Mental Health Nurse Incentive Program

Achieving through collaboration, creativity and compromise
Foreword

It is now well established, both nationally and internationally, that the delivery of mental health care at the primary health care level must be a priority.

Despite this, the focus of mental health care in Australia has continued to be on acute and hospital care.

The introduction of the Mental Health Nurse Incentive Program (MHNIP) was a unique initiative attempting to redress this situation, particularly benefiting people who experience serious and enduring mental illnesses and disorders. As with all new programs there have been many lessons learnt and there are opportunities to enhance the program. Despite the barriers, an increasing number of mental health nurses are delivering services under the program, in order to provide better mental health care to consumers and in pursuit of an alternative professional career for themselves.

This monograph, Mental Health Nurse Incentive Program: Achieving through collaboration, creativity and compromise, relates the experience of some of these nurses. In the absence of a formal evaluation of the program to date, this document is a grounded and valuable testament to the distinctive contribution mental health nurses make to the delivery of primary mental health care, demonstrated by the very tangible and positive outcomes for the clients they work with. It is clear from the included case studies that because of their specialised skills and experience, mental health nurses are able to fill gaps in service delivery and provide services that are otherwise lacking. In this way, the MHNIP provides distinct benefit to clients, their carers and families, other health care professionals and by association, the mental health of the community.

It is very pleasing to have substantive evidence of the efficacy and accessibility of the services that mental health nurses provide, and that mental health nurses are in the vanguard of collaborative primary mental health service delivery.

The experiences expressed in this monograph are a testament to the fact that the MHNIP initiative, established in 2007 by the Australian Government, has been a resounding success. The ACMHN has been involved in this program from its inception, through the initial implementation providing support and information, and in promoting its benefits to a generation of mental health nurses and other health professionals. As such, the ACMHN is invested in ensuring this innovative model of care continues to be delivered, developed and funded appropriately.

I strongly commend this monograph as one which offers new hope for people who experience mental illness or disorder and one which showcases mental health nursing professional practice at its best.

Peter Santangelo, President
Australian College of Mental Health Nurses
Over recent years we have seen a gradual shift towards funding and providing effective mental health services in the community. This has been sustained in the recent Federal Budget 2011.

When the Mental Health Nurse Incentive Program (MHNIP) was launched in 2007, it appeared to be a promising community-based program which focused on meeting the needs of people who experience severe mental ill-health. Organisations deemed eligible, such as GPs and private psychiatrists, could register with Medicare Australia to become eligible to receive funding to engage the services of a mental health nurse. It was thought that the benefits of the program would be three fold. Consumers of mental health services would get an accessible and flexible service designed to meet their needs and focused on wellbeing and recovery; medical practitioners would get clinical support from a specialist mental health nurse who would be able to spend more time with clients; and other relevant community, health and mental health services and programs would be utilised to support consumers and carers.

Since then, the program has proved to be a watershed for the delivery of coordinated, collaborative primary mental health care. There have been a number of other significant but unforeseen benefits. The program has kept many people out of hospital and helped them back into the workforce or other meaningful social lives – benefiting not only the individual, their family and community, but the public purse; and mental health nurses have been able to practise autonomously – having been provided with the freedom to use and adapt their extensive knowledge, skills and experience according to client’s needs.

In 2009, two years after the implementation of the MHNIP, Medicare Australia reported that 28,599 people had accessed the program and that 136,706 face-to-face services had been provided since inception. A year later in 2010, the number of people who had accessed the program had increased by 86%, with the number of face-to-face services having more than doubled.

The MHNIP has stimulated a new beginning for many of the nurses who have taken up the challenge; they have embraced the collaborative care model, demonstrated a vast capacity for creativity and enjoyed breaking away from more traditional mental health service settings, with many setting up their own private practice. In general, mental health nurses providing services under the MHNIP have compromised personal gains to make the program work. During the first year of the project’s operation, practitioners working under the program identified a need to come together to clarify, discuss and network with each other – this process was supported by the ACMHN and a conference was established and conducted in Canberra. The 2011 4th Annual ACMHN Primary Mental Health Nursing conference will be held in Canberra to a record number of participants.

The ACMHN support of the implementation of the MHNIP has resulted in the organisation being identified as a key resource for nurses and other health professionals. The role of the College in the success of
the program to date has been largely unrecognised, but staff in the national office have answered many hundreds of queries on the structure of the program, contract arrangements, financial and bureaucratic aspects of the program, how to become a Credentialed Mental Health Nurse and how to become an eligible organisation. In addition, we have been invited to speak about the program at conferences, workshops and through various organisational meetings and we have developed a MHNIP Toolkit which describes business plans and other useful information nurses need to consider when implementing the program on an individual level.

Over the past 5 years, while there have been many, many positive stories about the clinical aspects of the program, there have also been many negative stories, particularly about structural mechanisms. Negative stories create risk for the continuation of the program – particularly where they impact on the program’s capacity to attract and retain experienced mental health nurses. The ACMHN has undertaken many activities that have highlighted the success of the MHNIP. It has also highlighted the problems, including feedback gathered from at least two consultations with nurses practising under the MHNIP, and which have been represented to the Government.

This monograph has been published with the aim of providing another resource that demonstrates the success of the MHNIP and to highlight some of the improvements that need to be made. Credentialed Mental Health Nurses delivering services under the MHNIP have contributed case studies of their own experiences and a larger collection of case studies are available via the ACMHN website.

In preparing this monograph, I would like to acknowledge and thank all the mental health nurses who have contributed, staff at the College National Office, Marilyn Gendek for her efforts in sourcing the contributions and tireless support of the MHNIP, John Thrift for his contribution through design and Peta Marks editor extraordinaire.

Kim Ryan, Chief Executive Officer
Australian College of Mental Health Nurses
Adjunct Associate Professor Sydney University
Chair Coalition of National Nursing Organisations

The ACMHN support of the implementation of the MHNIP has resulted in the organisation being identified as a key resource for nurses and other health professionals.
An Overview of the Mental Health Nurse Incentive Program (MHNIP)

The initiative

In 2006 the Australian Government committed to provide funding of $191.6 million over five years towards coordinated care for people who experience ‘severe mental health disorders’. This was to be delivered through the Mental Health Nurse Incentive Program, or MHNIP as it is known.

