

This survey was commissioned by the ACMHN in 2012. It was a credibly constructed, trialed, ethically approved and monitored research project, reflecting sound and auditable methodology and analysis which passed muster in terms of the peer review process. So the findings ought to be taken notice of...

The survey findings suggest that the MHNIP has produced some very good outcomes... probably better than any other comparable programme... targeting people with such serious and complex problems. It suggests that nurses working in primary care settings outside of the governance of state mental health services can make a real difference to people.

N.B. The term nurse or mental health nurse is used interchangeably in this presentation and both refer to credentialed mental health nurses.

Who are they?

- 72% (n=171) **Female**.
- **Older** – Mean age 50.7 years (SD=10).
- **Experienced** – Most 20+ years
- Experience in MHNIP - Mean 2.6 years (SD=1.5 years).



The sample reflected the gender balance of the mental health nursing workforce with 72% being female.

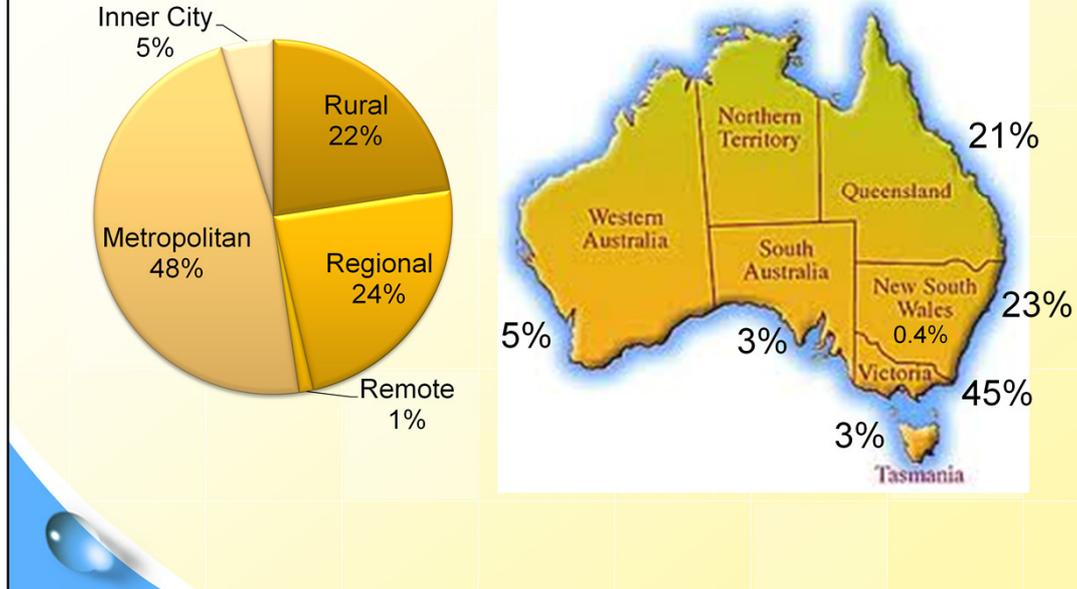
Mental health nursing is an ageing workforce but the respondents were somewhat older, ranging in age from 27 to 68 years and only 12% were under the age of forty.

The average age of respondents at the time of analysis was 50.7 years (SD=10).

There is a clear correlation between age and experience and the majority of people had spent their entire adult lives working in the mental health field and many had held senior posts in nursing, health management, academia or as therapists in Australia and abroad.

The average length of time that respondents said they had worked within the programme was 2.6 years (SD=1.5 years) and 85% had been working in the programme for more than a year (n=201).

Where are they?



45% of respondents (n=105) had a post code in Victoria, 23% from New South Wales (n=53), 21% from Queensland (n=49), and all other mainland states and territories were represented except for the Northern Territory. The distribution is similar to that reported in the recent evaluation except that this suggests a greater distribution of nurses working in regional centres or rural areas. 53% lived in metropolitan areas.

What do they know?

