

Mental Health Nurse Incentive Program

Case Studies Project Report

May 2010

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The views expressed in this report do not necessarily represent the views of the Australian Government.

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Executive Summary

The Mental Health Nurse Incentive Program (MHNIP) is part of the Australian Government's component of the National Action Plan on Mental Health 2006 – 2011. The MHNIP has been introduced as an alternative model of mental health care for those with serious mental illness, and significant impairment in their daily functioning. General practices, private psychiatrist services and other appropriate community providers (including general practice networks and private hospitals) can access sessional funding to employ mental health nurses to assist in the provision of coordinated clinical care for people, in the community, with severe mental health disorders.

Client outcomes expected from this collaborative approach to providing clinical support and services in the community are:

- to provide improved levels of care for people with severe mental health disorders
- reduce hospital admissions and readmissions for people with severe mental health disorders
- assist people with severe mental health disorders to stay well, and connect with their community.

Key functions of the nursing role are to provide in-depth assessment, contribute to care planning, provide a direct service to clients and their families, and most importantly, coordinate various aspects of the implementation of the client's mental health care plan.

The "Case Study of the Mental Health Nurse Incentive Program" project aimed to provide a case study report on a number of examples of the MHNIP across a range of settings. The case studies were intended to highlight the development, implementation and some early outcomes for the MHNIP.

This case study project investigated seven different sites where the MHNIP has been implemented, covering a variety of locations, service models and employment arrangements. Although no private hospitals or services from a remote location were included in the project, there was sufficient variation across the sites to explore different models, varying interpretations of the guidelines, a range of precipitating factors, and feedback from a range of sources about the impact the program is having.

As well as providing a detailed description of the implementation of the MHNIP at each location, this final report describes available information on clients' experience of care, their perception of the program more broadly, and some indication of mental health outcomes achieved. The report extends to a discussion of some of the themes that have emerged from within and across the seven localities. These in turn can inform the program evaluation planned by the Department of Health and Ageing.

Key questions that underpinned the case studies include:

- the perceived need that motivated the introduction of the MHNIP
- the way the role been interpreted and/or implemented in differing localities
- the service model used
- implementation challenges
- successes of the program
- any opportunities for enhancement.

A sample group of seven services was chosen from those who had volunteered to participate. These services are:

- Ballarat and District Aboriginal Corporation
- Bathurst Mental Health Nurse
- Clare Medical Service
- General Practice Association of Geelong
- Ipswich West Moreton Division of General Practice
- Longford Medical Centre

- Mackay Division of General Practice.

The size of the organisations included in the final sample, ranges from one nurse supporting one general practice to a large service with seven nurses supporting 29 practices. Services were drawn from five states, ranging from major city locations (Geelong, Ipswich), through inner regional centres (Bathurst, Longford, Ballarat and Mackay) to an outer regional town (Clare). There were no services located in a remote setting which offered to participate in the study.

There were four organisation types represented, along with examples of both direct and shared employment arrangements. Also included is an Aboriginal Cooperative that delivers primary health care services.

The methodology utilised up to four separate data collection processes including:

- an initial service survey
- stakeholder consultation at each site
- a client survey
- snapshot data collection.

Additional information was also sought from a number of national stakeholders.

Overall there was wide acceptance of the program and feedback from all stakeholders was extremely positive. General practitioners, psychiatrists, nurses, clients and non-government mental health service providers reported that the service is working well and is a welcome addition to the spectrum of mental health services available. In some cases, state mental health service managers were also included in the supporters of the program. Stakeholders reported that they thought that because of the MHNIP, many more people were receiving a mental health service in convenient and non-stigmatising settings.

The variety of service models seen, in the seven settings, shows that the MHNIP can be adapted to a range of situations and used to address different local scenarios.

There was considerable discussion about the current funding model and whether the sessional basis of the current model is the most suitable. In some cases, the auspice organisation had embraced the “incentive” concept of this program and could clearly recognise the benefits of the MHNIP over and above the financial commitment required of the organisation. State health services involved in delivering the MHNIP were making a significant financial contribution although concerns were expressed about their capacity to continue doing this over the long term, particularly if payments are not clearly indexed. It is interesting to note that none of the services included in this case study had chosen to introduce a co-payment.

At present, no limit has been set to the potential expansion of the program, although there has been limited uptake to date, in part it would seem due to the availability of credentialed nurses. This has resulted in an uneven distribution of the program, even within locations where the program operates.

The available evidence from all sources gathered in these case studies suggests that the program is currently reaching a much broader audience than that described in the program guidelines. Nevertheless, it is having a significant impact and is reaching many people in need of an ongoing mental health service.

Earlier intervention, shorter admissions and better follow-up in the community were also reported as outcomes for the program. GP knowledge about medications and medication reviews has improved, as has their confidence in working with people with mental health issues, and scarce psychiatry resources are better targeted.

Results from the client survey indicate 80% of people who responded to the survey reported improvement in their mental health. Almost half of the sample reported improvements in their social relationships, while a third said that they now have more friends. Better physical health outcomes were also reported as a result of the nurse being able to focus on these in addition to, mental health issues.

These case studies show some clear examples of the benefits of the co-ordination role of the nurse, both within the implementation of the mental health treatment plan, and more broadly to link in to a range of other community supports. Examples were seen of service models where the mental health

nurse is incorporated into an “in-house” interdisciplinary model, while in other places community service networking was used to provide the range of supports needed for clients.

Some locations however, reported a significant lack of resources in their community. It was not possible in this project to determine what impact the quantity of community resources available and the way that the nurse(s) is linked into these networks has on outcomes for clients. This may be a useful area for investigation during the evaluation.

Quality systems did not appear to be a major feature of most MHNIP services visited. Some had developed protocols and MOUs around how the service would roll out, particularly around lines of accountability, although local practice guidelines are not evident.

Data collection is an issue both observed and raised by stakeholders at all locations. Various difficulties in collecting and collating data were discussed. However, the most striking observation was the limited use of outcome data to measure treatment outcomes for individuals, and the lack of any analysis of this data to improve the program as a whole.

Project Aims

Australia's Mental Health

Slade et al (2009, p.15) estimate that within their lifetime, nearly half of all Australians will experience a mental health disorder and 20% will have a mental health disorder in any given year. Younger people are more likely to experience a mental health disorder. Australian women are more likely than men to have a mental health disorder and to seek help. The most common disorders in Australia are anxiety disorders (14.4%), affective disorders (6.2%), and substance use disorders (5.1%).

The World Health Organisation has identified that depression is likely to be the most prevalent health issue world wide by 2020. The prevalence of suicidal ideation, suicide attempts and death from suicide is a major concern. The *Living Is For Everyone (LIFE) Framework (2007)* reports that suicide deaths now represent 1.3 % of all Australian deaths. Females are more likely to attempt suicide, whilst attempts by males are more likely to result in death, with men representing 77% of all suicide deaths in 2007.

Begg et al (2007, p.59) noted that mental health disorders were responsible 13.3% of the total burden of disease and injury in Australia and almost half of the non-fatal burden of disease. Co-morbidity of mental health disorders and substance use disorders is common, and often associated with poorer treatment outcomes, a more severe illness course, and higher service utilisation. Physical health is also significantly poorer for people experiencing mental illness, resulting in reduced life expectancy.

Coghlan et al (2001, p.4) in a Western Australian study found that 'the overall death rate of people with mental illness was 2.5 times higher than the general population of WA'. This study found higher prevalence of heart disease, respiratory disorders, infectious diseases such as hepatitis C and HIV, injuries, deficiency anaemia and a much poorer prognosis once cancer was diagnosed. Data on 'hospitalisation rates' also suggested that people with mental illness do not receive the same level of medical treatment in hospital. Suicide was also a significant contributor to 'excess deaths' in people experiencing mental health issues, with the greatest period of risk occurring in the first two weeks after discharge from inpatient care. Poorer living arrangements can be one of the impacts associated with mental illness whilst a lack of secure accommodation can in turn contribute to poor mental health.

There are many social factors associated with poor mental health, including poverty, family breakdown, exposure to trauma or violence, substance misuse, social isolation, a family history of mental health disorders, and risk taking attitudes and behaviours.(Slade 2009) In contrast, factors associated with building resilience include social connectedness, having a sense of hope, being engaged in meaningful activities or employment, feeling safe, and having some sense of control in one's life. Economic and personal security, and having the skills to manage life events and stresses can be protective and assist in maintaining good mental health. These protective factors have become the focus of many Australian mental health promotion and prevention programs.

Notwithstanding these prevalence rates, it has been estimated that only 30% of people with a mental health disorder use mental health services (Bennett-Levy and Perry 2009). The rate is likely to be even less in rural areas, where access to mental health services can be difficult. The social and economic costs of mental health disorders (such as depression and anxiety) are increasingly being recognised by governments and the community at large.

A robust mental health system for all Australians requires timely access to a range of public, private and non-government services, delivered through flexible service delivery models that take account of the particular circumstances within each community. New technologies (such as, telepsychiatry and Internet-based services) have proved to be useful strategies in reaching a scattered population and broad based programs such as *beyondblue* have been able to reduce stigma associated with depression.

Policy context

The *National Action Plan on Mental Health 2006 – 2011* was endorsed by the Council of Australian Governments (COAG) and accompanied by an Australian Government commitment of \$1.9 billion over five years. The aim of the plan is to:

improve mental health and facilitate recovery from illness through a greater focus on promotion, prevention and early intervention; improved access to mental health services, including in Indigenous and rural communities; more stable accommodation and support; and meaningful participation in recreational, social, employment and other activities in the community. Improving the care system will involve a focus on better coordinated care and building workforce capacity (p.i).

The National Action Plan articulates a number of measures to enhance mental health services for people with mental health disorders and their family/carers. There are also a series of outcome and performance measures to monitor the implementation and progress of the plan. Some of the programs providing funds directly to primary health care providers include the following:

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access to Mental Health Care)

The *Better Access to Mental Health Care* program aims to increase timely access to mental health treatment and increase professional teamwork. It is based on a Mental Health Plan that is formulated by a General Practitioner and includes a referral to a psychiatrist, psychologist, and appropriately trained social workers and occupational therapists for Medicare subsidised treatment. The number of individual and group sessions that may be claimed through Medicare in a calendar year is capped.

Mental Health Services Rural and Remote Access (MHSRRA) program

The *Mental Health Services Rural and Remote Access* program complements the *Better Access to Mental Health Care* program. The program uses a flexible service model and funds organisations to provide allied health and nursing mental health services in rural and remote areas. The majority of organisations funded under this program are Divisions of General Practice, although other service types such as the Royal Flying Doctor Service of Australia and Aboriginal Medical Services have been included.

Access to Allied Psychological Services (ATAPS)

ATAPS enables GPs to refer clients to allied health professionals who deliver focussed psychological strategies. Through ATAPS, patients are eligible for a maximum of 12 sessions per calendar. Sessions can be individual and/or group therapy sessions, and provides patients with assistance for short-term intervention. If further sessions are required it may mean that the patient needs a longer term program to meet his/her needs. Divisions of general practice act as fundholders in this component of the Better Outcomes in Mental Health Care program.

In addition, the *Personal Helpers and Mentors Program (PHaMS)*, delivered through non-government organisations, aims to increase opportunities for recovery for people who have functional limitations resulting from a severe mental illness. The program uses mentors to help overcome social isolation and increase community connections. A range of programs providing respite and other supports for carers have also been funded under the plan.

