Case Studies in Support of the MHNIP Review

The ACMHN received many submissions from credentialed mental health nurses providing services under the MHNIP when developing the MHNIP Review. Here are some of the stories that we were not able to include in the publication, but which further demonstrate the skills, expertise and strengths of the mental health nursing profession:

Julie Lock

I have worked in mental health in both the UK and Australia over the past 30 years, in both public and private sectors. I have worked in the MHNIP for the past 9 months, working in several different GP surgeries in Gippsland. This is one of the best jobs I have ever had. I am respected and valued. I am able to do the job I am employed to do, and believe it is making a huge difference to the people I see.

I have found that the majority of patients are people who either

- Have been assessed by public mental health and have not been accepted for service
- Choose not to go to public mental health due to stigma
- Can’t afford private help or are unable to travel the long distance to Melbourne for private mental health assistance.

All of these people have a mental illness and would have previously struggled with the limited support that GP’s are able to provide. Some would have accessed limited assistance from a psychologist. Some would have simply fallen through the gaps, not receiving any help.

This is an excellent programme, well over due. The only improvement I can suggest would be to increase the service. To engage all GPs into the programme.

Julie Lock, Credentialed Mental Health Nurse, Working for CWG Division of General Practice.

Michael Farrell-Whelan
My name is Michael Farrell-Whelan and I have worked in mental health services for the last 35 years including the last 15 years as a bereavement counsellor on a palliative care team. Just over 12 months ago my wife and I went into private practice as grief and bereavement counsellors. At the same time I became a Credentialed Mental Health Nurse and was engaged by one of the local GPs in the Blue Mountains to see mental health clients under the MHNIP.

I have found the MHNIP a great project as I can case manage clients with a focus on the client rather than the bureaucracy, therefore the vast majority of my time is spent face to face with the client. It can be difficult to evaluate this project after only twelve months but anecdotally the GP has commented on having less “emergency” consultations with his mental health clients and now none of the people I see are case managed by the local mental health service.

Margaret Wells

I work two jobs, one in MHNIP. Last year, I worked full time in an extremely stressful mental health job, worked in MHNIP in the evenings and on week-ends and did my second Masters degree part-time. I worked in MHNIP because of the satisfaction it provides. It has encouraged me to grow and learn more. It has provided me the opportunity to develop a broad range of skills and to work with clients in ways that are creative, generative and helpful in reciprocal ways.

Clients love it, they can attend at the GPs, no one knows why they’ve come. I have approximately a 90 % attendance rate (clients rarely fail to attend.) They report improvements. I offer flexibility. I can work with children and adults. I work with families. I visit in their homes. I advocate for them in all types of settings.

The downside is, I don’t get paid enough to do this full time. Under the MHNIP scheme, I haven’t had a pay rise in three years. I can earn more doing a casual shift in a hospital. I don’t get professional development money. To attend a training course I lose income and pay for the course. I use my wage to purchase resources. I’m lucky to work with other MHNIPs so we have our own peer supervision together. Otherwise, there would be a risk of isolation and separateness doing this work.

GP’s often don’t have physical room to accommodate the MHNIP and we may find ourselves doing a home visit because there is no room in the clinic, we may have to delay service provision to clients. Generally, GP’s often don’t realise what we are capable of, I don’t think there is a broad understanding of the skills we can offer clients or GP’s.

Barbara Pentacost
I am working in the MHNIP. I started in 2008 one day a week and am now working 9 days a fortnight and the surgery is looking at taking on another MHN for 2 extra days per week. I am booked up 2 weeks in advance and there is a great need for mental health nurses fulfilling this role. It has meant that it frees the MHN’s at the hospital so they can take on a more crisis care role which in the past had to be slotted in to their already busy schedule.

The support I have received from the GPs has been enabling. Working closely with them has meant a more seamless service providing the clients with greater continuity.

It has also meant I have a chance to work within the community helping clients to start a Depression Support Network in a community that has nowhere at present for sufferers from Depression to go to get some peer support and activities. I feel that it gives me the chance to use my skills as a Mental Health Nurse and challenges me in a positive way each day.

