A Survey of Credentialed Mental Health Nurses working in the Mental Health Nursing Incentive Program:

Who are they? How do they work? What have they achieved?

September 2013
Foreword

It is with pleasure that I write the foreword to this report. The exclusive Mental Health Nurse Incentive Program (MHNIP) was established in 2007 and provides nurse-led mental health care to those with complex problems who access primary care. Credentialed mental health nurses, working collaboratively with other health professionals and service providers, have assisted many people, providing an array of services.

Commissioned by the Australian College of Mental Health Nurses, the purpose of this study was to understand the program and to evaluate its outcomes for consumers, carers and the nurses themselves.

It was found that the program has had a constructive influence on care for people with complex and severe mental health and social problems. In particular, it has demonstrated improved clinical and personal recovery for consumers; individual, case specific treatments; greater collaboration with other health professionals to broker targeted services; engagement with services by those consumers who would have previously been disengaged.

Information about the mental health nurses in the program was also gathered and included: demographics; services afforded; relationships; peer support, supervision and mentorship; and the nexus between the program and credentialed mental health nurses.

It was found that nurses adjust and shape their therapeutic approaches and interventions to individual consumer requirements and work with other health professionals, government and non-government agencies, and community services to support consumers and carers to solve problems and address their needs in a holistic way. Nurses harmonise care, work as case managers, engage in therapy, assess and plan care, provide medication advice and management, and assist consumers to engage with healthy lifestyle choices. In addition, they provide information to other health professionals, government workers and carers.

This study showed significant improvements for consumers across a range of areas: symptom reduction; occupational and social functioning; less coercive interventions; increased utilisation of available health, welfare and social supports. Service level improvements included greater resourcefulness and better use of specialist services.

Findings from this study demonstrate the effectiveness and efficacy of services provided by the credentialed mental health nurses in the program and will inform decisions about the program for the future.
I congratulate Dr Richard Lakeman and the research team for their excellent work in undertaking this study and I commend this report to you.

Professor Wendy Cross
President, ACMHN
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Executive Summary

The introduction of the Mental Health Nurse Incentive Program (MHNIP) in 2007 has been a unique initiative to deliver mental health care to people with complex needs in primary health care settings. The greater than expected uptake of the program since its inception has meant that many Australians have benefited from the range of services provided by Credentialed Mental Health Nurses (CMHN), working in collaboration with other health professionals and service providers.

There is a lack of data about the ‘typical’ role of the CMHN working within the MHNIP, and even less data about the outcomes for service users. Following the cap placed on the program by the Department of Health and Ageing in 2012 and the perceived threat to its continuation, the Australian College of Mental Health Nurses (ACMHN) commissioned this study. The aim of the study was to contribute to the body of knowledge about the MHNIP and gain knowledge about the characteristics of service providers and service users; obtain a snapshot of the scope of the role of CMHNs in the MHNIP; gather data about the program’s effectiveness for service users, and to explore models of collaboration used by CMHNs to most effectively achieve quality outcomes for service users and job satisfaction for CMHNs.

The study confirms the positive impact the MHNIP has had on primary mental health care for people with complex and severe mental health and social problems. Key findings include:

- Consumers\(^1\) have experienced significant outcomes in their clinical and personal recovery – this is supported by both quantitative and qualitative data collected in this study.
- The services provided by CMHNs are tailored to the person’s needs, drawing on the CMHN’s skills and experience in working with people who have complex problems, in case management and psychotherapy.
- The MHNIP has enabled CMHNs to work collaboratively with a diverse array of services and to successfully engage consumers with the services that they need.

\(^1\) In this report the term ‘consumer’ is generally used to refer to those individuals and family members whom are formally referred to the CMHN. This term may be considered synonymous with patient, client, service user or simply person and these terms are also occasionally used as appropriate.
• The program is being accessed by people with severe mental health problems who are also likely to have complex social, occupational/educational and physical health issues.

• All CMHNs utilised clinical supervision to support their professional practice.

Researchers from Southern Cross University surveyed current CMHNs listed on the ACMHN database. As credentialing is a requirement for mental health nurses to work in the MHNIP, and the ACMHN is the only organisation providing a credentialing service for mental health nurses in Australia, the database provides a comprehensive list of mental health nurses who are currently or have previously worked in the MHNIP. Responses from a cohort of 238 CMHMs were included in the study.

A series of open ended questions gathered information about: the demographics of the CMHN workforce; services provided by the MHNIP; evidence of collaboration and linkages; outcomes for consumers of MHNIP services; professional support for mental health nursing practice in primary health care settings; the impact that the current MHNIP structure has on CMHNs, and profiles of people who most commonly use the MHNIP.

Findings from the study identified that CMHNs are generally older than the average mental health nurse in the broader population, and are geographically located across metropolitan, regional and rural centres. CMHNs are all educated to a postgraduate level (as required by the ACMHN Credential for Practice program) and many hold a range of additional professional and academic qualifications.

Responses to questions about working arrangements indicated that most CMHNs were working part time, often with more than one ‘eligible organisation’ or doctor. Working arrangements and contractual agreements were diverse, ranging from CMHNs being employed in traditional arrangements with annual leave and study leave built into their agreements, through to self-employed or fee for service arrangements with a range of different individuals or eligible organisations. CMHNs who were not in employed situations indicated that they were required to meet costs associated with indemnity insurance, room rental, professional development, and administration expenses.

The study revealed that CMHNs adapt and tailor their therapeutic approach or specific interventions to individual service user requirements. The CMHNs collaborate and liaise
with other health professionals, government and non-government agencies, and community services to assist people to resolve problems and meet their psychosocial needs.

CMHNs emphasised their role in co-ordinating care, acting as case managers, undertaking assessments, planning care, providing medication advice and management, and assisting service users by promoting healthy lifestyles. Many respondents have post-graduate training and qualifications in the fields of psychotherapy and counselling, which they utilised as required. Education of other health professionals, government workers and family members was also mentioned as an important part of the CMHN’s role.

The survey collected quantitative and qualitative data on the effectiveness of CMHN interventions. Results were impressive, with findings suggesting that service users experienced significant improvements in symptoms as well as occupational and social functioning. Qualitative analysis demonstrated that service users experienced less coercive care, and made better use of available health, welfare and social supports in the program. It was also demonstrated that service level outcomes included more efficient use of existing resources and less but more effective use of specialist services.

An interesting finding was the severe constellations of symptoms experienced by service users on admission to the MHNIP, which tended to resolve over time following interventions by the CMHN in collaboration with other service providers.

The survey included questions about the professional support available to CMHNs. This was found to vary considerably, but all respondents indicated that clinical supervision was a critical element of their professional practice, and peer and collegial inter-professional relationships were important sources of support.

A question was added to the survey as a result of comments received from respondents. This question related to why CMHNs left the MHNIP. Responses indicated that the cap had impacted significantly on the sustainability of CMHNs working independently. Additional concerns were also raised about the remuneration and conditions offered to CMHNs, unsatisfactory commercial relationships with eligible organisations, and the structural design of the MHNIP which places limitations on the ability for some CMHNs to build sustainable businesses.
Findings from this research build upon the existing evidence which demonstrates the effectiveness and efficacy of services provided by CMHNs, and provides some guidance about future directions for the MHNIP.
Introduction
Addressing mental health problems in primary care settings has been an international and national priority for over a decade (see: World Health Organisation, 1998 & 2008). Australia has introduced various programmes to increase access to mental health care and treatment in primary care settings, particularly for high prevalence problems such as depression and anxiety. In 2006 the Council of Australian Governments (COAG) released an Action Plan that included the allocation of funding for the establishment of the Mental Health Nurse Incentive Program (MHNIP). This programme was intended to address the needs of people with complex and severe mental health problems.

The program, which commenced in 2007, enables eligible organisations such as general practices, private psychiatric services, Divisions of General Practices, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services to register with Medicare Australia to become eligible to receive funding to engage the services of credentialed mental health nurses (CMHN). The Department of Health and Ageing (2013) describe the intent of the program to:

...ensure that patients with severe and persistent mental illness in the private health system receive adequate case management, outreach support and coordinated care. The MHNIP also assists in relieving workload pressure for general practitioners and psychiatrists, allowing more time to be spent on complex care. Close and effective collaboration between mental health nurses, general practitioners and psychiatrists in the delivery of clinical support and services in the community is expected to:

• improve levels of care for people with severe mental disorders
• reduce the likelihood of unnecessary hospital admissions and readmissions for people with severe mental disorders and
• assist in keeping people with severe mental illnesses well, and feeling connected within the community.

The uptake of services through the MHNIP was exceptional, with over 140,552 session payments being made in the 2011-2012 year alone, and with annual growth ranging between 23 and 31% (Health Management Advisors, 2012).

Its success meant that the cost of the program exceeded budgeted forecasts and in May 2012 the Australian Government announced a cap on activity at the 2011 – 12 service levels pending the outcome of an evaluation of the program. The evaluation reviewed the program from a public policy perspective. Whilst the findings suggested that the program is strongly supported by GPs, psychiatrists and mental health nurses (MHN), with evidence that patients experience improved health outcomes, the report (Health Management Advisors, 2012) had a number of gaps, including limited information on the characteristics of consumers using the program or detail about the effectiveness of mental health nursing services. It also presented an uncritical endorsement of the way the programme was funded.
via eligible organisations. The report (Health Management Advisors, 2012) suggested that there is a need to incentivise nurses working in rural and remote areas, to strengthen operational guidelines and improve the collection and utilisation of outcomes information.

An Expert Reference Group consisting of members from key professional and other stakeholder groups has been established by the Department of Health and Ageing to consider how to address the issues raised in the evaluation, and to provide guidance on re-designing the program. The Australian College of Mental Health Nurses (ACMHN) is a member of this reference group.

This report commissioned by the ACMHN provides an additional level of insight into how CMHNs are able to use the program to provide recovery oriented services in primary health care settings. The program has significant value to consumers, other health professionals and service providers who support people with mental illness. The evidence of this study suggests that it is important that any re-design of the MHNIP retains features that support collaboration, diverse models of care, and enable CMHNs to work autonomously within their full scope of practice.
Background and context

1. Design of the MHNIP

The MHNIP provides a non-MBS incentive payment to community based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services who engage mental health nurses to assist in the provision of coordinated clinical care for people with ‘severe mental illness’. Established in 2007, the program is described by the Department of Health and Ageing (DoHA) as being:

...structured so that mental health nurses work in collaboration with private psychiatrists and general practitioners to provide a range of services including periodic reviews of the mental status of patients and medication monitoring and management.

The intent of the MHNIP is to ensure that patients with severe and persistent mental illness in the private health system receive adequate case management, outreach support and coordinated care’ (Department of Health and Ageing, 2013).

The Department of Human Services administers the MHNIP on behalf of DoHA. In order to be eligible for the program, organisations must be community based and either employ or access the services of a general practitioner with a Medicare provider number or a psychiatrist registered with Medicare.

The Department of Human Services describes ‘Eligible Organisations’ as including:

- General practices
- Private psychiatry practices
- Aboriginal and Torres Strait Islander Primary Health Care Services funded by the Australian Government through the Office for Aboriginal and Torres Strait Islander Health
- Divisions of General Practice, which may contract the services of mental health nurses to work with general practitioners with a Medicare Australia provider number or other medical officers (as approved by DoHA) working within their Division
- Medicare Locals, which are also eligible to receive payments under the MHNIP.

In order for mental health nurses to be engaged in the MHNIP, they are required to be nationally credentialed through the ACMHN Credential for Practice Program (CPP) and trained in the use of the Health of the Nation Outcomes Scale (HoNOS).

Payment for mental health nursing services is made by the Department of Human Services to Eligible Organisations which receive:
• A payment of $240 (GST inclusive) capped at 10 sessions per nurse per week
• A 25% loading applied to sessions provided in remote and outer regional areas, and
• A once-off establishment payment of up to $10,000 GST free to assist organisations with upfront costs associated with the MHNIP, such as recruitment and equipment costs.²

Session levels are currently capped at 2011–12 levels pending analysis of the findings of the evaluation project, which was completed in late 2012, and a further review of the program. An Expert Reference Group convened in 2013 (outlined above) will provide advice on the future design and management of the program.

2. The Research Study

This research study was commissioned following the placement of the cap on the MHNIP in 2012. The ACMHN and others were concerned that the cap was a potential threat to the program’s future, so it was identified that there was an urgent need to capture the perceptions of CMHNS whilst they were still working in the program. The ACMHN had previously included an on-line survey as part of its consultation with nurses in 2009 (Gendek, 2009). That survey had explored nurses’ perceptions of the MHNIP in the first two years of its existence. The program had grown significantly since the survey was undertaken, so by 2012 more recent data was required to gain a contemporary picture of the current status of the program from the perspectives of nurses working within it.

The ACMHN was in a unique position to undertake such research, since under the terms of the MHNIP nurses are required to hold a mental health credential. The Credential for Practice Program (CPP) is an initiative of the Australian College of Mental Health Nurses and has established the only nationally consistent recognition for specialist MHNs³. A database of current credentialed nurses is held by the ACMHN, thus providing a ready source of potential participants for the research.

The ACMHN invited Southern Cross University to undertake research on its behalf to gather qualitative and quantitative data about the effectiveness of the MHNIP. The lead researcher at the time (August 2012) was undertaking a phenomenological study, which explored how CMHNS working in MHNIP assisted service users (Hurley et al., 2013). It was anticipated that by undertaking a survey of mental health nurses as part of a formal research project, (which would include associated ethical review and over-site, peer review of products, and methodological rigor) findings were likely to add substantially to the body of knowledge and evidence base associated with MHNIP, and add credibility to (or call into question) the findings or assertions of others in relation to the program.

³Australian College of Mental Health Nurses (2013). What is credentialing? http://www.acmhn.org/credentialing/what-is-credentialing

Accessed 16 August 2013


Methodology
A reference group was formed consisting of MHNs who had experience providing mental health nursing, to assist in developing a survey instrument, review the questions, trial the online questionnaire and review the findings from the survey. The reference group convened regularly via teleconferencing and email.

Design of the Survey Tool

It was agreed that most questions in the survey should be ‘open’ rather than ‘closed’. This was partly in response to the style of questioning utilised in the DoHA evaluation questionnaire (Health Management Advisors, 2012) in which there were several instances of closed questions which suggested a poor understanding of how the MHNIP was operationalised in practice and prevented any kind of discovery of this through a closed line of questioning. For example, nurses were asked to tick a series of options relating to their employment by various options but none of the options would have been applicable to many nurses who were ‘engaged’ with multiple organisations in complex ways and employed by none.

In order to avoid presuming that responses might fall into predetermined categories, the ACMHN survey was constructed to enable discovery. The suite of questions included gathering data on:

- how CMHNs and other health professionals worked within the program
- how CMHNs worked with other agencies
- what education CMHNs had received which informed their role
- what ongoing support or supervision CMHNs received
- the main outcomes of the MHNIP program as perceived by respondents.

Shortly after the survey was deployed it was suggested by some nurses who had left the MHNIP that an additional single question be asked, ‘Why did you leave the MHNIP?’

Participants in the survey were also asked to provide a vignette of one of their ‘typical clients’. This element was included in response to the lack of information available on the characteristics or profiles of people who access MHNIP services.

Identification of participants

A pragmatic consideration was the time required by busy professionals to complete the survey and the lack of resources available to reimburse participants for their time. Existing data held by ACMHN on its credential mental health nurse database was therefore utilised to extract demographic information previously supplied to the College. Respondents were asked for their Credential number, which was used as a unique identifier in the survey. The ACMHN then provided a de-identified spreadsheet to the researcher which included information such as postcodes, date of birth etc. Unfortunately the database didn’t capture
all variables of interest such as the actual qualifications of nurses. This information was therefore gathered separately.

**Content of the Questionnaire**

The following questions were included in the questionnaire:

- How do you work collaboratively with other services?
- How do you work collaboratively with medical practitioners / referring doctors?
- What are the main roles you assume with people referred to the MHNIP?
- What have been the most significant outcomes for people with whom you have worked?
- What qualifications / training have you undertaken which have helped you most in the work you do?
- Please consider someone whom you consider typical of people you have worked with in the MHNIP:
  - What is their age?
  - What is their gender?
  - What is their medical diagnosis?
  - Please provide a profile including their presenting problems
  - Please detail the kind of interventions or activities you undertake in relation to the person.
  - Please describe the most significant outcomes / achievements to date.

Respondents were further invited to provide some online case studies that required inclusion of the following information:

- Person’s current age
- Person’s gender
- Person’s medical diagnosis
- Outline of main presenting problems
- HoNOS\(^4\) at entry and last entry (or on separation)
- Other significant outcomes
- Main activities undertaken with the person
- Number of service occasions provided to that person
- Focus of the relationship at the time of submission.

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\(^4\) HoNOS. Health of the Nation Outcome Scale. See [http://www.acmhn.org/career-resources/mhnip/honos](http://www.acmhn.org/career-resources/mhnip/honos), Accessed 17 August 2013
Distribution of the Questionnaire

Potential participants were contacted by email. Details of the emailed letter and the actual questionnaire can be found at Appendix 1. The questionnaires were deployed using Qualtrics Survey Software (Qualtrics Labs, 2009) which was accessed by respondents clicking on a link in their invitation e-mails.

The project was reviewed and approved by Southern Cross University Human Research Ethics Committee (Approval number ECN-12-206).