Other complementary programs improving access to mental health services include the More Allied Health Services (MAHS) program and Medical Specialist Outreach Assistance Program (MSOAP). The Mental Health Nurse Incentive Program sits within this context of a raft of primary health and community programs, that complement state funded acute and community mental health services.

National Advisory Council on Mental Health

The National Advisory Council on Mental Health (NACMH) was established in 2008 with the objective of providing timely, expert, balanced and confidential advice to the Australian Government on mental health issues and respond to requests from the Minister for Health and Ageing. The NACMH therefore provides a formal mechanism for the Australian Government to gain independent advice from a group of appointed experts to inform national mental health reform.

As part of their role, NACMH has the capacity to commission targeted research on mental health policy and service delivery issues, with a view to providing informed advice to the Minister. The NACMH 2008/9 to 2010/11 workplan identifies priority projects to be undertaken, including the “Case Study of the Mental Health Nurse Incentive Program” project. This project falls within the Innovative Service Models priority area, and is intended to feed into the planned evaluation of the program to be undertaken by the Department of Health and Ageing.

Mental Health Nurse Incentive Program

The Mental Health Nurse Incentive Program (MHNIP) is part of the Australian Government's component of the National Action Plan on Mental Health 2006 – 2011. Funding of \$191.6 million was allocated over five years, commencing July 2007. The funding allows general practices, private psychiatrists and other appropriate community providers (including general practice networks and private hospitals) to engage or retain mental health nurses to assist in the provision of coordinated clinical care for people, in the community, with severe mental health disorders. The MHNIP is intended to help community based patients with a severe mental illness get the right services at the right time, assisting to prevent unnecessary hospital admissions/readmissions.

Client outcomes expected from this collaborative approach to providing clinical support and services in the community are:

- improved levels of care for people with severe mental health disorders
- a reduction in hospital admissions and readmissions for people with severe mental health disorders
- assistance for people with severe mental health disorders to stay well, and connect with their community.

Responsibility for the MHNIP rests with the Australian Government Department of Health and Ageing, while funding for the program is administered through Medicare. MHNIP Guidelines outline how payments are made on a half-day, sessional basis and allow credentialed mental health nurses to work closely with the patient's psychiatrist or GP to facilitate the provision of coordinated clinical care and treatment for people with severe mental health disorders. A 25% loading applies to organisations operating in outer regional, remote and very remote areas, and one-off establishment grants are available.

Services provided by the nurse may include:

- establishing a therapeutic relationship
- medication management
- support for family and carers
- providing information on physical health care
- improving links to other health professionals and community support programs.

These services can be provided in a range of settings such as in clinics or at a patient's home.

Support provided under this program targets people with severe mental health disorders during periods of significant disability. A general practitioner or psychiatrist determines eligibility for the service on the basis of the following criteria:

- The patient must have a diagnosed severe mental health disorder, and
- the disorder must cause significant disablement to social, personal and occupational functioning, and
- the patient has had at least one episode of hospitalisation for their mental health disorder, or be at risk of future admissions, and
- requires continuing treatment over the next two years, and
- the general practitioner or psychiatrist is principally responsible for the patient's clinical mental health care, and
- the patient consents to treatment by the mental health nurse.

A Mental Health Treatment Plan must be prepared in collaboration with the mental health nurse, outlining the roles and responsibilities of both the treating doctor and the mental health nurse. The plan must be reviewed regularly by the GP or psychiatrist with input, where appropriate, from a clinical psychologist or other allied health professional. The Health of the Nation Outcome Scale (HoNOS) is to be completed at regular intervals.

Case study project

The “Case Study of the Mental Health Nurse Incentive Program” project aimed to provide a case study report on a number of examples of the MHNIP across a range of settings. The case studies highlight the development, implementation and some early outcomes for the MHNIP, with a focus on innovative settings. The project includes a sample of settings that demonstrate four of the five types of eligible organisations; a range of geographical locations (different states, and urban to regional and rural settings); and the different size programs in operation.

As well as providing a description of the implementation of the MHNIP at each location, this final report describes available information on clients’ experience of care, their perception of the program more broadly, and some indication of mental health outcomes achieved.

The report extends to a discussion of some of the themes that have emerged from within and across the seven localities. These in turn can inform the program evaluation planned by the Department of Health and Ageing. In addition, the report details opportunities identified during the process that suggests ways to:

- enhance the MHNIP
- enhance the capacity of Registered Organisations
- ensure sustainability of the MHNIP.

Methodology

Areas of interest

A number of areas of interest regarding the way that the MHNIP has been implemented in each locality were explored using an approach based primarily on qualitative methods of inquiry. The questions investigated included the following:

- What was the perceived need that motivated the introduction of the MHNIP?
- How has the role been interpreted and/or implemented in differing localities? What factors influenced this?
- What is the model of implementation?
- What have been the establishment challenges? What strategies have assisted with overcoming or minimising these?
- What relationships have been built and how?
- What successes has the program achieved? What has contributed to these?
- What are the ongoing challenges and what might assist with overcoming these?
- What are the opportunities for enhancement?

Sample selection

As of February 2010, preliminary Medicare data¹ reports a significant number of organisations have registered with the MHNIP since the inception of the program in July 2007. This group of organisations includes Divisions of General Practice, private hospitals, general practices, psychiatry practices, and Aboriginal primary health care services. A small number of new organisations signed up in February 2010, indicating a continuing interest in delivering this service. A total of 7,036 sessions were delivered in February 2010, with 120,651 sessions delivered since inception. This represents a total of 40,556 people receiving a service through the MHNIP, since inception. Approximately 40% of clients were males.

Prior to the commencement of the case study project, organisations registered to provide services under the MHNIP, were asked to indicate if they were willing to participate in the project. From the list of eighteen organisations that volunteered, a sample of seven organisations was chosen in consultation with the NACMH members. Details of the selected organisations are shown in *Table 1*. Selection was based on achieving a sample that included varying size of organisation, different auspice agencies and a range of geographic settings.

The size of the MHNIP service included in the final sample range from very small (one nurse supporting one practice) to large (seven nurses supporting 29 practices). Services were drawn from five states, ranging from major city locations (Geelong, Ipswich), through inner regional centres (Bathurst, Longford, Ballarat and Mackay) to an outer regional town (Clare). No services located in a remote setting offered to participate in the study.

The sample included four organisation types, along with examples of both direct employment of nurses and shared employment arrangements. There are three examples of shared employment arrangements, two are between a Division of General Practice and the local state mental health service (Geelong and Ipswich), while the third is an arrangement between a private agency, that employs mental health nurses, and an Aboriginal Cooperative that delivers primary health care services (Ballarat).

Initially, two other organisations were included in the sample. Unfortunately, the nurse from one service resigned the week prior to the first contact. This service did not anticipate being able to replace the nurse within a short time period and they withdrew from the study. This withdrawal

¹ Data provided by Medicare in April 2010.

reduced the number of states represented from six to five, and resulted in no example used of a MHNIP implemented in a private hospital. Contact with another service revealed some anomalies within the registration process which made them unsuitable for the case study.

Table 1: Sample of registered organisations participating in case study project

Service	State	Geographic location	Organisation type	Employment model	Size		Practices supported
					No of nurses	FTE	
Longford Medical Services	Tasmania	RA 2 – Inner Regional	General practice	Direct employment	1	0.8	1
Clare Medical Centre	South Australia	RA 3 – Outer Regional	General practice	Direct employment	2	1.6	1
Bathurst	New South Wales	RA 2 – Inner Regional	Private psychiatrist	Direct employment	1	1.0	6
General Practice Association of Geelong *	Victoria	RA 1 – Major City	Division of GPs	Shared employment	7	6.8	29
Ipswich West Moreton DGP	Queensland	RA 1 – Major City	Division of GPs	Shared employment	4	1.4	6
Mackay DGP	Queensland	RA 2 – Inner Regional	Division of GPs	Direct employment	6	6	9
Ballarat & District Aboriginal Corporation	Victoria	RA 2 – Inner Regional	Aboriginal Primary Health Care	Shared employment	2	1.2	1

* Includes limited information on an additional MHNIP program run by GPAG, *headspace* Barwon

Data collection

The methodology utilised up to four separate data collection processes across the seven sites:

1. An initial service survey
2. Stakeholder consultation in each of the seven localities
3. Client survey
4. Snapshot data collection.

In addition, information about the MHNIP was also sought from a range of national stakeholders such as:

- Australian College of Mental Health Nurses
- Australian General Practice Network
- headspace – National Youth Mental Health Foundation.

General Practice Victoria provided feedback from a forum that they had conducted. NACMH suggested some individual health professionals (for example psychiatrists from Darwin and the Kimberley) who might be able to contribute to the case studies.

A Case Study Template was developed to guide the investigation of each locality. This template was intended to capture the major features of the program in some depth while maintaining consistency across the different locations. This approach has also been used in reporting each of the case studies. *Table 2* provides a summary of the areas investigated.

Table 2: Case Study template

Domains	Areas to investigate
Commencement	Perceived need, establishment, time operational
Auspice body	Type of organisation, Governance arrangements
Location of program	Region covered, population demographics
Workforce	Employment model, Size of program, Capacity
Service Model	Role of nurse(s); where they provide services, management, clinical support
	Implementation, evolution of program
Partnerships	Care Coordination Strategies
Clients and carers	Access; Demographics, involvement in treatment plans, Diagnosis/es, outcomes
Service provision	Service Activity levels; Outcomes; Impact on demand
Quality mechanisms	Clients; GPs, Psychiatrists
Program themes	Strengths
	Opportunities, Issues
	Areas for improvements

Initial service survey

Baseline data from each service was collected using an electronic survey. This survey was designed to capture the key background information about the service prior to a site visit. This allowed the consultants to be well informed and prepared service providers for the type of information to be investigated in more depth at site visits and interviews. Services were also asked to provide copies of any background documentation such as demographic data, policies and procedures, and outcome data analysis. A copy of the service survey is at Appendix A.

Site visits

Site visits were arranged for each of the participating services. Depending on the size of the organisation, one or two consultants visited the service and met with relevant stakeholders over half to one and a half days. Informal interviews were held with managers, nurses, participating doctors (GPs and psychiatrists), mental health service staff (where shared employment relationships occurred), and some clients. Other stakeholders such as community based mental health services and Divisions of General Practice were also interviewed where possible. For those not available on the day, follow up telephone interviews were utilised.

The case study template was used to guide the interviews.

Client survey

An assessment of the experience of clients was to be a key feature of the case study project, along with outcome measurement. It was expected that this information would be held by each service and could be incorporated into the case study without additional data collection. However, the initial service survey identified that not all services had collected and/or collated client data such as, general client satisfaction or outcome data including the HoNOS.

A client survey was designed and provided to each service with reply paid envelopes. Nurses were asked to distribute the survey to all clients seen in the past month. An on-line version of the survey was made available. The survey asked clients for some demographic information as well as aspects of their experience of the MHNIP including:

- **information** about gender, age, Aboriginality and language spoken
- information about their **referral**, including how they found out about the service, how long they waited to see the nurse, length of service, and what helped them decide to use the service
- **service provision**, including where they see the nurse, who with, treatment planning and type of service
- **service coordination** and referrals to other supports
- personal **outcomes**, including what changes have occurred for them as a result of seeing the nurse, and whether they would recommend the service to others.

