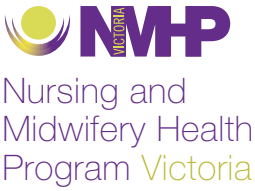

Evaluation of the Nursing and Midwifery Health Program

Final Report – December 2012

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Report Overview

The Nursing and Midwifery Health Program (NMHP) Victoria is an independent, not-for-profit service that exists to improve the health of nurses and midwives registered in Victoria. It is funded through nurses' registration fees and is governed by academic, professional, regulatory and industrial representatives with a stake in the health of the discipline of nursing. The NMHP is currently the only service of its kind in Australia. Similar programs exist in many jurisdictions of the United States.

The problem

In common with all citizens, nurses and midwives experience disruptions to health and wellbeing that can negatively impact on work life. Among a range of health problems, substance use problems and mental health problems are in particular known to impede job performance. These health problems are reported to occur in approximately 10-20% of the general community (Pidd *et al* 2006). The organisation of work and demands upon nurses and midwives are known to contribute to levels of occupational stress, suggesting that such health problems will occur at an average or greater rate among nurses and midwives.

The impact

Health problems among nurses and midwives have detrimental impacts at three levels:

- loss of productivity in the workplace. This can include: absenteeism, presenteeism (ie a person is at work but underperforming) and loss of expertise, if those affected leave the workforce (Pidd *et al* 2006)
- reduced quality or safety of patient care. If a nurse's work performance is impaired, this can have detrimental impact on patient care, ranging from patients receiving less that optimal care, to patients experiencing harm from unsafe practise or serious errors
- reduced wellbeing among nurses and midwives. Affected people cannot achieve their potential as professionals or sustain their contribution to society (Arthur 2005)

These impacts place a financial burden the healthcare sector and the wider community.

The NMHP program

Since mid 2006 the NMHP has provided a range of services to Victorian nurses and midwives. Core services of NMHP are: 1) direct support to nurses experiencing health problems; and 2) health promotion targeted to the nursing workforce.

The evaluation

This evaluation of the work of the NMHP was commissioned in 2009 by the (then) Nurses Board of Victoria (NBV). Program logic and mixed methods have been employed by independent researchers at the University of Melbourne, to determine the progress made by NMHP against its objectives, over the years of operation from 2006-2011.

The report

The full report is divided into three parts. The first is an Executive Summary of findings. Next, the body of the report details the logic of the NMHP, describes the service model, presents the findings related to program objectives and compares these with available literature about approaches to achieving health and safe practice among the healthcare workforce. Additional detail regarding methods, data and analyses from the range of sources employed are provided in Appendices.

Executive Summary

Evaluation brief

The NBV commissioned this study at the request of NMHP Board, to determine "the value of the NMHP to the public and the profession, and to publicly report findings"(NBV 2010 p1). Objectives were to:

- review NMHP processes and practices, with a view to determining a model of best practice
- evaluate the effectiveness of NMHP in assisting nurses and midwives to remain in practice
- identify potential improvements required to ensure accountability and guide decisions for future planning

Evaluation method

The evaluation design was mixed-methods, aiming to describe the service model, to address a range of evaluative questions derived from the program logic and also to triangulate findings. Approval was gained from the University of Melbourne Human Research & Ethics Committee to conduct the project. The project included three key stages:

- **A program logic map** was developed in consultation with the NMHP Board and with reference to NMHP documents, identifying three priority areas.
- **Empirical data were collected and analysed.** These included: routine NMHP referral and case data, publicly available NMHP program reports, existing service user feedback surveys and stakeholder views, gathered in four focus groups. Qualitative (focus group and survey) data were gathered from multiple perspectives: service users, referrers and regulators.
- **Program objectives** for each priority were analysed against qualitative and qualitative findings *(see Table 1: Objectives for evaluation arising from NMHP program logic).*

NMHP priorities

The following NMHP priorities were identified:

Priority 1: Address health problems that impact nurses and midwives (N&M) and their work

Priority 2: Promote N&M health widely across healthcare settings

Priority 3: Establish a best practice model for the organisation of NMHP

Evaluation findings overall

Overall, NMHP has achieved its foundation level objectives, by providing direct service case work and health promotion widely across Victorian healthcare settings and by transparently managing its business

NMHP has made progress on intermediate and high level objectives, to improve health among nurses, and to increase awareness among N&M and employers regarding N&M health needs and approaches to maintaining health. Main achievements are identified against their objectives, in the three priority areas.

Findings against objectives in priority areas

Priority 1: Address health problems impacting N&M and their work

Direct service provision: scope, intensity and access

- **NMHP reach is comprehensive.** In the 5 year period, direct service was provided to 647 nurses and midwives from all divisions of the nursing register, all areas of specialisation, across private and public sectors, from a mix of metropolitan and rural workplaces *(see Table 2a: Client characteristics)*
- **NMHP direct service is flexible.** The intensity of service ranges from screening, brief or infrequent contact (ie 1 to 4 contacts) for approximately 2/3 of cases, to more complex and flexible services, with many contacts in a case management model for 1/3 of cases
- NMHP screening and brief services include 1:1 centre-based and phone contact. This **brief service is comparable to intensity of an Employee Assistance Program (EAP). Differences are:** service is targeted to nursing contexts and practice challenges and the door remains open; median episode duration = 131 days (Inter-quartile range=154)
- **Case management services are comprehensive.** They include: liaison, advocacy and mediation between nurse, employer and regulator; assertive contact; support groups; and brokerage of primary care, financial and legal assistance. Duration of case management service ranges from 11 to 1153 days (median duration = 234 days, IQR = 195 days)
- **NMHP direct service is sensitive to risk associated with impairment**. Case management is targeted especially to those referred by employers and regulators, where risk to patient care is flagged (76 cases to mid 2011)
- **This model of care currently has no equivalent** (for comparison or competition) **in Australia**
- **NMHP is accessible.** The program receives referrals mainly directly from nurses themselves (89%), but also from employers and regulatory agencies; contact is initiated by phone
- **NMHP is responsive.** NMHP responds within a business day to inquiries and referrals; there is no gate keeping or waitlist associated with NMHP service. Barriers to access are: a) location, with problematic travel demand especially for outer metropolitan nurses; and b) awareness of service is still limited

Outcomes and satisfaction

- **Most nurses and midwives have been supported to remain in work or to return to work** in nursing – the majority (303/523 completed cases or 58%) are working by end of the episode of care
- **Nurses referred by the regulator or employer were also working** in nursing after the episode of service (36/58 completed cases or 73%)
- **Satisfaction with the service is uniformly very high** for direct service clients and equally among employers and regulators, regarding support, safety and employment outcomes
- The volume, intensity, outcomes and acceptability of NMHP **direct services match established Practitioner Health Programs internationally** (NCSBN 2011, DuPont *et al* 2009)

Priority 2: Promote N&M health widely across healthcare settings

- **NMHP staff have developed and widely disseminated high quality health information** in written and electronic form to healthcare organisations, nurses and midwives
- **NMHP health promotion reach has grown steadily over 5 years**, including through an NMHP wellness conference in 2010. Demand is growing. The volume and reach of health promotion activity is limited by the size of the NMHP team
- **Satisfied clients and referrers are promoting the NMHP** and help seeking in general
- **De-stigmatised attitudes in the sector are evident** in increased early referrals, self referrals, and help-seeking advice provided by employers and regulators, rather than reports of misconduct
- **The NMHPs integrated approach is strategic and effective.** Providing both health promotion and direct support enhances the credibility and the outcomes for these two major service elements

Priority 3: Best practice model for the organisation of NMHP

- **NMHP Board has displayed transparent governance processes** and outcomes through public documents
- **The organisation has built a strong reputation** amongst healthcare providers, and gained international recognition for its service model (Monroe & Kenaga 2011)
- NMHP has **contributed to the evidence base regarding alternative-to-discipline programs** through this evaluation

Recommendations

These recommendations reflect the NMHP aim to secure and develop the best practice model

Service provision

A strong case exists for the program continuing into the future, built on: a) clear need among nurses; and evidence that b) NHMP direct services are provided to a very high level of satisfaction; with c) positive work outcomes; d) reduction in stigma among nurses; and e) no comparable provider in the jurisdiction. Specifically actions recommended are:

1. NMHP **should disseminate achievements among stakeholders** in a variety of formats
2. NMHP should **differentiate their case management work from individual counselling-only** models and develop program resources to inform referrers and the sector, particularly highlighting advocacy and liaison, expert advice tailored to nursing context and peer support
3. NMHP should **make explicit their role in monitoring and enhancing safe conduct** of higher needs nurses, a role that will otherwise fall to regulators
4. NMHP should **investigate cross-referral arrangements** with other providers of individual counselling

5. NMHP should disseminate information about the **value of ongoing and increasing health promotion work, to improve early uptake** of assistance and **to reduce stigma**
6. NMHP could **improve access through extended hours and after hours,** for support groups and referrals respectively. There is not an obvious case in the data for increasing regional work

Ongoing data collection & evaluation

NMHP should **refine its routine dataset and strengthen ties with like services** internationally for benchmarking and with major health promotion agencies for HP research. Specifically:

7. **NMHP Board and staff should refine priorities and tools for data collection** from this point forward, making use of national indicators, to enable a strong ongoing program evaluation
8. **NMHP should form partnership for quality assurance (QA) level benchmarking activity** regarding its direct service provision. The program stands to gain recognition from benchmarking. QA activity is desirable in addition to further research, as cycles of quality feedback are shorter than research. NMHP service research can make a valuable contribution to national and worldwide evidence regarding models of care and outcomes. Case-based research will continue to present challenges, related to NMHPs sensitive data and the ethically vulnerable client group.
9. **NMHP should engage in research related to health promotion activity**. Funding exists to research health needs and impacts of health promotion on the large nursing and midwifery workforce
10. **NMHP should affirm in program materials the emphasis on nurses' and midwives' mental health needs** and **the NMHP role in health promotion**, as these have become core priorities

Organisation & structure

The NMHP is in the strong position of demonstrating an effective governance structure, headed by a Board with foresight. The changing environment prompts specific recommendations:

11. **NMHP Board should continue to address this question:** *Does NMHP have the right skill mix for program points of difference and for health promotions growth?*
12. **The NMHP Board should determine priority actions to sustain service provision** in the changing environment of national policy and funding

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Figures and tables

Appendices

Chapter 1: Background

The Nursing and Midwifery Health Program (NMHP) Victoria seeks to ensure a healthier and safer nursing and midwifery workforce, through the support and interventions it provides to nurses and midwives with drug and alcohol problems or mental health issues, and to managers and organisations dealing with these issues among their workforce. The program is funded entirely from nurse and midwife registration fees and governed by an independent Board, with a Chair and four Directors. Established in 2006 as a company limited by guarantee, funding for the program was secured through the (then) Nurses Board of Victoria, and supported by the Australian Nurses' Federation Victorian Branch.

The work of the NMHP is achieved by a team consisting of a fulltime CEO, an administrative manager and registered nurses recruited with expertise in mental health nursing and in drug and alcohol counselling. The NMHP is based in urban Melbourne in an inner city hospital site, with regular outreach services to four regional sites. All aspects of the service are free to registered nurses, midwives, employers and other referrers. Nurses can access the service whether or not they are employed. The NMHP team also develops health promotion information that is specific to nursing contexts and conveys this across the healthcare sector.

This program evaluation occurs at a key point in the evolution of the NMHP. Into its seventh year of activity, the program has: refined its governance processes, its model of practice; built profile in the healthcare sector and among nurses and midwives; developed expertise and achieved stability in its staffing. In this same period, the legislative and regulatory environment has changed, such that the role of Nurses Board of Victoria has given way to national and cross disciplinary regulatory processes and associated bodies, the Australian Health Practitioner Regulation Agency (AHPRA) and the Nursing and Midwifery Board of Australia (NMBA). In 2011, consultants (Siggins Miller) were engaged by AHPRA through NMBA to evaluate health programs for managing impaired nurses and midwives. The consultancy project was a gap analysis, designed to inform the regulator about the practices and variations in regulatory processes from notification to outcome, across the nation.

The goal of this NMHP evaluation is to provide a dispassionate assessment of the program for a diverse audience, a goal which has added salience given the current regulatory changes. The audience includes: the NMHP Board; the Victorian nurses and midwives who currently fund and access the program; regulators of nursing and other healthcare practitioners; policy leaders in healthcare workforce; relevant professional and industrial bodies; other health promotion and support providers in workforce; and academics locally and internationally with an interest in health services research related to workforce, quality and safety.

Key concepts, research and policy are outlined to set the scene for this evaluation study. We first introduce the **current literature regarding occupational stress**, its relationship to ill health, including mental health and substance use problems, and **prominent approaches to support workers** with such problems. We then consider specific implications for the needs and support of the nursing and midwifery workforce, the target population for NMHP. This chapter concludes with a summary of relevant **international and local policy directions**.

Occupational stress and ill health

Occupational stress or job stress is defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources, or needs of the worker (National Institute for Occupational Safety and Health USA, 1999).

Workplace stressors exist at the organizational level (eg shift work) and job level (eg conflict with a colleague). While a level of stress in workplaces is expected and may be unproblematic, health is negatively affected by excessive or sustained workplace stressors. Job stress can lead directly to disease (by increasing blood pressure, cortisol levels) and indirectly, via changes in health behavior including increased alcohol intake.

Effects of occupational stress reduce work-effectiveness in such areas as productivity, absenteeism, and disability (Nobrega et al 2010). Three key psychosocial features of work are associated with high levels of job stress and associated ill health: **low control** over work decisions, **high psychological or emotional demand** and **low levels of support** (LaMontagne *et al* 2008). Given the crisis response focus of many healthcare settings, and the levels of patient and family distress in such settings, acute healthcare environments are likely to produce occupational stress (Kirkcaldy & Martin 2000).

Stress related health problems include musculoskeletal disorders, mental and psychological ill health, and cardiovascular disease (Nobrega *et al* 2010; LaMontagne *et al* 2008). Associations between occupational health, stress, problematic substance use and mental illness are well established in the literature.

Attitudes to job stress, mental illness and substance use

In the past decade attitudes to mental health and to a range of mental health problems have shifted. Mental health and illness has been the subject of large health promotion and de-stigmatising campaigns across Western countries since 1990s. In Australia the beyondblue initiative has comprehensively tackled awareness and attitudes and expanded support services, mainly related to depression (Pirkis *et al* 2005).

Levels of mental health literacy and acceptance of high-prevalence mental health problems (depression and anxiety) have improved measurably across the community. Help seeking and treatment in primary care settings for mental health issues has increased markedly in Australia since this time (Harrison *et al* 2012).

However, no such campaign has focused on problems of substance dependence or help seeking for addiction (other than tobacco smoking). The issue of substance use amongst the professional workforce is still stigmatised. This cultural context may produce differences in experience of stigma among nurses and midwives experiencing mental health and substance use problems.

