Released potential; A qualitative study of the Mental Health Nurse Incentive Programme in Australia.

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ABSTRACT

The Mental Health Nurse Incentive Programme (MHNIP) is a Commonwealth Government funded scheme that supports people living with a mental illness. This program is valued by consumers, has a transformative impact upon the delivery of mental health care and expands the therapeutic roles of the Mental Health Nurses (MHN). Despite its significant impact the programme has received little attention from researchers nor critical discussion within the literature.

This paper first critically examines the MHNIP from the contexts of identities, autonomy and capabilities of MHNs and then reports on findings from a qualitative study that explored the experiences of staff working in the MHNIP.

Key findings from this study indicated that both the programme and the nurses working within it are addressing the unmet needs of people living with a mental illness. They do this by being holistic and consumer centred in providing a wide range of therapeutic interventions. As well, the MHNs in this study revelled in the freedom of their practice outside public health services and respect received from colleagues working in other disciplines.

KEY WORDS

MHN identity
Autonomous nursing practice
Holistic mental health care
Therapy
Mental health
Consumer centred

INTRODUCTION

The Medicare funded MHNIP has been established for 6 years and continued to grow in reputation and size until recent Federal Government budget cut backs curtailed its development. The MHNIP funds community-based general practices, private psychiatric practices, and other eligible organizations to engage MHNs in the provision of mental health services. Funding is provided by Medicare and seeks to improve the access to treatment for people living with a mental illness (Australian Government Medicare Australia, 2009). Allocated funding to eligible organizations for MHN sessions has grown from $2.7 million in 2007-08 to $35.6 million in 2011-12 (Senate Affairs Committee, 2012).

This important programme has had little formal evaluation. Meehan and Robertson (2012) explored the perceptions of General Practitioners (GPs) toward the required capabilities of MHNs to work effectively in the MHNIP, rather than the efficacy of the programme itself. Happell and Palmer (2010) as well as Happell, Palmer, and Tennent (2010) identified that the MHNIP funding offers a greater depth and

longitude of service provision to consumers than has been historically available, with 41,535 consumers receiving a service under the MHNIP in 2011-12 (Senate Affairs Committee, 2012). The Australian College of Mental Health Nursing (ACMHN) conducted surveys of MHNs participating in the programme in 2009 and 2011. While these surveys mainly focused on the structures of the MHNIP, the MHNs participating in the surveys also indicated improved consumer care was being offered. They also reported working beyond the instrumental scope of nursing described in programme documentation which positions nurses as working collaboratively with psychiatrists and general practitioners through providing services such as monitoring a patient's mental state, medication management and improving links to other health professionals (Department of Human Services, 2012).

The precise nature of the clinical capabilities and professional identities of MHNs is an area of some wider uncertainty, both within and external to the mental health nursing profession (Hurley, Mears & Ramsay, 2009; Carlye, Crowe & Deering, 2011). For mental health nursing and the wider nursing profession there is scant consensus as to whether nurses are legally and professionally capable of autonomous accountable practice, or being entitled and capable of merely identifying a health problem, referring to a other disciplines and then enacting the plans and treatments formulated by that discipline (Australian Nursing & Midwifery Council, 2006). It is precisely this issue that this paper seeks to respond to within the context of the MHNIP.

This timely study explores the experiences of the clinicians and managers working within the MHNIP with the particular interest of gaining a better understanding of the impact of the programme on the roles and identities being undertaken by MHNs.

METHODS

This study used an exploratory phenomenological approach directed at the conscious lived experiences of those working within the MHNIP. Such an exploratory approach is indicated as MHN roles and identities within the incentive programme have received relatively little research attention and are not well understood (Patton, 2002).

Participants and recruitment

A sample of professional and managerial staff was sought to participate in this study. The ACMHN list of credentialed nurses was used to purposively recruit participation by MHNS (N=6) working in the incentive programme, while a convenience sample of GPs (N=3), allied staff (N=2) and managers of eligible organizations for MHNIP funding (N=1) was recruited from outside of the nursing profession. All participants had worked for at least one year with the MHNIP, 3 were males and 9 were females and all had a least 5 years' experience within their own professional fields of practice.

