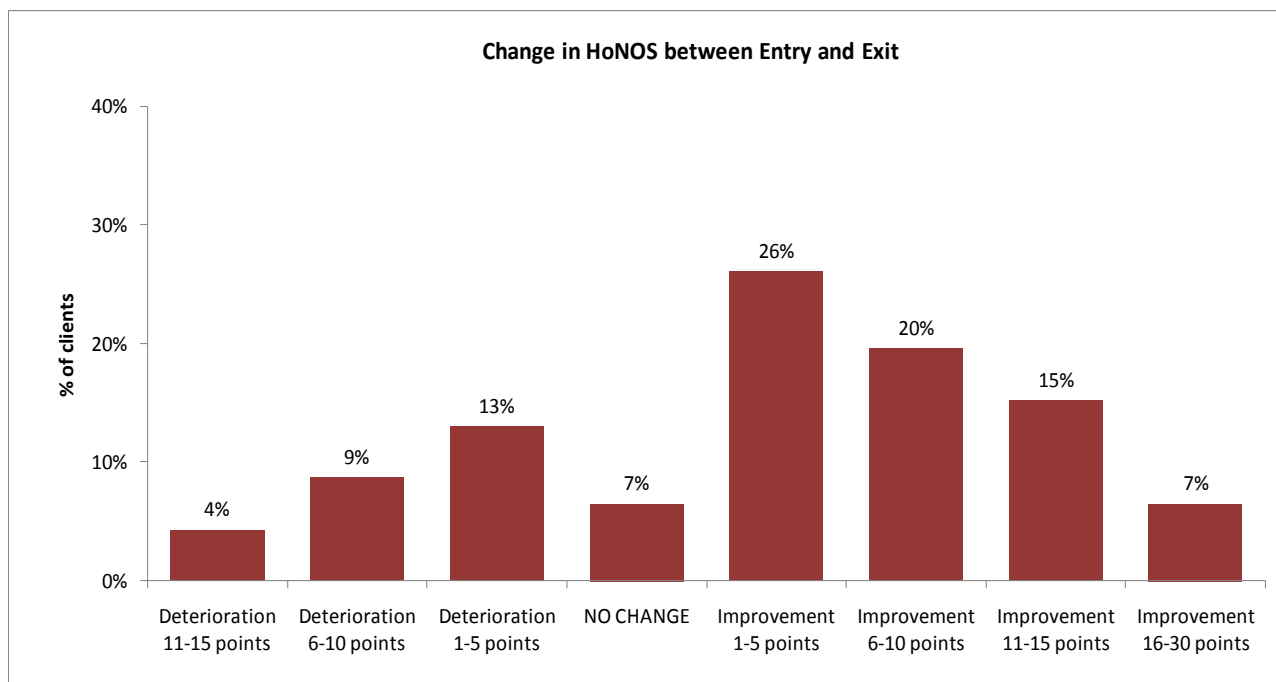
Testing identified a **statistically significant difference** between HoNOS at entry and exit for the **46 clients** with a HoNOS score at both time points (Wilcoxon test for paired samples⁸, p<.01), **confirming that clients recorded a significantly lower HoNOS score (and therefore, improvement) on exit from the Program.**

⁸ A non-parametric test was used as the data did not meet assumptions for parametric testing.

Of these 46 clients with HoNOS recorded at both entry and exit –

- ⇒ 67.0% recorded an **improvement** based on their HoNOS score,
- ⇒ 7.0% of clients recorded **no change** in HoNOS score, and
- ⇒ 26.0 % of clients recorded a **deterioration** based on their HoNOS score.

Figure 46: Change in HoNOS between Entry and Exit



- ⇒ The average change in HoNOS between entry and exit was **4 HoNOS points**.
- ⇒ According to Parabiaghi *et al*⁹, a change of 8 HoNOS points for an individual client would be needed to be confident that a *clinically significant change* had occurred.
- ⇒ A change of 8 points or more occurred for 14 (**30.4%**) of these 46 clients.

5.2.9 Change in HoNOS between entry and exit for clients who became well/functional

The preceding analysis was conducted on a group comprising clients who exited the Program regardless of their reason for exit. Some of these clients exited because they became well, some exited because they became too unwell, and others exited for other reasons. Therefore the analysis of change in HoNOS scores between entry and exit was also performed on the subgroup of clients who were known to have exited as a consequence of becoming well/functional.