Barbara Pentacost, Pioneer Health, Albany, WA

Diana Stephen

I am a nurse with 30 years experience and now find myself in the most productive and useful phase of my career practising in the MHNIP. For years I have been nursing people whose mental state has deteriorated to such an extent that their lives have often been ruined or broken. Working in a GP clinic I now work with people who realise they need help, know they are struggling and are receptive to my knowledge and experience. In a short time I have seen people who, if the MHNIP service had not been available, would have ended up in hospital or their situation would have crumbled to the point where problems would have impacted on their families and their relationships. I have received some very positive feedback and watched some quite significant improvements. On a personal level there is a lot of positive validation and job satisfaction. On a human level it must be a benefit to have the cycle of illness interrupted before significant damage is done. It has long been an issue in health that prevention is better than the cure, and for the first time this is a reality rather than a platitude.

Noel Molloy

My name is Noel Molloy and I was Credentialed late 2010. I live and work in the Werribee area, in the West of Melbourne. This is one of the fastest growing municipalities in Australia.

After 36 years in nursing, I decided that I needed a change. I have been the Clinical Nurse Manager of the Acute Adult Inpatient Unit for the past 8 years. I have been working in private practice for the past 4 months, while balancing my ‘day job’ and gradually building my referrals. I have a mixed
business, also providing clinical supervision to groups and individuals. I have also helped a number of individuals to apply for their credentialing and I hope that some of them will join me in establishing a local practice.

I am about to go on 7 months leave, a mixture of annual and long service. I hope to work full time in private practice.

What I have enjoyed most so far is my feeling the growing sense of independence and fulfilment as a nurse, but also meeting the needs of people who ordinarily would ‘fall through the cracks’ of the public health system. I have also had a group of very supportive colleagues, who have backed me all the way, including my wife (most important!!!). Fellow college members and credentialed nurses have only been too obliging to help me navigate the system, namely Dermot Moynihan, Craig Maloney and the wonderful Nina Hunter.

What has been difficult is getting GPs to refer. They are sometimes only happy to refer if you will rent a room or complete the mental health plan for them. Their documentation is in the main poor; ‘please see ABC for xyz’ is the total referral. Yet in the local area they are crying out for services……..Some do not understand the MHNIP and therefore don’t refer. Some do not understand when you reply to their question ‘what can you do for me?’ with the answer ‘add value to your service!’.

The paperwork for reimbursement is painful and I feel we should be paid directly, not through a third party. I know the College is pursuing this, but waiting three months to get paid is difficult if the ‘third party’ or you miss the submission deadline.

All in all, the positives far outweigh the negatives. I have found that I have to become a ‘salesman’ of sorts, selling my services, which has made me realise how undervalued we rate ourselves as experienced professionals.

Helen Meluish

I became a credentialed nurse 1 year ago and moved from acute community care to case management at the Division of General Practice where I am one of two nurses.

Initially I found the transition a little difficult having always been in acute mode but one year on I think I would find it difficult to now go back. There are many benefits to working in the environment I am in. I am a truly autonomous practitioner with the support I would have liked to have in my previous role but never had access to. I now receive not only peer support but supervision, and I am continuing to learn a great deal about the way I work. In my previous role I was hungry to learn new things and to develop in my role but sadly this was never offered and I felt very much like a number. Today I am
constantly learning, and in turn this makes me able to deliver a service which I feel should always have been available to our clients but never was.

The client load I have is around 20 of mixed needs. The work we are able to do with our clients is positive which I hope gives them a future and choices. We have been able to enable clients to get back into the workforce, whether supported or not and we work closely with a supported workplace of which I cannot speak highly enough. We have the opportunity to not only see clients at their place of work but also to be able to provide a group environment for them which is working towards becoming totally peer led. The clients are growing in front of our eyes and that is what makes us feel like the nursing we do actually matters and brings about change.

Our office environment is also wonderful with our management always very supportive of us in all we do. They allow us to get on with the job of nursing and we are no longer tied up in the red tape that had always been a barrier to care. We work in a ‘can do’ workplace.

Our job of course would not be possible without the support of many excellent GP’s, the Psychiatrists and the many and varied other services which are out there providing care. I now see my role as pivotal to all the other services involved. I try to make sure everyone has the right information, that it is up to date and that we are all working towards the client’s goals. Good communication is key in providing top quality care and is the right of the client you are advocating for.

With all that said I cannot forget to mention my colleague Kim. We work in different ways and have had different experiences in our nursing roles which brings about a fantastic team. We both want the absolute best for our clients and Kim is a great promoter of the good work that we do.

