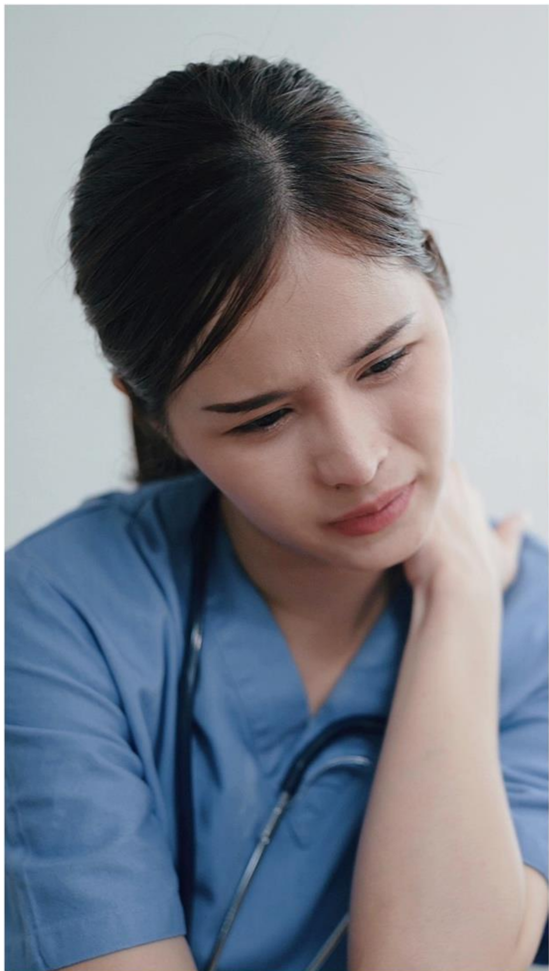

Nursing and Midwifery Health Program Victoria (NMHPV): A process and outcome evaluation

Technical report prepared for the Board of the Nursing and Midwifery Health Program Victoria

Chief Investigator

Dr. Rebecca Jarden RN, MN, PhD

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Evaluation Team

Chief investigator

Dr Rebecca Jarden (RN, PhD, MN)[1]

Co-investigators

Dr Naomi Brockenshire (PhD, MNSc, RN)[2]

Associate Professor Tracey Weiland (BBSc(Hons), MPsych(Health)/PhD)[3]

Associate Professor Aaron Jarden (PhD, MA, GradDipAppEthics)[4]

Research support

Dr Helena Bujalka (PhD)[2]

Advisor

Professor Marie Gerdtz (BN., Grad Cert A&E., GDAE&T., PhD, RN)[5]

Evaluation team affiliations

[1] Department of Nursing, School of Health Sciences, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Victoria, 3010, and Austin Health, Melbourne, Victoria, Australia; phone: +61 3 834 40734; rebecca.jarden@unimelb.edu.au; ORCID https://orcid.org/0000-0003-4643-7147

[2] Department of Nursing, School of Health Sciences, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Victoria, 3010, Australia.

[3] Melbourne School of Population and Global Health, The University of Melbourne, 207 Bouverie St, Carlton VIC 3053, Melbourne, Australia; tweiland@unimelb.edu.au; ORCID https://orcid.org/0000-0002-4053-5507

[4] Centre for Wellbeing Science, Melbourne Graduate School of Education, The University of Melbourne, Kwong Lee Dow Building, 234 Queensberry Street, Parkville VIC 3053, Melbourne, Australia; aaron.jarden@unimelb.edu.au; ORCID http://orcid.org/0000-0002-4293-7032

[5] Department of Nursing, School of Health Sciences, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Victoria, 3010, Australia; gerdtzmf@unimelb.edu.au; ORCID https://orcid.org/0000-0002-2100-994X

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1. Executive Summary

The Nursing and Midwifery Health Program Victoria (NMHPV) provides a range of support services for nurses, midwives and students to promote the individual's health, wellbeing and resilience, and reduce the risks to those who use nursing and midwifery services. The program is delivered by nurses and midwives, operating within a health and wellbeing framework incorporating prevention, intervention and restoration. The program employs a case management model of care to which nurses and midwives are either referred or self-refer. This program evaluation used mixed-methods research design to investigate: 1) if the program is working as it is intended to work, 2) to what extent the program is working and impacts of the program for participants, and 3) the opportunities for strengthening the program. Across the four studies of this evaluation, two cross-sectional surveys, a longitudinal survey, and a qualitative descriptive study, we have identified experiences and perceptions of nurses and midwives who engaged in the program as participants, clinicians and wider stakeholders. The response rate for all surveys was low, and due to this limitation, the qualitative data and analyses provide complementary depth and understanding.

1.1. Key findings and recommendations.

The following findings and recommendations were constructed from synthesising results across the program evaluation. In summary, this evaluation demonstrated NMHPV made a positive impact on the life of program participants (users of the program / service-users).

1.1.1. Is the program working as it is intended to work?

1) The cross-sectional survey results indicate NMHPV participants were highly satisfied with the program.
2) The in-depth qualitative exploration of participants experiences suggests the program had a positive impact on their lives.
3) The longitudinal survey sought to understand the effect of NMHPV on participant wellbeing, work wellbeing, illbeing and work illbeing over time. The small sample size constrained potential analyses thus we could not determine program effectiveness in these domains with certainty.
4) Across all four studies, participants reported high regard for NMHPV, from the nurses and midwives who had participated in the program, to the clinicians working within the program, to referrers to the program, to those who receive referrals from the program, to the broader industry stakeholders of the program.
5) Experiences of nurses and midwives engaging with the program were overwhelmingly positive and there were many highly regarded attributes of the program which are important to both acknowledge and be cognisant of as the program continues to evolve, such as:
   a. the shared foundational nursing and/or midwifery experience of both clinicians and participants which supported a common language and facilitated understanding, and
   b. effective program leadership, and autonomy and flexibility in the clinicians' role which facilitated and supported a positive working experience for clinicians.
6) The importance of the program being 'by nurses and midwives, for nurses and midwives' was considered critical to the success and value of NMHPV.

1.1.2. To what extent is the program working and what are the impacts of the program for participants?

1) We investigated prevalence, predictors, barriers and enablers of wellbeing, work wellbeing, illbeing and work illbeing for NMHPV program participants. In terms of predictors, enablers and barriers, there were no significant changes across time for any of the outcome measures. The small sample size for our longitudinal study, and lack of comparable studies for our cross-sectional study, means quantitative results must be considered with caution and offer an opportunity for future investigation.

2) The cross-sectional survey items measuring participant satisfaction and the qualitative descriptive study both provide evidence of a positive impact on the lives of program participants. Experiences were largely positive and there were many highly regarded attributes of the program.

1.1.3. What are the opportunities for strengthening the program?

1) Specific program promotion to reach particularly vulnerable populations (rural and remote, early career, students), but also more broadly so all nurses and midwives are aware of the program before they might need it.
2) Both 'crisis' and 'complexity' in program participant presentations was evident in the experiences described, supporting clinicians in addressing these crises and the complexity is an ongoing professional development opportunity.
3) Review and consider how to address participant expectations around complexity and crises, e.g., visibility of program scope - consider clarity of program boundaries and backup immediate crisis support.
4) Extend diversity amongst NMHPV team.
5) To facilitate future service evaluations, consider building on existing database of key outcome metrics, for example, as part of a follow-on project could explore changing K10 to K6 and using the additional 4 items to measure work-related illbeing/wellbeing and intent to stay/return to work. The recent transition to an online case management database system will also support future evaluations.

Exploring ways to retain the core strengths of the program whilst enhancing reach and diversity will be important next steps as the program continues to develop.

2. Introduction

The Nursing and Midwifery Health Program Victoria was established in 2006 and provides a range of support services for nurses, midwives and students experiencing issues impacting their health and wellbeing. A mixed-methods program evaluation was conducted in 2012 which reviewed the program's processes and practices to determine a model of best practice, evaluated program effectiveness in assisting nurses and midwives to remain in practice, and to identify potential improvements to ensure accountability and guide decisions for future planning. A decade later, the current independent evaluation built upon this foundational work to evaluate the NMHPV's service and case management model to identify opportunities for future improvements.

2.1. Background.

Retaining a health workforce to meet the increased demand for health care is crucial (Burns et al., 2020; World Health Organization, 2020b). This retention has an interdependent relationship with both wellbeing and illbeing of health workers. Work contributes to an individual's mental health (World Health Organization, 2013, p. 6), yet the wellbeing of health workers also influences the performance of organisations (Ray-Sannerud et al., 2015) and increased levels of resilience (Yu et al., 2019). Australian nurses and midwives reported higher levels of anxiety, depression and stress during the COVID-19 pandemic than the general Australian adult norms (Holton et al., 2021) and burnout is associated with patterns of adverse job characteristics, such as high workload, low staffing levels, long shifts and low control (Dall'Ora et al., 2020). For early career nurses, feeling valued, part of the team, learning, and being supported by other nurses underpinned their wellbeing (Jarden et al., 2021).

Health workers continue to manage the consequences of the pandemic of coronavirus disease, 2019 (COVID-19; International Council of Nurses, 2020). Given that around 10% of COVID-19 cases globally were among healthcare workers (International Council of Nurses, 2020) the impact of COVID-19 may be evident

in this service evaluation and will continue to support the investigation and recommendations for future preparedness. Evidence of the impacts of COVID-19 on health workers continues to evolve (Waters et al., 2021), identifying aspects such as nurse stress, anxiety, distress and fear (Hu et al., 2020). Recommendations for mental health support continue to grow (Maben & Bridges, 2020; Mills et al., 2020; Wong et al., 2020; World Health Organization, 2020a). Locally, in 2019 the Governor of the State of Victoria, Australia, formally established the Royal Commission into Victoria's Mental Health System (State of Victoria, 2021). The subsequent 2021 report highlighted the existing system was not "designed or equipped to support the diverse needs of people living with mental illness or psychological distress ... let alone to cope with unforeseen pressures that may arise" (p. 4, State of Victoria, 2021) and sets out 65 recommendations for transformation of the Victorian mental health system. The NMHPV is well positioned in contributing to a contemporary and adaptable mental health and wellbeing system, particularly considering the Commission's recommendations focusing on availability and access to treatment, care and support. This positioning of NMHPV is opportune to not only address and prevent nurses' and midwives' illbeing and work illbeing, but also to promote wellbeing and work wellbeing.

2.1.1. Context.

The NMHPV seeks to provide a:

> "free, confidential and independent support service for nurses, midwives and students experiencing sensitive health issues related to their mental health, substance use, family violence or any issue impacting their health and wellbeing. NMHPV also supports employers, managers, and People and Culture personnel to promote health and wellbeing amongst their nursing and midwifery workforce. NMHPV was designed by nurses and works within a recovery focused counselling framework, provided exclusively by experienced nurses and midwives"
>
> (https://www.nmhp.org.au/about-our-service.html)

Following referral to the program, participants' first point of contact is a professional, trained in working with people presenting with psychological problems, such as distress and providing reassurance. The participant is then assigned to a case manager who is a nurse or midwife, who assesses the participant, provides an individual care plan and support, which may include including referral, treatment, liaison with employer, and support to re-enter the workplace, as appropriate to the individual participant (https://www.nmhp.org.au/documents/NMHPV-Model-of-Care.pdf). With this outward facing service description in mind, the NMHPV sought independent evaluation of the program to understand if the program was working as it was intended to work, to investigate the extent the program was working and examine the impacts of the program for the participants, and the opportunities for strengthening the program. The current evaluation team constructed an evaluation program logic model (see Supplementary File 1).

2.1.2. Objectives and research questions.

The objectives of this evaluation were to investigate: 1) if the program is working as it is intended to work, 2) to what extent the program is working and impacts of the program for participants, and 3) the opportunities for strengthening the program.

To this end, we describe previous participants', referrers' and referral services' perceptions and experiences of their engagement with NMHPV, and measure new participants' levels of health and wellbeing on engagement with NMHPV, at exit from the program, and at 12-months following initial engagement.

The four research questions (RQs) were:

RQ1: What are the characteristics of nurses and midwives engaging in the program?
RQ2: What is the effectiveness of the case management model on the wellbeing of nurses and midwives?
RQ3: What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians?
RQ4: What are the experiences and perceptions of broader program stakeholders?

3. Methodology

This evaluation was underpinned by the philosophical paradigm of pragmatism to enable the focus to be on "what works" and determine solutions that best meet the needs and purpose (Creswell, 2013), and was guided by the World Health Organization (2007) recommendations for evaluation of mental health policies and plans, Centres for Disease Control and Prevention (CDC; USA Department of Health and Human Services Centers for Disease Control and Prevention, 2011), Victorian Government Department of Human Services evaluation framework (Round, 2005) and the methodology of Davidson (2004). Survey findings were reported according to STROBE (von Elm et al., 2007)and qualitative findings according to COREQ (Tong et al., 2007).

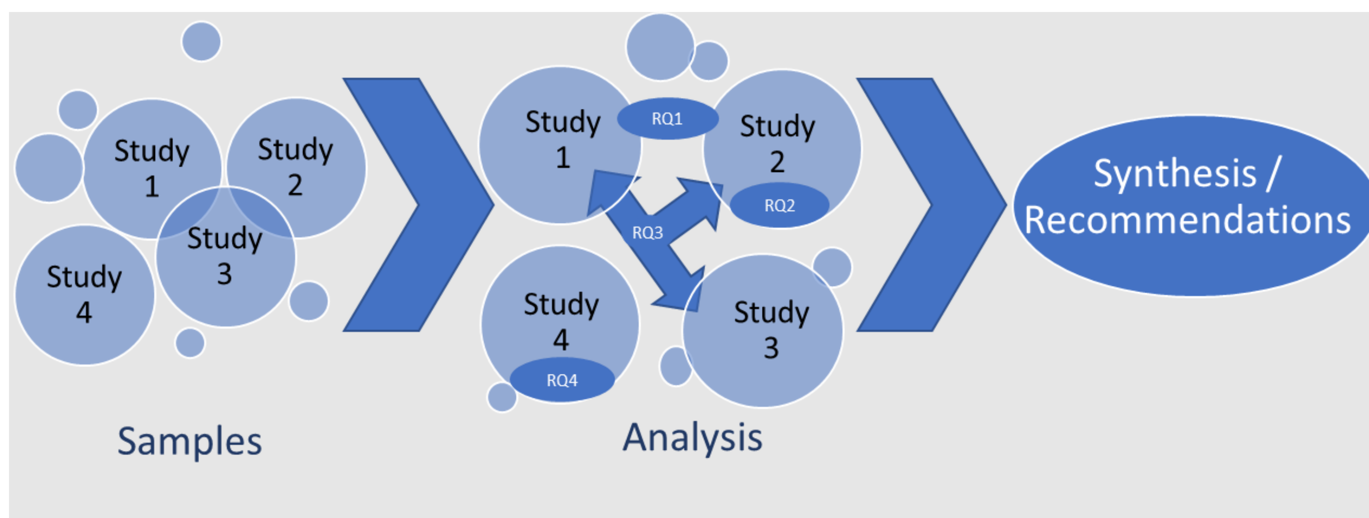
3.1. Design.

To address these research questions, a concurrent triangulated mixed-methods service evaluation was conducted using both qualitative and quantitative research methods to draw on the strengths of both and to address the complexity of the questions (Creswell & Plano Clark, 2007).

- Study 1 was an observational descriptive study (cross-sectional survey) of previous program participants until end of 2020,
- Study 2 was an observational exploratory prospective cohort study (longitudinal survey) of participants who engaged in the program from 2020,
- Study 3 was a qualitative descriptive study (interviews) of nurses and midwives who have engaged with the program as participants or clinicians, and
- Study 4 was an observational descriptive study (cross-sectional survey) of key program stakeholders.

Triangulation of studies, including sampling and analysis, is illustrated in Figure 1.

Figure 1. Concurrent triangulated mixed-methods evaluation design.



Data analysis and study findings were either reported individually or synthesised to address the four RQs and meet overarching objectives. To address: RQ1 (What are the characteristics of nurses and midwives engaging in the program) items from Study 1 and Study 2 were analysed, synthesised, and reported; RQ2 (What is the effectiveness of the case management model on the wellbeing of nurses and midwives), Study 2 findings were reported; RQ3 (What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians), items from Study 1 and Study 2, and all Study 3 interview data were analysed and reported, then findings were synthesised, RQ4 (What are the experiences and perceptions of broader program stakeholders), Study 4 findings were reported.

An overview of studies informing each research question is provided in Table 1.

Table 1. Overview of studies informing research questions.

	Study 1 Cross-sectional survey	Study 2 Longitudinal survey	Study 3 Interviews with program participants & clinicians	Study 4 Stakeholder survey
RQ1: What are the characteristics of nurses and midwives who engaged in the program?	Y	Y	N	N
RQ2: What is the effectiveness of the case management model on the wellbeing of nurses and midwives?	N	Y	N	N
RQ3: What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians?	Y	Y	Y	N
RQ4: What are the experiences and perceptions of broader program stakeholders?	N	N	N	Y

Y = Yes, N = No

3.2. Methods.

In this section we first report 'Instrumentation' as this relates to three of the included studies (Study 1, 2 & 4). Then we present 'Sampling and recruitment' broadly across all studies, and in more detail within specific methods for individual studies.

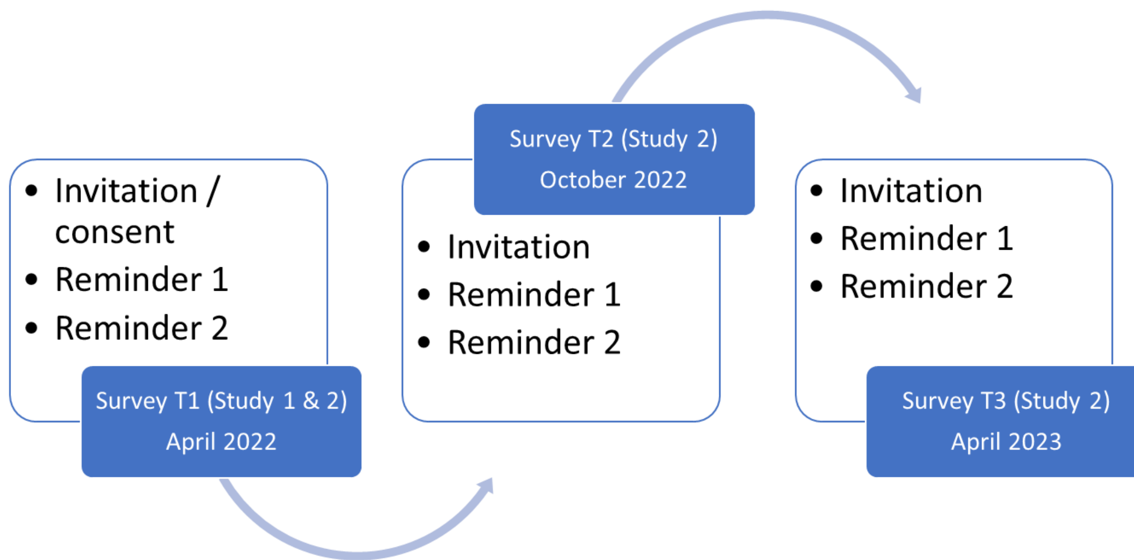
3.2.1. Instruments.

The three studies involving online surveys (Study 1, 2, and 4) used REDCap (Research Electronic Data Capture) electronic data capture tools hosted at the University of Melbourne to both collect and manage data. REDCap is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources (Harris et al., 2019; Harris et al., 2009).

3.2.1.1. Cross-sectional (Study 1) and longitudinal (Study 2) surveys of program participants.

In all, the surveys for NMHPV participants (both the longitudinal and cross-sectional versions) assessment battery comprised approximately 180 items (20 min) which captured the variables of interest. The first question in the survey asked respondents to indicate whether they had most recently participated in the NMHPV prior to 2020 or from 2020 onwards; those who indicated the former participated in the cross-sectional branch of the study, completing the survey at a single timepoint; those who indicated they had participated from 2020 onwards participated in the longitudinal branch of the study, which involved completion of the survey at three timepoints (baseline and two follow-up surveys, each separated by 6 months), see Figure 2.

Figure 2. Study 1 and 2 timeline.



Survey questions were of several different types, including:

- Questions about the NMHPV, including date ranges of participation in the program; referral pathways; 11-point scale-response perceptions of benefit of, and their satisfaction with, the NMHPV; an open-ended question inviting comments on the three best things about the NMHPV; and a question about whether they set goals as part of their participation in the program, and if they did, questions about their experience in setting and progressing towards achieving goals.
- Work demographic questions regarding their employment arrangements when they were a participant in the NMHPV, including their employment and registration statuses, their role, and years of clinical experience.
- Personal demographic questions captured gender, age, ancestry, relationship status, educational level.
- A question about consent to being contacted about participating in an interview.
- General and work-related wellbeing questions taken from existing validated measures, as detailed in Table 2.

Table 2. Study 1 & 2 instrumentation.

