3 Situation Analysis

This chapter describes the context of MHNIP's introduction and how the program operates. It includes details of budget expenditure and levels of program activity. The chapter concludes with a summary of the MHNIP program design features.

3.1 MHNIP POLICY CONTEXT

The Council of Australian Governments (COAG) agreed to a *National Action Plan on Mental Health* in July 2006. One of the four objectives of the Action Plan was:

> *"... increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time..."*[5]

MHNIP was one of the *Action Plan* initiatives that sought to improve coordination of patient care:

> *"... to prevent people who are experiencing acute mental illness from slipping through the care 'net' and reduce their chances of readmission to hospital, homelessness, incarceration or suicide..... Better coordinated services will also mean that people can better manage their own recovery..."*[6]

The *Action Plan* allocated $191.6 million over five years to the Mental Health Nurse Initiative. The COAG announcement was followed by the appropriation of Commonwealth funds for program start-up in 2006-07, with scaling-up of the program funded from 2007-08.

3.2 PROGRAM DESCRIPTION[7]

Program Guidelines (*the Guidelines*) which are accessible on the DHS web site describe how the program is expected to operate. DHS in consultation with DoHA periodically updates the *Guidelines*. They address a range of program features including:

- Program eligibility for organisations, mental health nurses and patients;
- Roles and responsibilities of medical practitioners and mental health nurses;
- Payment rates and claims processes; and
- Clinical guidelines including care planning processes and collection of patient data.

This section summarises key features of the program operations based on material in the *Guidelines*.

Under MHNIP credentialed mental health nurses working with *eligible organisations* engage collaboratively with psychiatrists and GPs to provide clinical nursing care and coordination of clinical services to patients with severe and persistent mental illness. MHNIP services are provided in a range of settings including clinics, community centres and patient homes.

There are no direct costs to the patient receiving a service under MHNIP. They may incur fees from visiting the GP or psychiatrist for preparation of a care plan or subsequent monitoring visits.

3.2.1 Program Eligibility Requirements

Organisation Eligibility

To be eligible to participate organisations must be community based and have a GP or a psychiatrist with a Medicare provider number. Eligible organisations include:

- general practices;
- private psychiatry practices, and
- Aboriginal and Torres Strait Islander primary health care services funded through the Office for Aboriginal and Torres Strait Islander Health.

Eligible organisations can engage more than one mental health nurse.

State and territory health organisations may not directly participate in the program but can enter shared employment arrangements with eligible organisations.

At 31 May 2012 there were 470 organisations actively participating in MHNIP.

Mental Health Nurse Eligibility

Credentialed mental health nurses have specialist qualifications and training in mental health. From 31 December 2009 a mental health nurse working within MHNIP had to be credentialed with the ACMHN and be trained in the use of *Health of the National Outcomes Scale* (HoNOS). This tool measures the health and social functioning of people with severe mental illness. Training in the administration of HoNOS is available through the ACMHN.

The number of nurses credentialed by ACMHN rose from 234 at the beginning of January 2009 to 1,153 by the end of June 2012, an average increase of 21.9 credentialed mental health nurses per month since January 2009.

Patient Eligibility

GPs and psychiatrists determine which patients have a *severe and persistent mental disorder* and are eligible to participate in the program. Patients must meet all of the following criteria:

- the patient has been diagnosed with a mental disorder according to the criteria defined in:
    - the World Health Organisation *Diagnostic and Management Guidelines for Mental Health Disorders in Primary Care* (ICD 10 Chapter V Primary Care Version), or
    - the *Diagnostic and Statistical Manual of Mental Health Disorders—Fourth Edition* (DSM-IV);
- the patient's disorder is significantly impacting their social, personal and work life;
- the patient has been to hospital at least once for treatment of their mental disorder, or they are at risk of needing hospitalisation in the future if appropriate treatment and care is not provided;
- the patient is expected to need ongoing treatment and management of their mental disorder over the next two years;
- the GP or psychiatrist treating the patient will be the main person responsible for the patient's clinical mental health care, and
- the patient has given permission to receive treatment from a mental health nurse.

