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EASTERN MELBOURNE

An Australian Government Initiative

21 Feb 2017

EMPHN Mental Health Nurses Incentive Program

Co-designing a mental health stepped model of care

Stakeholder forum for eligible organisations and credentialed mental health nurses.

FORUM OBJECTIVES To provide the CMHNs and EOs the preliminary thinking around EMPHN's MH Stepped Care model/approach.

To inform the stakeholders about the moderate to severe mental health needs of EMPHN's population.

To impart the message that the development of the EMPHN MH Stepped Care is not a destination but a journey and that we want the stakeholders to join us in that journey.

To obtain input from the stakeholders about their opinion on issues related to: hard to reach population, service gaps, workforce sustainability.

FORUM LEARNINGS/OUTCOMES · Moderate to severe mental health needs of population · Care concepts for the stepped model of care for above groups · Understanding which clients are falling through the gap and strategies to engage them · Clinical interventions offered by MH nurses and the populations they target

FORUM EXPERIENCE collaborative, engaging and opportunities to share knowledge and ask questions

CHECK IN...

What participants thought at the start of the workshop.

Hopes for the evening

Clarity and direction.

Ways to use the system more efficiently and knowing triggers for steps.

Not being pigeon holed with one step only - holistic approach.

Continuity of care and choice of provider.

Listen to people on ground doing the work.

Clarify our skill base as credentialed MH nurses.

Questions about the context

How do we work better together to achieve these outcomes and avoid silos?

Some health professionals not being factored in - even if skilled / low cost.

Given any thought to how we can mentor new people coming in to credentialed role?

Is there a role for sometimes missed types of issues and services e.g. how would nurses integrate?

Can you co-locate MH care nurses in the system - would you consider this?

What's the future of marrying drug and alcohol services with MH services?

Can you challenge siloed thinking?

What we love / value about MH care nurses

Diversity of nurses.

Client contact.

Constant change.

Patient journeys.

Holistic model of care.

Resilience of nurses facing challenges.

Unpredictability of the job.

Being positive.

Preventative and coordinated care.

Working with families in the home.

ACTIVITY 1 - PERSONAS

The first activity was designed to showcase the range of clients the nurses see and to keep these clients in mind throughout the workshop.

a. Work in groups to conjure up a realistic yet imaginary character profile who might reflect the types of patient you would see who has a moderate - severe mental illness.

b. Introduce the rest of the room to each person, i.e this is Jane - she is 49 yrs old and comes to see us X times about X condition.. .

c. Pin them up around the room to remind us of who we are working for...

		MEDICAL CONDITION	MEDICAL NEEDS	OTHER INFORMATION
PERSON 1	**AGE** 66 **GENDER** Transgender **LOCATION** Greenborough	PTSD, Cluster B, self harming, depression, anxiety - mis-diagnosed as bipolar.	Assess, monitor mental state and risk assessment, centrelink, advocacy, counselling, medical assessment, housing services, refer to drug and alcohol services, referral to PP for assessment and treatment plan.	Separated, 4 children, past history of sexual abuse, domestic violence, drug and alcohol issues. Currently homeless and estranged from family because of sexuality and MH issues.
PERSON 2	**AGE** 22 **GENDER** Male **LOCATION** Mooroolbark	Alcohol dependence and substance abuse, PTSD.	Alcohol withdrawal ongoing. Methadone consultation. Counselling. Psychoactive consultation.	Long-term homeless. Outreach psychosocial integration. Correctional services. Employment - NIC. Education - NIC - illiterate. Re-integration with family.
PERSON 3	**AGE** 34 **GENDER** Transgender **LOCATION** Borona Heights	IDDM, sleep apnoea, schizo-affective, borderline personality, narcissistic personality disorder, OCD.	Manage self harm, suicidal ideation, self esteem issues, social anxiety / isolation, sexual dysfunction, substance abuse.	Family rejection, employment difficulties, sexual abuse.
PERSON 4	**AGE** 57 **GENDER** Female **LOCATION** Bulleen	Lupus, osteo arthritis, obese, cardiac issues, anxiety, depression, CSA, BPD, substance abuse (alcohol and prescription drugs), hoarding.	Unemployed, public hsq, doctor, shops.	Totally rejected by all in family. No support group. Attending AA nightly. Hasn't seen daughters for 4 years. Doesn't even know where they live.
PERSON 5	**AGE** 21 **GENDER** Female **LOCATION** Ringwood	S2, substance misuse, weight gain, diabetic, insomnia.	Family violence, family history of MH issues and suicide. CSA, homelessness, financial issues and sexual health risk.	
PERSON 6	**AGE** 42 **GENDER** Female **LOCATION** West Heidelberg	Bipolar, major depression, anxiety, OCD, poly substances, DM, obesity.	Homeless, HACC services, DM, endocrinologist, no transport, DM educator, social worker, DHS, GP, mental health nurse, practice nurse, psychologist, PIR.	Daughter.