⁹ Parabiaghi A, Barbato A, D'Avanzo B, Erlicher A & Lora A. (2005). Assessing reliable and clinically significant change on Health of the Nation Outcome Scales: method for displaying longitudinal data. Australian and New Zealand Journal of Psychiatry, 29(8), pp 719-725.

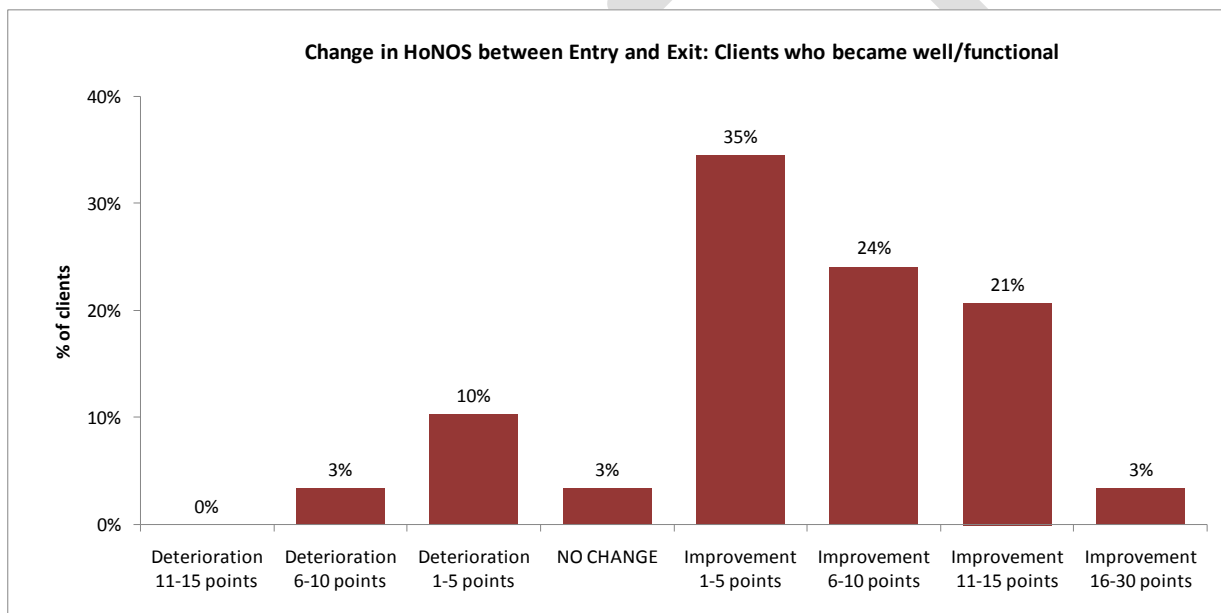
Of 82 clients who exited the MHNIP, **41** were known to have exited as a consequence of becoming well/functional and **29** of them had HoNOS scores at both entry and exit. The following analysis looks at change in HoNOS scores from entry to exit for these 29 clients who *became well/functional*.

The average HoNOS score on Entry for these 29 clients was **12.2** and their average HoNOS score on Exit was **6.6**.

Statistical testing identified a **highly significant difference** between HoNOS at entry and exit (Wilcoxon test for paired samples¹⁰, $p < .001$), **confirming that clients who became well/functional recorded a significantly lower HoNOS on exit from the Program.**

An improved HoNOS score at exit was recorded for 25 (**82.8%**) of the 29 clients who became well/functional. The average change in HoNOS between entry and exit was **5.7 HoNOS points**.

Figure 47: Change in HoNOS between Entry and Exit: Clients who became well/ functional



- ⇒ According to Parabiaghi *et al*¹¹, a change of 8 HoNOS points for an individual client would be needed to be confident that a *clinically significant change* had occurred.
- ⇒ A change of 8 points or more occurred for 10 (34.5%) of these 29 clients.

¹⁰ A non-parametric test was used as the data did not meet assumptions for parametric testing.

¹¹ Parabiaghi A, Barbato A, D'Avanzo B, Erlicher A & Lora A. (2005). Assessing reliable and clinically significant change on Health of the Nation Outcome Scales: method for displaying longitudinal data. Australian and New Zealand Journal of Psychiatry, 29(8), pp 719-725.

5.3 Conclusions – impact of the Program on clients

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.

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.

There was a statistically significant improvement in HoNOS scores over time for clients who had not yet exited the program ($p < .01$, see *Table 14*). Statistically significant improvements occurred between Entry and 1st Review and Entry and 4th Review for this group of clients. There was a statistically significant improvement in HoNOS scores between Entry and Exit for clients who had exited the program ($p < .01$).