A patient is no longer eligible for services under the program when:

- their mental disorder no longer causes significant disablement to their social, personal and occupational functioning, or
- they no longer need the clinical services of a mental health nurse, or

- the GP or psychiatrist, employed to treat the patient is no longer the main person responsible for the patient's clinical mental health care.

3.2.2 Roles and responsibilities

Mental health nurse role

Mental health nurses are the central component of the MHNIP service delivery arrangements. The clinical nursing care they provide may involve establishing a therapeutic relationship with the patient, working with family and carers, reviewing the person's mental state, providing information about physical health care, and working with the patient and carers to maximise medication compliance.

Nurse coordination activities may involve maintaining links with patients, undertaking case conference activities, coordinating access to services outside the primary care clinical setting, contributing to the planning and provision of patient care and interacting with a range of medical and other health professionals to facilitate patient care.

A HoNOS score must be determined for each patient who enters the program. The HoNOS tool must be administered every 90 days to monitor changes in patient symptoms and functioning and when a patient is exiting the program.

The *Guidelines* specify that a session is 3.5 hours in length. Eligible organisations can engage mental health nurses from between one and 10 sessions per week, per nurse, with an average nurse caseload of at least two individual services to patients with a severe and persistent mental disorder per session.

The *Guidelines* state that:

- as a guide, an eligible organisation engaging the services of a full-time mental health nurse should have a current minimum case load of 20 individual patients with a severe and persistent mental disorder per week, averaged over three months;
- when taking into account patient turnover, the expected annual caseload managed by a full-time mental health nurse is 35 patients with a severe and persistent mental disorder, most of whom will require ongoing care over the course of the year; and
- it is expected that a full-time mental health nurse engaged for 10 sessions per week would provide an average 25 hours of clinical contact time per week, with the balance of time spent in related tasks.

Medical Practitioner role

Participating medical practitioners are responsible for developing a *GP Mental Health Care Plan*, or an equivalent plan by psychiatrists. *Items 2700, 2701, 2715* and *2717* of the Medicare Benefits Schedule (MBS) for GPs define the steps for preparing a GP Mental Health Treatment Plan. The care plan must include specific reference to the roles and responsibilities of both the mental health nurse and the treating GP or psychiatrist. Treatment must accord with the plan and relevant clinical guidelines for management of the disorder. The medical practitioner and the mental health nurse must regularly review the care plan.

3.2.3 Payments to eligible organisations

Establishment payments

Eligible organisations are able to apply for a one off establishment payment to cover the upfront costs of engaging a mental health nurse. There are two payment amounts based on the length of metal health nurse engagement:

- $10,000 where the organisation engaged a mental health nurse for at least five sessions per week; or
- $5,000 where the organisation engaged a nurse for one to four sessions per week.

Sessional payments

Payments to eligible organisations for clinical services are made monthly by DHS. Eligible organisations must submit claim forms detailing the number of sessions undertaken within six months following the session.

The sessional rate for claims is $240 (GST inclusive) per session. A 25% loading is applied to the payment for *very remote*, *remote* and *outer regional* services (as defined by Australian Standard Geographical Classification Remoteness Classification), resulting in a rate of $300 per session. The sessional amount is intended to be applied to mental health nurse salary and oncosts, including personal and recreational leave entitlements.

Each application for payment by an eligible organisation requires a range of information, including:

- organisational information: the name of the organisation and the details and numbers of mental health nurses engaged;
- sessional information, including the date of the session, location and number of sessions provided; and
- patient information, including their Medicare card number and the number of face-to-face consultations received.

3.3 PROGRAM EXPENDITURE AND ACTIVITY LEVELS

3.3.1 Budget and Actual Expenditure

The original budget allocations and forward estimates for MHNIP are shown in Table 3.1. This table also gives actual program expenditure since commencement of the program.