Highly Educated:

- At least a PG Dip
- 32% with a masters degree
- 71% cited particular training in one or more forms of psychotherapy:
 - 23% had a degree level or higher qualification and
 - 48% had attended short courses



We asked people to describe what qualifications or experience was helpful in their role... not for an inventory of qualifications but we could infer that they were highly educated. To be credentialed they must minimally hold a post graduate diploma in mental health nursing. The majority held additional post graduate qualifications. In particular people often reported having higher qualifications or training in psychotherapy...

This account was typical....

Initially I had a psychiatric nursing certificate. I have since completed a Grad Dip in health services management, A Masters of Nursing (advanced practice majoring in mental health) and a masters of nursing (Nurse practitioner). I have a certificate in adolescent MH... I have attended training and advanced training in Interpersonal psychotherapy, and parent child interactional therapy. I have attended many workshops on working with sexually abused children and adults. I have trained in somatic body work, psychotherapy and Jungian psychotherapy in work place training. I have also trained in the Adult Attachment Interview and attended individual and group clinical supervision training.

Who are they?

How nurses were 'engaged' with eligible organisations were complex:

- 55% were in some kind of employment relationship
- 31% described themselves as contractors and 24% as sole traders.

The majority did not receive the full sessional payment but nevertheless met most costs and expenses themselves.



Only a half of nurses described being employed by eligible organisations. Many worked with multiple organisations and had negotiated different pay and conditions with each. Few nurses received the full sessional payment. Many rented their own rooms and met all of the costs themselves. This is noteworthy as there is an assumption that nurses are employed by eligible organisations. 98% also reported having negotiated ongoing clinical supervision which they typically sourced and if necessary paid for themselves and undertaken in their own time.

What do they do?

- **assessment (92%, n=209)**, care planning,
- **psychotherapy and counselling (94%, n=214)**
- psychosocial interventions including skills training and coping enhancement,
- linkage and liaison,
- physical health and medication
- consultation and education
- strength and hope based approaches

What do these nurses do? This really is the 36 million dollar question and a pivotal one as whatever they're doing might be related to the outcomes achieved. The programme specification propose that the nurses "...work in collaboration with GPs and private psychiatrists to review people's mental state, monitor and manage medication, provide information on physical health care to patients, and arrange access to other health professionals". Whilst nurses do these things if required it doesn't quite capture the breadth of interventions or the process of engagement. Nurses it seems do whatever might be needed. The predominant interventions mentioned by most respondents were assessment and the provision of psychotherapy or counseling. Some nurses were primarily providing psychotherapy or highly specialist services sometimes with quite specific populations e.g. children, youth, those with eating disorders. Some were primarily providing family therapy, or long term psychodynamic psychotherapy using the standard 50 minute hour. The majority of nurses it seems were tailoring a package of interventions or strategically selecting and employing psychotherapeutic techniques as required and as the relationship evolved. Thus for some people the nurse might assume a case management function or a consultancy role, whilst for others the role might be primarily therapeutic or focused on enhancing coping. This population of people with the most complex needs and severe symptoms are often difficult to engage in therapy even if it were otherwise available. Nurses it seems adapt an approach to the needs of the patient rather than triage people into a particular therapy. Some nurses reported that if the problems were simple or simply about symptom reduction then they might refer people to better access services but in many practices it was understood that the more complex presentations were referred to the nurse. Medical treatment formed only a small part of the narratives about what nurses do.

What do they do?

I work in a variety of ways. I act as a case manager with some clients and advocate for them. I monitor some clients as part of their legal sentence, I manage some people intensively as they are very unwell, seeing them weekly if required. I see other people less frequently as suits their needs, some people I use ACT therapy 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 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.

These themes were drawn from narratives of which this account is illustrative.

What have they achieved?

- **Reduced symptoms or improved coping**
- **Improved relationships and community participation**
- **Employment and study**
- **Improved Physical Health**
- **Medication Related Outcomes**
- **Reduced use of hospitalisation and public mental health services**
- **Improved access or better use of services**

Nurses were asked what the most significant outcomes of the programme were and were also asked to provide vignettes of clients with a description of their presenting problems, a description of how they worked with them and what they had achieved. Responses clustered into these themes. Some of which might be considered system level outcomes. Almost everyone mentioned reduced hospitalisation or more efficient use of mental health services. Contact with health, welfare and other public services were frequently reported to be less coercive or fraught with conflict.