The MHNIP was implemented on 1 July 2007 and provides incentive payments to fund eligible:
- Community based general practices
- Private psychiatry services, and
- Other appropriate organisations (such as Divisions of General Practice and Aboriginal Primary Health Care Services).

Organisations apply to Medicare Australia for an Eligible Organisation Identification Number (EOIN). This then allows the organisation to employ or engage a Credentialed Mental Health Nurse to provide coordinated clinical services for people who meet eligibility criteria and who would benefit from the program.

A one-off incentive payment is available per eligible organisation. The amount of this payment is based on the number of sessions the mental health nurse is to undertake each week. Services under MHNIP are provided at little or no cost to the client/client.¹

For most people who experience mental health issues, effective community-based treatment and support will reduce the need for acute hospital services, lead to improved health outcomes and reduce costs associated with accessing care. Unfortunately, as a result of persistent psychiatric symptoms, level of disability and/or isolation from family and other social support networks, people who experience severe long-term mental health problems are at high risk of failing to access a range of services appropriate to their needs. For this reason, mental health nurses delivering services under the MHNIP collaborate with psychiatrists, general practitioners and other relevant services and individuals, to provide services in a range of settings – such as a primary practice, in private practice or in a client’s home.

Mental health nursing is a specialised branch of nursing with a focus on the treatment of people who experience mental health problems or mental disorders.

The range of client-focused services Credentialed Mental Health Nurses provide are truly holistic, assisting people to maximise their life potential by overcoming the illness or coming to terms with its impact on their lives. These services include:

- Establishing a therapeutic relationship with clients
- Close liaison and support for family and carers
- Collaboration, networking, liaison, and where necessary, managing referrals to other services and health professionals
- Mental health assessment and monitoring
- Contributing to care planning and management including medication management, treatment and psychotherapies
- Psycho-education and provision of health promotion information.

Nurses may be engaged in a variety of ways in accordance with the MHNIP guidelines. For example, a nurse who has established a private practice might be contracted by a medical clinic or psychiatrist, another nurse may be employed by a general medical practice, and a Division of General Practice might engage a team of mental health nurses who deliver services to clients referred by local general practitioners.

"MHNIP enables organisations to provide a broad range of services outside the traditional structures of primary health care (e.g. working with AOD services, schools and students with mental health issues) and provides an alternative treatment pathway in the delivery of timely, effective mental health care.

Frequent communication with the treating doctor means decisions can be made collaboratively and treatment plans altered with immediacy. GPs value my clinical support and the ability to refer to me someone who requires much more time than they can afford – this gives them time to see more clients.

Ainslie Ivin-Smith
Credentialed Mental Health Nurse
Primary mental health care in action

MHNIP is an innovative and successful model of delivering primary mental health care – it allows services to be delivered flexibly based on the needs of the consumer, it supports the delivery of holistic care, and it utilises the broad scope of practice of mental health nurses.

Strengthening the primary health care system has been a key feature of the Commonwealth Government’s National Health Reform, with recognition that an improved system will:
- Ensure individuals and communities get the health care they need when and where they need it
- Help people better manage their health conditions in the community and prevent disease, and
- Free up hospital beds and emergency departments for those who need hospital based care.

Through the MHNIP, mental health nurses are achieving these aims for more than 64,500 people who have been treated since the program’s implementation.

In August 2008, the ACMHN conducted a survey of mental health nurses, which found that the MHNIP was:
- Meeting an obvious need in the community
- Delivering services that are flexible and responsive to the needs of consumers
- Supporting professional collaborations that facilitate holistic approaches to working with people and a recovery based approach
- Providing mental health nurses with the opportunity to practice autonomously.

Mental Health Nurses are supporting consumers and their families and carers to manage their health, and there is strong evidence that mental health nurses providing services under the MHNIP have reduced hospitalisations and prevented visits to emergency departments.

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Collaboration

Collaboration by health professionals is an element of the health care system that needs to be improved. However, it is a key strength and an essential element of the success of the MHNIP. The case studies in this monograph demonstrate the efficacy of collaboration between general practitioners and/or psychiatrists and the mental health nurse. Equally important is that mental health nurses work collaboratively with consumers to develop recovery plans and support them in their progress towards recovery.

Mental health nurses have had no difficulty incorporating collaboration into their service delivery under this program because it is essential to the provision of comprehensive care for people who experience severe mental health problems. The MHNIP enables nurses to be paid for the time they spend working with other health professionals, families/carers, and other service providers. This flexibility is in contrast to other primary care funding which is only available for direct provision of services to the individual.

“MHNIP has filled a gaping hole on Magnetic Island – I am the only mental health professional residing here. Now clients get consistent care from me, the GP and a visiting consultant psychiatrist. We have implemented early medication and education for people with psychosis; provided consistency for people with challenging behaviours; engaged, educated and developed rapport with people who have been diagnosed with schizophrenia but who are not taking medication; done home visits with depressed and physically infirm elderly; and initiated a short program on anxiety management.

I have been a mental health nurse for 25 years and love this job...all the power lies with the client...you have to be comfortable with autonomy and you need clinical supervision and support from colleagues. The GP says I have enabled her to work longer (in years) as she was burning out...this is a great program that provides better access to people who need mental health services.

Jillian Caunter, Magnetic Island, Queensland

Collaboration is a fundamental element of mental health nursing practice. It is a key strength and an essential element of success of the MHNIP.
Creativity

Under the MHNIP, mental health nurses have established practices that meet the needs of diverse communities. They provide services across the population spectrum; from children to older people, from indigenous groups to refugee populations, from inner city communities to rural and remote communities; and including clinical specialisations, such as working primarily with people who have been diagnosed with eating disorders or schizophrenia.

Mental health nurses have fully engaged with the possibilities of the MHNIP and created practices that meet the needs of their communities.

“Most clients I see are from a Korean background, as I am a bilingual. These clients are not aware of counseling services and would have certainly missed out – they usually only see GPs for physical illness. There is a lot to do with these neglected clients and carers. At times I work late but I enjoy the satisfaction I get from watching them improve and maintain their wellness.

I don’t want to increase my workload, so I don’t promote the MHNIP further. A problem I found was that GPs were not aware of the program and did not know how to start.