Table 3.1: MHNIP – original budget allocation, forward estimates and actual expenditure compared

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Original program budget allocation and forward estimates ($m)[a]	2.1	24.0	37.9	54.9	-	-
Actual program expenditure ($m)[b]	-	2.7	13.4	21.4	27.2	35.6
Annual growth in actual expenditure compared to the previous financial year (%)				59.7	27.1	31.0

(a) Source:http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2006-glance.htm
(b) Source: Department of Health and Ageing

From Table 3.1 it can be seen that initial take-up of the program was lower than planned. However, actual expenditure increased significantly in recent years, with increases over the previous two financial years averaging 29% in 2010-11 and 2011-12.

3.3.2 Activity Levels

Activity levels under MHNIP followed growth trends in actual expenditure. The number of sessional payments made by DHS under the program is given in Table 3.2.

Table 3.2: MHNIP – number of sessional payments to eligible organisations[a]

	2007-08	2008-09	2009-10	2010-11	2011-12
Number of MHNIP sessional payments to eligible organisations	8,320	50,627	86,456	107,046	140,552
Annual growth in number of sessional payments compared to the previous financial year (%)			70.8	23.8	31.3

Source: DHS
(a) Number of 3.5 hour sessions claimed, not individual services to patients

The May 2012 Budget announced that activity would be capped at 2011-12 service levels pending the outcome of this evaluation.

Table 3.3 shows the number of individual patients recorded by DHS as receiving assistance under MHNIP.

Table 3.3: MHNIP – number of individual patients receiving assistance by financial year

	2007-08	2008-09	2009-10	2010-11	2011-12
Number of individual patients supported by MHNIP during the financial year	6,998	20,608	30,196	38,939	49,842[a]
Annual growth in number of individual patients compared to the previous financial year (%)			46.5	28.9	28.0

Source: DHS
(a) HMA estimate. Actual number of patients at the time or reporting was only available for the 10 months to 30 April 2012 – 41,535 patients. The estimated patient numbers is a straight line projection for the remainder of the financial year, based on session levels for the previous 10 months.

The *Guidelines* require nurses to record the details of at least two patients that they support during a session in order to establish their eligibility to make a sessional payment claim. From the evaluation case study process it was established that not all mental health nurses record every patient contact on the sessional claim form where they provide support to more than two patients during the session. As a consequence the number of patients identified in Table 3.3 probably under-estimates the actual number of patients supported by MHNIP.

3.3.3 The Link between Nurse Numbers, Sessional Activity and Patients Supported

The number of credentialed nurses and their degree of engagement with the program drives the number of sessions provided under MHNIP, and the actual number of patients supported.

The on-line and case study data collection processes for the evaluation identified that not all mental health nurses working under MHNIP work full time (ie many work less than 10 MHNIP sessions per week). ACMHNs advised that a survey of its members in 2011 determined that credentialed mental health nurses engaged in MHNIP service delivery were providing an average of 26 MHNIP sessions per month.

Table 3.4 summarises the data collection results on average levels of sessional service provision over various times (week, month and per annum).

Table 3.4: Average sessional workloads of mental health nurses working under MHNIP – a comparison of different data sources

	HMA On-line Survey		HMA Case Studies		ACMHN Survey	
	Range	Mean	Range	Mean	Range	Mean
Level of full time equivalent employment	0.1 – 1.0	0.78	0.2 – 1.0	0.7	0.1 – 1.0	0.6
Sessions per week	0 – 10	7.6	0 – 10	7.1	0 – 10	6.2
Sessions per month[a]	0 – 44	32	0 – 44	30	0 – 44	26
Sessions per year[b]	335 – 384		314 - 360		272 - 312	

(a) Based on 22 working days per month
(b) Based on 44 and 52 weeks per annum

DHS data was used to calculate the average number of services received by eligible patients. This decreased from 17.9 services per patient per annum in 2009-10 to 13.1 in 2010-11 (see Table 3.5). Similarly, the total number of services per 3.5 hour session claimed decreased from 6.3 services per session in 2009-10 to 4.8 services per session in 2010-11.