What have they achieved?

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....

People did report relief from index symptoms, often with an accompanying reduction, cessation or negotiation of an acceptable medication regime. What was perhaps most interesting was the frequency with which occupational, social and relational outcomes were mentioned. Those diagnosed and medically treated for low prevalence mental health problems like schizophrenia and bipolar affective disorder in this country have some horrendous occupational and social trajectories. Being in receipt of 'medical treatment' alone doesn't seem to improve outcomes and might even worsen some. So the claims of being able to support people maintain their supportive social networks and employment, or assist people into study or employment is impressive indeed.

What have they achieved?

... 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...

These are examples of vignettes provided

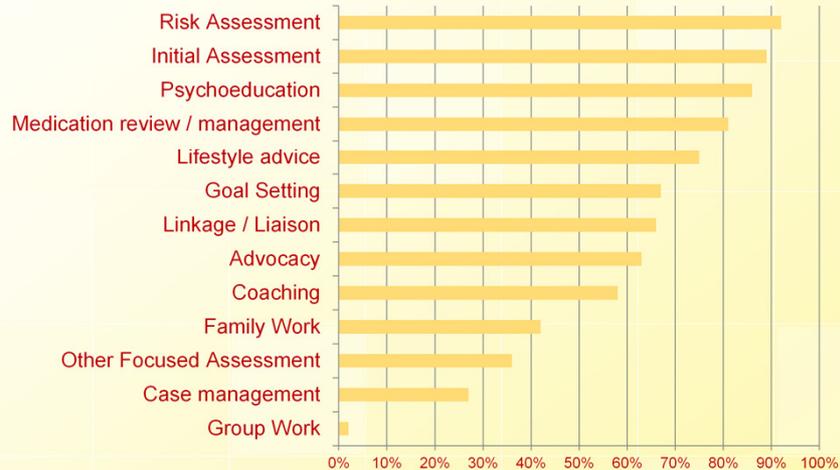
What have they achieved?

Diagnostic Group	%	n	Mean HoNOS 1	Mean HoNOS 2	Mean Change	Mean Occasions of Service
F30-31.9 Bipolar	25%	16	17.4	7.3	-10.1	30.8
F32-34 Depression	27%	17	22.2	8.2	-14	25.5
F40-48 Anxiety Disorder	22%	14	21.6	10.1	-11.5	35.5
F20-29 Schizophrenia	20%	13	23.8	12	-11.8	45.0
F60-69 Personality Disorder	6%	4	26.5	15.5	-11	86.6

Nurses were invited to submit outcome data for recent people with whom they had worked as well as information about the number of occasions of service, diagnosis and kinds of services they provided. 64 HoNOS scores on referral were paired with the last HoNOS undertaken. The mean HoNOS scores provided were quite 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) although what the actual clinical significance of this is open to speculation. For all diagnostic groups the change from referral to second measurement was statistically significant and for all groups I would suggest that changes were clinically significant. The individuals had received been 2 and 250 occasions of service (mean 37.5, SD=48).

What have they achieved?

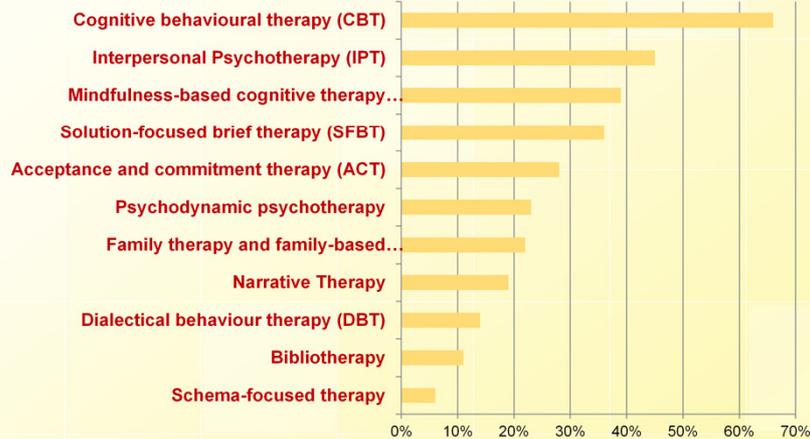
Interventions undertaken with service user sample



The vignettes were examined and a list of 'interventions' employed were inductively generated from the data. Most service episodes involved a detailed initial assessment, risk assessment, psycho-education, medication review, lifestyle advice, goal setting, coaching, linkage and liaison with other services and advocacy...