Data Analysis

1. Quantitative data

The questionnaire responses were downloaded in a spreadsheet format and imported into NVivo\(^5\) for assistance with analysis. Descriptive statistics were used to describe the profiles of CMHNs and the people with whom they work.

2. Qualitative data

Qualitative data from the survey was subject to thematic content analysis (Braun & Clarke, 2006). Content analysis has its roots in quantitative traditions whereby particular instances of text are counted within a transcript.

Thematic content analysis has evolved in the qualitative tradition to mean multiple things. In this study, the response to each question was collated, and starting with the first line the researcher determined what each statement represented. From this, a category was generated. The dataset was then scanned for other instances of the category. The next discrete idea or statement was then read and a further category generated. This process of category generation and scanning was undertaken until all of the data was accounted for, and all variances within the data captured. All categories were then examined for patterns, outliers and consistency, and some categories were collapsed into others or made into higher-level categories. The category generation process utilised was inductive (driven by the data) rather than deductive (driven by a preconceived theory). The researcher’s recording and analysis of the data by category aimed at faithfully representing what respondents said.

The categories or themes could also be quantified, and where appropriate, such quantification was expressed in the number or percentage of respondents who mentioned a particular category. The significance of these numbers is open to contention as it is not necessarily a measure of importance. Finally, the analysed data were presented back to a reference group for their opinions and views of the way the responses were represented.

\(^5\) NVivo is a qualitative data analysis computer software package produced by QSR International. It has been designed for qualitative researchers working with very rich text-based and/or multimedia information, where deep levels of analysis on small or large volumes of data are required (Wikipedia 2013). [http://en.wikipedia.org/wiki/NVivo](http://en.wikipedia.org/wiki/NVivo). Accessed 17 August 2013.
The reference group members generally commented that the findings were in accord with their own experiences.

**Results**

The report of the findings from the survey has been broken down into the following key areas of interest:

1. MHNP workforce characteristics
2. Mental health nursing services provided by the MHNP
3. Evidence of collaboration and linkages
4. Outcomes for consumers of MHNP services
5. Professional support for mental health nursing practice
6. Program structure impacts on CMHNs
7. Profiles of people who use the MHNP services

1. **MHNP workforce characteristics**

The Credentialed Mental Health Nurses (CMHNs) who work in the MHNP share many characteristics with other nurses working mental health, but they are generally older and probably more highly qualified. Geographically, there are more CMHNs who work in MHNP who are located in Victoria compared with the nursing workforce as a whole, but it appears there are greater numbers outside metropolitan areas (AIHW 2012).

**Key points**

- The average length of time that CMHNs had worked within the program was 2.6 years.
- A little under half of respondents worked outside metropolitan areas.
- Most CMHNs (88%) worked with more than one doctor.
- All respondents held postgraduate qualifications.
- Training in the field of psychotherapy was common and 71% of respondents reported psychotherapy training was helpful in their work.
**Method**

Of the 283 responses to the on-line survey, only 238 responses were included in the analysis. Respondents were included if they had previously or were presently working under the MHNIP, had completed all demographic questions and had responded to at least one qualitative question. Some numerical data was entered by respondents in text and others gave a range from which the median was calculated. There were 226 responses to the question asking nurses what training or education was helpful in their work.

Respondents were asked to provide their Credential number issued by the ACMHN, and further demographic information was matched against this.

**Findings**

**Age and Gender**

The age of respondents ranged from 27 to 68 years and only 12% were under the age of forty years. The average age of respondents at the time of analysis was 50.7 years (SD=10). Seventy two per cent of respondents (n=171) were female, 28% were male.

**Place of work**

The location of respondents was based on information provided to the ACMHN in their most recent credentialing application. Figure 1 illustrates the breakdown of location by state/territory.
The majority of people reported working in metropolitan or inner city areas (53%, n=123) and the remainder worked in rural, regional or remote settings (as illustrated in Figure 2).

Duration and frequency of work in MHNIP
The average length of time that respondents reported they had worked within the MHNIP was 2.6 years (SD=1.5 years). Some respondents had only just started in the program (7 had been working for less than 3 months). However 85% had been working in the program for more than a year (n=201).

Working arrangements
- Most respondents worked part time (averaging 8 sessions per week)
- Most respondents worked more than one session per week
- 22% worked 5 or less sessions per week
- Average face to face consultations was 16 per week (SD = 9)
- Average number of consumers seen each session was 2.1

Referrals
Responses indicated that there was a wide variation in the number of referring doctors each respondent works with. Details are displayed in Figure 3.
Those nurses employed by Medicare Locals received referrals from a greater number of medical practitioners with one person estimating that they received referrals from up to 200 doctors.

![Figure 3: The number of medical doctors who refer to the CMHN](image)

**Qualifications**

- 20% (n=46) of respondents reported that they had a first qualification in psychiatric or mental health nursing (often obtained overseas) and stated that this was an asset in their role
- 8% (n=18) stated their comprehensive or generalist nursing qualifications were an asset

All respondents to the survey held postgraduate qualifications. The majority had at least postgraduate diplomas in fields such as mental health nursing, counselling or psychotherapy. Key findings were:

- 32% of respondents held one or more mental health related Masters degrees with mental health nursing (n=43) and psychotherapy (n=29) being the most common majors.
- Eleven CMHNs reported having attained or were working towards a Nurse Practitioners qualification.
• Two respondents held doctoral qualifications and several others were working towards PhDs.
• A considerable number reported having higher degrees unrelated to mental health.

Additional education

• 71% (n+161) respondents reported that they had undertaken education in psychotherapy citing training in one or more forms of psychotherapy as being useful.
• The most commonly reported schools of psychotherapy used were Acceptance and Commitment Therapy (ACT) (36%), Cognitive Behavioural Therapy (CBT) (28%) and Family therapy (FT) (12%).
• 42% of respondents reported training in another modality such as dialectic and behavioural therapy, mindfulness, motivational interviewing, gestalt, narrative therapy, interpersonal or psychodynamic therapies.

Discussion

The demographic profile of respondents is generally consistent with national data relating to nurses working in mental health. The Australian Institute of Health and Welfare (AIHW 2012) estimate that in 2011 there were 17,738 nurses (both registered and enrolled nurses) employed principally in mental health. Of these almost one third (32.5%) were male which is similar to the sample in this study. The MHNIP sample is however, older with a mean age of 50.7 years compared with 46 years for the overall workforce. This may signal a level of experience and expertise required for the MHNIP role and the professional and/or financial capacity for nurses to move into less secure positions at this life stage. The MHNIP sample probably represents more experienced nurses who have achieved a higher level of educational attainment than nurses in the general workforce.

Just under half of the CMHNs work outside metropolitan areas, which contrasts with AIHW data (2012) that indicates 73% of all nurses working in mental health work in major cities. This indicates that the MHNIP is increasing access to specialist mental health practitioners in regional and rural Australia. The evaluation of MHNIP undertaken by Health Management Advisors (2012) expressed a concern about the concentration of MHNIP in some states. However, a greater analysis of the geographic distribution of the MHNIP across
metropolitan, regional and rural areas is needed, as their conclusions are discordant with these study findings.

The study provides further insight into CMHNs’ patterns of work in the MHNP. The recent evaluation of MHNP (Health Management Advisors, 2012) looked at the average number of sessions per nurse and findings were consistent with this study. This provides confidence that the sample in this study is representative of all CMHNs working in the program. However, this study is also the first to collect information on the duration of nurses’ participation in the program. There has also been little data available previously on the number of medical practitioners (as opposed to medical organisations) that CMHNs work with under the MHNP. The study demonstrates that while there are less than 500 organisations registered to use the MHNP, there are considerably more medical practitioners who refer people to CMHNs under the MHNP. A conservative reading of Figure 3 suggests there would be in excess of 1400 medical practitioners accessing the program.

Responses by CMHNs working in MHNP demonstrate that the cohort is highly educated in their specialty. This is unsurprising given that the mandatory credentialing requirements for MHNs include evidence of a relevant post-graduate or specialist qualification.

A surprising finding is the breadth of specific training and experience in particular forms of psychotherapy or counselling reported by participants. As various forms of psychotherapy were identified by Gendek (2012) as being components of graduate diplomas and Masters programs in Mental Health Nursing, it is likely, therefore, that results identified in the survey may even underestimate the level of training in these techniques.

Health Management Advisors (2012) attempted to categorise ‘interventions’ undertaken with service users at case study sites and estimated that ACT was used with 80.8% of service users followed by CBT (76.9%), brief solution focused therapy (76.9%) and motivational interviewing (61.5%). It is unclear how the researchers arrived at these categories or figures but they nevertheless are congruent with CMHNs’ reported training in particular forms of therapy and also the roles they reported assuming with service users.
2. Mental health nursing services provided through the MHNIP

Key points

- Credentialed Mental Health Nurses (CMHNs) adapt and tailor interventions and collaborate with others as necessary to assist people to resolve problems and meet their psychosocial needs.
- The functions and roles CMHNs adopt when delivering services through the MHNIP cannot be readily reduced to a list of discrete interventions.
- A prominent role adopted by CMHNs was that of counsellor or psychotherapist.
- The main activities CMHNs undertook when delivering services through the MHNIP were:
  - Assessment, care planning
  - Consultation and education
  - Linkage and liaison
  - Medication management
  - Physical health management
  - Psychotherapy and counselling
  - Psychosocial interventions including skills training and coping enhancement
  - Utilisation of strength and hope based approaches

Method

CMHNs were asked to describe the main roles that they assumed under the MHNIP. There were 228 responses to this question. Most respondents listed a range of roles that they assumed, or provided a narrative account of the types of activities that they undertook. Responses were analysed using thematic content analysis.

Findings

The narrative accounts given by respondents typically provided an explanation of the activities CMHNs undertook, their therapeutic approach, and the roles they assumed. They also provided insight into the client populations they worked with and the relationship they had with other health professionals and organisations.
Given the narrative nature of responses, typically addressing numerous issues, few responses fitted comfortably into any single category. Instead they tended to traverse numerous areas. The following were the dominant themes:

- Assessment
- Care planning
- Consultation and education
- Linkage and liaison
- Medication management
- Physical health
- Psychotherapy
- Psycho social interventions, skills training and coping enhancement
- Strength and hope based approaches

Most responses detailed the particular populations with whom CMHNS worked, and the various assessment activities and key interventions undertaken. Example can be found in Appendix 2.

As various narratives demonstrated, nursing roles encompass assessment, psychotherapeutic interventions, case management, collaboration with other agencies and physical health care.

**Assessment**

Most CMHNS (92%, n=209) described assessment as pivotal to their role and a core component of their activities. Nurses often mentioned that they undertook a broad psychosocial assessment, but some responders also specified areas of assessment, for example, psychiatric history, mental state, physical health, and coping and treatment assessment. The purpose of assessment included triage (in some instances), monitoring people’s wellbeing, informing diagnosis and treatment, care planning and serving as the basis for providing advice to others.

Some respondents mentioned particular screening tools or outcome measurements that were used according to need.

...A full bio-psycho-social mental health assessment [leading to the] development of a nursing care plan which highlights areas of issue for the client, our goals and
specifically what we shall do to achieve those goals. Built into this care plan are regular review dates and use of HoNOS, K10, Becks depression scale, Becks anxiety inventory and LUNsers, where appropriate...

CMHNs described undertaking a mental state examination and assessing risk at regular intervals.

I perform a mental state examination and risk assessment on every occasion I interact with the client, and direct care and activity scheduling accordingly and as appropriate, liaising with the doctor or public psychiatric service if there are immediate concerns.

Fifteen respondents spoke explicitly about the importance of being able to undertake physical health assessment and many more respondents alluded to physical health assessment when describing their roles in health promotion. CMHNs described monitoring weight, taking blood pressure, reviewing pathology results and undertaking ECGs as required.

Initially, the client is fully assessed and mental health management plan established with the client. This not only includes mental health but general health as well. I have found that having a nursing background has enabled me to pick up medical conditions that have contributed to the client's mental health [problem] that hasn’t been diagnosed prior (e.g., thyroid conditions etc.)

Care Planning

Some respondents described how they helped with the construction of the GP Mental Health Treatment Plan, but a number of CMHNs (24%, n=54) spoke of being solely responsible for developing a mental health treatment plan or for undertaking a separate care planning process to that of the GP Mental Health Treatment Plan. For most of those who mentioned treatment or care planning they spoke of negotiating this in the first instance with the consumer, and sometimes with family.

I undertake assessments and plan interventions with individual clients, taking into consideration the assessment and plan outlined in the referral.

It was also evident from survey responses that people with more complex needs were
referred to the CMHN who then made an assessment and planned care according to need. If necessary the CMHN might involve other people. Many referred to joint supervision or case review conferences to present updates, or further plan interdisciplinary or shared care (this is discussed in more detail later).

(At the) first appointment I do a comprehensive Mental State Examination. I do a mental health care plan and work out the clients short and long term goals. I identify risks and what supports the client might already have. Next visit we look at the client’s mental state and how they are functioning. Every client is individual and their needs are very different and diverse. I do Cognitive Behavioural Therapy with the client, look at their physical health and refer to relevant organisations. Each visit I identify risks. I look at supports and what outside groups might be suitable e.g. parenting group for Mums with Mental Illness, XXX Christian Outreach Volunteer program (this group might give mental health clients a phone-call or go for a coffee). I give printed information and work books to clients, when they are well enough to do this e.g. on depression, anxiety, anger management, assertive training, and information on medications. I also refer to Mindfulness Program, which is run at our Medical Centre by one of the GPs and the other mental health nurse.

Consultation and Education

Nurses frequently mentioned providing ‘psycho-education’ (19%, n=43) to others. The scope of education described was broad, including education about medications and medication side effects, community supports, mental health and coping strategies. Education was provided to consumers, carers, GPs, practice staff, allied health professionals and staff in other services. Some nurses mentioned providing consultation and advice to GPs or other health professionals on topics such as medication management, psychological approaches to care and appropriate services for further referral.

I provide a wealth of knowledge regarding mental health services within the GPs’ local community and beyond. Many of the newer GPs have very little understanding of Mental Health services.

Liaising with, and providing information and emotional support to carers and families was also often described.
Linkage and liaison

The importance of linkage and liaison with other services was frequently cited by participants, and is discussed in the section entitled Evidence of Collaboration and Linkages.

Medication management

Medication management was specifically mentioned by approximately half of the CMHNs. Key areas of medication management identified by CMHNs included:

- Monitoring medication efficacy
- Monitoring for adherence to prescribed regimes
- Titration of medications and helping people reduce their medications safely
- Provision of advice and education regarding undesirable side effects
- Making recommendations for medications with a more acceptable effect profile
- Monitoring people receiving neuroleptics for metabolic syndrome, and managing emerging problems in conjunction with the prescriber.

A few CMHNs (n=6) stated they administered injectable depot forms of medication. Some nurses provided detailed descriptions of the medication management aspect of their role. For example a nurse who worked with a psychiatrist in an adult attention deficit hyperactivity disorder clinic stated:

_Most referrals to clinic see me first for initial assessment - history taking, mental state exam, vital signs etc. After seeing a psychiatrist for diagnosis and treatment I monitor them as they start and increase stimulant medication and observe for side effects and co-morbid conditions e.g. anxiety and/or depression. I provide some counselling and psycho-education. In addition I correspond with GPs regarding progress, and discharge back to the GP care when ready, ensure that DDU [Drugs of Dependence Unit] approvals are valid and in date, monitor if second opinions are required, deal with interstate controlled drug regulation boards..._

Physical health management

CMHNs working within the MHNIP program identified that monitoring the overall physical health of the person was a key activity. Several respondents described how physical health
assessment is a routine component of their work, findings from which may result in referrals to services such as diabetic educators, dieticians or other health providers.

Many respondents recorded that they also provided direct advice and coaching relating to lifestyle and general physical health in order to optimise people’s health. This included promoting and motivating clients to exercise, and providing dietary advice.

Several mental health nurses also spoke of having roles in managing chronic illness in partnership with other health professionals and establishing exercise or health lifestyle group activities.

**Psychotherapy** and utilisation of psychotherapeutic skills

Almost all respondents (94%, n=214) spoke of undertaking some specific form of psychotherapeutic intervention or being versed in particular psychotherapeutic approaches, which were employed flexibly and according to their clients’ needs. Many were explicit about adapting or employing elements of particular schools or using techniques integrated into their general approach. Thus, the utilisation of these skills appeared needs driven rather than diagnosis driven. These needs were revealed in part through the assessment process, but also seemed to emerge as the relationship between nurse and consumer developed.

I monitor the person’s mental state, gather information to assist in the clarifying the person’s diagnosis, provide psycho-education, medication advice and guidance, problem solving, connecting with community support agencies, liaise with the Alcohol Tobacco and Other Drug Service, sexual health services, access homeless support services, support in accessing the Guardianship and Administration Tribunal, attend involuntary treatment order reviews, encourage increased knowledge of rights when admitted (especially under ITO [Involuntary Treatment Order]), collaborate with community case management in developing transition to primary mental health care (not a case management approach). I liaise with families via family meetings as

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6 Psychotherapy may be broadly defined as the treatment of mental health problems by psychological means. The Psychotherapy and Counselling Federation of Australia state “Psychotherapy and Counselling are professional activities that utilise an interpersonal relationship to enable people to develop self-understanding and to make changes in their lives. Professional counsellors and psychotherapists work within a clearly contracted, principled relationship that enables individuals to obtain assistance in exploring and resolving issues of an interpersonal, intra-psychic, or personal nature. Professional Counselling and Psychotherapy are explicitly contracted and require in-depth training to utilise a range of therapeutic interventions, and should be differentiated from the use of counselling skills by other professionals.” Close to 25% of this sample appeared to practice psychotherapy and many others used interventions drawn from psychotherapy.
needed, my primary interpersonal counselling approach is Glasser’s Reality Therapy along with a mix of Cognitive Behavioural Therapy, Schematic Focussed Therapy, Motivational Interviewing, Acceptance Commitment Therapy and of course yoga relaxation. I also use mental visualisation with meditation.