Needs and supports among nurses and midwives

Two streams of research are relevant to the needs of nurses in Australian contexts: studies investigating workplace stress, ill-health and help seeking across Australian workforces; and studies locally and internationally investigating occupational health of nurses.

Trinkoff et al (2000) surveyed 3600 American nurses. They showed how depressive symptoms reinforced substance use among nurses, across varied levels of stress. More recently, LaMontagne et al (2008) surveyed a random sample of 1051 Victorian workers, assessing them for rates of depression and job stress. They estimated that job strain accounted for approximately one in four cases of depression in this sample.

Australian studies identified higher than community average levels of occupational stress across several fields of nursing, including emergency nursing, nursing management and mental health nursing (Safe Work Australia 2010; Happell, Pinikahana, & Martin 2003). Rates were comparable with occupational stress among workers across all the emergency services. In a recent study of workplace stress among 196 psychiatric nurses' in Victorian acute and forensic settings, almost 30% of respondents displayed post-trauma symptoms (Lee, 2011). Protective factors identified in these workplaces were aggression management training, job security and experiencing the work team as supportive.

A review by Beauregard, Marchand and Blanc (2011) of non-work determinants of mental health indicated that social networks beyond the family protected workers mental health. Their synthesis of thirteen large workforce studies showed how factors other than work contribute (both positively and negatively) to workers' stress and health, including family caring roles and financial stresses.

Berryman (2002) focussed on nursing workforce and investigated the links between workplace experience of stress, substance use problems, mental health problems and help seeking. She conducted a baseline study of substance use and mental health problems for Australian nurses, identifying the problems, needs and barriers to assistance. Nurses in her study had higher rates of alcohol, tobacco and benzodiazepine consumption than the general population. She also explored the experience of help seeking, for a sample of nurses. Wide acceptance of alcohol and tobacco use as normal within the culture of nursing led to denial of dependence and delay in recognizing problematic substance use or seeking help (Berryman, 2002). Workplace conditions and cultural factors appeared to feed high levels of stress and increased substance use. Berryman's study provided some of the impetus for formation of the NMHP (then the VNHP).

Nurses' experiences of mental health and substance use problems can also be set against community norms. As reported in the Australian Year Book 2012 (Australian Bureau of Statistics (ABS) 2012), 11% of the adult Australian population reported experiencing mental and behavioral problems. In the National Survey of Mental Health and Wellbeing (ABS 2007), one in five (ie 20% or 3.2 million) were assessed as having a current mental health disorder, defined as having had symptoms of that disorder in the 12 months prior to interview. Women were more likely to experience anxiety disorders (18% compared with 11% for men) and affective disorders (7% compared with 5% for men). Men had twice the rate of substance use disorders (7% compared with 3% for women). The Year Book 2012 results also showed that among Australians aged 18 years and over, one in eight drank alcohol at levels placing them at risk or high risk for long-term harm (12%) (ABS, 2012).

Given the continued reporting of workplace stress among nurses (Safe Work Australia 2010, Lee 2011) it is reasonable to anticipate that nurses continue to experience substance use and mental health problems at or above community levels. However, it is challenging to estimate the extent of ***need for intervention*** and support among nurses with mental health and substance use problems.

Unanswered questions

Job stress may be high among nurses, but answers to these questions are not currently clear:

a) what proportion of nurses experience excessive stress?

b) what is the extent of nurses' ill health?

c) to what extent is nurses' ill health related to job stress or to other factors?

Most importantly for the evaluation of a program such as NMHP, **we cannot define at the outset the relationship between health problems and breaches in safe practice by nurses and midwives**. No studies in Australia or internationally correlate safety breaches with problems of mental health or substance use. To investigate this knowledge gap in the Victorian setting is beyond the scope of this evaluation.

Interventions for nurses with mental health and substance use problems

To this point we have identified that nurses will have support needs related to mental health and substance use problems that may negatively impact on nursing work. The international and local literature describes a range of interventions with relevance to this population, though published evaluations of their effectiveness are scarce. Before exploring potential solutions we identify the barriers that impede nurses and midwives seeking assistance.

Several intersecting obstacles to help seeking and receipt of effective interventions are identified. Through the Patient Experience Survey 2010-11, barriers to healthcare for Australians were identified. As reported in the Australian Year Book (ABS, 2012), the most common barriers to seeking healthcare were identified as "'waiting times too long or no appointments available' (49%) and 'no service available in the area at the time it was needed' (25%)" (p410). Azaroff et al (2002) also identify barriers to workers in America reporting and seeking appropriate help for a range of health issues: casual/tenuous employment; not taking unpaid leave; reluctance to leave work to others; expecting problems (even trauma and illness) as part of work-life; unable to afford help or lacking relevant health insurance; having no GP/primary care relationship; expecting bureaucratic hurdles before help; expecting that assistance will be ineffective. It can be reasonably argued that such barriers to help seeking can apply to nurses and midwives in Australian contexts.

In addition, for nurses and midwives there is stigma associated with admitting mental health or substance use problems (Lillibridge *et al* 2002). Nurses and midwives are particularly upheld as people who are trustworthy, among other valued and ethical characteristics (Roy Morgan Research, 2011). This social standing of nurses can amplify shame and fear among nurses and midwives and impede their acknowledgement or timely disclosure of such problems.

However, the wider healthcare literature suggests that other issues may be just as powerful as stigma in preventing early help-seeking. Whatever the barriers, their impact on help-seeking is evident in the mismatch between levels of help-seeking among nurses, midwives and other health professionals and the expected rate of problems in these populations (Monroe & Kenaga, 2011).

Public health approaches to improving health of the workforce including nurses

Workplace wellness programs are a growing avenue for increasing workers' health. A recent report commissioned by national health insurer, Medibank, identified that such programs are implemented in a minority of Australian workplaces, and more frequently in private than public sector (Price Waterhouse Coopers (PWC) National Health Practice 2010). The report concludes that there is a pressing need for growth in wellness programs in workplaces, including public sector agencies.

At present, the onus is on employers to initiate wellness programs. Industrial bodies have set policies, regarding reducing job stress and enhancing the healthy climate in workplaces for nurses (Australian Nurses' Federation (ANF) 2010). As yet this appears to be an underdeveloped area for intervention. Echoing this conclusion, the national beyondblue program, the major health promotion initiative addressing mental health needs of Australians, currently identifies as a priority and funds research into workplace-based interventions to promote healthier workforce (beyondblue 2010).

Case-based approaches to dealing with workers' ill health: Employee Assistance Program (EAP) models

Since the 2000s in Australia, the common approach to addressing work-related health needs is to refer workers to Employee Assistance Programs (EAPs). A literature review by Azaroff and colleagues (2001) highlights the consistent practice model of EAPs, providing office-based or telephone counseling with individuals. The focus of EAP support is on building coping skills in the individual employee, during a number of counseling appointments. EAPs do not apply a case management model that might include brokering assistance, advocacy, flexible access or outreach.

This model of service is consistent with the training of EAP providers mainly as psychology practitioners in Australia. An evaluation by Arthur (2002) of a cluster of EAP programs in UK suggested that a significant subgroup of 1/3 employees required more complex and substantial support than the time limited counseling provided by those EAPs. Within this individualized service model, EAP practitioners may not have access to senior or influential people in an organization, to recommend, mediate or to challenge practices in the workplace.

A further limit to the potential of EAP to meet the needs of nurses relates to access. Access to EAP services cannot extend to all registered practitioners; to be eligible for EAP nurses must also be employed. This is because EAPs are funded by employers, therefore a nurse who resigns or whose employment is terminated has no access to EAP services.

The review (Azaroff *et al* 2001) and the service evaluation (Arthur 2002) arose in the USA and the UK respectively, over a decade ago. Caution must be taken when using these findings to understand practice of EAP programs in Australia. The EAP models reported, and the approaches to public healthcare and regulation in those contexts and at that time may not effectively match current

Australian contexts. No published research considers the practice or the impact of EAPs in Australia, or specifically for nurses.

Alternative-to-discipline health practitioner programs in USA, Canada and UK

The USA is the only country to develop and comprehensively replicate Practitioner Health Programs with a specific focus on medical, nursing and other health workforce. These programs are variously aligned to a myriad of regulatory, registering and professionally bodies across most states, and mainly serve the disciplines of medicine and nursing (Federation of State Physician Health Programs (FSPHP) 2012). The health programs that can be accessed by nurses explicitly advance a partnership and support role rather than punitive action, in a manner similar to NMHP (Monroe & Kenaga 2011). These USA based programs are overtly geared to assisting with the problem of substance use/addiction among practitioners, but also provide support for problems of mental health and other health issues.

Definitive research findings are lacking regarding these programs; a small number of evaluations of Practitioner Health Programs (some of which are accessible to nurses) provide the best available data for comparison with NMHP (DuPont *et al* 2009). A pilot service to doctors was more recently developed in UK, under the auspice of the Royal College of General Practitioners (RCGP 2011).

The local and international policy context for addressing nurses health needs

Across workforce policy, regulation policy and industrial policy, the needs of nurses with substance use and mental health problems gained some international recognition in the early 1980s (American Nurses' Association (ANA) 1984). However, three key dilemmas dominate service development and impede effective progress in addressing this issue: disciplinary versus supportive approaches to impairment and risk, generic versus tailored approaches to worker health, and reliance on volunteer peer support versus paid programs.

Conservative policies from regulators in many jurisdictions promote compulsory peer reporting, formal investigation and sanctions (Royal College of Nursing UK 2005). While disciplinary policies are intended to protect patients and the public in general, there are good reasons for regulators and employers to offer effective alternatives to disciplinary processes. Disciplinary policies and interventions sit awkwardly beside alternative-to-discipline (ATD) policies and peer support models. Such models are usually promoted by professional organizations (Hughes *et al* 1998, Monroe & Kenega 2011).

Since 2000 the noted international trend towards generic employee assistance programs (EAPs) has seen support services contracted to consulting firms, to address employee needs across industries as diverse as the building sector, policing and healthcare (eg. Worksafe 2010). This trend draws the focus away from specialist programs, lead by members of a health profession and tailored to the particular context and needs of members of that health profession.

Some services that specialize in interventions with nurses experiencing substance use and mental health problems argue for the merit of peer and volunteer based services, such as have grown in

parts of the USA. This approach is favoured in particular by those Nurses' Health Programs (NHP) that are established by professional organisations (such as the Statewide Peer Assistance for Nurses (SPAN), which is auspiced by New York State Nurses' Association (NYSNA) 2012). However, there are problems of sustainability with volunteer provided approaches (Fletcher, 2003) and these NHPs are usually partnered with longer term providers of monitoring and support.

Significance of evaluation

Evaluation and research is urgently required, to articulate and compare program designs and outcomes, for the sake of midwives and nurses, the nursing workforce and for safe healthcare. There is also a need to establish research collaborations across programs, to generate evidence for benchmarking, using indicators of importance related to healthy workforce, patient safety, economics and cost efficiency. This report is the product of independent research commissioned by Victoria's (previous) state based regulator, to evaluate the process and outcomes of the NMHP. A range of issues introduced here are examined again in the discussion section of the report, as they apply to the program logic model of the NMHP.

Chapter 2: Evaluation Design and Method

The aim of this project was to systematically describe the services provided by NMHP and to evaluate the work of the program against its purpose and objectives. The design was mixed methods, appropriate to answer a diverse set of evaluative sub-questions. Quantitative methods were employed to reliably measure service activity and outcomes, and qualitative methods were used to gather rich data about subjective experience of the service and impact.

This evaluation employs program logic as a premium approach to collecting, organising and analysing complex and disparate information about a multifaceted program of activity. Program logic is a way of accounting for the components and activities of human service programs (Martin & Kettner p.25, 2010). A program is represented by either a matrix or flow diagram, delineating inputs to actions to outputs and outcomes, also displaying the details and the influence of programs strategies and activities on the outcomes.

In the early stage of this project, the program logic of NMHP was clarified, to show how the program is expected to work. The relationship between the components of the program could then be tested and evaluated for fidelity to the programs objectives and aims.

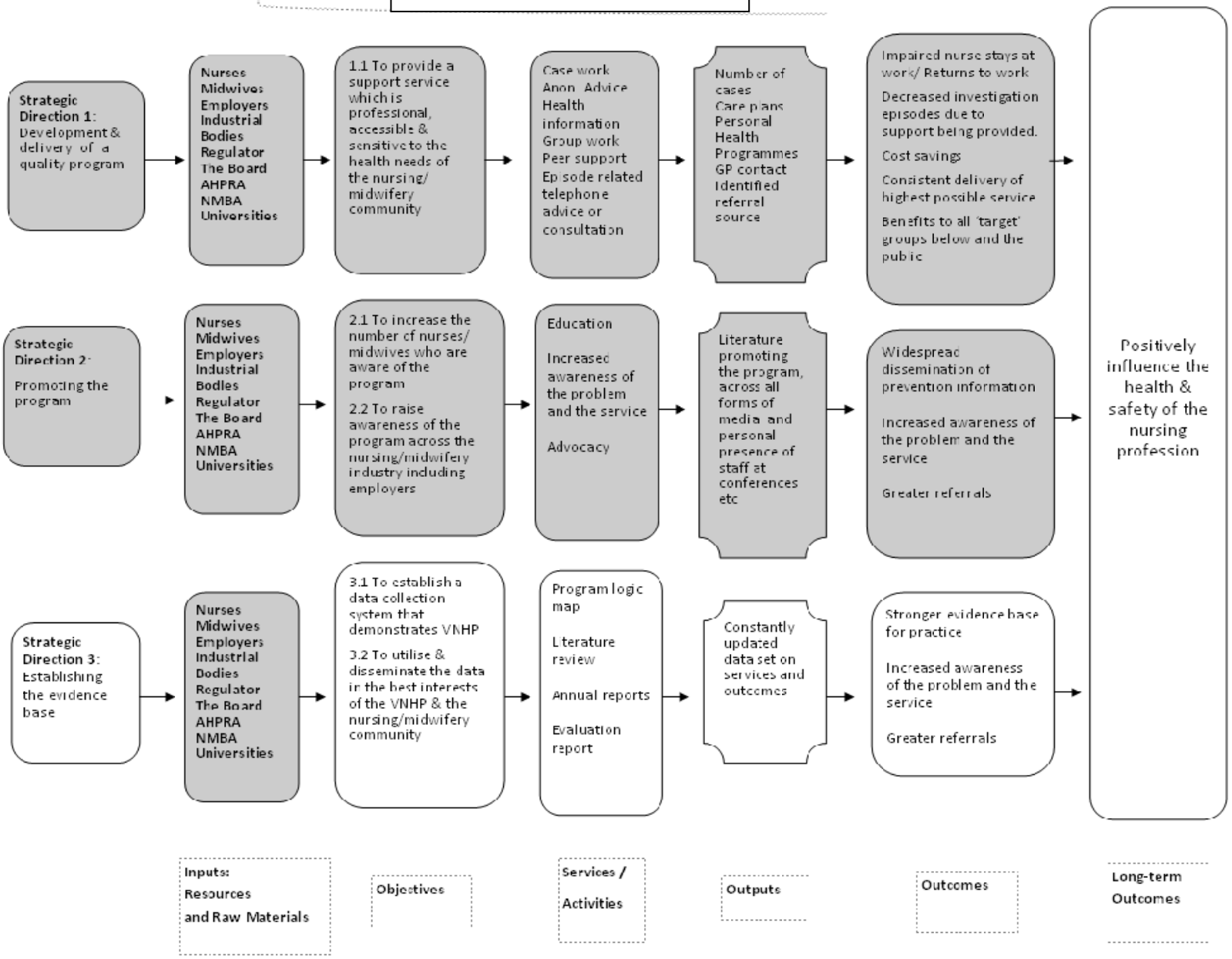
Approach to clarifying the program logic of the NMHP

Clarifying the program logic helps to "develop a shared understanding of the program that can be communicated to others" (Pirkis & Livingston p. 3, 2000). A logic diagram for the NMHP was developed and refined in consultation with the Board of Governors, experienced researchers and the staff. Drawing on existing program documents, we developed a draft program logic map, incorporating the seven strategic directions developed and outlined in the NMHP annual reports since 2007. This map was reviewed and discussed with the NMHP Board and the diagram was then refined.