Procedures – Data collection and analysis

As an exploratory qualitative method was used, semi-structured interviews that sought rich and in-depth accounts of lived experiences from those existing at the interface of MHNIP was used for data collection (Patton, 2002). Semi structured Interviews were conducted from June 2012 through to September 2012 and lasted from between 30 minutes to 80 minutes. Interviews were conducted at the convenience of the participants who were initially posed questions on their perceptions of the roles and capabilities of MHNs under the incentive programme. Further questions were forwarded on the processes underpinning witnessed MHN practice and the impact this may have for all stakeholders of the MHNIP.

The audio recorded interviews were transcribed into text with four individual investigators independently analyzing these for emergent themes (Pope & Mays, 2006). This analysis consisted of reading and re reading the transcripts, as well as immersive listening to the audio recordings of the interviews. Data was initially grouped into common patterns emerging from the words of the participants and then into themes supported by further data (Polit & Beck, 2004).Findings were contrasted until consensus on emergent themes was reached between all investigators.

Ethics

Ethics approval was sought and obtained from the Southern Cross University ethics committee.

FINDINGS

Theme: Holism. Key features of this theme were that the MHN responds to the needs of both the consumer and the organizations in which they were situated through utilizing the flexibility of the session based structure of the MHNIP.

> *(Research Participant 11; MHN) "I've had someone referred who was delusional, but when we tease it out, it's been a background of severe poverty and hardship and they're creating an alternative reality that's easier to live with. ..If it's only a psychologist involved, they're not really learning about all the other parts of themselves. They'd just be dealing with the anxiety and you can't just deal with that because they need to look after other things happening in their life".*

Holism emerged from the data as a theme that underpins specialist mental health nursing practice within the MHNIP. This holism was not just simply in the form of bio-psycho capabilities, linking the physical and the mental, but included a significant capacity to respond to consumers' social contexts. The consumer was viewed as a whole, as opposed to a spotlight focus being adopted to a cluster of symptoms, either physical or mental, or to a diagnostic entity.

Through a shared working relationship the nurse interpreted the consumers' health and social treatments, as well as the bureaucracy involved in securing and managing those services. This allowed the consumer to have informed engagement with the holistic interventions being offered from the treating team of health professionals. In turn this positioned consumers to take an active role in planning resources needed to assist themselves to moving to their own self-defined goals, along their journey. This metaphor of journey was evoked from MHNs seeing people as a complicated whole.

> *(Research Participant 5; MHN) "So you know, you're going on a journey, you're working with them on the road, you're walking along the road with them you know".*

This is more than a form of case management where need is identified and service brokered. The broad and holistic approach to working with people, families and communities when combined with flexibility of service delivery, facilitated in the funding model, enabled MHNs to emerge as a resource in crisis management through the eyes of professional colleagues and service mangers. A further element of holism beyond the bio-psycho-social was the impact on systems. The MHNs took an active role in community development, including the professional community of the networks within which they delivered service.

The MHNIP programme funding structure was characterized by 'flexibility' as mentioned by the majority of participants, in that consumers can be seen outside of the clinic and contact is not prescribed as face to face within a predetermined restrictive timeframe. Within this context the broad base of professional capacity of the specialist MHN enables complex and unscheduled crisis to be worked with.

> *(Research Participant 6 MHN) "I can think of a few examples where the psychologists feel maybe a little bit out of their depth with a suicide risk...they feel like we're better placed to manage and monitor patients in a crisis. So we do quite a lot of that, quite a lot of crisis management".*

This is again the inherent flexibility in the programme but is largely based on nature of the holistic practice of MHNs. Nurses not only have the time to manage a crisis but the ability to engage in transformative psychotherapy, biomedical and social interventions.

Theme: Releasing potential. Key features of this theme include MHNS 'escaping' the public health system and expertly using the therapeutic skills they had trained in.