Table 14: Summary of changes in HoNOS scores over time

Interval	No. clients with HoNOS at both time points	% of clients showing Improvement	% of clients showing No Change	% of clients showing Deterioration	Average Change
<i>Clients who had not yet exited the MHNIP (n=189)</i>					
Entry to 1 st Review	158	64%	11%	25%	3.3 HoNOS points improvement*
1 st to 2 nd Review	57	48%	9%	44%	0.6 HoNOS points improvement
2 nd to 3 rd Review	40	52.5%	5%	42.5%	0.2 HoNOS points deterioration
3 rd to 4 th Review	16	50%	19%	31%	1.8 HoNOS points improvement
<i>Clients who had exited the MHNIP (n=82)</i>					
Entry to 1 st Review	41	66%	5%	29%	2.5 HoNOS points improvement
Entry to Exit	46	67%	7%	26%	4.0 HoNOS points improvement**
<i>Clients who had exited the MHNIP due to becoming well or functional (n=41)</i>					
Entry to 1 st Review	28	71%	4%	25%	2.8 HoNOS points improvement
Entry to Exit	29	83%	3%	14%	5.7 HoNOS points improvement***

*A statistically significant change occurred between **Entry and 1st Review** ($p < .01$) and also **Entry and 4th Review** ($p < .01$, not shown).

**Statistically significant change ($p < .01$).

***Statistically significant change ($p < .001$).

Of the 46 clients with HoNOS scores recorded at both entry and exit –

- ⇒ **67% recorded an improvement based on their HoNOS score,**
- ⇒ **7% of clients recorded no change in HoNOS score, and**
- ⇒ **26% of clients recorded a deterioration based on their HoNOS score.**

Clients with lower (better) HoNOS scores at entry were more likely to exit the Program, whereas clients with higher (worse) HoNOS scores at entry are likely to remain in the Program, as would be desired ($p < .05$).

The number of months that clients spent in the Program before exiting was significantly related to their HoNOS score at entry, with higher (worse) scores on entry mildly associated with a longer period of time before exit (Pearson correlation, $r = .252$, $p < .05$), as would be expected.

Slightly more than half of the 79 clients for whom an Exit Reason was recorded had left the Program because they *became well/functional*. Statistical testing identified a highly significant difference between HoNOS at entry and exit for those clients ($p < .001$), confirming that clients who became well/functional recorded a significantly lower HoNOS on exit from the Program.

DRAFT

6 OUTCOMES ACHIEVED FOR SERVICE PROVIDER PARTICIPANTS

6.1 Resourcing issues

6.1.1 Caseload patterns –Medicare data

MHNIP Guidelines require a **current** minimum case load of 20 individual patients with a severe mental disorder per week, averaged over three months, and an expected **annual** caseload per FTE Mental Health Nurse of **35** clients with a severe mental disorder, most of whom being expected to require ongoing care over the course of the year.

On this basis, the Adelaide, Perth, and Taree sites have met or exceeded the Guideline, the Warrnambool site is just below at 34.3 (and is a relatively newly established site) while Toowong is well below at 28.1.

As Figure 48 shows, the average caseload (number of clients seen per FTE Mental Health Nurse, averaged over 3 months) tends to remain within the range of **30 to 35 clients** per FTE Mental Health Nurse, when data from all sites are combined.

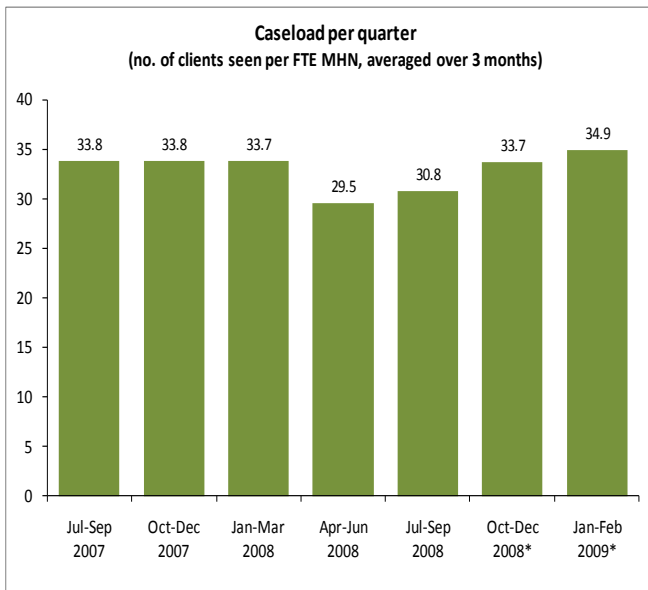
Average annual caseloads vary between sites, from **28.1 clients** per FTE Mental Health Nurse at Toowong Private Hospital (whose operation is characterized by home visits) to **37.9 clients** per FTE Mental Health Nurse at Ramsay Health Care Adelaide (see *Figure 49*). The Adelaide site has been the last in this group to commence operations and is the smallest operation so far (employing only one Mental Health Nurse), both of which may be factors in the high caseload compared to other sites.