What is the program logic of the NMNP?

The diagrammatic representation of the program logic in a Program Logic Map (Figure 1: over page) highlights the first three strategic directions of NMHP as central to the process of evaluation. The problem that informs the program, and the underpinning assumptions are detailed after the Program Logic Map. Assumptions which underpin the program were drafted and refined to provide context of the problems this program addresses and to explicate the relationship between the components of program.

Figure 1 NMHP Program Logic Map



Specify the problem

"The VNHP [ie *Victorian Nurses' Health Program, the previous program title*], originally developed to support our colleagues whose health was impaired due to substance use, has also been supporting nurses and midwives with high prevalence mental health concerns such as stress, anxiety and depression since 2007…..With the changes that have occurred as a result of the new national registration scheme, the VNHP has taken the decision to formally change its name [to the]Nursing and Midwifery Health Program, Victoria." (Taylor 2011).

At the time the NMHP was established, stakeholders were aware of research in Victoria which highlighted problematic substance use among nurses, a problem in common with international nursing community. Berryman's (2002) baseline study of substance use and mental health problems for Australian nurses drew attention to two important matters: the extent of substance use and mental health needs and the barriers to assistance. Berryman's study provided impetus for formation of the NMHP (ie then the VNHP).

Assumptions about the cause of the problem

The widely held assumption that nursing is stressful work is born out in studies cited in the background section of this report; stress among nurses and midwives has multiple compounding causes. Nurses experience the physical demands of patient care and shift work, as well as the continuous exposure to illness, trauma and crisis.

Ordinary nursing and midwifery work practice includes being in contact with an array or group of patients continuously and responsively, often in a ward. This work flow contrasts with the work practices of many healthcare colleagues, whose contact with patients in a working day is episodic and focused on patients in sequence and as individuals. This characteristic nursing work flow contributes to **low control** over work demand, a known occupational stress. Nursing work requires a continual reconfiguring of the nurses emotions to optimize the patient's sense of being cared for and safe (Duncan 2002). **High emotional demand** is a second prime occupational stress (Trinkoff *et al* 2000).

The work flow is such that there are limited opportunities for shift working nurses to retreat, to repair after or during distressing experiences. Depletion and distress will in general be tolerated to the end of a shift. Relief and escape from distress and stress can be facilitated by drug and alcohol use. In addition to these workflow factors, nursing work can compound serious drug use, if controlled substances are easier to access (Berryman 2002).

Assumptions about the best program response to problems for nurses

A critical assumption underlying the NMHP is expressed in the phrase 'by nurses for nurses'. An assumption of solidarity between nurses and within the discipline is more than a statement of peer support. The NMHP staff and Board express the view that the NMHP should be nurse led, in order to overcome a known feature of fear, stigma and shame for nurses, evident in the reluctance of nurses to disclose impairment. One factor within this argument is that nurses experiencing problems may want to deal with problems inside the professional group, not wanting to expose mental health or addiction 'flaws' to colleagues outside nursing. This preference to disclose problems and gain support from peers is mirrored in studies of doctors' occupational health and help-seeking (Hu, Fix, Hevelone *et al* 2012).

In addition, nurses and midwives may also experience particular relief, and affirmation of a positive nursing identity, through receiving acceptance and a helpful response from specialist practitioners within the discipline, through the NMHP.

The NMHP model also assumes that nurses do (or will) have a positive attitude towards peer support and care. This assumption is reflected in the peer support group component of the program. Nurses who are case workers are seen as professionals, with the added understanding of stressors unique to nursing (ANA 1984).

The NMHP deliberately takes a liberal (alternative-to-discipline) stance towards nurses and midwives as responsible help-seekers and collaborators in their own return to safe practice (Monroe & Kenaga, 2011). This positioning serves as a corrective to the idea that nurses are stigmatized by their professional nursing peers. It promotes the view that nursing as a discipline takes responsibility for professional obligations to ensure safe practice among co-working and professional colleagues.

The program assumes that prevention, early intervention and self referral are preferable to remedial action and intervention under duress. As NMHP asserts on the website: "…early intervention is the best way to address health problems and encourage our colleagues to contact us to discuss how we can best help".

Nurses collectively are the funders and in that sense owners of the NMHP service, through paying registration dues. This reinforces solidarity and ownership, and the notion of 'by nurses for nurses'.

On the basis of the program logic and interwoven with these assumption, a matrix of objectives were developed for investigation. Against these we matched existing and new sources of data, in order to evaluate the program against its own logic *(see Table 1 over page).*

Table 1: Objectives for evaluation arising from NMHP program logic and data sources

Aim	4:Increase the safety & health of practicing nursing & midwifery workforce			
Highest level objectives:	1:13 Improve health of N&M[1] workforce *a,b,c*	1:14 Reduce loss to N&M workforce *a,b,c*	2:7 Decrease stigma of AOD & MH problems among N&M *b,c,d,e*	3:6 Increase knowledge re effective model of service provision *e*
outcomes	1:11 Improve health of N&M experiencing AOD[2] /MH issues *a,b,c*	1:12 Increase return to workforce after episode of direct service *a,b,c*	2:6 Increase awareness of AOD, MH problems across N&M *a,b,c,d*	3:5 Add to existing research re N&M needs & services *a,d*
	1:9 Make/ sustain health improvements *a,c*	1:10 Increase early inquiries (from nurses still in work) *a*	2:5 Increase awareness among N&M of supports available *a,b,c,d,e*	3:4 Benchmark NMHP against other services *a,e*
transition	1:7 Reduce rate of re-referrals *a,c*	1:8 Increase 'return to work plans', retained in work *a,b,c*	2:4 Increase links with /HP[3] info to employers *a,b,c*	3:3 Evaluation activities show impact of NMHP *a,b,c,d*
	1:5 Increased inquiries / self referrals *a,b,c*	1:6 Increase uptake of supports in primary care *a,b,c*	2.3 Increase HP activity among groups of N&M *c,d,e*	
delivery	1:3 Demonstrate referrals /registered clients across nursing work settings *a,b,c*	1:4 (links to primary care providers) establish/use selfcare tools *a,b,c*	2:2 Deliver HP messages to populations of N&M *c.d.e*	3.2 Produce detailed information about the work of NMHP *a,b,d*
Key initiatives commenced	1:1 Accept referrals & provide information *a, b, c*	1:2 Provide case work/ Episodes of care *a,b,c*	2.1 Tailor & make available HP information for N&M *c,d,e*	3.1 Governance , planning & reporting systems *a,b,d,e*
	Priority 1: Service provision to address health problems impacting N&M and their work		Priority 2: Health promotion (HP) among N&M	Priority 3: Establish organisational (best practice) model

Evaluation data sources:

a. Routine quantitative dataset for registered clients of NMHP

b. Annual feedback survey of registered clients of NMHP - mixed quantitative and qualitative data

c. Stakeholders' focus group (FG) data: ci =Service users FG; cii = Referrers FG; ciii = Regulators FG; civ = asyncronous FG of rural and regional referrers

d: Web tracking data about the NMHP website

e: Publicly available policy and other documents regarding NMHP: Strategic Plans, Annual Reports, publications

f: Census and other population survey data accessed from Australian Bureau of Statistics

[1] N&M =Nurses and Midwives

[2] AOD – Alcohol and other drugs

[3] HP = health promotion

Evaluation data sources, data collection and ethical issues

A mix of primary and secondary data sources were used to build a picture of the work and the impact of the NMHP against its objectives. The evaluation was designed to make fullest possible use of existing data, in line with the clinical data mining approach (Epstein 2009). Data mining makes efficient use of existing information as research resources, an approach which is reasonable to contain the cost of research. This approach also minimises burden and intrusion of research on all stakeholders and particularly on vulnerable participants, such as nurses and midwives using the NMHP.

In the planning stages, we established that a considerable amount of data existed and could be accessed for use in evaluation. However, we identified that there was inadequate existing data about referrer views and experiences and the service user data were limited to a brief response survey. For this reason we supplemented existing data by conducting three focus groups, with referrers and regulators (x2) and service users (x1).

The use of existing data and the collection and analysis of the focus group data was approved by the Human Research Ethics Committee of University of Melbourne. The project proposal that was provided for ethics review and subsequent approval are provided as Appendix 1a and 1b.

The data sources described here are: routine service data about episodes of direct service, feedback survey data, publicly available documents and materials and focus group data.

Routine service provision data

Since inception, NMHP has maintained a database of individual referrals, services provided and outcomes. The organisation has given priority to collecting and regularly reporting activity data, for quality and governance purposes. The service administrator maintained the dataset and ensured completeness.

These service data have been mined for this evaluation, to characterise the direct case work carried out by NMHP team, being a large volume of their work and linked to the first strategic priority. The routine data for all cases over the 5 years from July 2006 – June 2011 were provided to the researchers electronically (in an Excel spreadsheet) by the administrator of NMHP. The list of fields as coded is provided in the Appendices (*see Appendix 1a*). All identifying details (names, addresses, etc) were removed. Case data were imported to SPSS to conduct descriptive analyses as appropriate to the question.

Descriptives include: percentages, mean values and standard deviations, and median values and interquartile ranges, where data was not normally distributed. In some instances correlational analysis - paired t-tests and chi-square tests - are reported as appropriate to indicate significance of between-group differences.

Publicly available reports, documents and health promotion materials

The NMHP has uploaded quarterly activity reports on the NMHP website and collated these in their Annual Reports. These reports and other web-based information were accessed to characterise the governance arrangements and the health promotion activities of NMHP from 2006 to 2011. Some details are tabled and others are appended to the report. *(see Appendix 2 sample of NMHP activity report/annual report).*

Feedback survey

The NMHP annually sends a two-page client evaluation survey to registered clients, ie anyone registered as receiving an episode of care with NMHP for the previous 12 months. The survey has included questions about service use, such as date of engagement with the program and number of sessions attended and participation in groups.

The NMHP client evaluation survey was not designed as a psychometric tool and cannot be handled as such. The tool does not collect any demographic information, so it is only possible to report annual response rates, as one indicator of representativeness. The survey invited a mixture of yes/no and short answer responses, about aspects of the program. Since 2011, some survey questions also invited Leichardt score responses, still with space for short answers and comments. Since the quantitative data relate to a small subsample of the whole 5 years worth of survey responses, we do not report these scores.

The strength of the survey lies in the plentiful qualitative responses, which are the focus of analysis in this report. We conducted a thematic analysis of the qualitative data, alongside the data from focus groups. Anonymous survey responses were gained from 123 of 523 direct service clients, a response rate of 24% overall. A copy of the 2011 survey and our full analysis of the survey data is provided in Appendix 3.

Focus group data

Recruitment

Of the three focus group interviews, two were conducted face to face in premises of the University of Melbourne and one was conducted online. NMHP service users were invited to express interest in focus group participation, via a letter sent to all NMHP clients who had completed an episode of care in the 2010/11 financial year. Further invitations were sent to all employing agencies from which NMHP had received a referral in the five years of operation, and by email to APHRA staff. The initial invitation letter (included in project proposal *Appendix 1a*) was distributed by the NMHP administrator to 120 potential participants across the two categories sought (service user and employer/referrer of service user). This approach prevented the researchers from gaining access to the contact details of users and referrers. The researchers were only aware of the contact information of those NMHP users and referrers who responded by email to express interest in participation.

Nineteen people participated in the three focus groups. Eight NMHP service users attended the first focus group and three staff from different sections of AHPRA attended a second face to face focus group. The remaining eight participants engaged in a focus group interview using asynchronous online group technique (Hansen & Hansen 2006).

Focus group participants provided diverse perspectives from key stakeholders of the service, for whom there is no other/routine data available. The focus groups samples were framed to elicit rich feedback, whilst also being feasible within the scope of the project. Past contact with NNHP was expected to increase the likelihood of informed feedback. The letter invited any referrer, manager or employer to express interest in participation, by providing contact details to the researchers.

Conduct of the Service User Focus Group

The Service Users focus group was consisted of a mix of clients in terms of age, area of nursing and

length of time of contact with NMHP. This group discussed some bullet point statements drawn from three of the NHMP quality feedback questions. These topics concentrated on the experience of using the NMHP, ie: *What were the most useful experiences for you [in your contact with the VNHP]? What support was most important for you to return to work or continue at work? What if any were the barriers to your attendance at VNHP?* (see the Client focus group interview schedule, in Appendix 1a).

The group discussion was focused this way for two main reasons. First, this focus helped to limit disclosure of personal information that may be sensitive or harmful for the participant (such as disclosing distressing workplace experiences or illegal activity). Second, the evaluations that have been completed for the VNHP do contain rich information on the subjective and outcome aspects of the experience. A focus on aspects of the existing user feedback was considered the most pertinent, in order to confirm, enrich and elaborate on the data for this evaluation.

Conduct of the Employers/Referrers Focus Groups

Five APHRA staff responded to the initial invitation but only three could attend a focus group. Two Melbourne based employers who had referred staff to NMHP also responded, but were unable at the last minute to join the group. They did later contribute to the third online focus group.

The APHRA focus group with three attendees gave a unique perspective to the data. Two of the participants had been previously employed by the Nurses Board of Victoria, before APHRA, and described the profound positive changes which had occurred in their practice with the advent of the NMHP.

A third group was formed from those who responded to the initial referrers/employers focus group invitation, but did so from regional and rural Victoria where the travel to Melbourne for a one hour group session was not feasible. This group consisted of employers; six out of eight were regionally or remotely based in Victoria. These employers had either referred staff to NMHP or had contact when a staff member had come to the attention of the regulator. These participants all answered the same questions as the AHPRA focus group but by email. The researchers then posted a 'notice board', with the questions and participant answers. The participants could read each other's comments and make further comment or add questions. This notice board was open for two weeks, to allow question and answers among the group.