Measure or Items	Description	Scoring details	Possible Range
Happiness and Life Satisfaction *(from Work on Wellbeing, WoW, assessment battery, a collection of previously validated scales, measures, & individual items)*	A question about life satisfaction and a question about happiness.	Items scored on a 10-point scale from 0 (Not at all satisfied)-10 (Completely satisfied)	Each item is on a scale of 0-10.
Health and Lifestyle Factors (WoW)	Four items assessing satisfaction with overall health, diet, sleep quality and level of physical activity.	Items scored on a 10-point scale from 0 (Not at all satisfied)-10 (Completely satisfied). The health and lifestyle score was calculated by an average of four questions (perceived health, nutrition, physical activity, sleep) and then converting to a percentage. Greater scores indicate greater health and lifestyle wellbeing.	0 – 100.
Work wellbeing (WoW)	11 of the 17 work wellbeing items from the Work on Wellbeing assessment were selected.	Items scored on a 10-point scale from 0 (Not at all satisfied)-10 (Completely satisfied).	Items treated individually, each on a scale from 0-10.
Utrecht Work Engagement Scale (UWES, Schaufeli et al., 2006)	Two items from the UWES were selected.	Each item is scored on a scale of 0 (Never) to 6 (Always).	These items were treated as individual variables, each on a scale of 0 to 6.
Brief Resilience Scale (BRS, Smith et al., 2008)	The 6-item scale assesses the ability to bounce back or recover from stress.	Each item is scored on a scale of 0 (Not at all like me) - 10 (Completely like me). 3 negatively worded items are reverse scored.	The overall score is calculated by summing the responses to the 6 questions, giving a possible range of 0-60, with higher scores indicate greater resilience.
Kessler-10 (K10, Kessler et al., 2003)	A global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4-week period.	10 items are scored on a 5-point scale, 1 (None of the time)-5 (All of the time).	Scores for 10 items are summed, total possible range is 10-50, greater scores indicate greater level of psychological distress.
Flourishing Scale (Diener et al., 2010)	The 8-item scale assesses self-perceived success in areas identified as important for psychological flourishing, including relationships, meaning and purpose, self-esteem and optimism.	Items are scored on a 7-point scale from 1 (strongly disagree) to 7 (strongly agree).	The eight items are summed, and scores range from 8 to 56. A high score on the scale indicates respondents have a positive self-image in important areas of functioning.

Work-related burnout scale of the Copenhagen Burnout Inventory (Kristensen et al., 2005)	A 7-item scale assessing work-related burnout, or “the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work” (Kristensen et al., 2005).	Each item is scored on a five-point scale; four items are scored on a scale of Always (100) to Never/Almost Never (0); the other three items are scored on a scale of 100 (To a very High Degree) to 0 (To a Very Low Degree). One item is reverse scored.	The overall burnout score is an average of the scores for each item. A lower score indicates lower burnout.
DASS Stress (Lovibond & Lovibond, 1996)	A 7-item stress scale is sensitive to levels of chronic non-specific arousal and assesses difficulty relaxing, nervous arousal and being easily upset/agitated, irritable/over-reactive and impatient.	Each item is scored on a 4-point scale ranging from 0 (did not apply to me at all) to 3 (applied to me very much or most of the time).	Sum the 7 items then multiply by 2, to produce a score ranging from 0-42. Higher scores indicate greater perceived stress. Scores are categorised as Normal (0-10), Mild (11-18), Moderate (19-26), Severe (27-34) and Extremely Severe (35-42).
Strengths Use and Strengths Knowledge (Govindji & Linley, 2007)	Adapted in accordance with the Work on Wellbeing assessment battery, which uses three questions for Strengths Use and three questions for Strengths Knowledge.	Responses are on an 11-point scale from 0 (Strongly Disagree) to 10 (Strongly Agree); the scores for the three strengths use questions and the three strengths use questions are summed separately.	A total possible range of 0-30 for the Strengths Use subscale and for the Strengths Knowledge scale.

Notes: BRS = Brief Resilience Scale, DASS = Depression, Anxiety and Stress Scale, K10 = Kessler 10-item scale, UWES = Utrecht Work Engagement Scale, WoW = Work on Wellbeing assessment battery

Forced response was employed for items in multi-item validated scales for which items needed to be summed (or averaged) to provide and overall scale score.

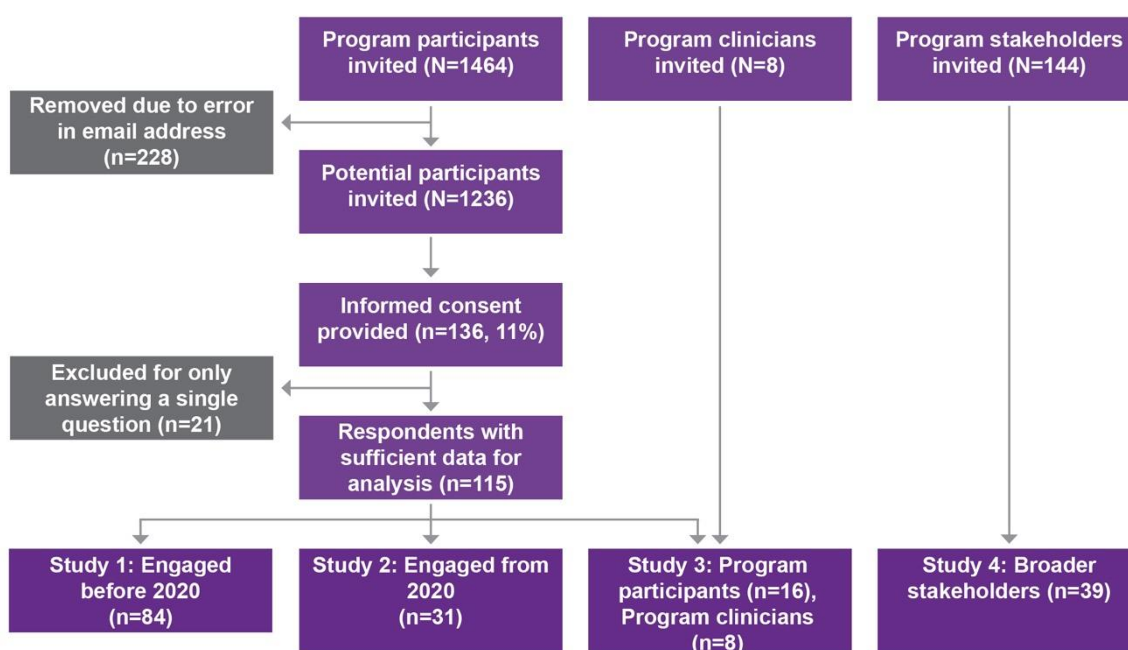
3.2.1.1. Cross-sectional survey of program stakeholders.

Data were collected using a battery of researcher-developed demographic, Likert scale, rating questions, and free-response questions aligned with the research questions as no relevant and specific validated instruments were identified in a comprehensive review of the literature.

3.2.2. Evaluation sampling and recruitment.

For Study 1, 2, and 3, the target population was nurses/midwives who had participated in the NMHPV at any time since it was established. For Study 4, the target population were broader stakeholders of the program. A summary of recruitment across all four studies is illustrated in Figure 3.

Figure 3. Summary of recruitment across studies.



Participants were recruited through a range of methods summarised in Table 3.

Table 3. Recruitment across studies.

	Study 1 Cross-sectional survey	Study 2 Longitudinal Survey	Study 3 Interviews with program participants and clinicians	Study 4 Stakeholder Survey
Participants	Nurses/midwives who had participated in the NMHPV at any time prior to 2020.	Nurses/midwives who had participated in the NMHPV from 2020 onwards.	Current and past program participants and clinicians at the NMHPV.	Stakeholders included: Chief nurses at Victorian hospitals, Deans of Nursing at Victorian universities/colleges that offer nursing/midwifery courses, individuals at the ANMF, individuals at health services, organisations that the NMHPV reports referring participants to.
Recruitment method	Direct email invitation to participant with unique survey link.	Direct email invitation to participant with unique survey link.	Clinicians: Direct email to clinicians (details were provided to the researchers by the NMHPV) Program participant: Direct email invitation to respondents in the cross sectional /longitudinal surveys who indicated in the survey that they were willing to be contacted for an interview.	Group email, which contained an anonymous link, to individuals and organisations that were identified as stakeholders; email list compiled from addresses supplied to the researchers by the NMHPV, and by the researchers.
Data collection period	April-May 2022.	April 2022-April 2023.	Clinicians: October 2022-January 2023. Program participants: June 2022-March 2023.	August 2022.

Notes: ANMF = Australian Nursing and Midwifery Federation, NMHPV = Nursing and Midwifery Health Program Victoria

3.2.3. **Study 1 and Study 2.**

Study 1 was an observational descriptive study (cross-sectional survey) of program participants who engaged in the program before 2020. Study 2 was an observational exploratory prospective cohort study (longitudinal survey) of program participants who engaged in the program from the beginning of 2020.

3.2.3.1. Sampling and recruitment.

During participation in the NMHPV, participants indicated on administrative documentation whether they could be contacted in the future for the purposes of program evaluation. Following formal ethics committee approval (see section 3.4), NMHPV participants who had indicated they may be contacted, and who had been involved with the program at any point since its inception up until May 2022, were contacted. Potential study participants' email addresses (n = 1464) were uploaded into Redcap, the survey scheduling feature of which was used to invite participants via email to participate in the survey, which could be accessed from a link unique to the participant. Participants were informed that upon completion of the survey they would be entered into the draw to win a $50AUD voucher (they could opt out of the draw by checking a box in the survey). At six-day intervals, up to two reminder emails were sent to potential participants who had not yet replied. The survey remained open for a total of eight weeks after the initial email was sent. Baseline data were collected from April-July 2022. Of the 1464 contacted, 228 email addresses either no longer worked (bounced) or were incorrect. Of the remaining 1236, a total of 136 (11%) provided consent to participate. Of the 136, a total of 21 answered only the first question thus were excluded, the remaining respondents with sufficient data for analysis were 115. Participants were separated into two cohorts. Of the 115 respondents, 84 engaged with NMHPV before 2020, so these participants completed just the cross-sectional survey, Study 1. The remaining 31 respondents engaged from 2020, so these participants were enrolled in Study 2 (longitudinal survey) and completed the same survey two more times. The automated survey scheduling functionality within REDCap was programmed such that invitations to complete surveys at the second (6-month follow-up) and third (12-month follow-up) timepoints were sent to all respondents who indicated in the baseline survey that they had participated in the program since 1 January 2020. The second time-point (6-month follow-up) was open during October 2022, and third time-point (12-month follow-up) survey was open during April 2023.

3.2.3.2. Data analysis.

Survey data were exported as .csv files from RedCap, then imported into IBM SPSS Statistics for Windows, version 29 (IBM Corp., Armonk, N.Y., USA) for analysis. In the cross-sectional and longitudinal surveys of NMHPV participants, study participants who answered no more than the questions about the dates that they were engaged with the program were discarded from the analysis. For questions about the respondents' role, registration, and employment at the time of their participation in the NMHPV, responses of "I can't remember" was recoded in SPSS as a missing value. For each outcome variable at each timepoint, descriptive statistics (mean, standard deviation, range) were calculated. Repeated measures (one-way, within subject) ANOVAs were conducted for each outcome variable (i.e., illbeing and wellbeing indicators) to determine whether there were changes in the scores over time.

3.2.4. **Study 3.**

Study 3 was a qualitative descriptive study of nurses and midwives who had engaged with the program as participants or service providers (clinicians).

3.2.4.1. Sampling and recruitment.

Program participant selection was through prospective sampling of nurses and midwives who had participated in the program, completed the electronic survey of Study 1 or Study 2, and opted into interview by selecting 'yes' to the invitation in a survey item. These program participants were then contacted by e-mail and invited to interview (n = 51), with 16 providing consent. All current program clinicians (n = 8) and three former clinicians were invited by e-mail; in total 8 provided consent.

3.2.4.2. Data analysis.

Using a descriptive qualitative study design (Sandelowski, 2010), semi-structured, in-depth, approximately 1-hour, interviews were conducted online via zoom between October 2022 and January 2023 (RJ & HB). The

interview guide is provided in Supplementary File 2. Interviews were recorded then transcribed using OtterAI™ prior to analysis. Before, during, and after our reflexive thematic analysis (RJ, HB, NB), as researchers we met and explored preconceived expectations related to the research and how these may have influenced development of the research questions, methods, interview questions and analysis (Braun & Clarke, 2022). In this reflexive stance and through this exploration we developed an ethical and political self-awareness. Two of the researchers conducting the qualitative analysis were 'insiders' as registered nurses, and one a health and social sciences researcher – all three had formal research training (Doctor of Philosophy). None of the research team had experience as a participant nor clinician of the program being evaluated. Interprofessional peer review and debriefing supported conceptualisation, as recommended by Morse (2015), exploring researchers' positioning and influence on the research.

Through our analysis, we constructed a description of nurses and midwives experiences of the program from the perspective of both participants and clinicians adopting the six-step inductive thematic analysis approach of Braun and Clarke (2022), 1) familiarising self with data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining themes, and 6) producing the report. Steps 1) to 3) were conducted initially independently by the researchers using the transcripts, with the support of data management tools NVivo™, Microsoft Word™ or Excel™. Then at step 4 the initial themes and subthemes were reviewed and refined by the researchers together until gaining consensus and finally naming the themes, where meaning was generated through the interpretation of the data (for elaboration see Braun & Clarke, 2022). Findings were reported as a narrative summary supported by the nurses and midwives' quotes. The themes identified were considered alongside the survey data and then synthesised as part of the overarching program evaluation. Findings are presented in section 4.

3.2.5. **Study 4.**

Study 4 was an observational descriptive study (cross-sectional survey) of key program stakeholders.

3.2.5.1. Sampling and recruitment.

Key stakeholders were identified through the study sponsor, study adviser, and state-wide academic, health and professional industry publicly available contact e-mail addresses. In total, 144 stakeholders were invited to participate. The lead researcher contacted stakeholders via email and invited them to participate by following a link to an anonymous online survey. Of the 144 stakeholders, 39 (27%) provided consent. The survey was open for three weeks from 8 August - 31 August 2022.

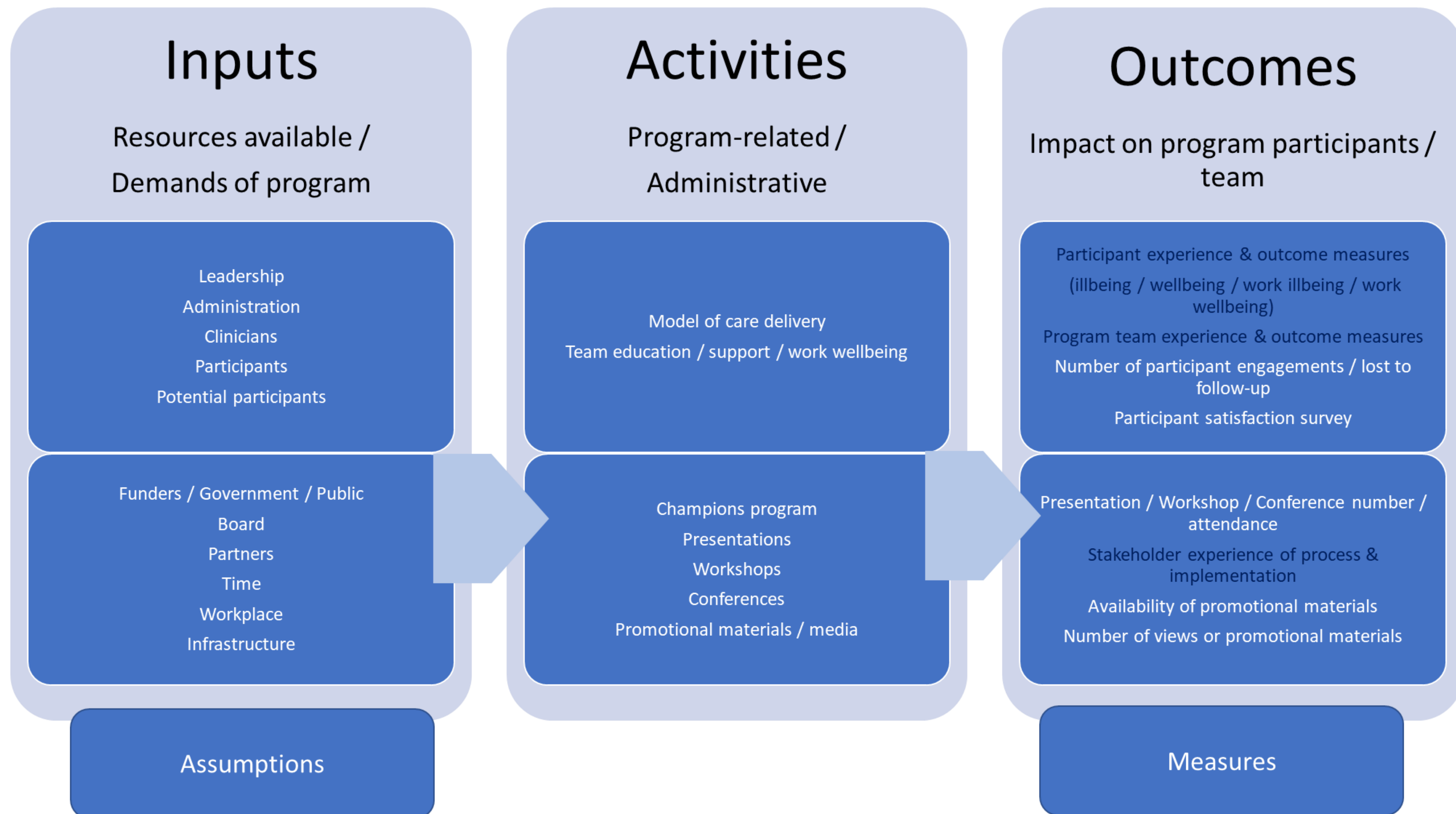
3.2.5.2. Data analysis.

Survey data were exported as .csv files from RedCap, then imported into IBM SPSS Statistics for Windows, version 29 (IBM Corp., Armonk, N.Y., USA) for analysis. For each outcome variable, descriptive statistics (mean, standard deviation, range) were calculated. Free response questions were organised by content area in Excel, then frequencies and sample quotes reported.

3.3. Delimiters.

To manage the scope of this project, there were important structures, processes and outcomes not included in this evaluation. Some of these have been addressed by other projects, such as an earlier 2012 evaluation, gap analysis, and economic evaluation (https://www.nmhp.org.au/about/our-service.html). Additionally, there were stakeholders not included in this mixed methods evaluation such as key program team members including the Board of Directors, Chief Executive Officer, or the Program Administrator, given the potential conflict of interest in either initiating the evaluation or supporting data collection. We have broadly conceptualised this program using a logic model (see Figure 4).

Figure 4. Program logic model.



The focus of this evaluation was towards the impact of the program (see 'Outcomes' in Figure 4), exploring three key areas in dark blue font: 1) NMHPV participant experience and outcomes, 2) NMHPV team experience, and 3) broader NMHPV stakeholder experience. Other aspects of the model offer future opportunities for evaluation.

3.4. Ethical approvals.

This mixed methods evaluation was approved by the Human Ethics Committee of The University of Melbourne (2022-22821-25367-3). Informed consent was obtained from all participants. For the survey this included integration of the plain language statement and consent form into the RedCap survey. Respondents were informed that their responding to the survey questions constituted consent to participate. Program participants and clinicians provided written consent prior to interview.

4. Results

Results are reported for each of the four RQs. Where data from multiple studies inform the question, each relevant study is reported independently then synthesised.

4.1. RQ1: What are the characteristics of nurses and midwives who engaged in the program?

The cross-sectional and longitudinal (T1) surveys contributed to answering RQ1, *What are the characteristics of nurses and midwives who engaged in the program?* Of the 1236 potential participants, 136 consented to participate, representing a response rate of 11%. Of the 136 people who consented to participate in a survey, 21 completed no more than the first two questions (i.e., regarding the dates that they were engaged with the NMHPV) and were excluded from analysis. Of the remaining 115 participants included in the analysis, 84 reported engaging with the program prior to January 2020 and therefore completed the cross-sectional survey, and 31 reported engaging with the program after 2020 and therefore were provided the opportunity to complete the longitudinal survey. The results presented in this section are based on the responses of the 115 participants who completed either the cross-sectional survey or the first time-point of the longitudinal survey.

4.1.1. Demographic profile of nurses/midwives who accessed services of the NMHPV.

The personal demographic characteristics of the respondents at the time when they participated in the NMHPV are summarised in Table 4.

Table 4. Participant characteristics.

Variable	NMHPV Participant prior to 2020 (n=84)		NMHPV Participant in 2020 or later (n=31)		Total (n=115)	
Age						
Mean (SD)	52.14 (12.21)		47.96 (9.80)		50.89 (11.65)	
Range	26 – 71		28 – 64		26 – 71	
Missing data	18		3		21	
	N	**%**	**N**	**%**	**N**	**%**
Gender						
Female	59	87%	26	96%	85	89%
Male	9	13%	2	4%	11	11%
Missing	16	-	3	-	19	-

Children						
Yes	45	67%	19	72%	64	68%
No	22	33%	9	29%	31	32%
Missing	17	-	3	-	20	-
Relationship status						
Single	15	22%	5	21%	20	22%
In a relationship (< 1-yr)	3	4%	1	0	4	3%
In a long-term relationship (>1-yr)	8	12%	4	17%	12	13%
Married	30	44%	15	50%	45	46%
Divorced	6	9%	2	8%	8	9%
Separated but not divorced	3	4%	1	4%	4	4%
Prefer not to say	2	3%	0	0	2	2%
Other	1	2%	0	0	1	1%
Missing	16	-	3	-	19	-
Highest level of education completed						
College/university graduate/TAFE	23	34%	11	38%	34	35%
Post-graduate certificate	14	21%	6	21%	20	21%
Post-graduate diploma	18	27%	9	33%	27	28%
Masters' degree	9	13%	0	0	9	10%
Professional doctorate or PhD	1	2%	0	0	1	1%
High School Certificate	3	4%	2	8%	5	5%
Missing	16	-	3	-	19	-
Ancestry						
Oceanian	16	24%	5	21%	21	23%
North-west European	31	46%	15	58%	46	49%
Southern and Eastern European	6	9%	2	4%	8	8%
North African and Middle Eastern	0	0	0	0	0	0
South-east Asian	1	2%	2	0	3	1%
North-east Asian	1	2%	1	4%	2	2%
Southern and central Asian	0	0	0	0	0	1%
Peoples of the Americas	0	0	0	0	0	0
Sub-Saharan African	1	2%	0	0	1	1%
Prefer not to say	12	18%	3	13%	15	16%
Missing	16	-	3	-	19	-

Aboriginal or Torres Strait Islander						
Aboriginal	0	0	1	4%	1	1%
Torres Strait Islander	0	0	0	0	0	0
Neither Aboriginal nor Torres Strait Islander	68	100%	26	92%	94	98%
Prefer not to say	0	0	1	4%	1	1%
Missing	16	-	3	-	19	-

Note: percentages rounded to nearest whole number; Abbreviation: TAFE = Technical And Further Education

The average age at which the nurses/midwives accessed the NMHPV was 50, and most participants identified as females (89%) who were married (46%) with children (68%). Only 1 respondent (in the post-2020 cohort) reported identifying as Aboriginal. Respondents' work demographics are summarised in Table 5.