The client survey is at Appendix B.

In total, five out of seven services distributed the survey to clients seen in the previous month. The Ipswich and Geelong auspice bodies did not distribute the survey tool.

At the time of the site visit Ipswich was completing a formal evaluation of their MHNIP. This evaluation included a client survey. The agency decided that an additional survey could be a burden to clients. However, anecdotal information on clients' perceptions was provided by the Ipswich evaluators and is detailed in the Ipswich case study.

At Geelong, the partnership determined that the survey should be subjected to an ethics approval process before distribution. The timelines for the ethics process and this project did not align, hence the survey was not distributed to their clients.

Snapshot data collection

Once the initial service surveys were returned and a number of site visits were conducted, it became apparent that there was very little quantitative data available about the program. Information was not readily available about aspects of the program, such as:

- the target group for each area
- service use per client
- outcomes that were being achieved.

While each service collects HoNOS data on clients at the required intervals (entry to the service, at 90 days, each subsequent 90 days and at discharge), services have not been provided with an electronic data collection tool nor have they developed their own systems to keep this data electronically. Therefore, services were unable to generate reports which might be used to improve the service. In Ipswich HoNOS data has been incorporated into the evaluation currently underway, but was not available for this case study project. Further discussion about the limitations of available data can be found in the following section.

In most cases, nurses' record information about interventions in case notes, at the client's practice. Claim forms detailing the number of sessions provided and the client's Medicare number are compiled by the registered organisation.

During the site visits, services estimated the demographics of the client group including, their main diagnosis and the average length of interventions.

In order to gather some comparable data about clients receiving MHNIP services, services were asked to complete a snapshot data collection over a one week period. A tool was designed that allowed each nurse to complete some brief information about every client serviced within a one week period. This data included:

- how many clients were treated or contacted by the mental health nurse
- each client's age and gender
- whether they were seen face to face or contacted by telephone
- how long they had initially waited for a service
- primary diagnosis
- whether there were concurrent substance abuse issues.

Additional information was also requested about the last ten clients discharged from the service. For each of these clients, nurses were asked to report:

- total number of sessions
- referrals to other community services.

The data collection tool, along with response category options for each item, is at Appendix C.

Case study summaries

Longford Medical Service

Longford is a town in northern Tasmania, twenty kilometres south of Launceston. It is rated by the Australian Standard Geographic Classification (ASGC) as 'Inner Regional', with a predominantly white Anglo-Saxon population of approximately 3,000 people. The surrounding area is largely agricultural.

The Longford Medical Service employs eleven GPs and services a population of almost 10,000 from the surrounding area, from two premises. The MHNIP commenced in early 2009 with one credentialed mental health nurse employed directly by the practice for eight sessions per week. The nurse provides services via face-to-face interviews, telephone consultations and home visits. Stakeholders report that demand for the service is high, and Longford Medical Service have considered recruiting a second nurse.

Reported outcomes include a reduction of demand on GP time, a reduction in hospital admission for the client group, and reduced demand for community mental health case management services. Stakeholders generally expressed strong support for the program, with the practice willing to explore other ways to continue the service should the funding for the MHNIP cease.

Clare Medical Centre

Clare Medical Centre (CMC) is situated in rural South Australia, two hours drive north of Adelaide. The township and surrounding farms and vineyards has a population of approximately 8,350 people, and are classified as by ASGC as 'Outer regional'.

CMC is the direct employer of two nurses (1.6 FTE) under the MHNIP, providing support to ten GPs and a visiting psychiatrist. The program builds on a previous study aimed at improving coordination and effectiveness in mental health treatment. CMC also employs or hosts a range of allied health practitioners, providing a strong base for integrated patient care.

The role of the nurses is primarily to provide coordination of care, although therapeutic interventions, education and support around medication, and group programs are also part of the service. Professional support for the nurses is highly valued, with peer supervision, regular multi-disciplinary case discussions and five days professional development per annum included in employment conditions.

Contributing factors to the success of the program include commitment and enthusiasm of practice staff, the range of 'in-house' services available, and effective streaming of clients through various mental health practitioners. Program outcomes include more efficient use of psychiatry hours, improved relationships with community mental health, improved treatment and continuity of care for in-patients, fewer transfers of mental health patients to Adelaide, and better networking between community-based services. An unintended outcome has been increased patient flows to the practice from other communities.

Bathurst Mental Health Nurse

Bathurst is the oldest settlement west of the dividing range in New South Wales and is three hours drive from Sydney. Bathurst is a regional centre with a population of approximately 38,000 people, although it also services a considerably wider rural area, and is classified by ASGC as 'Inner Regional'.

Mental health services are limited and involuntary patients must be transferred to Orange, about an hour's drive away. The MHNIP is small with one nurse employed directly by a private psychiatrist. The nurse works from the psychiatrist's rooms and regularly receives referrals from six general practitioners.

The role of the nurse includes education for clients, family and general practitioners; anxiety management strategies; ongoing client support and linking with other support services. The nurse works under the direction of the client's GP, and within a supportive mental health network. There is

a significant focus on supervision and ongoing professional development for the nurse, subsidised by the psychiatry practice.

Prior to the MHNIP, the nurse worked for the psychiatrist, in a private capacity, on a fee for service basis. Moving to a free service has resulted in a changed client demographic, with many more people with a personality disorder now using the service. Some clients have been able to effect major life changes as a result of working with the nurse, including significant reductions in in-patient care. Effective professional networking and strong relationships with GPs are key factors in the success of this program.

General Practice Association of Geelong

Geelong has a population of approximately 200,000, and is Victoria's second largest city, is classified by ASGC as 'Major City' and is one hour's drive from Melbourne. MHNIP services from Geelong also support the Surfcoast.

There are two separate MHNIPs that are delivered through the General Practice Association of Geelong (GPAG). The larger program is the result of a partnership between GPAG and Barwon Health, and is designed to build effective working relationships between mental health services and GPs, provide an earlier intervention and better access to mental health services, and prioritise acute services. This program uses a shared employment arrangement to place seven (6.8 FTE) mental health nurses from Barwon Health across 29 practices, and provide support to more than 100 GPs. Barwon Health makes a significant financial contribution to the arrangement, providing a clinical coordinator, underwriting employment costs of the nurses and providing ongoing supervision for the nurses. GPAG is the registered organisation, responsible for lodging claims for payment and managing referrals and relationships with practices. The nurses' role is in part determined by their personal interests and clinical strengths, and always involves assessment and working in partnership with the GP.

Outcomes for the program include a strong partnership between GPAG and Barwon Health; better access to primary mental health services, particularly for people from disadvantaged localities; and some suggestion of a reduction in referrals to the mental health team.

GPAG also directly employ one mental health nurse who works from *headspace* Barwon, a multidisciplinary care centre for young people with a range of issues including mental health disorders. This service uses an integrated model of care involving GPs, psychiatrists, psychologists, youth workers, AOD workers, sexual assault and generalist counsellors. The nursing role is broad; it includes, working closely with school welfare officers and targets young people with a range of severe mental health disorders. Many young people seen through this service are aged under sixteen. The flexibility of the MHNIP suits this service model, although the time required to work with young people can impact on payments.

Ipswich West Moreton Division of General Practice.

Ipswich is a large regional city with a population of approximately 200,000 people, is classified by ASGC as 'Major City' and is situated one hour's drive south west of Brisbane. Predominantly an industrial centre in the past, Ipswich is growing quickly and attracting new industry and investment. There are more children and young people, more Aboriginal people and more jobless families with young children leading to a low socio-economic profile.

The Clinical Director of Mental Health Services is a strong advocate for achieving better outcomes for people with mental illness through high quality care in the primary health sector. A pilot program was conducted, prior to the MHNIP, which provided support for GPs to increase their knowledge about mental illness and confidence to treat people in the community. The current MHNIP model has four part-time nurses employed by Ipswich Mental Health, but contracted to the MHNIP. Ipswich West Moreton Division of General Practice (IWMDGP) is the auspice for the program, and works in close partnership with GPs and the mental health service. An evaluation of the program has recently been completed, the report is due soon.

Feedback from stakeholders was very positive. Outcomes include a culture of collaborative practice between mental health services and GPs; more appropriate referrals for acute care; better access to psychiatry in the community; and more mental health clients being safely managed in the community.

Recruitment of additional staff, sustainability of the program and the financial contribution of Queensland Health were identified as issues to be addressed.

Mackay Division of General Practice

Mackay is a large regional city on the Queensland coast with a population of approximately 85,000; it is classified by ASGC as 'Outer Regional'. The major industry is coal mining, and full-time employment rates are significantly higher than the Australian average.

The MHNIP is run by the Mackay Division of General Practice (MDGP) in a direct employment model. MDGP also provide a psychology service and other allied health services to the community. There are six full-time nurses employed through the program, with one based at Airlie Beach. A Health Service Manager and the team leader provide line management.

Nurses work from both medical clinics and separate therapeutic rooms due to space restrictions in some practices. The role of the nurses is to coordinate care, engage other supports for clients and family members provide education and support around medication, and deliver therapeutic interventions. There is flexibility within the model to allow nurses to develop their interests and utilise their particular skill set.

Mental health services through Queensland Health are considered under-resourced and there has been no public psychiatrist in the region for some time. The MHNIP in Mackay has no access to a psychiatry service, however the program has uncovered significant needs. Outcomes include better support for people with mental health issues and for the GPs working with them.

Ballarat and District Aboriginal Corporation

Ballarat is the second largest regional city in Victoria and is situated one hour's drive west of Melbourne. It is classified by ASGC as 'Inner Regional' and has a population of approximately 110,000 people in the city and surrounding area. Indigenous people make up approximately one percent of the population, many of whom are originally from other regions.

Ballarat and District Aboriginal Corporation (BADAC) provide a wide range of primary health and community programs for the local Aboriginal population. For the MHNIP, BADAC has entered into a partnership agreement with Australian Mental Health Services (AMHS), a private company. Nursing staff are employed by AMHS, which also provides their clinical supervision and professional development. BADAC contributes office space, computers, transport, mobile phone and all on-site expenses. There are two mental health nurses at BADAC; one is employed full time in a clinical role, the second nurse delivers a range of organisational development activities in addition to two days clinical work under the MHNIP.

This model has provided a culturally acceptable mental health service for the Aboriginal people of Ballarat. Positive outcomes include the community acceptance of the service; its ability to link people to other supports both in-house and into acute care when needed; better mental health outcomes for service users, including lower rates of hospitalisation; and the broader organisational development that has occurred within BADAC.

Findings

Client survey

A total of 57 people returned a client survey from the five services who agreed to distribute them. Of these, only one person chose the on-line option, with the remainder completing the written survey. A breakdown of responses by service is at *Table 3*, and shows a marked gender bias with 44 (77%) female respondents. This is not reflective of the people using the MHNIP overall, as can be seen from individual service data, and from the Medicare data. Of the respondents, four people self identified as Indigenous, and of these one was male. All people responding to the survey identified English as their first language.