Caseloads tend to vary over time, across phases of operation and as different procedures and staffing profiles are introduced at each site.

Calculating caseloads based on the number of unique clients seen per FTE Mental Health Nurse reduces the influence of month-by-month variations and provides a picture of service activity which is unrelated to the number of Mental Health Nurse sessions per month.

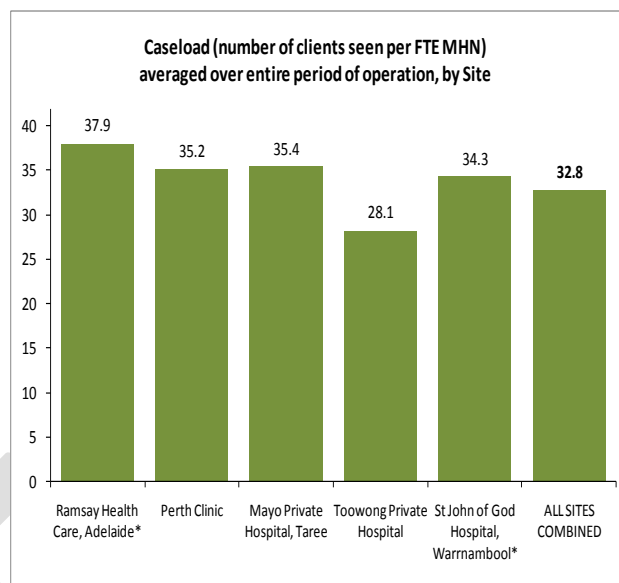
The caseload averaged across all sites and the entire period of MHNIP was **32.8 clients** per FTE Mental Health Nurse. Note that this average for all sites is strongly influenced and lowered by the data from Toowong Private Hospital, as Toowong's operation comprises 41% of all MHNIP sessions.

Figure 48: Average caseload (no of clients seen per FTE MHN, averaged over 3 months), for each quarter since Program inception



* Caseloads are based on available data; note that information was not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09.

Figure 49: Caseload (no of clients seen per FTE MHN) averaged over entire period of operation, by site

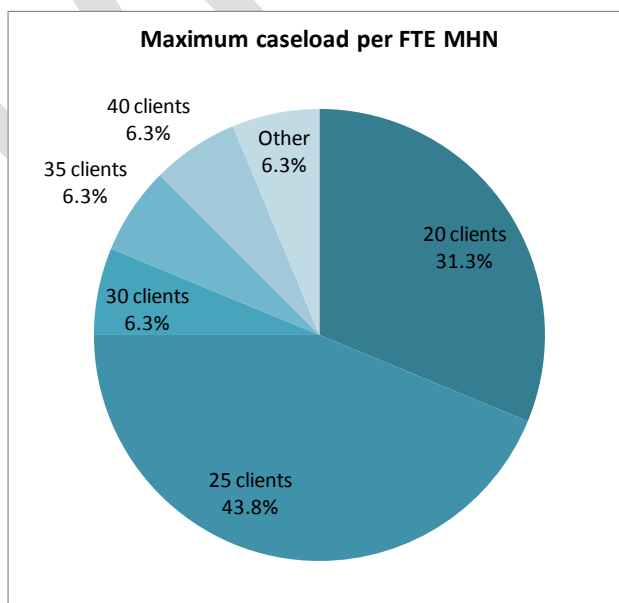


* Caseloads are based on available data; note that information was not available for Ramsay Health Care and St John of God Hospital for Dec-08 and Feb-09.

6.1.2 Quantifying maximum caseloads – survey data

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 50* indicates, the majority (75.0%) have quantified this at between **20 clients (31.3%)** and **25 clients (43.8%)**, which is much lower than site data indicate.