Specific schools of psychotherapy cited by CMHNs included: solution focused, reality therapy, psychodynamic, narrative therapy, interpersonal, integrative, hypnotherapy, gestalt, dialectic behavioural therapy (DBT), family therapy, cognitive behaviour therapy (CBT), acceptance and commitment therapy (ACT), and motivational interviewing. ACT, CBT and family therapy (27% n=27) were most frequently mentioned. Additionally respondents mentioned providing psychotherapy or psychotherapeutic interventions to particular groups such as people with alcohol and drug related problems, sexual abuse or trauma victims, parents and children and people experiencing grief. Some also acknowledged providing non directive pregnancy counselling (an additional MBS item which is available to nurses with particular training).

A number of respondents (n=35) stated that they saw their role as mainly providing psychotherapy, with the same boundaries as a psychotherapist. However, from the information provided, there appear to be variations from a traditional psychotherapy relationship, which are related to the acuity and case complexity of the clients seen.

My main role is in therapy. I offer a psychoanalytically informed psychotherapy. Most of the patients referred have had recent and or long-term psychiatric admissions... I support them if they are at risk to themselves or others and if necessary would help to admit them to hospital. Thus far the only patient I have helped admit to ED was after a seizure. It is common practice for me to ring a patient if they are feeling suicidal or are at risk of behaviours likely to be injurious to their health or others. This includes calling a patient who does not attend an appointment and making appointments based on need and acuity. Most patients see me twice a week for 50 minutes and I also have some patients who have their session over the phone due to distance, lack of access to public transport or financial restraints.

In addition, data indicated that the nursing role was distinguished from the traditional psychotherapist role by the flexibility with which nurses adapt their role or assume others as necessary.
My primary role is as a psychotherapist. However as most of the clientele are of a complex nature they may require some 'mental health nursing' expertise which can lead to interventions outside of the [traditional] psychotherapeutic role e.g. medication monitoring, co-opting GP in a care role with a severely borderline suicidal patient, or being the instigator of parenting support classes for a patient with compromised techniques.

Another nurse described her use of family therapy in conjunction with other approaches:

...some people I use ACT therapy with and we work on their issues using this proven method of therapeutic intervention. Depending on the needs of the client and their family I may use my family therapy background and do family therapy with them. My work varies greatly according to the needs of the client, their family, the nature of the issues. If this is housing I contact the housing organization, if the issues are school based I will contact the school, if they have drug or alcohol issues I will use my contacts and experience in this area.

Supportive counselling plays a major part of my role and allows me the opportunity to introduce elements of psycho-education. Problem solving is also a part of this. I also have specialised training in Cognitive Behavioural Therapy and latterly Acceptance Commitment Therapy, and use these therapies with most people. Sometimes this is formalised, but often I use elements of these therapies as dictated by the client's abilities and commitment. Grief counselling is generally required at some point with almost all clients.

Psycho-social interventions, skills training and coping enhancement

More than half the respondents identified the use of psychosocial interventions, skills training or coping enhancement strategies if it was considered appropriate to aid in the recovery of clients. Examples described included assisting people with problem solving or adopting a ‘walk and talk’ approach with people who might otherwise be reticent about opening up, talking or exercising.

Skills such as ‘mindfulness’ were reported to have been incorporated into various schools of psychotherapy or psychotherapeutic programs such as DBT.

After gaining rapport, I use a 'mindfulness' approach encouraging clients to process
and accept their emotions and losses. This has been particularly useful in grief counselling where clients have lost partners through death and divorce, and several clients who have struggled with other losses such as loss of health or independence.

Some mental health nurses alluded to coaching roles relating to lifestyle, particularly promoting exercise, good nutrition and sleep hygiene. For example, one respondent facilitated a weekly group exercise and lifestyle program for people with chronic health problems. Some nurses used the term ‘life coach’ to describe this role, ‘... teacher of life skills such as assertiveness training, goal setting and relaxation techniques’.

Data also indicated that CMHNs demonstrated an interest in the general psycho-social problems that concerned consumers, including supporting people to access budgeting advice, housing assistance, social resources or food vouchers. Respondents also described accompanying clients to dental appointments and assisting with shopping if the client experienced social anxiety or avoidance symptoms.

I require the client to drive the relationship and to determine their needs and the characteristics of the professional relationship. I participate with them in their life, at their home and carrying out their life's activities. I do not operate from premises or have 'formal' sessions with them. For example, activities might include grocery shopping, swimming laps at the pool, going for bushwalks, getting used to trips on trains, buses, visiting crowded shopping centres for exposure therapy, role playing challenging encounters and financial budgeting.

Strength and hope based approaches

The importance of promoting self-management by conveying hope and working with people’s strengths was highlighted in the responses of some CMHNs.

Under the MHNIP I am able to work holistically, within a strengths based framework to assist patients in learning how to self-manage their symptoms. For example, a patient presents with depression and chronic pain, I can work with them to address the pain and at the same time use focused psychosocial interventions to assist them in relieving their depressive symptoms.
Nurses described working flexibly, often outside of the scope of traditional ‘clinic based’ modes of health care provision to establish relationships and build on people’s skills, capacities and capabilities.

We have put groups of clients together and run both men’s and women’s groups. We have facilitated the clients learning how to run the groups themselves and we have withdrawn ourselves and one of the groups has continued, being run by the women. The men’s group continues to be facilitated by a mental health nurse but has been successfully running now for over 2 years. These men were all previously socially anxious and isolated (all have schizophrenia diagnosis) and they now independently attend events together and visit each other’s homes. Some have formed friendships. It is the most rewarding nursing work I have ever done.

Discussion

CMHNs working within the MHNIP described how they assumed multiple roles with service users depending on individual needs. This supports Peplau’s (1952) work, which identified that the selection and adaption of roles according to the immediate needs of the service user is a key feature of mental health nursing. However, this feature is problematic in that nurses often fail to articulate what they do (Herceleskyj et al, 2013; Hurley, 2009) and it can render the work of the nurse invisible. Whilst some of the interventions described by respondents may be fundamental, they were chosen purposefully in order to build an optimal therapeutic relationship with the service user.

The themes identified from the survey reflect the core features of nursing practice, as described in the National Competency Standards for the Registered Nurse, which states that:

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes. The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual’s responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately (Nursing and Midwifery Board of Australia, 2006, p. 1-2).
The activities and roles described by CMHNs working in the MHNIP include, and extend beyond the program specifications for the role of the mental health nurse to “… work in collaboration with psychiatrists and general practitioners to provide services such as monitoring a patient’s mental state, medication management and improving links to other health professionals and clinical service providers” (Medicare, 2012). Most respondents described the provision of clinical nursing services consistent with their professional identity as mental health nurses, and definitions of mental health nursing. Others described themselves as case managers for some clients, but this role changed according to need and circumstance. This suggests that flexible adaptation of roles is what characterises the work of CMHNs working within the MHNIP.

The survey findings reveal that CMHNs working in the MHNIP emphasise the importance of physical health (perhaps a consequence of working in primary care settings and working with general practitioners). This is consistent with other surveys of nurses working under the MHNIP (Happell, 2013) suggesting that service users are receiving holistic physical care, and nurses are actively engaged with service users addressing physical health problems and attempting to address modifiable risk factors and facilitate healthy lifestyles. This is an important finding given the significant life expectancy gap and physical co-morbidities that people being treated for mental illness have been found to experience (Lawrence et al, 2013).

Responses to the survey indicate that the key roles of psychotherapist or counsellor appear to be adapted in distinctive ways. There is tentative evidence from the literature that at least some nurses are providing needs adapted or integrated psychotherapeutic approaches to people with highly complex needs (Margison, 2005; Lakeman, 2006; Shanley and Jubb-Shanley, 2012). The findings from this survey are consistent with Hurley’s (2009) findings that nurses make a unique contribution to ‘talk based therapies’ through adopting a service user focus (in contrast to focusing on techniques or manuals), utilising the personal self and spending time with the service user. This is further supported by Hurley et al’s phenomenological study (2013), and the findings of the recent evaluation of the MHNIP (Health Management Advisors, 2012).

Data indicates that CMHNs have utilised the MHNIP to provide niche services to diverse groups of people. The survey findings suggest a broader range of service user groups and a
greater degree of specialism than other case studies seem to suggest (National Advisory Council on Mental Health, 2010; Health Management Advisors, 2012). Some CMHNs appear to be working exclusively with particular groups such as children, adolescents, homeless people, those with eating disorders, people with substance abuse problems or service users from particular ethnic or cultural backgrounds.
3. Evidence of Collaboration and Linkages

Key Points

- CMHNs described working with other organisations consistent with the principles of clinical case management, which includes the case manager also being the service user’s primary therapist
- CMHNs described referring, liaison and shared working with a broad range of government and non-government organisations
- CMHNs described advocacy for the service user as an important part of their role in relation to other services
- CMHNs had a practical working knowledge of how to access state mental health services if needed.

Method

The survey included a question that asked:

How do you work collaboratively with other services?

226 respondents answered this question.

Findings

Most CMHNs reported making referrals, liaising, shared working, advocacy or providing education to and with a diverse range of agencies and health professionals. The majority of respondents listed the agencies they worked with (by name or type of agency) and outlined some of the ways they communicated or interacted:

*On a regular basis I liaise with psychiatrists, psychologists, pharmacists, ATODS [Alcohol, Tobacco and Other Drugs Service], police, adult guardians, rehab services, public trustee, hospital Clozapine clinic, government organizations (e.g. Department of Housing), non-government support services (e.g. Lifeline), public and private mental health service providers, public and private medical health service providers, welfare organisations other organisations e.g. Heart Foundation, ATSI [Aboriginal and Torres Strait Islander] services, TASC (legal advocacy). I refer clients to many different organisations and liaise with many organisations to promote holistic care.*
Often there is a need to advocate for the client. I organise and attend case meetings. I am able to visit clients whilst [they are] inpatients to commence discharge planning.

Respondents demonstrated a broad knowledge of resources available in their local communities, including helping people to access tertiary mental health services and other health services, and community and welfare services on an ‘as needs’ basis. Many CMHNs spoke of linking people to other specialist health services such as alcohol or drug treatment services, homeless support services, diabetes educators, respite services, transcultural health services, nursing services, and meals on wheels.

Respondents also mentioned a plethora of government agencies such as Centrelink, Department of Housing, Legal Aid, the Guardianship and Administration Tribunal, TAFE, universities, Community Corrections and Child Protection, which they routinely dealt with, as well as many non-government organisations such as employment agencies, lifestyle support agencies and support groups.

... My work varies greatly according to the needs of the client, their family, the nature of the issues. If this is housing I contact the housing organization, if the issue is school based I will contact the school, if they have drug or alcohol issues I will use my contacts and experience in this area...

Collaboration with other primary health care providers

Respondents reported collaboration and linkages with other primary health care providers, and identified the value placed in the different roles that others assume within the health care team. Many nurses mentioned making referrals to psychiatrists to clarify diagnosis or for recommendations on treatment.

...I provide linkages for clients who need more intensive follow up with a public mental health facility... One client recently commented to the GP that she was thrilled with the service that had been offered and the timely manner in which she was linked in with the service she required. I help the GP refer for one off assessments to a psychiatrist...
Referral

Survey respondents described making referrals to other agencies and if necessary providing practical and emotional support to the person to ensure that they link successfully to the service. They described completing referral documentation, convening meetings, accompanying them to appointments, advocating on the person’s behalf and maintaining contact with the organisation over time.

Depending on the client’s needs and abilities, I will support them to contact the NGO, or other health, welfare or support service, but often I have to advocate on behalf of the client. I work in a collaborative manner, completing initial referral where required, supporting the client to attend initial appointment. Once the client is engaged I liaise with client’s case manager or support person and collaboratively manage their care with at least 3 monthly contact to ensure client’s overall goals are being addressed in an ongoing manner.

Collaboration with other service providers

Survey respondents described how the CMHN is likely to be perceived by others as having a useful working knowledge of resources in the community and is therefore a conduit of information to other members of the team. Some nurses indicated that they provide shared care or co-case-manage people’s care with public mental health services or in partnership with a non-government organisation. Others assume the primary case management or care co-ordinator role when multiple agencies are involved.

...I take the role on as primary care coordinator for clients with multiple issues, multiple service involvement, often complex challenging behaviour, where there is an identified need for a cohesive and organised response by services.

Respondents described regularly attending meetings with a range of agencies including housing, disability support agencies, justice and other NGOs.

I attend case conferences with complex presentation clients who use multiple agencies. I work with intellectual disability services within the group homes to assess clients, provide education to staff and clients, monitor use and effectiveness of prescribed medications. I attend case meetings with Juvenile Justice Dept to coordinate treatment and planning for youths with mental health issues...
...Regular case conferences with child protection, centre link, welfare agencies, Salvation Army, St Vincent de Paul, AOD services etc are part of the service that I offer...

Connections with public mental health services

Survey participants wrote of having experience working in a range of public health services including adult, child and youth, consultation liaison, and forensic services, and maintaining productive working relationships with these services. Establishing these networks were identified as being valuable when helping people access services in a timely way.

... state mental health staff service respect my skills, and accept my assessments in the pathway to primary care and psychiatrist assessment...

Public mental health services are able to provide services beyond the scope of the MHNIP, such as out of hours crisis response or facilitation of admission to hospital.

... as I have a long standing history with the local mental health service... I have strong links and a solid reputation, which helps ease the collaboration we need at times around crisis situations.

CMHNs spoke of visiting consumers or people referred to the program in hospital and being involved in case conferences and discharge planning meetings.

...If a client is admitted to an inpatient unit I will make contact with them, I will try and visit that patient, be available for care plan construction, discharge planning even though I cannot claim them for my stats because having continuity of care and keeping the connection is very important to me.

Not all attempts at working with organisations were reported as being successful, however, with one survey respondent describing difficulties in establishing a useful working relationship with a public health service.

Advocacy

Survey participants reported undertaking advocacy to help their clients access the services and supports they needed.

This is the bulk of my work, as I tend to act as a case manager rather than therapist. The patients I have referred to me require this. I act in many cases as the patient’s
advocate or support person. I have on numerous occasions arranged team meetings between all services involved in order to get something happening. Services will often call me for advice on management of mental illness and also about medication.

Responses from the survey indicated that this advocacy role included:

- Contacting providers to obtain food, welfare vouchers and concessions on some services
- Lobbying public mental health services to obtain supported accommodation
- Writing reports for the courts
- Helping clients navigate government services, for example, to apply for disability support pensions, and to be placed on a priority housing list
- Organising access to other health services such as dental care.

Respondents also reported supporting their clients to make choices about engaging only with services that supported their recovery.

.... My clients don’t necessary get well by continuously linking them with services that pathologise and disempower them. I encourage my clients to look at themselves as healthy, functioning individuals who are on a journey of realising their strengths. Of course, we visit Centrelink when we have to but in order to ‘qualify’ for their services an illness hat has to be put on. It’s not a good experience and needs to be balanced by a happy joyful life giving activity afterwards. One of my clients has been in and out of acute units since she was 19 years of age. She is now 36 and had never been into a coffee shop in her life. Her link with that coffee shop is now more important to her than many others. It tells her she’s normal, like everyone else. My clients have often said to me ’I don’t want to go back there, they’re all mad’!

Education

CMHNs provide education, advice and support to other services, individual workers and organisations. Some nurses reported being involved in the formal provision of education to non-government organisations. This was typically unpaid work.

I have a great collaboration with mental health support agencies in this town and offer training at no cost to them a couple of times a year. We establish behavioural management strategies and discuss the outcomes, a quality approach.
Respondents also reported providing education to other organisations that were not health related, and to government agencies in order to work effectively with MHNIP consumers.

Being a mental health nurse you have to take a holistic view, issues are not always necessarily mental health issues. Issues surround housing, money (Centrelink), employment and welfare of children. Many of these organisations have no idea how to cope with people with mental health issues... Involves lots of phone calls.

Some respondents also spoke of establishing good working relationships by being involved in joint training with other staff of Medicare locals, the public mental health system or local mental health professionals’ networks.

Discussion

The program specifications for the MHNIP emphasise that CMHNs may improve links to other health professionals and clinical service providers under the broad umbrella of ‘coordinating clinical services’ (Medicare, 2012). The program specifications stress a brokerage role, and the Personal Helpers and Mentors (PHaMs) service (managed by the Department of Families, Housing, Community Services and Indigenous affairs) receives a special mention as facilitating access to welfare services and facilitation of personal recovery. Interestingly, while respondents described providing direct referral or liaison with welfare services, the PHaMs was rarely mentioned.

Forms of case-management have become the cornerstone of community mental health services in most western countries over the past 30 years (Kanter 2010). Models of case-management can be distinguished by the extent to which the case manager brokers out services to other agencies or attempts to provide a ‘full service’ to people from within the program.