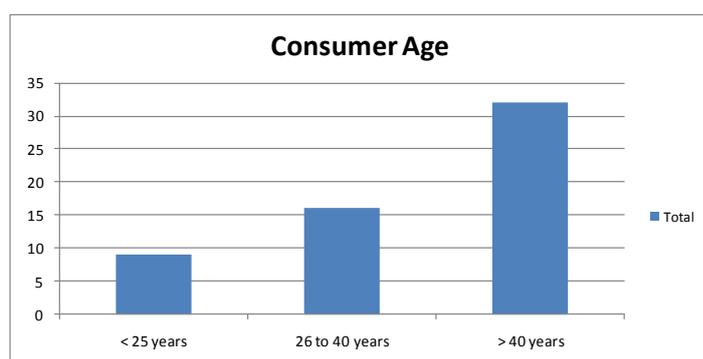
This survey cannot be considered a representative sample of clients using the MHNIP. However, the results do give some indication about the experiences of people who used the service.

Table 3: Client survey response

Service	Number returned	Gender		Indigenous status
		Male	Female	
Longford Medical Services	9	1	8	0
Clare Medical Centre	13	2	11	0
Mackay DGP	23	9	14	2
Ballarat & District Aboriginal Corporation	1	0	1	1
Bathurst	11	1	10	1
TOTAL	57	13	44	4

Figure 1 identifies that over half (32) of the people who responded to the survey were aged over 40, and a further third (16) were aged between 26 and 40 years. Only nine people responding to the survey were aged less than 25 years.

Figure 1: Client age - survey



Most people (79%) first heard about the MHNIP through their GP, while the remainder heard about the program through a friend or family member. Most people (61%) waited between one and four weeks to see the nurse, and only 12% had to wait more than a month for an appointment.

It was hypothesised that the convenience and lack of stigma associated with a service located in a medical practice would be a significant factor in whether people would be willing to see a mental health nurse. Clients were asked to nominate which factors helped them decide to use the program. They could choose more than one option. *Table 4* details that for this sample of service users, the location was a factor for almost half (46%), giving only limited support to the notion that location is a

significant feature of service usage. The most common response to this item was the doctor's referral (80%) helped with the decision to engage with a mental health nurse, while 54% cited their willingness to make personal changes.

Table 4: Factors effecting service usage

What helped you decide to see the nurse for your mental health issues?	Number	Percentage
Doctor's referral	46	80%
Family/friend	11	19%
Convenient location	26	46%
No service available before	11	19%
I wanted to make personal changes in my life	31	54%
Other	5	8%

Of this client sample, fifty-four clients (95%) consulted with the nurse on their own, while three were accompanied by a family member. A further six clients indicated that they sometimes see the nurse with a family member or carer. The majority of people (66%) consult the nurse at their own doctor's clinic, 17% have received a home visit, and ten people, from this sample, consult the nurse at another doctor's clinic. In total, 47 clients (82%) reported that they have a treatment plan, two people indicated they did not have a plan and another eight were not sure. A total of fifty-three people (93%) indicated that they are involved in making decisions about their treatment.

Clients were asked to provide information about the type of support they were receiving from their mental health nurse. These options were based on the type of support that might be provided to people who meet the criteria for the MHNIP, that is, people with a severe mental health disorder who are significantly disabled by their disorder, and who are at risk of hospitalisation. Respondents were able to nominate as many options as applicable. Table 5 identifies that approximately four out of five people responding to the survey received psycho-education, three-quarters received assistance with recognising early warning signs and a total of 88% reported receiving assistance with dealing with everyday life issues. More than two thirds received education about their medication and more than half received support to take their medication regularly. More than half the sample also has assistance with their personal relationships and received help with other health issues.

"... just thank you for being there. (Without the nurse) I might not be alive now."

Table 5: Type of support received

Please tell us about the support you receive	Number	Percentage
The nurse has helped me to:		
➤ Understand my illness	46	80%
➤ Recognise my early warning signs	42	74%
➤ Understand my medication	37	65%
➤ Take my medication regularly	31	54%
➤ Deal with everyday life issues better	50	88%
➤ Improve my relationships	35	61%
➤ Manage other health issues	32	56%
➤ Other	7	12%

Of those who nominated other types of support, one person was given help with finding other support services such as respite care and home help; one received assistance with budgeting; and one person with a disability received help with day to day "things". The remaining four people did not specify what other assistance they received.

While other evidence presented later in the report may suggest that the MHNIP is not always targeted to those at risk of hospitalisation, these responses suggest that the type of services provided under the MHNIP to this group are appropriate for the program target group.

Respondents were asked to indicate how long they had been receiving service from the nurse; 20% indicated less than three months, 32% indicated between 3 and 6 months. Of the remainder 14% had been seeing the nurse between 6 and 12 months, while 32% had been seeing the nurse for more than 12 months. Since these results only relate to this particular sample, no conclusions about average length of service provision can be drawn from this data. However, it is clear that for some people at least, this service is meeting their need for a long-term service without restrictions on the number of sessions. The snapshot data collection discussed below attempted to collect further data in relation to average length of service.

Another key feature of the MHNIP is the provision of service coordination for clients to access a range of health services and other community based services to reduce social isolation and increase community connectedness. The survey therefore, enquired about other services that people may have been referred to as part of their interaction with the nurse. People were asked to indicate any service(s) they had been referred to by the nurse. *Table 6* identifies that only a small number people from this sample had been referred to another service. Those referrals that were made were predominantly to drug and alcohol services and social/activity groups.

In total, 11 people reported being referred to at least one additional service including; housing service (7); employment or education (6); Social activity group (11); Personal Helpers and Mentors (5); A Drug and Alcohol service (9); Psychologist (1) and Commonwealth Rehabilitation Service (1). Podiatry, dental services, psychiatry and a mindfulness group were also listed by at least one person.

Table 6: Referrals

Have you been referred to other services?	Number of respondents
Housing program	7
Employment or education	6
Social/activity group	11
Personal helpers and mentors	5
Drug/alcohol service	9
Community mental health service	6
Other	7

An attempt was made to gauge client outcomes as a result of receiving a mental health nursing service through the MHNIP. The survey asked people to respond to a series of statements using a five point Likert Scale ranging from “Strongly Agree” through to “Strongly Disagree”. The results

Mary’s story

Mary (not her real name) is a 42 year old married woman with two children aged 18 and seven years. Mary is described as an excellent mother, has a supportive husband, and is committed to her treatment. Mary has a diagnosis of Borderline Personality Disorder with depressive features, Anxiety Disorder and Fibromyalgia. Mary has a long history of suicide attempts and frequent hospital admissions. At times in the past she would access her GP and the clinic nurse almost daily and required injections of pain medication three or four times per week. Mary has made a number of serious suicide attempts over the years. Mary’s high levels of distress and serious suicidality resulted in psychiatric admissions on average for one in every four weeks. On occasion, Mary would be monitored in A&E overnight rather than admitted.

Mary’s mental health issues are complicated by her physical health condition. The medication given to relieve the pain of her Fibromyalgia also has a depressive effect, exacerbating her mental health issues. Her suicide attempts have resulted in some liver damage. Mary had received various community-based mental health services in the past but they were not able to provide the intensity and continuity required. For a period of five years, Mary had also suffered from agoraphobia and was unable to leave the house alone. During this period, her husband took time off work to take her to appointments.

In the two years since she has been receiving a service from MHNIP, Mary has only been hospitalised twice and her use of intramuscular pain medication has been reduced to once every ten to twelve days. Mary continues to see her GP for short reviews on a weekly basis and only receives three days medication at a time in a Dose Administration Aid. Mary continues to have regular sessions with the nurse and her husband has received some support.

Mary gave permission for her story to be used because she wants funding for the MHNIP to continue.

obtained for these items are detailed in *Table 7*, and provide a very positive picture of the impact this service has had on the lives of clients. Of the respondents, approximately four out of five people indicated that their mental health is much better now and they feel more in control of their lives; three-quarters said that their life has improved; and two thirds said they are now more motivated. Almost half of the sample reported improvements in their relationships, while a third said that they now have more friends. Only two people were non-committal about their satisfaction with the service and a further two people did not answer this question. However, fifty-three people (93%) indicated that they are satisfied with the service, with more than half of the sample answering “strongly agree”. Since people who respond to the survey are still clients of the service it is likely that even more positive responses might result if a sample of discharged clients was surveyed.

Table 7: Client outcomes

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No response
My mental health is much better now	20	25	9	2		1
My life has improved	21	22	10	3	1	
I have more hope for the future	20	25	10	2		
I feel more in control of my life	14	34	6	3		
I am more motivated to do things	11	27	16	1	1	1
My close relationships have improved	9	19	22	5	1	1
I have more friends	7	13	27	8	1	1
I am satisfied with the service	31	22	2			2

Overall, people who responded to this survey were satisfied with the service they received. More than 80% of the sample reported that the service was provided in a way that meets their needs and another ten percent said that the service sometimes meets their needs. All but one person (98%) said they would recommend the service to others. People responding to the survey were given an opportunity to comment on what had been most helpful, and least helpful about the service, as well as any general comments they might have. The sample of comments below illustrates how positive people were about the service:

Client comments
➤ <i>I would no doubt have been admitted to hospital again if I did not seek help. This would have put more pressure and anxiety on me. Very happy with my nurse. She understands me.</i>
➤ <i>... has been helping to keep me alive during a long period of being in crisis. He is always a positive in my negative life. Same person every time: a positive plan: worked with me, not telling me what to do: regular times in an unthreatening environment: my GP was able to be involved at all times.</i>
➤ <i>Having spent a lot of time doing community mental health stuff - shoved around from person to person this has been so much better and safer for me.</i>
➤ <i>No cost involved and able to see the nurse once a week continuously for over a year without any problems</i>
➤ <i>Mental health nurses do an amazing job and have helped my entire family.</i>
➤ <i>I need this service. I wish it could be weekly. I'd have more time when feeling better.</i>
➤ <i>He L.I.S.T.E.N.S 2 Me!!!</i>
➤ <i>From my personal point of view I think it is great. If anyone was thinking of expanding this service I think it would help a lot of people like myself.</i>

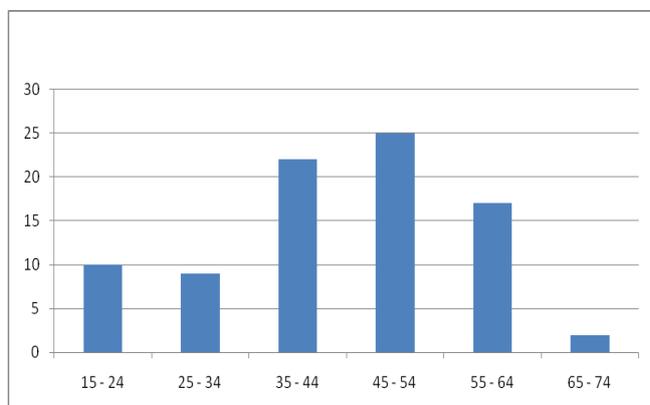
Snapshot data collection

Since there was little comparable data about services available, it was decided to conduct a snapshot data collection across a one week period to capture simple data regarding all clients during that week. Both Clare and Geelong MHNIPs were able to produce some client data and chose not to participate in the snapshot collection. The remaining five services did collect data although for Ipswich, data was received from only two of the four nurses employed to deliver MHNIP services.

Data was received in relation to 85 clients across the five services. Of these, 63 (74%) were women, and 22 (26%) were men. This sample therefore is somewhat different from the overall numbers seen in the program since inception, as supplied by Medicare (April 2010). According to their data, the gender distribution is closer to 60% women, and 40% men.