ACTIVITY 2 - CO-DESIGN WORKSHOP

Each table group will work on one question per table (using templates). Groups swap after 15mins and work with new group for 10mins, then swap again 10mins (4 rounds in total).

1. What do you like about MHNIP? What works with the program currently and shouldn't change?
2. Describe what MHNIP offers mental health consumers that isn't offered elsewhere in the system?
3. What doesn't work well? What needs to change?
4. What are the gaps with the existing program that need to be addressed? What do consumers find challenging? Please include any ideas you have to address these gaps.
5. What currently concerns or frustrates your clients about the program?
6. What do you think is the role of community mental health nurses in the stepped model of care?
7. How do we as a sector overcome the difficulties of reaching populations of need?
8. What clinical interventions could be provided by Mental Health Nurses?
9. Open discussion

Q1 WHAT DO YOU LIKE ABOUT MHNIP? WHAT WORKS WITH THE PROGRAM CURRENTLY AND SHOULDN'T CHANGE?

Employ 60 mental health nurses in EHPHN area.

Flexibility for clinicians (time, clinical skills), out reach / clinic based.

Able to provide continuity of care and to be able to develop the relationship with the patients.

We can decide - frequency of support to patients depending on their needs - autonomy.

Low social economic group - can reach mental health services because of MHNIP program.

The mental health nurses in MHNIP program are credential, highly experienced, provide care door to door.

Cost effective program that shouldn't be taken away for patients who need most.

Not being geographically constrained at present.

Embedding MHN's upskills other workers - increasing capacity and improving efficiency.

Can work as a co-worker and availability for 2nd consultation.

Embedding with GPs builds relationships and encourages skill development - added support.

Expert on gateway to tertiary services.

Sessions can be used for clinical supervision.

Very innovative model e.g. groupwork, single, outreach, school based.

Ability to go to court with clients if required.

Creates linkages with private psychiatrists, psychologists and GPs.

Job satisfaction - good alternative to public mental health services.

Can do out of hours if required.

No age barrier - consistent relationship.

Founded on evidence based practice.

De-stigmatises mental illness.

Local provision of services integrated with own health services - integrated, accessible, one stop shop.

Speaking the same language as tertiary services.

Q2 DESCRIBE WHAT MHNIP OFFERS MENTAL HEALTH CONSUMERS THAT ISN'T OFFERED ELSEWHERE IN THE SYSTEM?

For mental health diversity in the community.

Create new opportunities for MHN.

Making MHN accessible to the community.

MHN to work privately, autonomously.

Utilise "experience" and skills in the primary health sectors.

Supporting GPs and other primary health workers.

Strengthening PHC with mental health support.

Educating the community and reducing stigma around mental illness through integration.

Supporting families and accessing services for the people they care for.

Reducing the need for public mental health services.

Level of autonomy for nurses. Time allocated for a session benefits client care i.e. not restricted by time - better quality of care and mental health assessments.

Indefinite style of operation means better opportunity to develop a therapeutic relationship that allows person centred care.

Can be subcontracted as a positive. Nurse is more accountable - raises accountability. Allows a nurse to be at their best. Direct responsibility for patient care - can't delegate responsibility to someone else. Good way to assess clinical practice for nurses.

Flexible to support client.

Linkages with multi-disciplinary professionals.

Evidence based practice.

Credentialed mental health nurses - and ongoing professional development.

No promotion.

The need for GP / psychiatrist to be the host of MHNIP.

Continuity of care through the length, breadth of all step levels.

Advocacy.

Highly respected.

Proven skills, experience and readily available.