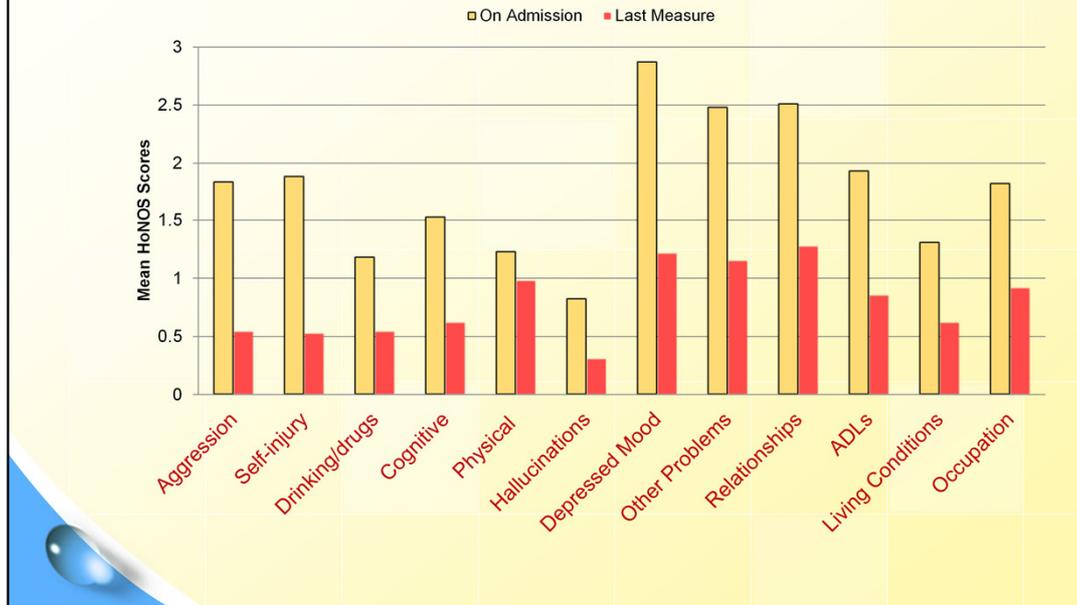
What have they achieved?

Main psychotherapeutic approaches undertaken with service user sample



The main psychotherapeutic approach or frame that was explicitly mentioned in the vignettes was also induced. 65% of nurses employed some CBT techniques... and as can be seen interpersonal psychotherapy, mindfulness, solution-focused brief therapy or acceptance and commitment therapy were also employed.

What have they achieved?



So what difference did this all make? The high mean total HoNOS scores probably indicate that people are referred to the MHNIP with multiple problems of moderate to high severity, whereas hospital admission may be prompted by specific problems rather than case complexity. This graph shows the mean change in all subscales from referral to last measurement. Mean scores only look at some kind of typical score but nevertheless this suggests quite an impressive reduction in problem severity in all areas to on average problems being sub-threshold or mild. All changes were statistically significant except for changes in physical health problems.

Limitations

- Undertaken at a time of demoralisation
- Self-report of outcomes
- Volume of data

There are a number of limitations to this piece of research that need to be acknowledged. It was undertaken at a time of relative demoralisation of the workforce as the freeze had just been announced, although the consequences of the freeze such as the loss of employment, the non-renewal of contracts or the reduction in session hours was not clear at that time and there was no obvious bias in the reports of nurses.

It is a problem that the outcomes reported by nurses cannot easily be triangulated with service user reports or hard empirical data. We did approach DOHA requesting access to data on MBS usage and the MHNIP with a view to exploring if there was any actual reduction in hospitalisation or service usage. However, we were refused because the programme was being evaluated, although the evaluation didn't access this data. We also don't know the extent to which the outcomes reported in this sample might be generalised to those involved in the programme as a whole.