The oldest people included in this sample were 70 years and the youngest was 15 years, showing the broad age range of people accessing the service. However, as depicted in *Figure 2*, a total of 64 (75%) of these people accessing the service were aged between 35 and 64 years. A further 19 were aged 34 years and under, while only two were over 65 years.

Figure 2: Client age – snapshot data



Of this group, 29 (34%) had been hospitalised in the past for mental health issues, indicating that at least this number of clients met that particular eligibility criterion.

The co-occurrence of drug and alcohol issues with mental health issues is well recognised. This knowledge has not always impacted on practice in the mental health field, where screening for AOD issues is often not standard practice. In this sample, only 25% were recognised as having a concurrent AOD issue, which is considerably lower than might be expected.

During interviews with service providers, both managers and nurses, had indicated that the service is mainly being accessed by people with mood disorders, followed by those with anxiety and to a lesser extent by those with a personality disorder or a psychotic disorder. The data from this sample is shown in *Figure 3*, and show that over 50% of the sample is classified as having a mood disorder, with approximately 20% presenting with an anxiety disorder. Given that these two disorders are

Bob's story

Bob is a 26 year old single man diagnosed with Post Traumatic Stress Disorder. Bob started on antidepressant medication several weeks before seeing a MHNIP nurses. Bob had previously attended the local mental health service but no follow up occurred. Bob had recently been involved in an argument with his neighbours, as a result he was charged with threatening with a weapon. As a consequence, his employment was at risk.

Bob was referred by the GP with escalating anxiety symptoms and insomnia. Bob was quite guarded and difficult to engage, and assessment revealed he was experiencing psychotic symptoms including voices and paranoid thoughts. Bob has a past history of drug use, but not in the past two years. Bob had intermittently engaged with various mental health services throughout the state, but found his mistrust of people was unbearable to the point that he would move on, and not follow treatment.

An urgent assessment with the mental health team psychiatrist for a review of diagnosis and treatment was arranged by the nurse, who then attended the appointment with Bob. Daily contact was maintained with Bob, either face to face or via telephone to monitor his response to the medication. The nurse liaised with his family for support, education and awareness and supported Bob in arranging two weeks sick leave.

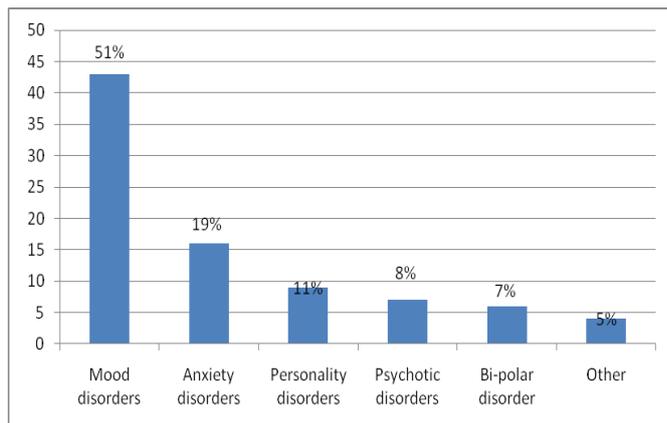
The nurse also advocated strongly for the mental health service to look beyond his drug use history. Subsequently Bob's diagnosis was changed to paranoid schizophrenia and anti-psychotic medication was commenced.

The nurse prepared reports for court; Bob's illness and his willingness to receive treatment were recognised and he was placed on probation with no mental health orders. He continues to receive treatment and has maintained his employment.

considered to be “high” prevalence disorders, it would be expected that the greatest number of clients would present with these conditions.

The incidence of bi-polar disorder and other psychotic disorders in the general population is estimated at approximately 3%. At least 15% of people in this sample were diagnosed with one of these disorders. There is no way of knowing from this data what proportion of people in the other categories experienced significant impairment with their mental illness.

Figure 3: Primary diagnosis



Sue’s story

Sue is 59 years old, and lives with her husband and independent son. Sue was referred to the nurse for previously untreated anxiety which she had experienced since early adulthood. Sue presented with a range of anxiety symptoms including feeling frequently stressed and overwhelmed, racing thoughts, impaired concentration, sleep disturbance, muscle aches, fear and social isolation.

Sue did not want to take medication and attended weekly counselling sessions with her emotional wellbeing nurse instead. These sessions have focused on psycho- education, identifying triggers for worrying, learning strategies to help manage anxiety, problem analysis/solving strategies and development of her adaptive coping and self management skills. During these sessions Sue identified that she has difficulties expressing her emotions and needs. Sue and her husband now attend the nurse fortnightly to help Sue develop assertive communication skills.

Sue’s anxiety symptoms are now minimal, with her initial HONOS score of L0 increased to 4. Sue has achieved her short-term goals of improved management of everyday tasks, and increased coping skills. Sue can now attend social functions and complete tasks such as supermarket shopping. Sue reports that her anxiety is no longer a burden for her, and her next goal is to travel interstate with her husband mid-year.

Emerging themes

This section presents some of the key themes emerging from the seven case studies. The sample of organisations was chosen to illustrate the flexibility and variation in the type of service model and local arrangements that could be used to take advantage of this program. Despite the variability in setting, previous arrangements, service context and employment options, there was still considerable commonality across all the sites.

The most overwhelming feedback about the MHNIP, in all its variations, was the high level of acceptance and support for the program. This support was received from all stakeholders, regardless of the particular service model employed in that location. The feedback included:

- General practitioners feeling better supported in their work with people with mental illness, and their knowledge and confidence has improved.
- Psychiatrists appreciate the support the nurses provide, including allowing the psychiatrists more capacity to better target their services.
- Nurses have their expertise recognised, are able to work reasonably autonomously, have more career options, and can see positive outcomes as a result of their work.
- Community agencies can see the value for their clients who in many cases are now better able to access assistance with mental health issues.

Many of the themes emerging from the case studies are tightly inter-connected. For example, the type of employment model chosen, and the broader service model that evolved was influenced by what was already in place prior to the MHNIP, the unique circumstances of the particular location, and the personal interests of key players. This in turn impacted on the way the funding was used, and the interpretation of the guidelines. The discussion that follows will attempt to separate the major themes into discrete groupings.

Funding

Program funding has been based around a fixed payment per half day session, where the nurse sees at least two clients with a severe mental health disorder per session. Program guidelines state that this payment is “*intended to be applied to mental health nurse salary and on-costs, including personal and recreation leave*”.

In practice, services raised a number of difficulties around this funding formula. These include the following:

- There is no allowance in the funding for other associated costs such as supervision and professional development, computers, and reimbursement for travel costs.
- The loss of income from the room has been a deterrent for a number of general practices and the cost of extending premises to accommodate the nurse is prohibitive
- It can be difficult to structure liaison time with other professionals and agencies within the session format.
- Where there is a shared employment arrangement with a state mental health service, nurses continue to work under conditions that allow them to accrue time each day, with a day off per month. This is difficult to reconcile with a formula that pays on a sessional basis.
- In other places where there is direct employment arrangement, similar difficulties exist in relation to unavoidable extra time accrued and time off in lieu arrangements.
- Where the registered organisation is a Division of General Practice, administration time needs to be deducted from the payments.
- In those places where a number of nurses are employed, there has been a tendency to create a team leader position to provide line management and clinical support. (Geelong and Mackay)

- In a number of sites, the MHNIP is seen as specialist work and nurses are remunerated above base level.
- In some regional and rural locations, travel time can be considerable, meaning that it may be difficult to provide a service to two people within a session.
- A rural loading of 25% is available for remote locations. However a number of people commented that this may not be adequate to allow the model to work effectively in very remote areas.

Services have used a number of strategies to address their particular issues with the funding model. The most common strategy is for the employing organisation to absorb the additional costs, and for the participating general practices to provide the nurse's room free of charge. Supervision and administration costs are covered in a variety of ways.

In the case of Ipswich, the Division takes an overheads fee from the Medicare payments to cover their administration costs and program management, while the Ipswich Mental Health Service (IMHS) covers the shortfall in nursing costs. IMHS has also sourced additional funding for a psychiatric registrar who provides supervision to the nurses and a rotating service through GP practices. IMHS has committed considerable funds to enable the program to operate. The perceived uncertainty about how long the program will continue has resulted in unwillingness to commit further to the program until this is clarified, despite an established demand for expansion. Similarly in Geelong, expansion of the program is not planned until the funding is secure.

The smaller services at Bathurst and Longford where a single nurse is employed by the practice can see the value in providing the service and absorb additional costs such as professional development through the practice. Some general practitioners are happy to forego the rental on the room in exchange for a greater throughput in their own practice when there is less demand for long, complex consultations.

In Clare, the location assists with costs, since they are able to claim the rural loading. Nurses are allocated an additional week of personal leave per annum for professional development. Their effective internal organisational systems and focus on case conferencing also allows them to claim additional funds under the case conferencing Medicare item to bring in additional revenue.

While most of the nurses are engaged in case conferencing with GPs on a regular basis, few of these are claimed. BADAC for example covers all non-salary costs associated with the program from other resources but have not been in the habit of claiming the frequent case conferencing that occurs with GPs. This strategy can be used where the nurse is directly employed by the practice to offset other costs, or can be used by the GP to offset the lack of rental income. However, where the nurse is employed by a Division of General Practice, any case conference costs are claimed by the participating practice, and not the Division.

Feedback received during the consultations suggests that program size is likely to be a limiting factor to the MHNIP. If the program is too small, costs associated with the program cannot be recouped through other avenues or offset by increased GP throughput. The exception to this is the psychiatrist employing one nurse. This model appears to work since the nurse supports clients from a number of GP practices.

There were a number of examples where the auspice organisation had embraced the "incentive" concept of this program and could clearly recognise the benefits of the MHNIP over and above the financial commitment required of the organisation. State health services however expressed concerns about their capacity to continue subsidising the program in the long term, particularly if payments are not clearly indexed.

It is interesting to note that none of the services included in this case study had chosen to introduce a co-payment. Some however were considering a co-payment, but were concerned that the copayment would deter some clients from the program.

The program guidelines state that where 'shared employment arrangements' are utilised that the participating private organisation cannot claim the MHNIP establishment payment. This requirement may have been a disincentive for the expansion of the program in the future.

Interpretation of the program guidelines

Interpretation of the program guidelines has varied between sites and this appears to be influenced by a number of factors, including what was already in place, the unique circumstances of that location, and the personal interest of key players. The most significant variation in interpretation observed was in relation to client eligibility. The guidelines clearly identify this program as targeted towards those with severe mental illness, who suffer significant impairment in daily life, and who have been, or are at risk of, hospitalisation without intervention.

All available evidence, including stakeholder feedback and snapshot data collections, suggests that a proportion of people using the service meet most of these criteria, although not all service users appear to be at risk of hospitalisation. Given the small sample of organisations in this project, this may be an area for further investigation during the evaluation to establish the exact nature of the current target group.

It must also be noted however that a number of people participating in this program appear to be experiencing serious impairment in their lives, even if they are not at immediate risk of hospitalisation, and may be receiving an effective service for the first time. Again, it might also be useful during the evaluation to investigate whether the service model may be appropriate for a broader range of clients than originally anticipated.

The ability to use telephone calls as a legitimate client contact has been well utilised in a number of locations. For example, the snapshot data from Mackay suggests that a significant proportion of work is done via phone calls. This may reflect some of their issues regarding available clinic space, geographical barriers, transport, etc. In other places, phone calls or short consultations are used along side two long consultations to make the best use of each session. Telephone calls may also be used where there are transport difficulties or where a clinic's policy prohibits home visits.