Knowledge of the rich Hx and know better re individual care.

Q3 WHAT DOESN'T WORK WELL? WHAT NEEDS TO CHANGE??

Develop more credentialed mental health nurses.

Education - PHN to allocate money to monitor junior nurses who have an interest in becoming credentialed.

The lack of increase in funding provided per session since inception. There has been no increase in session rate since the MHNIP program began in 2007. The lack of fluidity with the sessions allocated to the eligible organisations. Sessions are allocated to the eligible organisations (GPs and PP), however the MH nurse needs to be able to share sessions between the eligible organisations.

Family work funding. Broad range of support services.

MH nurses need to be involved and present in the stepped care model.

Acknowledgement of client acuity - clients needing a full session i.e. court hearing, initial assessment.

Unit cost per session makes it very difficulty to attract staff, as the public sector get same rate of pay plus sick leave, salary packaging.

The unit costs should be increased for an outreach model versus clinic based.

Get rid of HONOS as it doesn't accurately reflect acuity.

Understanding all mental health nurses scope of practice - credentialed MH nurses and practitioners.

More security and certainty for everyone involved in the program.

Broader range of referral path ways.

Open referral opportunity (no mental health care plan).

Q4 WHAT ARE THE GAPS WITH THE EXISTING PROGRAM THAT NEED TO BE ADDRESSED? WHAT DO CONSUMERS FIND CHALLENGING? PLEASE INCLUDE ANY IDEAS YOU HAVE TO ADDRESS THESE GAPS.

Lack of dual recognition in clinical practice and data collection.

Inadequacies of HONOS to reflect the clients presentation and level of care, not a useful tool.

Lack of access to Bulkbilling consultant psychiatrists.

No access for clients with no Medicare card e.g. asylum seekers, refugees, including interim Medicare cards.

No cover for sole MHN clinicians - concern is potential for burn out e.g. covering for leave.

Lack of capacity to provide psycho-ed in schools to monitor first presentations.

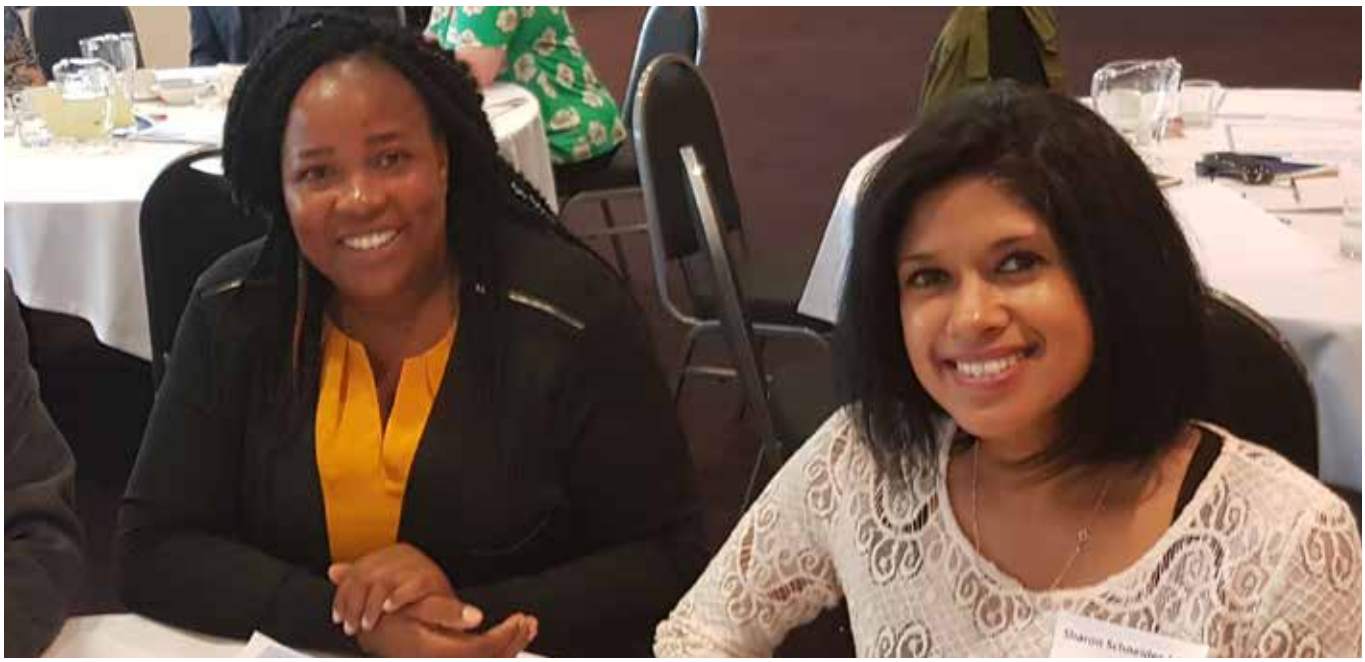
Aged care MH especially for males.

