

# *RDNS Model of Mental Health Care*

## *Final Report*

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# 1 Executive Summary

## 1.1 Introduction

Royal District Nursing Service (RDNS) is the oldest and largest community nursing organisation in Australia. Each year, RDNS' staff of 1,000 nurses provides general and specialist home nursing services to almost 30,000 predominantly older clients across Melbourne. The presence of risk factors such as chronic illness, social isolation and financial hardship contributes to the development of co-morbid mental health problems in many RDNS clients. Such clients may not meet the intake criteria for specialised mental health services leaving them with unmet mental health care needs. The RDNS Model of Mental Health Care aims to address this gap with the introduction of a Mental Health Clinical Nurse Consultant (CNC) whose role is to undertake mental health assessment and care plan formulation with clients, and provide support and consultation to RDNS staff. In addition to developing and trialling a Mental Health CNC role in a community nursing environment, the 12-month project involved the collection of information on staff issues in relation to the provision of care to clients with mental health problems, the development of a profile of RDNS clients with a mental health diagnosis, a feasibility study on nurses screening for depression and the preparation of Draft Guidelines for Service Provision.

The proposed trial and evaluation of the RDNS Model of Mental Health Care incorporating nurse screening, the Mental Health CNC role, client care planning and liaison with and referral to external services, has three central aims:

1. To ascertain staff perspectives regarding mental health care at RDNS
2. To establish a profile of RDNS clients with co-morbid mental health conditions
3. To implement and evaluate a Model of Mental Health Care

Accordingly, the specific objectives of the RDNS Model of Mental Health Care Project are to:

1. Identify issues related to the provision of care to clients with mental health issues at RDNS by conducting focus groups with field nurses and nurse managers
2. Undertake a profile of RDNS clients with a co-morbid mental health diagnosis by using data collected over the 2004/2005 financial year in the RDNS client database to describe:
  - a. The characteristics of RDNS clients with co-morbid mental health conditions
  - b. The kinds of mental health conditions present in RDNS clients
3. Conduct a feasibility study of nurse screening for depression utilising the Geriatric Depression Scale at three participating RDNS Centres in the Western Region
4. Describe and understand the effects of nurse screening for depression on:
  - a. Referral systems (field nurses referring to the Mental Health CNC)

- b. RDNS staff at participating Centres including the feasibility of nurse screening
- 5. Trial a Mental Health CNC role at participating Centres
- 6. Describe and understand the effects of the trialled Mental Health CNC role on:
  - a. Client outcomes including client satisfaction
  - b. RDNS staff at participating Centres including the feasibility of formal and informal referral and liaison systems, and care planning systems
- 7. Develop Draft Guidelines for Service Provision to support an ongoing model.

## **1.2 RDNS Staff Perspectives on Mental Health Issues**

In the early stages of the project, focus groups were conducted to identify some of the key issues and staff perspectives related to mental health and the provision of care by RDNS staff to clients with co-morbid mental health issues. Participants included field nurses, clinical nurse consultants, liaison nurses and nurse managers. The focus groups were recorded and thematically analysed.

Nine themes were identified:

### ***Theme 1 – Inadequate care for RDNS clients with co-morbid mental health issues***

Focus group participants expressed concern that there was no established process at RDNS to provide care to clients with co-morbid mental health issues and that this often resulted in a random approach to care. Care continuity was reported to be difficult as many clients with challenging mental health issues were moved from nurse to nurse in order to share their care among staff. Participants further explained that RDNS nurses had a limited understanding of mental health and mental health assessment. An additional constraint to providing effective mental health care for RDNS clients involved limited ability to undertake care, including the administration of psychotropic medication, over an extended period of time. The participants expressed a belief that this situation arose from funding difficulties and associated resource limitations.