Across the seven organisations there was limited use of group programs as a service delivery option. One service identified group programs as an effective service delivery method but they were unsure about how to claim appropriately.

MHNIP guidelines require eligible organisations to develop formal protocols for managing a number of clinical issues such as eligibility, mental health care plans, the use of relevant clinical guidelines, qualifications of staff, clear role descriptions and lines of accountability, and the safety of staff in all service provision settings. All services indicated that they have established protocols, or designated existing protocols that are used to cover various aspects of the program. This included using policies and protocols from the employing organisation, and formal agreements between various parties such as participating GPs.

There were instances where stakeholders consider these policies to be an impediment to effective service. For example, in Ipswich, the nurses are employed by the area health service and are unable to conduct home visits as they cannot meet policy requirements around safety (the requirement to have two staff members) and transport (use of a fleet vehicle).

The College of Mental Health Nurses perspective is that the funding guidelines should be such that anyone with a mental health concern, regardless of severity, can be referred by a GP to a MHNIP nurse. It was also suggested by the College that the nurse should be able to provide whatever support is required, including focused psychological strategies.

Service models

Each service model is the result of a unique interpretation of the program guidelines to fit the particular circumstances existing at the location prior to the introduction of the MHNIP. In some instances, a similar program was already operating and the MHNIP was seen as an opportunity to expand the existing program to a wider group of clients, or to access ongoing funding for a time limited pilot project.

For example, the Ipswich model was already operating in a similar way with time limited funding, whereas in Bathurst, fee payment had previously been a barrier for many potential clients. In Geelong, Barwon Health and the General Practice Association of Geelong had been delivering Clozapine clinics through general practices for many years prior to the MHNIP. Their partnership was used to expand their collaboration to support a wider client group.

The interests of key players were also a contributing factor to the model developed. For example, key players from the Clare Medical Centre had a keen interest in multi-disciplinary approaches to health care, and the practice had attracted a range of allied and other health practitioners to work from their premises. In this case, a project aimed at improving coordination of responses for mental health issues preceded the MHNIP.

The enthusiasm of participating GPs and psychiatrists for improving mental health services was a common theme, as was flexibility and creative use of resources.

The employment model used was a key variable across the sites. A direct employment model by a single GP practice or private psychiatrist is used in three sites; Longford, Clare and Bathurst. The first two are privately owned general medical practices and the third is a private psychiatrist. The MHNIP appeared to work well under these arrangements in these situations, although two of these reported that the practice makes a financial contribution to meet all costs associated with the program. The third site receives an additional rural loading, and utilises claims for case coordination meetings, in a systematic way to meet additional costs.

A direct employment model is also used by two Divisions of General Practice. One of these is in Mackay, where mental health services through Queensland Health are considered under-resourced and there has been no psychiatrist for some time. Approaches made to Queensland Health to explore the possibility of a shared employment model have not proceeded. The second example of a nurse directly employed by a Division of General Practice exists in the *headspace* program in Geelong. This is a specific arrangement to suit the particular needs of the *headspace* consortium.

A shared employment model between the local Division of GPs and an area health service has been utilised in two models covered by the case study project. The first of these is in Geelong where seven nurses continue to be employed by Barwon Health, under the same conditions as their peers, while being deployed to work from general medical practices alongside other partner initiatives such as Clozapine clinics. This model has the advantage of maintaining a constant workforce, and ensures nurses are well supported and retain their entitlements. Disadvantages are primarily financial and were discussed in the previous section.

The second example of shared employment between a Division of GPs and an area health service is in Ipswich, where there are strong professional relationships between key personnel in both organisations.

An additional example, of shared employment is utilised in the Aboriginal medical service in Ballarat. Here the nurses are employed through a private nursing company. This model has worked well for the Aboriginal medical service, since all the clinical and professional responsibility including supervision and ongoing professional development, is the responsibility of the employing agency. The medical service has no issue with providing a number of resources to support the program, and feel that they have benefited in many other ways.

The role of the nurse also varies considerably across sites. While all nurses offer a range of services that fit under the general categories described in the MHNIP guidelines, the emphasis on particular aspects of the role is influenced by:

- the key aims of the program in that location
- the availability of other allied health practitioners and psycho-social support programs
- the particular skills and interests of the nurse.

For example, feedback from Longford suggested that they did not believe the program suited to the needs of people with a borderline personality disorder. In contrast, the nurse from Bathurst is very comfortable working with this group and over time that service has attracted more people with a personality disorder.

In services where a number of nurses are employed under the program, there appears to be some room for individual nurses to develop specific aspects of the role that particularly interest them. For example, the Mackay service has one nurse providing mostly outreach services in order to engage and link clients to a variety of supports, whilst another nurse is primarily clinic based, providing services such as medication support to patients, advice to the GP, and therapeutic and nursing interventions.

In Geelong, while all nurses provide mental health assessments and work closely with individual GPs, two nurses provide therapeutic interventions such as family and couples therapy; another takes on

prevention/early intervention activities; and a fourth nurse provides a linkage and practical support role, as well as therapeutic support. In addition, one nurse provides primarily a pharmacotherapy role, with this service committed to clients with substance use issues.

The Mackay service also has nurses working in different ways depending on their skills and experience, and the clinic they support.

All nurses however, have a coordination role and assist GPs with assessment and developing mental health treatment plans, including medication regimes. Nurses identified a number of theoretical frameworks used in their practice, but acknowledged that they are now referring more often to psychologists to help manage service demand.

Some services clearly differentiated the nursing role from that of the local psychologists, identifying that the nurse has a greater knowledge of medication and risk assessment. The nurse's ability to see people for an indefinite number of sessions also determines their greater suitability to support clients with high support needs. Clients may be referred on to a psychologist for a specific intervention once other issues are sufficiently resolved.

The extent to which GPs are involved in treatment appears to vary more in respect to the interest level of the GP rather than the service model. Some GPs are heavily involved in treatment and will attend part of the nurse session. Others see the nurse as a mental health expert and are happy to have more time to spend on other patients. All models utilise the practice case notes to record nursing interventions to ensure practice is integrated and the GPs are informed about progress. This practice has implications for data collection as discussed elsewhere.

The MHNIP has been designed with private practice in mind, either general medical practices or psychiatry practices. However, small practices may not have enough clients to support even a part-time nurse on a consistent basis. For these practices, joining forces with other similar practices and using the Division of General Practice as the auspice organisation may be a better option. Whilst this option addresses the issue of size, the funding model may still be considered marginal by some Divisions of General Practice, depending on the level of administration time that is required.

Larger practices that employ a number of GPs, such as Longford and Clare, appeared to be able to sustain their programs with in-house referrals and both practices.

At present there is also no limit to the potential expansion of the program, although there has been limited uptake to date. This has resulted in an uneven distribution of the program even within locations where the program operates. Within the context of which service models best suit particular situations, the future evaluators may consider a focus on the broader applicability of the program to remote areas, and other areas where there is limited access to general practice as an entrée to the service.

The variety of service models seen in these seven settings shows that the MHNIP can be adapted to a range of situations and used to address different local scenarios.

Work force

Recruitment of suitable nurses was raised in every location. Many talked about the role of the nurse under this program being quite different from that within a mental health team, and that a different skill set is required. These skills mostly relate to the ability to work autonomously, to be able to take responsibility for assessments and decision, to be able to work collaboratively with doctors and other health professionals, and to be comfortable working in an independent and potentially uncertain environment. The College of Mental Health Nurses indicated that there is some difficulty with determining the actual number of mental health nurses amongst the pool of nurses that are currently working because their nursing registration does not indicate this.

Shared employment arrangements allow nurses to work in the role for a time to gauge their suitability with no penalty if they choose not to continue. Feedback suggests that nurses know within weeks if the role suits them. In some instances, the MHNIP role is recognised as a more complex role and is remunerated accordingly.

While most services have had difficulties recruiting suitable nurses for the MHNIP role, there are also shortages of mental health nurses within state/territory mental health services. Particularly in rural areas, the two workplaces are seen to be in direct competition with each other for the available pool of nurses. Area health services have the advantage of being able to offer people job security and

alternative career paths. The shared employment arrangement, while bringing some additional costs, allows nurses to retain their job security and entitlements while venturing out into a non-traditional role in the community.

A similar solution has been reached at Longford for example, where the nurse continues to work one day per week for the area health service to preserve her position and retain her entitlements. Perceptions that funding for the MHNIP is not secure have fuelled these concerns and in some cases prevented the expansion of the program.

Credentialing was raised as a major workforce issue, particularly since January this year. Many people described the credentialing process as onerous, and a serious impediment to the recruitment of more nurses.

Maintaining credentials under current funding arrangements can be difficult since some organisations report experiencing difficulties finding the resources to pay for supervision and ongoing training.

Some nurses talked about contacts made with other MHNIP sites and networking, particularly through the annual conference. As a result, parity of employment conditions across sites and models was raised as a potential issue impacting on recruitment.

Supervision of nurses was raised as a critical ingredient for good practice in a number of locations, and a variety of supervision models are in use. Supervision is provided by psychiatrists, a psychiatric registrar, psychologists and mental health nurses in both individual and group settings. The variety of models in use is illustrated in the following:

- Barwon Health has created a team leader position to support the nurses working in the MHNIP.
- Australian Mental Health Services provide supervision internally to all nurses working through their organisation, and have recently employed a psychiatrist whose role will include supervision.
- Ipswich Mental Health service created a psychiatric registrar position, and use this person to provide supervision and case review for the nurses, a rotating psychiatric clinic in participating general medical practices, and an educative role for the GPs.
- The nurse in Longford accesses private supervision from a local psychologist.
- The nurse from Bathurst has weekly supervision with her psychiatrist employer, and monthly supervision with another psychiatrist.

Access to psychiatry was an issue in some locations, with little or no direct access to a psychiatrist. For example, nurses in Mackay felt some pressure associated with being seen by GPs as the experts in mental health, while not having any access to secondary psychiatric consultation. In other services the psychiatrist is an integral part of the service model, providing both a direct client consultation service and supervision for the nurses and GPs.

Data collection

As previously noted, nurses record their interventions with clients in the electronic practice notes of the organisation where they deliver the service. This allows the GP to see when the client has been seen and what has been achieved. In Bathurst, a similar practice is followed, although case notes are recorded in the psychiatrist's client file and three monthly detailed reports are sent to the treating GP.

The nurse also keeps a paper record of which clients have been seen which is used to compile claims for Medicare.

While these practices have been developed to address particular facets of the MHNIP record keeping and information collection, there are some inadequacies that arise. Using the doctor's client record allows the nurse and GP to work closely together with a client, even if there are minimal opportunities for face-to-face contact between the doctor and nurse.

However, where there are a number of nurses employed through a third party, there is no ability to centrally collate data on clients for the program as a whole. Where this issue has been investigated, it appears that there is significant variability in electronic capacity between general practices.

HoNOS data is collected at required intervals but is not routinely entered into a database or interrogated for service improvement purposes. HoNOS is commonly used as an outcome measure for clients with mental health issues. When used as a regular review tool, it gives an indication of the impact of treatment on the current mental health status and functioning of the client.