Table 5. Respondents employment characteristics when participating in the NMHPV.

	NMHPV Participant prior to 2020 *n* = 84		NMHPV Participant in 2020 or later *n* = 31		Total sample *n* = 115	
Variable	**N**	**%**	**N**	**%**	**N**	**%**
Employment status as participant						
Employed but not working	10	13%	10	28%	20	17%
Unemployed	7	9%	2	8%	9	9%
Working <35 hours per week	31	41%	9	36%	40	40%
Working>35 hours per week	25	33%	9	28%	34	32%
Cannot remember	3	4%	0		3	3%
(Missing)	(8)	-	(1)	-	(9)	-
Registration as participant						
RN	49^	64%	23	77%	72*	68%
RM	10^^	13%	3#	10%	13**	12%
EN	9	12%	3	10%	12	11%
Graduate RN (first year of practice)	3	4%	1	3%	4	4%
Graduate RM (first year of practice)	1	1%	0		1	1%
Student RN	2	3%	0		2	2%
Student EN	1	1%	0		1	1%
Cannot remember	1	1%	0		1	1%

Missing	(8)		-	(1)		-	(9)		-
	N	**Mean (SD)**	**Range**	**N**	**Mean (SD)**	**Range**	**N**	**Mean (SD)**	**Range**
Years of clinical experience as participant (was not asked to those who selected student or graduate)	73	18.85 (14.23)	0 – 47	29	22.32 (10.93)	1 – 40	102	19.48 (13.41)	0 – 47

^ including 1 who reported being dual registered RN/RM; ^^ including 9 who reported being dual registered RN/RM; #including 3 who reported being dual registered; *including 1 who was dual registered; **including 12 who were dual registered; percentages rounded to nearest whole number; Abbreviations: EN = Enrolled Nurse, RM = Registered Midwife, RN = Registered Nurse.

Most study participants reported being employed at the time of accessing the NMHPV; less than 10% reported having been unemployed at the time of participating in the program. Respondents were primarily RNs, with fewer being registered as an RM or EN. Very few (less than 5%) respondents reported being a graduate (first year of practice) or student at the time of participating in the NMHPV. Overall, NMHPV participants had a wide range of years of clinical experience (0 - 47 years), with an average of 19 years. Working classification level and role type of NMHPV participants who reported being registered at the time of participating in the program are reported in Table 6.

Table 6. Classification and role of NMHPV participants who were registered as RN and/or RM when they were participating in the NMHPV.

Characteristic	NMHPV Participant prior to 2020				NMHPV Participant in 2020 or later				Total sample			
	RN N = 49		RM N = 10		RN N = 23		RM N = 3		RN N=72		RM N = 13	
	n	%	n	%	n	%	n	%	n	%	n	%
Classification												
Grade 1	2	4%	1	10%	2	6%	0	0	4	5%	1	8%
Grade 2	8	16%	2	20%	6	28%	0	0	14	19%	2	15%
Grade 3	5	10%	1	10%	1	6%	1	33%	6	9%	2	15%
Grade 4	1	2%	1	10%	1	0	0	0	2	2%	1	8%
Grade 5	2	4%	1	10%	0	0	0	0	2	3%	1	8%
Grade 6	1	2%	0	0%	0	0	0	0	1	2%	0	0
Grade 7	4	8%	1	10%	1	6%	0		5	8%	1	8%
Clinical Specialist	8	16%	2	20%	5	22%	1	33%	13	18%	3	23%
ANUM/AMUM	10	20%	1	10%	2	11%	0	0	12	18%	1	8%
NUM/MUM	0	0%	0	0	2	11%	0	0	2	3%	0	0
Clinical Consultant	3	6%	0	0	0	0	0	0	3	5%	0	0
Educator	3	6.1%	0	0	2	11.1 %	0	0	5	8%	0	0
DoN/ADoN/DoM/ADoM	1	1.5%	0	0	0	0	0	0	1	2%	0	0
Other	1	1.5%	0	0	1	0	1	33.3 %	2	1.5 %	1	7.7%
(Missing)		-		-		-	-	-		-	-	-
Role												
Working clinically	30	61%	6	60%	18	78%	2	67%	48	66%	8	62%
Working non-clinically	3	6%	0	0	1	6%	0	0	4	6%	0	0
Working in Management	6	12%	1	10%	3	11%	0	0	9	12%	1	8%
Working in a specialist clinical Role	7	14%	2	20%	0	0	0	0	7	10%	2	15%

Other	3	6%	1	10%	1	6%	1	33%	4	6%	2	15%
(Missing)	0	-	0	-		-	0	-		-	0	-

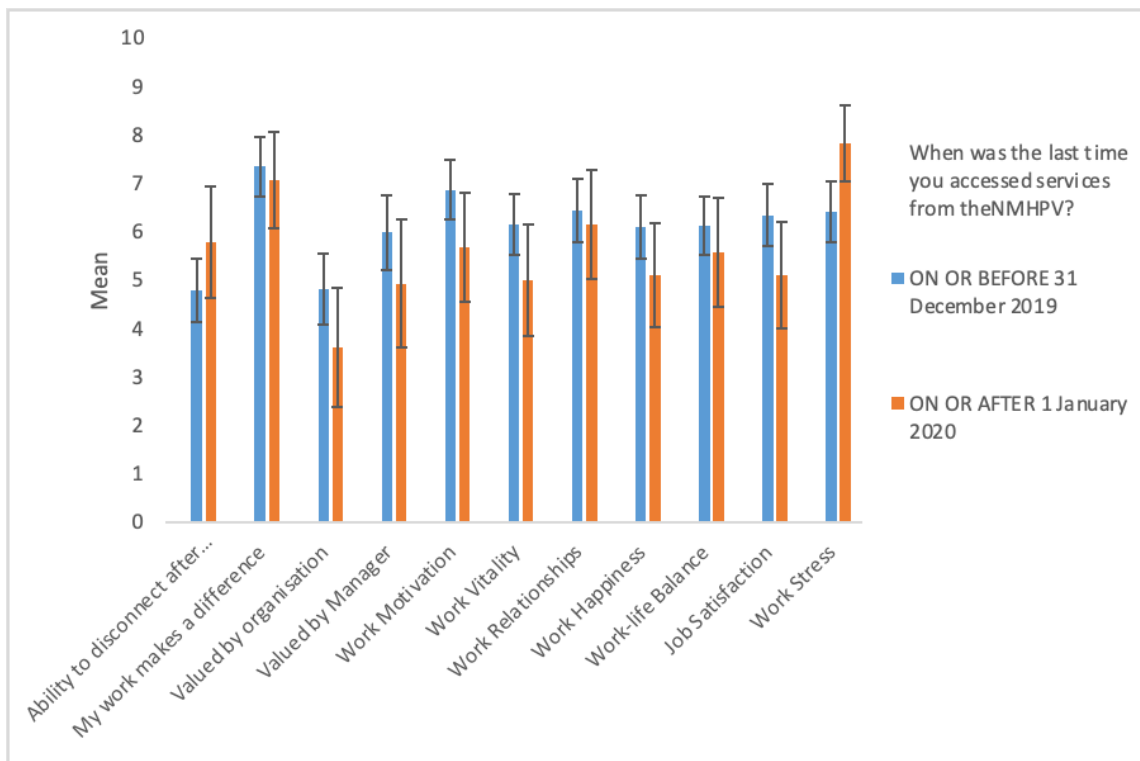
Notes: ADOM = Associate Director of Midwifery, ADON = Associate Director of Nursing, AMUM = Associate Midwifery Unit Manager, ANUM = Associate Nurse Unit Manager, DoM = Director of Midwifery, DoN = Director of Nursing, MUM = Midwifery Unit Manager, NUM = Nurse Unit Manager, RM = Registered Midwife, RN = Registered Nurse.

This distribution of results illustrates that nurses/midwives who access the program were spread across a wide range of professional classification levels. In terms of the role in which respondents worked when they accessed the NMHPV, the majority were in clinical roles.

4.1.2. Work wellbeing profile of nurses/midwives who accessed services of the NMHPV.

Respondents' levels of work wellbeing across different domains are illustrated in Figure 5.

Figure 5. Mean level of wellbeing across 11 work wellbeing domains for respondents who participated in the NMHPV.



Notes: before 2020 (blue) or since 2020 (orange). Responses were on a scale from 0 (Not at all satisfied) to 10 (completely satisfied). Error bars are 95% confidence intervals. Ability to disconnect after… = Ability to disconnect after work.

Tabulated results are presented in Supplementary file 3. Overall, the pattern of results indicate that work wellbeing is not high, with the means scores of individual items approximately at the midpoint of the scale range for most items. Across both cohorts, the work wellbeing domain that was most favourably endorsed was the perception that their work 'makes a difference'. Across both groups, the positively-worded work wellbeing domain that was rated least favourably was the perception that they were 'valued by the organisation' that they work for. The negatively-worded work wellbeing domain, perceived work stress, was rated poorly by most respondents.

For all domains except the perceived ability to disconnect from work, respondents who participated in the NMHPV prior to 2020 reported greater wellbeing than those who participated since 2020. For each domain, independent samples t-tests were carried out to compare the work wellbeing of the pre-2020 and post-2020 cohort; statistically significant differences were present for four of these 11 work wellbeing domains: job satisfaction ($t(98) = 2.172$, $p = .032$); work vitality ($t(98) = .332$, $p = .041$; work motivation ($t(98) = 2.050$, p

= .043); and work stress (t(98) = -2.38, p = .010). In summary, lower levels of work wellbeing were reported by respondents who participated in NMHPV since 2020 in comparison to those prior to 2020.

4.1.3. Work illbeing profile of nurses/midwives who accessed the services of NMHPV.

A summary of respondents' level of work-related burnout is presented in Table 7.

Table 7. Levels of work-related burnout (as measured by the work subscale of the Copenhagen Burnout inventory) in the pre-2020 and post-2020.

	Pre-2020			Post-2020			Combined group			Comparator Sample	Independent samples t-test significance
Variable (possible range)	M (SD)	Range	n	M (SD)	Range	n	M (SD)	Range	n	M (SD)	
Burnout – work subscale (0-100)	47.12 (21.30)	3.57 – 96.43	72	63.09 (21.80)	28.57 - 100	28	51.12 (22.91)	3.57 – 100	96	44.69 (19.23)#	.01*

#Study of 978 Australian midwives in 2017 (Creedy et al., 2017).

The group mean for the pre-2020 cohort (M = 47.12) fell within the 'Low/No Burnout' range, and the group mean for the post-2020 cohort (M = 63.09) fell within the 'Moderate Burnout' range; there was a statistically significant difference between the two groups (t(98) = -2.62, p = .005). Burnout levels reported in the present study were greater than those reported in a study of Australian midwives (Creedy et al., 2017).

To further explore burnout beyond group means, the prevalence of different severities of burnout were determined and are reported in Table 8.

Table 8. Prevalence of levels of work-related burnout in the pre- and post-2020 cohorts, and for the combined sample.

	Pre-2020		Post-2020		Combined Group	
Burnout prevalence	n	%	n	%	n	%
Low/No (<50)	34	47.2%	10	35.7%	44	44.0%
Moderate (50-74)	29	40.3%	9	32.1%	38	38.0%
High (75-99)	9	12.5%	8	28.6%	17	17.0%
Severe (100)	0	0%	1	3.6%	1	1%

Whereas 12.5% of the pre-2020 cohort had levels of burnout that high, over 30% of the pre-2020 cohort had levels of burnout in the high-to-severe category. Using the same scale with a group of Australian midwives in 2017, Creedy et al. (2017) found that only 7% of the sample had high-to-severe burnout.

4.1.4. General wellbeing/illbeing profile of nurses/midwives who accessed services of the NMHPV.

Wellbeing was assessed with several variables, including the Flourishing Scale, a composite indicator of satisfaction with health and lifestyle based on four items from the Work on Wellbeing questionnaire, a

question about happiness, and a question about life satisfaction. Respondents' levels of general wellbeing and illbeing across several domains are presented in Table 9.

Table 9. NMHPV participants' general wellbeing across four different indicators.

	Pre-2020			Post-2020			Combined			Comparator Sample M (SD)	*t*-test significance
Variable (possible range)	M(SD)	Range	n	M(SD)	Range	n	M(SD)	Range	n		
Flourishing Scale (8-56)	44.16 (9.82)	8-56	74	44.00 (7.47)	17-53	29	44.12 (9.18)	8-56	103	47.03 (5.96)^	.936
Health and Lifestyle Indicator (0-100)	58.70 (20.73)	0-100	73	57.75 (14.39)	25-92.5	30	58.42 (19.04)	0-100	103		.820
Happiness (0-10)	6.40 (2.09)	1-9	75	6.27 (2.21)	1-8	30	6.36 (2.11)	1-9	105		.772
Life satisfaction (0-10)	6.80 (2.05)	1-10	74	6.67 (1.94)	3-10	30	6.76 (2.01)	1-10	104		.765

^Jarden et al. (2022): sample of 49 nurses in Victoria during the 2020 pandemic

There were no statistically significant differences between the two cohorts on any of the general wellbeing variables. Notably, the level of flourishing was lower than that reported by a group of nurses surveyed in Victoria during the 2020 wave of the pandemic (Jarden et al., 2022). Participants levels of illbeing, as assessed by the K10 measure and the Stress subscale of the DASS measure are summarised for each group, and for the groups combined, in Table 10.

Table 10. NMHPV participants' illbeing across 2 indicators.

Variable (possible range)	Pre-2020			Post-2020			Combined				Comparator Sample	
	M (SD)	Range	n	M (SD)	Range	n	M (SD)	Range	alpha	n	M (SD)	t-test significance
DASS – Stress subscale (0 – 21)	16.64 (10.20)	0 – 42	72	20.5 (10.09)	4 – 42	28	8.86 (5.13)	0 – 42	.92	100	10.48 (8.26)^	.091
Kessler-10 (10-50)	20.01 (9.56)	10 – 50	70	20.88 (6.73)	12 – 33	28	20.19 (8.80)	10 – 50	.95	100	19.7[&]	.751

^Delgado et al. (2021), a study of 450 RNs working in mental health setting in Australia.
&Stubbs et al. (2021), a study of 433 hospital workers (including 133 nurses) in a large tertiary teaching hospital in NSW, during the 2020 pandemic.

There were no statistically significant differences between the two groups for either indicator. Notably, stress levels were higher than those reported by a sample of nurses during the 2020 wave of the pandemic in Victoria (Delgado et al., 2021). According to the clinically relevant categories of the DASS Stress scale, the group average (M = 8.86) was in the mild category. The group mean (M=20.19) for the K10 was in the mild distress category and was not significantly different to a group of 433 hospital workers in NSW in 2020 (Stubbs et al., 2021). To provide further insight, beyond group means, into the prevalence of states of illbeing, the prevalence of each clinical category of stress and psychological distress were also examined (see Table 11).

Table 11. Prevalence of states of stress (DASS-Stress) and psychological distress (K-10) for each cohort and the combined group.

	Pre-2020		Post-2020		Combined		Comparator Sample^
	n	%	n	%	n	%	
DASS Stress prevalence							
Normal (0-14)	35	48.6%	10	35.7%	45	45%	75%
Mild (15-18)	9	12.5%	4	14.3%	13	13%	9.3%
Moderate (19-25)	11	15.3%	8	28.6%	19	19%	8.0%
Severe (26-33)	12	16.7%	2	7.1%	14	14%	6.0%
Extremely severe (34+)	5	6.9%	4	14.3%	9	9%	1.3%
K-10 Psychological Distress prevalence							
Normal (0-19)	43	61.4%	16	57.1%	59	60.2	
Mild distress (20-24)	11	13.1%	3	10.7%	14	14.3	
Moderate distress (25-29)	4	4.8%	6	21.4%	10	10.2	
Severe distress (≥30)	12	14.3%	3	10.7%	15	15.3	

^Delgado et al. (2021), a study of 450 RNs working in mental health setting in Australia.

Although the sample predominantly reported normal to mild levels of both stress and psychological distress, over 20% of participants reported stress in the severe-to-extremely severe category, and psychological distress in the moderate-to-severe category.

4.1.5. Strengths use, strengths knowledge and resilience.

Three variables that have been identified as relating to wellbeing and illbeing were also assessed; descriptive summaries of strengths use, strengths knowledge, and resilience are summarised in Table 12.

Table 12. Summary of variables known to relate to wellbeing and illbeing.

	Pre-2020			Post-2020			Combined sample			Comparator Sample	Significance of independent samples t-test
Variable (possible range)	**M (SD)**	**Range**	**n**	**M (SD)**	**Range**	**n**	**M (SD)**	**Range**	**n**	**M (SD)**	
Strengths Use (0-30)	21.22 (6.10)	0 – 30	69	19.46 (5.86)	6 – 30	28	20.71 (6.06)	0 – 30	97	-	.198
Strengths Knowledge (0-30)	23.62 (5.84)	0 – 30	69	23.00 (5.44)	9 – 30	28	23.44 (5.71)	0 – 30	97	-	.629
Brief Resilience Scale (0 – 60)	31.32 (8.46)	1 – 48	74	30.79 (11.53)	4 – 48	29	31.36 (9.19)	1 – 48	103	40.81^ (11.38)	.951

^Jarden et al. (2022): sample of 49 nurses in Victoria during the 2020 pandemic

There were no statistically significant differences between the cohorts for these three variables. Notably, the level of resilience in the present study was lower than that reported by a sample of Victorian nurses during the COVID-19 pandemic in 2020 (Jarden et al., 2022).

	Time 3	16	5.12 (3.63)	0-10	
Work Vitality [a]	Baseline	29	4.93 (2.91)	0-10	p = .351 (n.s)
	Time 2	21	5.29 (3.07)	0-9	
	Time 3	16	4.81 (3.29)	0-10	
Work Motivation [a]	Baseline	29	5.72 (2.8)	1-10	p = .668 (n.s)
	Time 2	21	5.81 (3.04)	0-10	
	Time 3	16	5.12 (3.01)	0-9	
Valued by Manager [b]	Baseline	29	5.10 (3.48)	0-10	p = .367 (n.s)
	Time 2	21	5 (3.58)	0-10	
	Time 3	16	4.5 (4.10)	0-10	
Work Stress [a]	Baseline	29	7.76 (2.03)	4-10	p = .749 (n.s)
	Time 2	21	7.05 (2.22)	3-10	
	Time 3	16	7.44 (2.53)	2-10	
Valued by organisation [b]	Baseline	29	3.83 (3.35)	0-10	p = .395 (n.s)
	Time 2	21	4.29 (3.36)	0-9	
	Time 3	16	3.5 (3.12)	0-9	
My work makes a difference [b]	Baseline	29	7.17 (2.59)	1-10	p = .943 (n.s)
	Time 2	21	6.76 (2.68)	0-10	
	Time 3	16	6.94 (2.59)	0-10	
Ability to disconnect [b]	Baseline	29	5.65 (2.98)	0-10	p = .230 (n.s)
	Time 2	21	5.62 (2.58)	1-10	
	Time 3	16	6.19 (3.39)	0-10	
Work Pride [c]	Baseline	28	4.54 (1.14)	2-6	p = .877 (n.s)
	Time 2	21	4.62 (1.24)	2-6	
	Time 3	16	4.44 (1.31)	2-6	
Work Inspiration [c]	Baseline	29	3.83 (1.41)	1-6	p = .419 (n.s)
	Time 2	20	3.85 (1.60)	0-6	
	Time 3	16	3.37 (1.78)	0-6	

[a]Questions from the Work On Wellbeing assessment battery, [b]Questions suggested by the NMHPV sponsors for this evaluation, [c]Questions from the Utrecht Work Engagement Scale (Schaufelli et al., 2006).

Across the three time points, there was no statistically significant changes across any of the work wellbeing variables, except for Job Satisfaction, which declined from baseline to timepoint three (12-month follow-up).

4.2.2. **Work illbeing profile over time.**

Burnout increased over time from a mean of 60 to 64, however, this change was not statistically significant (see Table 14).

4.1.6. Associations between study variables.

To explore associations between the study variables Pearson correlation coefficients were explored. Correlations were also explored between all variables and age at the time of participating in the NMHPV, and years of clinical experience when engaging with the NMHPV were also explored; the full correlation matrix is presented in Supplementary File 4. Moderate-to-strong correlations ($r \geq |0.4|$) are highlighted.

None of the study variables were correlated with age or clinical experience. Health and lifestyle indicators had a moderate correlation with other wellbeing indicators, and with most work-wellbeing indicators. Health and lifestyle was also correlated with resilience and with strengths use (although not strengths knowledge). None of the satisfaction with NMHPV variables correlated with wellbeing or illbeing indicators. Resilience was not associated with any of the work wellbeing variables or burnout. Resilience was inversely associated with stress (as measured by the DASS-Stress Subscale, $r = -.504$) and inversely associated with psychological distress (as measured by the Kessler-10, $r = -.450$). Resilience was positively associated with happiness ($r = .538$) and life satisfaction ($r = .438$).

4.2. RQ 2: What is the effectiveness of the case management model on the wellbeing of nurses and midwives (longitudinal)?