Table 3.5: Summary of average number of services per MHNIP eligible patient, 2009-10 and 2010-11

Financial year	Services	Sessions	Patients	Services per patient	Services per session
2009-10	540,048	86,456	30,196	17.9	6.3
2010-11	508,511	107,046	38,939	13.1	4.8

Source: DHS
Figures presented in this table should be interpreted with caution as the accuracy of this data could not be confirmed

3.4 DESIGN FEATURES OF MHNIP: A SUMMARY

Based on the summary of MHNIP operations presented in Sections 3.1 to 3.3 it is now possible to present a summary of the key program design features – see Table 3.6

Table 3.6: MHNHIP Design Features

Program Design Characteristic	Current MHNIP Design Feature
Model of care	• Target group: people in the community with a severe *and* persistent mental illness. • Credentialed mental health nurses work closely with GPs and psychiatrists to provide coordinated clinical services. It should be noted that GPs and Psychiatrists are the primary care givers. • The *Program Guidelines* outline functions that mental health nurses should undertake. • There is no cap on the number of sessions a nurse has with a patient • A nurse can be engaged to provide between one and ten sessions per week, per organisation, with an average nurse caseload of at least two individual services to patients per session.
Program Participation	• Eligible (ie registered) organisations, comprising self-selected: o Private primary care services – general practices and private psychiatry practices o Medicare Locals o Divisions of General Practices o Aboriginal and Torres Strait Islander Primary Health Care Services funded by the Australian Government through the Office for Aboriginal and Torres Strait Islander Health (OATSIH).
Funder	• DoHA
Purchaser	• DoHA is the funder and purchaser (based on retrospective payment of claims in arrears). • Purchasing intelligence: DHS reports.
Demand management	• Nil, until application of the session cap in May 2012. Prior to this activity levels were driven by supply side factors: o number of eligible providers; and o number and availability of credentialed nurses.
Planning	
Practice level	• Triaging at the practice level.

(a) *Characteristics adapted from the framework presented in Duckett, S., and Willcox, S., The Australian Healthcare System, Oxford University Press, South Melbourne, 2011, p.10-11.*

HMA uses the findings from the evaluation assessment presented in Chapters 4 to 6 to critique these program design features and suggest ways forward for future program design (see Chapter 7).

3.5 PREVIOUS MHNIP EVALUATION AND REPORTS

3.5.1 Expansion to private hospitals

In 2009 the Australian Institute for Social Research released a report titled *Evaluation of the pilot of the MHNIP in the private hospital setting*. This report has not been publicly released. The report reviewed the impact of introducing the program at seven pilot private hospital sites. It major findings were:

- there was a strong endorsement of MHNIP within the private hospital setting from its key stakeholders;
- the pilot testing allowed access to services to patients who were unable to or had been rejected by the public mental health system;
- stakeholders in the private hospital system viewed MHNIP as having more strengths than weaknesses and that its weaknesses related to resourcing rather than the service delivery model itself;
- MHNIP had lessened the waiting times to see a psychiatrist in the private hospital setting; and
- There was a high level of patient satisfaction with MHNIP.[8]

The report also recommended that MHNIP should be implemented as an ongoing program in private hospital settings. The cost analysis conducted for the MHNIP evaluation suggests that extension of MHNIP to private hospitals has the potential for cost savings through reduced hospitalisations in addition to better patient outcomes.

3.5.2 Case Studies project

In 2010 the National Advisory Council on Mental Health (NACMH) released a report outlining a series of seven case studies relating to MHNIP. The report provides details on the program context, and examples of differing service models. The report also includes details on the profile of MHNIP patients in each health service and stakeholder feedback about the MHNIP. The key findings from this report include:

- there was wide acceptance of the program and feedback from all stakeholders has been extremely positive;
- the MHNIP is being implemented within a variety of different service models showing that the MHNIP can be adapted to suit the needs of the local community;
- a shortage of appropriately credentialed nurses has resulted in limited uptake of the program to date;
- the program is most likely reaching a wider variety of mental health patients than what is described in the program guidelines;
- the main outcomes from the program include earlier intervention, shorter admissions, improved patient follow-up in the community and improved knowledge and confidence for GPs in dealing with mental health issues;
- patient surveys indicated that 80% of people reported an improvement in the mental health as a result of the program; and
- some of the issues reported within the program included lack of resources in some locations, lack of quality systems and limited use of outcome measures to determine treatment outcomes.[9]

A detailed comparison of the current evaluation findings against these previous projects is provided in Appendix B.