> (Research Participant 10: MHN)'*…I don't think I realized just how de-skilled I was becoming, how I was not being used at all to my potential. As a custodian, so often, even in the community, as a community mental health nurse in crisis teams and assertive outreach teams in the UK and in Sydney, I was so becoming a basic security guard at times... "*

A consistent thread through the narratives of respondents was a sense of being liberated from elements of the public health system which had previously constrained their practice. All nurses in the study had extensive experience in the public health system, experience that was recognized and valued by both nurses and research participants from other disciplines. However, elements of social control and the restrictive nature of some of the nursing roles in the public mental health system actively enticed MHNS to join the MHNIP as an avenue to work in roles more congruent to their capabilities, values and ethics of care.

As the nurse quoted below and many other participants noted the terms of the MHNIP programme provide a degree of "freedom" to see people for as long as might be needed, however nurses needed to be effective, engaging and motivated as otherwise consumers would not attend. This non-coercive way of relating was different to the instrumental or surveillance functions that nurses may have been required to assume in previous roles:

> (Research Participant 6: MHN) *"… it's very much more therapeutic. It's very much based on the therapeutic alliance. That's how I make progress - by developing a rapport and a trust with patients who can see the fact that I do have time for them, … I care about them, that they do matter. And so often they don't have any*

experience of that in the past. It's quite refreshing for them, it's a new thing. So they come back, week after week, and I see them till they recover and they start to do better"

Also apparent from the interview data was that MHNs working within the incentive programme were also releasing potential within the wider mental health services. Many participants spoke of diverting consumers away from the public health system into the MHNIP, filling gaps within the public system and managing crisis without drawing on the resources of crisis services. One participant MHN noted that they would see people instead of the psychiatrist or when other forms of therapy or intervention failed. This in turn affected the entire care delivery system in that psychiatrists were able to see additional people consummate to needs of the consumer and capability of the psychiatrist. This individual was able to provide a form of continuity of care over a long period of time and see people through hospital admissions and their recovery:

(Research 7: MHN *…the public sector is terribly overburdened, and is incredibly unresponsive, they'd get somebody they didn't know, and it had a high turnover of staff….*

Theme: New understandings of the MHN. Key features of this theme include MHNs assuming new roles under the MHNIP by building their identity outward from historical roles. Predominantly this expanding identity was that of delivering psychotherapeutic interventions from a highly qualified platform.

(Research Participant 2; Service manager) *"MHNs can offer the same and sometimes more psychological intervention levels than what a psychologist can offer"*

Nearly all MHNs in this study had advanced training in psychotherapy and the MHNIP provided an avenue for them to employ their specialist skills. The nursing participants had qualifications in a range of therapies including CBT, family therapy, narrative therapy, Jungian therapy, gestalt therapy and integrative counselling. As the nurse quoted below suggests these therapy approaches require formal training and integration with existing models of nursing practice:

(Research Participant 5' MHN) "You need firm therapy training; you need to be very clear on your model of practice"

This theme links closely with the previous themes of holism and releasing potential but is presented separately due to the density of qualitative data showing MHNs offering formal psychotherapy as part of their standard practice. It was the way that these skills or techniques were employed that sets the nurse apart from other health professionals engaged in psychotherapeutic interventions. Firstly,

psychotherapy and counselling were offered in addition to the traditional understandings of what MHNs do, such as undertaking initial assessment, risk assessment and medication management, as well as delivering bio- -social care. In other words these nurses were not abandoning historical roles for ones of possible greater perceived worth but were rather molding these into a new form of mental health nursing standard practice. Secondly, these new roles of psychotherapy were fundamentally been undertaken covertly. While the MHNIP constructs MHNs as being merely responders to the care plans of others, these MHNs were leading complex psychotherapeutic care that incorporated the breadth of the consumers' needs; but undertaken in a manner that did not directly challenge existing disciplinary power structures.

One exceptionally experienced and qualified MHN and psychotherapist encapsulated how MHNs have transformed themselves into a new type of MHN/psychotherapist:

> (Research Participant 11:MHN)"*I was seeing a girl* (for family therapy)*whose mother has personality disorder, bipolar disorder and was an alcoholic, so I felt it was better for me to be travelling to see her than for her mother to be driving into to see me*"

Valuing consumer-centric approaches. A key feature of this theme was that nurses in the MHNIP were focused upon achieving better outcomes for consumers of mental health services through consumer centred approaches.