At a service level, this data can be aggregated to give a measure of both accurate targeting of the service and efficacy of the intervention(s) provided. Registered organisations reported that they were given no direction about how this information could be stored electronically, or how it might be used as a service improvement tool. Consequently this data is being collected routinely but not being used effectively at the organisational level.

A number of stakeholders suggested that a standard database would be useful, while one service was prompted to look at some outcome data as a result of questions asked by the consultants. Relevant HoNOS data has been used in the evaluation currently underway in Ipswich but was not available for the case study project.

Mental Health Outcomes

As indicated in the previous section, there was little collated quantitative data relating to mental health outcomes for clients using the program. There were anecdotal reports from a number of services that the MHNIP had reduced the number of in-patient episodes for individual clients. However, there was no data available from mental health services that indicated a decrease in admissions. This is not surprising given that many of these programs were quite small and would be unlikely to have a noticeable impact on number of admissions.

A more appropriate way of measuring the impact of the MHNIP on hospital admissions might be to track the progress of a sample of clients to identify any significant changes in service usage.

As discussed earlier, there was some suggestion that there may be some “drift” away from the intended target group to include people who may not meet all the criteria for a service, particularly relating to risk of hospitalisation. Nevertheless, many more people are now receiving a service for their mental health issues, and clients feedback via the survey would suggest that many of them had serious functional impairment, and were in need of a long term service.

‘(the nurse) has been helping to keep me alive during a long period of being in crisis.’

Earlier intervention, shorter admissions and better follow-up in the community were also reported as outcomes for the program. GP knowledge about medication and medication reviews was also noted to have improved, as had GPs’ confidence in working with people with mental health issues.

Results from the client survey indicate that almost eighty percent of people who responded to the survey reported improvement in their mental health, and three quarters said their life has improved. Almost half of the sample reported improvements in their relationships, while a third said that they now have more friends.

Other health outcomes

Feedback from a number of sites, and through the consumer survey, reported a better focus on clients overall physical health in addition to their mental health needs. Nurses have the time and continuing relationship to allow a focus on the whole person. This might mean reminding the client to ask for their general health check, suggesting other possible contributing factors to the mental health presentation, and in some cases reminding the GP through case notes.

‘Weight, sugar testing, blood pressure are always good. (it is) very good looking after yourself much better. Thank you.’

Consequences/Impact

A number of other outcomes resulting from the implementation of the MHNIP were reported. A significant outcome for some GPs is their capacity to achieve greater throughput in their practice when they no longer need to spend extended consulting time with clients

‘This service is essential and valuable. Whilst we [LMS] would definitely not like the funding to cease, if necessary, we would find the means to self-fund the service.’

with mental health disorders. This was particularly true for GPs who were not confident in this area of practice. Significant reduction on GP time has occurred in trying to get a distressed client admitted to hospital.

In some cases, GPs value the nursing service to the extent that they would find a way to provide a similar service even without funding.

Two of the services visited (Bathurst, Clare) reported that they have also been able to better target psychiatry time as a result of the MHNIP. The psychiatrist is now used exclusively as a consultant to conduct assessments, recommend treatment plans and review client progress, as well as providing supervision and participating in case reviews.

The service in Ipswich now has access to a psychiatric registrar who fills a similar role and has significantly increased access to psychiatry services in the community through clinics held in medical practices. The reciprocal benefit is the training and experience the registrar receives around the experience of GPs and how best to support them in their work.

An additional consequence of the MHNIP is the potential impact that hosting a MHNIP nurse may have on neighbouring practices. In Clare, for example, the practice manager has noticed that people are coming from much further afield to attend the practice, with the express purpose of accessing the mental health services offered. Conversely, in Geelong, there has been a concerted effort not to refer people through the discharge planning process from acute care to practices where the nurse visits in an effort to minimise client movement to particular practices.

Access/Barriers

There was wide belief that the MHNIP had significantly improved access to appropriate mental health services. In Ballarat, the Aboriginal population is now receiving a culturally safe and accessible service. The Bathurst service is supporting people with personality disorders; a group who have traditionally had enormous difficulty accessing appropriate support. In Mackay, the MHNIP is delivering an alternative to the resource poor state mental health service. A number of consumers reported getting a service for the first time. The lack of a co-payment was also seen as very positive, and co-location with the medical practice, in most instances, makes the service very accessible.

There was little mention of potential barriers that might exclude people from the service. However, many people with limited incomes find it difficult to even access a GP due limited bulk-billing arrangements. Additionally, only a proportion of GP practices have signed up to the program, and a small number have now withdrawn. Despite the wide acceptance of the program where it was observed operating, the program is not yet universally available.

A barrier identified related more to local protocols. In some locations, home visits were not offered since the program was unable to meet the conditions outlined in health service policy under which the nurses work. For some clients, particularly for those with transport or mobility issues, or conditions such as social phobia, home visits may be the most appropriate method of service delivery. Work is continuing to address this issue at those sites where health service policy prohibits home visiting.

Partnerships

In line with current mental health evidence and policy, the MHNIP emphasises service coordination and social connectedness for clients as key activities. Interviews at each site were held with a range of stakeholders, including other service partners, to determine the extent to which the nurses were linked into other community supports and referred clients on.

These case studies show some clear examples of the benefits of the co-ordination role of the nurse, both within the implementation of the mental health treatment plan, and more broadly to link in to a range of other community supports. A mental health service that is based on a recovery model must utilise the full range of community services that support people to move forward in their lives after experiencing an episode of mental illness. There must also be the capacity to move people through the service in order to continue to meet demand.

Good examples were seen of service models where the mental health nurse is incorporated into an “in-house” interdisciplinary model. In other places community service networking was used to provide the range of supports needed for clients.

At two of the MHNIP sites studied an “in-house” integrated care model was in use, to respond to the broader needs of their client group. For example, the Clare Medical Centre offers mental health nursing within the context of co-located visiting psychiatry (adult and child/adolescent) service, psychologists, drug and alcohol counselling, speech pathology, podiatry, dietetics, diabetes clinic and of course, general practitioners. This allows a continuum of care to be achieved through regular case conferencing, and integrated practice models.

The Ballarat and District Aboriginal Corporation (BADAC) offers the local Aboriginal population a range of targeted community based services, including child care, maternal and child health, housing, and employment support, in addition to the medical service.

These models appear to be particularly useful for more geographically isolated communities such as Clare, where services are limited/part-time, and coordination can present major problems unless services are co-located. Also for specifically targeted populations, such as those serviced by BADAC, clients are reluctant to access services at other ‘mainstream’ locations.

There are some excellent examples in this sample of area health services partnering with their local Division of GPs to improve coordination, jointly deliver programs, and build strong partnerships to enhance client outcomes. The program in Ipswich for example is particularly focussed on the interface between mental health services and general practice, and the program in Geelong has built on the success of the pre-existing Clozapine clinics. In these instances however, there is limited evidence of the use of other community services, although in Ipswich representatives from the community sector reported a strong sense of collaboration between agencies.

Partnerships are critical in all aspects of this program, and particularly so between the nurses and the GPs they work with. In many cases nurses are seen as the experts, with GPs learning about mental health treatment, including new medications, side effects, and alternative regimes from the nurse, and gaining confidence in their ability to work effectively in mental health. Some GPs were reported to use the nurse to debrief at times about difficult clients and particularly appreciate the nurses’ ability to navigate the “maze” of the acute care system.

Critical factors in the development of these nurse/doctor partnerships are the nurse’s ability to work within the “culture” of the medical practice; their accessibility; their knowledge; and their linkages to other services. Also required, is a process of ongoing orientation of new doctors to the MHNIP.

Sustainability

Throughout the site visits, there was a perception of uncertainty about the length of time the program would run for. This uncertainty has had an impact on workforce issues such as recruitment and credentialing, with some nurses reluctant to commit to the program as a permanent career choice. Some have chosen not to continue in the program, while others have retained their employment in the local mental health service as a backup. In other places, funding uncertainty has resulted in a reluctance to expand the program or permanently back-fill nurses seconded to the MHNIP until funding is secure.

The recent announcement by the Council of Australian Government, for additional funding for the MHNIP may address this issue.

A further \$13 million has been committed over two years to employ an additional 136 mental health nurses and provide an estimated 11,700 extra services. The Mental Health Nurse Incentive Program is demand-driven and the places will be available nationally.¹

Areas for further investigation

As stated in the previous section, this is a program that has proved to be enormously popular with key stakeholders whom we received feedback from in each of the seven case study localities. The model has also been sufficiently flexible to be taken up by a number of different types of providers including partnerships between area health services and divisions of general practice.

However there are aspects of the initiative that would bear further investigation through a program evaluation process. These aspects relate to the intention of the program funding, the funding model, quality mechanisms and challenges for growth of the program into the future.

Service models and target group

- How does the MHNIP program fit in the current continuum of care that is available in most localities? Are there areas of duplication and/or are there opportunities for ensuring greater integration of the various commonwealth and state/territory mental health service types?
- Are there service models that are more effective in meeting different client needs and/or are there key components that should be incorporated by all models?
 - What elements should be included in a MHNIP nurse's role?
- Which disorders are currently being responded to through the MHNIP, and to what extent?
- Does the population currently being serviced match the intended target group?
- Is there benefit in broadening the MHNIP target group? If so, what would be the new selection criteria and what potential benefits would be yielded?
- How applicable is the MHNIP to places where there is significant socio-economic disadvantage, including remote Australia?

Funding models

- What is a sustainable funding model for the MHNIP?
- What auspice arrangements are likely to be sustainable into the future?
- What are the financial implications of broadening the target group?

Quality mechanisms

- What is the most appropriate data to be collected?
- What action needs to be taken to ensure that data collection and analysis does occur and informs ongoing service provision?
- What quality mechanisms might be used by MHNIP services to ensure that the perspectives of clients inform the development of high quality service provision?

Future expansion

- Are there aspects about the current program funding that will inhibit wide uptake of the program across a diversity of settings?
- Is the current method of credentialing the most appropriate way to ensure that nurses have the skills to adequately fill this role?
- What action needs to be taken now to address the workforce shortages that will restrict the capacity to grow the program to match demand?

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Mental Health Nurse Incentive Program (MHNIP)

NACMH Case study project

Preliminary survey

The National Advisory Council for Mental Health (NACMH) has engaged Australian Healthcare Associates (AHA) to develop a report comprised of seven case studies that describe the implementation of the Mental Health Nurse Incentive Program (MHNIP) in different contexts across Australia. The report will discuss themes that have emerged from within and across the seven localities. This will in turn inform the program evaluation, to be conducted in the near future.

Each service model used to implement MHNIP is likely to be different, reflecting the particular needs of the local community. Similarities and differences, along with implementation issues, successes and challenges will be explored across each site. Areas for discussion include:

- How has the program been implemented in each locality? What factors influenced this?
- What service model has been developed?
- What challenges were encountered during the establishment stage? What strategies have assisted with overcoming or minimising these?
- What relationships have been built and how?
- What successes has the program achieved? What has contributed to these?
- What are the ongoing challenges and what might assist with overcoming these?
- Are there any opportunities for enhancement?

Your organisation has been selected as one of seven to participate in this case study project. Your insights into the implementation of the MHNIP in your organisation will provide the NACMH with valuable information to inform their advice to the Minister for Health and Ageing.

As the initial step in this project, AHA is requesting that you complete the attached survey. Information gathered through this preliminary survey will provide a valuable information base for site interviews. This should assist with keeping the time required for face-to-face interviews to a minimum.