For people with highly complex mental health problems, various forms of intensive or assertive case management (with most services being provided by a small, highly skilled team), have demonstrated efficacy, whereas brokerage alone appears ineffectual (Bedell et al, 2000). Some reviews have suggested that weak forms of case management increase hospitalisation rates with few gains (Marshall et al, 1998), whilst others suggest that case management is generally associated with positive outcomes especially when associated with assertive community treatment (Ziguras et al, 2000). Reports from respondents to the
survey indicate that the majority appeared to be operating from a hybrid model (Bedell et al, 2000) more closely aligned to intensive case management (Kanter, 1989). It has long been argued that case managers within this model should not simply be an intermediate broker of services but the service user’s primary therapist (Lamb, 1980) and many CMHNS in the MHNIP appear to have been operating in this role.

Respondents reported working with a wide range of agencies involved in a person’s life including non-clinical services. It has been demonstrated that the best combination of outcomes for people who have been homeless and experience mental illness (including housing stability, hospitalisation and improvements in wellbeing) are achieved with a combination of housing support and assertive community treatment; whereas the weakest outcomes have been found for intensive case management alone (Nelson et al, 2007). The MHNIP in itself cannot deliver such a combination of services, so CMHNS must capitalise on their relationships with other agencies and attempt to establish teams of supports for service users such as the provision of additional support in as the provision of housing. The findings from the survey indicate that this is occurring.

Evidence also indicates that clinical or symptom related outcomes are frequently entwined with social and occupational issues, and not every person referred to the CMHN needs additional services from others. Responses by the CMHNS to the survey indicate that they have an appreciation of these shifting roles required by service users and react appropriately.
4. Outcomes for consumers of MHNIP services

Key points

• Outcomes for consumers accessing MHNIP encompass both clinical and personal domains of recovery. Both qualitative and quantitative findings suggest that people can experience significant improvements in symptoms as well as occupational and social functioning.

• CMHNs report that service users experience less coercive care and make better use of available health, welfare and social supports in the program.

• Service level outcomes include more efficient use of existing resources and less but more effective use of specialist services.

• Service users appear to have severe constellations of symptoms on admission to MHNIP but these tend to resolve over time.

Method

One survey question asked participants in the survey to describe the most significant outcomes and/or achievements associated with MHNIP. 225 responses were received and were analysed using thematic content analysis (Braun and Clarke, 2006). Additionally CMHNs were invited to provide case vignettes, which included a HoNOS score on referral to the program and details of the last recorded HoNOS score.

The detailed findings are presented elsewhere (see: Lakeman, 2013; Lakeman & Bradbury, 2013). The following section, however, provides a summary of some of the key themes and findings and includes supporting quotations.

Findings - Qualitative

Reduced symptoms or improved coping

Survey participants provided powerful examples of the benefits of MHNIP services provided to clients, including reducing symptoms or improving coping capabilities.

... a lady [was] very isolated due to her major anxiety. She would only leave her house for groceries and did not have any friends or social contact. Over a period of 18 months working with her she had gained insight about her anxiety and started to form friendships and venture out of her house more. She is noteworthy given her SEVERE suicide attempts often resulting in surgery. She was attempt free and more content in life.

Respondents also reported stories of people who appeared to have achieved full clinical recovery.
They are alive! They no longer bounce in and out of hospital, they no longer meet the criteria for a mental disorder and by their own report they are living productive and fulfilling lives.

...The most significant outcomes include lifting the mood of depressed patients; being to function and returning to work...reducing anxiety and being able to carry out task that have eluded them for months and sometimes years....

**Improved relationships and community participation**

Most nurses mentioned how service users’ relationships with friends and family improved, and provided examples of people participating more actively in their communities. Reports included stories of service users who were socially isolated on referral to the program, but following interventions, this resolved over time with people re-engaging in social activities, including joining clubs and organisations.

*Some of the outcomes may be unable to be measured but include quality improvements such as a general increase in wellbeing through living a happier and more productive lifestyle. Many report better relationships with other members of their families and a genuine appreciation for what they are helped with under this program...*

**Employment and study**

Occupational and employment outcomes were frequently mentioned. CMHNs provided examples of people clarifying their occupational or life goals and commencing or sustaining study and employment.

*...There have been some incredible outcomes for clients I work with including returning to active work after long periods unemployed... finding some direction in life, learning how to deal with their own emotions more effectively ...*

**Improved Physical Health**

Nurses provided examples of improved physical health, including weight loss and better management of health generally. For some people this was a consequence of better co-ordination between services. For others, enabling access to physical health services provided a conduit to address mental health concerns.

*I work with] very difficult homeless clients... once a decent rapport has been built and usually that’s because we have detected poor general health issues [and then] we can work on the mental health issues with some success.*

**Medication Related Outcomes**

Some respondents mentioned how negotiating a medication regime that was satisfactory to the service user was an important outcome, and others mentioned the significance of achieving sustained adherence to prescribed medications. There were also many responses that discussed noteworthy outcomes, such as service users experiencing reduced need for
medication, managing on reduced dosages or being able to cease some of medications entirely.

The most significant outcomes have been that people have learnt how to manage their disorders i.e. recognizing symptoms, medication compliance, how to recognize contributing factors/triggers to relapse...

Reduced use of hospitalisation and public mental health services

Reduced use of tertiary health or state mental health services was cited by almost every CMHN responding to the survey. Some noted that various service users had poor experiences in the past with state mental health services, but interventions from the CMHN resulted in service users reporting that on occasions when services were needed the experience was more positive.

Reduced use of state mental health services was also a natural consequence of clinical and personal recovery.

... A 25 year old female who was in and out of hospital, with severe self-harming and a borderline personality disorder has now left mental health services and is working full time, is driving a car and is in a stable relationship. She has also stopped most medications now...

... Another 44 year old man with bipolar affective disorder with psychotic symptoms had long admissions to hospital. Now with continued support has been free of hospital for 15 months and is stable, in a good relationship and is considering employment again...

Improved access or better use of services

Several respondents provided examples of service users making better use of services or having access to the most appropriate service to meet their needs. The following vignette describes how the nurse was able to work collegially with other specialists to address a range of complex problems:

... A 60 year old man with bipolar affective disorder, epilepsy, several other chronic diseases, chronic pain and limited mobility... He had two hospital admissions to the Area Mental Health Service in the year prior to being referred to me. His wife was his sole carer and developed depression herself. They had become bankrupt after having a successful business when the husband became unwell with a brain tumour. I was able to get to know the couple and assess their needs through a series of home visits. Together with the GP’s help we were able to:

1. Monitor and adjust his medication as required

2. Detect signs of Acute Brain Syndromes and get prompt treatment, which avoided hospital admission on a number of occasions (due to urinary tract infections and cellulitis).
3. Referrals to specialists including a urologist and a neurologist

4. Referral to the Specialist Alcohol and Drug Services to [help him] come off opiates that were no longer helping with the chronic pain and causing him to be foggy and sleep a lot in the day times. This has allowed for him to become more active, lose weight and have more motivation.

5. Arrange treatment for the cellulitis, which included a referral to a podiatrist for compression bandaging.

6. Referral to the occupational therapist, which led to rails in the home and an assessment and application for a scooter.

7. Assistance with the department of housing which lead to cheaper and more secure accommodation. This has had unforseen spin-offs e.g. the client has developed a keen interest in vegetable gardening and he feels able to invest in developing the garden knowing he will not have to move.

8. Family education and at times couples counselling and family therapy, which has led to better family relationships and family support.

9. Referral to Community Interlinks to get funding for shoes and compression stockings, and explore respite options.

His wife is now able to go and stay with their interstate children and grandchildren for short periods and come back refreshed and the family are starting to visit again, knowing that her husband is well enough to look after himself in her absence. The client feels less dependent on his wife and is enjoying renewed relationships with the family. The couple feel supported and confident in the care they are receiving. At one stage I needed to provide daily visits but now it is one visit a fortnight.

Managing risk and reduce coercive interactions

CMHNs working in the MHNIP described how their roles enabled them to be able to safely contain, or intervene appropriately in risky situations.

One young man with bipolar affective disorder would have died from a drug overdose/suicide attempt had I not contacted him in the middle of it. Despite it occurring at a time when I would normally have finished work, the flexibility of the work enabled me to resume work to arrange emergency intervention. This required my travelling to his home to 'break in' to allow the paramedics to revive him.

As well as being able to reduce the need for coercive mental health interventions, respondents cited examples of reduced substance misuse and associated criminal offending, reduced need for child safety interventions, increased attendance at school or reduced truancy in some instances, and successful advocacy or positive outcomes in relation to the criminal justice system.
Recently, through working with the client and her parole officer, I was able to help both write valuable reports for the court with the outcome that the client did not have to go to prison. Obviously my role involved more than just helping to get the reports written, as the client was given time and strategies to work through her anxiety and low mood regarding the potential for incarceration. She is now very keen to work on her residual anger and personality issues and looks forward to a more productive and meaningful life.

Independent living

Numerous examples were provided by respondents to the survey, of service users being able to exercise more choices in their lives. For some, this meant reduced need for health professionals’ involvement or discharge from the program. For others it involved utilising the supports available to them but having much greater autonomy than they previously enjoyed.

Most patients report increased happiness with life and the ability to live their life how they chose...

Findings – Quantitative

Sixty four service user profiles were submitted to the study, which included detailing pairs of HoNOS scores\(^7\). The profile sample consisted of 58% females. The ages of people ranged between 17 and 83 years, with a mean age of 43.4 years (SD = 14.9 years). The individuals had received been 2 and 250 occasions of service (mean 37.5, SD=48). Their primary medical diagnoses were categorised as depressive disorders (27%, n=17), bipolar affective disorder (25%, n=14), schizophrenia or a related disorder (30%, n=16) or personality disorder (6%, n=4). Six people were discharged, and 6 service users were considered acutely unwell at the time. Most people were considered stable (64%, n=41) or were being visited intermittently for support when needed (13%, n=8).

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\(^7\) HoNOS is a tool to measure the health and social functioning of people with severe mental illness, developed by the Royal College of Psychiatrists (UK). The tool consists of 12 simple scales by which service users with severe mental illness are rated by clinical staff. Ratings should be repeated after treatment or other intervention and then compared to provide a clinical outcomes measure. The scales cover a wide range of health and social domains- psychiatric symptoms, physical health, functioning, relationships and housing, and are scored according to the format: 0 = no problem through to 4 = severe to very severe problem. RC Psych, (2013). http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/generalinformation/faq.aspx#whatis Accessed 16 August 2013.
The mean HoNOS score at time 1 was 21.47 (SD=7.83). The mean scores were particularly high for those people diagnosed with personality disorder (as illustrated in figure 4). Age (F(1,62)=1.32,P=0.26) and gender (F(1,62)=0.169,P=0.68) were found to have no effect on the change scores. The change on total HONOS scores was found to be highly significant on a paired t-test (t(63)=12.13, p<0.001). Therefore it is extremely unlikely that such a difference would occur through chance or sampling variability.
Figure 5 shows the mean HoNOS subscale scores on admission and at second measurement. Paired t test indicated that all changes except the physical subscale change were highly significant (i.e. p<0.004).

Discussion

These findings provide a picture of the important outcomes of care episodes as perceived by CMHNs working in the MHNIP, and are supported by quantitative outcome data. Many made reference to the perceptions of service users. Both the HoNOS scores and qualitative data appear to indicate significant reductions in symptoms over extended periods of time (mean of 37.5 occasions of service). These reported benefits, particularly the social and occupational outcomes, are impressive. Few programs are able to claim to make such a difference to a population characterised by such complex needs. However given the self-report nature of the study, biases in reporting cannot be ruled out, and it cannot be assumed that such positive outcomes are enjoyed by all service users.

The mean HoNOS scores reported here are exceptionally high on admission and are close to 6 points higher than the mean score of those admitted to inpatient care in Australia (Burgess et al., 2006). Meehan and Robertson (2013a) found that scores on admission in one region in Australia were higher than those found in ATAPS\(^8\) and less than those one

would see on admission to hospital. The general pattern of distribution of subscales was similar, suggesting the overall scores are accurate but possibly over inflated. They do suggest, however, that people referred to the MHNIP present with complex and severe problems, and that the program is valuable in helping people to address their health needs.
5. Professional support for mental health nursing practice

Key points

• The majority of mental health nurses reported receiving regular, formal clinical supervision
• Survey respondents reported that the costs associated with professional development were largely met by the individual CMHN
• Peer and collegial inter-professional relationships were important sources of support

Method

Participants in the study were asked to ‘describe the kind of training, support and supervision you receive to help you in your role’. A content analysis of the responses was undertaken. 223 responses were received, and responses to this question were typically short (<200 words).

Findings

Clinical Supervision⁶

Most respondents to the survey (94%, n=208) explicitly stated they received some form of ‘clinical supervision’. The frequency of clinical supervision reported varied from weekly to every two or three months as available, or as needed. The mean frequency reported was every 3.5 weeks (SD=1.7).

Clinical supervision appeared highly valued by the nurses although not always by the organisations they worked for. One fifth of nurses (n=41) stated that they paid for their own supervision and undertook it in their own time regardless of their employment / contractual arrangement with the eligible organisation.

Regular clinical supervision is paramount to this position. It can be a very isolating role. I meet with [my] supervisor 2 weekly to discuss clients and any concerns or difficulties... I also have meetings with other nurses in [the] same role...

I arranged my own supervision every couple of months... I was unable to find a group supervision opportunity where I was situated. Most of the supervision I found was expensive considering I worked only 2 sessions a week. My employer did not pay for it.

I receive clinical supervision In Brisbane although I live in XXX. The Medicare Local is not particularly supportive of my Professional Development and refused to release me for 2 hours on a Friday to go for supervision... So I do it in my own weekend time.

⁶ The ACMHN position statement on Clinical Supervision describes it as: a formally defined alliance between practitioners, the Supervisor [an experienced practitioner] and the Supervisee[s], which is focused on professional support through facilitated reflection. Clinical Supervision is usually conceptually distinguished from case review, personal performance review and therapy.
I get a small financial contribution $350 annually to attend conference, training etc. I organise and pay for my own clinical supervision

Those who perceive their role as psychotherapeutic or had a specialist skill set and had postgraduate qualifications in psychotherapy tended to be unequivocal about the kind of qualifications or experience of their supervisor, and paid accordingly.

I pay a private generalist counsellor and a relationship psychodynamic counsellor for my supervision. This costs $260 monthly. I feel it would be better if I had more supervision but I can’t afford this.

I have peer supervision with some likeminded colleagues... group supervision with a psychoanalyst and group expert with my colleague who facilitates adolescent and young person’s group work with me. I attend Balint group at the practise I work at.

Several respondents also spoke about attending personal therapy and other psychotherapeutic skill development or support groups (such as Balint10)

Individual supervision fortnightly with a senior ANZAP faculty member. Peer supervision fortnightly with 3 ANZAP faculty members. Reading Group fortnightly with psychotherapy colleagues. My personal Psychotherapy weekly with a psychiatrist trained in the psychoanalytic psychotherapy I practice. Ongoing professional development with several psychotherapy organisations providing complementary approaches to treatment e.g. Existential Practice, Jungian Analysis, Relational Psychotherapy.

A few survey participants (n=11) said that they received clinical supervision as part of university studies they were undertaking and a similar number received clinical supervision and met their professional development needs largely through alternative employment such as state or district mental health services. Others created opportunities for clinical supervision within their own practice and appeared quite positive about this.

Supervision is ongoing in a group setting... [I also have]... Peer support with the 2 other MHPN in the organisation... Peer support in form of monthly meetings with other MHPN in the Northern area..

Nurses appeared to make a distinction between modes of supervision (individual and group) and between case reviews, discussing management with the collaborating medical doctor, or hierarchical clinical oversight. Where the term appeared to be used to refer to clinical or case review it was coded as such and not treated as clinical supervision.

...Since commencing in this role 2 ½ years ago I have [been] undertaking a great deal of training in Perinatal & infant therapies. I have group clinical supervision with a psychoanalyst once a month and individual supervision monthly. I also access case review with a multidisciplinary team weekly.

10 A Balint group is an experiential, small group educational activity in which practicing clinicians meet regularly to discuss difficult or intriguing cases. The focus is on the psychological aspects of clinical practice, and particularly the emotional content of the clinician-patient relationship. Balint groups provide a supportive setting in which clinicians can rediscover the human side of patient care and it can add a refreshing new dimension to their work and avoid burnout. Balint Australia (2013). http://balintaustralia.org/about-balint-groups/ Accessed 17 August 2013.
74% (n=165) stated that they received regular clinical supervision with an individual supervisor, usually a nurse but sometimes a therapist, psychologist, social worker or consultant psychiatrist.

_**I have ongoing clinical supervision on a monthly basis by a consultant psychiatrist in Melbourne. I also meet weekly with a local psychologist for support and supervision of each other.**_

Group supervision was reported by 29% (n=65) of survey respondents. For a third of those CMHNs, this was the only supervision they received, but most reported that they accessed both group and individual supervision.

**Training and Conferences**

Just under half (n=103) of the nurses responding to the question “describe the kind of training, support and supervision you receive to help you in your role,” included a reference to training in their response. 18% (n=46) stated they attended conferences as part of their ongoing professional development. Only 5% (n=11) mentioned ACMHN conferences or education events, but this probably understates the number of people attending conferences, as most did not specifically refer to the particular conferences they attended.

Respondents largely focussed on organisational support for training, with analysis indicating that feedback was mixed, and included positive and negative responses.