All the six mental health nurses interviewed for this study indicated their background lead them to value the consumers' views and experiences. These consumer experiences informed the development of therapeutic approaches, despite the MHNs having very different approaches to therapy.

MHNs reported that consumers valued their support/treatment by a nurse often in preference to other disciplines due to the attention being paid to responding to their self-identified needs. A Nurse working for a group of psychiatrists said:

> *(Participant 5: MHN) "they had to put on a second nurse because my case load was so full - this was a result of demand from consumers".*

A manager indicated that mental health nurses person centred ways of engaging with consumers with difficult complex needs meant that they continued in the therapeutic relationship longer.

> *(Participant 2: Service Manager) Sixteen sessions isn't enough for those people. So these are people who have often had, totally chaotic childhoods, um...lots of abuse and neglect……I'm surprised at how many of those chaotic*

> *borderline people actually engage and go back again and again. Because usually they've chewed through half a dozen psychologists and are not interested in doing that kind of thing....*

The GPs interviewed for this study spoke very highly of the service the MHN gave. They valued the ability of the nurse within the flexibility of the funding arrangements of the programme to give the consumer the time they needed, they valued the specialized skills of the MHN and all GP participants reported that from their view the broad focus of nursing equipped the MHN to truly work "with" people at the center of care.

> *(Participant 1: GP) The MHN can do assessments and develop client centred treatments that were effective*.

The GPs saw the flexibility of nurses to respond to the expressed needs of consumers as one of the advantages that distinguished them from other mental health professionals. This broad based consumer centric focus was identified as not only transformative in the lives of consumers but has also impacted systems. A GP (Research Participant 8) noted the presence of the MHN to be "truly invaluable".

Discussion

MHNs within this study were shown to be behaving as clinical leaders; autonomous practitioners directing their own interventions in partnership with consumers while simultaneously maintaining long established MHN collaborative practices with other disciplines This is reflective of RNs and hence MHNs being academically prepared and endorsed by the national regulatory authority to engage in autonomous practice – with the legal responsibilities that that implies. The RNs role, although collaborative by nature, do not practice 'for and on behalf of another profession'. The notion that the medical practitioner automatically holds the ultimate responsibility for care and liability for nursing practice is no more than a circulating myth (Cashin, Carey, Watson, Clark & Newman, 2009).

English and Australian case law does not substantiate this myth, in 1951 Lord Denning confirmed this, in the English case of Cassidy v Ministry of Health ([1951] 2 KB 343 cited in Kerridge et al., 2005,p293), when he confirmed that nurses are not the servants of medical practitioners.

The assumptions embedded in the language of who gets to say what in terms of care, has become enshrined in Medicare directed policy. The notion of ultimate medical practitioner decision making is reflected in the funding arrangements under the MHNIP. This is classed as a practice nurse funding scheme and MHNs within the programme are conceptualized as medical extenders and enables of medical care (Cashin, Buckley, Watson, Newman, Carey, & Waters, 2010).

The dissonance between the clinical leadership behaviours reported in this study and the roles defined for MHNs is noticeable, particularly in terms of the nurse been recognized as a leader of practice and in the undertaking of structured psychotherapeutic interventions by nurses. While the

MHNs in this study were shown to be evolving their practice, they appear to be doing so covertly or at least without recognition from those beyond the boundary of the MHNIP. Browne, Cashin and Graham (2012) warn such failure to articulate what MHNs actually do, continues this lack of recognition and will only entrench existing perceptions of what MHNs have the capacity to do.

The evolution of MHN standard practice to be incorporating psychotherapeutic therapies was also important. While a number of studies identify MHNs as engaging in such therapies (Beech, 2000; Crowe, Whitehead, Carlyle, et al, 2012) findings from this study show that this is being undertaken in a manner that maintains traditional MHN roles, rather than dumping them in favour of interventions that potentially attract greater perceived professional worth. Arguably this strengthens not only the capacity of MHNs to provide a wider range of holistic care to consumers but also provides a role that MHNs undertake that can be more easily recognized and articulated (Leishman,2004).