Myong De Conceicao
Southern Sydney, NSW
Compromise

One overwhelming theme emerges from the case studies published here; the success of this program has been achieved on the back of the compromises (mainly financial), made by mental health nurses and the organisations they work with.

Mental health nurses must be highly qualified and experienced to succeed in these autonomous roles. On average, mental health nurses delivering services under the MHNIP have more than 10 years mental health nursing experience. In leaving the public sector, many mental health nurses have had to accept a reduction in their salary level, alongside a loss of conditions such as professional development allowances, superannuation, access to shift work and accompanying penalty rates, clinical supervision and other professional resources and support.

Payments for services provided under the MHNIP have not increased since the program commenced in July 2007.

This has exacerbated the discrepancy in pay rates in MHNIP roles with the public sector and has impacted, in some cases, on nurses continuing with the program.

MHNIP payments also restrict access to services in several ways. Only clients whose general practitioner or psychiatrist has registered as an eligible organisation can access the program. Many GPs and psychiatrists are not aware of the program and/or are not persuaded of the potential benefits of the program for their clients. Others don’t wish to assume the responsibility entailed in becoming an eligible organisation or the administrative burden. Another unfortunate consequence of the MHNIP payments being made to the GP or psychiatrist is that some organisations retain a (sometimes large) percentage of the fee, even when they do no more than transfer payment to the Mental Health Nurse who is providing the service. This has resulted in some nurses working under the program for considerably less than their counterparts who receive the full session fee or leaving the program altogether.

Nurses and organisations report that the MHNIP does not provide sufficient funding to remunerate mental health nurses appropriately for the services they provide.

“I worked under MHNIP for a large medical practice for 18 months prior to resigning last year to take up a public sector nursing position, at just less than $86,000 p.a. While working in the MHNIP, I was paid $25 per hour, and later, after much haggling, $33 per hour. I worked part time and I was paid on average less than $25,000 p.a.

I prepared mental health care plans and conducted mental health reviews, for which the practice claimed MBS rebates. After I saw the client and did the plan or review, they would spend 5 minutes with a GP so the paperwork could be finalised. Including the session payments, I estimate the practice earned about $200,000 from my work there.

Some medical practices do not understand the benefits to their clients, and financially to themselves, of employing Credentialed MHNs under the MHNIP, so they don’t pay realistic wages.

Michael Percy
Credentialed Mental Health Nurse
Time for change

The mental health nurses who have made the journey from public mental health services to primary mental health care under the MHNIP have done so with the support of the ACMHN. These nurses have made a significant personal and professional transition with many challenges along the way. It is due to the personal perseverance and commitment by these trailblazing nurses that the program has flourished.

The ACMHN considers the MHNIP has been a success in terms of primary mental health care and supports its continuation. This has been evidenced in numerous communications between its members and other involved health professionals. However, there are a number of issues that need to be addressed.

Between the commencement of the program on 1 July 2007 and the 2008 Federal Budget, mental health nurses provided services to over 2,500 clients at 380 sites across Australia under the MHNIP. While promising, this was less than the potential and therefore, savings from the MHNIP were identified and removed from the program. In recent years, the uptake of the program has grown substantially such that the Government revised budget estimates and in the 2010–11 Budget had to announce increased funding to support this growth.

There has been no substantive development or change in the program since its inception – the issues raised as concerns and barriers by nurses in the early days of the program remain. A program evaluation by the Department of Health and Ageing is soon to commence and is scheduled for completion in May 2012. However, this timeframe prevents any financial or structural improvements until possibly the Federal Budget in May 2013. By then it will be six years since the implementation of the MHNIP without provision for ensuring nurses are willing to continue working under the program.

The ACMHN calls on the Commonwealth Government to:

- Increase program payments
- Invest in professional support for mental health nurses
- Invest in support for general practice, psychiatrists and other organisations to establish the program
- Support the expansion of the program into other organisations supporting people who experience mental health issues (e.g. Headspace)
- Develop an online administration system.

The ACMHN urges the Australian Government to recognise the MHNIP as a successful collaborative mental health service of choice for people who experience mental health problems and prioritise actions for its sustainability sooner rather than later.

The ACMHN believes now is the time for the MHNIP to be managed and supported as a mainstream primary mental health program. With over 64,500 people benefiting from this program, there must be an investment in the program administration and support.

The case studies in this monograph clearly demonstrate the benefits of the MHNIP to people who experience mental health disorders and their families and carers, the primary health care system, and the Australian community. While the evaluation of the program will soon commence, the organisations and individuals who are using the program now cannot afford to wait for another 12 months or longer to see these changes made.

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1 Federal Budget 2008
After having been a psychiatric nurse practising in hospitals on ward duties, working shifts, and weekends since 1976, my new position in the MHNIP is almost beyond belief.

Last year, I started looking for a job I could totally relate to as a Credentialed Mental Health Nurse (CMHN). I answered an advertisement, which was simply requiring a CMHN who favoured the ‘recovery paradigm’ of care. By mid week, I was having lunch with the co-practice managers, psychiatrist Alan and mental health nurse John, it was clear our ideas, vision and hopes for people experiencing mental health problems were the same.

Since then I have been working with up to 16 people under the MHNIP, some who were identified as having a ‘serious mental illness’, and some who were considered ‘too difficult’ to manage within the public mental health system. I feel liberated organising my days and visits, and collaborating with the people I see on what will happen at appointments, and planning the future together. I no longer consider
I am ‘working’ as I enjoy what I do so much. It is something I always imagined, and hoped for, but didn’t truly believe could exist. The people I work with see me as a professional who is honest, down to earth, and fun to be with. My colleagues respect my judgement and offer advice at times.

My approach is ‘normalisation’ as some people have slipped through the cracks in the system, been forgotten, and often seen as a statistic living on a disability pension with no future. They are encouraged to join groups to expand their social network, and perhaps learn new or improve existing skills.

Sessions are based on whatever is considered will assist with continued recovery. This may include escorting the person to appointments with other therapists; helping them shop for healthy food options to improve their mental and physical state; assisting with budgeting; eating out to facilitate engagement within the local environment; or trips to the movies, swimming pool, and gym. Families and other significant people are involved so as to maintain a solid structure, foundation and support. Only one person I work with has required a brief period of hospitalisation during a crisis.