Lack of provisions of MH nurses in all TAFE colleges.

Suggestions: Use mental health nurse practitioners who can prescribe meds. Upgrade Fixus. Appropriate funding for non face to face consultations.

Q5 WHAT CURRENTLY CONCERNS OR FRUSTRATES YOUR CLIENTS ABOUT THE PROGRAM?

- Clients: Lack of security of ongoing care. Disruption of continuity of care. Flexibility of sessions. Limited access for carers support, carer's being burnt out.
- GPs: Concern about ongoing patients care. If program is not ongoing, waiting rooms will clog up. Capacity to maintain highly skilled workforce.
- Providers: Job security. Risk of working solo with the community. Unreliable clients - not attending appointments. Limited time to liaise with the multi-disciplinary team. Not adequately funded to do outreach. No pay rise after 10 years. For nurses to be able to work independently as contractors alongside other MH professionals. Time factor trying to get through to CATT. Recredentialising every 3 years. Fixus model of reporting. Not being able to co-locate with other services e.g. centrelink. Having to source funding for clients. Lack of integrated care services.



Q6 WHAT DO YOU THINK IS THE ROLE OF COMMUNITY MENTAL HEALTH NURSES IN THE STEPPED MODEL OF CARE?

Assist with referral and linkage to appropriate MH services if client migrates / moves area.

Advocacy for refugees / new arrivals.

Education for other service providers.

Debriefing of colleagues / GP clinic staff / others.

Monitor / supervisor for others including students.

Assist with research, nursing research, GP research.

We hold and contain people at risk (suicide, self harm, relapse, aggression, homicide, grief) via therapeutic relationship.

Work / support people with unresolved grief.

Working with carers / family.

Monitoring for cycling episodes - through the steps of the model.

Ongoing psychoeducation for clients / family / community.

We could provide comprehensive assessments at every stage; schools, 20s, 50s, 65+.

Provision of long term care to people with severe mental illnesses who need continuity of care.

Provide interim support to people working for services to become involved.

Telephone counselling and support for clients and people in crisis.

Liaising with psychiatrists / GP during admission / discharge from hospital.

Clinical coordination of care - not linear integrated model.

Brief intervention service - ability to identify needs of clients. Facilitate referral to appropriate services.

Holistic picture of client - ability to work efficiently on recovery / discharge goals.

Identifying risk / planned care with GP and other allied health professionals. Having a functional relationship with clinical services / family / carers etc.

Advocate for clients.

Monitoring medications / risks / mental state.

Therapeutic intervention / evidence based treatment.

Assessment - comprehensive / referral.

Be part of all of the stepped model of are i.e. groups / programs in well / at risk groups - MHN have skills.

Provide continuity of care - don't pass a client to another worker because they don't fit in the box anymore.

Coordination of care - collaboration with other services.

Family liaison - inclusive, holistic service.

Flexibility of service provision.

Providing flexible service that is responsive to needs to very vulnerable of the community i.e. outreach.

Provide support, liaison, advice and a working relationship with GPs to improve client outcomes across all levels.

MHN have broader knowledge base and skills which will apply across all levels.

Coordination of care, flexible service, consumer focused.

Incorporation of all scopes of practice in primary mental health care, mentorees, MH nurses and practitioners.

Clients should be able to enter the stepped care model at any level - consideration of intake assessment - nurses may be able to more appropriately direct care when located at a GP practice.

Provide brief intervention to the well population / at risk group level - provide wrap around services. Ensure clients don't fall between gaps in stepped care.