The longitudinal survey (study 2) contributed to answering RQ2 *What is the effectiveness of the case management model on the wellbeing of nurses and midwives?* Of the 31 respondents from the baseline survey (reported in Section 5, RQ1) who reported engaging with the program after 2020, 22 went on to consent to the mid-point survey (6-month follow-up), and 16 went on to consent to the end-point survey (12-month follow-up). Fifteen respondents completed surveys at all three timepoints. At the second timepoint (6-month follow-up), eight of 22 respondents (36.4%) reported having accessed the services of the NMHPV in the time since having completed the baseline survey. At the third timepoint (12-month follow-up), nine of 16 respondents (56.3%) reported having accessed services of the NMHPV since completing the previous survey. Therefore, at the final timepoint, approximately half of the sample had engaged with the NMHPV at some point during the six months preceding April 2023, and approximately 50% of the respondents had not engaged with the program for at least six months.

4.2.1. Work wellbeing profile over time.

Descriptive summaries of work wellbeing over time, across 11 work wellbeing domains, are presented in Table 13.

Table 13. Summary of work-wellbeing variables across three timepoints.

Measure	Timepoint	N	Mean (SD)	Range	Repeated measured ANOVA significance
Job Satisfaction [a]	Baseline	29	5.10 (2.81)	0-10	$p = .020$*
	Time 2	21	5.95 (2.60)	0-9	
	Time 3	16	4.31 (3.16)	0-8	
Work-Life balance [a]	Baseline	29	5.45 (2.95)	0-10	$p = .422$ (n.s)
	Time 2	21	5.62 (2.60)	0-9	
	Time 3	16	4.5 (2.78)	0-10	
Work Happiness [a]	Baseline	28	5.12 (2.78)	0-8	$p = .297$ (n.s)
	Time 2	21	5.81 (2.82)	0-9	
	Time 3	16	4.69 (3.05)	0-9	
Work Relationships [a]	Baseline	29	5.96 (3.01)	0-10	$p = .425$ (n.s)
	Time 2	21	6.48 (2.73)	0-10	

Table 14. Burnout over time.

Variable (possible range)	Baseline M (SD)	Baseline Range	Baseline n	Midpoint M (SD)	Midpoint Range	Midpoint n	End-point M (SD)	End-point Range	End-point n	Comparator Sample M (SD)	Repeated measured ANOVA significance
Burnout – work subscale (0-100)	59.94 (21.79)	28.57 - 100	28	57.65 (21.38)	17.86 - 92.86	21	64.06	25.00 - 92.86	16	44.69 (19.23)#	p=.640 (n.s)

#Study of 978 Australian midwives in 2017 (Creedy et al., 2017).

Regarding the prevalence of burnout, the proportion of respondents at timepoint three (12-month follow-up) that were in the high burnout category was higher (44%), compared to baseline (29%) and timepoint two (6-month follow-up; 29%), see Table 15.

Table 15. Prevalence of burnout over time.

	Time 1		Time 2		Time 3	
Burnout prevalence	n	%	n	%	n	%
Low/No (<50)	10	35.7%	8	38.1%	4	25%
Moderate (50-74)	9	32.1%	7	33.3%	5	31.3%
High (75-99)	8	28.6%	6	28.6%	7	43.8%
Severe (100)	1	3.6%	0	0%	0	0%

4.2.3. General wellbeing/illbeing progression over time.

Descriptive summaries of general wellbeing indicators over time are presented in Table 16.

Table 16. Descriptive summary of outcomes on 4 wellbeing indicators.

Variable (possible range)	Time 1 M(SD)	Time 1 Range	Time 1 n	Time 2 M(SD)	Time 2 Range	Time 2 n	Time 3 M(SD)	Time 3 Range	Time 3 n	Comparator Sample M (SD)	Repeated measured ANOVA significance
Flourishing Scale (8-56)	44.00 (7.47)	17-53	29	44.32 (5.91)	33 - 55	22	44.56 (5.24)	31 - 51	16	47.03 (5.96)^	p=.681 (n.s)
Health and Lifestyle Indicator (0-100)	57.75 (14.39)	25-92.5	30	53.75 (15.62)	17.5 - 82.50	22	54.69 (14.05)	22.5 - 77.5	16	NA	p=.367 (n.s)
Happiness (0-10)	6.27 (2.21)	1-8	30	6.14 (1.08)	3 - 10	22	6.12 (1.59)	2 - 8	16	NA	p=.823 (n.s)
Life satisfaction (0-10)	6.67 (1.94)	3-10	30	6.55 (1.87))	2 – 10	22	6.44 (1.09)	5 - 8	16	NA	p=.815 (n.s)

^Jarden et al. (2022): sample of 49 nurses in Victoria during the 2020 pandemic

Over time, none of these wellbeing indicators changed substantially. As indicated by the comparator sample, the respondents in the present study scored lower on the Flourishing Scale than a sample of 49 nurses during the 2020 pandemic in Victoria (Jarden et al., 2022).

Descriptive summaries of general illbeing measures are summarised in Table 17.

Table 17. General illbeing over time.

Variable (possible range)	Time 1			Time 2			Time 3			Comparator Sample	
	M (SD)	Range	n	M (SD)	Range	n	M (SD)	Range	n	M (SD)	Repeated measured ANOVA significance
DASS – Stress subscale (0 – 21)	10.5 (4.75)	2 – 21	28	10.24 (3.81)	4-19	21	10.25 (4.45)	3 - 18	16	5.73 (4.05)^	p=.368 (n.s)
Kessler-10 (10-50)	20.88 (6.73)	12 – 33	28	22.12 (5.76)	15- 33	21	20.33 (5.41)	13 - 33	15	-	p=.127 (n.s)

^Jarden et al. (2022): sample of 49 nurses in Victoria during the 2020 pandemic

Over time, levels of stress (as measured by the DASS Stress subscale) and psychological distress (as measured by the K-10) were relatively stable. The prevalence of stress and psychological distress over time are reported in Table 18.

Table 18. Prevalence of stress and psychological distress at different levels of severity over the three study timepoints.

	Baseline		Time 2		Time 3	
	n	%	n	%	n	%
DASS Stress prevalence						
Normal (0-14)	10	35.7%	6	28.6%	5	28.6%
Mild (15-18)	4	14.3%	4	19.0%	4	19%
Moderate (19-25)	8	28.6%	4	19.0%	1	19%
Severe (26-33)	2	7.1%	6	28.6%	4	28.6%
Extremely severe (34+)	4	14.3%	1	4.8%	2	12.5%
K-10 Psychological Distress prevalence						
Normal (0-19)	16	57.1%	9	42.9%	8	53.3%
Mild distress (20-24)	3	10.7%	5	23.8 %	4	26.7%
Moderate distress (25-29)	6	21.4%	4	19.0%	2	13.3%
Severe distress (≥30)	3	10.7%	3	14.3%	1	6.7%

The prevalence of stress and psychological distress at different levels of severity remained relatively stable over the study period.

4.2.4. Strengths use, strengths knowledge and resilience over time.

Strengths use, strengths knowledge, and resilience over time are reported in Table 19.

Table 19. Strengths use, strengths knowledge and resilience over time.

	Baseline			Time 2			Time 3			Comparator Sample	Repeated measured ANOVA significance
Variable (possible range)	**M (SD)**	**Range**	**n**	**M (SD)**	**Range**	**n**	**M (SD)**	**Range**	**n**	**M (SD)**	
Strengths Use (0-30)	19.46 (5.86)	6 – 30	28	18.33 (6.70)	2 - 30	21	17.67 (7.23)	1 - 29	15	-	*p* = .819 (n.s)
Strengths Knowledge (0-30)	23.00 (5.44)	9 – 30	28	23.24 (3.87)	17 - 30	21	23.00	17 - 30	15	-	p=.851 (n.s)
Brief Resilience Scale (0 – 60)	31.4 (11.00)	4 – 48	29	29.33 (10.71)	3 - 51	21	28.00 (8.90)	2 - 41	16	40.81^ (11.38)	p=.906 (n.s)

^Jarden et al. (2022): sample of 49 nurses in Victoria during the 2020 pandemic

There were no significant changes over time for strengths use, strengths knowledge, or resilience.

In summary, the longitudinal survey (study 2) contributed to answering RQ2 *What is the effectiveness of the case management model on the wellbeing of nurses and midwives*? There was no change across any of the outcome measures across the three timepoints.

4.3. RQ3: What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians? (all survey and interview data contributing to these questions)?

The cross-sectional, longitudinal and qualitative descriptive studies contributed to answering RQ3, *What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians?* Data from the cross-sectional (study 1), longitudinal (study 2), and qualitative descriptive (study 3) studies were analysed and reported in the findings independently, then triangulated and contextualised in the discussion. For the cross-sectional and longitudinal studies, items related to satisfaction with program, perceptions of the best things about the program, referral pathways, goal setting were tabulated, analysed and reported as descriptives (tabulated), and correlations explored between wellbeing and illbeing variables and participant satisfaction, then described as a narrative summary. For the interviews, transcripts were analysed and are reported thematically.

First, we report analysis of the survey data (cross-sectional study 1 & longitudinal study 2) for items in which program participants were asked about satisfaction with the program, perceptions of the best things about the program, referral pathways, and goal setting, and our analysis of correlations between wellbeing and illbeing variables and participant satisfaction. Second, we report interview analysis of both program participants and clinicians.

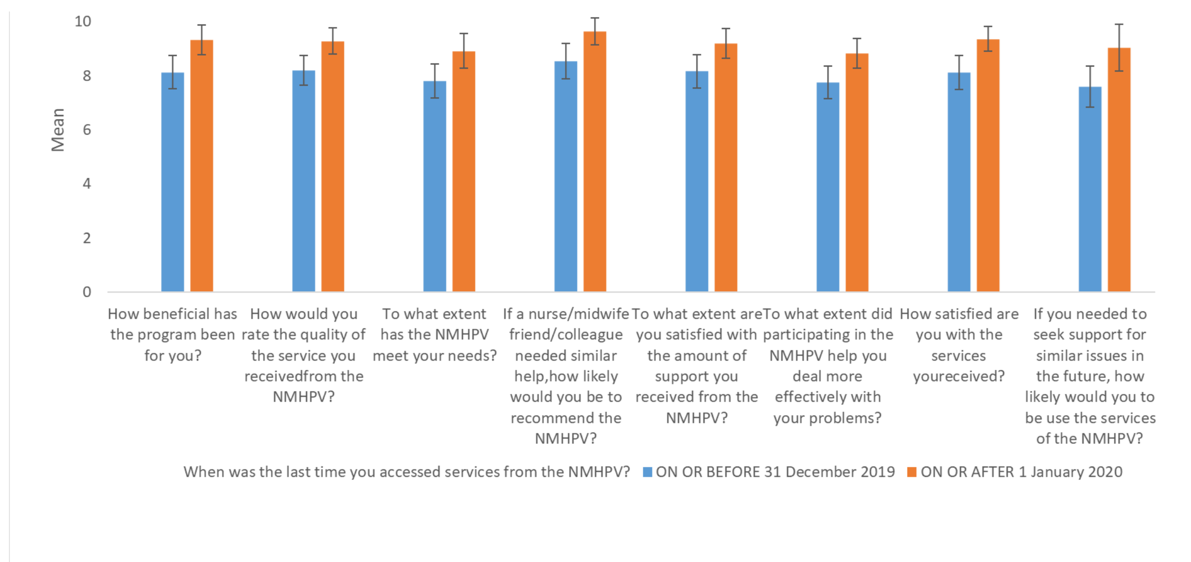
4.3.1. Analysis of survey data.

Four items from the cross-sectional (Study 1) and longitudinal (Study 2) surveys were analysed and reported.

4.3.1.1. Satisfaction with the NMHPV.

Respondents who had previously engaged with NMHPV answered eight survey questions about their satisfaction with NMHPV (see Figure 6).

Figure 6. NMHPV participants' satisfaction with NMHPV.



As presented in Figure 6, satisfaction was high in all areas. Notably, respondents who had engaged with the NMHPV more recently (since 2020) reported greater satisfaction that those who had engaged with the program before 2020, and this difference was statistically significant for all items (see Supplementary File 5 for full descriptive statistics for each item for each group). It is unclear whether this difference is due to changes in service delivery over time which truly affect participant satisfaction, or whether these results are due to recall bias, which is a well-established phenomenon whereby the greater the interval between using a service and being surveyed or interviewed about satisfaction with it, the poorer the recall.

Associations between the eight participant satisfaction variables and the general and work-related wellbeing and illbeing variables were also explored with Pearson correlation coefficients (the full correlation matrix is presented in Supplemental File 4). None of these variables were associated with each other.

4.3.1.2. Perceptions of the best things about the NMHPV.

One hundred and four respondents reported one or more of the 'best things' about the NMHPV. After excluding one comment that was not in English, and exclusion of two negative comments, content analysis was performed on 101 comments. A summary of the content of responses is summarised in Table 20.

Table 20. Summary of comments in response to the question "what are the three best things about the NMHPV?".

Theme	Sub-theme	Illustrative comment(s)	Number of comments	Alignment with program objectives[1]
Advice, Guidance, Support, Strategies				Develop and deliver services which promote case management and care coordination, and which are inclusive for diverse population groups, promote prevention, provide supportive responses and prioritise intervention and restoration of the individual's health, within a health and wellbeing framework
	Facilitated/inspired self-management strategies	*"I learnt some valuable thought patterns that I still use today."* *"The tools I now have in my head and written down to use in my daily life, to refer to when needed, knowing I'm ok."*	12	
	Strategies and tools	*"practical assistance, not just analysis!"* *"Constructive plan moving forward."*	27	
	Support and help	*"Excellent advice and support"* *"Brilliant facilitator who really gave me some Insight into my situation and amazing support"*	35	
Being listened to, being heard, being understood, being validated		*"Understanding. My first consultant was mental health nurse. She fully understood my situation."* *"I could vent and cry and felt listened and understood."*	69	Provide peer-based support services that are person-centred, evidence based, easily accessible through technology and sensitive to the health needs of the nursing and midwifery community, including prioritising those in susceptible and marginalised groups within the professions.
By nurses, for nurses		*"The counsellor had a nursing background herself so she was able to really understand the context unlike other counsellors."* *"The opportunity to discuss workplace issues with people who have share the lived experience of health professionals."*	34	Provide peer-based support services that are person-centred, evidence based, easily accessible through technology and sensitive to the health needs of the nursing and midwifery community, including prioritising those in susceptible and marginalised groups within the professions.

Group discussions or activities		*“Group discussion about important discussion points such as the nursing standards”* *“Meeting others who were struggling”*	7	Provide peer-based support services that are person-centred, evidence-based, easily accessible through technology and sensitive to the health needs of the nursing and midwifery community, including prioritising those in susceptible and marginalised groups within the professions.
Kind, compassionate, caring, friendly and warm		*“Friendly empathetic person at the end of the phone”* *“Kindness Empathy and understanding”*	22	Develop and deliver services which promote case management and care coordination, and which are inclusive for diverse population groups, promote prevention, provide supportive responses and prioritise intervention and restoration of the individual’s health, within a health and wellbeing framework.
Non-judgemental		*“The willingness to listen and not judge and acknowledge the difficulties I was experiencing in a toxic workplace”* *“The person I spoke to let me tell my story without judgment.”*	14	Provide peer-based support services that are person-centred, evidence-based, easily accessible through technology and sensitive to the health needs of the nursing and midwifery community, including prioritising those in susceptible and marginalised groups within the professions.
Practical features				
	Availability / timeliness	*“how very responsive to my request for support in a timely manner”*	11	
	Confidential	*“Someone confidential to help me work through my feelings, and experiences at work.”*	3	
	Continuity with clinician	*“Continuity with provider”*	6	
	Ease of access	*“That I can get any contact at any stage, I don't need a referral or specific health condition to participate.”*	10	
	Free	*“The service is free so when money is an issue you are not having to payout*	13	

		substantial amount of money"		
	Logistics	*"Availability and flexibility re location, times, mode (in person or via phone if needed)"*	7	
	Environment	*"Low key but inviting...non-clinical"*	2	
Safe		*"Having a safe space to discuss metal health issues"* *"The program allowed me to voice my worries and issues in a completely safe environment"*	6	Develop and deliver services which promote case management and care coordination, and which are inclusive for diverse population groups, promote prevention, provide supportive responses and prioritise intervention and restoration of the individual's health, within a health and wellbeing framework.
Independent/separate from work		*"Able to talk to someone uninvolved with work"*	3	
Skilled professionalism		*"knowledge and professionalism of staff members was exceptional"*	19	Maintain service policies, procedures, and guidelines which promote and sustain diversity, inclusion, and equity, in keeping with the diverse needs of our consumers and professional standards.
Successful outcome		*"I got myself out of a bad situation and went on to get a new job that I enjoyed."*	9	Develop and deliver services which promote case management and care coordination, and which are inclusive for diverse population groups, promote prevention, provide supportive responses and prioritise intervention and restoration of the individual's health, within a health and wellbeing framework.
The clinician		*"Connection I made with the counsellor that I saw"*	9	To provide peer-based support services that are person-centred, evidence-based, easily accessible through technology and sensitive to the health needs of the nursing and midwifery community, including prioritising those in susceptible and marginalised groups within the professions.

[1]Source: https://www.nmhp.org.au/documents/Annual-Report-2022.pdf

The frequency of words from the free response question "What are the three best things about the program", developed in NVivo^{TM} is presented as a word cloud in Figure 7.

Figure 7. Word frequency cloud of program participants' perceptions of the three best things about the program.

Note: Cloud includes all words, limited to a word length of a minimum of four letters. Larger font size represents a higher frequency.

4.3.1.3. Referral pathways to and from NMHPV.

Respondents were asked to indicate how they had been referred to the NMHPV; most were self-referred (see Table 21).

Table 21. Referral pathways to and from NMHPV.

		NMHPV Participant prior to 2020 (N=84)		NMHPV Participant in 2020 or later (N=31)		Total sample (N=115)	
		N	%	N	%	N	%
Referral Pathways	Self-referred	52	62	20	64%	72	62%
	Work referral	7	8	4	13%	11	10%
	Cannot remember	6	7	1	3%	7	6%
	Other	19	23	6	19%	25	22%
	ANMF/union	10		4		14	
	AOD Support Service	1		0		1	
	Education institution	1		0		1	
	Friend	1		0		1	
	GP	2		0		2	
	NMHPV	1		2		2	
	Psychiatrist	1		0		1	
	Nursing & Midwifery Board	1		0		1	
	Workshop	1		0		1	
Referral to other services	Did your engagement with the NMHPV lead you to seek different types of support or other services?						
	Yes	32	41	14	47	46	43
	No	36	47	16	53	52	49
	Cannot remember	9	12	0	0	9	8
	Missing	7	-	1	-	8	-
	Please describe the other services you accessed[b, c]						
	Psychologist/ psychiatrist	17	53	7	50	24	52
	GP	7	22	2	14	9	20
	AOD Support	3	9	0	0	3	6
	Union/ANMF	2	6	2	14	4	9
	EAP/Employment support	2	6	1	7	3	6
	Online resources	2	6	1	7	3	6
	Family support services	2	6	1	7	3	6
	Legal services	1	3	1	7	2	4
	Other	2	6	1	7	3	6

[a]Response options 0 (Not at all) – 10 (Completely). [b]Responses do not sum to number of people who responded to this question because some respondents reported accessing more than one service type. [c]Expressed as percentage of respondents who reported accessing any service.

Approximately half of respondents reported accessing other services as a result of participating in the NMHPV, with the most common service being that of a psychologist.

4.3.1.4. Goal setting as part of the program.

Respondents were asked about goal setting in terms of achievability and progress towards these goals, as part of their experience of the program (see Table 22).

Table 22. Goal setting as part of the program.

