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?
Acknowledgements

The Australian College of Mental Health Nurses acknowledges the support and input provided by members of the ACMHN Reference Group:

Ann Maree Billings, Registered Nurse, Credentialed Mental Health Nurse™, Eastern Melbourne Medicare Local

Stephen Carroll

Professor Andrew Cashin, Registered Nurse, Mental Health Nurse, Nurse Practitioner, PhD Southern Cross University

Lindsey Crockett

Toni van-Hamond

Associate Professor John Hurley, Southern Cross University

Richard Lakeman, Senior Lecturer, Southern Cross University, Principal Researcher and Author of the study

Denise Poyser, Credentialed Mental Health Nurse™

Breda Ryan, Registered Nurse, Credentialed Mental Health Nurse™, MBL

Kim Ryan, Chief Executive Officer, Australian College of Mental Health Nurses Inc.

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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 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.
- 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 data base. 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.

CMHNS adapt and tailor their therapeutic approach or specific interventions to the individual’s needs.

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.

What do Credentialed Mental Health Nurses do?

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 Axis 2 clients, 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 they 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 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 no wrong door with our service".
Who uses MHNIP services?

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

**Presenting problems / Reason for referral:**
The client was initially referred by the GP to me to assist with managing mood and anxiety. The 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.

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.

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.
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 group home organised by the mental health service.

Interventions:
ADLs, 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 in 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 previously powerless situations.

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
• 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)
• 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 an Client is no longer physically or verbally aggressive towards others. 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.

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.