As far as cost benefits to the system we are of course saving a lot in reduction of bed days. This is backed up by information by our supported workplace that shows reduced absenteeism from their workplace and reduced hospital admissions. It is however difficult to attract nurses into our workplace due to the lengthy and time consuming credentialing process. A positive change in this area would make it easier to increase our workforce. Pay is another reason why attraction can be difficult as the pay should reflect what nurses are able to achieve in the public setting and not pay less. You are of course asking for a highly qualified nurse to work autonomously and provide an excellent service. Therefore if you want a good nurse you really need to pay the money to reflect that.

Finally the referral system to the MHNIP program could be simplified. Many of our referrals can come via non-eligible organizations (Primary mental health care providers e.g. NGO’s) and these clients do not often have GP’s. Therefore to widen the referral system to be initially assessed by the us at the Division and then to link them with a GP could be more appropriate.
Eligible organizations could be expanded to include supported workplace environments, primary healthcare organizations and the mental health nurses themselves should be able to work independently of the GP’s.

Sharon Booth

I have been working in the MHNIP since its inception. The program has been wonderful for clients; their families the medical staff in the community, NGO’s and of course the nurses.

Clients

The clients receive a specialised service that is focused on their needs. This includes mental health assessment, risk assessment, needs assessment, counselling, medication monitoring and mental state monitoring as well as psychoeducation and substance abuse treatments. I provide consults, liaison with family, key stakeholders and the primary practitioner. I refer clients for specialist consults when required, (e.g. neurology, cardiologist, dietician etc., and to clinics and programs that include issues like sexual assault, domestic violence eating disorders.

The clients get an holistic service and have longitudinal care which is not able to be provided through the public health system and is not provided by the GP. Clients can have long appointments with their nurses and not rushed in and out. They can remain within the program as their needs require and it is cost neutral to mental health clients almost all who have a disadvantaged financial situation.

The families feel strengthened by the support of the experienced mental health nurse with whom they can share their experiences and concerns. This enables a wider support system for the client when the family can be involved with the nurses in helping the client to achieve their optimum functioning. If families have concerns about the illness they can have it explained which will include strategies to assist the client to keep well.

GPs

The GP involvement is also supported by a specialist clinician nurse. With the nurse monitoring the clients and their mental state, issues can be addressed in a more timely fashion in many cases, thus keeping them out of acute care in the local hospital and saving valuable public health care dollars. The numbers of hospital days overall are reduced when clients have assertive care in the community either by preventing the need for admissions or allowing the client to be discharged to responsible professionals in the community.

NGOs
The NGOs have embraced the program as the specialist mental health nurses have been supportive in the care and management of the issues that the clients face with housing, employment, medication management, financial issues, and social issues. These basic needs we take for granted but are huge issues for persons with mental illness who cannot always advocate and negotiate these things for themselves.

Nurses

What I like about the program is that it allows me autonomy; I have my own consulting rooms centrally located to local mental health services, and public transport. I love the engagement with the clients and their families. It raises the self esteem of clients that someone is actively caring for them and I have had lots of positive feedback from families who are thankful to have a mental health nurse who understands the issues caring for their loved one.

In my role supporting other health professionals, I provide education for the GP’s and practice nurses. I conduct case presentations and reviews which often includes the client and family as well as NGO partners. I assist the GP with medication management issues and refer as necessary to the consultant psychiatrist for review.

Improvements needed

The program needs to encourage more mental health nurses into practice. We need education support, we can provide role modelling and clinical placements supported through the schools of nursing.

The HoNOS does not accurately reflect functional improvements in the client as it is subject to the person completing the assessment. A more accurate measure would be a questionnaire that the client can respond to and also to include how having their own mental health nurse supports them in the community when in crisis.

We desperately need to increase the number of sessions as currently 10 is not enough given the demand on our services. I often work a 10 hr day and with only 10 sessions this fills only 3 days a week.

The fact that session numbers are capped, and the remuneration is also capped is unique in that no other profession has restrictions on their provision of services.

The program has been a success so it's time to broaden the parameters given the benefits to the clients and society.