		NMHPV Participant prior to 2020 (N=84)		NMHPV Participant in 2020 or later (N=31)		Total sample (N=115)	
		N	%	N	%	N	%
Goal Setting	Did you set goals as part of your most recent involvement with the Program?						
	Yes	32	42.1%	17	56%	49	45.5%
	No	44	57.9%	13	44%	57	54.5%
	(Missing)	(8)	-	(1)	-	(9)	-

		NMHPV Participant prior to 2020 (N=84)			NMHPV Participant in 2020 or later (N=31)			Total sample (N=115)		
		Mean (SD)	Range	N	Mean (SD)	Range	N	Mean (SD)	Range	N
Goal Setting	[if goals were set] To what extent do you feel that the goals you have set are achievable within the timeframes you have set?[a]	8.35 (2.20)	0 – 10	31	7.76 (1.85)	4 – 10	17	8.15 (2.08)	0 – 10	48
	To what extent do you feel like you are progressing with the goals you have set?[a]	8.16 (2.24)	0 – 10	32	7.53 (1.70)	4 – 10	17	7.94 (2.08)	0 – 10	49

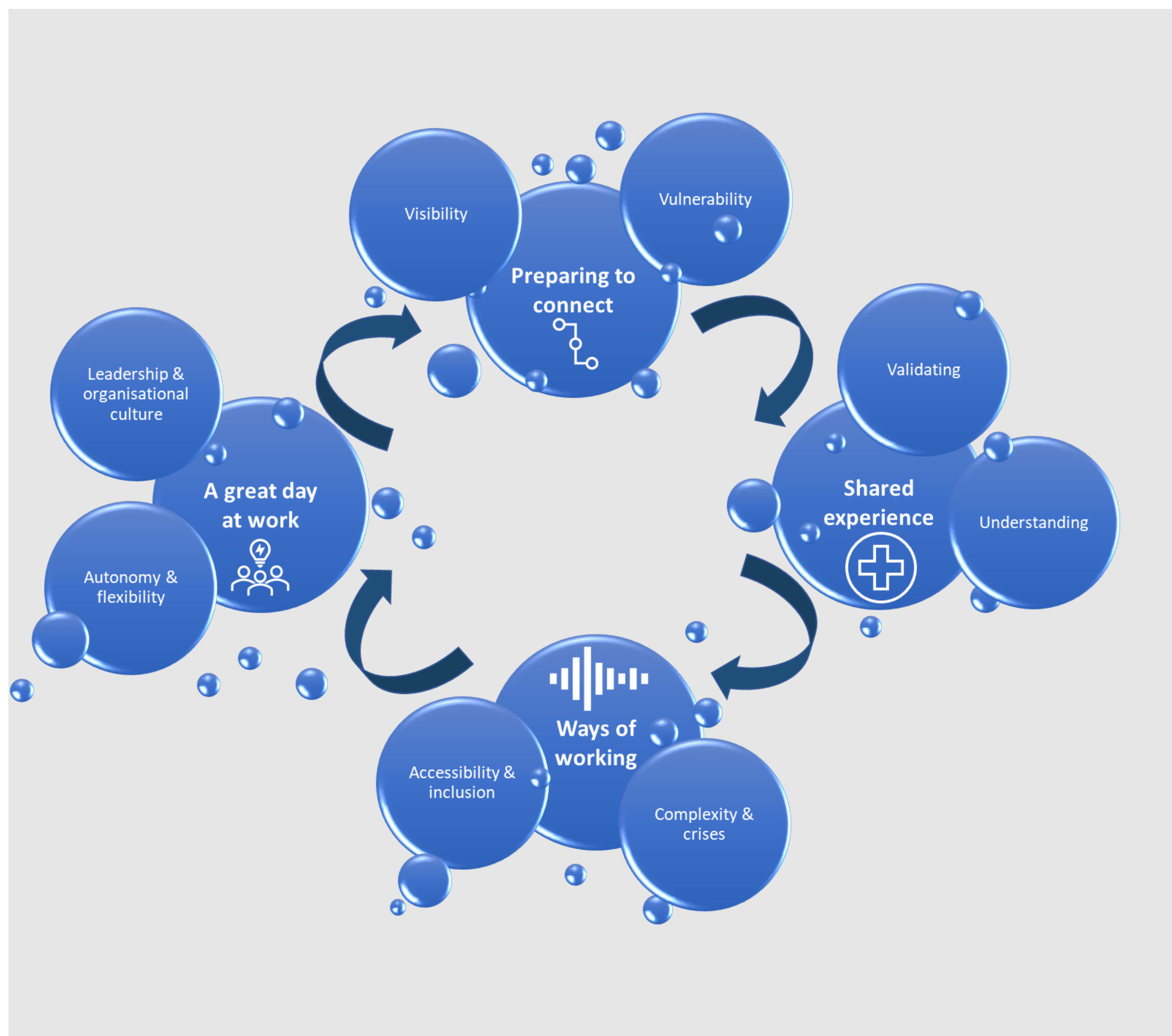
[a]Response options 0 (Not at all) – 10 (Completely). [b]Responses do not sum to number of people who responded to this question because some respondents reported accessing more than one service type. [c]Expressed as percentage of respondents who reported accessing any service.

Roughly half of respondents indicated that they had set goals when participating in the NMHPV, and on average, perceived that these goals were achievable. These findings regarding the importance of goal setting align with the NMHPV Strategic Objectives, which emphasise the principle of person-centeredness in the model of care.

4.3.2. Analysis of interview data (program participants & clinicians).

Eight clinicians and 16 program participants were interviewed (HB/RJ) from between 45 minutes – 2.5 hours. For the clinicians, given the small and potentially uniquely identifiable population, demographic data are not reported. For the program participants, most were nurses, median age was 54 years, (M = 51, SD = 11), had engaged with the program between 2011 and 2022, for reasons relating to mental health/wellbeing. Thirteen were still practising nurses or midwives. In our analysis of the interview transcripts, we constructed four themes encompassing program participants' and/or clinicians' experiences (see Figure 8).

Figure 8. Program participants' and clinicians' experiences and perceptions.



These four themes included 'Preparing to connect', 'Shared experience', 'Ways of working', and 'A great day at work'. Each theme is now described further detail.

4.3.2.1. Theme 1. Preparing to connect

Preparing to connect encompassed participants experiences, thoughts, and feelings in their steps towards engaging with the program. Two sub-themes were constructed, 'Visibility' and 'Vulnerability'. Participants emphasised promotion of the program widely to support improved visibility and reach, highlighting the value of resources to support prevention and self-assessment of risk. Ongoing promotion was suggested to reinforce availability of the service and address pre-conceived barriers to accessing support.

Visibility

At an organisational and operational level, promotion and reach of the program were felt by clinicians to be a high priority from entry to practice programs through to graduates and early career nurses and midwives and beyond, focusing on the uniqueness of the program as a space for nurses and midwives and ensuring all nurses and midwives learn about the program when they are well, or can easily find it when they need it. Drawing from technology and social media, champions, nursing and midwifery leadership and management, and collective strengths of stakeholders were all suggested mechanisms for promotion,

"*our social networking, all of our promotional stuff, like when you look at other programs, they have whole teams that do that. And it's always been left to us, so it's always very ad hoc, and like, we're flying by the seat of our pants all the time trying to make that happen...nurses and midwives are so incredibly busy that*

they only remember what they need at that time. Yeah. And so if they don't need it, then and then it's forgotten. So they might have heard of us somewhere along the line. But if they don't need us, they won't remember. Yeah. And hence the marketing and social media, what it like whatever marketing, you know, like, if we had a whole department that was doing that, potentially everyone would know about us." (Clinician)

Participants initially found the program through a range of avenues such as a website, brochure, poster, through to referrals from Union or a colleague, hearing of others positive experiences, and the Champions program. More promotion and stronger local referral systems, such as by health organisation senior management, were proposed by participants to be important,

"*I would love to see if it's facilitated, if it can be facilitated, or I would love to see, some in-service on a local level, particularly, like I said, [...] we're dealing with a lot of - this is the perfect opportunity and the perfect time for the NMHP to get in and get involved. […] there's a lot of let's just say, you know, we're not exactly leading with kindness at the moment. So I think this is the perfect opportunity for NMHP to get involved because we've just come off the back the back end of a two-year lockdown. People's mental health is not great, people's drug and alcohol problem - people's drug and alcohol misuse and substance abuse rates are up. And I think I would love to see on a local level, NMHP sort of stepping in and being like: We're here, it's confidential, we're a service that can provide support for whatever you're going through."* (RN371)

Promotion was suggested as a means to indirectly save patient lives, underpinned by early intervention and prevention,

"*Think of the prevention, think of how many nurses you hear the stories of like they're struggling, and everyone knows that they're two that they're one bad day away from killing someone? Yeah. What would happen if there were if they had been referred to the service that I had been? Where, how many people could be saved? If there was someone there saying, hey, there is a service here. Use it. Figure out, get yourself together. Because you're about to kill someone. It will save lives. It probably already has*" (EN81)

"*There was a roundtable setting talking a bit about mental health. One of the best things there […] was a really good slide that I actually wanted to get a copy of about assessing whether you're cruising – 'Okay', you know, slightly at risk or highly at risk […] which I thought was really valuable in terms of identifying, you know, whether your your mental health is at risk because of what's going on. So I found that really useful.*" (RN/RM224)

Vulnerability

There was an acknowledgement of more recent promotion local in the organisations by industry (program) experts and through social media. This promotion was felt to be particularly important to break down "taboo" and clarify misunderstandings for those who might not be sure if the fit the "category" to contact the program,

"So even though it wasn't a nursing related issue, because I was worried that, you know, wasn't nursing related. But because I was still actively working and needed to perform my role as a nurse with my background, the background problem going on, and to so the best things about the first phone call, yeah, for me was relief, that I wasn't dismissed as not worthy of the program. I suppose that was probably the biggest relief that I was actually listened to." (RN1170)

Additionally, there was *fear in making contact*, where nurses and midwives expressed feeling worried, nervous, apprehensive, and vulnerable on engagement,

"*...just all those just all those normal those normal gendered things that you know, that you possibly like a sign of weakness talking about these things, and sort of like, you know, making like, you know, making like too much out of it and all that sort of thing and possibly, possibly, yeah, possibly coming across. It's all that it's all that idea about sort of, like, you know, sharing, you know, sharing sort of, you know, relatively private things about the workplace with people that you don't really know. So possibly feeling possibly feeling vulnerable and exposed*" (RN51)

The opportunity to speak with someone unrelated to their employer's organisation appealed to several who were looking for a confidential service independent from their place of employment,

" the hospital does have the counselling, but I went to see one person one time and just their language and the how they were putting it it was like that, yeah, this this is not going to work. And I think I tend to be very distrustful of management where I work and so even just knowing it's their program even though I know rationally that it's confidential and you know that it's what's the word I'm looking for. Impartial. I think I had sort of resentments and things there. So I prefer to seek it out in other avenues " (EN31)

4.3.2.2. Theme 2. Shared experience

Shared experience encompassed participants' and clinicians' thoughts and feelings about the program's model of clinicians having lived experience of nursing and/or midwifery practice. Two sub-themes were constructed, 'Understanding' and 'Validating'. Participants' expressed feeling that they and their concerns were understood and validated through engaging with the program. This understanding and validation seemed inextricably linked to the program being delivered by clinicians and their lived experience of nursing and/or midwifery practice, a key feature of the NMHPV model of care.

Understanding

Clinicians' felt their lived experience of nursing and/or midwifery practice was invaluable, alongside the broad diversity in clinician experiences to support the delivery of the program,

"You know, you've got that background knowledge, you know, all the intricacies that other people don't understand in terms of, you know, the lingo, the language, the, you know, the experience of, you know, the demands of working in a busy ward, you know, that connection sort of on that level." (Clinician)

Participants resoundingly expressed the importance of the clinicians being colleagues or peers, and sharing their lived experience of nursing and/or midwifery,

"*I was able to give real examples of in, in my workplace, and the way I was feeling and my behaviors and what I was doing and what was concerning, we kind of went through scenarios, I could explain scenarios to them. And they understood because they'd been in a similar workplace. Yeah.*" (RNRM 492)

Seeking support from a colleague, a peer, someone who understood, was meaningful to participants, particularly for those who had spoken with other professionals who did not have the foundation of a shared understanding,

"*for a number of other issues, that people might go to the [program] with, I think those things would be very much helped by going to that program, partly because, you know, it's, it's pretty much run by nurses, for nurses. And I think that's an incredible strength. […] if you haven't been a nurse, you can't really understand what it's like to be a nurse. And that's why that's what I think is a real strength of the program. And I think that's what sets it apart from [other programs]… being able to speak to somebody who knows what a late early is for is, you know, is a really good is a really good foundation, because it's hard, I think, for nurses to ring up and say, I need some I need support. I'm not, I'm not okay. And to be able to ring somebody who has kind of stood in your shoes is, I think, the essence of its success, really, because you know, that's the thing that bonds you. Understanding.*" (RN453)

The shared understanding, having someone knowledgeable of their work, and speaking with someone with a shared professional language was invaluable to participants. This shared understanding felt reassuring and enabled vulnerability, a sense they did not need to translate as they were understood,

"*it's easier, because you don't translate … so you can start off, the conversation can flow. And you're getting to the nitty gritty of things…Just inherently, it's so much simpler. And it just takes one more level of the dialogue out, because you can just cut to the chase and they equally can respond with something that you can understand because it's how, our language is different, I guess. Yes. Because of the nature of it, our jobs and caring, and empathy, and all those things. So you've got this professional, clinical critical thinking kind of role, but wrapped up in emotion. So you've got really good at balancing those two things and peeling them apart for you. So you can see that one might be compromising the other or having an effect on the other. And it's really, I found helpful.*" (RN308)

Participants considered it important that this was a program of nurses and midwives supporting each other,

"*there's been a lot said about, you know, nurses, you know, they eat their own young and, and things like that. It it, it can be true to some respect, some nurses don't support each other. And I think with that program, you've got nurses supporting nurses.*" (EN594)

Validating

Participants overwhelmingly spoke of the program being fantastic, exceeding expectations, that it was essential, and shared their positive feelings about the program,

"*... I just can't talk about it highly enough. I speak about it quite openly. I'm not ashamed to tell people that I've used it. You know, when I've had things going on, and, you know, I think that that whole thing of just acknowledging, yeah, what you're going through is real, it has an impact, not just on your mind, but your body as well.*" (RN/RM224)

"*I just hope that the people who run the program know that, you know, I had a happy ending.*" (EN81)

"*I would love to go back and see [clinician name]. And just for a success story for her I think and just to just to say that she can pass that on*." (RN371)

These positive statements extended to their experiences working with the clinicians relating that they felt validated, comfortable, supported, understood, nurtured, and listened to,

"I felt that she understood. Yeah. So maybe it was just the right person the right time. I think that makes a lot of difference […] and that was probably the best thing I ever did. Just finally had someone to talk to independently about it." (RN294)

"I found it inclusive, I found they were very sort of, you know, open to my problems that they you know, weren't judgmental, they made me feel like, you know, what I was saying…They made me feel like my, you know, like my concerns my issues mattered. Like they that they weren't kind of dismissed as something as something trivial and just you know, go back and back up and you'll be okay. So I was taken seriously Yes, I was taken seriously." (RN51)

"*I felt, you know, I guess relieved in myself that I was doing something about my problem, and that I was taking a step to, I was acknowledging that I guess I needed help and acknowledging that there was a problem and acknowledging that it was okay to ask for help. So I think I felt relief from that sense that I was now acknowledging a problem and getting help with it.*" (RN371)

Participants also reported that knowing that they were not alone was important,

"*[hearing of others] who had gone through what I had gone through and had come out the other side and had been successful […] So listening to those sorts of stories sort of gave me hope that I could get through it, I guess and that it wasn't going to be all doom and gloom.*" (RN371)

"*So, I think going and doing the champion study day with like-minded people, and just went, 'Oh god there's more of me out there. It's okay'.*" (RN838)

For some, the program was a helpful short-term solution, as either a safe entry point to the system and an initial person to talk to until other psychological services became available, or to complement other identified supports,

"*I was seeing a therapist on the outside. But having somebody that you feel maybe some sort of rapport with, like they understand your role was was a big thing for me approaching the program. Yeah, yeah. It's different when you talk to us psychologists or psychiatrists, who's not a nurse. There's the trust, but it's different.*" (RN891)Participants felt it helped to talk to someone, the structured (or less-structured) short sessions, pace, and pathway were helpful, it felt tailored, and it tapered off nicely whilst retaining a safety net and sense of being able to go back if needed,

"*So and then I think as the intensity started dying down, things started becoming less crisis, more change, more change, and so flux, the period of like a period of flux, where it's like, things are changing, you're*

finding a new normal. You know, I think they started cutting back on a bit more on the counselling. They always left the open... I think we ended with the offer being open, if you ever need it, you can always call us. […] I will always be grateful for the service. Like, it was an amazing thing. And it kept me sane, kept me being able to be like, figure out" (EN81)

Others would have preferred their first point of contact to have been someone more nurturing, or a more tailored program,

"I was never given sort of like a tailored program...And I think that's something that maybe I should have had, like I should have, you know, maybe you should have had a tailored program, and they should have been, like, you know, maybe you should come back and see us in two weeks or three weeks, or, you know, sort of setting like keeping that relationship going between client practitioner sort of situation, I think, would have been helpful for my case, rather than me having to, you know, make those appointments myself, because, you know, I might, you know, not I mean, I'm, I was obviously very determined and passionate and really wanted to get the best case for myself. So, I was proactive in booking those appointments. But I think a lot of people might not have that strength to do that themselves. And I think, particularly if they're in situational crisis, they might not feel the energy or the, you know, the drive to be sort of booking themselves in and things like that" (RN371)

"*… and then I guess the I feel like they might, you know, for people who are a bit hesitant to get involved, you know, having a, an example timeline, or a plan that describes, you know, what a usual course, might look like in terms of duration, and, you know, what you can expect, might actually help sort of, use a bit of structure to, to, or help help a person understand what they're getting into.*" (RN280)

4.3.2.3. Theme 3. Ways of working

Ways of working encompassed participants' and clinicians' thoughts and feelings of engaging and experiencing the program and case management model. Two sub-themes were constructed, 'Accessibility and inclusion' and 'Complexity and crises'. Participants referred to factors that enabled or inhibited their participation, ranging from practical factors to cultural and psychosocial factors. Both clinicians and participants highlighted person-centric features of the NMHPV that increase its accessibility and adaptability to the individual, including varied meeting formats, low barriers to entry in terms of cost and scheduling, and flexibility around the number of sessions.

Accessibility and inclusion

There was a sense of importance for clinicians in working within a service that is free, accessible, separate from the workplace, confidential, and there was a sense of this contributing to social justice,

"*is accessible to everyone regardless of their capacity to pay, so it's free… So for me, there's a real social justice component to this program… this service is absolutely tailor made for nurses, and has a deep understanding of not only the issues that an individual might be facing, but the sort of environmental and cultural context in which it occurs … that arm's length, and that absolute disconnect between ourselves and work helps us to create a stronger therapeutic alliance.*" (Clinician)

Program participants highlighted the importance of having services available nearby and in-person, particularly for those in regional centres,

"*But certainly, if it was, if it was expanded, they could probably have, you know, offices in major regional towns or something. […] I wanted to meet in person, because of my past experience with counsellors. Yeah. So I, I was prepared to travel to the [city] to meet with my support person.*" (RN1170)

The challenge of accessing services in the country was the reality,

"*I work in the country; I live in the country. It is harder to get any sort of service up there. […] But it's just different in that there's more isolation, I think, in the country. And, yeah, I think there is more benefit, because we struggle.*" (EN31)

Clinicians thought there were opportunities to enhance cultural awareness and competence and to increase diversity amongst the clinician team to support inclusion which also extended to challenges matching program participants with clinicians based on their strengths and knowledge which was not always feasible within the small team,

"…*the lack of diversity in the team. Yeah. So diversity of all descriptions. So you know, cultural diversity is lacking. Probably age diversity is lacking it, you know, every sort of, I guess, minority is lacking. So diverse diversity, I think is something that definitely needs to be addressed*" (Clinician)

"*I think, like, moving with the times, like, we really do have to up the game on a few things that are changing … there are a lot of things that are now in our attention, or in our consciousness that we would need to be aware of and need to start kind of addressing. Yeah, I mean, there's, there's so much we could be doing, like, indigenous health or First Nations, nurses, and midwives, you know, that, like, there's so much stuff we could be doing*" (Clinician)

From the perspective of a participant, the program was perceived to be inclusive and non-judgemental,

"*I guess the first thing was just, you know, knowing that that program was there, and that I could go and talk to somebody, you know, if my if sort of, like, if that I could talk to somebody if my if the trying to phrase it here, just if the other support networks, were not sort of working, that there was like somebody else that I was, you know, really able to go to? Yeah, I found it inclusive, I found they were very sort of, you know, open to my problems that they you know, weren't judgmental, they made me feel like, you know, what I was saying…They made me feel like my, you know, like my concerns my issues mattered. Like they that they weren't kind of dismissed as something as something trivial and just you know, go back and back up and you'll be okay. So I was taken seriously Yes, I was taken seriously. So yeah, I guess I guess all those all those things. Yeah.*" (RN51)

For some participants, the initial matching with a clinician was perceived to be good, they felt they were seen quickly, and they appreciated the consistency in continuing to work with the same clinician,

"*one person was very, yeah, was very valuable. Having continuity. One person I know, it's not always practical. But certainly for me that continuity, because I didn't have to retell my story in a sense*" (RN1170)

Others would have preferred their first point of contact to have been the nurse or midwife,

"*when I first rang up, and kind of, I just, I didn't realise that I was gonna be speaking to a receptionist first off, and so I've sort of started to tell my story and why I wanted some support. And she said, "I'll take your information and get someone to call you within 24 hours." So, you know, there's that moment where you've plucked up the courage to actually talk to somebody and then have to wait again, which I understand now is part of the process. And when I recommend other people to do go or engage, I'll say what to expect that you'll when you ring, you'll get a receptionist. They'll take brief information, and then a counselor will ring you back within 24 hours.*" (RN/RM224)

Participants engaged with clinicians via the phone, online, or in-person, and this was described as working well for most,

"*That was valuable too, that I had access to the program via the phone. .. anytime I needed help, and I was given in a very timely manner, a support time, so I didn't have to wait a long time to get help. And that was really valuable, too. Because often when you need help, it's often immediate that you need it ... the support person was really valuable to me. And … accessible…I was just so amazed at the program*." (RN1170)

Engaging was perceived easy for most, who liked the accessibility across these mediums, although meeting in person was a preferrable option for some,

"*I was given the opportunity to meet, that was great. I do appreciate the one on one. I'm at the pointy end of my career. I'm one of those people I look, I think it's it's why I'm a nurse, I like human contact. I like interacting with people. These Zoom meetings are great, and they're convenient. But it just doesn't provide what you can have when you're in the same room with another person*." (EN31)

Clinicians shared the value of recent extensions of communication mediums to support online, phone, and in person consultations with program participants who might not otherwise have access, increasing flexibility and availability to meet, particularly where appropriate in-person meeting space is limited,

"…*think the fact that now, because of COVID, actually, we've got a lot of people are just doing it on Teams. So you know, you can, it's just much easier. So we've got a much broader reach as well*" (Clinician)

"*…people would probably much prefer to just do a session on Microsoft Teams than drive all the way in to an office, you know, so I haven't had anyone in the whole almost year have been here request to see me in person.*" (Clinician)

"*…this phone based and, and yeah, electronic e-based tele has changed things dramatically. And I think overall it has increased. If it has any advantage, it has the advantage of access.*" (Clinician)

Participants found the open-ended availability of sessions valuable,

"*that was an amazing benefit. That it's free access. Yeah. And it seemed like I wasn't limited to say six. You know, like some counseling, you're limited to certain sessions. At no time was I told you're not allowed to have any more. So that was really valuable as well.*" (EN81)

The program being cost-free was also important for many,

"It's also valuable, that it's not costly. Yep. So that is a really was fantastic. You know, you know, you just have to be part of the union to access it. So that was an amazing benefit. That it's free access." (RN1170)