Our flexible approach means I can visit anybody who requires additional support, and they all have my phone number so I am contactable by phone during extended office hours. Furthermore, there is need only for minimal medication; some are taking nothing at all, but they are encouraged to discuss the need, be it temporary, should it arise. This allows the person to feel responsible and enables them to make decisions about their own health.

In addition, a group from our practice, including four practitioners, recently had a holiday weekend in Buxton. The healing that took place on that weekend I believe was immense. We did activities together and it was a joy to hear the laughter outside into the early hours of the morning. New friendships have been formed, new skills have been developed, and the feelings of isolation, loneliness and alienation have been replaced by feelings of inclusion, socialisation, ‘acceptance’, and self respect. I strongly believe that recovery can only truly take place within a therapeutic environment and each day I see people who continue to recount the memories of their holiday and continue to flourish.

New friendships have been formed, new skills have been developed, and feelings of isolation, loneliness and alienation have been replaced by feelings of inclusion, socialisation, ‘acceptance’, and self respect.

It is programs such as the MHNIP that are important in providing the means for the people we work with to continue to grow and once again feel worthwhile within a judgemental society. However, for the program to continue, improvements are needed. For example:

- Assistance with funding to establish community projects such as ‘drop in’ centres
- Payments more frequently than monthly. Delays in payment could deter other nurses from joining the MHNIP, or inflict financial hardship upon them and their families
- Assistance with funding office space to enable staff to ‘gather together’ for clinical reviews, ‘case studies’, to house necessary paperwork, and receive telephone messages from and regarding clients
- Assistance with payment to attend continuing professional development activities which assist with the re-credentialing process.
I have worked in a variety of health sectors and services over many years providing mental health care. I believe that the private sector significantly contributes to mental health services and enables clients to have choice and control within their sphere of treatment. Further, the availability of high quality private sector mental health services assists in alleviating the pressure on an already burdened public mental health system.

I am employed to provide services under the MHNIP at Perth Clinic, a private psychiatric inpatient hospital in Western Australia. Providing the program at the clinic offers the clients continuity as they are seen in an environment that is familiar, and the proximity fosters open communication between the mental health nurse and psychiatrist, particularly if there is a need for more immediate consultation regarding a client’s wellbeing.

The major benefit of this service is that it allows clients to receive extra services without restriction on the time or the frequency of visits. This is important because their treatment plan can be customized to suit their level of wellness at any given time. Another important benefit is that MHNIP enables clients to receive extra services without additional cost. Many clients are in positions of increased financial stress associated with the illness and therefore, to be able to access services for free is a major relief not only to clients but also carers.

Over the six months at Perth Clinic, I collected data on clients’ level of wellness, as well as conducted client satisfaction surveys. The results to date are very positive.

Eighteen client satisfaction surveys were returned. Of these:
- 100% of clients surveyed would recommend the service to other clients, and
- 100% of clients rated the service Good to Excellent.

Clients were asked to rate their satisfaction with the services provided and the average score out of a maximum of 7 is shown in the table below.

Clients were also given opportunity to make comment on what they thought was most important to them when receiving mental health care. The main themes make reference to:
- Expertise of the mental health nurse and professionalism of the service
- Opportunity to communicate issues pertaining to their mental health issues and being involved in the treatment process in maintaining wellness, and
- Affordability, reliability and availability of the service.
In the area of client improvement, HoNOS scores reviewed pre- and post-intervention have been encouraging. From October 2010 to April 2011, a total of nine clients have been discharged from the program with an outcome of treatment completed. All of these clients showed improvement in their mental status as per the HONOS scores.

Despite the obvious benefits of the program to the clients and their carers, I would also like to mention the benefits of the program I receive as a clinician. The ability to practice in an autonomous position and work closely with my clients and their carers where I can see the benefit of the intervention I provide is immensely satisfying.

Working under MHNIP has inspired me to undertake further post graduate studies with the aim of extending my career in mental health. Further, it has led me to encourage other registered nurses to obtain specialist skills in mental health so that they too can have the opportunity to work under a program that provides such positive professional rewards.

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<th>How Satisfied are you? (Max = 7)</th>
<th>Importance to you? (Max = 7)</th>
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<td>Access/referral to the MHNIP program was easily organized</td>
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<td>MHNIP was appropriate to my needs</td>
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<td>I was provided with adequate information on the treatment services</td>
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<td>My treatment plan was discussed with me</td>
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<td>I was able to express my concerns to staff</td>
<td>6.55</td>
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<tr>
<td>The program assisted the patient to manage their illness/symptoms</td>
<td>6.44</td>
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<td>The program has improved the patient’s confidence in coping at home</td>
<td>6.66</td>
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<td>The program has decreased my need for hospitalization</td>
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Many clients are in positions of increased financial stress associated with the illness and therefore, to be able to access services for free is a major relief – not only for clients, but also for carers.
Achieving social justice, reducing stigma and collaborating across the community sector

Alan Hainsworth
The MHNIP has given me a new lease of life. It has allowed me as a skilled clinician to express myself and deliver a genuinely holistic approach to the most vulnerable people in our community.

I am so lucky to have spent two years working in the heart of Kings Cross with a busy addictions specialist GP and have now moved to Byron Bay, a semi-rural community with nice scenery but an underbelly of quiet suffering for its inhabitants.

In the general practice environment we work with people across the full gamut of mental health disorders. I believe the biggest difference between working in the primary care environment and the ‘mental health system’ is the trust issue. Many clients have had negative experiences in the mental health system often reporting inappropriate levels of incarceration, coercion and risk-aversion all at costs to their dignity. As a mental health nurse working in general practice it is my duty to protect clients from the over-medicalisation of psychological pain, distress and social disadvantage. This approach has dual benefits of assisting clients back to optimal health without stigma as well as corollary cost benefits to the public purse.

Practicing under the MHNIP in the inner city, I was able to develop a close relationship with the local government agency that provided assistance to people who were long term unemployed. The Salvation Army Employment Plus scheme identified 90 clients on the basic Newstart Allowance who were suffering chronic mental and physical ill health, usually including severe alcohol and drug dependence. A significant proportion of these people were street homeless or living in precarious circumstances and in most cases had experienced significant childhood trauma and episodes of incarceration. Commonly the client had no GP and had not been seen by a doctor for many years.