Sharon Booth FACMHN Clinical Nurse Consultant
Linet Hilsberg

Why I like working in the program:

- I have independence from structured working hours that exist in mainstream Government employment.
- The freedom to sit in a coffee shop or other place with a group of new mums with bubs and not have to ‘watch the clock’ to be back at the office.
- The flexibility to do my notes and Medicare Billing.
- If I wish to work until 7pm one night and start late the next day, I don’t have to ask permission just inform the practice of my movements for safety reasons.
- Having a ‘no appointment- walk- in’ service 2 days per week for ongoing clients.
- Walking into the shopping centre to get lunch, being recognised as the nurse from the surgery and not get back to the office for at least an hour as people stop to talk to you to refer someone who they are worried or concerned about.
- Having the freedom to take time off without applying for leave is a bonus.
- The flexibility and professionalism of working with NGO’s in the community.
- Positive feedback from clients within the community knowing they have access to a health professional without having to go to the hospital and wait for hours on end.
- Receiving positive feedback from relatives and others who have had contact with the MHNIP who are not clients of the service.
- Knowing I am making a positive difference to the community by offering this service bulk billed.

Benefits of the program

- Less waiting time for clients for assessment if they are unwell or it is an emergency.
- An easier pathway into a mental health service.
- Support from MHNIP following discharge.
- Ongoing support that is not ‘6 visits then finish’.
- Easier referrals and access to other Allied Health Services.
- Linking in with Centrelink, Mission Australia, ATODS, Homeless Persons Program, Police, DoCHS, Legal Aid solicitor, domestic violence unit at local courthouse, connecting with parole as well as other local NGOs who are attempting to improve pathways for accessing mainstream mental health services.
Co-ordinating and making accessible these services including open communication to clients and their families.

Offering a 6 day per week service including other Allied Mental Health clinicians who are working in the surgery as well as in the local area. Currently we have clinical psychologist, youth mental health social worker, acupuncture doctor, dietician, and sleep clinic and lung function nurse all operating within our practice. Linking in with these other services when needed is a benefit to the clients’ welfare and overall health.

I rather like to think that the cost benefit is to the client, not the hospital. The support from the MHNIP is important for them to know that they have a link into the system which is reliable, effective and professional in ongoing active treatment and in an emergency. To turn up to a service, be seen almost immediately is a benefit in the clients’ eyes.

**Client satisfaction**

- Feedback is given by client to practitioner or GP
- Evidence from DASS at HoNOS review also shows improvement in treatment with clients GP. This in conjunction with an overwhelming number of clients attending would indicate that clients are satisfied with the program.
- To date at this surgery there have been over 168 clients assessed and admitted to the program or seen as a ‘once off’ since Jan 2010. Referrals following assessments when appropriate into mental health services either to hospital, psychologist, social worker or other service are offered as part of the MHNIP supports.
- Acute care follow up following discharge and working with local mental health team is paramount to the success as clients who may ‘fall through the net’ will normally attend their GP which is where the MHNIP is operating from.

**Improvements needed**

- Increased payment to the practitioner. This has not been increased since the time of commencement. By the time tax, superannuation, insurance and other costs in running a company have been paid, the pay is less than a nurse who is employed in a hospital. If payment is not increased within the next 3-4 years, I will not be able to work in this program as I will be running my company at a loss.
- To increase benefits to cover expenses.

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**John Walker**

From my experience, MHNIP:
- Puts mental health nurses in the community; allowing them to be more accessible to the people who need them. Nurses can work in an area that they choose, specialise in, and maximise the use of their skills base.
- Provides a more visible face to the profession of Mental Health Nursing
- Supports General Practitioners; and reduces the load of Psychiatrists; nurses caring for people, and these persons requiring less contact with the Dr. /Psychiatrist.
- Leads to a more holistic treatment plan, and it often uncovers deficiencies in people’s life style, that the nurse and treating team can address and repair with the persons, making them a healthier person and adding to their understanding of themselves and others.
- Facilitates closer relationships with people, and we learn more about them,
- Enables more continuity of care and timely responsiveness, especially in times of increased stress. it is much easier and useful to assist and advocate for people by ‘being there’ with them when they are (a) having difficulties, or (b) are learning /practicing new skills, and developing confidence in themselves

Practising under the MHNIP, I have learnt so much more about so called ‘mental illness’ and developed a healthier and broader skills and knowledge base from which to assist people.

I have found that; the deeper one gets to know a person, the less Mental illness one finds; however the more social, spiritual, emotional, and developmental debilitation becomes evident. People are often ignorant of so many of the understandings of social mores, hygienic practices, interactional patterns, sexual norms, and a host of general behavioural expectations.