The method for this focus group was drawn from literature which has described and validated the method over the past decade. Online focus groups developed in a similar context to this research project; where researchers sought the participation of geographically dispersed individuals in research (Hansen & Hansen 2006). An online group allows the collapse of distance barriers, with no cost or use of resources. By making it asynchronous, participants could respond at different times which accommodated work commitments, whereas running an online discussion at a set time (synchronous) may have contributed to time pressures for some. Flexible timing also worked against "virtual jet lag" (Stewart & Williams, 2005) where one time of day was unlikely to suit all the shift workers involved.

Sweet (2001) writes that a major advantage of online focus group is that it is more difficult for any one person to dominate the group: "an overbearing respondent does not have the same power or

influence with words as a dialogue stream" (p.135). Sweet argues further that online groups create a more equitable atmosphere where "influencing factors such as gender, age, ethnicity, accents, physical appearance or condition, and shyness" (p.135) are diminished.

The respondents in the online focus group were diligent in their initial answers to the focus group questions. The notice board only provoked a few questions to others in the group, but it extended the group conversation. Participants added many comments on the notice board in response to the initial answers, mainly expressing agreement or satisfaction that their experience had been so well articulated by other group members.

The literature regarding online focus groups discusses the tendency for group interaction to be questions and answers between the researchers and the participants, more than a discussion among participants (Hansen & Hansen, 2006; Stewart & Williams 2005). This was partly true in our case, but the length and depth of participant responses provided rich data, without any interruptions or answers being cut off, as can happen in face to face discussion. The requirement to write answers produced very articulate responses (Hansen & Hansen, 2006).

Analysis of focus group and survey feedback qualitative data

Focus groups were conducted with stakeholder groups, to supplement existing data sources. Groups included direct clients of the service, regulator referrers and employer referrers. Face to face focus groups were conducted and audio recoded at the University of Melbourne. Data were transcribed and then reviewed by the researchers. All names and identifying details were replaced with pseudonyms. Written data from the asynchronous electronic focus group records were similarly de-identified.

Focus group recordings and transcripts were reviewed by both researchers. The researchers then worked independently, coding prominent statements regarding NMHP's role in relation to perceived needs in workplace. They grouped and identified contrary cases in the data. The first stage of coding was then compared for reliability and clarity of meaning and further developed, through a second phase to identify core themes from the feedback. Independent coding served as a means of triangulation for the analysis, to increase comprehensiveness and credibility (Silverman, 2008).

The data from the three focus groups were analysed separately in the first instance. However, when investigating the intersections and differences between the information from the different groups, we found more commonality than anticipated. For example, all stakeholders expressed clear need for information and support, though each participant group (service users, employers and referrers) required some**what** different information content.

The qualitative data were arranged into themes under headings and subheadings. This complementary set of de-identified qualitative data was summarized and synthesized, to contribute to the analyses of the extent to which VNHP goals are currently met.

Synthesis of data analysis

The entire and complementary set of de-identified client data, survey data and referrer focus group data was summarized, analysed and then synthesized, to systematically identify the extent to which NMHP goals are met.

Chapter 3: Findings

This chapter draws on all data sources analysed to systematically address the evaluation questions related to the objectives of program. In order summarise the findings, the chapter begins with tabled descriptions of the direct clients of the service, interventions received, duration and outcomes, and three associated figures. Then next two data tables report the health promotion activities of the NMHP. These data are complemented with a summary and final table regarding the qualitative themes from feedback surveys and focus groups, regarding clients' and referrers' experiences of the service. These summarised data form the basis for the subsequent analysis of the program achievements.

Profile of NMHP registered clients

Considerable information is collected routinely regarding nurses who are registered as clients of NMHP, making it possible to characterise the client profile in detail. In the following tables we profile registered clients of NMHP for the 5 years from commencement in 2006 to mid 2011.

In addition to their direct work with registered clients, staff of NMHP deal with phone enquiries in business hours, from nurses, referrers and members of the public. Such calls may relate broadly to the direct service provision function of the NMHP, providing support and advice around mental health or substance use issues, or calls may relate to the health promotion activity, providing health promotion information. The provision of support and information via these phone contacts may be important for the constituency of nurses and midwives. However data about this activity and outcomes is not systematic gathered, so it was not possible to effectively quantify and report this work. From this point forward in the report, direct service findings relate only to the services provided to registered clients, about which there is a considerable and complete data set.

Table 2a (over page) profiles the nurses and midwives engaged in direct service with NMHP from 2006-2011. The summary of all clients is then divided into the two streams: those presenting with a primary substance use problem, being a substantial minority (42%) and those with a primary mental health problem being the majority (58%). This ratio is noteworthy, as staff and management of NMHP initially expected to work with nurses with primary substance use problems. The NMHP staff have expertise in Alcohol and Drug counselling and treatment and in Mental Health Nursing, which is evidently appropriate to the population.

Across all client population categories, there was a close alignment between the population using the NMHP service and nursing population as a whole. For example, the Nurses' Board of Victoria Final Annual Report for 09/10 (NBV 2010b, p8) reported gender distribution of registered nurses: 91% Female (83,919) Vs 9% Male (N=8,457) out of total 92376 registered nurses. This ratio accords with the gender ratio for NMHP clients.

Table 2a: Characteristics of registered NMHP clients 2006-2011

All clients **Characteristics of NMHP clients**	**Total** (N=647)	**Primary Substance Use** N (%) 273 (42%)	**Primary Mental Health** N (%) 374 (58%)
Gender			
Female	533 (82 %)	212 (78%)	321(86%)
Male	114 (18 %)	61 (22%)	53(14%)
Age (years)			
missing data	37 (4%)		
21-30	68 (11%)	26 (11%)	39 (11%)
31-40	144 (24%)	71 (29%)	73 (20%)
41-50	185 (30%)	73 (30%)	112 (30%)
51-60	168 (28%)	52 (21%)	116 (32%)
61 +	48 (8%)	20 (8%)	28 (8%)
(age group total)	610	242	368
Division of Nursing			
1	468 (72%)	202 (74 %)	266 (26%)
2	97 (15%)	37 (14%)	60 (16%)
3	30 (5%)	11 (4%)	19 (5%)
Midwife	15 (2%)	6 (2%)	9 (2%)
Student of nursing	37 (6%)	17 (6%)	27 (7%)
Country of Training			
Australia	613 (95%)	269 (99%)	344 (92%)
Outside Australia English speaking	20 (3%)	4 (1%)	16 (4 %)
Outside Australia NESB	14 (2%)	0	14 (4 %)
Area of Nursing			
Acute (Surgical/General)	157 (24%)	76 (28%)	81 (22%)
Aged Care	117 (18%)	42 (15%)	75 (20%)
Mental Health / AOD	79 (12%)	35 (13%)	44 (12%)
Community	49 (8%)	16 (6 %)	33 (9%)
Student	34 (5%)	15 (6 %)	19 (5%)
Theatre	41 (6%)	23 (8%)	18 (5%)
Midwifery	36 (6%)	11 (4%)	25 (7%)
Palliative Care / Oncology	30 (5%)	10 (4%)	20 (5%)
Critical Care	31 (5%)	14 (6%)	17 (5%)
Emergency Department	24 (4%)	11 (4%)	13 (3%)
Unknown	17 (3%)	7 (3%)	10 (3%)
Other	12 (2%)	2 (1%)	10 (3%)
Administration	12 (2%)	9 (3%)	3 (1%)
Rehabilitation	8 (1%)	3 (1%)	5 (1%)
Which Referral Pathway was used?			
AHPRA	15 (2%)	4 (1%)	11 (3%)
Assisted Referral	43 (6%)	30 (11%)	13 (3%)
Nurses Board of Vic	18 (2%)	11 (4%)	7 (2%)
Self Referral	571 (90%)	228 (84%)	343 (92%)
Metro / Rural & Regional			
Metro	481 (74%)	216 (79%)	265 (71%)
Rural & Regional	166 (26%)	57 (21%)	109 (29%)

Within the population of registered clients, a subset (N=183) were engaged in direct service of a more substantial duration and intensity, categorised by NMHP as case management. Table 2b profiles the subgroup of NMHP clients engaged in case management.

Table 2b: Characteristics of NMHP clients receiving case management 2006-2011

Clients with case-management Characteristics	**Total** (N=183)	**Substance Use** n (%) 127 (69%)	**Mental Health** n (%) 56 (31%)
Gender			
Female	145 (79%)	97(76%)	48(86%)
Male	38 (21 %)	30 (24%)	8(14%)
Age (years)			
missing data	14(7%)		
21-30	1(1%)	1 (1%)	0
31-40	19 (11 %)	14 (12%)	5 (9%)
41-50	42 (25%)	30 (27%)	12 (21%)
51-60	49 (27%)	31(27%)	18 (32%)
61 +	58 (34%)	37(33%)	21 (37%)
(total age group)	169	113	56
Division of Nursing			
1	143 (78%)	100 (79 %)	43 (77%)
2	16 (9%)	12 (9%)	4 (7%)
3	8 (4%)	4 (3%)	4 (7%)
Midwife	4 (2%)	4 (3%)	0 (0%)
Student of nursing	12 (7%)	7 (6%)	5 (8%)
Country of training			
Australia	176 (96.5%)	124 (97.5%)	52(92%)
Outside Australia English speaking	6 (3%)	3 (2.5%)	3 (4 %)
Outside Australia NESB	1 (0.5%)	0	1 (4 %)
Area of nursing			
Acute (Surgical/General)	55(30.5%)	39 (30.5%)	16 (28%)
Aged Care	27 (15%)	15 (12%)	12 (20%)
Mental Health / AOD	20 (11%)	14 (11%)	6 (12%)
Community	12 (7%)	7 (6 %)	5 (9%)
Student	9 (5%)	6 (5 %)	3 (5%)
Theatre	14 (8%)	11 (8%)	3 (5%)
Midwifery	9 (5%) 81	7 (6%)	2 (7%)
Palliative Care / Oncology	7(3.5%)	4 (3%)	3 (5%)
Critical Care	10 (5.5%)	7 (6%)	3 (5%)
Emergency Department	10 (5.5%)	8 (6.5%)	2 (3%)
Unknown	1 (0.5%)	1 (0.5%)	0 (3%)
Other	2 (1%)	1 (0.5%)	1 (3%)
Administration	5 (2.5%)	5 (4%)	0 (1%)
Rehabilitation	2 (1%)	2 (1%)	0 (1%)
Which Referral Pathway was used?			
AHPRA	4 (2%)	2 (1%)	2 (3%)
Nurses Board of Victoria	12 (7%)	9 (7%)	3 (5%)

Employer Assisted Referral	29 (16%)	27 (21%)	2 (3%)
Self Referral	138 (75%)	89 (70%)	49 (89%)
Metro / Rural & Regional			
Metro	131 (72%)	96 (75%)	35 (62%)
Rural & Regional	52 (28%)	31 (25%)	21 (38%)

Compared with the Table 2a, this table shows the load for presenting or primary problems is reversed. That is, more clients presenting with primary substance use problem received this higher intensity of case management (69%) at NMHP, compared with mental health presentations (χ^2 (1, N = 523) = 278.52, p= 0.000). The proportion of NMHP clients from metropolitan and rural settings that received case management was similar to the proportion in the caseload overall.

Other trends regarding caseload intensity relate to gender and age of case managed clients. A higher proportion of male clients have received case management compared with the proportion of male clients registered with NMHP overall. The clients with case management have been of notably older age than the registered NMHP clients overall and case managed clients were also older than the nursing workforce. A smaller majority of case managed clients were self-referred, compared with NMHP clients overall.

Profile of NMHP direct service provision

Direct services to registered clients included a mix of: face-to-face assessment, brief interventions (ie up to four face to face contacts), phone support, counselling, facilitated support groups tailored to mental health or substance use problems, community based peer support group (substance use only), financial or legal counselling and referral to primary care, specialist and other services. Additional case management activities included: monitoring of substance use, negotiation with specialist or primary care treatment, mediation and advocacy between the nurse and the employer and/or staff of the regulator.

Table 3 characterises the services and interventions received by clients of NMHP. The sample for the table (n=523) is smaller than the whole client population (N=647) for the evaluated period, because it excludes ongoing cases (n=124).

Table 3: Interventions for registered clients – completed cases 2006-2011

Interventions	**Total N= 523**	**Substance Use** n=245	**Mental Health** N=278
Screening & Referral	111 (21%)	35 (32%)	76 (68.5)
Assessment/Brief Intervention	229 (44%)	83(36%)	146 (64%)
Case Management	183 (35%)	127 (69%)	56(31%)
Duration In Days Range (Med/IQR)	1-1153(131/154)	1-1153 (152/200)	1-989 (114/118)
Non- Case Management: Additional Interventions:- (N=340)			
NMHP Support Groups	35(10%)	26 (74%)	9 (26%)
Counselling	101(30%)	33 (33%)	68(77%)
Community Group Attendance	71(20%)	39(55%)	32(45%)
Finance/Legal	17(.05%)	2(12%)	15(88%)

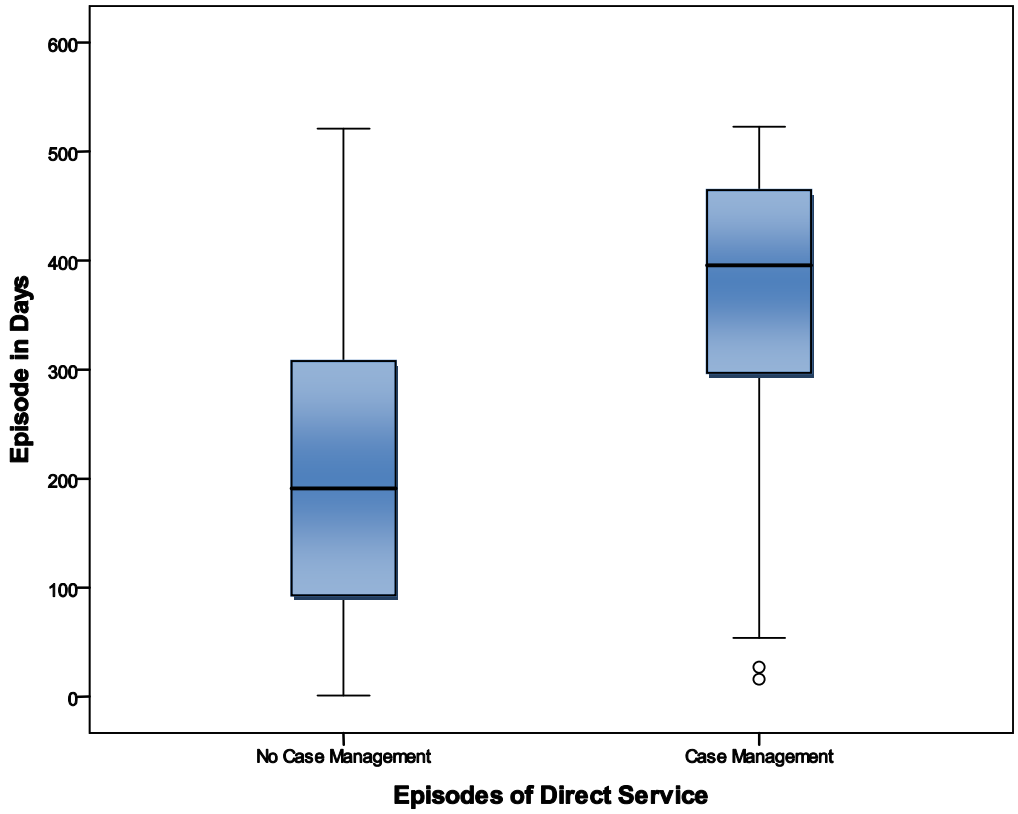
Case Management: Additional Interventions:- (N=183)			
NMHP Groups	73 (40%)	69 (95%)	4 (5%)
Counselling	63 (34%)	47 (75%)	16 (25%)
Community Groups	45 (25%)	38(85%)	7(15%)
Finance/Legal	7 (4%)	5 (71%)	2 (19%)
Duration In Days Range (Med/IQR)	11-1153(234/195)	11-1153(236/223)	63-533 (217/166)

This data sheds further light on differences in care pathways for clients with primary mental health problems, versus clients with primary substance use problems.