Addressing the health needs of these people was prioritised, including stabilising long standing conditions like epilepsy and diabetes. New problems were diagnosed and treated including rapid entry to the methadone program and referral to Hepatitis C specialists, as well as specialised trauma counseling. A significant number were in severe dental crisis and were referred to a local dentist under the Medicare dental scheme. The revolutionary change in wellbeing from finally having a healthy mouth and able to enjoy eating food again without pain was staggering. I was also surprised at how reliable each person was in attending appointments given their otherwise ‘chaotic and disorganised’ label.

In consultation with Centrelink we were able reassess their social support needs so that many were appropriately transferred to the Disability Support Pension, and many were assisted in to priority housing and off the streets. I have spent many tedious hours completing medical application forms and reports on behalf of clients. I can’t say that “I love filling in forms” but as an advocate it gives me enormous satisfaction to assist clients finally succeed in their battle with bureaucracy. Achieving social justice is a big motivating factor in why I continue to do this job.

The MHNIP allows me to spend quality time with clients, using a narrative approach to get to the root of their problems. I usually spend a full hour with each person, which allows for trust-building and leads to developing a plan for resolving both the current symptoms of the illness and its underlying causes. The client feels un-rushed and listened to, often for the first time in a system not designed to accommodate such an approach. My GP colleagues have commented on how much it supports them by having a professional clinician work with who has the time to finally resolve what has seemed irresolvable for so long.

Here in the heart of Byron Bay I see many characters looking for healing. The mental health nurse is flat-out. My caseload is as diverse as ever. The stress level is high but it is nice to be able to go snorkeling during one’s lunch break!
After we attended the ACMHN Primary Mental Health Conference in Canberra in 2010, my partner Jane De La Fronde and I were inspired to set up Recover Victoria, an independent mental health nurse-led community organisation that provided services under the MHNIP. Since then our services have expanded and we now employ 10 staff including allied health professionals from occupational therapy and social work.

Soon we will open our third and largest establishment, The Recovery Centre, in Victoria’s north. Here clients will be offered free allied and alternative health services, including an innovative new program ‘Hands on Health’. This will introduce chiropractors, osteopaths, massage therapists and other disciplines into our dedicated mental health team. We also have exciting strategic collaborations with large NGOs offering mental health services to people who are homeless and providing mental health education and supervision within the Aged Care sector.

The MHNIP has allowed us to develop much needed services that can be adapted and tailored to our clients ever changing needs. The flexibility to offer sessions within our clinics and offer outreach services to those more disabled by their mental illness has been priceless and greatly appreciated by our clients. A number of clients are restricted by their financial circumstances – we offer them phone support, which promotes continuity of care that may have been lost if
the this option wasn’t available. Uniquely, the program recognises the socioeconomic instability experienced by people with mental illness, and demonstrates that recovery isn’t inhibited by these restraints. Tailoring services this way makes the MHNIP a leading mental health service.

Client outcomes
Within the last year we have had 100 referrals and the benefits of this service are in the facts:

- On referral, 40% of clients expressed suicidal ideation and this has dropped to an amazing 2%
- Regular hospital admissions were experienced by 46% of clients and all had an admission 1 month prior to the referral, but this rate has also dropped to only 4 admissions in 12 months.

Two of our clients stated:

‘Recover Australia has done more for me in the last 6 months than the whole 10 years I’ve been within the system. …you have had time to listen, and I mean really listen and you are responsive to my needs. Why wasn’t this service available 10 years ago?’…

‘…for 25 years I’ve had agoraphobia and seen health professionals who just sent me away with homework, you actually got up and got out with me and now I have my life back, I cannot explain what you’ve done for me and my family, my daughters have their mum back’

Recover Australia believes that the creation of the MHNIP has raised the profile of highly skilled mental health nurses within the health community as well as giving these nurses the opportunity to showcase their individual clinical skills, develop creative and sustainable relationships with clients that foster recovery and empowerment, and hold a respected and valued position within the community. One of our consultant psychiatrists states, ‘I would trust Recover Australia’s mental health nurses judgement and opinion of client care over most doctors, you really are doing a great job out there’.

Recommendations
Recover Australia works within the MHNIP but there are limitations and restrictions that, if changed, could make a great program into an outstanding program. These restrictions have been frustrating at times as mental health nurses only want to offer the best service they can to their client group. As service providers in collaboration with our clients we are the experts on how the service should be operated, delivered and monitored more effectively.

Therefore we recommend that:

- The Government promote this service, as there has been a lack of education for both health professionals and consumers
- Credentialed Mental Health Nurses should have the option to become the Eligible Organisation to make the service more widely available for consumers
- The reporting of sessions needs to be online and the pay scale needs to be the same as our allied health counterparts delivering service under Better Outcomes and ATAPS.

On referral, 40% of clients expressed suicidal ideation and this has dropped to an amazing 2%
Working under the MHNIP since April 2008 has allowed me to use all my knowledge and skills gathered over 37 years in a wide range of professional settings. I have experienced a sense that my mental health nursing skills, knowledge and experience are valued and respected by both the people for whom I provide specialist services, and other professionals with whom I come in contact.

Practicing under the MHNIP I enjoy an opportunity for autonomous practice and flexibility – the cornerstone of my practice – and it has fostered fresh avenues for professional curiosity! I am better able to incorporate the bio-psycho-social-spiritual approach and I am also better able to direct my practice according to the needs of the clients, rather than the needs of any specific health service, agency or organisation.

**The benefits**

Examples of MHNIP evaluation feedback from my clients:

“I can actually tell people now that I’m genuinely happy”

“Good that different providers on the same page ... helps your whole journey when others know what’s happening...comfortable that I’m not spoken to or at, but WITH, TOGETHER ...”

“GP’s time is limited & valuable so I feel guilty [when] I need sometimes just to talk”

“The ability to tell [my] story, then the follow up comments to the family at times shedding new light on issues encountered”

Health and wellbeing outcomes for people have included: improved healthy ways of living; enhanced interpersonal communication skills; continuity of care opportunities; illness relapse reduction/prevention; harm minimisation, particularly related to alcohol and other drug use.