I have learnt also that people like to be treated as if they fit into the community, not as if they are different from it. We, the nurses and other health professionals in our practice, de-mystify mental illness at every opportunity, and seek to assist the general public to recognise the person who is suffering is primarily that, a person, not an illness. There is a much lower understanding of mental illness in our community than you would think; it seems imperative at times that addressing this lack of knowledge needs to become a primary focus for the Credentialed Mental Health Nurse.

**Activities that have evidenced people benefits, satisfaction, and have cost benefits for the health system**

Under the MHNIP we have been able to use a range of activities that have had benefits for the people we work with and for the health system. We have

- Created group activities, and celebrations, bringing people together to share with us and each other.
i.e. Facilitated ‘camps’ with groups of our people. Travelled, shared, eaten, played, and enjoyed each other’s company. (We are asked, often, when is the next one?)

- Assisted people to decrease their medication, in a careful and deliberated manner, with the knowledge and involvement of family.

- Responded to prolonged ‘critical times’, by increasing our involvement, and thereby negating the need for Catt involvement, or possible admission; one by-product of which has been the maintenance of our relationship, rapport, and credibility.

- Provide financial aid to individuals who are unable to fund an item of need; or to obtain educational materials or opportunities from any other source. This is done via a Practice Support Fund, contributed to from each member of our group.

- Been able to offer support and counselling more easily to extended family members, and often advocate for the primarily ill person.

- Strengthened our relationship with G.P’s and other community practitioners.

**What could be improved?**

- Credentialed nurse income be paid every fortnight, via Medicare.

- Electronic submission would simplify the claims process, and avoid delays and errors.

- There is ambiguity in the interpretation of the guidelines of the program, particularly in regard to face-to-face consultations, phone consultations, group clinical reviews; and clinical supervision.

- Different claims processors have differing advice on the correct way to complete the claim forms, which is an ongoing confusion for us.

- The capacity to continue care after two years.

- Increase the ten sessions per week, which is limiting, partly in order to respond to the community’s needs, but also, as we utilise a variety of group activities, we would be able to have more people participating in their own personal growth and change.

- Ensure that Credentialed Mental Health Nurses they have the most up to date and sound community based mental health knowledge available.

- Access to funding that would be available to commence and / or expand life enhancement projects, initiated by Credentialed Mental Health Nurses, that can be proven to be valuable to the people we care for.

We find that the majority of people we support have little ‘meaningful activity’ during the day. Many of them want to find some kind of work; others have talents and / or skills that they would like to utilise, and develop further; others just sit around aimlessly, unconvinced of the need to do much at all. Many
are socially isolated, despite living in dense suburban areas, they all want contact with others, and something to do, but find it difficult to self initiate change. Everything we do is aimed at integrating individuals into their community, assisting them to developing social, financial, and personal capabilities, repairing relationships, and to become meaningful members of society. That’s got to be saving dollars!

Our practice has a few projects that we would like to develop, that will respond to the issues above, and involve most of the people we care for, however these will be time consuming, and it is financially improbable that we could get them off the ground without aid. We want to do more.

Finally
Credentialed nurses have the capacity to promote 21st century mental health practice, and lead by example, in order to participate in the profound changes that need to and will occur, in the future of general and mental health. I am deeply concerned that the title of Credentialed Mental Health Nurse can be given to young inexperienced practitioners after only three years of experience in the profession.

John Walker
Practice Manager, Improving Outcomes, Melbourne

Ainslie Ivin-Smith

I have been working as a mental health nurse under the MHNIP for over 2 years, in a rural area in New South Wales. In that time I have experienced its benefits on clinical, professional and personal levels.

MHNIP provides people with the opportunity to access mental health care in the primary health setting. It serves to reduce the stigma people feel accessing psychiatric care at the “mental health centre”. MHNIP enables clients to receive expert treatment from their trusted local GP surgery.

MHNIP provides better access to mental health care. I deliver care to people who may not meet criteria for access to a mental health service provided by Area Health Networks. MHNIP can be considered as a safety net for those who may fall through “the cracks” of other treatment providers. I can attest to this as I have worked previously in the public mental health system and can now find myself able to work with people with mental health needs who are also struggling with addiction and dependency issues, whose care is often traded between agencies.