This data builds a picture of the service mix, in terms of service elements, complexity, duration and intensity of engagement for clients. At the more intensive end, the service model does not equate to any other service or practice in Victoria. It does accord with the complex services provided by NHPs in some jurisdictions in the USA.

Figure 2 highlights duration of completed episodes of care, comparing duration for clients receiving case management or not.

Figure 2 Duration of Complete Episode for Case Managed and Non-Case Managed Clients 2006-2011



This figure confirms that duration of direct service is significantly longer with case management (N= 183) than without case management (N=340), as earlier noted (χ^2 (1, N = 523) = 278.52, p= 0.000). This adds to the picture of case management as a more substantial direct service, distinguished from time-limited interventions such as are common for EAP programs.

Outcomes for clients of NMHP

Table 4 reports outcomes for clients of NMHP at the point of case closure. Outcomes in terms of employment are very important to nurses and a priority for the NMHP. These results should be read with caution, because the data routinely collected at NMHP regarding work status were weaker than most other fields[4].

Table 4: Outcomes for all clients & for case managed clients

Employment Outcomes - all registered clients	**Total N=523**	**Substance Use** N =245	**Mental Health** N =278
Supported To Remain At Work	252 (48%)	119(49%)	133(48%)
Not Applicable Or Not Known At Time Of Closure	142 (22%)	77(31%)	65(23%)
Has A Return To Nursing Plan In Place	78 (15%)	27(11%)	51(18%)
Returned To Work In Nursing	51 (10%)	22(9%)	29(10%)
Employment Outcomes - Case managed clients	**n= 147**	95	52
Supported To Remain At Work	84 (57%)	62 (65%)	22 (42%)
Has A Return To Nursing Plan In Place	30 (20%)	14 (15%)	16 (31%)
Returned To Work In Nursing	33 (22%)	19 (20%)	14 (27%)

Table 4 shows that the majority of clients are supported either to remain at work or return to work (58%). For almost a quarter of the completed cases, work status was not known or captured at the exit point. This may be due in some cases to clients ceasing contact with NMHP. Some clients are actively assisted to plan for return to work (15%). For the subset of clients who receive case management, 77% are working at closure and the remainder have a Return to Nursing plan in place.

Table 5 highlights the profile and outcome of the minority but important subset of clients who were referred by others to NMHP, from 2006-2011. Clients may be referred to NMHP by a colleague, by the employer or by the regulator following a notification, all termed 'assisted referral'. The fact that another person made the referral to NMHP (versus self-referral) indicates that there was a perception by someone else that the mental health or substance use problem had impacted the nurse's practice in some way. Therefore, these assisted referral pathways also signal potential for harm to patients. Inputs and outcomes for this client group are important to explore, because the stakes are high for the nursing careers of these clients and also for their safe practice with patients. In many fields of the table the numbers are small; in these instances percentages are not included.

[4] Data and definitions for data fields regarding clients' work were problematic. Work status was not known at closure for many clients with brief interventions. Work status at registration was later used by case managers to determine the outcome field: "supported to remain at work". But work status at entry did not differentiate those who have continuing employment status and took annual leave or sick leave at point of registration with NMHP. The data field completed at case closure labelled "returned to work in nursing" only captured those who were not employed at registration. Where a client retained employment but was on leave, or negotiated work return themselves, these cases could also (by default) be assigned to the group 'NA or Not known at time of closure'

Table 5: Characteristics and outcomes for clients referred by employer or regulator during 2006-2011

Assisted Referrals
Total No: 76

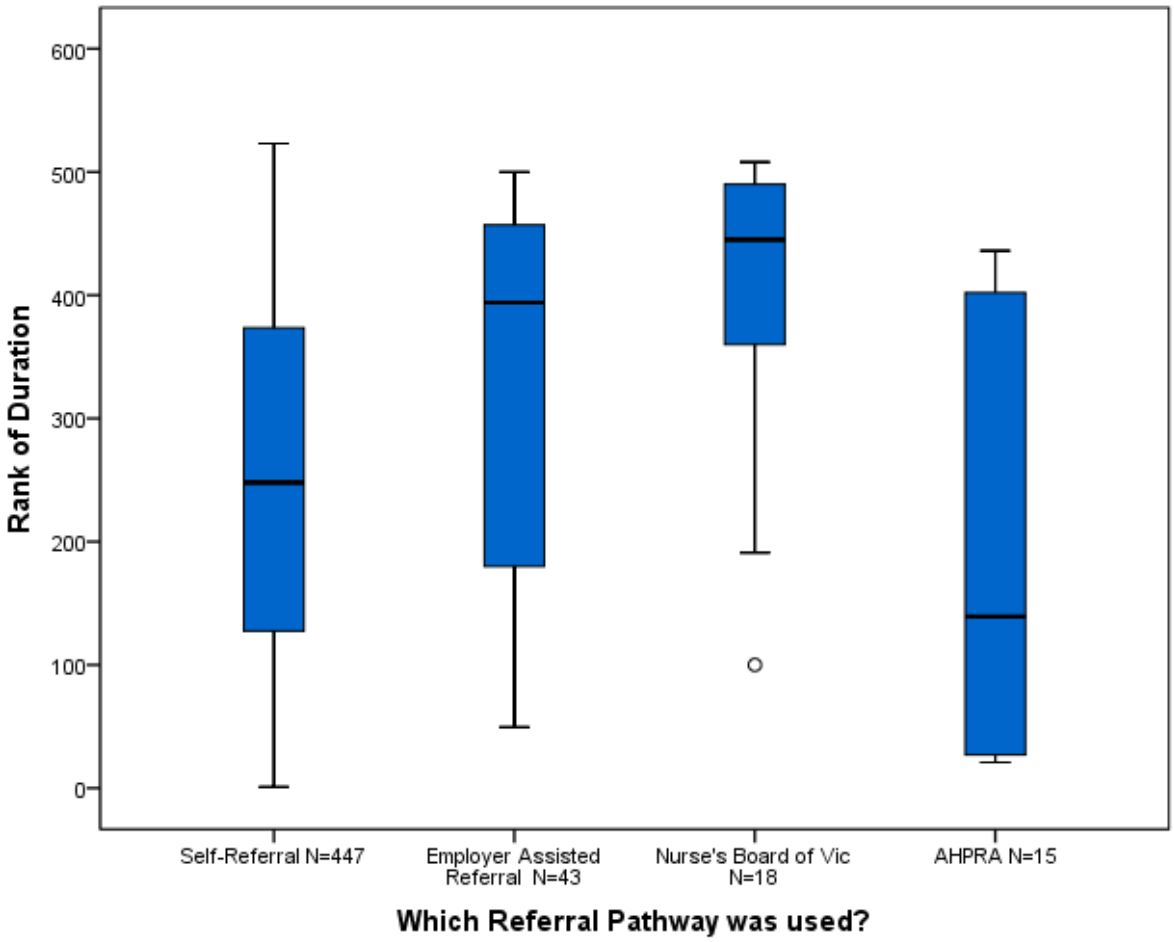
	APHRA	**Nurses' Board of Victoria**	**Employer Assisted**
Primary Problem			
Substance Use	4	11	30
Mental Health	11	7	13
Interventions			
Case Management	4	12	29
Assessment/Brief Intervention.	2	4	5
Screening & Referral	0	0	2
NMHP Support Groups	0	7	16
Counseling	2	6	13
Community Support Groups	0	3	10
Financial/Legal	0	0	3
Outcomes			
Duration Of Episode Range in Days (Median/IQR)	21-436 (190/385)	100-508 (445/152)	49-500 (394/293)
Employment Outcomes:			
Supported to remain at work	1(7%)	6(33%)	20(46%)
Has a return to Nursing Plan in Place	2(13%)	7(40%)	5(12%)
Returned to work in Nursing	2(13%)	2(11%)	6(14%)
Incomplete Episodes	10 (67%)	3(16%)	12(18%)
Health Outcomes			
Has Been Given Relevant Information Regarding Their Condition	6	16	36
Maintained Healthier Pattern Of Substance Use /Identified Behaviour	3	11	23
Commenced Personal Health Program incl. GP/Counseling/Community Support Groups	3	12	26
Care Plan Developed Appropriate Referrals	4	14	30

The data shows that service intensity and duration was fittingly greater for this group and the employment outcomes were as good as for self-referred clients, at 73% of completed cases.

Considered together with Table 2b, this data shows that nurses and midwives with substance use problems were more often referred to NMHP via employers or regulators and more often receive NMHP case management, compared with the group presenting with mental health problems. This pathway and intensive response suggests they represent as a group the more serious end of the spectrum of need for support.

Figure 3 (over page) shows the relative duration of service for clients depending on the referral pathway. This comparison highlights the differences in service provided to clients who were self-referred, versus those clients referred by others.

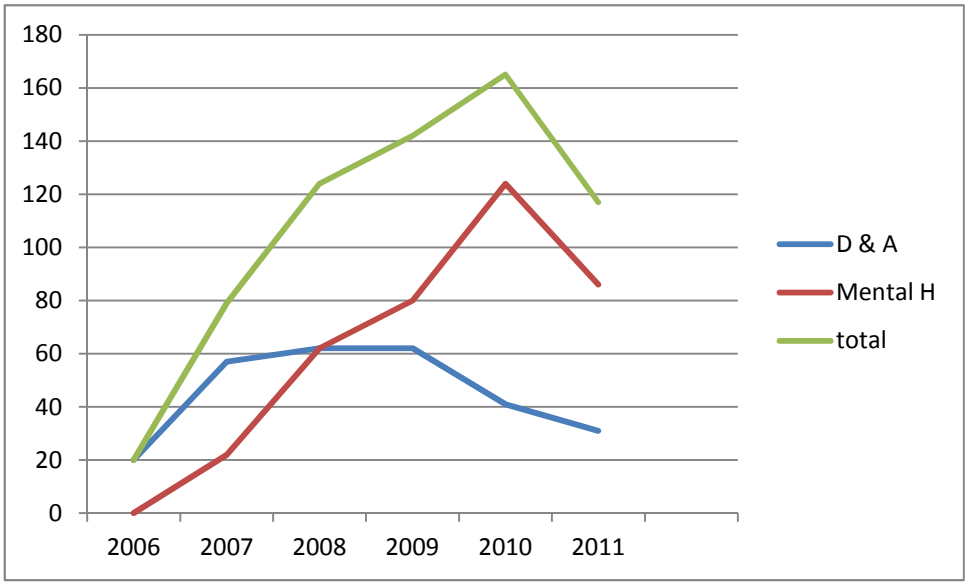
Figure 3 Duration of Episode for Each Referral Pathway



Clients with assisted referrals were managed for longer than self referrals, except in the case of the 15 referrals from AHPRA. APRHA was a new referral source in 2009/10 and therefore many AHPRA referred cases were still open/incomplete at time of reporting, are not included in the sample. Even including the completed AHPRA referred cases, the difference in duration between self referred and other referred is significant ($\mathcal{X}^2$ (1, N = 523) = 320.43, p= 0.01).

Having characterised the case load, services provision and client outcomes overall and for different referral pathways the following Figure 4 (over page) identifies trends in referral over time. It shows growth in referrals since commencement, and the differentiation of increasing referrals for primary mental health problems, versus relatively stable referral numbers for substance use problems.

Figure 4 NMHP referrals over time



The apparent decrease in overall referrals from a peak in 2009/10 to 2010/11 is explained by NMHP staff as due in part to two factors: the levelling off since 2008 of new cases for primary substance use problems and a particular peak of mental health referrals in 2010, following the Victorian bushfire disaster. The NMHP service administrator reports that the referrals for financial year 2011/12 were 204 in total. However, detailed analysis of data from this most recent year is outside of the timeframe granted ethics approval for this evaluation.

Health promotion activities of NMHP

Table 6a summarises work that NMHP staff undertook in community education and health promotion activities, on a regular basis. The CEO and members of NMHP staff have speaking engagements in hospitals, universities, other healthcare providers, industrial organisations and at conferences across the state and country. Events and numbers of participants were routinely reported in quarterly and Annual Reports.

Table 6a: Health promotion activities of NMHP

	Health promotion settings	# events	# participants
	To Hospitals & HR	39	4326
	To Universities	10	890
August 2010 -July 2011	Peer Support, Other Health Care Providers and Unions	13	1450
	Conferences	23	6100
	Total health promotions	**85**	**12766**

In addition to these activities, the NMHP offers health promotion information on its website, including in-house publications and links to a wide range of resources and social service organisations related to substance use and mental health issues. Web tracking has only occurred

since the organisation became the NMHP in 2010. Table 6b summarises twelve months of activity on the website.

Table 6b: Health promotion via NMHP website

April 2011- May 2012	Unique Visitors	Number of Visits	Pages Viewed
Total	**2,743**	**4,394**	**17,980**

The table above details the levels of activity recorded for the NMHP website, indicating the utility of this resource. The data for the earlier 2010/11 financial year showed 1600 unique visitor to the website who viewed 11,000 pages of data.

One further set of data gathered at first contact reflects the health promotion aspect of NMHP. That is, at point of registration clients report the ways that they learned of NMHP and/or were encouraged to contact NMHP.