In my experience, there has been mostly a positive response when working to enhance a collaborative approach in the primary care setting. This has involved a wide variety of others as a ‘team’ with, and for the person, including lay people who share the life of the person experiencing mental health concerns. I have also used HoNOS, K10 and ad hoc client feedback forms while developing audit tools. These have supported the anecdotal and observational improvements of individuals who engaged in the MHNIP over the past three years.
For improvement

- Annual indexation of MHNIP payments as a minimum. The costs of providing the service are increasingly covered by the, presumed, philanthropic efforts of mental health nurses. How can experienced mental health nurses be encouraged to consider the option of, or continue providing services under the MHNIP if reimbursement does not reflect the advanced practitioner responsibilities?

- Authorise Credentialed Mental Health Nurses as the ‘Eligible Organisation’. When GPs and psychiatrists are not prepared to become an ‘Eligible Organisation’ but would like their clients to have support of a Credentialed Mental Health Nurse in the community they are restricted by the program requirements and their clients miss out on the opportunity to be involved with a collaborative care arrangement. It is frustrating for a clinician to not be able to provide equitable access to care.

- Equitable access to care: Some who experience mental illness are not engaged with any health providers. Opening up the MHNIP referral avenues to include self-referrals and from others providing services to people experiencing mental health problems, would help address not only mental health issues but also co-morbidities prevalent in this population. Given the emphasis on holistic and collaborative care as a cornerstone of mental health nursing, we the MHNIP mental health nurses are able to encourage and assist people to access equitable healthcare by facilitating access to other disciplines – including GPs and psychiatrists.

- Reliable access to Public Respite and Recovery facilities (Step-down/Step-up) from MHNIP. At times the access has been denied to clients I work with as the person “did not have a psychiatrist within the public system”!
‘Walking together’: MHNIP provides continuity and consistency for Aboriginal community members

John Parkinson

The MHNIP allows St John of God Healthcare in Warrnambool to meet the needs of those people who experience a mental illness, from across the region. The service commenced in February 2008 with a team of three Credentialed Mental Health Nurses, the equivalent of two full time staff. Due to increased clinical demand, the team has since expanded to five mental health nurses providing the equivalent of nearly four full time staff. Geographically, we cover five shires and as most contact occurs within the client’s own environment, this can involve travelling up to 1.5hrs in any one direction from Warrnambool.

We adopt a multi disciplinary case management approach to the provision of clinical and social care, and engage other health professionals and clinical service providers where appropriate.

Many of the clients that we see under the MHNIP have not received specialist treatment opportunities at public mental health services, due to increasing
referrals and demand in that sector from the community. The uniqueness of the MHNIP service is the flexibility that it allows mental health nurses to deliver care on an as needed approach and work directly with GPs to address their specific concerns about clients.

Between July 2010 and May 2011 there were approx 82 new referrals, which show the increasing demand for mental health care across the region.

Reducing Inpatient Admissions
Due to greater flexibility in meeting the client’s needs in their own home, there has been a noticeable reduction in hospital admissions. In the 2008 financial year there were 33 in-patient admissions from a total of approximately 77 clients. In the following 12 months, there were 24 admissions from total of 143 clients; and by the 2010 financial year there were only 8 admissions from a total client group of 180. Through more frequent contact with clients who experience high prevalence disorders, we have been able to manage their symptoms, risk and overall care without requiring inpatient admission. The MHNIP nurses are now involved with more than 80 local GPs and two private psychiatrists throughout the region.

Aboriginal Mental Health
The service also engages with the local Aboriginal community due to the commitment of a mental health nurse and also because the MHNIP provides greater flexibility and responsiveness to longer-term disability for this marginalised group within our society. The community have multiple and complex health problems and some services are not able to ‘walk with them’ for an extended period of time. What has become very obvious is that in order to gain trust and rapport, and to chip away over time at challenging unhealthy lifestyles and coping skills, an eclectic and genuine approach is vital to increase resilience. Community feedback is that mainstream services often keep doing the same thing in reacting to crisis events only and do not progress any further with their social, emotional and physical situations.

The MHNIP provides continuity and consistency for Aboriginal community members. It allows one person to walk with them and connect them into services whilst supporting them when other providers have moved on.

Many of the clients that are seen under the MHNIP have not received specialist treatment opportunities at public mental health services due to increasing referrals and demand in that sector...

Women’s Wellbeing Group
Another unique program we are developing is the Woman’s Wellbeing Group. Funding was received through the Disability Support Program and will be facilitated by mental health nurses with clients who are registered under the MHNIP. The women to be included in the group will be those who have become socially isolated due to their mental illness. The goal is to promote social inclusion and encourage a healthy lifestyle. It will also allow participants an opportunity to develop friendships, increase socialisation and discuss lifestyle goals among other things.

This program will be run in a private gym, which will make clients feel comfortable and safe. Larger fitness centres can often be very overwhelming for clients who have poor self-esteem. The goal of the course is to build self-confidence, which may then enable the participant to feel more comfortable attending a larger fitness centre following the completion of the program. The MHNIP allows the flexibility required to meet the needs of these women, who would otherwise not be receiving specialist mental health care.

With increased referrals and reduced inpatient admissions, it is clear the MHNIP and the expertise of the mental health nurses allows St John of God Warrnambool to meet the diverse needs of the community within the southwest region of Victoria. It also has enhanced the breadth of this service through specials needs programs.
The MHNIP is a most satisfying way of working with people who experience mental health difficulties. Currently I am working in the southern beach side area of Melbourne as an independent contractor for the Bayside General Practice Network. I conduct seven to eight MHNIP sessions regularly, at four general medical practices.

The people I see appreciate the de-stigmatised location a general practice offers, as well as the flexible access to my services which increase and decrease to meet their current needs. Being situated in the practice also means I can instant message doctors who are happy to join our session to solve a medical issue. The main goal is to increase the capacity of the medical practices and there has been no shortage of people identified who would benefit from the MHNIP.

I work in close contact with the GPs; all my clinical notes are recorded electronically on the client’s medical record, this allows both of us to keep abreast of what is happening for the client. The collaborative environment means we are easily accessible to each other e.g. most of the doctors actively seek out a quick verbal update on the day I see their client. The GPs have expressed their appreciation for the increased level of reporting and services for clients, and appear to appreciate having someone to share the burden of care.