The survey generated large quantities of narrative data which is difficult to reduce and represent. The final report written for the ACMHN and awaiting editing and page setting is likely to run into 10s of thousands of words.



Limitations aside, by all measures and according to every commentator the MHNIP has been a success.

However, this survey did highlight some problems as the programme is essentially founded on 'a practice nurse model' whereby the nurse is not assumed to have any particular specialist knowledge or skills and is assumed to be working for and on behalf of medical doctors. This is not a collaborative model but a servile one. Subordination is barely compatible with collaboration. To date nurses and others it seems have largely been able to subvert the stated assumptions in the programme and deliver effective specialist services not because of the prescribed 'model of engagement'... indeed it is probably despite of it... and a testimony to the flexibility, skill and remarkable capacity of mental health nurses to be anything but tall poppies that the programme has achieved such success.

The nurse can only see someone if seen by a doctor working for a specific eligible organisation with whom they are engaged. If the person wants to exercise choice and see another doctor, or indeed if the doctor leaves, or changes his or her fee structure then the nurse can't continue to see them. What other specialty operates like this? None! The MHNIP is a tertiary service operating in a primary care setting so most people would have no objection to medical practitioners being gatekeepers to the service although nurses of all professional groups have the most enduring track record of deference to medicine and would likely facilitate

access to medicine if needed... Almost all the problems related to the operation of the programme reported by nurses related to being placed in a deferential relationship to the eligible organisation and not being able to deal with DOHA directly.

Many nurses have been starkly reminded that primary care is run on business models founded on subsidised professional monopolies and if they can't generate income for practices their position is tenuous. With the MHNIP being frozen they have no recourse to earning other money if the number of sessions allocated was less than they anticipated. Thus people are leaving or have been forced out of the programme... and I suspect after this experience they are unlikely to return. They did after-all by and large take huge drops in remuneration and forwent any kind of pay rise for the last five years in order to enjoy feeling efficacious.

It is fascicle that these specialist highly educated experts in evidence based psychosocial treatment, with decades of experience working with people with the most complex needs can't even augment their income by working in better access.

I am in accord with Robert Kings recent criticism of better access when he says that professional affiliation has not much to do with who can deliver evidenced based interventions and he suggested it should be opened up to all suitably qualified professionals. The same is probably true of what we now know of the MHNIP... If people have adequate training and a track record of working with people with the most complex needs then they should probably be encouraged to undertake the work. Nurses or at least these nurses appear to be well placed to undertake this work and indeed are amply qualified to

Conclusions

Mental health nurses:

- are highly educated and experienced specialists.
- have reached the target group of people with the most complex presentations.
- flexibly tailor specialist psychotherapeutic interventions and broker services
- have the potential to improve psychosocial outcomes for otherwise underserved groups

Mental health nurses working in MHNIP are highly educated and experienced specialists in providing mental health care to people with complex needs. In the context of the MHNIP they have engaged with the target group and have demonstrated the potential to flexibly tailor specialist psychotherapeutic interventions and manage complex cases. They have the potential to improve psychosocial outcomes for otherwise underserved groups.

Conclusions

- The specialty status and service provided by MHNs needs to be formally acknowledged.
- The flexibility to engage with people for as long as needed is the one element that needs to be preserved in the programme.
- The provision of service should not be contingent on seeing a specific doctor.

The specialty status and service provided by MHNs needs to be formally acknowledged.

The flexibility to engage with people for as long as needed is the one element that needs to be preserved in the programme. Most of the other elements such as the specified relationship with the eligible organisation and treating doctor should be abandoned as they dis-incentivise involvement in the programme.

Whilst the MBS continues to be the main mechanism for funding interventions in my view the MHNIP should be replaced with an MBS item number with regular reporting requirements. Of course such specialists should also have access to other MBS numbers and the nurses should be left to negotiate their own contractual relationships with practices as most have already.

The MHNIP has fairly comprehensively proven the feasibility and usefulness of having specialist mental health nurses in primary care.



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The full report will be published by the ACMHN in 2013. Several papers arising from this study are submitted or accepted for publication.

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