Table 7: How clients of the direct service gained information about NMHP

How Did You Hear About NMHP?	Total	Episode Year 2006	2007	2008	2009	2010	2011
Union	167	2	7	24	40	50	44
Employer	122	2	11	24	31	36	18
NBV/AHPRA	95	6	19	24	15	5	26
Doctor/Health Service	73	3	13	22	16	13	6
Media	62	3	6	8	20	23	2
Colleague	44	1	9	10	5	13	6
Other	74	1	9	11	15	25	13
Not Known	10	2	5	1	0	0	2
Total	647	20	79	124	142	165	117

Table 7 indicates that nurses were advised or assisted to contact the service by employers and regulators and other nurses. It is clear that the NMHP is known and accessed by nurses, doctors, employers and regulators. It is notable also that many more clients are given information about NMHP by colleagues or employers and staff of the regulatory agencies than are formally referred by those same agencies. This action shows that key members of healthcare sector are supporting an alternative-to-discipline response and assisting nurses to self-refer for help. This development reflects a less stigmatised response to nurses' problems than could be the case. This finding speaks to the health promotion role of the NMHP.

Qualitative findings: stakeholder views of NMHP

The following is an analysis of the qualitative data gathered for the project. After introducing the key themes, data extracts are tabled to illustrate to each theme. The data highlight elements of the program that were considered by stakeholders (ie NMHP clients and referrers from the regulatory bodies and employers) to be important and effective.

Effusive positive feedback

All stakeholders were unstintingly positive in feedback about their contact with NMHP. In the case of clients of the service, the emotional tone was often intense, also surprised and grateful. Clients spoke of the most valued program details, including one to one counselling, common ground with other nurses in groups, and the powerful change effected in their lives as they worked with NMHP. Referrers used superlatives to describe NMHP staff as highly effective, knowledgeable, empathic and competent. Referrers described a feeling of relief in knowing the NMHP was involved in a case, feeling that the burden for important decisions was shared and that the judgments of the NMHP staff could be trusted.

Value of nurse as case manager

Clients frequently identified the importance of the peer element, as providing solidarity with the nursing discipline; they also valued affirmation of the client's nursing identity by a nursing counsellor. Clients expressed relief in regard to their work demands being understood by NMHP staff. They praised the practical assistance and advice that was applicable to their work setting. Referrers and regulators identified the expertise of nurse case managers providing advocacy and mediation in meetings. They noted how NMHP could articulate issues and potential solutions that were very fitting to the client's work situation and also to the complex demands and issues relevant to management of different nursing services.

Expert advice/ consultancy

All stakeholders looked to the NMHP as experts in the high stakes situations. NMHP were relied on to provide advice regarding elements of workplace safety, workplace dispute, nurse competence, relevant laws and regulations, support and intervention for the presenting problems. Expert and timely health and safety advice was valued by for employers, expert resource in mediation and in exploring options was valued by regulators; expert advice was valued by clients, regarding treatment options, practical work and lifestyle changes and approach to workplace negotiations.

Barriers to attending

When pressed to identify shortcomings of NMHP service, all participants returned to an issue of increased access to the service. They mentioned the need for support or phone consultancy at times of day out of business hours, the travel cost and travel time for clients, and the need for expansion of community based support groups. The stigma and shame associated with distress and not coping, and the stigma of substance use problems in particular was identified by clients as a barrier to help-seeking. They considered this needed greater action, via activities such as work-based education programs for nurses and managers, and campaigns to improve occupational health for nurses.

Desire for more information

Clients and employers wanted more accessible information and more routinely visible information, for example embedded in HR processes, to inform colleagues and workplaces about the likelihood of such problems and the available supports. This would reduce delay in help-seeking, prevent more severe problems.

Table 8: Extracts illustrating themes from clients and referrers surveys and focus groups.

Theme	Data extracts
Effusive positive feedback	**emotional tone: intense, surprised, grateful** *Couldn't speak highly enough of this program. Also my case manager has been amazing at providing support… (survey)* *I found your program invaluable as I didn't feel ashamed, embarrassed or degraded when I was at my lowest and extremely vulnerable. When I left groups and individual sessions I always felt uplifted and motivated,.. (survey)*
	valued program details *I cannot put a price on how much Monday night sessions and the group means to me. It is a life saver!! (survey)* *Biggest benefit was one-to-one sessions. Beneficial to know there are others out there in similar positions and being able to talk to them. The one-to-one support was invaluable and helped me reconnect and develop local support networks (survey)*
	powerful change *Without this group I don't think I could have been so successful in my recovery. I have been attending this group for nearly 2 years (survey)* *And the fact that when I first met my contact [at NMHP] I felt like the nursing profession didn't betray me when I really needed help (client focus group)*
Value of nurse as case manager	**Peer element, solidarity in the discipline** *To have a counsellor from a nursing background, who was clearly independent from NBV and employers, was absolutely refreshing and I felt I was able to talk freely (survey)* *in this circumstance it's just totally understood, I think, because they've probably been there. Unless you've been in it - it's like a war zone… nobody else knows what the war zone is like… (client FG)* *The non-judgmental, positive, empathetic, relevant support from actual nurses not just counsellors. Thanks for helping resuscitate my nursing career [original emphasis]. (survey)* *The case workers understood the changes in nursing and the work opportunities around, that could bring satisfaction (client FG)*
	Advocacy and mediation in meetings *So, I had one of them [NMHP] come along to one of the interviews that we had and he would just pick up the bits where I started to get a bit lost or a bit off what*

	I needed to say. And that really helped…(Client FG) *And when you're in the interview situation you might ask the [NMHP] practitioner and they might give you not the straightest answer. But then the support person will just say, "I think Joe or Andy wants clarification here. Can you just elaborate?" They can just help aid so you can actually get to the crux of the matter… (Regulator FG)*
Expert advice/ consultancy	**Expert advice for employer** *The approach has been extremely useful. As a DON [sic, Director of Nursing] I am pleased that I have another 'tool' to use to manage these difficult situations in my workforce. Telephone contact excellent and regular written reports excellent and inform my HR processes (Employer FG)* *I got great communication, clear management plans, support and advice. Most importantly a positive outcome for the staff member (Employer FG)*
	Expert resource and support for regulator *From someone who's working for the regulatory authority I always found it reassuring for myself too knowing, as soon as we knew that someone from the Health Program was coming in with a nurse you'd sort of think, "Oh, thank God." Because you knew it was going to go OK on most parts. (Regulator FG)* *every letter that we sent out to a nurse advising them about a complaint in relation to their conduct or health or performance. a pamphlet would go out advising them to seek support through the Victorian Nurses Health Program… (Regulator FG)*
	Advice for client *They [NMHP] say to you, "OK, if you can't go back to that environment it's OK. There are other opportunities out there for you that perhaps would be better suited for you." So they don't have a bias, compared to in your own workplace,…(client FG)* *They seem to sort of, you know, allay that fear and debrief that stress and give them some strategies on how to deal with things and then how to move forward (regulator FG)* *Making sense of an unfamiliar situation, guidance advice help in dealing with NBV(survey)*
Barriers to attending	**Time of day, travel cost & travel time, stigma:** *I have a young child as well. So, it was - I probably brought my child in twice and he slept while I was talking fortunately (Client FG)* Hours of 9-5, Monday to Friday were problematic for the referrers because they limited the chance to refer shift working nurses (referrers FG) Several of the rural/regional referrers spoke of fears when describing the

	professional issues in their context. (referrers FG)
Desire for more information	**to inform colleagues and workplaces:** *There needs to be much more awareness of NMHP in workplaces. I could have used the services several years ago.(survey)* *Have more information sessions at hospitals about your role and get mentioned on hospitals intranet [sites].(Client FG)* *Expand the program and make more nurses aware of services. Emphasise that it is not just about problems with D&A and the services are just as helpful for dealing with stress and preventing more serious mental health problems (survey)*

The overarching feature of the qualitative data was the way NMHP met the expectations of the range of stakeholders, even though these groups sometimes had competing interests, leaving each group highly satisfied. Participants from each group expressed accounts of the NMHP meeting their own needs. They also reported experiencing and witnessing expert brokerage across the groups: nurse, employer and regulator. None of the participants involved with NMHP experienced the NMHP as showing partiality or taking one side in a potentially fraught situation of dispute. As disinterested researchers, we were told by the stakeholder participants that the NMHP provided valued support to all parties, but that in the end NMHP was on the side of the patients, ensuring safe practice.

Outside of this program evaluation project, NMHP requested a provisional estimate of the cost of losing experienced nurses from the public health system in Victoria. This advice was sought from a Research Fellow, Centre for Health Economics, Monash University. The account by Dr Paula Lorgelly is tabled in Appendix 4. *Economic evaluation of NMHP impact on healthcare costs related to nursing workforce*.

Having provided this descriptive data and analysis of relevance to the evaluation, the following section of the chapter directly addresses the evaluation questions arising from the program logic. The achievement of objectives is summarised in Table 9 (over page) and explanations for each one follows, from foundation level objectives to high level objectives.

Table 9: Achievement of objectives in NMHP program logic

Aim	4:Increase the safety & health of practicing nursing & midwifery workforce			
Highest level objectives:	1:13 Improve health of N&M workforce	1:14 Reduce loss to workforce	2:7 Decrease stigma of D&A, MH problems among N&M	3:6 Increase knowledge re effective model of service provision
	1:11 Improve health of N&M experiencing A&D /MH issues	1:12 Increase return to workforce after episode of care	2:6 Increase awareness of D&A, MH problems across N&M	3:5 Add to existing research re N&M needs & services
	1:9 Improve /sustain registered clients' health	1:10 Increase early inquiries (from nurses still in work)	2:5 Increase awareness among N&M of supports available	3:4 Benchmark NMHP against other services
(transition)	1:7 Reduce rate of re-referrals	1:8 Increase 'return to work plans', retained in work	2:4 Increase links with /HP info to employers	3:3 Evaluation activities show impact of NMHP
	1:5 Increased inquiries / self referrals	1:6 Increase uptake of supports in primary care	2.3 Increase HP activity among groups of N&M	
(delivery)	1:3 Demonstrate referrals /registered clients across nursing work settings	1:4 (links to primary care providers) establish/use selfcare tools	2.2 Increase awareness of supports available	3.2 Produce detailed information about the work of NMHP
Key initiatives commenced	1:1 Accept referrals & provide information	1:2 Provide case work/ Episodes of care	2.1 Tailor HP & share information for N&M	3.1 Establish governance , planning & reporting systems
	Priority 1: Service provision		Priority 2: Health promotion	Priority 3: Organisational (best practice) model

Extent to which NMHP objectives are achieved:

Objective fully achieved	
Objective partially achieved / strong evidence	
Objective partially achieved / limited evidence	
Objective not yet achieved / no evidence	

Key findings related to foundation level objectives, key initiatives and program delivery: all objectives achieved, with strong evidence

Priority 1 - Service provision

Four foundation level objectives were evaluated under this priority.

1:1 Accept referrals & provide information

Referrals to and direct service provision by NMHP has steadily grown. Demand grew from 20 cases in the first year to 117 cases in 2010/11.

Qualitative feedback data from clients and referrers suggests that first contact is very satisfactory. As on many fronts, survey feedback regarding access is unstinting positive. The only mentioned service gap is crisis access: "always get the call on Friday afternoon."(AHPRA member).

Lack of gaps suggests the team is maintaining nimble or flexible approach, not constrained by a bureaucratic burden. Such responsiveness may not be typical of public sector mental health or drug and alcohol services after 5 years of service.

1:2 Provide case work/ Episodes of care

Data shows growth in direct services provided over time: *see Figure 2: Growth in referrals over time.*

In addition, routine data shows how NMHP has developed and is providing **case work across a range of intensity:** evident in durations of episode data. Duration of episodes of care range from 1 to 1153 days, median duration was 131 days, between 4 and 5 months (IQR= 154 days). At the intensive end of the service spectrum, NMHP worked with 183 clients in case management over the 5 years. The median case management episode duration was 234 days, or almost 8 months (IQR = 195 days)(S*ee also Table 3 and Figure 4).*

1:3 Demonstrate referrals /registered clients across nursing work settings

The representativeness of the registered client population is striking. Nurses and midwives accessed the services equitably across gender, age, division of register, work setting and geographic regions, apparently in line with nursing population. The accord is illustrated, for example, by the female/male ratio of 82%/18%, close to NBV figures of 90%/10% registered nurses in 2009/10 *(See also Table 2a).*

1:4 Use self-care tools and establish links to primary care providers

According to qualitative data, self-care and problem solving is the core content of individual sessions. Routine client care involves referral to GP and other supports. Case closure includes linkage to primary care service/GP provision of self care materials.

It's entrenched, that it must be something I've done wrong rather than, you know as you mentioned, it's a bit endemic of the system itself. And you - they really offered that you're feeling this way for a reason and it's OK to feel the way you're feeling. And they came up with strategies for me, really,

really good strategies, and are still coming up with good strategies when I need it, that I've never thought about, you know, to protect. (Client FG)

And they put me in touch with other referrals, which was support to help me to pull me ahead. I needed treatment for a while and I needed extra support for a while. So, that was indeed very helpful. (Client FG)

Summary: There is clear ongoing demand for the direct service, evidence of a service response that is accessible, flexible, and of service intensity targeted to needs and a high level of satisfaction with NMHP services received.

Priority 2 – Health promotion

Two foundation level objectives are reviewed under this priority.

2.1 Tailor & make available HP information for N&M

This objective is achieved through NHMPs multi-media and communications strategy. Achievement is evident in the range of NMHP resources, such as brief articles loaded on the NMHP website and the rate of hits and download-demand for the website. Web tracking of activity on the site for 2011-12 showed 2743 unique visitor to the website viewed nearly 17,000 pages of information. (*See Tables 6a and 6b).*

2:2 Deliver HP messages to populations of N&M

This objective is clearly achieved through an ongoing strategy and program of nurses' education delivery at events, evident through publicly available NMHP activity reports. This large volume of education and workshops (such as 85 events and more than 12,500 nurses contacted in 2010/11 financial year) are undertaken primarily by CEO; other team members engage in peak opportunities.

Summary: the NMHP is increasingly active, experienced and recognized for provision of tailored Health Promotion to nurses and midwives, employers and other stakeholders.

Priority 3 – Good governance

Two foundation level objectives are reviewed under this priority.

3:1 Implement clear governance, planning & reporting systems

Transparent governance is achieved through the governing Board, and provision of Terms of Reference, minutes of meetings and membership. Governance is laid open to public scrutiny through Board profiles, and publicly available Annual Reports, including financial statements *(see Appendix 2).* Governance has been amended over time to reflect changes in regulation and funding process.

3:2 Produce detailed information about the work of NMHP

This objective is achieved through regular reporting channels, documents endorsed by the Board; as evident and made available on the NMHP website.

Summary: The NMHP as a public sector not for profit organisation has maintained an active and effective Board, with representation of major stakeholders, through which the program is transparently governed.

Key findings related to intermediate/mid level objectives: all objectives partially achieved, with strong evidence to support that conclusion

Priority 1 - Service provision

Six intermediate level objectives are reviewed under this priority.

1:5 Increase inquiries / self referrals

This objective is met. Self referral is assumed to be a better and earlier pathway to recovery. Clear evidence shows that the numbers of referral from others has remained steady but self-referral to NMHP has increased, from 80% of all referrals in 2006 to 93% in 2010 and 89% in 2011.