There have been a number of situations where we have been able to avert suicide attempts and admissions to hospital as a result of the MHNIP. This also has a direct effect on other services by reducing local Emergency Department workload, and minimising acute psychiatric and general bed use. An excellent example of this is a client I had been visiting very regularly due to an unstable bipolar disorder and physical problems including angina. This client spent the week-end in the local Coronary Care Unit and was discharged home with nitrate patches. She didn’t think they were working and stopped using them after two days. I discovered she had not been shown how to apply them properly and after explaining how they worked, she found that they actually worked quite well! Without this intervention, re-hospitalisation would have been inevitable.

The clinical time I spend with clients is far greater than when I was working in the public mental health system. The GPs have expressed their surprise at my knowledge of, and ability to access a wide range of services, and how I ensure involvement of other community services are more effective for clients. In turn, I am constantly surprised at how many GPs (there are over 30) note from the electronic diary when I am seeing one of their clients and are interested in how the session went.
Unfortunately there are downsides to the MHNIP. I now earn considerably less than I did in the public system for a nurse of my skill level, particularly when superannuation, annual leave, sick leave & public holidays are factored into the calculation. I have very little job or income security and I have not received any increase in remuneration under the MHNIP since it was implemented.

Despite the overwhelming appreciation of this service by the GPs, I am a guest and do not contribute anything towards the cost of the room used, I.T. access or reception work at the practice. As is often the case in nursing, inadequate funding creates a seeming lack of recognition of my skilled contribution. I live with the concern that the clients I see could easily loose access to the service if the goodwill of the many people involved continues to be stretched. I regret the number of missed opportunities in the last two years for expansion of the MHNIP in our area because the sums did not add up.

The GPs are surprised at my knowledge of, and ability to access a wide range of services, and how I ensure other community services are more effective for clients.
In 2005, motivated by a sense of injustice and enthusiasm to make a difference, my friend James Southan and I decided to move into private practice, delivering mental health nursing to people who were homeless. Our start up was the health promotion charity ROAM Communities for which we won awards and gained recognition across the sector.
The viability of our practice benefitted greatly from the MHNIP rollout, which commenced in June 2007 and provided more consistent funding for our work. We have always enjoyed working amongst vulnerable populations and over the past few years have expanded our work through partnerships with the University of Sydney, the Salvation Army and Aboriginal Medical Services. Between us we currently provide 4 nurse led clinics to vulnerable youth, indigenous people and those who are homeless.

We can only claim reimbursements for care delivered to people who are referred by GPs or Psychiatrists. I work with vulnerable people who are experiencing complex mental disorders and often prefer to avoid the medical profession. From the client's perspective then, this requirement is an unnecessary barrier, and means I can't get paid until clients are seen by a medical practitioner. For example, one client who came to me asking for help was homeless and complaining of increased anxiety and agitation. He related a traumatised childhood where he was frequently abused by his mother and often presented to hospital emergency departments with multiple bruises. He recalled throwing kittens into a fire and a dog into the path of an oncoming train when he was six. Heading into his teenage years he engaged in the sexual abuse of young cousins. Then led a transient lifestyle moving between NSW Government funded housing and his mother who suffered from a drug addiction. He stated he “hated doctors” and he was in need of far more attention than the usual system could provide. I offered to help him, which resulted in several sessions of free psychotherapy until he was willing to see a GP for review.

Another challenge is the funding arrangement for the MHNIP, which can leave providers out of pocket. Currently the program requires that every time I deliver care to a client, a claim form must be completed. It is not an electronic system; the form has to be printed out and forwarded to Medicare Australia. This paper based process can result in up to 40 forms being submitted per month and the system runs a very high risk for mistakes as I have experienced. One month a bundle of my forms worth over $7,000 were misplaced! I was informed by phone that I would have to appeal the mistake, which meant I would have to wait three months to be paid. This could have sent me out of business but luckily a Medicare staff member found the forms on her desk three days later!

Despite the challenges, client feedback has been terrific and I am often humbled by how thankful people are for the help I am able to offer them.

At times my work is unpaid, because some of the clients I see don’t fit the Medicare guidelines for MHNIP.

Despite the challenges, client feedback has been terrific and I am often humbled by how thankful people are for the help I am able to offer them.

For example, after experiencing two years of therapy through another provider, one client told me “I wish I’d got to you sooner, I really like the way you teach me about it as we go.”
In October 2007, I teamed up with a private psychiatrist and by mutual agreement I contracted my services as a private practitioner under the MHNIP. A framework for conducting the service was developed which provided structure and clear guidelines for the provision of care for clients, role clarity between us and other health care providers, continuity of care through implementation of weekly clinical meetings, and the offer of three monthly case reviews between myself, the psychiatrist, clients and their significant others.

We also agreed that my services would be conducted primarily in clients homes (dependent on risk assessment), as this would provide a more accurate assessment and greater understanding of the individual’s problems, concerns, issues and lifestyle. It also allowed for greater engagement with families.

Evidence of outcomes and savings of over $20,000 per client
Anne Palmer

Positive outcomes for clients and families
Clients referred under the MHNIP have complex needs and between October 2007 and January 2009 I had 37 referrals. From the start we were interested in whether the MHNIP would have an impact on:

- The symptoms experienced
- Percentage of families involved in the treatment and care of the person
- Collaboration and coordination of care
- Rates of hospitalisation
- The health care dollar.
We collected data over this first fifteen months and found the following outcomes:

- **Decrease in severity of symptoms.** Average admission HoNOS score was 23 and the average discharge HoNOS score was 6 (n=15)
- **72% of families** had involvement in the treatment and care of the individual. The others were not involved either because the client refused or, in a very small percentage, decided not to be involved
- **During the period of the study** we liaised with or refused clients to over 40 different agencies, organizations or professional bodies
- **Hospitalisations (to the local private hospital) were reduced** – there were only a small number of clients (15) for which data could be produced that reflects their episodes of hospitalisation 12mths prior to entry and 12mths after entry into the MHNIP. Prior to care under the MHNIP, admissions (including day client admissions) totalled 230. Twelve months after care under MHNIP admissions had decreased to 138. The decrease in admission rate is not only significant for the client from a quality of life perspective, but it is very significant from a health care dollar perspective.