In addition to enacting leadership and capacity to deliver formal psychotherapies MHNs in this study also described a greater focus of consumer choice. Participants in this study were identified as having moved away from coercive practices that have long been associated with mental health service delivery (Lakeman, 2012), through enacting advanced engagement capabilities. While engagement has been established within the MHN literature as being integral to good practice (Dziopa,& Ahern, 2009) in the context of the MHNIP enagagement was supported and encouraged by the entrepreneurial structures of the MHNIP that in effect allows consumers to 'shop' for services with greater freedom than what they could do within the public health sector alone. The public mental health sector was identified in this study, as it was in the earlier surveys on the MHNIP (ACMHN, 2009; 2011) as being problematic. Arguably and despite many examples of excellent nursing practice MHNs experience a 'failure to thrive' as a profession within this system but when given the opportunity to exercise the full scope of their autonomous practice they become transformative for; the systems they work in, consumers and themselves.

Study limitations

The purposive and convenience approach to sampling limit the generalization of findings to all MHN within the incentive programme.

Implications for Practice

The MHNIP has had a significant and positive impact on consumers, the delivery of mental health care and the MHN profession. The Australian College of Mental Health Nurses (ACMHN) run 'Credential for Practice Programme' has approximately 1080 MHNs credentialed (Australian College of Mental Health Nursing, 2012). While some of these MHNs sought this endorsement on the national register as a mark of specialist identity, it's worth rests as much with ensuring an income from for nurses through the MHNIP (Happell & Palmer, 2010; Happell, Palmer, & Tennent, 2010).

It can be argued that the MHNIP adds to the perceived worth of MHNs through Medicare payments. However, in reality the funding is paid to General Practitioners (GPs), psychiatrists and organizations who work within the programme. The received view is that nurses provide therapeutic services for and on behalf of medical practitioners, who then pay the nurse as if salaried to them. Incentive monies designed to embed the programme are paid directly to either the medical staff or to the organizations who pass part of the monies on to the MHN doing the work (Department of Health and Aging, 2012).

Indeed the funding rules of the MHNIP offer an insight into the identity and capabilities of MHNs, as perceived and constructed by government and those who advise mental health policy. The MHNIP can be seen as a policy that constructs MHNs as being merely 'a responder' to the clinical planning and direction of others. It is also a policy that attempts to constrict MHN practice to historical roles of risk assessment, mental state examination and the ill-defined practice of generic support (Cummings & Slevin, 2005). There appears to be little recognition that MHNs deliver psychotherapeutic interventions, despite the profession's increasing contribution to this practice (Hurley, 2009; Shanley & Jubb-Shanley, 2012) or their ability to independently deliver care within a multi-disciplinary framework.

In contrast to this limited view of what mental health nursing does - this study and the 2011 survey of 246 community MHNs working in the programme indicated that participants experienced autonomy and independence of practice with a flexibility that was absent within the public system (ACMHN, 2011). This disparity between the restrictive funding rules and the autonomous specialist interventions is suggestive that MHNs are engaging in covert identity performances beyond the levels of capability attributed to them by Medicare but recognized in their scope of practice by AHPRA. Indeed an earlier report on the MHNIP also reported results that indicated that MHNs felt their capabilities were often undervalued or misunderstood (ACMHN, 2009).

CONCLUSIONS

Findings in this study and previous research indicate that the MHNIP is operating as an effective and valued service independent of the often overburdened public system. As well as filling in service gaps, the findings from this study suggest the MHNIP should be viewed with a wide strategic perspective. In the context of the MHNIP funding being effectively frozen until June 2013 (Department of Health and Ageing, 2012) and that the Australian Government acknowledges that service shortfalls not only exist but are in need of additional support (Department of Health and Ageing, 2011) such a perspective could be viewing MHNs as offering new potential to an ailing public system. Credentialed MHNs within MHNIP having their own item numbers under Medicare and greater integration of MHNIP into the public health system are two interesting possibilities.

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