3.6 MENTAL HEALTH PROGRAMS

Both the Australian Government and state and territory governments are involved in the delivery of supports to people with mental illness.

For people with severe and persistent mental disorders, service needs are more than just about clinical care. Housing, social connectedness, secure income, employment and general health services are all essential supports to restore and maintain well-being.

State and territory governments deliver a range of services for individuals living with severe and persistent mental illness, including a range of in-patient and rehabilitation services.

The Commonwealth also funds a number of activities which aim to support people with severe and persistent mental illness and which provide for the broad range of their needs, clinical and other. These include:

Partners in Recovery (PIR)

Partners in Recovery (PIR) is a new program aiming to facilitate better coordination and more streamlined access to clinical and other services and supports that are required by people with a severe and persistent mental illness. The program is geared to coordinate multiple organisations from across a number of sectors to work in a more collaborative and integrated way. The objectives of PIR are:

- facilitating better coordination of clinical and other supports and services to deliver 'wrap around' care individually tailored to the person's needs;
- strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group;
- improving referral pathways that facilitate access to the range of services and supports needed by the PIR target group; and
- promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.

Suitably placed and experienced non-government organisations will be engaged as PIR organisations in Medicare Local geographic regions to implement PIR in a way that complements existing support and service systems and any existing care coordination efforts already being undertaken.

Support for Day to Day Living in the Community (D2DL)

The *Support for Day to Day Living in the Community* (D2DL) program aims to improve the quality of life for individuals with severe and persistent mental illness by providing an additional 7,000 places in structured and socially based activity programs. This initiative recognises that meaningful activity and social connectedness are important factors that can contribute to a person's recovery.

Phase 1 of the D2DL program ran from 2006 until 2009. During this phase, 49 sites from all states and territories were invited to submit funding applications. From the funding applications received, 60 grants were awarded under the initiative.

Phase 2 of the D2DL program ran from 2009 until June 2011. In this phase, 48 sites participated while 59 grants were awarded under the initiative.

Expansion of the Early Psychosis Prevention and Intervention Center (EPPIC) model

In the 2010-11 Budget, the Federal Government committed to funding four additional EPPIC sites in partnership with interested states and territories. The 2011-12 budget changes commit the Government to engage states and territories to share the cost of funding and supporting an additional 12 centres, bringing the total number of centres to 16, amounting to a $222.4 million commitment over the next five years.

The EPPIC model provides intensive clinical and non clinical support for young people experiencing first episode psychosis promoting early detection and management, holistic support including help with management of housing, education and employment goals.

Personal Helpers and Mentors (PHaMS) service

The PHaMs service is a complimentary initiative to MHNIP managed by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). The PHaMs service aims to provide:

- increased opportunities for recovery for people with severe mental illness;
- a strengths-based, recovery approach; and
- assistance to people aged 16 years and over whose ability to manage their daily activities and to live independently in the community is impacted by severe mental illness.[10]

In addition, the Commonwealth funds the following primary mental health programs aimed at providing short-term evidence based psychological therapies to those people with more common and primarily mild – moderate mental illnesses:

- *Access to Allied Psychological Services (ATAPS)* - Funded through Medicare Locals, ATAPS allows GPs to refer patients to allied health professionals who deliver focussed psychological strategies.
- the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access)* initiative, which provides Medicare Benefits Schedule rebates for services provided by psychologists and eligible social workers and occupational therapists, on referral from GPs, psychiatrists and paediatricians.; and
- the *Mental Health Services in Rural and Remote Australia (MHSRRA)* program, which provides additional funding to community organisations in rural and remote areas for allied and nursing mental health services.