_The organisation has been very supportive of me taking study leave as required and I have obtained my own supervision as required for my therapy training._

_Initially I was very supported by the organization to attain credentialing. Training was highly encouraged but is now difficult to source unless it is a requirement of the funding received by the organization. For example it was not deemed appropriate for me to attend the Mental Health Nurse conference run by the College. Anything interstate is not encouraged._

_... Since I’ve been with XXXX Health I have received no training which supports me in my practice. I have spent over $6000 in funding my own need to maintain my credentialing status. I do receive supervision once per month and attend a business meeting once per month, during that session we have the support of a Psychiatrist who provides clinical advice..._

Overall, there were few responses which were wholly positive about the support they received from their employer or organisation to undertake training or attend professional development activities. The following, however, illustrates a very positive response from one survey participant:

_**I receive more training and professional development than I ever did in the public mental health system. I attend in house professional development weekly, regular mental health professional network meetings, and any other mental health related training that is offered by the Division / Medicare Local network. My employers provide an amazing amount of support and are very protective of me. They encourage me to become involved in local networks, such as reconciliation and school based mental health training. They have also provided study leave and paid for extra training. I receive group supervision on a 3-4 weekly basis, which my employer was insistent that I attend. They are wonderful.**_
Training wasn’t always perceived to be costly, with many respondents stating they attended in-house presentations when they were able. Others stated they attended pharmaceutical company presentations, virtual webinars, and regularly read journals.

Twelve per cent of CMHNs (n=26) stated they were involved in some way with the Mental Health Practitioners Network (MHPN), either attending or facilitating local events or being involved in the webinar series. A small number of people mentioned a budget allocation for training, conferences or education provided by eligible organisations. The most generous allowance detailed in the responses was $1500 per year and three days leave.

Nurses spoke generally of accessing training in specific psychotherapies, or attending updates on pharmacology. The training available in primary care settings was mentioned as not always sufficiently targeted or useful for specialist practitioners.

**Case Review and Medical Supervision**

Case review and medical supervision were identified by respondents as a further source of support. 29% (n=65) of respondents discussed reviewing or discussing cases with medical colleagues, often consultant psychiatrists, as useful in their practice development. Responses to other survey questions suggest that most if not all nurses regularly discuss cases with medical colleagues. This was not always considered a learning experience for the CMHN who might be providing consultation to the colleague. However, specifically in relation to mental health issues some respondents spoke of benefiting from the advice of psychiatrists.

*Ongoing education from psychiatrist in management of ADHD, ASD, learning disorders and communication disorders. He is always available for consultation and advice. He often supplies relevant articles to read.*

Similarly discussing cases with GPs was considered helpful for professional development especially in relation to the physical health of people. 5% of people (n=12) mentioned team meetings as combining an element of education or skill development.

**Peer Support**

Peer support was identified by survey respondents as valuable. 26% (n=57) mentioned some form of peer support in addition to formalised clinical supervision. People described collegial relationships they enjoyed with members of their teams.

*We have direct access to a community based psychiatrist who is very supportive of ourselves as staff and our approach to treatment in general. My boss is one of the most experienced community based mental health nurses in the state and a great resource re: supervision. The multi-disciplinary team offers different points of view also.*

The availability of supportive peers sometimes mitigated the lack of availability of other training opportunities.

*Group supervision and peer support within the work place is great... I have attended many training courses in my own time*
Discussion

By far the most commonly cited form of support that CMHNs indicated that they received in their role, was clinical supervision. Many CMHNs pro-actively sought clinical supervision with their own choice of supervisor, and paid for this or undertook it in their own time. Almost this entire sample of mental health nurses, which represented close to half of CMHNs working in the program, reported one or more modes of clinical supervision.

The most common findings from the data indicated that:

- respondents sought supervision for role or practice development
- CMHNs sought supervisors who could best enhance their skills
- most supervisors were MHNs, but sometimes therapists or other health professionals were accessed.

Clinical Supervision is a core component of contemporary professional mental health nursing practice and central to practicing within the ACMHN Standards of Practice for Australian Mental Health Nurses (2010). The ACMHN has actively encouraged mental health service employers to positively support and promote clinical supervision through organisational policies, procedures and workplace culture. (ACMHN 2012)

CMHNs who took part in the survey, reported seeking clinical supervision in innovative and inexpensive ways such as through peer supervision groups (Lakeman and Glasgow, 2009). This appeared to be a compromise over individual supervision for some, and for others it was an adjunct serving other developmental and support needs. The methodology used in this study did not allow exploration of the purposes to which clinical supervision was directed, although the literature indicates that there is some evidence that clinical supervision can improve patient outcomes (Bradshaw, Butterworth and Mairs, 2007) as well as reduce burnout and increase job satisfaction in nursing (Hyrkäs, Appelqvist-Schmidelechner, & Lemponen, 2010). Clinical supervision has a long pedigree in psychotherapy and counselling and many CMHNs in this study reported used clinical supervision as a means to enhance their skills in these areas.

Clinical supervision is usually conceptually distinguished from case review, personal performance review and therapy. Respondents in the survey were able to articulate the differences between clinical supervision, case review, managerial or professional supervision and/or collegial support. Previously there has been contention about such distinctions, although in nursing this seems to be resolving (Lynch, Hancox, & Happell, 2010).

Non-nursing commentators appear less able to differentiate the purposes of different forms of supervision. For example, in the recent evaluation of the MHNIP (Health Management Advisors, 2012, p.xi) the authors state that:

...clinical supervision is determined on a site basis between the medical professional and the nurse and is perceived as an issue of clinical governance.
The authors suggest that:

*Quality could be improved if there was a more standardised approach* and assert that *self-employed mental health nurses do not have any obvious clinical supervision* (p.46).

This is clearly not the case (as this survey found) and the authors’ misunderstanding of clinical supervision is further illustrated by the suggestion that a clinician

...managing MHNIP patients admitted to hospital [might be comfortable discharging people they knew were returning to] ...the care of a mental health nurse working under the supervision of a medical practitioner (page 52).

This statement incorrectly alludes to ‘supervision’ as some kind of oversight of the practice of nursing by medical practitioners and is a perception at odds with the realities reported by CMHNs, and notions of professional autonomy (Wade, 2001).

The CMHNs in this survey reported they accessed educational and professional development opportunities where they could, including through formal study, attendance at short courses and conferences, through opportunities in the workplace and via alternative employment. They cited peer review, and collegial discussions and processes such as team meetings as supporting them in their role.

The Mental Health Professional Network (http://www.mhpn.org.au/) was often cited as an important source of knowledge and support. Having opportunities to network with other health professionals working in primary care settings but particularly other mental health nurses working in similar roles was considered exceptionally important and respondents reported going to some lengths to do this. Consistent with Dallender and Nolan’s (2002) findings, it can be inferred that these nurses derived much of their work satisfaction from the positive outcomes they achieved. However, collegial relationships and networks were also cited as an important source of satisfaction and support in their roles.

Whilst respondents reported that some workplaces were clearly supportive of their professional development, many others stated that they received minimal or no support from eligible organisations. For those that explicitly mentioned sources of payment for professional development, the individual CMHN almost always bore the costs. There is no specific guidance relating to what might be considered the essential professional development requirements for a CMHN working in the MHNIP, and furthermore, it is a mark of professionals to determine their own developmental needs (Wade, 2001). However, evidence from the survey indicates that cost may restrict many nurses’ choices of professional development activities.
6. Program structure impacts on CMHNs

Key points

• CMHNs engaged with eligible organisations in a variety to ways, with many having an employment or contractual relationship with more than one organisation.
• Few CMHNs in MHNIP reported a standard employee relationship with wages and standard conditions.
• CMHNs in MHNIP often negotiate contracts with eligible organisations to provide a service and receive a proportion of the session payment made by Medicare. In such arrangements it is common for the CMHNs to be responsible for meeting expenses such as indemnity and other insurances, leave, superannuation and room rental.
• The program specification which requires CMHNs to provide services through an eligible organisation reduces access to the program, reduces flexibility and choice for service users and is a disincentive for MHNs to consider working within the program.
• Remuneration and conditions, unsatisfactory commercial relationships with eligible organisations, and the impact of the cap on the MHNIP were identified as the main reasons for nurses leaving the program.

Method

A question in the survey asked respondents to outline how they were employed or engaged with eligible organisations. Two hundred and forty people responded to this question.

Responses described problems encountered by CMHNs, which arose from the program structure and requirements, and had resulted in some CMHNs leaving the program. At the suggestion of respondents, an additional question was added to the survey asking why people had left. Fifteen people responded.

Findings

These responses could be clustered into several key inter-related themes. These were:

• Method of engagement
• Remuneration and conditions
• Unsatisfactory relationships
The impact of the cap on the MHNIP

Method of engagement

Methods of engagement varied considerably with data revealing that little over half of respondents (n=132, 55%) were in an employment relationship with an organisation. Other respondents described themselves as contractors (n=75, 31%) and / or independent sole traders (n=58, 24%). Many CMHNs were engaged with multiple organisations in various ways or had experimented with different methods of engagement. The following account reflects some of this complexity:

*I have worked under the MHNIP in 3 different positions: Employed full-time by a GP practice in QLD; Engaged as a private practitioner (contractor) with two medical centres in NSW; and now I am the director of the Eligible Organisation, I engage the General Practitioners who are interested in benefiting their clients by involvement with the MHNIP. The decision to set up my own eligible organisation came after much consideration about the limited session fees, the lack of interest within medical centres of becoming an eligible organisation due to the requirements and unknown future of the program. With the session fees which have not increased since the implementation of the program the 'wage' I could be allocated by a medical clinic after all their costs were covered was in line with a graduate nurse, certainly not a wage that acknowledges the experience and education of a credentialed mental health nurse and simply not practical. I previously left my other roles for various reasons but namely due to restrictions and functions within the role. If a GP clinic employs a CMHN (in my experience) they request that clinicians do things which bring more money into the clinic, such as GP Mental Health Care Plans for people who are not even involved in the MHNIP. This option I found was very money targeting and my expertise and the benefits to patients were disregarded. On my resignation the Director of the medical clinic even stated that the MHNIP was not making enough profit for them to continue it, despite the patient feedback surveys and positive community outcomes.*

15 respondents worked part time in the MHNIP and the remainder of the time in state funded mental health services or were in a shared employment relationship.
I am employed by Queensland Health, but work full time providing primary mental health care to GP practices within the Ipswich area. Queensland Health also provides a rotating senior psychiatric registrar who provides reviews across the 2 practices.

The sole trader/independent contractor or self-employed model of engagement appeared unproblematic for many people. However, for others who provided niche or specialist clinical services for particular sub-groups of consumers, the requirement to only receive referrals through a GP at the eligible organisation was perceived as inefficient and wasteful.

I subcontract my services to XXX Medical Centre. So the medical practice is an eligible organization. There are over 18 GPS in this practice. Essentially any GP from this practice can refer. However I work very closely with 4 to 6 of the GPs whom appreciate what I have to offer. Many don’t quite understand the program... The Medicare program is too rigid, this means other GPs, paediatricians and psychiatrists can't refer to me directly and I have to redirect them to the XXX Medical Centre... The paediatrician is a big source of referral to me... particularly clients with ADHD [Attention Deficit Hyperactivity Disorder] and comorbidity to ODD [oppositional defiant disorder], learning difficulties as well as anxiety and or depression. Again I have to redirect the referrals back to [the medical centre]... This makes the system less efficient.

Some nurses had been entrepreneurial in terms of working in a collective fashion or establishing a business to broker the MHNIP to practices.

[I am] contracted by [the] eligible organisation to run MHNIP and manage nurses, finalise session logs and adhere to Medicare requirements. Payment is put into my account to pay for nurses contracted including myself as I run MHNIP under [my] own business and pay for own rental and ongoing costs. The eligible organisation kept the $10,00011.

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11 The MHNIP includes a once-off establishment payment. [link]

Accessed 17 August 2013
Remuneration and conditions

Whilst it was not always clear what the nature of the contract was that people had with eligible organisations, some respondents (n=58) stated that they received a wage, with others reporting that they received additional employment benefits.

I am employed permanently by a family medical centre; it has 2 principals and numerous doctors working there. I am employed to do 10 sessions a week and payed on an hourly rate with annual leave etc and a study allowance provided.

Some responders described more ambiguous conditions stating for example that they received an hourly rate or that they were contracted as a sole trader with a general practitioner and received remuneration based on an hourly rate. At least half the CMHNs who reported working on an hourly rate were part time and some worked in this way with multiple practices.

Some eligible organisations were private businesses employing all staff in one or more practices.

I am employed on a part time basis by a corporate business company that purchased the GP surgery I worked in just prior to commencing MHNIP in Sept 2011. They have adopted a "wait and see" approach to the service but were keen just prior to the last budget and the freezing of the program to look at further developing their interest in MHNIP. At present I am the only credentialed MHNIP worker for them in NSW. I am seconded to this post. My previous role was practice nurse.

As independent practitioners, many people appeared to receive the MHNIP sessional payment directly. Others reported the sessional payment being processed via the eligible organisation, which took a share of between 12.5 – 30% of the payment for rent or administration, including services such as making bookings. Other responders reported paying a daily room rental, or hired their own rooms independently. The nurses mostly met their own costs associated with professional registration, indemnity insurance, telecommunications and setting up an office. For people who contracted to multiple practices arrangements could be different with each practice.

I work for 3 eligible organisations. Two I approached and the other organisation a large GP practice 2 of my colleagues and I wrote to outlining the MHNIP and what we
could do for them in terms of clinical support and financial advantage as complex clients would then have more support from us and require less contact with GP's allowing them to see other clients. All practices I work for contract to me for services. In one I am paid the whole amount.... and they charge $66 admin fee once per month. I work from my home and see clients there. Another I work at the premises and they take 10% per session unless it is a remote session and then I receive the whole amount. The third takes 20% and I work from their rooms. They have set up lovely counselling offices.

Approximately 10 people appeared to have an employment relationship with a private psychiatrist and some enjoyed conditions of work not typically available to others.

[I’m] employed by a clinical psychiatrist in her private practice. She pays $44 per hour plus use of a car for home visits and to garage.

Respondents who mentioned the establishment payment (of $5000 to $10000) indicated that in most cases the eligible organisation retained this even when there were no apparent expenses on their behalf. Some CMHNs, however, reported that they had successfully negotiated the need for the establishment grant to set up their position.

Whilst some respondents stated they were appropriately remunerated or they received the full sessional payment, most did not receive the full payment, and where engagement with a practice was in the form of an employment contract, pay, conditions and security were generally inferior to that obtainable in State funded services.

I am a mental health nurse with extensive clinical skills and academic qualifications. I thoroughly enjoyed the work that I was able to do in a rural area in GP practices and believed that I was able to make a significant contribution to improving the mental health of the consumers using the service (2008-2009). Unfortunately, my position was administered by a Rural GP Network and the remuneration offered was less than what I received as a registered nurse/therapist for a community mental health team and much less than what I now receive as an academic where I am in a role with the capacity to influence practice.
Support structures

The lack of resources and safety supports was a concern expressed by respondents, who indicated the importance of having a supportive team structure, material resources, ample human resources and the availability of clinical supervision.

The following account indicates potential safety issues for CMHNs working in isolated situations:

On occasions the visit was potentially unsafe... a new unknown client, a boarding house, a drug user. I would always be on my own and despite giving the office my number they were not interested in the risk issues. They never rang or checked on me and weren't mindful of my concerns. On one occasion I was in a house where two women were fighting and one had previous convictions for assault. It was scary mainly as my being there had triggered it. On my return my employer thought it was funny and no one understood the predicament I felt myself in.

Some eligible organisations reportedly did not even provide the most basic of infrastructure, and one respondent specifically indicated that the lack of support had led to her feeling ‘burnt out’ resulting in her leaving the MHNIP.

[I started with the] 'eligible organisation' and found that nothing was in place. I was faced with 2 years of filing and had to personally buy the stationery to make up the folders. I bought a chair so when the visiting doctor was around that I had a chair to sit in! ... No forms - such as letter head paper, assessment forms, HONOS forms, client consent forms and on it goes - no progress notes either. So I set about making them up, got a typist friend who put the finishing touches onto it. And then went to the printers to get it printed....And then to get the letter that stipulated my sessions were now cut back.. the owner of the clinic was too disorganised to sign my log and fax it off for me - well that was the LAST straw. I left after 4 weeks work... I am now unemployed as they employed someone into my position.

Eligible Organisation type

Survey respondents identified engagement with a broad range of eligible organisations. These included being employed by:
private psychiatrists (characterised by CMHNs who reported having advanced psychotherapeutic skills and training).

...I am 'employed' by a Psychiatrist/Psychoanalyst. We conduct the initial assessment together and if we and the patient are agreeable we begin a longer term psychotherapeutic style of engagement. Some patients do not require or are not ready for psychotherapy in as much as their needs are more acute and so I would support them similar to what an acute care service might do. The Psychiatrist oversees my work and provides regular (weekly) supervision and is available for me to consult and seek advice as necessary.

- university health clinics
- mixed roles with the MHNIP providing one income stream amongst many.

I am the community service manager for the MHNIP and also manage the Assertive Community Treatment Program (private health funded). I am also the Mental Health Act Delegate for the ... Private Hospital, the senior nurse in regards weekly audits of the controlled drug register and case manage a group of clients. The hospital pays me a fortnightly wage for which I am entitled to be paid annual leave, sick leave and other leave types. I am also the nominated signatory for claims sent to Medicare Australia.

- Medicare Locals or Division of General Practice. 25% of respondents identified being employed or contracted by Medicare Locals in various capacities. Data indicated that the Medicare Local sometimes brokered the services of the CMHNs to particular clinical programs or facilities such as Headspace.