Qualitative data shows that re-engagement is highly acceptable to past clients and these nurses actively encourage self-referral by any peers:

I liked about the Victorian Nurses Health Program was the referrals as well and the fact that they were able to refer me on and they were able to be there for me even when I didn't need them all the time. But whenever I needed them then I could sort of come back to them as and when and they could always be there for me. You know, there was a different caseworker but they would always pick up from - you know it was - you know. (Client FG)

Looking at subgroups of clients, the rate of referral for the nurses with presenting substance use problems has remained steady, as has the rate of self-referral for these problems, over the 5 years. This finding is in keeping with international alternative-to-discipline programs, but suggests that disclosure of substance use problems may well remain stigmatised.

1:6 Increase uptake of supports in primary care

This objective is partially met, as there can be no statement of how comprehensively. Evidence from the routine data is confirmed in qualitative accounts, that registered clients are actively referred to primary care and that this rate has increased in keeping with the increased caseload. Still the NMHP caseload represents a modest sample of the larger population of nurses and midwives who may benefit from such support. Also we have no measure of the extent to which clients remain engaged with primary care.

1:7 Reduce rate of re-referrals

This objective is partially met, as there are indeed low rates of re-referrals. The rate of re-referrals to NMHP is consistently very small over the five years; it is not possible to analyse trends over time in regulator and employer re-referral, with such small samples and no baseline data. Focus group data suggests that AHPRA staff experience low rates of repeat complaints regarding nurses engaged in NMHP, and that this may be different from other discipline groups and jurisdictions.

1:8 Increase 'return to work plans', retained in work

This objective is partially met, as again there is clear evidence of return to work plans among NMHP clients. The rate of nurses and midwives remaining in work and/or returning to work has been steady across the duration of the service at 58 % of all completed cases. This number is likely to be a underestimation of the percentage who are working after an episode with NMHP, as it excludes continuing cases (20%) and missing data (22%) for cases from earlier database systems.

It is notable that nurses out of work would not be eligible for EAP support to assist return to work. In survey feedback and in focus group, nurses explicitly stated that NMHP support had prevented them leaving nursing:

For me, personally, I feel that it made a difference between actually continuing to work and not to. And actually at one point I actually was - decided not to work because I was under so much pressure emotionally. And I thought I wasn't going to cope with actually continuing to keep my job. And Victorian Nurses Health Program helped me to get back on my feet and actually manage to pull through at a vulnerable time and keep my job (Client FG).

The additional 78 nurses with return-to-work plans represent important workforce gains in Victoria. The extent to which return-to-work-plans are fulfilled after case closure is untested.

1:9 Improve clients health / sustain health improvements

This objective can be demonstrated as achieved in some cases, therefore is partially met. The quality and quantity of data gathered regarding clients' health gains is not strong enough to demonstrate improvements across the client population; the qualitative data shows health gains made and sustained for participating nurses and midwives.

We're talking all professionally here. But what does it do to your own personal self esteem, you know? Because some people, they just crumble. I mean it'd take a lot to recover that to think that you were worthwhile enough to contribute anywhere, to your family, to another profession. That's what would have happened to me anyway. (Employer FG)

1:10 Increase early inquiries (from nurses still in work)

The program has achieved some progress regarding this objective. From a baseline of no specialist service prior to NMHP, the team demonstrates high rate of self-referral of nurses and midwives that are still working. Though participants report taking advice to prevent a crisis, and offering advice to others regarding seeking help early, strong evidence to support this objective is lacking. The rate of enquiries and referrals increased over five years; whether or not these approaches are made earlier cannot be ascertained.

Summary: The service data is not sufficiently nuanced to definitively answer these evaluation questions about effectiveness. Qualitative data shows good effects for those participants.

Priority 2 – Health promotion

Three intermediate level objectives are reviewed under this priority.

2.3 Increase HP activity among groups of N&M

This objective is partially achieved by continuing program of HP activities; this is evident in the events such as the 2010 conference with strong self-care theme, engaging nurses actively in workshops as well as information based activity. These are clear instances of active engagement, but evaluation cannot robustly establish the education penetration across workforce or self-care uptake in everyday.

2:4 Increase links with /HP information to employers

This objective is partially met, as some employers are clearly informed themselves and actively linking nurses and midwives to supports. This can be seen in the rate of clients being advised to attend NMHP by their employer *(see Table 7: How did you hear about NMHP?)* and as supported by comments from referrers' focus group. There will be healthcare employers in Victoria who have not had contact with NMHP.

2:5 Increase awareness among N&M of supports available

There is limited evidence for partial achievement of this objective. The participants from all focus groups reflected on learning and gaining awareness from dealings with NMHP. Here and in surveys, NMHP clients reported a baseline of little awareness themselves of supports prior to contact with NMHP, and an increased awareness in their own experience, their workplace and colleagues. Some instances, such as peer referral to NMHP, indicate awareness among some nurses and midwives. No data is available to report baselines or trends in awareness across the whole workforce.

Priority 3 – Good governance

Two intermediate level objectives are reviewed under this priority.

3:3 Evaluation activities to demonstrate the impact of NMHP

The NMHP has since inception provided to the public regular reports at a governance and quality assurance level, but the indicators and reports have not been designed to produce rigorous evidence of impact. So there is clear evidence that that the objective has been partially achieved. This evaluation project substantiates that research and evaluation activity is undertaken by NMHP.

3:4 Benchmark NMHP against other services

There are at present no services and data in Australia or internationally with which NMHP is benchmarking. This evaluation provides a starting point from which NMHP may negotiate a benchmarking arrangement.

Summary: The absence of a comparator service or detailed array of outcome data for NMHP limits capacity to evaluate mid level achievements with a high degree of certainty. Census and other population data suggests that many more nurses and midwives will experience problems of mental health or substance use than are currently seeking help from the NMHP.

Written and focus group feedback from clients of the service show consistently that there is still a low level of awareness of the NMHP service among ordinary nurses, leading to later referral than is desirable.

Key findings related to highest level objectives and program aim: Most objectives partially achieved, with limited supporting evidence

Priority 1 - Service provision

Four high level objectives are reviewed under this priority.

1:11 Improve health of N&M receiving service

Limited evidence suggests this objective is partially achieved. Some evidence for health improvement among NMHP clients is reflected in qualitative examples, such as:

Without this group I don't think I could have been so successful in my recovery. I have been attending this group for nearly 2 years (survey)

It [NMHP] is not just about problems with D&A and the services are just as helpful for dealing with stress and preventing more serious mental health problems… (survey)

No systematic data provides evidence of health improvements sustained beyond engagement in the program. Anecdotally the Focus Group participants from the regulator discussed fewer re-referrals for nursing cases, when compared with other professions they monitor.

1:12 Increase return to workforce after episode of care

The routine data provides evidence of 51 nurses and midwives returning to work, and 252 retained in work at the point of closure, over the 5 year period. This data is supported qualitatively with accounts from some participants that they were either prevented from leaving nursing, or assisted to regain work in nursing:

At one meeting someone brought up having no structure in their life and it made me realize I don't either. After my second relapse, it made me think. I have since returned to work and am starting to get structure back in my life.

Though this raw number of nurses returning to work is modest, economic analysis *(see Figure 7)* suggests that this level of impact has a substantial cost benefit (estimated $7.23million) to the Victorian Healthcare sector.

The rate or nurses working at the time of referral balances against evidence of clients engagement in workforce at end of episode.

1:13 Improve health of N&M workforce with experience of A&D /MH issues

This objective is partially met, as evidenced by extension of 1:11; that is we are informed by some Victorian nurses that their own health is improved.

1:14 Reduce loss to workforce

Evidence in the form of accounts from the client group suggests this objective is also partially met (*See objective 1:12*). Individual nurses report that NMHP specifically prevented them leaving work in nursing, a key aspect of client satisfaction and a source of pride for those nurses.

Summary: Many factors apart from engagement with NMHP will impact Victorian nurses' health, so aim to impact at this level is ambitious. We elicited not one single items of evidence that NMHP engagement had a detrimental effect on health, or work readiness, retention or resumption. This is relevant because health harms and loss to workforce following disciplinary processes are evident in the literature.

Priority 2 – Health promotion

Two high level objectives are reviewed under this priority.

2:6 Increase awareness of D&A, MH problems across nurses and midwives

This objective is partially achieved: The numbers of nurses in contact with NMHP education is substantial, but the size and the turnover in the workforce is greater. Qualitative data suggests that many people in contact with registered clients have not heard of NMHP.

2:7 Decrease stigma of D&A, MH problems among nurses and midwives

This objective is also partially achieved. It is difficult to determine attitudes across the broader population of nurses and midwives, but all qualitative data shows change to positive and de-stigmatising attitudes (reduced self-stigma) in the client population themselves and among employers and members staff of the regulating bodies. A level of reluctance on the part of nurses to seek help, prior to engagement is reported by clients of the service. This feedback affirms that the problems of mental health and substance use and related help-seeking are currently stigmatised, among nurses and midwives.

There is evidence that stigma is decreased among some nurses, particularly program participants. Strongly positive statements from clients about the quality and impact of service are provided after service was received, despite reluctance initially. Statements of willingness to recommend the service to others are evident across all client feedback.

Summary: The health promotion messages of NMHP are clear and actively disseminated, using mixed media. However a majority of the nursing population will not have engaged with NMHP materials.

Priority 3 – Good governance

Two high level objectives are reviewed under this priority.

3:5 Add to existing research re nurses' and midwives' needs & services

This objective is partially achieved: The NMHP produces quality level evaluation routinely and is engaged in peer reviewed publications, such as Hamilton & Taylor (2011), other work is currently under review.

3:6 Increase knowledge regarding effective model of service provision

The NMHP achieves this objective to some extent through evidence based Health Promotion and through this project.

Summary: The program is clearly geared to address the higher level objectives and the qualitative data produced shows instances of NMHP impact across all priority areas.

The absence of a comparator service (in Australia or internationally), the lack of nursing workforce health and outcome data, the low rate of adverse events that can be attributed to nurse impairment, and the absence of such reports all impede the ability of evaluators to strongly evaluate change in outcomes against high level objectives, or to benchmark NMHP performance against its program aim.

Chapter 4: Discussion

This chapter provides a synthesis of findings against NMHP program objectives, assumptions and the relevant literature and policy materials. Key discussions relate to: the distinctive NMHP model of service in regard to case management and targeted health promotion and the unanswered questions needing further research. Throughout, there is an emphasis on identifying opportunities for the future of NMHP, arising out of the evaluated clear contribution made by NMHP up to this point.

The NMHP showed foresight in establishing a case load database from inception, capturing important information about its direct service provision. Similarly, its governance approach to public reporting of activity via the website, and the provision the website as a tool for health promotion for nurses and midwives, has provided vital information to evidence its health promotion and governance priorities.

The existing data, supplemented with focus group data, enable the researchers to analyse and present evidence of progress against program goals and objectives at three levels. **This analysis has shown that the NMHP clearly achieves all of its foundation level goals, achieves all of its mid level goals to some degree and achieves some of the high level goals to a degree.**

The NMHP team demonstrably expends its efforts in a targeted way, across its three strategic priorities. That is, the NMHP has built up expertise and activities in direct service provision and in health promotion, regarding problems of mental health and substance use among nurses and midwives, over more than 5 years of operation. The Board has refined the NMHP's governance activity and accountability, to reflect and respond to changing policy and service environment.

This organisation has evolved in its purpose, priorities and profile in Victorian healthcare. As the only service of its kind for nurses and midwives in Australia, it has built and maintained collegial links with a wide range of interested parties. These include major healthcare providers, industrial bodies, academic institutions, colleges of nursing, private providers of health and wellness support, and the Victorian Doctors' Health Program. Further afield, the program has earned a positive reputation in the USA, among Nurses' Health Program providers and researchers (Monroe & Kenaga 2011).

This evaluation project has tested the NMHP performance against its stated objectives. Positive impact and outcomes of the service upon the population of nurses and midwives of Victoria are evident; but there is a shortfall in data to quantify some of the NMHPs mid level and high level effects. High level objectives reflect the ambitious goal, to improve the health and safe practice of Victorian nurses and midwives.

Through the lens of program logic evaluation, it is clear that the organisation ***has not fully achieved its aim*** in the sense that the work is finished. It is reasonable to assume there is significant unmet need, ongoing demand and potential for NMHP to make further ground against the stated aims and objectives. In this sense, the evaluation result supports the intention of NMHP, 1)to continue service provision and health promotion and 2) to refine its approach to meeting needs of nursing and midwifery workforce, for the benefit of this workforce and for patient care.

We have said that high level and mid level objectives are assessed here as only partly met, since the researchers could not draw other conclusions, using the available data. The overarching aim of the program is to ensure the safety and health of the practicing nursing and midwifery workforce. This aim and the high level objectives - of improving the health this workforce, reducing health-related loss to the workforce, decreasing stigma and disseminating an effective service model - are ambitious. It is to be expected that these objectives are not fully met as yet, since their fulfillment would evidence substantial culture change across the healthcare sector, the kind of change that occurs over a considerable time. In this regard, the NMHP faces obstacles more substantial than a lack of data to enable the realisation of its vision.

Achievement of the NMHP high level aims requires wider 'buy in' to the objectives of the program. These objectives need the backing of policy, in such spheres as occupational health and safety, public health, healthcare workforce planning and regulation. NMHPs objectives will certainly be of interest to these sectors. National policy in the US articulates a position on addressing the health of health practitioners since the 1980s, but so far Australian policy does not.

In particular and speaking more practically, NMHP objectives can only met by investment (of time, expertise and money), through active partnerships with stakeholders beyond the specialist team. The NMHP program has to this point grown from a grass roots vision within the discipline of nursing, with the backing of industrial bodies, academics and a state regulator. The NMHP Board and staff are in the positive position of having sound working relationships with stakeholders including regulators and industrial and professional groups, who have also been partners in NMHP governance.

The recent evaluation of health related notifications to the regulator, undertaken by Siggins Miller, (2012) confirmed the good standing of NMHP. It compared broadly the approaches taken in each state and territory to managing impaired nurses and midwives. The results of that gap analysis project concur with the findings of this evaluation overall; that NMHP provides a service that is effective and valued by all stakeholders to nurses where a risk to patient safety, and that there is no comparable service available for Australian nurses. The authors concluded that the regulator should undertake cost analysis of NMHP, as necessary groundwork for considering a national program.

All NMHP stakeholders engaged in this project were confident that the work of the program manages well the balance of ensuring safe practice and keeping nurses in work, a conclusion that must save healthcare costs. This view is supported by a preliminary economic analysis (Appendix ??), estimating NMHP services to have saved more than $7million in staff replacement costs across the healthcare sector of Victoria to 2011.

Since the Siggins Miller (2012) project did not encompass service user views, or investigate case work process or outcomes, it could not detail what were the key elements of the NMHP program or the impact. The following sections highlight aspects of the program that are distinctive to NMHP, important to its objectives and warrant focused discussion.