Q7 HOW DO WE AS A SECTOR OVERCOME THE DIFFICULTIES OF REACHING POPULATIONS OF NEED?

Form dual diagnosis links / programs. Consider increasing use of group work for some in need.

Review and remove the age restriction i.e. >65 years so services can continue for those who need services maintained.

Rural community, people over 65 years who cannot access MHN services, LGBTIQ.

Self (patient) referral to access services - reduce complexity of referral e.g. person can call / complete form online and email directly to service provider.

Homelessness, outreach, domestic violence, asylum seekers, primary schools, dual diagnosis, high schools, universities, headspace.

Working with other services e.g. doctors, psychologists, outreach workers, police.

Intake way of assessing needs. We need to be a flexible workforce (professional skills).

Low socio-economic communities with level of social disadvantage e.g. postcode 3081.

Strategies: Develop strong MOU and relevant agencies. Advertising and information - accessible and in community languages. Focus on education / liaison with family and carers. Increase range of professionals who can refer to agencies. Establishing regular links for CALD communities.

Review original funding criteria.

Constant changes to services names and what they can do is unhelpful.

Q8 WHAT CLINICAL INTERVENTIONS COULD BE PROVIDED BY MENTAL HEALTH NURSES?

What do you mean could be? We / they are already providing...

Interventions that are catch phrased by psychologists.

CBT - psychologist / motivational therapy - psych nurse reality orientation. Mindfulness. Here and now, living in the moment. CBT - psychologist / change negative thoughts processes. Care plans. Risk assessment. Medication. Counselling. Crisis intervention. Advocacy. Legal representation.

Nurses already do "meat on the bone" practical interventions, not secondary consultations.

Nurses are also social workers, OT, counsellors, brief intervention, legal representation, financial, sexual and physical health services coordinators in liaison with corrections officers.

Establish a therapeutic relationship. Education. Risk assessment. Practical intervention. Care and treatment planning. Liaison. Dual diagnosis counselling. Recognising e.g. ADHD, ABI, ADD, autism.

Physical health screening. Full mental state assessment. Family support / education. Report writing. Relapse prevention.

Educating families on relapse prevention and signs / symptoms of illness. Suicide prevention.

Working with LGBTQI. Adolescents work. Sexual health. Harmonisation.

Monitoring, managing medication, adverse effects, side effects, therapeutic effects.

We follow through the journey with a client from the beginning through to the end. Sometimes this is years of intervention.

Liaison with pharmacies.

Once ATAPS / better access sessions are used up - the psychiatric nurse fills the counselling gaps until the sessions resume.

MSE, HONOS, KIO - use of psychological assessments, mental health examination.

We follow through the journey with a client from the beginning through to the end. Sometimes this is years of intervention.

Crisis intervention.

Case management. Brief intervention model.

Psychiatric nurses use a holistic model. We are a flexible discipline.

Maintain professional integrity.

Nurses have a non rigid approach, we are flexible, come from a humanistic approach. Behavioural approach.

We do everything with a holistic approach - solution focused.

Support of carers - provide psycho-ed to families creating resilience. Liaise with carer support program.

Suicidal rates are high in Australia because funding priority is aimed at wrong intervention - you do not refer patients for 10 sessions with suicidal ideations! They need flexible and responsive approach.

Suicide intervention should always be a high step intervention - of a psychiatric nurse not ataps psychologist.

Why can't credential nurses have a provider number?

Look at mental health commission recommendations for the future of primary health care. See Lakeman, Santangio and other reports within the stepped care model. Stepped care needs to be flexible to incorporate MHN to ensure more collaborative process.

OPEN DISCUSSION

Lack of communication between police / CATT during urgent / emergency.

No increase in session payment of $240 since commencement in 2007.

The need for 3.5 hours per session (how can you service 2 clients?) based on patient needs i.e. taking a patient from EPPING to South Yarra to psychiatrist. For example Northpark Private currently has no psychiatrist bulk billing.

CALD - no interpreter services. Being able to access interpreters. Assisting patients to explain needs to GP or psychiatrist. Go with patients to interpret English. Education required for staff.

No need for GPs / psychiatrists to be an intermediary for MH nurses working privately. MH nurses takes the same responsibility in ATAPS so why not in MHNIP?