MHNIP provides an alternative treatment pathway in the delivery of effective and timely mental health care. The benefit of having direct and frequent communication with the patients treating doctor
underpins the MHNIP. Decisions can be made in collaboration, and treatment plans altered with immediacy. GP’s are unburdened by long consultations, which can be attended by the MHNIP, allows greater throughput and ability to see more patients. The G.P.’s value my clinical support and the ability to refer to me someone who requires much more time in assessment and mental health care than they can generally provide. I enjoy working collaboratively with the doctors, who I have built positive professional regard.

I am not bound by multi tiered, complicated entry systems, which can inhibit a person’s ability to access care. I can see people in a timely manner, and be very flexible in my clinical delivery.

Working in primary care promotes a more holistic perspective, as I am mindful of the impact of one’s physical health on a person’s mental health, as well as the potential impact of mental illness on the body.

I have had the privilege of working in an aboriginal medical service, something normally not possible as a non-indigenous person. I learned some invaluable lessons, and experienced what it might feel like to be in the minority. I was challenged to develop new ways of working that would meet the needs of the client population. They appreciated being able to receive mental health care in an environment where they felt comfortable, able to tell their story, outside the mainstream system, where stigma, and racial issues sometimes remain.

The success of the programme is evidenced by the continued referrals from G.P.’s and the community mental health service via the GP. The demand on the MHNIP service is such that I could extend my clinical practice. I am currently aware of G.P.’s who would like to access the support of a MHNIP nurse, but are restricted due to a lack of nurses working under the programme.

Some challenges for improving the programme would be in administration, in the way sessional information is recorded, and delivered to Medicare.

I enjoy being able to set the parameters of my practice, within the broad scope of the MHNIP guidelines. I enjoy the level of autonomy afforded me, and value the flexibility in my role. I appreciate being recognized for my contribution, through increased salary. I am excited by the future possibilities and opportunities that may develop through working under the MHNIP.

Birgit Schaedler

The MHNIP has great potential to show case true holistic care for persons diagnosed with a variety of mental health problems. It is this potential and an outstanding program coordinator at our local GP Network that made me come back to the program after initial disillusionment.
Having worked in the Public system for many years, I find it particularly refreshing that I can now concentrate on the person rather than the diagnosis. Being able to engage with a varied population on an outreach basis was at first a little daunting, however, the benefits are extensive. Seeing people in their own home for an assessment rather than a busy ED gives as we all know, a much better ‘big picture view’ of needs to address, in my view that is where the strength of Credentialed Mental Health Nurses lie. It has encouraged me to broader my knowledge base and skills, in order to enhance recovery. Talking about true lifestyle changes and helping set and achieve them is very rewarding. So too, is the ability to work with families and other professionals. The ability to engage in practical learning strategies with the client is invaluable and very helpful in creating a good working relationship, by allowing the client to be themselves. A further advantage is the ability to work with a limited number of clients at a given time, rather than having to accept a huge case load which does not allow for much client centered care.

Not being attached to a single GP clinic allows me to work in a variety of settings, including Headspace, PSS and private Psychiatrists, which allows me to widen the circle of communication. Other mental health providers were initially surprised to hear from me requesting contact to unify the care provided, but now find it helpful and so do the clients. I count myself very lucky to be able to provide a holistic service to my clients, to learn new skills and use them, rather than being part of the slow skill erosion which has very much affected the work of some MHN working in the public system.

Obviously I do have a wish list of improvements to the program. Firstly, let’s make it a true MHNIP by providing the financial incentive to the nurse rather than the GP. Initially I found it very odd that the supposed specialist (MHN) has to be ‘supervised’ and is dependent on the non specialist. However, taking steps to remedy this has slowly encouraged more professional respect from some GPs. Sadly that has no impact to whom the set up incentive monies go. The claim system could do with a fresh view – many clients need more time initially and sometimes you only get to see one per session, especially if you work with a limited number of clients. Maybe we could move away from a strict sessional approach and introduce flexibility to allow per appointment claims, as in ATAPS. Otherwise there is a danger that a good program can deteriorate into just another throughput model and that does not benefit the client either.

Despite this, I believe that by standing up for our (MHN) professional values and by taking initiative we, as MHNs, have a wonderful chance to grow and contribute like never before.