Extending the service was considered important for reach with the support of strong resourcing to sustain workforce whilst maintaining team cohesion, keeping sight of program intent, and maintaining respect and confidence built by the organisation over the years,

"*I don't know whether it there might be capacity for it to become more than an entry service. I know, I know, the team does run the other, you know, they do the promotion, I'm aware they run groups for drug and alcohol rehab, and this sort of thing. But I just wonder if there would be greater capacity to employ people… who, you know, are able to provide more than an entry level type of service, actually, you know, for those sorts of people who are waiting six months for psychology, you know, maybe something, someone … to sit on the team and actually be able to work with people and their trauma on a deeper level, so I wonder if that is another maybe another element to add to what we're able to offer.*" (Clinician)

"*so I think, yeah, maybe expanding more … offering like, say, an online support group for specific cohorts like grads or students, like they've got at the moment, they're running a support group for people with addictions once a week. […] I feel like always that lens of trying to grow, improve, make the service better, you know, encompass all aspects of health.*" (Clinician)

Complexity and crises

The goal setting, knowledge, and advice were felt to be practical and helpful,

"*…it was very practical [advice], because that's what I needed. I didn't need you know, meditation and you know, all that. I needed practical advice. Yeah. And [the program clinician] was able to steer me in the right way… that's why I was very happy to talk about the program. Because it actually was the most valuable thing through my whole process. That was the most useful that I'd found."* (RN1170)

Developing a sense of knowledge and the skills to continue on without the program was progressive,

"…and then towards the end, I had enough knowledge to then start accessing my own self education in what I was dealing with, so she was the catalyst for then me going on to help myself as well, which I couldn't have done without her." (RN1170)

"*And they get you through that horrid space, and then work with you. And then go, you know, you've actually got this and they give you the reins back. And they never take the reins away from you.*" (RN838)

For one RN, the active engagement in addressing problems with the support of the clinician was challenging,

"*I thought overall, it was quite a quite a nurturing setup. But I also thought they asked me some questions which were quite, you know, thoughtful, and required me to, you know, agonize over the answers like this, is, it's not all Tea and Sympathy. And I think that's good. If you struggling to nut out a problem, you can go and talk to your neighbour, if you just want Tea and Sympathy. But if you really want to move on, then you need to be seeing somebody who has a few skills and can stretch you a bit. Otherwise, you might as well talk to your friends*" (RN453)

Clinicians described the importance in the flexibility and autonomy in building therapeutic relationships with participants, drawing from their strengths across a range of knowledge and experiences such as counselling, adapting to the person's unique situation whether this be a single meeting through to intermittent meetings across years as different participant needs arise,

"I mean, we can we hold people for quite a long time. And that's great that we're given autonomy to do that. And, and some people for whatever reason, just can't reach out for that next step of seeing a psychologist…" (Clinician)

"*I guess the rapport you build with the consumer of the program, whether or not they felt listened to heard validated, you know, understood, all of that kind of stuff. And often, you know, it was the listening that they were after they wanted somebody to hear their story and to empathize with their story and to understand what was going on for them. And, you know, often that can't be easily understood and done in just one session, you know, in one sort of 50-minute session. So, you know, often people felt that they had more to say, or more to follow up on…*" (Clinician)

Yet also, understanding and setting boundaries as to what the service does offer, and what it does not, was a common theme, suggesting different ways of working with participants who are also engaging with other health professionals such as psychologists or who may need referrals to alternative support services,

"*…say, really clearly, you do understand I'm not a psychologist… we can refer you"* (Clinician)

The program and case management model did not suit the needs for all, with some nurse and midwife participants suggesting their needs were too complex,

"I was seeing so many other professionals at the same time, they couldn't find anything. It was unrealistic, you know, for the [Program] to find the answers" (EN525)

Others wanted faster contact,

"*…I got the impression that the person who picked up the phone and was making those arrangements is actually putting a bit of thought into it and that was really, that was really nice that I got to stick with someone, but also someone was quite earnest in what they were doing and I appreciated that. And I think when, when [they] did say, … it's going to be a couple of weeks until you can have a chat to them was a bit like, oh, a couple of weeks isn't great, because I sort of felt pretty ordinary at that stage. So I guess, you know, sort of something more timely would have been ideal, but I think that if it was, if, if the situation was dire, then there's obviously other resources out there that would meet that need. Yeah.*" (RN280)

For some program participants, more time with the clinicians or stronger linking with (or referrals to) other services was suggested to be a helpful option,

"*So I guess maybe, if there were psychologists, or someone linked in, because I only saw nurses. If they had a very easy referral process into someone else, and especially what especially because it was, it's work related. And that's kind of why I went to the program, because I was like, I need to understand why I behave the way I do when I walk into my workplace. It never used to be like this. Yeah. And so I think maybe someone who had a little bit more of experience. So psychologists or a psychiatrist, a bit more experience with the trauma would have been really helpful.*" (RNRM492)

Misconceptions of the program as a crisis service were also expressed,

"… it's a crisis. Yeah. And it was there to sort of get me into a secure state. It was basically to get me tided over into like, you get other services involved. And they made that very clear when you started out. You know, it's a crisis service." (EN81)

Boundaries of the program were felt to be clear, particularly in terms of integration and engagement with other services,

"*I had been having issues with depression [and] anxiety over the years, and had always been using a psychologist. And that was very helpful. But I also thought I might benefit from having a person with a professional knowledge of, you know, the issues that were occurring because some of the issues were actually related to people that I was working with, so I thought it might be beneficial. [the program clinician] was very careful. [They] knew that I was seeing a psychologist so that things that we covered, were not*

things that would be covered by the psychologist. [They] didn't want to be impacting on those boundaries, wanted to be very professional about that… [They were] very careful in that respect. [They] didn't want to be overstepping it, and sort of maybe impacting the information or the, the knowledge, or the whatever I was working with the psychologists. Yeah. Yeah." (EN594)

Recognition of boundaries was echoed by clinicians, who were cognisant of the scope of the program, and report adapting their support to fit the needs of participants and their individual needs, within the constraints imposed by the mental healthcare system more broadly, and to function as a safe entry point into the mental health care system,

"During those first few sessions, [I] try to link [the participants] into, you know, other more long term. So it's so ... I view us as an entry service. So we can do, you know, obviously, we can work with them for a short term. But if they sort of need sort of a psychological input, for example, so they might need to be referred to a psychologist because their needs are greater than this service is set up to, to offer, we would start doing that in the first few sessions. But having said that, a lot of nurses recently are saying that they can't get in to see psychologists because of the wait.... And there's something ridiculous like a six month wait for a psychologist, so I'm really just […] supporting and not, you know, doing any sort of deep work with [the program participant] because that's not the job of this...the service." (Clinician)

The focus on mental health support was valuable for many, but one RN was also hoping for career guidance, ways of getting back to the workplace or profession, and would have liked a more tailored program,

"I still don't have the answers about how I could return work. That was clear, actually, that that was one of the reasons why I went up to to ask how can I return to work? At that point in time, I was thinking, well, how can I return to [acute care] nursing [...] And I was hoping that there was some sort of program that could guide me back to work. Yeah, but it was not. There was nothing we definitely didn't talk about that." (RN891)

For some, shifting the conversation from individual level, to situating problems within the broader systemic context of the health workforce and culture, was felt to be an important and unrealised step into the more political or advocacy context,

"*I think it's a great initiative. And I think it was helpful to me. But I also felt though, and continue to feel that all of the initiatives that are put in place, still put a lot of personal responsibility onto people for things that are systemic problems. And I don't want to sound overly, overly dramatic or like, Like I'm putting together things that that perhaps don't belong together in terms of, you know, absolute seriousness, but I feel like in all of these things, the [program] and the all the wellness stuff rolled out at work, there is still an absolute inability to look at the structural issues. And therefore I feel like there is some level of victim blaming that I'm meant to be managing a system that now is actually thoroughly broken. It was quite broken before. And now it's thoroughly broken. And we are going to continue to patch it up with stuff. That is, I think, in some ways, well meaning, but sometimes I feel like yelling at people, can you not put us in this situation in the first place, there must be people for whom this is actually their job to fix this. And by that I mean state and federal governments. And I mean, the population at large needs to work out what choices they are making, when they don't want to pay tax. You know, they really want to a lot of stuff that they have not wanting to pay for. And I think it's a hard thing to do. But it's a conversation that I think nurses take a lot to become politicized. And I see them listening to all of this and saying, oh, you know, we can go and get a wellness box, or they're, you know, putting on donuts today or there's massages, I want to scream. I really, honestly want to scream.*" (RN453)

Others felt that whilst the program did not provide all the answers they still felt comfortable being there and think it is a great program,

"even though I didn't get out of it, what I needed was, I think it was a really great program. And I remember reading about it and just thinking…how have I not known about it? How [is] this not in every state? Like I remember being really impressed with, you know talking about the mental health" (RNRM492)

4.3.2.4. Theme 4. A great day at work

A great day at work was constructed as a theme from the experiences, thoughts, and feelings of clinicians feeling prepared for and engaging with program stakeholders, team, and participants. Two sub-themes were constructed, 'Leadership and organisational culture' and 'Autonomy and flexibility'. Overall, clinicians'

expressed positive perceptions of work culture at the NMHPV, emphasising strong leadership, which had flow on effects such as enabling strong and productive teamwork and relationships.

Leadership and organisational culture

Clinicians choose to work in the role for a range of personal reasons, from feeling passionate for nurses' and midwives' health and wanting to be more proactive in supporting the workforce, through to enjoying the work and diversity in the role and keeping a hand in nursing. Leadership and management were felt to model inclusion, support, valuing, responsiveness, and transparent communication,

"I think we've got good leadership, I think we're responsive to the needs of what's happening to Victorian nurses." (Clinician)

"They're good leaders, but it doesn't feel that they're managing like they're not controlling or micromanaging or making like decisions without [consultation] … it's always in consultation with the staff, like 'what do you guys think? let's make collaborative decisions'…quite extraordinary leaders, there's really incredible leadership and the leadership is what makes a difference in organisations … ***just love that leadership****, really just put that in bold letters in your report*." (Clinician)

This extraordinary leadership was felt to be complemented by the team dynamic and fit.

"The key strength for me is the team. And I think it's easy to be flippant about it. But we've got a really positive work environment, which to do the work we do, I think is a key. And because of its positive work environment is based on the team members" (Clinician)

"*…we bring our values, core values of the organization into our discussion around, you know, what, have you seen, how have you experienced any of these values, so, we can acknowledge each other if we feel like we've been heard or supported or cared for … actually bringing those values to life, you know, they're not just stuck up on the wall…that's really important."* (Clinician)

From an individual and team perspective, whilst some clinicians felt well supported and team connection was strong, others felt there was good support but an opportunity for more in-person connection to develop a sense of belonging.

"*it would just be good to for our team to get together a bit more regularly*" (Clinician)

"*it would be nice to just be around people like in the same space and to be able to say, Oh, this is going on, like you learn from people when you're around them, rather than having to, like, make a phone call, or you're just more likely to have that casual kind of conversation. And also, I think, for me, just getting to know people in the team is beneficial to that sense of belonging and feeling connected. So having yeah, having more time, physically within the team, rather than me just working by myself at home. I mean, I like working from home, but I think the downside of that is that we miss out on the team bonding team building*" (Clinician)

Clinicians embraced having space to explore innovation and improvements to make an authentic difference to participants and for themselves, offering suggestions such as building on existing educational opportunities to integrate further formal clinician education, structured case study reviews, and external clinical supervision for all,

"*having case presentations, which I think personally are the, if they're done properly, with people being prepared. I think it's the best sort of form of education, because listening to what people actually do*." (Clinician)

"*better at, I think, is the regular case review and structuring a bit better, rather than just 'Has anyone got anything to chat about?' and which is good, but to have actually maybe just have a structured case review once a fortnight or something like that to allow that space to be able to go 'I'd really like to put this all to the team in a formal sense'*." (Clinician)

Autonomy and flexibility

Being able to work autonomously in an adaptable and person-centred model of care was felt to be valuable,

"*can get creative with it … it's very dynamic… it's very person centered, you know, one person might might want specific strategies about how to help their physical health, and someone else might just want to vent and talk about what's going on...you can judge it based on each person's kind of life situation.*" (Clinician)

Clinicians enjoy and appreciate the collegiality, support, flexibility, and connection amongst the NMHPV team,

"*it's just the engagement with the participants, the nurses and the midwives, and when you really feel a great day would be when you really feel like you're making a difference, and they're feeding that back immediately to like, sort of things like relief or just feeling heard […] having participants like that gives me a lot of satisfaction at work […] the nursing workforce needed support, and so if I can play a part in that, so that kind of inspired me […] one of the big things is flexibility, I have autonomy, but I have a team and support as well. So the flexibility to do as many sessions as I think they need or may not need. Yeah, that's huge. So in terms of the model, I think it's got good structure and a good team. But individually as a clinician, there's a lot of flexibility to work with clients*" (Clinician)

Throughout the four themes of 'Preparing to connect', 'Shared experience', 'Ways of working', and 'A great day at work', participants' and clinicians' experiences of engagement with the program and the case management model have been elucidated. Experiences were largely positive and there were many highly regarded attributes of the program. These attributes are important to both acknowledge and be cognisant of as the program continues to evolve. Examples of these highly regarded attributes included the shared experience of clinicians and participants which supported a common understanding, and effective program leadership, autonomy and flexibility which supported clinicians in their role. There were also opportunities for strengthening the program identified across all subthemes such as program promotion to reach particularly vulnerable populations, considering participant expectations around complexity and crises, and extending diversity amongst program team.

4.4. RQ4: What are the experiences and perceptions of broader program stakeholders?

The stakeholder cross-sectional survey (study 4) addressed RQ4, *What are the experiences and perceptions of broader program stakeholders?* Specifically, we sought to investigate 1) key referrers' experiences and knowledge of NMHPV, any new mental health and psychological wellbeing supports and resources they would like to see developed, and their perceived future intent to refer, and 2) key referees' experiences and knowledge of NMHPV and any suggestions for further mental health and psychological wellbeing supports and resources they would like to see developed. We first present the range of ways respondents engaged with NMHPV. Second, we report findings from respondents who refer or recommend nurses/midwives to NMHPV. Third, we report findings from respondents who are referred NMHPV participants and provide services to these nurses/midwives. Finally, we report the overall perceptions of all wider stakeholders of NMHPV.

4.4.1. Ways of engaging with NMHPV.

Thirty-nine respondents (27% response rate) consented to participate. Of these, 6 (15%) did not complete the survey in its entirety. Three respondents indicated that they had not heard of the NMHPV. Of those that had heard of the NMHPV, 26 reported having referred or recommended nurses/midwives to the NMHPV in the past; five reported having provided services to participants of the NMHPV; 21 reported having shared information about the NMHPV with colleagues, friends or staff; and four reported not having engaged in any of the three ways reported above, despite having heard of the NMHPV.

4.4.2. Referrers to NMHPV.

Of the 26 who reported having previously referred or recommended nurses/midwives to the NMHPV, 24 went on to answer additional questions about their perceptions of, and satisfaction with, NMHPV. Four reported having referred friends, 12 reported having referred colleagues, 13 reported having referred staff members/employees, and 13 reported having referred their patients or clients (note, it was possible for participants to select multiple responses here so numbers do not add up to 26). In terms of the primary organisation at which referrers work, most reported being primarily employed at industrial or professional organisations when referring nurses/midwives (n = 15), followed by tertiary healthcare organisations (n = 6),

primary healthcare services (n = 2), and peak nursing/midwifery bodies (n = 1). Primarily stakeholders decided to refer to, or recommend, NMHPV due to it being an independent organisation, see Table 23.

Table 23. Features of NMHPV which influenced stakeholder decisions to refer to or recommend the program.

Features influencing referral decision	N	Minimum	Maximum	Mean	Std. Deviation
Independent	24	8	10	9.63	.647
Confidential	24	8	10	9.54	.721
Does not require a formal referral	24	6	10	9.17	1.167
Designed and delivered by nurses / midwives	24	7	10	9.13	1.035
Free	24	6	10	9.04	1.367
Victorian state-wide service	24	4	10	8.54	1.865
Not time limited sessions	24	0	10	7.79	2.874
Observed impact of program on others	24	1	10	7.63	2.779
Quality Innovation Performance (QIP) accredited organisation	24	0	10	5.83	3.002

Respondents who had previously referred or recommended someone to the NMHPV were invited to leave comments about their decision to do so; 13 respondents left comments, which are summarised in Table 24.

Table 24. Factors influencing the decision to refer someone to the NMHPV.

Content area	Example quote	Number of comments*
Reputation for good outcomes	"*I find that nurses and midwives really benefit from NMHP Counselling*"	6
Breadth of concerns addressed		1
Quality of clinicians	"*From my experience, the staff are friendly, caring, skilful*"	2
Good availability / accessibility		1
Knowledge of the profession and industry	"*it is so wonderful for them that the Counsellor has an underpinning knowledge of nursing/midwifery and the member doesn't have to explain the underlying picture.*" "*Nurses/midwives supporting nurses/midwives*"	4
Organisational reputation	"*Very aware of the service, the CEO and incredible staff and impact on our members (nurses and midwives)*"	3
Unique role of the NMHPV in the industry	"*We often provide information about the NMHPV to nurses or midwives that disclose to us that they are experiencing social issues, mental health issues or family violence as an additional support resource alongside the Nursing and Midwifery Support Service*"	2

*Number of comments sums to more than the number of respondents who left a comment because some comments referred to more than one content area.

The most frequently represented factors influencing respondents' decisions were the program's reputation for good outcomes (n = 6), followed by clinicians' knowledge of the profession and industry (n = 4).

Eleven respondents left comments in response to the question "What works well in the process of referring/recommending someone to the NMHPV". Two comments were irrelevant to the question of what works well about the process of recommending/referring the program to others. The most frequently

represented aspects that were reported to work well were self-referral options ($n = 2$), friendly and receptive organisation and clinicians ($n = 2$) and promptness or timeliness of engagement ($n = 2$), see Table 25.

Table 25. What works well in the process of referring or recommending someone to the NMHPV.

Content area	Illustrative comments	Number of comments*
Ability to self-refer	"*improvements to the website in relation to self-referral options have been positive*"	2
Friendly, receptive organisation and clinicians	"*Always friendly and helpful. Feel comfortable talking to the staff myself and when referring.*"	2
Group sessions in the workplace	"*We got NMHPV to run individual and group sessions in the health services during COVID wave and it was very well received*"	1
3rd party directly referring to NMHPV	"*Works well when can contact NMHPV (following discussion with member) and request them to contact the member, as the member won't always reach out, but will engage if contacted.*"	1
Independent	"*the fact it is independent, unlike the EAP offered by their Employer.*"	1
Promptness/timeliness	"*Able to get urgent consultations in a prompt timeframe.*"	2
Reputation for good outcomes	"*Members have reported that they have found the service beneficial*"	1
Understanding of the nursing profession	"*They are nurses so understand the nursing discipline.*"	1
Information	"*website access/brochures/business cards*"	1

*Number of comments sums to more than the number of respondents who left a comment because some comments referred to more than one content area.

Nine respondents left responses to the question "What could be improved in the process of referring someone to the NMHPV?". Three comments were positive (e.g., "It already works very well"). Two comments were irrelevant to suggestions for improving the referral/recommendation to the NMHPV and were removed. Suggestions included "*possibly a crisis line*", "*more staff to decrease wait time*", and "*more information related to type of issues which nurses can seek assistance with*". One stakeholder suggested exploration of text counselling,

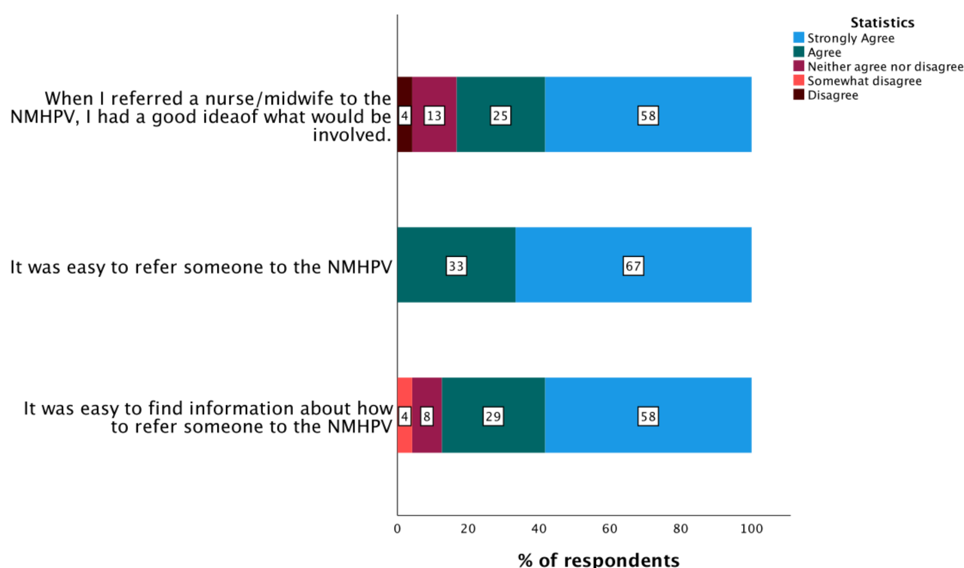
"*More and more young people converse via text. I'm not sure how flexible this service is with text counselling but this is maybe an area that can be explored more*"

Finally, a systematic referral / feedback loop was proposed,

"*Provide a specialist referral service / email / contact so that we have a direct means of doing so... some feedback to advise whether referral had been acted upon through a systematic mechanism*"

Experiences of stakeholders when referring to or recommending NMHPV were largely favourable. Most respondents had a good idea of what would be involved, and found it easy to do so, as illustrated in Figure 9.