Figure 50: Maximum caseload per FTE MHN



Of course, variations in case load capacity will occur depending on factors such as –

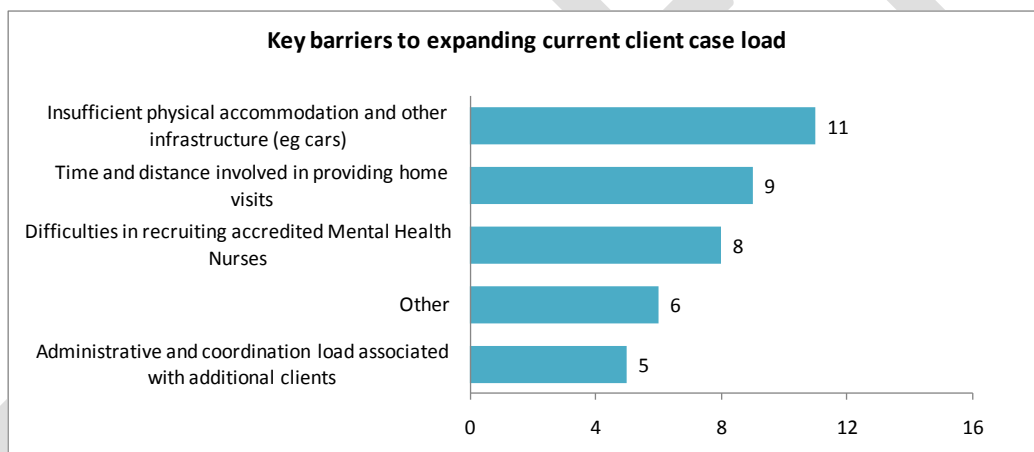
- Severity or complexity of the client’s condition
- Client’s location and travel time required for home visits (which doesn’t apply to those using a clinic based delivery only).
- Service location – those in rural and remote areas having greater distances to travel.

6.1.3 Barriers to expanding current case loads

The main barriers to expanding the current case load were described as involving (see *Figure 51*) –

- **Lack of infrastructure** – such as, accommodation, cars
- **Time and distance involved in providing home visits** to clients
- **Difficulties in recruiting accredited Mental Health Nurses**
- **Administrative and coordination load.**

Figure 51: Barriers to expanding case load



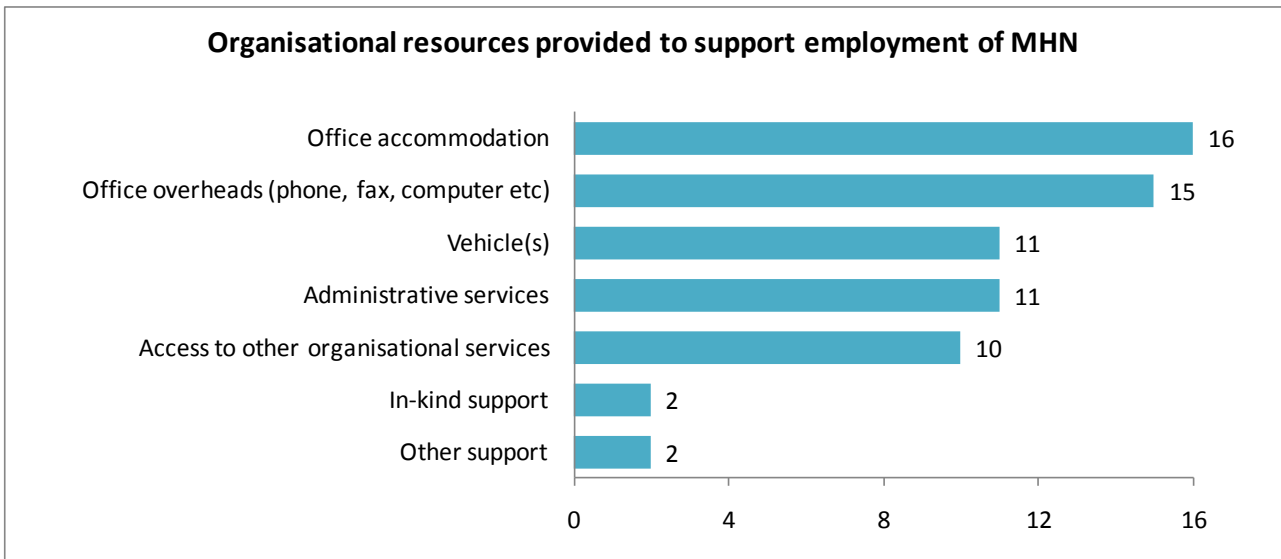
Note. Multiple responses possible

6.1.4 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 52* indicates, these confirm the qualitative findings and involve –

- Office accommodation
- Office overheads, such as, phone, fax, computer
- Administrative services
- Vehicle/s
- Access to other services provided by the organisation
- In-kind support
- Other support.