The survey should take approximately 20 minutes to complete. Please save a copy and complete electronically before returning via email. Please attach any relevant documents (such as population data, position descriptions, program guidelines, consumer feedback) to your return email.

If you require assistance, please contact Rossi Lyons or Peter Orchard at Australian Healthcare Associates on 1300 336 062.

Please complete your survey by **XXXXXXX** and return to:
Rossi.Lyons@ahaconsulting.com.au



Norma Currie
Director
AUSTRALIAN HEALTHCARE ASSOCIATES

MHNIP Preliminary survey

Please provide the following information based on the implementation of the Mental Health Nurse Incentive Program in your organisation. This survey has been designed to be completed electronically.

INSTRUCTIONS FOR COMPLETING THE SURVEY

Save a copy of the document.

Type your responses into the grey boxes, which will expand as you type.

Where a choice is required, point the cursor and left click the mouse on the appropriate box.

If you require assistance at any time, please contact **Peter Orchard** or **Rossi Lyons** at Australian Healthcare Associates on 1300 336 062.

Employer organisation.

Name:

Location

Contact details:

Type of organisation:

Please tick one box only.

- Private Psychiatrist Division of General Practice
 Aboriginal Health Service General Practice
 Other Please give details

Governance arrangements:

Are there any formal partnership arrangements in place for program management?

- Consortium Advisory group
 Other Please give details

Employment arrangements:

Nurses employed through:

- Auspice body Shared employment
 Other Please give details

Service model

What is the address of the main service location?

How many sites does the service operate from?

What is the RRMA Classification of your service?

- Urban Regional (Inner) Regional (Outer) Remote

Estimated population of catchment area:

If available, please attach population summary

Nurses

Number of mental health nurses employed

Number of nurse sessions per week

Total number of clients seen per week

Average nurse case load (per FTE)

Average length of intervention (months)

Average number of sessions per client

Referring doctors

Number of General Practitioners referring to the MHNIP service

Number of Psychiatrists referring to the MHNIP service

Service delivery mode:

How and where is your service usually delivered? (More than one option can be selected)

- Individual sessions
 Individual plus family/carer
 Group sessions
 Doctor's surgery
 Home visit
 Other Please give details

Accountability:

Which organisation/position provides line management for the nurse(s)?

Who provides clinical supervision for the nurse(s)?

How is the MHNIP budget managed?

What outcome data is routinely collected?

How is this data used to inform the program?

Program development and implementation

Who was involved in planning the implementation of the MHNIP program?

- Auspice body*
 Consortium
 Local mental health service
 Mental health network
 Other Please give details

Is there a management or advisory committee to oversee the program?

Yes

No

Have specific policies and procedures been developed for the MHNIP program?

Yes

No

If Yes, please attach copies.

Attachment

Relationships with other services/supports for clients

What other mental health specific services and supports are available for clients in your area?

Check as many boxes as needed

- | | | |
|--|---|---|
| <input type="checkbox"/> Community mental health service | <input type="checkbox"/> In-patient unit | <input type="checkbox"/> Rehabilitation program |
| <input type="checkbox"/> Supported accommodation program | <input type="checkbox"/> Day program | <input type="checkbox"/> Client support group |
| <input type="checkbox"/> Family and carer program | <input type="checkbox"/> Employment program | <input type="checkbox"/> Personal Helpers and mentors |
| <input type="checkbox"/> Other Please give details | | |

Do your clients have access to AOD (alcohol and other drugs) programs?

- | | | |
|--|---|--|
| <input type="checkbox"/> Counselling | <input type="checkbox"/> Peer support group | <input type="checkbox"/> Detox program |
| <input type="checkbox"/> Other Please give details | | |

Is there a local mental health network meeting in your area?

Yes No

If yes, does your agency participate in this network?

Yes No

Have you developed any formal protocols as part of implementing the MHNIP?

- | | |
|--|------------|
| <input type="checkbox"/> Referral protocols | With whom? |
| <input type="checkbox"/> Memorandum of Understanding | With whom? |
| <input type="checkbox"/> Other | With whom? |

Have you developed any formal partnerships as part of implementing the MHNIP?

If so, with whom?

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> MHNIP Advisory Group | <input type="checkbox"/> Mental Health network | <input type="checkbox"/> Other |
|---|--|--------------------------------|

Your clients

How do people find out about your service? Check as many boxes as needed

- | | | |
|--|--|---|
| <input type="checkbox"/> Psychiatrist referral | <input type="checkbox"/> GP referral | <input type="checkbox"/> In-patient unit |
| <input type="checkbox"/> Community mental health | <input type="checkbox"/> Local media | <input type="checkbox"/> Community organisation |
| <input type="checkbox"/> Other clients | <input type="checkbox"/> Self-help group | <input type="checkbox"/> Other |

What client information is routinely collected?

Please attach your client data collection form.

Attachment

Please number the disorder groupings below in the order most frequently managed through your program.

Mood disorders Anxiety disorders Psychotic disorders Personality disorders
 Bi-polar disorder Suicide/self-harm Other

What is the estimated proportion of clients who present with concurrent alcohol and other drug issues? %

Quality measures

Do you provide clients with written information about your services? Yes No

What outcome measures do you use?
 Please attach any collated data Attachment

Do you have any aggregated/de-identified feedback from clients about the service? Yes No

If so, please attach a copy. Attachment

Do you routinely collect feedback from general practitioners and psychiatrists? Yes No

If yes, please attach any tools used and collated data Attachment

Do you routinely collect feedback from other stakeholders? Yes No

If yes, please attach any tools used and collated data Attachment

Additional information

Do you have any additional information that would help us better understand your service?
 Please give details

Key Stakeholders

Please provide contact details for your key stakeholders
 (eg GPs; psychiatrist; community mental health; in-patient unit; rehabilitation service)

Name	Position	Agency	Phone number

Thank you for completing the Survey.

Mental Health Nurse Incentive Program Consumer Survey

The Mental Health Nurse Incentive Program is funded by the Department of Health and Ageing. It aims to improve people's health by making more mental health services available in the community.

We understand that recently you have been seeing a mental health nurse on the advice of your GP or psychiatrist.

- ▶ This survey is being conducted by Australian Healthcare Associates on behalf of the National Advisory Council on Mental Health.
- ▶ The survey asks you about the services you have been receiving from:
XXXXXXXXXX.
- ▶ We would like to hear about your experience with the service and whether it has been helpful.
- ▶ You do not have to complete and return this survey if you do not wish to.
- ▶ Your replies to the survey questions are completely confidential and will not be identified in any reports.
- ▶ No information about you or your responses to the survey will be given to your service provider.
- ▶ Should you have any questions or concerns, please call us on 1300 788 667 for the cost of a local call.
- ▶ Please return your completed survey, **including this page**, in the reply-paid envelope provided - no stamp is required.
- ▶ Alternatively, you can complete the survey on-line by going to www.ahaconsulting.com.au/mhnip_survey.aspx

1. Are you?

Male Female

2. How old are you?

Under 25 years 26 to 40 years over 40 years

3. Do you identify as Aboriginal or Torres Strait Islander?

Yes No

4. Is English your first language?

Yes No

If you answered No, what is your first Language? _____

5. How did you hear about the mental health nurse service?

My GP My psychiatrist Hospital

Friend or family member Other (please give more detail) _____

6. Who referred you to the nurse?

My GP My psychiatrist Hospital

Other (please give more detail) _____

7. How long did you have to wait before seeing the nurse?

Less than 1 week 1 - 4 weeks More than 4 weeks

8. How long have you been seeing the nurse?

Less than 3 months between 3 and 6 months between 6 and 12 months

More than 12 months

9. What helped you decide to see the nurse for your mental health issues?

Please tick as many as needed

Doctor's referral Family / friend

Convenient location No service available before

I wanted to make changes in my life

Other (please give more detail) _____

10. When you see the nurse, are you:

Please tick as many as needed

On your own With a family member /carer In a group

11. Where do you see the nurse?

- At my doctor's clinic At another doctor's clinic At home
 Other (please give more detail)

12. Are you involved in decision making about your treatment?

- Yes No Sometimes

13. Do you have a treatment plan that you, your doctor and your nurse have all agreed to?

- Yes No Don't know

14. Please tell us about the support you receive

Please tick as many as needed

The nurse has helped me to:

- Understand my illness
 Recognise my early warning signs
 Understand my medication
 Take my medication regularly
 Deal with everyday life issues better
 Improve my relationships
 Manage other health issues
 Other (please give more detail)

15. Have you been referred to other services? (please tick as many as needed)

- Housing program Employment or education
 Social/activity group Personal helpers and mentors
 Drug/alcohol service Community mental health service
 Other (please give more detail)
-

16. Is support from the nurse provided in a way that best meets your needs?

- Yes No Sometimes

17. For each of the following statements, please tick which answer applies to you

As a result of the support provided by the mental health nurse.....	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
My mental health is much better now	➤ <input type="checkbox"/>				
My life has improved	➤ <input type="checkbox"/>				
I have more hope for the future	➤ <input type="checkbox"/>				
I feel more in control of my life	➤ <input type="checkbox"/>				
I am more motivated to do things	➤ <input type="checkbox"/>				
My close relationships have improved	➤ <input type="checkbox"/>				
I have more friends	➤ <input type="checkbox"/>				
Overall, I am satisfied with the service	➤ <input type="checkbox"/>				

18. What has been most helpful about seeing the nurse? Please give details.

19. What has been least helpful? Please give details.

20. Would you recommend this service to others?

Yes No Maybe

21. Do you have any other comments or suggestions?

Thank you for taking the time to complete and return this survey

MHNIP - CASE STUDIES: Data Collection

Service Name: _____

Nurse Identifier: _____

Patient contacts in 1 week	Method of contact	1st appoint.	Wait time until 1st appoint. (see comment #1)	DNA for appoint.	Age	Gender	Primary Diagnosis	AOD issues	Previous hospitalis'ns for MH
Patient 1									
Patient 2									
Patient 3									
Patient 4									
Patient 5									
Patient 6									
Patient 7									
Patient 8									
Patient 9									
Patient 10									
Patient 11									
Patient 12									
Patient 13									
Patient 14									
Patient 15									
Patient 16									
Patient 17									
Patient 18									
Patient 19									
Patient 20									
Patient 21									
Patient 22									
Patient 23									
Patient 24									
Patient 26									
Patient 27									
Patient 28									
Patient 29									
Patient 30									

Please Note
 If you are completing this spreadsheet using a computer, there are drop down lists that come up for each column, except for "Age" and "Total no. of sessions" which simply require whole numbers.
 If you are completing a paper version of this sheet, the content of the drop down lists is provided on the attached sheet called Drop Down Lists for Reference.

Comments
Comment #1: Wait time until 1st appoint. - This refers to how long a new patient has waited from the date of referral to their first appointment with a nurse. This is only to be recorded for those clients that are new appointments during the week.
Comment #2: Total no. of sessions - This refers to how many individual sessions in total that a patient had undertaken with a nurse at the time of discharge.
Comment #3: Referred to at least 1 community support - This includes referral of patients/carers to support groups, domestic violence services, men's shed, housing, employment assistance, rehabilitation, respite, psychological services,

Last 10 patients discharged	Total no. of sessions (see comment #2)	Referred to at least 1 community support (See comment #3)
Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		
Patient 6		
Patient 7		
Patient 8		
Patient 9		
Patient 10		