Birgit Schaedler has worked as part of a CAT service in the community and the ED for the last 10 years. It was during this time and initial time spent working in an acute unit that the thought crystallized, that we are missing a large part of the big picture in the treatment of mental illness. Birgit
Anne Hamilton

Recently, I began working part time in the MHNIP with a GP Division in Adelaide. I started on 15 hours per week, but because of the work load I had to increase my hours. I am happy to be doing this work. However, my experience outlines some of the handicaps encountered that impact on an even better MHNIP service.

I have not had the length of time yet to fully develop my role, and to formulate a workable service plan with each client. With orientation, reading, prioritising clients etc., it has been difficult to touch base with GPs, other health and support workers, and NGOs, with whom I can work. Establishing rapport is essentially the main focus of my first assessment/ intervention. I have taken over from a 'contract' clinician, who left prior to my being employed. I did not have the benefit of a 'hand-over' and it is necessary to reassess all the clients. Documentation history is passable but minimal.

The current focus of my practice is to prioritise my work load with the already established clients. In between all this, I have to find the time for case reviews and team meetings.

The guidelines indicating 35 clients for this position are, for me, really idealist, albeit for the MHNIP program. In a previous role I worked full time in the country with 25 clients, over an 80 km radius. That work load was more than enough with time for documentation, travel, assessments and follow-up. Not to mention contacting/negotiating with GPs and arranging psychiatric reviews, communicating with family/significant others for a workable management plan.

It will take me at least 6 months to get the old clients re-assessed and, in between, visit new ones referred by GPs. When I get to see the 28 plus doctors in the clinics of the Division is a question of time. I am making house calls for assessments, in the 3-4 suburbs of the Division and there are other areas, as yet unexplored, for home visits. I can also see clients in the Divisional office, although I do like to home visit which gives me a holistic understanding of the client's respective living environment. It also helps those many clients are so financially disadvantaged that transport is a significant issue.

I had a meeting last week with a team leader who told me that there is no one else who can be employed as qualified as I am being a Credentialed Mental Health Nurse. However, my pay rate is $36.04/hour, $5/ hour less than the State award I was paid previously.
Having said all of the above, I am not discontented. I love the work and have supportive colleagues which are a real bonus.

Helen Reeves

Soon after I began working under this initiative I remember writing an abstract for a conference titled "A psych nurse feeling alone". Understanding how to put this new opportunity into practice in the early days was a little daunting. Negotiating with GPs, working out a model for practice and payment etc. took time. Almost three years on for me, and most of these issues have been resolved.

**Delights of working under MHNIP:**

- autonomy - working within my comfort zone
- my practice matching my style, without overlays imposed by a management system
- little bureaucracy- that alone is such a relief!
- developing relationships with people that are not affected by imposed time restraints
- the flexibility of collaboratively deciding how often and for how long the client and I see each other
- opportunity for outreach as client and I collaboratively see fit
- opportunity to begin to develop stronger community links on an individual level, at a pace that suits the client
- opportunity to slowly develop social networks with clients
- choice of how much/little work I do after meeting the requirements for eligibility
- flexibility of working hours, family and lifestyle friendly
- benefits to both the clients and myself having the clinic administration staff doing all the bookings
- no cost to client
- not worrying financially if a client does not attend, having the opportunity to follow up clinically as to why this happened
- lack of stigma, as client has normal appointment within a GP clinic

**Not so delightful:**

- remuneration: no benefits- e.g no long service, sick or annual leave
- professional development: all done in my own time and without support
- availability and cost of supervision
- holding the risk if anything goes wrong
- access to the public health system to discuss concerns: there are no clear pathways, this relies on goodwill and prior relationships which is difficult if the practitioner is new to the area.
- struggle with guidelines to link with community services: clients are not keen to be pushed off to community services, they don't want a replication of the case management prevalent in the public health system.

- struggle to define the MHNIP: spirit of MHNIP
  see people with mental health distress still falling through the gaps of Better Access, but not necessarily with a severe mental health disorder.

How wonderful to so easily put together a list of why my work is so enjoyable. All of the above have just rolled off. With reflection and time, I could without doubt, add more to this list. I would certainly enjoy increased remuneration, especially not having had any increase in payment in nearly three years. However, this alone is not sufficient to deter from the pleasure of going to work, to see patients I am happy to see, for an amount of time I am cheerfully willing and able to spend with them, in a setting appropriate to their needs, under a framework that promotes recovery and reduces stigma, and secure in the knowledge I do not have an enormous backlog of paperwork to complete!