**Health cost savings through MHNIP**
Using the data from the hospitalizations of our 15 clients, the savings to the private health funds for those clients amounted to $307,655 which is on average a saving of $20,510 per client.

Data released by the Department of Health and Aging (DOHA) in the first 12months after the implementation of MHNIP showed that 2500 clients were treated under the program. Hypothesizing a conservative figure of only 25% of these clients having the same decrease in their hospitalisation as outlined above, this would equate to a potential saving of nearly $13 million in admission costs in that first year. By now thousands of people have been able to access the MHNIP and the savings as a result of this service provided by mental health nurses should not be underestimated, and should be recognised.

**Benefits for the community**
The MHNIP provides an opportunity to be creative in the way service is delivered, and in my case, by a private psychiatry practice. Apart from the measured outcomes there are other benefits for the practice that were identified, in that it:

- Supports continuum of care
- Has enabled clients to access support on a psychological and practical level that would not have been available to them previously
- Provides closer monitoring of clients who are acutely unwell and supports continued outpatient treatment
- Supports objective observations in the homes of clients facilitating better quality information
- Increased emotional support for client and their response to treatment is enhanced.
This has been the most interesting and challenging clinical position of my 20+ year career in mental health. There is so much need here and access to support services in regional areas is so limited. One of the enormous benefits of the MHNIP is that I am able to spend paid time with parents, families and schools, accessing mentoring and respite services, talking to DOCS, GPs, dietitians and paediatricians to enable a coordinated approach for the young people and families that I work with. This component of the work takes a lot of time and I believe is the reason why many private clinicians choose not to take on children and young people. It is also the reason I am able to stay working with people in this age group.

I have been amazed at how complex the situations are for the young people I see, particularly since many of them have found it impossible to access short, medium or long-term care through a public mental health service. The capacity to work to the full extent of my scope of practice under this program is very satisfying – I variously provide individual or family therapy, case management, medication monitoring, mental status assessment, I contribute to the psychiatrist’s capacity to accurately assess our clients because I am able to spend so much more time with them and their families; I can provide support to teachers, advice to GPs and work with the young person and their family to sort out the treatment priorities.

One thing I have learned about children and adolescents is that they need time. Time to think, time to be silent (and to give you the silent treatment if they want!), time to test you out, to see if they can trust you, time to work out what it is that’s going on inside. Quite often, after an hour of hanging out, just as I’m leaving, a young person will tell me something important – the thing that has been hanging around waiting for the trust to be strong enough to risk sharing it. I know that I would never have been able to access this type of information in a 15 or 30 minute session. Progress can be slow, but it is hard-won and therefore very satisfying.

For me, this feedback (received via SMS) from the parent of one of my clients sums up my experience of the flexibility of working under the MHNIP:

Hi Peta. Just read your letter to Minister Butler re: lack of funding for (our son) and others. Peta, I just wanted to say thank you so very much, not only for this, but for everything you have done for us and (our son). Though you may not hear it often, please know that (ex-wife) and I are truly amazed and grateful for the wonderful advances you have forged for his and our wellbeing and his education. Thanks again.

The things I hope will stay the same

- Everything about the way I can deliver services, treatment and care – to the full scope of my clinical practice.
- Flexibility of the service provided – daily, weekly, monthly – over 3 months, 2 years or 10. It’s a magnificent gift to families who are used to being shunted from one provider to another.
- That I continue to be remunerated for non face-to-face work; otherwise, I will not be able to continue working under the program.
- The opportunity to sit with someone for whatever period of time they need, not having to rush them out the door after 30 minutes (or 101).
• That this program is person-centred and recovery-focused. It is built on the needs of the person. No other program I know of is like it, which makes it truly unique.

The things I hope will be reviewed
I have been approached by a number of paediatricians who would like to refer clients to me. In a regional area, where psychiatrists are thin on the ground, this would be a sensible option. A lot of clients miss out because they do not see the specific psychiatrist that I currently work with. An obvious solution would be for me to be the ‘Eligible Organisation’ and accept referrals from wherever they come. Mental health nurses are, by their essence, collaborative practitioners, so to my mind, this subtle change would not in any way compromise the collaborative nature of the program.

The funding structure is unfair for some. I am fortunate in working with a psychiatrist who values my role, who understands the contribution skilled mental health nursing services provide to her clients and who has absolutely no desire to skim money off the top of the sessional rate. As as result, I get the full session payment. I know of many other nurses who are being paid hourly rates much less than they would get for their level of experience in the public health service and who accept this because they love the work. To my mind this is unacceptable. Of course, I cover all my own costs – insurance, petrol, car, mobile phone, clinical tools, computer, book keeping, office rental etc, so the hourly rate is still relatively low compared with what I could get working elsewhere.

The session logs! I would have thought that providing an online option, with an opportunity to register a client (and therefore not have to write out their medicare number and all other details every time you see them) would be a given in this day and age.

Quite often, after an hour of hanging out, just as I’m leaving, a young person will tell me something important – the thing that has been hanging around waiting for the trust to be strong enough to risk sharing it.
The case studies in this publication and the experiences of numerous other mental health nurses have highlighted the benefits of the program and the areas for improvement. As Lindsey Shepherd put it,

“We understand that the MHNIP is what it is. There are limitations and restrictions to the program that if changed could make a great program into an outstanding program.”

Mental health nurses and the ACMHN have been vocal advocates for the program since it commenced. We remain committed to the program as it delivers impressive outcomes for consumers.

The ACMHN makes the following recommendations to transform the MHNIP into an outstanding primary mental health program.

We look forward to the ongoing growth and development of the program, incorporating these recommendations.

- Ensure the long term adoption of the MHNIP by organisations and mental health nurses by increasing the sessional funding and indexing that payment to ensure it remains financially viable to deliver services under the MHNIP
- Increase access to the MHNIP for consumers by allowing mental health nurses to register as the Eligible Organisation
- Encourage more general practitioners and psychiatrists to use the program by promoting it widely and clearly identifying the benefits to those providers and their clients
- Increase the number of mental health nurses eligible to deliver services under the MHNIP by supporting the introduction of measures that will more easily enable Mental Health Nurses to become credentialed e.g. an online portfolio to support the Evidence Based Record
- Reduce the administrative burden by developing an online session logging system.