NMHP current position, future opportunities

Direct Service Model including case management

A direct service 'by nurses for nurses' was a dominant feature of the NMHPs strategic plan from inception. The spectrum of direct services and the more intense case management practised by NMHP, and characterised in this report, holds significant appeal for nurses and midwives, employers and regulators. Currently NMHP provides its direct service to an unusually high level of satisfaction. This evaluation identifies that the NMHP **displays a key point of difference in the Australian context, by providing targeting complex case management services** (in addition to counselling), to address nurses' health and safety in practice.

The services most like NMHP's case management are those provided by alternative-to-discipline (ATD) Health Programs in the USA (Monroe & Kenaga 2011). The large number of these services (>100) are embedded in diverse, state based regulatory frameworks. They vary in scale and in the comprehensiveness of service provided. American ATD Health Programs are geared in the first instance to addressing substance use problems, but most deal also with mental health issues.

As noted earlier in the report, there are no comprehensive evaluations of Nurses' Health Program, against which NMHP's performance might be compared. The only published study of a specific Nurses Health Program surveyed clients for feedback, regarding two programs run by the state licensing board in Alabama (Fogger & McGuinness 2009). The study aim was to compare client satisfaction with an ATD program versus a disciplinary (drug use) monitoring program. The 173 participants reported that assertive support of ATD was valued, drug monitoring was cumbersome, but both structured approaches assisted nurses to maintain their health and work. The NMHP evaluation echoes that finding.

As summarised in the Australian medical literature, the USA based Physicians Health Programs "typically evaluate doctors who may have problems and monitor them after treatment. They operate to ensure that a doctor complies with the provisions of treatment and is able to practice; few programs provide care per se..." (Brown & Schneidman 2004, p391). A survey of 39 Physicians Health Programs by DuPont et al (2009) reported that direct services included long term support, referral to community support, liaison and reporting to regulators. On average, each of these programs accepted 34 new cases per year, considerably less than NMHP. Another difference is a much lower rate of self referral, on average only 26% across the 39 programs. The higher rate of assisted referral and the long duration of support and monitoring suggests that these programs are engaged less often in early intervention than is the NMHP. A description (not an empirical study) by Bettinardi-Angres et al (2012) of the pathway to NHPs also suggests that referrals to these nursing programs mainly occur at a later stage, with involvement of the employer and regulator. The study by Brooks et al (2012) described a dominant substance abuse orientation across PHPs, such as arranging intensive AOD detoxification and detailed contracts for abstinence and drug testing. The programs included other features similar to NMHP, of advocating and liaising with regulators and employers, through intensive case management.

Our analysis shows that NMHP likewise pays particular attention to the needs of nurses and midwives with substance use problems, working with these people more intensively in case

management and over a longer time than when mental health issues are the presenting problem. Similarly, the NMHP works intensively with the small number of people referred via employers and the regulatory body. In these cases it is clear that the NMHP offers interventions that differ from the service of employee assistance programs, in terms of NMHP's ongoing role and comprehensiveness.

Case management provided by NMHP contributes to important nursing and midwifery health and workforce outcomes, compare favourably with international programs. Economic analysis suggests substantial healthcare savings are achieved by the program, even if the direct case load is modest.

At present, there are no services provided in competition with the NMHP model in Victoria, nor are equivalent services provided to nurses and midwives in other parts of Australia. It is unclear how the benefits of counselling, support, interagency liaison, advocacy, mediation, or the outcomes of retaining nurses and midwives in work, are achieved in other jurisdictions in Australia.

As noted, there is a gap in policy and service response Australia-wide to date. Rather, health at work is dealt with via generic policy. For example, problematic substance use affecting work is explicitly addressed in occupational health and safety policy (such as Comcare, Australian Government 2008, or Worksafe Department of Commerce 2010, in Western Australia). Such policy promotes obligations of employers and employees, with the identified support being individualised counselling via contracted EAP providers (Pidd *et al* 2006). This policy and program response applies across industries and workplaces as diverse as building, education, retail and health. At the level of health professional regulation, policy and law require mandatory reporting among professionals regarding misconduct (NMBA 2010, AHPRA 2010). When misconduct arises from health problems then sanctions are defined, but policy does not guide or operationalise an alternative-to-discipline response.

DuPont et al (2009) reported that half of surveyed PHPs in USA were auspiced by independent, not-for-profit foundations, a third by state based professional associations and a minority by the state licensing board. In the UK until recently, policy settings provided for discipline of misconduct within the nursing policy arena (RCN 2005) and a generic response to support in the workplace. For example, the Royal College of Nursing (2005) deferred to the National Workplace Initiative and the Drug Action Teams, to assess and broker treatment for an individual nurse. Although not available to nurses or midwives, a new alternative-to-discipline program development in the UK is the Practitioner Health Program, piloted by the Royal College of General Practitioners (RCGP 2012). Like the USA precedents, this program promotes the peer support element of 'doctors for doctors' and employs practitioners specifically skilled in mental health and substance use interventions.

It is unclear how the Australian policy and regulatory environment will impact the future of the NMHP and, by association, how it will impact on the opportunities for support to nurses and midwives. A key task for the NMHP must be to communicate the significant needs and ongoing demands from nurses and midwives for support. The NMHP must also explain the distinctive processes and outcomes of their model of direct service, for wider examination.

NMHP Role in Health Promotion

Beginning with an aim to promote the direct service, NMHP staff have developed and disseminated information to healthcare organisations, operational managers, nurses and midwives about self

care, help-seeking pathways, and other support opportunities. Their reach has extended over time, contributing health promotion materials and workshops to conference events, including convening an NMHP wellness conference in 2010. The profile of the NMHP has increased as health promotion activities have expanded in reach and volume, over the evaluation period. What began as incidental part of the work of the NMHP is now a substantial second strand. **The NMHP team has built resources, expertise and reputation in health promotion.**

In this regard, the NMHP differs from most of the ATD programs in USA. Most of the 39 evaluated ATD Physician Health Programs (DuPont 2009) reported a small scale of health promotion, geared primarily to substance use. Among the Nurses Health Programs (NHP), some larger established NHPs do have a clear health promotion component (eg SPAN in New York State), which is evident at organisation websites. The SPAN program is partnered with an academic research centre at University at Albany, School of Public Health. With a few such exceptions, it is difficult even to locate contact details for the NHPs in many states. Where websites can be found, they announce the existence of an organisation but provide nothing like the range of useful resources freely provided and tailored to nurses and midwives by NMHP.

The NMHP displays an integrated approach to providing health promotion and direct support. HP materials serve as a resource for the individual support work; correspondingly the credibility of the direct service increases the appeal and impact of health promotion messages. Importantly, this evaluation suggests that the combination impacts on stigma associated with mental health and substance use problems among nurses and healthcare organisations, one of the high level objectives of the NMHP.

Stigma prevents nurses and others seeking help at all, or doing so early. In an environment where stigma is potent, nurses' referrals for intervention are more likely to come late and with some duress, from employers or regulators (Berryman 2002). The referral patterns for NMHP over 5 years increasingly suggest an improvement in attitudes towards mental health and substance use issues among employers and nurses themselves. The increasing number of self-referrals and nurses' willingness to re-engage with the service after setbacks in recovery are evidence that stigma is improved amongst this population. Correspondingly, a substantial and increasing number of self-referred nurses report hearing about the service from advice from the employer or regulator. This is an important development. It provides evidence firstly that employers and the regulator know about NMHP service options. Secondly, it shows that employers and regulators see the NMHP alternative-to-discipline approach as a viable and early alternative, in many instances, to making a complaint and instigating disciplinary action.

There is potential for the HP element of the program to be strengthened. The practice-level expertise, credibility and networks of NMHP would be complemented by partnering with academic centres for public health, whose business is synthesising evidence and converting it into clear HP messages. NMHP could also explore opportunities for HP partnerships with key health agencies in Australia, such as the largest AOD harms prevention agency, the Australian Drug Foundation, and beyondblue, the destigmatisation initiative for mental health and especially depression. In keeping with the current research priorities of beyondblue, NMHP could seek funds for HP and an associated evaluation in nursing workforce.

NMHP dissemination, evaluation and contribution to research

The services and practices of NMHP are, as best as we can determine, in line with international alternative-to-discipline assistance and monitoring programs, including Nurses Health Programs (NAOP 2012, Monroe, Pearson & Kenega 2008) and many Physician/Practitioner Health Programs (DuPont *et al* 2009), that are active in most state jurisdictions of the USA, where practitioner impairment is addressed most comprehensively. There is a pressing need for development of benchmarking for programs addressing nurses' health.

Published PHPs program designs and research data almost all pertain to doctors/physicians needs. Evaluations so far focus on interventions provided to doctors /physicians, even when the term 'practitioner' is used, as it is in approximately half the PHPs in USA and in the newer Practitioner Health Program in UK, associated with the Royal College of General Practice (RCGP 2011). This evaluation provides a solid baseline regarding NMHP service activity. So there is as yet no sound data on outcomes of ATDs for nurses.

The NMHP Board and staff gain from lessons learned through undertaking this evaluation. The routine data collected is extremely useful as it stands and can be enhanced, particularly by emphasis on work outcomes and (if possible) measures of sound/safe practice. The organisation should develop a strategy for ongoing evaluation pitched to quality assurance and benchmarking. Ideally, the NMHP will identify a US based ATD program that would be willing to partner with the NMHP for a significant period, such as 3-5 years, to share program information, and baseline and outcome data (see for example *Intervention Project for Nurses*, Florida http://www.ipnfl.org/).

New fields that would complement the existing dataset are: screening and repeat measures of wellbeing, health, mental health, substance use. Such data collection tools would add some burden to clients, but this could be offset by using them in counselling, to inform discussions of change and progress. Fields or definitions of other data that is collected could be tightened for precision of reporting and for greater ease of use by NMHP practitioners.

Specifically with regard to work, the service and the stakeholders need well-differentiated data about: work situation at time of referral, work status tracked through the episode of care and work outcomes on closure. The NMHP could approach an Human Research Ethics Committee for advice about seeking ongoing permission to report data for this quality assurance purpose. This set of data would assist with refining the program and allow for stronger economic analysis, based on outcomes.

For a research focus, the best investment would be on medium to longterm work outcomes for referred clients and health promotion gains for participants/target groups.

Limitations of the evaluation

This evaluation of the NMHP is limited in several ways. Though it capitalises on a diverse array of data, evaluation would benefit from data that enables more detailed analysis of outcomes of interest to stakeholders and the community, particularly in terms of nurses' work and safe practice. This observation feeds back into recommendations about a routine data set for a service such as NMHP.

The project captures activity across a solid time period, but even in the period of completing the evaluation, the environment and the NMHP continues to change.

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The report ends with summary of conclusions and recommendations. These closely tie into the Executive Summary at the front of the document.

Chapter 5: Conclusion & Recommendations

Achievement of program objectives

A range of routinely collected service data, organisational supplemented with focus group data provides evidence that **the NMHP clearly achieves all of its foundation level goals**, **achieves all of its mid level goals to some degree** and **achieves some of the high level goals to a degree**. The evaluation project findings and their implications are summarised here:

- The NMHP team expends its efforts in a targeted way, across its three strategic priorities
- This organisation has evolved in its purpose, priorities and profile in Victorian healthcare
- That is, the NMHP has built up expertise and activities in direct service provision and in health promotion, regarding problems of mental health and substance use among nurses and midwives, over more than 5 years of operation.
- NMHP provides its direct service to an unusually high level of satisfaction
- NMHP **displays a key point of difference in targeting complex case management services**, in addition to counselling, to address nurses health and safety in practice. It differentiates NMHP from the generic support programs provided in other Australian jurisdictions and for other workforces.
- Case management shows some evidence of contributing to important nursing and midwifery workforce outcomes and perhaps to the economic value of the program
- The NMHP team has **built material, expertise and reputation in health promotion**
- The NMHP Board has refined the Program's governance activity and accountability to reflect and respond to changing policy and service environment
- Positive impact and outcomes of the service upon the target population is evident; but there is a shortfall in data to quantify some of the mid level and most high level effects
- The organisation has not fully achieved its aim in the sense that the work is finished; in the absence of strong data it is reasonable to assume there is significant unmet need, ongoing demand.
- There are no national or international studies of programs addressing nurses' health, against which the program could be benchmarked.
- The **services and practices of NMHP are in many regards in line with other alternative-to-discipline** programs of support and monitoring, including Nurses Health Programs (Monroe, Pearson & Kenaga, 2008) and Physician/Practitioner Health Programs(DuPont *et al* 2009).

Recommendations

These recommendations reflect the NMHP aim to secure and develop the best service model to increase the health and safe practice of nursing and midwifery workforce.

Service provision

A strong case exists for the program continuing into the future, built on: a) clear need among nurses; and evidence that b) NHMP direct services are provided to a very high level of satisfaction; with c) positive work outcomes; d) reduction in stigma among nurses; and e) no comparable provider in the jurisdiction. Specifically actions recommended are:

1. NMHP **should disseminate achievements among stakeholders** in a variety of formats
2. NMHP should **differentiate their case management work from individual counselling-only** models and develop program resources to inform referrers and the sector, particularly highlighting advocacy and liaison, expert advice tailored to nursing context and peer support
3. NMHP should **make explicit their role in monitoring and enhancing safe conduct** of higher needs nurses, a role that will otherwise fall to regulators
4. NMHP should **investigate cross-referral arrangements** with other providers of individual counselling
5. NMHP should disseminate information about the **value of ongoing and increasing health promotion work, to improve early uptake** of assistance and **to reduce stigma**
6. NMHP could **improve access through extended hours and after hours,** for support groups and referrals respectively. There is not an obvious case in the data for increasing regional work

Ongoing data collection & evaluation

NMHP should **refine its routine dataset and strengthen ties with like services** internationally for benchmarking and with major health promotion agencies for HP research. Specifically:

7. **NMHP Board and staff should refine priorities and tools for data collection** from this point forward, making use of national indicators, to enable a strong ongoing program evaluation
8. **NMHP should form partnership for quality assurance (QA) level benchmarking activity** regarding its direct service provision. The program stands to gain recognition from benchmarking. QA activity is desirable in addition to further research, as cycles of quality feedback are shorter than research. NMHP service research can make a valuable contribution to national and worldwide evidence regarding models of care and outcomes. Case related research will continue to present challenges, related to NMHPs sensitive data and the ethically vulnerable client group.
9. **NMHP should engage in research related to health promotion activity**. Funding exist to research health needs and impacts of health promotion on the large nursing and midwifery workforce

10. **NMHP should affirm in program materials the emphasis on nurses' mental health needs** and **the NMHP role in health promotion**, as these have become core priorities

Organisation & structure

The NMHP is in the strong position of demonstrating an effective governance structure, headed by a Board with foresight. The changing environment prompts specific recommendations:

11. **NMHP Board should continue to address this question:** *Does NMHP have the right skill mix for program points of difference and for health promotions growth?*

12. **The NMHP Board should determine priority actions to sustain service provision** in the changing environment of national policy and funding

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