I provide MHN services to a number of different Primary Health Care organisations in partnership with my employing Medicare local including Indigenous Health, headspace (youth mental health) and several GP clinics.

Unsatisfactory relationships

Responses from the survey indicated some concerns relating to the business relationship CMHNs had with their eligible organisations. Examples included:

- The perception that the CMHN was perceived as an instrument to make money for the organisation
• Income generated by CMHNs by undertaking tasks such as writing or updating mental health care plans was not passed on to the CMHN

• Issues relating to the inability of CMHNs to communicate directly with Medicare, with correspondence typically directed to the eligible organisation

I work independently in the sense that I rent my own rooms (as a percentage of my income), pay my own indemnity insurance and so forth. The doctor refers to me but took the entire establishment payment and this caused a little bit of ill-feeling as I met all the establishment costs. I don’t receive the Medicare summaries directly despite being a contact person but nevertheless pay rent on what I bill at the end of each month. I don’t get to see the reconciliation for months (if at all) but I usually receive less than what I bill for various reasons so end up being out of pocket. I love the work I do and I’ve never been more effective at putting my years of professional education into practice but will likely cease my practice when my insurance is up for renewal.

• Issues relating to payment for sessions, which is directed from Medicare to the eligible organisation rather than the CMHN

I was not the contact person, so Medicare failed to give me any information on my pays...I waited for over 8 months before being paid, and the owner kept 6-8 sessions, and failed to communicate...We should be paid accordingly, and currently employers are paying as they like, and not what our role deserves... At the moment a lot of GPs are seeing MHNP is a source of revenue generation, and go quite a distance to undermine the MHN.

• Issues relating to CMHNs need to rely on an individual health practitioner to make referrals to them. Responses indicated that this creates a tenuous employment relationship and affects the relationship between the nurse and the consumer. Should the service user elect to see another GP not within the eligible organisation then the relationship between the nurse and service user ceases.

The head GP insisted on charging for my service against my wishes and those of the other 4 GPs in the practice. As predicted my face to face contacts quickly fell from an
average of 24 over 5 sessions a week to 12 over 3 sessions a week making the job unsustainable.

The effect of the cap on MHNIP sessions

Respondents to the survey indicated that the effect of the cap on the MHNIP was to create uncertainty and to freeze efforts by CMHNs who were attempting to grow their practice into a sustainable source of income

*I am leaving the MHNIP due to the freeze on funding, I am now unable to grow my private work with GPs...*

Other respondents indicated that their sessions had been cut or their contracts abruptly cancelled.

*I work for X which serves 5 eligible organisations. However since the freeze with Medicare it has proven difficult to sustain level of support as one EO has ceased contract with us without any consideration to their clients follow up and with total disregard to the non-payment of contact time of the nurses....*

Feedback from the survey indicates that others had plans for commencing work within the program put on hold:

*I could not apply for the MHNIP due to the fact that the freeze occurred the week the medical centre applied and we were too late. I was bitterly disappointed as I had worked towards this particular job for over 2 years e.g. getting my masters and then preparing for my credentialing. I am working in the mental health ward... and shall re-evaluate my career move in 2013.*

For some respondents the MHNIP cap program has led to a re-evaluation of the benefits of working in the state funded mental health sector.

*I have recently moved interstate. I had done the MHNIP for 3 years. I would not consider doing the MHNIP again. I would be concerned that the program would not be continuing. Also the amount of time spent on paperwork and justifying what you are doing in each session, to me was very stressful. I would much rather be working in either the public/private sector in an inpatient or community setting where the pay
is much better, the job security is there and you are well supported. There is ongoing professional support and I am enjoying my job doing a clinical role again!!

Responses to the survey did not provide sufficient information to evaluate the effect of the cap on consumer access to the program, although it could be assumed that the uncertainty about the impact on payments if registering new consumers may mean that people will not take on new referrals or alternatively not end consumer contacts when appropriate.

A response in the survey specifically noted that from a psychotherapeutic viewpoint the cap may impact on the continuation of a therapeutic relationship. A CMHN and family therapist who specialises in working with families coping with anorexia nervosa stated:

... my MHNIP session quota has been reduced from 48 per year to 36 [by DOHA], which means that it will actually COST me money to do it (when I take into consideration insurance and office hire expenses). I'm disappointed, because I really enjoy the clinical contact and obviously am committed to my existing clients recovering, however, I'm not so committed that I'm willing to pay for the privilege! The psychiatrist I work with is begging me to just charge people, but that just adds a layer of inaccessibility to my existing clients who I know would not be able to afford it, and one of the key things I like about the MHNIP is that it satisfies my need to be benevolent...

Discussion

Models of employment

Very little was previously known about how CMHNs engage with eligible organisations. General Practice Queensland (2009) suggested that there were four main employment models distinguished by who actually employs the CMHN and this employment arrangement dictates the role of the key stakeholders:

- Shared employment arrangements – a collaboration between state mental health services and private organisations, in which the nurse is employed by the state and seconded to private practice.
- Direct employment – where a practice employs or contracts directly with the mental health nurse to provide services for a nominated number of sessions.
• Division of General Practice/Medicare Local employment – a nurse is employed by a Division of General Practice/Medicare Local, which enters into a contract with participating practices for the nurse’s service.

• Division of General Practice/Medicare Local contracts - the Division/Medicare Local is responsible for recruiting the general practices, however once a nurse is assigned to a practice, he/she operates in the same way as any private contractor, accepting referrals, managing their workload, rebooking appointments and essentially running their own business.

In this survey data indicated that CMHNs predominantly operated in a hybrid model, receiving referrals and liaising closely with referring medical doctors, but otherwise by agreement managing their own workloads and often submitting required documents on behalf of the eligible organisation. It is clear that many nurses had different arrangements with different eligible organisations.

Responses to this survey indicated that over half of respondents were sole traders or worked under contract. This contrasts with the findings reported by Healthcare Management Advisors (2012) in their evaluation survey, which reported only 16.7% of CMHNs were employed under contract. However, the researchers in the evaluation survey acknowledge that the wording of questions failed to quantify the conditions of employment/contractual arrangements with eligible organisations.

**Issues relating to the establishment grant**

The findings from this survey contrast with the Healthcare Management Advisors (2012) report, which stated that ‘case study organisations’ did not raise any concerns around the rules governing the allocation of the $5-10,000 establishment grant, were ‘comfortable with the process for claiming it’ and had usefully deployed it.

Respondents in this survey reported that it was rare for nurses to receive any benefit from the establishment grant. Whilst those in employed relationships had use of practice facilities (e.g. a room), most respondents spoke of meeting all of their own expenses, being charged a fee for room rental or hiring their own rooms, paying for their own indemnity insurance and professional development activities including clinical supervision.
Healthcare Management Advisors (2012) suggested that organisations used the establishment grant to cover the gap between first claim and payment from Medicare (which could take up to two months) but this would only be likely in cases where the nurse was directly employed by a practice (rather than contracted) as otherwise cash-flow would depend entirely on what had been billed to Medicare.

**Reasons for leaving MHNIP**

Responses to the additional question in the survey about why CMHNs have left the MHNIP reflect some of the difficulties alluded to in other parts of the survey. The CMHN working in the MHNIP is highly dependent for their income and support on the ‘eligible organisation’. It is clear that some are better administered than others, and that some are motivated principally by profits.

The MHNIP guidelines introduce a complex arrangement whereby the CMHN is engaged with an organisation and can only see patients referred by a specific doctor associated with the organisation. The CMHN’s relationship with Medicare is mediated by the eligible organisation, and the CMHN’s relationship with the service user is mediated by both the eligible organisation and the specific doctor. This complexity leaves CMHNs in a vulnerable position as was evidenced by the introduction of a gap fee for general practitioners in a practice, which resulted in the effect of reducing the number and profile of service users the nurse could see.

Respondents also indicated that other constraints relating to the security of the service user/service provider relationship of the MHNIP were factors leading to their leaving the program. Service users may have a tenuous relationship with a medical doctor or they may want to exercise their free choice and see another medical doctor. If this doctor is not with the same eligible organisation the nurse must stop working with the person regardless of the quality of the relationship she or he may have. This is a serious flaw in the MHNIP.

Healthcare Management Advisors (2012) conclude that ‘there is a high level of support from medical practitioners for the model of care embedded in MHNIP...’ However, responses to this survey indicate that the collaborative approach to care happens in spite of the program not because of it, and is a source of concern to many nurses.
Other issues emerged immediately as a result of the impact of the cap on MHNIP services introduced by DoHA in June 2012. Some CMHNs had their contracts terminated, and a number of youth mental health services (such as Headspaces), which have subsequently opened, have had no means to engage a mental health nurse.

Data from this survey was gathered soon after the introduction of the cap, so has not identified its long term effects. However, responses indicate that when CMHNs reach their capped number of sessions they will need to terminate contact with service users.

**Remuneration and under-resourcing of MHNIP**

Some survey responses which highlight issues with the MHNIP suggest that not only are there concerns relating to the structure of the program, but also raise the issue of the MHNIP being under resourced. Sessional payments have not increased since the program’s inception – unlike wages in other sectors (including state mental health services) which have increased significantly in this time. However, responses in the survey indicate that increases in sessional payments alone will not necessarily impact on the CMHN’s income, as methods of remuneration are quite inconsistent, and may only benefit the eligible organisation.

The 2012 cap on the MHNIP has crystallised attention on the disparity between the MHNIP and other similar programs. Respondents indicated that the MHNIP, if funded as a Medicare Schedule rebate for services in the same way as the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative, would secure positions for CMHNs and avoid many of the concerns raised in this survey. Unlike the MHNIP cap, whilst the number of sessions that allied health professionals could claim in their program was capped, this did not result in allied health professionals necessarily being made redundant. As this study has demonstrated, the CMHNs working in the MHNIP are exceptionally qualified and experienced, and consideration should therefore be given to including them in the Better Access Initiative.
7. Profiles of people who use MHNIP services

Key Points

- The spectrum of diagnoses of profiles reflects the findings of other studies, which is that the MHNIP is accessed by people across a spectrum of mental illness diagnosis, and is not confined to ‘low prevalence’ disorders.
- People who are accessing MHNIP have complex social, personal and occupational issues in addition to a diagnosed severe mental illness.
- Carers and families are benefiting directly and indirectly from the support provided to consumers.

Method

Survey respondents were asked to provide a profile of someone who typically used their service. Two hundred and five profiles were provided. Specifically they were asked to provide details of age, gender, medical diagnosis, presenting problems or reasons for referral, the main interventions undertaken with the person and main outcomes achieved. The following two vignettes provide examples of the many profiles received.

A further sample of case vignettes are presented in Appendix 3. These are broadly representative of the types of cases encountered. Minor editing has been undertaken to enhance readability.

Vignette 1: A 16 year old female with a diagnosis of Anorexia Nervosa

Presenting problems / Reason for referral:

This client was referred upon discharge from her first period of hospitalisation in local paediatric unit. This had been a 12 week admission and she was involved in a re-feeding program, nasogastric feeding and family support. The psychiatrist I work with was seeing this young person and her family in hospital and they decided to continue seeing the psychiatrist privately on discharge. The psychiatrist referred her to me and I began seeing the client and her family after discharge.

Interventions

Initially, I provided Maudsley-style family based therapy focusing on supporting parents to increase and normalise nutritional intake, while developing a relationship with the young person. The family therapy process resulted in the decision by the client's mother to separate from the father and remove herself and her children from a domestic violence situation - she could see that the family dynamics were not helpful to her daughter's recovery and had in fact been influential in the development of the mental health problems of her daughter. The mother has also sought individual counselling and is receiving treatment for depression, which is a very positive outcome and a function of my support of her role as parent and the
strong relationship we have established. I have worked with this client in a psychotherapeutic relationship, identifying and addressing some of the precipitants and maintaining factors of the mental health problems, developing skills (using cognitive therapy techniques, dialectical behavioural techniques, mindfulness and motivational techniques), to provide support (both at home and from my office, via email and SMS) and case coordination as appropriate (e.g. with dietitian).

Outcomes

I have supported this young woman over the past 2 years and while she has had several relapses, only one has resulted in a brief admission. She is currently within the healthy weight range and we are now working in a more focused way towards psychological recovery in terms of adolescent development (rather than physical recovery) i.e. building on her strengths and developing coping skills. She has now returned to school and is engaging with life in an age-appropriate manner. Her family situation is now stable and her mother is receiving mental health support for her own depression.

Vignette 2: A 57 year old male with a depression post stroke

Presenting problems / Reason for referral:

Acute Suicidal Ideation, secondary to depression and alcohol abuse and following recent CVA and marital breakdown

Interventions:

• Initial risk assessment lead to immediate hospitalisation.
• Closely working with hospital based careers initially, then back to GP and myself.
• Initial twice weekly appointments, now fortnightly as suicide risk now minimal.
• Ongoing provision of; counselling; family therapy; psychosocial assessment and psychoeducation
• Advocacy and support, both face to face and in court reports as he has undergone a number of court cases.
• Home visits as needed, especially given his precarious financial situation.
• Referral to NGO’s for financial and alcohol counselling

Outcomes:

• Reduced Suicide Risk
• Depression now well under control and understood
• Reduced alcohol intake
• Strong trust based relationship
Findings

- The average age of clients (where a specific age was provided) was 39.4 years (SD=12). Ages ranged from 12 years to 80 years.
- 63% of clients were female (n=129).

The medical diagnosis (sometimes there were more than one) provided in the client profiles were converted into ICD-10 diagnostic codes (See Figure 6). The majority of profiles related to people with diagnoses of mood problems, either bipolar affective disorder, major depression or with another diagnosis with depression being a complicating factor. 32% cent of people (n=66) had multiple medical diagnosis.

![Figure 6: Diagnosis of people in profiles provided by mental health nurses](image)

Respondents were also asked to provide an outline of the presenting problem or reason for referral. These revealed considerably more complexity than the diagnostic categories convey with social, family, financial and other health issues being common themes.

These profiles provide greater insight into the interventions CMHNs undertook and the way in which they work with clients. They support the findings of the survey in relation to the services provided through the MHNIP.
References


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Appendix 1 – Survey

Thank you for taking part in this survey of nurses working in the Mental Health Nurse Incentive program.

The ACMHN has commissioned Southern Cross University to undertake this survey to build an evidence based about the work of CMHNs within MHNIP and the outcomes achieved.

All information that could personally identify you will be removed from any reports that are prepared from this survey.

We are asking for your credential number in order to save you the time of entering information that you have previously provided during the credentialing process.

There are two parts to the survey. This first part should take no longer than 15 minutes to complete.

We would appreciate you providing as much detail as possible about the work you do in response to the open ended questions.

At the end you will be invited to contribute to a database of clinical profiles about people whom you work with. This second part asks you to supply de-identified outcome data (age, gender, diagnosis and HoNOS scores) of people that you have worked with. I appreciate that providing this information may be time consuming but your input would help us build a strong evidence base for the program.

For further information about this survey please contact Dr Richard Lakeman (The Principal Researcher).

Please enter your Mental Health Nurse Credential number (this was sent in your letter of invitation)

How long have you worked under the Mental Health Nurse Incentive Program?

Years  Months

On average how many face to face contacts with consumers do you have each week?

How many GPs and/or psychiatrists refer clients to you under MHNIP?

The following questions are open to enable you to provide a rich description of what you do and how you work. Please provide as much detail as you can.
Please describe how you are employed by or engaged with an eligible organization

Please describe how you collaborate with medical practitioners

Please describe the main roles you assume or interventions you use with people referred to you under the Mental Health Nurse Incentive Program

Please describe how you work with other organisations such as NGOs, state mental health services, welfare and support services

Please describe the most significant outcomes for people with whom you have worked

What qualifications or training have you undertaken which has helped you most in the work you do?

Please describe the kind of training, support and supervision you receive to help you in your role.

The following questions are designed to enable us to create profiles of the kinds of people seen by Mental Health Nurses. Please consider someone whom you have worked with that might be considered typical of the people you have seen.

What is the person's age?

What is the person's sex?  Male  Female

What is the person's main medical diagnosis? (Please use ICD Codes if known)

Please provide an outline of the person's presenting problem / reason for referral

Please describe the main interventions or activities you have undertaken with the person

Please describe the most significant outcomes or achievements associated with this person
Appendix 2 - Vignette

A typical description of the assessment activities and key interventions of a CMHN providing services through the MHNIP:

‘Under MHNIP I provide a comprehensive bio-psycho-social treatment plan. I undertake a MSE and risk assessment at each review, I provide evidence based treatments based on psychiatrist diagnosed mental health condition, including illness education, medication education, compliance, use, effectiveness, side effects; motivational interviewing, activity scheduling, problem identification and solving, stress identification and management, breathing exercises, progressive muscle relaxation, CBT, social skills, communication, anger management, dialectical therapy for clients with an Axis 2 diagnosis, and psychotherapy - all dependent on the needs and capacity of the client.

I also undertake physical health reviews and link to diabetic education, dieticians, GPs or service relevant to their need. If clients refuse to attend other services, I provide this service. I also provide drug and alcohol counselling and link with detox where needed. I support clients to re-engage in their community and may attend initially to support attendance. I assist with return to school or work, liaise with all people involved in a significant ongoing way in the clients life (with consent) I provide family education and support to optimise outcomes.