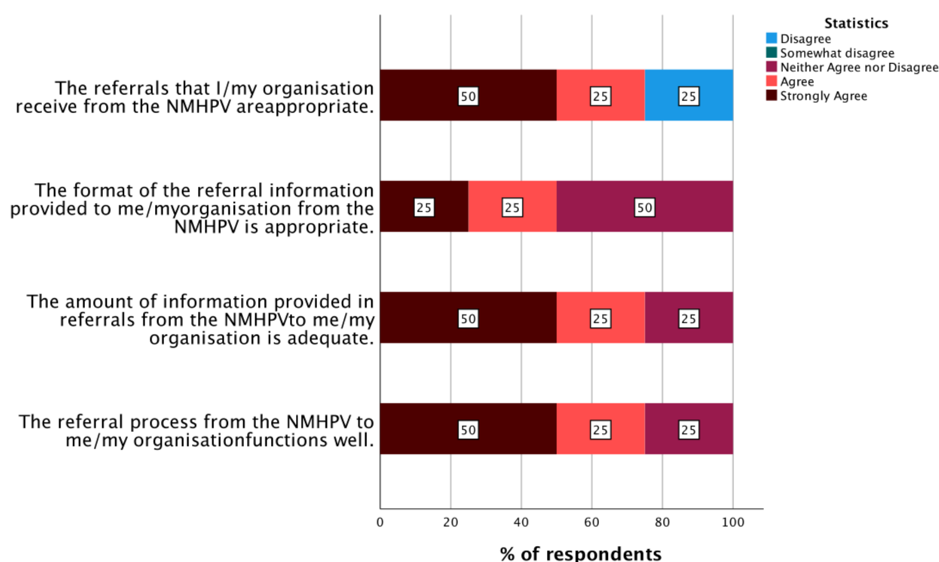
Figure 9. Experiences of referrers to NMHPV.



4.4.3. **Providers of services to participants of NMHPV (referees)**

Five respondents reported having provided services to participants referred *from* the NMHPV. Experiences were largely favourable and are summarised in Figure 10.

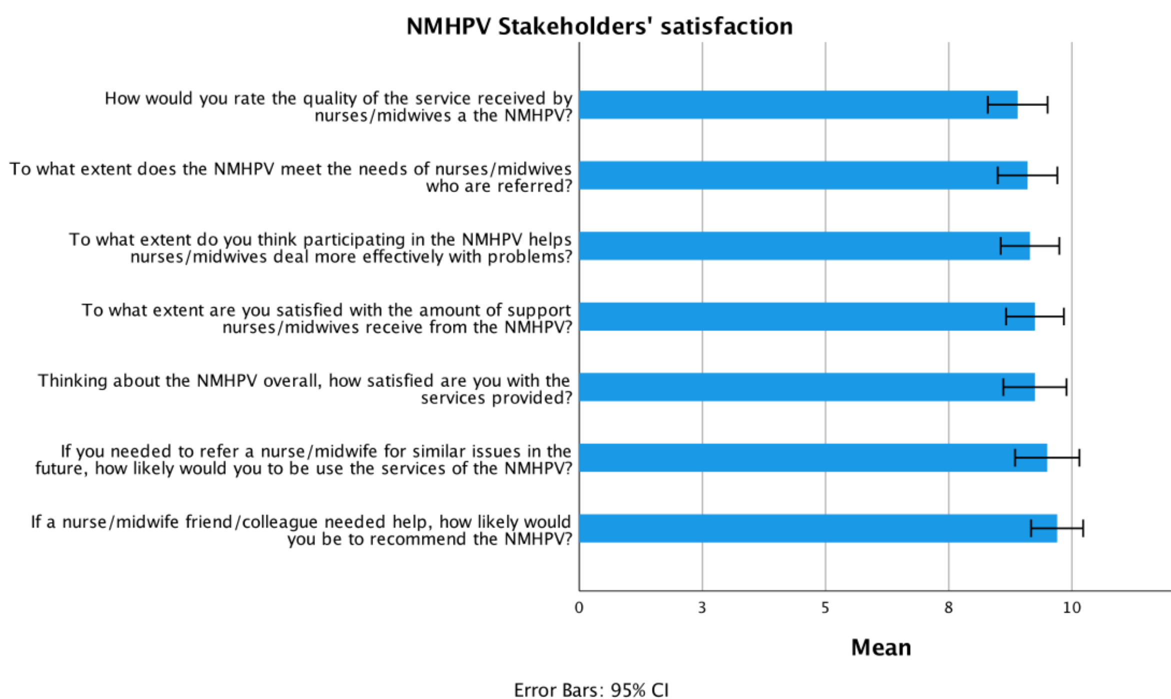
Figure 10. Experience of receiving referrals from NMHPV.



4.4.4. **Overall perceptions of the NMHPV**

All survey respondents who indicated they had previously heard of the NMHPV (*n* = 33) were asked a series of questions about their satisfaction with the NMHPV. The possible range was 0 – 10, with a score of 10 being the most favourable response, and an alternative option “I don’t know/I am not sure”. Those who selected the response option “I don’t know/I am not sure” were excluded from analysis for individual items. Responses were highly favourable, as illustrated in Figure 11.

Figure 11. NMHPV stakeholders' satisfaction.



Respondents were invited to enter up to three comments about the best aspects of the program**.** Twenty-one respondents left three comments, an additional two respondents left one comment. The content area of 'By nurses, for nurses' was most frequently reported, as reported in Table 26.

Table 26. The three best things about the NMHPV.

Content area	Illustrative comments	Number of comments*
By nurses, for nurses	"*Nurses and Midwives are speaking with a qualified Counsellor who understands what they do and the environment that they work in*" "*Having the NMHPV staff be nurses and midwives themselves. We work in such unique circumstances, and in situations that our family/friends/even trained therapists may not fully understand*" "*Counsellors are nurses/midwives and understand the challenges that nurses and midwives face*"	17
Free	"*Free - my members are sometimes facing termination/DV/addiction, and accessing resources that are free is a huge benefit to them*"	14
Confidential	"*Confidentiality is very important; in a rural town everybody know everybody and their business to boot so it is extremely difficult for anyone to access services without someone seeing you going in or coming out. you then become part of the gossip*"	14
Timeliness and availability	"*accessible - timely intervention... I have referred people who have time-critical issues...and require immediate assistance.*"	8
Independent	"*not related to workplace*"	5

Kindness, compassion and support	"*The feeling that somebody is listening to you & has some positive advice*"	4
Telehealth / remote access	"*The ability to contact via electronic means, this is important for rural who are unable to attend face to face appointments due to distance*"	3
Engages with the sector / industry	"*Provides great support to us as a Nursing team, reassuring. Even ran a PD session for us to assist with our more complex student issues*."	3
Experienced / professional clinicians	"*professional counselling and support service for nurses and midwives*"	2
No limit to the number of session	"*No limits on visits*"	2
Flexible and able to meet varied demands	"*That it offers a range of services*."	2
Resources provided	"*Resources*"	1
Based in Victoria	"*Based in Victoria*"	1

*Number of comments sums to more than the number of respondents who left a comment because some comments referred to more than one content area

In summary, stakeholder experiences and perceptions of the program were highly favourable.

5. Synthesis and discussion

The objectives of this evaluation were to investigate: 1) if the program is working as it is intended to work, 2) to what extent the program is working and impacts of the program for participants, and 3) the opportunities for strengthening the program. Across the four studies of this evaluation, we have identified experiences and perceptions of nurses and midwives who engaged in the program as participants, clinicians and wider stakeholders.

5.1. RQ1: What are the characteristics of nurses and midwives who engaged in the program?

The cross-sectional and longitudinal (T1) surveys contributed to answering RQ1, *What are the characteristics of nurses and midwives who engaged in the program?* Strengths use (but not strengths knowledge) was positively associated with some indicators of general wellbeing, including flourishing ($r = .479$) and life satisfaction ($r = .549$), and with most of the work wellbeing domain indicators (see Supplementary File 3). This finding is consistent with literature reporting positive associations between strengths use in occupational settings and work engagement and wellbeing (Bakker & van Woerkom, 2018). The survey response rate was low, but as expected, the majority of respondents were female, and the average age was over 50, consistent with the data reported in the previous evaluation of the NMHPV (Hamilton & Duncan, 2012).

Burnout is a major concern in the health workforce, both pre-, during, and post-pandemic (Galanis et al., 2021; Kurtzman et al., 2022). Risk factors for burnout include increased workload and inadequate resources. Notably, burnout levels were higher in the present study compared to a study of Australian midwives in 2017 (Creedy et al., 2017). Furthermore, levels of burnout were statistically significantly higher in the cohort who more recently participated in the NMHPV compared to those who had engaged with the NMHPV earlier (i.e., prior to 2020). Similarly, work wellbeing across many domains was significantly lower in the cohort who had participated in the NMHPV more recently, compared to those who had participated prior to 2020. In the present study, work-related burnout was associated with low levels of work wellbeing across numerous domains. Focusing on enhancing work wellbeing (e.g., job satisfaction, work happiness, work strengths use,) may reduce health professionals' flight risk more than strategies to reduce illbeing (such as burnout) alone, given the strength of the relationship between flight risk and work wellbeing ($r = -.76$) is twice that of

the relationship between flight risk and burnout (*r* = .49) (Jarden et al., 2022). These findings may indicate that those currently engaging with NMHPV are experiencing greater levels of work-related burnout and targeting areas of work wellbeing may provide a mechanism for addressing burnout.

Although the sample predominantly reported normal to mild levels of both stress and psychological distress, over 20% of participants reported stress in the severe-to-extremely severe category, and psychological distress in the moderate-to-severe category. In two recent studies of stress and psychological distress in Australia, allied health professionals, and mental health nurses were investigated. Hitch et al. (2023) surveyed Australian allied health professionals (including podiatry, speech pathology, physiotherapy, but not nursing/midwifery) over three timepoints between May 2020 and December 2021, and found that stress, as measured with the DASS Stress scale, significantly increased across all intervals, with 15% of the sample reporting severe-to-extremely severe stress at the final timepoint. Delgado et al. (2021) surveyed 450 mental health nurses in Australia from 2017-2018, and showed that 7% were in the severe to extremely severe category. In our current study, participants of NMHPV reported higher levels of stress than the sample of nurses pre-pandemic, however, not as severe as the sample of allied health professionals during the peak period of the pandemic in Australia.

Resilience has been identified as a trait that assists nurses manage and overcome stressful situations. For example, Rushton et al. (2015) found inverse associations between resilience and burnout, and resilience and stress, and positive associations between resilience and hope. Delgado et al. (2021) reported high correlations between workplace resilience and psychological wellbeing. Respondents in the present study reported lower levels of resilience than a sample of Victorian nurses during the 2020 pandemic (Jarden et al., 2022), assessed with the same measure. Consistent with this literature, the present study identified inverse relationships between resilience and stress, and between resilience and psychological distress, and positive relationships between greater resilience and greater happiness, and between greater resilience and greater life satisfaction. Aligned with the current work of NMHPV in working with nurses and midwives to strengthen resilience, continuing the active work both with the case management model and work within organisations, and more broadly, to support health promotion / prevention of illbeing is an important endeavour.

5.2. RQ2: What is the effectiveness of the case management model on the wellbeing of nurses and midwives?

The longitudinal survey (study 2) contributed to answering RQ2 *What is the effectiveness of the case management model on the wellbeing of nurses and midwives*? There was no change across any of the outcome measures across the three timepoints. The small sample size and dropout rate in the longitudinal study means that there is insufficient statistical power to make conclusive conclusions about the effect of the NMHPV on levels of wellbeing and illbeing over time. Notwithstanding the insufficient power, there is the potential that there is indeed no measurable change. Indeed, a recent observational study of wellbeing of nurses found no change across three timepoints each separated by three months during the peak pandemic period in Victoria (Jarden et al., 2022). Furthermore, although a recent systematic review of interventions to improve nurse wellbeing found some interventions improve outcomes such as stress and anxiety, many studies fail to detect differences (Melnyk, 2020). Given these potential limitations, the qualitative data and analysis of program participant and clinician experiences and perceptions provide complementary depth and understanding to this longitudinal survey.

5.3. RQ3: What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians?

Three studies contributed to answering RQ3, *What are the experiences and perceptions of nurses and midwives engaging in the program as participants and clinicians?* We have analysed and reported four items from the survey data regarding participant satisfaction, referral pathways, goal setting and perceptions of the 'best things' about the program. Program participant satisfaction was high in all areas. Survey participants highly valued clinician facilitation of their development of self-management strategies, the support, clinician availability and timeliness of meetings, the confidentiality, continuity, ease of and free access to the service.

Consistent with data reported in a previous evaluation of the NMHP (Hamilton et al., 2012), the predominant referral pathway was self-referral. These survey responses were explored in further detail in the interviews in the qualitative descriptive study (study 3). Throughout the four themes of 'Preparing to connect', 'Shared experience', 'Ways of working', and 'A great day at work', participants' and clinicians' experiences of engagement with the program and the case management model have been elucidated.

Experiences were largely positive and there were many highly regarded attributes of the program identified, which are important to both acknowledge and be cognisant of as the program continues to evolve, such as, 1) the shared foundational nursing or midwifery experience of both clinicians and participants which supported a common language and facilitated understanding, and 2) effective program leadership, and autonomy and flexibility in the clinicians' role which facilitated and supported a positive working experience for clinicians. There were also opportunities for strengthening the program identified across all subthemes such as, 1) program promotion to reach particularly vulnerable populations, 2) considering participant expectations around complexity and crises, and 3) extending diversity amongst program team. Both 'crisis' and 'complexity' in program participant presentations was evident in the experiences described, supporting clinicians in addressing these crises and the complexity is an ongoing professional development opportunity. Given the nature and diversity of participant cases, baseline capability of all clinicians and the potential for assumptions of the clinician as an insider need ongoing consideration, particularly if/when the clinician team is extended. Maintaining strengths and capability of clinicians in terms of reflexivity, trauma-informed care, therapeutic engagement with people with complex psychosocial needs, supported decision making, recovery-oriented person-centred care remain fundamental, and this may extend to the program administration regarding triaging capability. Exploring ways to retain the core strengths of the program whilst enhancing reach and diversity will be important next steps as the program continues to develop.

5.4. RQ4: What are the experiences and perceptions of broader program stakeholders?

The stakeholder cross-sectional survey (study 4) addressed RQ4, *What are the experiences and perceptions of broader program stakeholders*? Primarily stakeholders decided to refer to, or recommend, NMHPV due to it being an independent organisation. The most frequently represented factors influencing respondents' decisions were the program's reputation for good outcomes and clinicians' knowledge of the profession and industry. The ability for participants to self-refer, friendly and receptive organisation and clinicians, and promptness or timeliness of engagement were key aspects reported as working well in the program. Suggestions for improvements in the process of referring someone to NMHPV included the possibility of a crisis line, more staff to decrease wait time, systematised referral mechanism and feedback loop, text counselling, and further information about service. Experiences of stakeholders when referring to, or recommending, NMHPV were largely favourable. Most respondents had a good idea of what would be involved and found it easy to do so. Experiences of those engaging with NMHPV by providing services to participants referred from the program were largely favourable. All stakeholders who had previously heard of the NMHPV reported highly favourable levels of satisfaction. Stakeholders most frequently reported the best aspect of the program as 'By nurses, for nurses'.

5.5. Limitations

The response rate in Study 1 was low, something not unique to this evaluation and potentially reflecting the broader research and evaluation context. Only 11% of those invited participated, therefore findings are not representative of the experiences and characteristics of all nurses and midwives who participate in the NMHPV. The small sample size and dropout rate in Study 2 limits generalisability. This problem was exacerbated by the heterogeneous sample – some (~50% of) participants at timepoint 3 had engaged with the program since completing the baseline survey, whereas others had not accessed services since baseline, 12 months ago. Therefore, it is possible that there are differences in outcomes for those who were actively engaged with the program (and perhaps in a more acute stage of resolving personal or work-related issues), compared to those who had completed their participation in the program. The small sample size in the present study means that it was not possible to investigate this further. The low response rate and subsequent dropout during the longitudinal survey may indicate survey fatigue, and/or speak to a bigger issue regarding whether potential participants believe participation in an evaluation will afford real change.

There was also the potential for a response bias in the longitudinal survey and it was possible that participants who had a better experience with the NMHPV were more likely to complete the survey at follow-up timepoints or were more actively engaged with the program were more likely to respond to follow-up surveys (just to name two potentials). There was a potential for a memory (recall) bias across all studies. We would recommend a prospective longitudinal study adequately powered to measure wellbeing, work wellbeing, illbeing and work illbeing over a longer period of time (e.g., 5-years) to explore effect of the program over time.

6. Conclusions

In this program evaluation we have investigated if the program is working as it is intended to work, to what extent the program is working and impacts of the program for participants, and the opportunities for strengthening the program. We identified the program is working as it is intended to work. Participants reported high regard for NMHPV, from the nurses and midwives who had participated in the program, to the clinicians working within the program, to referrers to the program, to those who receive referrals from the program, to the broader industry stakeholders of the program. The importance of the program being 'by nurses and midwives, for nurses and midwives' - that is, clinicians' lived experience working as nurses and/or midwives – was considered not only unique, but also critical to the success and value of NMHPV. Given this highly valued feature, NMHPV was perceived to hold an important and unique place within the broader mental health and wellbeing system, and both clinicians and participants identified the role, integration, and boundaries of the NMHPV service, whether in terms of acting as a safe entry point to the system or as an adjunct to services provided by other organisations. Experiences of nurses and midwives engaging with the program were overwhelmingly positive and there were many highly regarded attributes of the program which are important to both acknowledge and be cognisant of as the program continues to evolve, such as the shared foundational nursing or midwifery experience of both clinicians and participants which supported a common language and facilitated understanding, and effective program leadership, and autonomy and flexibility in the clinicians' role which facilitated and supported a positive working experience for clinicians. We investigated prevalence, predictors, enablers and barriers of wellbeing, work wellbeing, illbeing and work illbeing. In terms of predictors, enablers and barriers, there were no significant changes across time for any of the outcome measures. The small sample size and dropout for our longitudinal study, and lack of comparable studies for our cross-sectional study, means quantitative results must be considered with caution and offer an opportunity for future investigation. We identified several opportunities for strengthening the program including specific program promotion to reach particularly vulnerable populations (rural and remote, early career, students), but also more broadly so all nurses and midwives are aware of the program before they might need it. We identified the need to review and consider how to address participant expectations around complexity and crises, e.g., visibility of program scope - consider clarity of program boundaries and backup immediate crisis support. We identified the recommendation to extend diversity amongst NMHPV team. We proposed to facilitate future service evaluations, consider building on existing database of key outcome metrics. Both 'crisis' and 'complexity' in program participant presentations was evident in the experiences described, supporting clinicians in addressing these crises and the complexity is an ongoing professional development opportunity. Exploring ways to retain the core strengths of the program whilst enhancing reach and diversity will be important next steps as the program continues to develop.

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7. Supplementary Files

Supplementary File 1. Proposed evaluation logic approach.

The following table outlines the proposed evaluation logic approach (adapted from Gullickson, 2020)

Step (Purpose)	Notes
1. Clarify evaluation purpose and assess evaluability *(Elucidates the reasons for conducting an evaluation and determine whether it is appropriate to do so.)*	Evaluate the process and outcomes of the NMHPV case management model. Identify opportunities and make recommendations to improve future service provision of NMHPV.
2. Define the evaluand *(Describes the phenomenon to be evaluated and sets the boundaries for the evaluation.)*	NMHPV is a: a) free, b) confidential, c) independent, d) support service for nurses, midwives and students experiencing issues impacting their health and wellbeing, e) led by nurses, f) build and sustain healthy and safe nursing and midwifery professions. Case management model seeks to empower and work with participants and includes: a) Consecutive phases of continuous cycle to assess, plan, action, review, b) Participant focused, c) Participant identified goals and steps to achieve these, d) Participants provided with information about available resources, e) Approach is collaborative and coordinated, f) Key aspects (from detailed model document): i) referral and screening, ii) assessment, iii) case planning, iv) case co-ordination, v) monitoring and review, vi) exit planning and case closure, vii) evaluation, viii) empowerment. Nb: Previous evaluation in 2012.
3. Define the group to which the evaluand belongs *(Enables search for existing theories, norms, research, criteria, standards, frameworks, taxonomies, and evaluations to inform the evaluation process.)*	Health program. Funded by Victorian government.
4. Identify criteria/ delineate evaluation questions *(Sets the parameters for how we can know if the something defined in Steps 2 and 3 is a good something.)*	What is the impact of the NMHPV case management model on participants' therapeutic goal attainment? What is the impact of the NMHPV case management model on participants' occupational health, work well-being and engagement in the workforce?
5. Identify performance standards *(Defines the threshold of performance that equates to "good" for this evaluand.)*	Participants 1) attain therapeutic goals to a standard they determine as acceptable; 2) occupational health, work well-being, and engagement in the workforce are maintained at, or improve to, a standard they determine as acceptable; 3) seek support/services as they have determined in their goals; 4) remain engaged in the program throughout the agreed upon period; 5) access the program support and/or referrals in agreed upon timeframes. The program is reported to be accessible to actual and potential participants. Potential participants report they know how to engage with the program.