Youth mental health for early intervention.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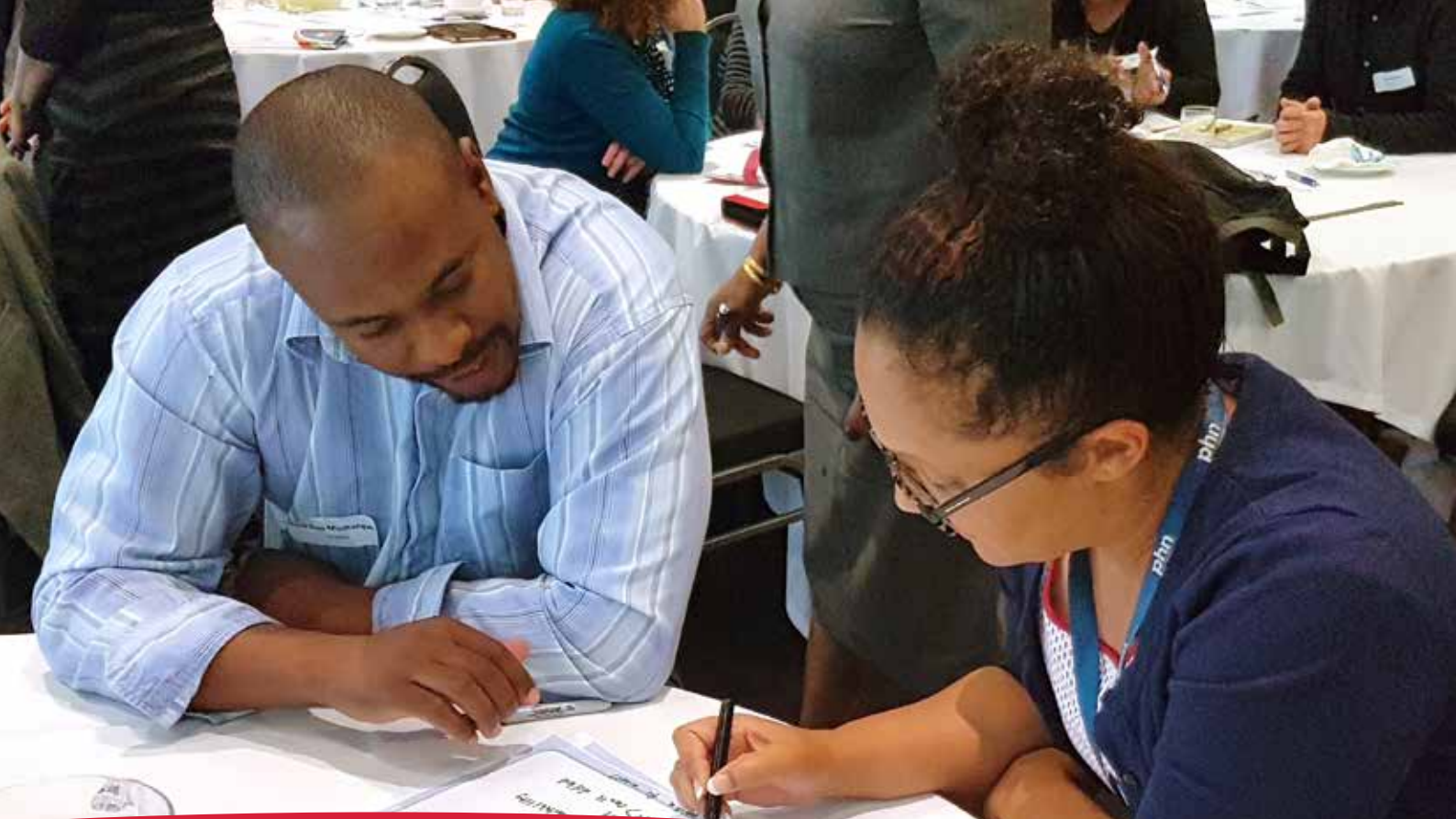

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Summary report prepared by MosaicLab

mosaic LAB

www.mosaiclab.com.au

PLEASE NOTE: While every effort has been made to transcribe participants comments accurately a small number have not been included in this summary due to the legibility of the content. Please contact Keith Greaves at Keith@mosaiclab.com.au for any suggested additions.