I believe physical health is a part of my role with my clients as is their re-engagement in a fulfilling life. My role is dependent on the need of each individual patient and may be full case management or CBT sessions or full family group interventions. I work with people who are experiencing first episode psychosis, drug induced psychosis, chronic schizophrenia, clozapine clients, depression and anxiety, bipolar affective disorder, BPD where hospitalisations occur and many clients with poly-substance abuse with forensic issues. No one is excluded due to the experience of the treating team of credentialed nurses and our psychiatrist who does not charge for disadvantaged clients. There is a ‘no wrong door’ policy with our service.
Appendix 3. Profiles of people who use MHNIP services

1. 23 year old female with a diagnosis of Major Depression

Presenting problems / Reason for referral:

This young woman was referred to me as being depressed and anxious, finding it difficult to get out of the house. She had three children under six, had lost her licence for five years, and was living in fear of the imminent release of her partner from prison. The relationship had previously been a violent one. She had a history of drug abuse, but had managed to stop all drugs except for occasional cannabis use. She was serving a two-year suspended sentence for aiding her partner in a robbery.

Interventions:

The initial task from my point of view was to establish a working relationship and provide her with some hope. She was fortunate that she had a supportive family, who were prepared to stand by her and help her out where they could. She was in regular contact with her probation officer and I encouraged her to continue to work with them. She also engaged with Alcohol and Drug Services briefly, but her usage of THC was considered to be negligible. I helped her understand the role of medication and what she could and couldn't expect it to do. She had previously been taking her antidepressant irregularly, but became more compliant after learning more about it.

Apart from my supporting role, I used Acceptance and Commitment Therapy exercises to help her begin the process of accepting that her life was what it was, and help her to look for the areas she could change. She decided to cut all ties with her partner before he was released from prison and her probation officer helped her to take out a family violence order against him. I helped her organise members of her family to come to stay with her for a few months when he was released, to help give her the strength to report any breaches. I taught her some mindfulness exercises to help her to shut off her thoughts when they threatened to overwhelm her. I was able to provide simple strategies that she could fit into her daily life as the mother of three young daughters, and helped her to find her own answers. As much as possible I allowed her to put her plans into motion herself, in order to increase her self-confidence.

Outcomes:

In taking action to solve some of the issues in her life, the symptoms of her depression lifted. Her anxiety remained, but she gained some measure of control over it, as she had some precautions in place to protect her safety as much as possible. This young woman was able to take on the role of making responsible decisions for her life. She reconnected with her family, from whom she had distanced herself while involved with her partner. They were instrumental in helping her to provide some measure of safety for herself and her children, while the client was able to rebuild her relationship with her own mother and siblings. She became actively involved with the school who were concerned about the behaviour of her
eldest child, which had a good outcome for both the client and her child. Her symptoms were alleviated somewhat by the medication, in that she was able to see some hope in the future and was able to motivate herself to do the things she needed to do. Her self-esteem improved as a result of her achievements. She became less housebound, and started to take an interest in her community outside her immediate family. Ultimately, she felt she no longer needed my input.

2. 45 year old male with a diagnosis of Bipolar Affective Disorder

Other issues included anxiety, IV drug abuse, chronic pain, narcotic analgesia abuse and thoughts of self-harm.

Presenting problems / Reason for referral:

To deal with anxiety, depression and poor coping; Management advice; Medication advice or review; Substance withdrawal management (heroin); Financial issues associated with supporting his drug habit. He attends a pain management clinic. He feels that he is not taken seriously. He frequently attends ED.

Interventions:

A full mental health assessment and GP file review.

• Education regarding anxiety and depression secondary to chronic pain.
• Coping management advice
• Medication advice or review
• Liaison with the pain management clinic and GP
• Education regarding safe injecting techniques
• Assist with detox
• Liaise with various services including the psychiatrist, pain clinic, GP regular and GP-Suboxone prescriber

Outcomes:

Patient has not used IV heroin for the last 3 months. His court case for speeding fines while unwell (manic) was resolved and he only got a small fine. He is attending the pain clinic regularly and taking advice from his GP. He is attending mental health appointments and rebuilding fractured relationships with the treating team. His pain is better managed so he doesn’t have to use IV heroin. He is not presently suicidal and a GP management plan is in place.
3. 28 year old female with a diagnosis of major depression

Presenting problems / Reason for referral:

The client had a history of depression and anxiety and then had a baby, which added extra stress precipitating a major depressive episode (post natal depression).

Interventions:

Assessment, medication management, linking with support services, psycho-education, techniques to manage anxiety and depression especially mindfulness and CBT; Individual psychotherapy, parent-infant psychotherapy and couple therapy.

Outcomes:

The couple feel comfortable with being left alone with their baby. The client’s mood and anxiety is stabilised and I helped them to be able to communicate with each other. I helped her partner understand what was happening for her.

4. 75 year old female with a diagnosis Major Depression and dementia

Presenting problems / Reason for referral:

Depression, recent diagnosis of dementia, previous psychotic episode. Lives alone in her own home, but has no family in Australia. He is reluctant to engage with services or accept community care. There is a risk of neglect and further deterioration in mental state.

Interventions:

Gradual therapeutic engagement, building trusting relationship and working towards acceptance of community services, medication monitoring, mental state monitoring, risk assessment, psycho social support, outdoors activity (coffee, walk etc).

Outcomes:

Patient finally agreed to accept services after 3 months of contact with myself, mood improved as helped through the process of how to manage diagnosis and future.

5. 37 year old male with a diagnosis of recurrent depressive disorder

Presenting problems / Reason for referral:

Client was initially referred by GP to MHN to assist with managing mood and anxiety. Client has 20 year history of depression and anxiety, with some PTSD symptoms following the witness of a murder when aged 17. He had been involved over the years with many short-term services, without much improvement. He continued to be depressed and experience
significant anxiety, which resulted in social disengagement, inability to engage in work and relationship issues. Physically he is obese with poor diet and lifestyle and associated risks to health.

Interventions:

- The development of a therapeutic space in which client can trust and share openly.
- Encouragement and assistance to address physical health concerns.
- Community engagement - linking into community activities.

Outcomes:

Through the development of a long term therapeutic relationship, client has learned to trust the process of sharing thoughts and feelings, to re-engage with community and life, to understand more about his illness. He now attends a private psychiatrist (who bulk bills) and medication has been adjusted. He expressed some closely held psychotic thoughts after a long time working with him...

6. 35 year old female with a diagnosis of Schizophrenia

Presenting problems / Reason for referral:

Local aboriginal lady with family history of major mental illness, several admissions to psychiatric unit. Utilises aboriginal co-op GP, ongoing relapses, unable to cope with parenting issues, problems with budgeting, housing, very poor physical health. Minimal contact with public mental health and ongoing change overs of clinical therapist.

Interventions:

Weekly home visits with patient and family (who all have paranoid schizophrenia) assessment of current mental health, problem solving re budgeting and housing referral to appropriate organisation with me attending and supporting her.

Outcomes:

Having the family feel comfortable with me visiting. Having the fence repaired after 20 years of the family making requests.

7. 52 year old female with a diagnosis of Borderline Personality Disorder

Presenting problems / Reason for referral:

No private health cover / Numerous law suits and court cases / Inappropriate anger outbursts / No boundaries / Sexually promiscuous / Impulsive behaviours such as drinking and gambling which are very distressing and problematic but not severe enough to warrant input from public health system
**Interventions:**

Over the past year and a half I have been doing 1 to 1 DBT skills training once a week for an hour

**Outcomes:**

She is now at TAFE doing her HSC / She has stopped gambling / she only drinks socially / She has learnt skills to manage her relationships / She is able to manage her emotions and tolerate distress

**8. 27 year old male with a diagnosis of organic personality disorder and learning disability**

**Presenting problems / Reason for referral:**

Poor functioning in all activities of daily living, unemployed, volatile young man with poor impulse control, mood instability and limited opportunities because of learning disability. No engagement with any health professional other than GP. Family concerned and the client presented to his GP for help, wanting "a better life".

**Interventions:**

- Therapeutic engagement with both the client and family
- Full assessment of mental state and risks.
- Commencement of medication and support with compliance
- Referral and organising of NGO support worker to assist with budgeting and psycho social interventions.
- Referral to employment agency through Centrelink
- Referral to Learning Disability Program at the Justice department as he was involved with the court system
- Regular physical tests, ECG's and bloods, weight in conjunction with GP
- Family support
- Counselling with patient

**Outcomes:**

Part time employment secured. Physical health and weight has improved. Was recently diagnosed with hypothyroidism and is now having treatment. Co-operation with treatment plan. He reports feeling very empowered.
9. 42 year old female with a diagnosis of Bipolar Affective Disorder

Presenting problems / Reason for referral:

Bipolar disorder for ten years since youngest child was born with a serious medical problem. My client has both manic and depressed episodes, she has been unwell frequently and we work on the issues involved.

Interventions:

There are many issues we work on, my client was sexually abused as a child by a family member, we have worked on her issues from that through acceptance and commitment therapy. We have worked on her medication compliance and have adjusted her medications with her GP and psychiatrist. I am currently doing family therapy with her complex family issues. I continue to monitor her mental state any risks and her medication. I am also seeing her daughter separately to help her get through her adolescence, while her mother is experiencing mental illness.

Outcomes:

She has not had a significant relapse for 18 months now despite lots of stresses, this is somewhat of a record and one we both proud of.

10. 27 year old man with a diagnosis of Schizophrenia

Presenting problems / Reason for referral:

Interventions:

Engagement. I assisted him finding out cost of gym membership. Providing ongoing support and encouragement to attend. I have liaised with his job network agency, which they greatly appreciated.

Outcomes:

On the last visit, he proudly told me that he was going to the gym. He is now going approximately 5 days a week. There was an improvement in his appearance. He had had a haircut and shaved off his beard. Also he was comfortable enough to tell me that he had stopped some of his medication, and following discussion was willing to consider alternatives. Had this service not been available he would have gradually deteriorated again. He would have needed to be recommended and admitted to hospital, and the cycle would continue. I am hopeful that this can be prevented.

11. 55 year old woman with a diagnosis of Generalised Anxiety Disorder

Presenting problems / Reason for referral:
Anxiety, depression and isolation

Interventions:

Assessed, and treatment plan agreed - relaxation strategies, sensory modulation, activity planning, cognitive therapy, accompanying client out to coffee shops, community centres for activities, finding bus routes, liaison with psychiatrist, GP and family, paperwork.

Outcomes:

Increased anxiety management strategies, improved mood, and ability to use bus independently and access local group activities

12. 45 year old male with a diagnosis of Schizophrenia

Presenting problems / Reason for referral:

Auditory hallucinations, disorganised thought processes, poor medication compliance (on Clozapine) with moderate side effects of medication (constipation, abdominal distension, sialorrea), homelessness, social isolation and a history of "revolving door" admissions

Interventions:

Formalised a comprehensive "staying well plan" addressing side effects of medication, coping with the "voices", dealing with worsening of "voices", accessing emergency help during and after hours. Twice weekly 1:1 sessions.

Outcomes:

This client HAS NOT HAD any further admissions since his referral, his financial affairs are now managed by the State Trustees and we have applied to the Department of Housing to be placed on the priority List to have him allocated a Housing commission flat.

13. 45 year old male with a diagnosis of Schizophrenia

Presenting problems / Reason for referral:

Persecutory delusions that his neighbours' electricity was interfering with his physical health therefore he was going to neighbours switching off their electricity from the main switch. Lack of insight / Non-adherence to medication / Poor self-care / About to be evicted from community housing due to poor maintenance of the unit / Regular complaints from neighbours about him switching off their electricity and accusing them of being the cause of his physical illness / Morbidly obese

Interventions:
Creating a rapport with the client / Insight building / Motivational interviewing towards medication compliance and monitoring adherence / Psychoeducation / When the client’s mental state was stable, education on healthy habits including diet / Basic budgeting education so that he can cook healthy meals instead of buying fast foods / Walking groups / Motivational interviewing towards exercising and adopting healthy habits.

Outcomes:

Medication adherence and stable mental state / Healthy eating habits and exercise and is progressively losing weight from 150kg / Engaged Home Care to assist with cleaning the house / Currently going to TAFE studying community services / Nil hospital admission in last 2 years.

14. 36 year old female with a diagnosis of Schizophrenia

Presenting problems / Reason for referral:

Enduring Schizophrenia. First admission at 19 years of age, continuous long term admissions leading up to 36 years of age. Lives in a group home organised by the mental health service.

Interventions:

Assistance with Activities of Daily Living (ADL) skills development, socialisation, building her identity and her idea of herself as an individual who has some power to determine her life. Uncovering her innate intelligence, which had been buried by a combination of medication side effects (extreme lethargy and drowsiness), systematised disempowerment and a chronology of life losses. In short, digging the woman out of the hole created by circumstance.

Outcomes:

Taking an interest, followed by having pride in her appearance. Education on nutrition and developing the ability to read and understand food labels and to make healthy choices and prepare food to nurture her body. Developing awareness of things that please her and expanding her joy. Beginning a physical exercise regime. Socialising with a group of women and finding herself a valued role within that group. Establishing a more balanced relationship with her mother and her 16 year old daughter. Having many intelligent discussions that weren’t about symptoms or illness management but rather who she is and what she thinks about the world and it’s happenings. Having a valued opinion. Advocating for herself in situations where she previously felt powerless.
15. **40 year old female with a diagnosis of Schizophrenia**

**Presenting problems / Reason for referral:**

- Long history of schizophrenia from age of 19
- Needs assistance with medication adherence
- Assistance when required for physical conditions such as diabetes and osteoporosis
- Has children who verbally abuse client and constantly harass her for money, rent, etc
- Has psychotic episodes from time to time and needs more assistance than GP can provide
- Client discharged from district mental health service

**Interventions:**

- Going for walks, as the client and her husband are both smokers and very unfit
- Some social outings for coffee
- Has required assistance in the past with talking to children’s headmaster
- Facilitated referrals to COPMI, Champs camps

**Outcomes:**

- Has been able to get part time work
- Spending less time in hospital / able to 'nip things in the bud' when unwell as DHHS does not provide long term support so client often very unwell by the time she come to the attention of DHHS.

16. **38 year old female with a diagnosis of social phobia and depression**

**Presenting problems / Reason for referral:**

Self-harming, suicidal thoughts and generally low mood. Social anxiety and isolated. Lives at home with parents and older brother. Along with her father, is the co-carer of her mother with Parkinsons and a brother with Down's syndrome. This person is not working or studying. She has child-like thinking, emotional dysregulation and is prone to 'all or nothing’ thinking. She lives in a negative family environment with emotional abuse. She needs support and encouragement to become more socially engaged and independent.

**Interventions:**

Established therapeutic relationship, gradual exposure therapy, established activities list and respite planning, referred and liaised with Lifeworks program, referred and liaised with Compeer, a volunteer companion service (arranged joint sessions to establish trust) before the patient was able to engage in activities with her companion, organised respite and provided support for patient to stay away from home for the first time in her life, life coach, play therapy, housing support - made applications and accompanied patient to meet with housing officers, wrote to local politicians for housing support, conflict resolution, offered
physical health advice, person centred work, psychodynamic, assertiveness training, self-esteem work, offered life skills teaching such as writing a budget, challenged negative, stuck thinking and offered other ways of thinking, crisis planning, encouraged increased socialisation and reinforced any attempts at this, have worked with dependency to help client understand where it comes from while slowly building some independence, preparing client for independent living, role plays and letter writing to express herself.

Outcomes:

The client has become more socially engaged, going out more and has moved from being with problematic friends to selecting better, more positive people to be around. She is more assertive and in a better position to live independently when housing finally becomes available. She is starting to consider other options other than the extremes when a problem arises.

17. 62 year old female with a diagnosis of Borderline Personality Disorder

Presenting problems / Reason for referral:

Contacting Mental Health Services on a regular basis following decompensation when something in her life goes awry. Numerous minor overdoses and several calls for help. Long standing financial problems, social isolation and limited family support. Lives on outskirts of city as cannot afford to live closer and thus has few available supports. A lonely person. Binge drinker.

Interventions:

Worked very closely with her GP. Some ACT and Relaxation but mostly CBT with supportive psychotherapy. Provision of space and time to ventilate in a non-judgemental manner. Consistent in my visits and interactions. Have provided some transport for hospital attendances when not able to drive. Have supported he in her attempts to join social groups and also do some voluntary work. Liaised with her worker from a local NGO - contact inconsistent and irregular.

Outcomes:

Obtaining some short term paid work! Doctor very impressed. Also joining the local bowling club (this may not last but it is a positive) and decreasing her binge episodes. Increased awareness of strengths and less attempts to overdose or contact local mental health services.

18. 32 year old female with a diagnosis of Borderline Personality Disorder

Presenting problems / Reason for referral:
Inability to concentrate, unable to focus as a result of 'rape' a few years ago. Very depressed associated with the court process. Now on a disability support pension and is unable to work "never will again". Significant prescription drug abuse now. GP 'shopping' for multiple scripts. Self-harm attempts and hospitalisations X 2 over the past two years. Eating disorder, binging and purging. Aggressive partner, no disclosure of abuse. Very little social support evident. Very poor family of origin history. Reason for referral: To develop enough strength to make a statement for court. To get out of this depression and avoid self-harming behaviour.

Interventions:

Engagement with this person was extremely difficult. She would not talk for many weeks. She would sit and rock in the chair for most of the time. The main intervention was to gain her trust to help her find the words to say what she could not previously say or think. We addressed the assortment of prescription medications she was taking and her way of getting the prescriptions. I maintained a transparent and honest relationship with the care providers, her GP and the treating psychiatrist. We thought about and worked on her eating disorders and other anxieties.