6. Justify the criteria and standards *(Sets up support for the definitions of "good" in the evaluation process; addressed potential claims of evaluative as subjective.)*	As part of the evaluation project the first phase will included developing an agreed upon set of standards.
7. Measure; observe evaluand's performance *(Provides the evidence about what the evaluand does. Primarily descriptive, but informed by values, e.g., what counts as evidence, what data sources and indicators have been determined as important.)*	NMHPV participants: experiences; reason for engagement, employment status, area of work, referral source, type of intervention, health outcomes at time of closure, K10 health outcome, employment outcomes at time of closure. People/organisations who refer to the NMHPV: experiences. People/organisations who receive participant referrals from NMHPV: experiences.
8. Justify the measures *(Addresses threats to quality in Step 7.)*	Triangulate (based on the mixed methods approach): 1) Participants', referrers' and referees' subjective experiences (key to depth); 2) Participants objective data - retrospective (limited in psychometrics) and prospective (to broaden psychometrics); (key to determining potential associations and population comparisons).
9. Synthesis an evaluative judgement *(Combines the descriptions and aspects of judgement into a verdict about the goodness of the evaluand.)*	Reporting will include: 1) Retrospective data, 2) Prospective survey data, 3) Prospective interviews.
10. Justify the synthesis method *(Provides support for the choices made in Step 9.)*	Triangulation of qualitative and quantitative methods will strengthen findings in ways not possible with single methods.
11. Report judgement *(Communicates judgement to audiences. Considers all the possible ways in which the process and findings of an evaluation will be reported and the audiences to whom they are reported.)*	Reporting will be to NMHPV who will determine broader dissemination. Wider key stakeholders may include (but are not limited to): 1) Current and future nurses and midwives; 2) Current and future organisations who employ nurses and midwives; 3) Current and future patients and significant others; 4) Current and future funders of NMHPV.

Supplementary File 2. Interview guide.

Interview guide for program participants

Introductions…

1. Are you a nurse or midwife?
2. What inspired you to become a nurse/midwife?
3. Are you still practising as a nurse?
4. What does a great day at work look like to you?
5. Tell me about how you first heard of the program.
6. Describe your first phone call/experience.
7. Describe your first experience with the clinician.
8. Describe next steps after the first conversation with the clinician?
9. When you think back to your experience with the program, tell me if/how it met your initial expectations? Why?
10. Do you have any other comments you would like to share about your experience with the NMHPV?

Interview guide for clinicians

Introductions…

1. What inspired you to join NMHPV?
2. What does a great day at work look like to you working as a clinician at NMHPV?
3. What do you see are the greatest strengths of the program?
4. What do you think are the opportunities for strengthening the program?
5. Tell me about program: awareness/referral pathways/access/engagement/model of case management/outcomes/future.

Supplementary File 3. Work wellbeing.

Variable (Possible Range)	Before 2020 N=84			After 2020 N=26			Total sample N=110			Independent samples t-test significance
	Mean (SD)	Range	N	Mean (SD)	Range	N	Mean (SD)	Range	N	
All things considered, how satisfied are you with your present job? (0 – 10)[a]	6.38 (2.61)	0 – 10	71	5.10 (2.81)	0 – 10	29	6.01 (2.71)	0 – 10	100	.032*
How satisfied are you with the balance between the time you spend on your paid work, and the time you spend on other aspects of your life? (0 – 10)[a]	6.14 (2.50)	0 – 10	71	5.45 (2.95)	0 – 10	29	5.94 (2.64)	0 – 10	100	.236
How happy do you generally feel at work? (0 – 10)[a]	6.11 (2.69)	0 – 10	70	5.11 (2.78)	0 – 8	28	5.83 (2.74)	0 – 10	98	.100
How satisfied are you with your workplace relationships? (0 – 10)[a]	6.41 (2.72)	0 – 10	70	5.97 (3.01)	0 – 10	29	6.28 (2.80)	0 – 10	99	.471
In general, how alive and vital do you feel in your job? (0 – 10)[a]	6.15 (2.58)	0 – 10	71	4.93 (2.91)	0 – 10	29	5.80 (2.72)	0 – 10	100	.041*
How motivated are you in what you are doing for your job? (0 – 10)[a]	6.92 (2.54)	0 – 10	71	5.72 (2.85)	1 – 10	29	6.57 (2.68)	0 – 10	100	.043*
How valued do you feel by your manager (0 – 10)[a]	5.99 (3.20)	0 – 10	70	5.10 (3.48)	0 – 10	29	5.73 (3.29)	0 – 10	99	.227

How valued do you feel by your organisation (0 – 10)[c]	4.83 (3.03)	0 – 10	70	3.83 (3.35)	0 – 10	29	4.54 (3.14)	0 – 10	99	.150
Do you feel like you make a difference doing your job? (0 – 10)[c]	7.37 (2.55)	0 – 10	70	7.17 (2.59)	1 – 10	29	7.31 (2.55)	0 – 10	99	.726
I am proud of the work I do. (0 – 6)[b]	4.83 (1.16)	0 – 6	72	4.54 (1.14)	2 – 6	28	4.75 (1.16)	0 – 6	100	.251
My job inspires me. (0 – 6)[b]	4.15 (1.47)	0 – 6	71	3.83 (1.42)	1 – 6	29	4.06 (1.45)	0 – 6	100	.310
How difficult is it for you to disconnect from work when you are not at work? (0 – 10)[c]	4.79 (2.72)	0 – 10	71	5.66 (2.98)	0 – 10	29	5.04 (2.81)	0 – 10	100	.163
On average, how stressful is your job? (0 – 10)[a]	6.48 (2.58)	0 – 10	71	7.76 (2.03)	4 – 10	29	6.85 (2.50)	0 – 10	100	.310

[a]Questions from the Work on Wellbeing (WoW) assessment battery [b]Questions from the Utrecht Work Engagement Scale (Schaufeli et al. (2006), [c]Questions suggested by NMHPV sponsors for this evaluation.

Supplementary File 4. Correlation matrix between main study variables.

	Age	yrs_clin_exper	hlth_score	Flourishing	Happiness	Life Satisfaction	Job Satisfaction	Work-life Balance	Work Happiness	Work Relationships	Work Vitality	Work Motivation	Valued by Manager	Valued by organisation	My work makes a difference	Ability to disconnect after work	Work Pride	Work Inspiration	Work Stress	Burnout	DASS	Kessler-10	How beneficial has the program been for you?	How would you rate the quality of the service you received from the NMHPV?	To what extent has the NMHPV meet your needs?	If a nurse/midwife friend/colleague needed similar help, how likely would you be to recommend the NMHPV?	To what extent are you satisfied with the amount of support you received from the NMHPV?	To what extent did participating in the NMHPV help you deal more effectively with your problems?	How satisfied are you with the services you received?	If you needed to seek support for similar issues in the future, how likely would you to be use the services of the NMHPV?	Brief Resilience Scale	Strengths Knowledge	Strengths Use
Age	1.00	.761**	-0.02	-0.09	-0.09	-0.06	-0.08	-0.09	-0.05	-0.14	0.01	-0.03	-0.10	-0.04	0.02	-0.05	0.19	0.04	0.11	0.06	0.02	0.13	0.14	0.16	0.13	0.20	0.16	0.11	0.14	0.20	0.05	0.15	0.01
yrs_clin_exper	.761**	1.00	-0.09	-0.10	-0.15	-0.11	-0.17	-0.09	-0.13	-0.05	-0.14	-0.13	-0.08	-0.08	-0.15	0.00	-0.06	-0.15	0.05	0.11	0.08	0.15	0.02	-0.04	-0.05	0.01	0.01	-0.01	-0.02	0.20	-0.11	0.13	0.08
hlth_score	-0.02	-0.09	1.00	.598**	.582**	.656**	.428**	.456**	.527**	.422**	.524**	.499**	.350**	.325**	.405**	-0.12	.374**	.422**	-0.09	-.350**	-0.18	-.304**	0.14	0.06	0.11	0.06	0.12	0.12	0.13	0.13	.401**	.297**	.430**
Flourishing	-0.09	-0.10	.598**	1.00	.531**	.733**	.408**	.332**	.510**	.460**	.441**	.408**	.326**	.323**	.447**	0.03	.460**	.510**	0.12	-.210*	-.286**	-.375**	.204*	0.10	0.18	0.09	0.18	0.19	0.19	0.17	.300**	.336**	.479**
Happiness	-0.09	-0.15	.582**	.531**	1.00	.779**	.359**	.329**	.434**	.398**	.449**	.384**	.277**	.220*	.310**	-0.04	.263**	.330**	0.07	-.299**	-.447**	-.443**	0.19	0.10	0.13	0.11	0.14	0.18	.217*	0.15	.538**	.239*	.393**
Life Satisfaction	-0.06	-0.11	.656**	.733**	.779**	1.00	.471**	.387**	.579**	.497**	.556**	.493**	.377**	.256*	.427**	0.03	.397**	.447**	0.14	-.205*	-.298**	-.357**	0.18	0.11	0.13	0.11	0.15	0.18	.201*	0.16	.438**	.321**	.549**
Job Satisfaction	-0.08	-0.17	.428**	.408**	.359**	.471**	1.00	.699**	.911**	.734**	.882**	.787**	.799**	.758**	.630**	-0.14	.522**	.674**	-0.10	-.589**	-.244**	-.315**	0.17	0.10	.211*	0.08	0.17	0.12	0.18	0.17	0.08	.228*	.443**
Work-life Balance	-0.09	-0.09	.456**	.332**	.329**	.387**	.699**	1.00	.699**	.625**	.648**	.546**	.570**	.521**	.375**	-.199*	.277**	.362**	-.199*	-.459**	-0.12	-.275**	.227*	0.17	.231*	.198*	.269**	.239*	.255*	.279**	0.09	.263*	.400**
Work Happiness	-0.05	-0.13	.527**	.510**	.434**	.579**	.911**	.699**	1.00	.757**	.891**	.786**	.756**	.706**	.616**	-0.07	.521**	.669**	-0.06	-.565**	-.301**	-.361**	0.13	0.05	0.16	0.04	0.14	0.10	0.15	0.13	.205*	.222*	.479**
Work Relationships	-0.14	-0.05	.422**	.460**	.398**	.497**	.734**	.625**	.757**	1.00	.704**	.587**	.701**	.578**	.525**	-0.06	.308**	.438**	-0.02	-.420**	-.261**	-.300**	0.17	0.09	0.18	0.10	0.18	0.09	0.20	0.17	0.09	.252*	.427**
Work Vitality	0.01	-0.14	.524**	.441**	.449**	.556**	.882**	.648**	.891**	.704**	1.00	.862**	.711**	.656**	.648**	-0.08	.536**	.710**	-0.03	-.550**	-.297**	-.361**	0.16	0.10	0.20	0.12	0.18	0.10	0.19	0.15	.251*	.250*	.476**
Work Motivation	-0.03	-0.13	.499**	.408**	.384**	.493**	.787**	.546**	.786**	.587**	.862**	1.00	.673**	.659**	.707**	-0.09	.616**	.770**	-0.06	-.479**	-.283**	-.304**	0.04	0.01	0.12	0.01	0.05	0.01	0.07	0.10	.213*	.209*	.467**
Valued by Manager	-0.10	-0.08	.350**	.326**	.277**	.377**	.799**	.570**	.756**	.701**	.711**	.673**	1.00	.797**	.514**	-0.15	.408**	.530**	-0.13	-.592**	-.313**	-.319**	0.04	0.03	0.16	0.00	0.10	-0.01	0.10	0.00	0.10	.226*	.424**
Valued by organisation	-0.04	-0.08	.325**	.323**	.220*	.256*	.758**	.521**	.706**	.578**	.656**	.659**	.797**	1.00	.521**	-0.05	.416**	.541**	-0.13	-.482**	-0.16	-0.19	0.10	0.04	0.19	0.03	0.12	0.04	0.09	0.08	0.00	.252*	.387**
My work makes a difference	0.02	-0.15	.405**	.447**	.310**	.427**	.630**	.375**	.616**	.525**	.648**	.707**	.514**	.521**	1.00	-0.01	.712**	.758**	0.15	-.281**	-0.19	-.246*	0.14	0.11	.208*	0.08	0.12	0.12	0.16	0.17	0.20	.346**	.445**
Ability to disconnect after work	-0.05	0.00	-0.12	0.03	-0.04	0.03	-0.14	-.199*	-0.07	-0.06	-0.08	-0.09	-0.15	-0.05	-0.01	1.00	-0.01	-0.02	.486**	.428**	.323**	.223*	0.07	0.11	0.11	0.05	0.10	0.09	0.06	0.16	-0.19	-0.12	-0.14

	Age	yrs_clin_exper	hlth_score	Flourishing	Happiness	Life Satisfaction	Job Satisfaction	Work-life Balance	Work Happiness	Work Relationships	Work Vitality	Work Motivation	Valued by Manager	Valued by organisation	My work makes a difference	Ability to disconnect after work	Work Pride	Work Inspiration	Work Stress	Burnout	DASS	Kessler-10	How beneficial has the program been for you?	How would you rate the quality of the service you received from the NMHPV?	To what extent has the NMHPV meet your needs?	If a nurse/midwife friend/colleague needed similar help, how likely would you be to recommend the NMHPV?	To what extent are you satisfied with the amount of support you received from the NMHPV?	To what extent did participating in the NMHPV help you deal more effectively with your problems?	How satisfied are you with the services you received?	If you needed to seek support for similar issues in the future, how likely would you to be use the services of the NMHPV?	Brief Resilience Scale	Strengths Knowledge	Strengths Use
Work Pride	0.19	-0.06	.374**	.460**	.263**	.397**	.522**	.277**	.521**	.308**	.536**	.616**	.408**	.416**	.712**	-0.01	1.00	.789**	0.06	-.255*	-0.19	-.230*	0.05	0.03	0.13	0.01	0.08	0.07	0.12	.204*	0.19	.358**	.415**
Work Inspiration	0.04	-0.15	.422**	.510**	.330**	.447**	.674**	.362**	.669**	.438**	.710**	.770**	.530**	.541**	.758**	-0.02	.789**	1.00	0.05	-.362**	-.269**	-.335**	0.02	0.00	0.05	0.00	0.04	0.02	0.09	0.09	0.17	0.17	.342**
Work Stress	0.11	0.05	-0.09	0.12	0.07	0.14	-0.10	-.199*	-0.06	-0.02	-0.03	-0.06	-0.13	-0.13	0.15	.486**	0.06	0.05	1.00	.495**	0.14	.246*	0.05	0.05	0.07	-0.01	0.05	0.06	0.07	0.11	0.04	0.03	-0.06
Burnout	0.06	0.11	-.350**	-.210*	-.299**	-.205*	-.589**	-.459**	-.565**	-.420**	-.550**	-.479**	-.592**	-.482**	-.281**	.428**	-.255*	-.362**	.495**	1.00	.454**	.417**	0.06	0.09	-0.01	0.07	-0.02	0.02	0.02	0.08	-.203*	-0.12	-.326**
DASS	0.02	0.08	-0.18	-.286**	-.447**	-.298**	-.244*	-0.12	-.301**	-.261**	-.297**	-.283**	-.313**	-0.16	-0.19	.323**	-0.19	-.269**	0.14	.454**	1.00	.694**	0.16	.209*	0.12	0.19	0.11	0.10	0.10	0.14	-.504**	0.01	-0.11
Kessler-10	0.13	0.15	-.304**	-.375**	-.443**	-.357**	-.315**	-.275**	-.361**	-.300**	-.361**	-.304**	-.319**	-0.19	-.246*	.223*	-.230*	-.335**	.246*	.417**	.694**	1.00	0.07	0.07	0.09	0.05	0.01	0.06	0.00	0.09	-.450**	-0.04	-0.15
How beneficial has the program been for you?	0.14	0.02	0.14	.204*	0.19	0.18	0.17	.227*	0.13	0.17	0.16	0.04	0.04	0.10	0.14	0.07	0.05	0.02	0.05	0.06	0.16	0.07	1.00	.906**	.912**	.883**	.921**	.918**	.935**	.814**	-0.01	0.20	.221*
How would you rate the quality of the service you received from the NMHPV?	0.16	-0.04	0.06	0.10	0.10	0.11	0.10	0.17	0.05	0.09	0.10	0.01	0.03	0.04	0.11	0.11	0.03	0.00	0.05	0.09	.209*	0.07	.906**	1.00	.886**	.922**	.907**	.879**	.941**	.789**	-0.05	.222*	0.19
To what extent has the NMHPV meet your needs?	0.13	-0.05	0.11	0.18	0.13	0.13	.211*	.231*	0.16	0.18	0.20	0.12	0.16	0.19	.208*	0.11	0.13	0.05	0.07	-0.01	0.12	0.09	.912**	.886**	1.00	.875**	.951**	.902**	.921**	.811**	0.00	.219*	.233*
If a nurse/midwife friend/colleague needed similar help, how likely would you be to recommend the NMHPV?	0.20	0.01	0.06	0.09	0.11	0.11	0.08	.198*	0.04	0.10	0.12	0.01	0.00	0.03	0.08	0.05	0.01	0.00	-0.01	0.07	0.19	0.05	.883**	.922**	.875**	1.00	.903**	.838**	.937**	.747**	-0.03	.217*	.218*
To what extent are you satisfied with the amount of support you received	0.16	0.01	0.12	0.18	0.14	0.15	0.17	.269**	0.14	0.18	0.18	0.05	0.10	0.12	0.12	0.10	0.08	0.04	0.05	-0.02	0.11	0.01	.921**	.907**	.951**	.903**	1.00	.908**	.959**	.800**	0.01	.221*	.238*

	Age	yrs_clin_exper	hlth_score	Flourishing	Happiness	Life Satisfaction	Job Satisfaction	Work-life Balance	Work Happiness	Work Relationships	Work Vitality	Work Motivation	Valued by Manager	Valued by organisation	My work makes a difference	Ability to disconnect after work	Work Pride	Work Inspiration	Work Stress	Burnout	DASS	Kessler-10	How beneficial has the program been for you?	How would you rate the quality of the service you received from the NMHPV?	To what extent has the NMHPV meet your needs?	If a nurse/midwife friend/colleague needed similar help, how likely would you be to recommend the NMHPV?	To what extent are you satisfied with the amount of support you received from the NMHPV?	To what extent did participating in the NMHPV help you deal more effectively with your problems?	How satisfied are you with the services you received?	If you needed to seek support for similar issues in the future, how likely would you to be use the services of the NMHPV?	Brief Resilience Scale	Strengths Knowledge	Strengths Use
from the NMHPV?																																	
To what extent did participating in the NMHPV help you deal more effectively with your problems?	0.11	-0.01	0.12	0.19	0.18	0.18	0.12	.239*	0.10	0.09	0.10	0.01	-0.01	0.04	0.12	0.09	0.07	0.02	0.06	0.02	0.10	0.06	.918**	.879**	.902**	.838**	.908**	1.00	.926**	.820**	0.05	.237*	.265**
How satisfied are you with the services you received?	0.14	-0.02	0.13	0.19	.217*	.201*	0.18	.255*	0.15	0.20	0.19	0.07	0.10	0.09	0.16	0.06	0.12	0.09	0.07	0.02	0.10	0.00	.935**	.941**	.921**	.937**	.959**	.926**	1.00	.841**	0.03	.252*	.244*
If you needed to seek support for similar issues in the future, how likely would you to be use the services of the NMHPV?	0.20	0.20	0.13	0.17	0.15	0.16	0.17	.279**	0.13	0.17	0.15	0.10	0.00	0.08	0.17	0.16	.204*	0.09	0.11	0.08	0.14	0.09	.814**	.789**	.811**	.747**	.800**	.820**	.841**	1.00	-0.06	.268**	.216*
Brief Resilience Scale	0.05	-0.11	.401**	.300**	.538**	.438**	0.08	0.09	.205*	0.09	.251*	.213*	0.10	0.00	0.20	-0.19	0.19	0.17	0.04	-.203*	-.504**	-.450**	-0.01	-0.05	0.00	-0.03	0.01	0.05	0.03	-0.06	1.00	.217*	.272**
Strengths Knowledge	0.15	0.13	.297**	.336**	.239*	.321**	.228*	.263*	.222*	.252*	.250*	.209*	.226*	.252*	.346**	-0.12	.358**	0.17	0.03	-0.12	0.01	-0.04	0.20	.222*	.219*	.217*	.221*	.237*	.252*	.268**	.217*	1.00	.819**
Strengths Use	0.01	0.08	.430**	.479**	.393**	.549**	.443**	.400**	.479**	.427**	.476**	.467**	.424**	.387**	.445**	-0.14	.415**	.342**	-0.06	-.326**	-0.11	-0.15	.221*	0.19	.233*	.218*	.238*	.265**	.244*	.216*	.272**	.819**	1.00

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Supplementary File 5. NMHPV participants satisfaction with program.

Variable	Before 2020 N=84			After 2020 N=26			Total sample N=110			Significance of 2-sample t-test
	Mean (SD)	Range	N	Mean (SD)	Range	N	Mean (SD)	Range	N	
How beneficial has the program been for you?	7.63 (2.86)	1 – 10	83	9.19 (1.45)	5 - 10	31	8.05 (2.64)	1 – 10	114	.004**
How would you rate the quality of the service you received from the NMHPV?	7.96 (2.43)	0 – 10	78	9.23 (1.17)	5 - 10	31	8.32 (2.22)	0 – 10	109	.007**
To what extent has the NMHPV meet your needs?	7.41 (2.92)	0 – 10	78	9.03 (1.50)	4 – 10	30	7.86 (2.70)	0 – 10	108	.005**
If a nurse/ midwife friend/colleague needed similar help, how likely would you be to recommend the NMHPV?	8.35 (2.77)	0 – 10	80	9.55 (1.41)	5 - 10	31	8.68 (2.52)	0 – 10	111	.024*
To what extent are you satisfied with the amount of support you received from the NMHPV?	7.71 (2.86)	0 – 10	80	9.19 (1.49)	5 – 10	31	8.13 (2.63)	0 – 10	111	.007**

To what extent did participating in the NMHPV help you deal more effectively with your problems?	7.17 (2.95)	0 – 10	81	8.81 (1.40)	5 – 10	31	7.63 (2.71)	0 – 10	112	.004**
How satisfied are you with the services you received?	7.76 (2.90)	0 – 10	79	9.32 (1.33)	5 – 10	31	8.20 (2.64)	0 – 10	110	.005**
If you needed to seek support for similar issues in the future, how likely would you to be use the services of the NMHPV?	7.36 (3.36)	0 – 10	75	9.06 (2.11)	2 – 10	31	7.86 (3.13)	0 – 10	106	.010*

POSTERA CRESCAM LAUDE
THE UNIVERSITY OF
MELBOURNE