Figure 52: Resources provided to support the employment of a MHN



Note. Multiple responses possible

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

- Clinical supervision provided and paid for by nurses themselves as a group meeting monthly.
- 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.**

7 FUTURE ENHANCEMENTS RECOMMENDED 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 15*.

Table 15: 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	
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

Improvement sought	Mental Health Nurses nominating	Psychiatrists nominating
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 –

- The reliance on auspicing organisations to fill gaps in the funding provided.
- The capacity of the MHNIP to manage cultural diversity.
- Promotion of the MHNIP to psychiatrists and GPs.
- Accountability requirements associated with Medicare funding.

7.2.1 Funding to achieve positive client and service system outcomes

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.

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).

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.

Feedback from the sites also identified that funding is not provided when clients fail to attend scheduled appointments. Services will have set time aside for this and are severely disadvantaged by something that is outside of their control.

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 –

- 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.

7.2.3 Mental Health Nurse working conditions under the MHNIP model

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.

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 (that is 50+), and are unlikely to surrender hard earned security and associated employment benefits. For nurses to move to a program like the MHNIP, these conditions will need to be addressed, together with enhancing the opportunity to acquire increased skills and knowledge. At the same time, 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.

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.

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 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.

7.2.6 Future Monitoring and Evaluation

There are clear indications that the MHNIP is producing positive outcomes for clients, psychiatrists and GPs. The extent and sustainability of this benefit, as well as the cost-effectiveness of the Program, must be the focus of a future (ongoing) monitoring and evaluation effort.

Future monitoring and evaluation of the MHNIP may also explore other program- and system-level issues, such as:

- Exploration of additional funding models (for example, utilising private health insurance)
- Examining the interface (and potential overlap) between public and private mental health services
- Impact assessment that incorporates a cost-benefit, cost-comparison or cost-effectiveness analysis
- Exploring and comparing outcomes associated with different models (eg clinic-based, home visiting or hybrid) and with the public and private MHNI Programs
- Analysis of the sustainability of outcomes, by tracking clients over time.

Ongoing evaluation efforts will be enhanced by the availability of more data (increasing sample sizes and enabling more conclusive judgements to be made) and by the refinement of data collection mechanisms at the service level.

7.3 Recommendations

Recommendation 1:

It is recommended that the MHNIP in private hospital settings be implemented as an ongoing Program.

Recommendation 2:

It is recommended that funding (beyond what is currently provided) supports infrastructure costs, including office accommodation and operating costs, and the purchase and maintenance of vehicles.

Recommendation 3:

It is recommended that greater flexibility be applied to Medicare guidelines relating to the number of sessions undertaken so that services are not financially disadvantaged when clients do not turn up for appointments.

Recommendation 4:

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 recommended 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.

Recommendation 5:

It is recommended that the MHNIP in the private sector provide opportunities for further professional development, job security and salary and financial benefits to make it competitive with public sector conditions, thereby increasing its capacity to attract appropriately credentialed and experienced Mental Health Nurses.

Recommendation 6:

It is recommended that the cultural accessibility of the MHNIP be enhanced through the development of Indigenous-specific and CALD-specific service offerings – either within existing services or as specialist services. This would require the development of partnerships with appropriate Indigenous and CALD mental health service providers to design and deliver inclusive services to both target groups.

Recommendation 7:

It is recommended that existing reporting for Medicare be redesigned to be as concise as possible, and offered in electronic format.

Recommendation 8:

In light of the number of clients being admitted to the Program who do not meet current eligibility criteria, it is recommended that Program Guidelines be reviewed, possibly with a view to changing the number of criteria that must be met to achieve eligibility.

Recommendation 9:

It is recommended that if the MHNIP pilot in the private hospital setting is given ongoing program status that monitoring and evaluation processes incorporate the data collections systems developed for this evaluation, and that consideration be given to –

- a. Tracking clients over time to analyse the Program's long term impact.
- b. Examining the interface between public and private Program services.
- c. Using the longer term data available to incorporate cost-comparison or cost-effectiveness analysis
- d. Exploring additional funding models, for example, utilising private health insurance.