Outcomes:

Although she was not very well when she left this service she did gain a sense of self-efficacy and was able to make a statement. She continued to struggle with her prescription medication regime. Her GP was fully aware and interested. I felt her depression shifted, she became more activated and I feel had she continued with the work she would have benefited significantly. I know she was frightened. She was struggling with the option of being hospitalised but as I have mentioned, this was another frightening experience in the past. Her GP was integral to her ongoing care. I have left the option open for this person to return to my care (If there is a service to return to?)

19. 27 year old female with a diagnosis of Schizophrenia

Presenting problems / Reason for referral:

• Poly substance dependence, past hospitalizations, referred on discharge from hospital.
• Her ex-partner had taken her daughter and was not allowing contact.
• Residual symptoms present. Side effects +++ from meds
• Admitted into the residential Drug and alcohol rehab unit that I work in

Interventions:

• Full psychiatric assessment undertaken and immediate review with psychiatrist due to significance of side effects.
• Medications altered and monitored this process and level of side effects.
• Educated other staff (non-medical) on what was happening and advocated to modify her program, with good success.
• Education given to family and client. Reassurance also given to both.
• Lots of support and given the opportunity to tell her story.
• Goal setting.
• Education given to client and family on addiction and the impact of this.
• Worked on relapse prevention strategies and coping strategies
• Treated her drug dependence and mental health problems in a joint manner.
• Monitored her physical status and arranged appointments with neurologists etc.

Outcomes:

• Regained access with her daughter and worked on the relationship with her ex-partner and parenting plans.
• Remains symptom free.
• Side effects settled.
• Worked hard on her addiction and was able to take on senior roles within the rehab centre.
• Undertaking study.
• Family work undertaken and has started to reconnect with her family
• Solid understanding of her Diagnosis and how to minimize the impact on her life.

20. 44 year old female with a diagnosis of depression with anxiety features and Borderline Personality Disorder with daily self-harming by burning

Presenting problems / Reason for referral:

Anxious depressed lady with a history of six years of self-harming and chronic suicidality. She lives alone and has never had been in a relationship, she experiences extreme isolation and has an extremely critical family life. On presentation her depression was progressively getting worse and her self-harming more regularly. She had been referred to a psychiatrist and tried on a number of different antidepressants and mood stabilizers with only limited effect. She is reluctant to try an admission to hospital and has not found out-patient group therapy helpful in the past. Prior to being referred to me she had seen a psychologist for approximately 12 months using a CBT therapy. However, her mood was continuing to deteriorate.

Interventions:

I have been working with this lady for the past three years. I generally see her twice weekly for insight oriented psychotherapy. He has engaged well in the treatment though has had to work through some very personally humiliating experiences. Though the therapy I provide is psycho-dynamically oriented, we do still draw on her CBT skills to manage some of the extreme anxiety. She continues to self-harm though less intensively, she occasionally has suicidal ideations but in now more willing to talk about the emotions that cause her to feel that way she has not actively acted on the thoughts in many months. Her antidepressant
and mood stabilizer medications have been able to have the dosage reduced this has been important as she was experience metabolic side-effects.

Outcomes:

She is remarkably still alive and I say “still” with trepidation, as her progress is slow but at least measured. We have reduced her serotonin load, which has reduced her susceptibility to serotonin syndrome a life threatening condition and her metabolic syndrome risk-factors. Treatment needs to continue as aggressively and as reliably as it has done under the MHNIP as hospitalisation and limited treatment sessions have had little benefits to her in the past.

21. 25 year old female with a diagnosis of Bipolar Affective Disorder and Substance Abuse

Presenting problems / Reason for referral:

She presented with lowered mood state, suicidal ideation, high anxiety, alcohol abuse, isolative behaviour, restricted social activity, family conflict, low self-esteem and a poor opinion of counselling or support.

Interventions:

Engagement through discussion of previous experiences with counselling. Goal setting and motivational interviewing techniques for alcohol abuse. Discussion of diagnosis and information regarding treatment, prognosis, course etc. Anxiety management including relaxation, mindfulness, exposure and desensitisation therapy. Liaison with vocational agencies with client consent. Family discussions regarding sibling relationships. Relapse prevention.

Outcomes:


22. 45 year old male with a diagnosis of Bipolar Affective Disorder

Presenting problems / Reason for referral:

BPAD, depressive episode, suicidal ideation with recent plan (not current). Inadequate treatment. Fear of taking other medication and gaining weight.

Interventions:
- Engaged client, develop rapport and establish some initial trust.
- Provision of counselling and support. Risk assessment, ensure safe.
- Provision of education re illness and benefits of treatment.
- Liaison with GP regarding treatment options.
- Monitoring of mental state and efficacy/adverse effect of treatment.
- Education regarding importance of compliance and provision of reassurance.
- Recommendation of referral to Psychiatrist for medication review.
- Recommendation for chronic disease management plan to enable referral to dietician and exercise physiologist.

Outcomes:

The client is settled and safe and coming in regularly for monitoring and support. He has developed greater insight into his illness and is accepting of his diagnosis. He is compliant with treatment plan and engaging with other allied health professionals. He is communicating his stressors and has a shared goal to prevent exacerbation of symptoms or further relapse.

23. 39 year old female with a diagnosis of Bipolar Affective Disorder

Presenting problems / Reason for referral:

This divorced woman returned to live with her aging mother, who also has Bipolar Disorder and Dementia. They live in a small two bedroom cluttered apartment. The client doesn't drive and relies on the mother to drive her to appointments. The client was spending most of her time in bed reading or sleeping, complaining of pain and "chronic fatigue". She would speak of suicidal thoughts and hopelessness. There were no other family or friends. The client stated that she had been living like this over the past 10 years after a work place accident and a divorce. Prior to that she had been diagnosed with Bipolar Disorder but had more energy, creativity and held down good jobs. Has rheumatoid arthritis and fibromyalgia.

Interventions:

- Established good rapport.
- Supported the GP’s who were having difficulty with the demands she was making for medication and often presenting irritable or depressed moods.
- Motivational Interviewing
- Referral to Specialist Alcohol and Drug Service to learn about her pain management and options.
- Accompanied to each appointment with the SADS and assisted in following through with the choices to reduce and gradually withdraw, increase exercise, seek out physiotherapist (with a female, which can be difficult in a rural area).
- Assisted with reclaiming space in the flat.
- Monitored medication and arranged medication reviews to address mood instability.
- Encouraged and supported to study for a drivers Learners Permit.
- I assisted the client in getting an aged care assessment for her mother and to get support through Community Interlinks and the local shire.
- Worked together with the client (and her mother) to address their hoarding.
Outcomes:
- Self-esteem and confidence returning.
- Able to invite two old friends for dinner. Previously her and her mother too were ashamed of the state of the unit and could not access the dining room table for clutter.
- The client has also been accepted as Chairperson for ****, which has drawn on previous skills and helped her to re-gain some confidence and provided a first step to meeting new friends.
- She has a much better tolerance and understanding of her pain and strategies other than pills to manage it.
- I currently see this woman and her mother about once a fortnight to continue with her rehabilitation.

24. 48 year old female with Bipolar Affective Disorder

Presenting problems / Reason for referral:

25 year history of BPAD with episodes of mania and depression with overwhelming anxiety that required frequent admissions to a mental health facility. She had been a client of the acute care team (ACT) and was seen twice weekly for approximately 2 years. Mania settled but depressive and anxiety issues remained. Has difficulty coping at work and has relationship difficulties. Vulnerable to being taken advantage of financially. Poor coping and problem solving skills. Inability to manage finances appropriately.

Interventions:
- Monitor mental state and seek appointments with psychiatrist and/or change in medication pending her mental state.
- Assisted her to develop simple coping and problem solving strategies.
- Assisted in managing her finances in terms of ensuring she paid bills on time, budgeting and seeking expert advice in managing her finances.
- Provided support and advocacy at her work place when she underwent process of being medically retired due to inability to fulfil substantive position as an Admin Officer (AO2) (lowest level).
- Liaison with her work place supervisors, psychiatrist and GP regards work issues.
- Provision of information to her GP via GP MH care plan.
- Liaison with her psychiatrist and attendance at appointments with him to ensure she could ask him questions prepared beforehand rather than get too anxious and say very little.
- Monitor medication and encourage her to have local pharmacist manage her scripts to remind when repeat scripts required.
- Psycho-education for her and family.
- Family support for her and family.

Outcomes:
She was successfully medically retired (after 30+ years in public service) without having a major relapse and requiring to be in hospital. During this time her sister and brother in law were diagnosed with cancer. Her father went into a nursing home. Her ex-husband died. Her mother was diagnosed and died of cancer of kidney. She undergoes back surgery for spinal blocks twice a year. She finally was approved for the DSP and had QSuper pay out. She moved to her deceased mothers unit closer to family for support having decided to leave rental place in Brisbane (financially a good decision). Has paid off all debts and has a financial advisor in place. Family are more supportive. Seeking volunteer work. Will likely see another psychiatrist at *** and I will discharge her from the MHNIP in coming months.

25. 22 year old female with a diagnosis of Bipolar Affective Disorder, Borderline Personality Disorder and a Eating Disorder

Presenting problems / Reason for referral:

- Discharged from public MH Youth Service and declined service from Adult Area Mental Health Service
- Seeing Psychiatrist & psychologist (ATAPS)
- Chronic medium - high risk to self suicidality and self-harm, multiple psychosocial stressors and social functioning impaired due to mental health disorders and chronic symptoms
- Fluctuation in stability of mental health and lost 70 KG in 6 months.
- Significant Suicide attempts in past and many admissions to CAMHS & Adolescent, Adult and medical in patient admissions over 5 -6 years often involuntarily.
- Referred to Mental Health Nurse as requiring additional support to monitor medication, RISK management, support re eating disorder and due to recent pregnancy.

Interventions:

- Supportive therapy
- Liaise with Psychologist, psychologist and GP as required
- Further assessment of eating disorder and facilitate referral for specialist consultation
- Provided monitoring and education, re eating disorder/ diet/ etc.
- Liaise with GP re blood test monitoring to review key indicators i.e. potassium levels.
- Monitor and manage risk and mental state as has over number months changed medication (mood stabilisers)
- Develop assist in safety planning as required and review as necessary
- Provide phone support as required
- Liaise in writing and complete a number documentation as required to support referral for consultation re eating disorder and GP re medical assessment required.
- Reports to GP periodically.

Outcomes:

- No recent admissions
- Client feels supported as can have more frequent contact and better use psychologist for therapy rather than crisis support and to ventilate over stressors
- Partner also has extra support
Other team members (Consultant & psychologist happier with increased support as ATAPs funding inadequate to provide sufficient ongoing clinical support to client with level of complexity and chronic risk)

26. 13 year old male with a conduct disorder and parent-child relationship difficulties

Presenting problems / Reason for referral:

- Aggressive outbursts - both physically and verbally towards others, aggressive towards property
- Oppositional and defiant towards parents, teachers and authority figures
- Suspended regularly from school / academically struggling
- No friends and poor friendships
- Breaking and entering property and stealing from others
- Older brother has illicit drug problem (crystal meth and is also aggressive)
- Father diagnosed with schizophrenia and also had hearing problems (deaf)
- Mother diagnosed with depression
- Parents had separated and reconciled several times over the course of my client's life, and had reconciled at the time of the referral
- Maternal grandmother a support to the family
- All adults were concerned that client would develop schizophrenia, and client was able to 'get away' with his behaviours as parents did not know what to do.

Interventions:

- Family therapy - bought in grandmother to be a part of the parenting team.
- Explored appropriate consequences and behavioural strategies for client. Client responded well to this intervention.
- Engaged client with the local youth services - engaged in appropriate programs that were of interest for the client.
- Father got hearing aid and was able to parent client more effectively
- Client and parents attended CHAMPS group (children of parents with a mental illness), Parents attended the parent group where they received support regarding client's challenging behaviours. Their own questions about mental illness were answered.
- Client attended the children's group where he learn about mental illness and mental health.
- Engaged client in individual therapy with myself, which involved play therapy and solution focused therapy to reduce the aggressive outburst
- Child Focused Parent work with parents
- Regular consultation with client's then primary school and now secondary school to reduce suspensions the client was receiving due to behaviours.

Outcomes:
• Client is no longer engaging in criminal activities, aggression is no longer an issue. On the odd occasion when client has destroyed property, parents have managed this situation appropriately and client has responded well. Parents are able to set limits and have expectations of client. Client's initial presenting problems are no longer a concern.
• Client still academically struggles in some subjects and does get suspended from school due to 'silly' behaviours, but is no longer presenting with the same behaviours as he did in primary school.
• Client no longer presents with conduct disorder behaviours, but can be oppositional and defiant at times, but this is not a daily occurrence as it was previously, and these behaviours only occur on a rare occasion.

27. 46 year old male with a diagnosis of Adjustment Disorder

Presenting problems / Reason for referral:
• Loss of business, major outstanding tax issues with threat of jail and financial ruin leading to marital breakdown, lost contact with teenage children and homelessness.
• Cyclical pattern with one previous serious contemplation and planning of suicide

Interventions:
• Initial support, crisis and safety planning through marital breakdown and twelve month recovery from major depression
• Linked to psychiatrist to rule out bipolar disorder and obtain recommendations for antidepressant
• Monitored effects, side effects
• Actively supported to:
  - maintain and build fragile links with estranged children
  - develop healthy eating and exercise patterns
  - link with GP for ongoing routine health care checks
  - reconnect socially and maintain links to few close friends he had lost contact with
• Advocacy with taxation issues to obtain stay of proceedings while pro-bono accountant found to work with client
• Coached and assisted to recognise importance of and develop skills of maintenance tasks as well as more interesting aspects of work/life.

Outcomes:
• Fully recovered from depressive episode
• Reunited and seen as a 'different and wonderful dad' by his 19 and 22 y/o children
• Accepted back and supported by his family of origin
• In a new and supportive relationship
• Building a new business while developing new skills in managing that business to avoid cycle of failure
• Attending to taxation issues with assistance from pro-bono accountant - and managing overwhelming anxiety, fear, shame and humiliation related to providing a written summary and timeline of all contributing business and personal events.
• Speaking about two suicide attempts in detail for first time.
• Recognising the gift of his journey because it has led him to make wiser, better informed choices about his and his family's future. No hospitalisations or CATT care required

28. 65 year old female with a diagnosis of Depression

Presenting problems / Reason for referral:
Suicidal ideation and depression requiring hospitalisation. Also required hospitalisation for heart disease. / She is homeless, financially struggling. Estranged from any siblings that are in Australia, and her children and grandchildren are in Albania and struggling to get visas. Since immigration in 2001 has lost her husband and since has been essentially homeless boarding with other Albanian families. Is in crisis and has unrealistic expectations of what can be achieved with the immigration process.

Interventions:
• Monitoring of risk factors and mental state.
• Obtaining access to interpreter services as previous CMHN was using the family member that she boarded with as an interpreter which is against best practice.
• Have facilitated appointments with dental hospital and the waiving of fees due to financial hardship. Also provided me with opportunity to use interpreter once the dentist had finished. CMHN’s do not have access to waiving of interpreter fees. I have advocated for her GP clinic to complete the forms to obtain TIS client ID.
• Have referred her to bulk billing psychiatrist who works from our office and therefore enabling interpreter access.
• Have linked her in to the local supports that provide food packages and vouchers.
• Extensive work in liaison with MOSS to organise housing applications and recently just pipped at the post for transitional elderly housing.

Outcomes:
• Feelings of not being alone paramount.
• Links and progress with housing applications.
• Physical health is being well managed.
• In process of working with unrealistic expectations but with the current freeze and reduction of hours per EO it is making it incredibly difficult to be client centred.

29. 50 year old female with Depression
Presenting problems / Reason for referral:

Domestic violence within the marriage, background of trauma and insecure attachments, poor protection from adults, may have been sexually abused. The development of incapacitating mental health problems, not able to cope, not able to work, clinical symptoms of depression. We may start with a simple description of the problem but our work uncovers significant complexity.

Interventions:

- Establish a relationship where trust is created.
- Allow a person to tell their story without condemnation or judgement.
- Over time the person knows that a MHN will be consistent and not behave erratic or be inconsistent.
- Stabilise the heightened symptoms of PTSD and reduce the intrusive thoughts that cause stress, anxiety and panic.
- Meditation, Mindfulness exercises, give relaxation CD’s
- See initially weekly until that person is settled.
- Assess their physical / social / spiritual health.

Outcomes:

Through this work they begin to rediscover their true identity, develop some new skills to deal with life, can live life not being scared out of their skin, learn to trust again, feel calmer and more relaxed, consider other paths & options say for work or in relationships. Gain better insight and perspective of life and self. Start to cope better, feel happier.

30. 55 year old male with Post Traumatic Stress Disorder

Presenting problems / Reason for referral:

Assaulted at workplace, which triggered pre-existing PTSD and has led to ongoing depression/social phobia.

Interventions:

Graded exposure to hierarchy of feared situations on a weekly basis. ACT principles as related to scary images / thoughts. Anxiety management and relaxation techniques. Lifestyle review and ongoing opportunity to ventilate and problem solve.

Outcomes:

We now attend a wide range of cafes for lunch, can attend grocery shopping and complete messages or errands. Attendance at major exhibits in crowded situations in Melbourne. Client has greater control over what he can do and less anxiety as a consequence.