### ***Theme 2 – RDNS staff concerns in caring for clients with co-morbid mental health issues***

Many RDNS staff had concerns in sharing care with mental health services due to their lack of confidence in mental health services. They further explained that some RDNS staff felt unsafe caring for clients with schizophrenia who they believed were unpredictable and may physically threaten them. Participants commented on their lack of knowledge in mental health regarding crisis and risk management, cultural issues, day-to-day management of a person with schizophrenia or personality disorders, and their limited understanding of behavioural management strategies.

### ***Theme 3 – RDNS staff beliefs regarding the care of clients with co-morbid mental health issues***

Participants commented on a number of staff beliefs in relation to the care of clients with co-morbid mental health issues. Some staff did not wish to care for clients with mental health issues as they found them too challenging. Participants further explained that some staff feared clients with mental health issues, such as those with schizophrenia, as they believed they were potentially dangerous. Some RDNS staff were reluctant to explore mental health issues with clients as they believed that they were responsible for any associated

psychological discomfort or distress the client may feel as a result. Participants noted that some RDNS nurses believed that their lack of knowledge about how to manage challenging behaviours was harmful to some clients as it reinforced the client's challenging behaviours.

#### ***Theme 4 – Mental health education needs for RDNS nurses***

Participants noted that most RDNS nurses had no formal training in mental health and therefore mental health education was a requirement for all clinical nurses. They reported that education needed to target day-to-day care and management of clients with co-morbid mental health issues in the community, for example obtaining relevant information from referral sources, identifying mental health issues for clients and appropriate district nursing interventions, using screening tools and understanding how to interpret the results, identifying changes in clients' behaviour and understanding how to manage challenging behaviours.

#### ***Theme 5 – Need for guidelines for service provision regarding caring for clients with co-morbid mental health issues***

Focus group participants identified the need for guidelines about providing RDNS services for clients with co-morbid mental health issues. According to these people, these guidelines should clarify criteria for RDNS to accept referrals for clients with mental health issues, they should provide guidance regarding the quality and type of information about a client's mental health to obtain from a referral source and/or mental health service, and they should guide care coordination between RDNS and mental health service providers including the post discharge mental health care plan and the ongoing role of the mental health provider, GP and RDNS.

#### ***Theme 6 – RDNS nurse issues regarding screening clients for depression with the Geriatric Depression Scale (GDS)***

Participants described a variety of responses from RDNS nurses to the GDS: some staff liked to use it and other staff disliked using it. Many staff preferred to rely on their intuition and 'gut' feel while talking to the client. Participants commented that some nurses found the GDS questions open to interpretation and that nurses needed education regarding the use of the tool and interpretation of what the scores mean.

#### ***Theme 7 – The value of the RDNS social worker service for clients with co-morbid mental health issues***

Participants commented on the value of the social work service at RDNS in providing some support to RDNS clients in relation to their mental health issues. Social workers have training in mental health and assist clients by making referrals to GPs and to services such as ACAT regarding mental health problems. Participants noted that RDNS nurses referred some clients to social workers regarding behavioural issues as the nurses did not have a good understanding of clients' behaviour.

#### ***Theme 8 – Improvements (potential) to RDNS service provision for clients with co-morbid mental health issues***

Focus group participants commented on potential improvements to mental health care for RDNS clients: Mental Health Clinical Nurse Consultants (CNCs) at RDNS and resource nurses in mental health at RDNS Centres. They considered that the inclusion of one or two questions about mental health on the Preliminary Assessment Screening Tool would assist in phone screening clients. Participants explained that improved collaboration with mental health services, for example case discussion, and clarification of discharge plans and follow-

up by mental health services would improve care for RDNS clients with co-morbid mental health issues. They further noted that as an organisation RDNS needed to recognise that many of our clients have co-morbid mental health issues and ensure that the service provides equal and equitable service for all clients including those with mental health issues, clients with drug and alcohol issues and clients with challenging personalities.

### ***Theme 9 – RDNS mental Health Clinical Nurse Consultant role (potential)***

Participants explained that a Mental Health CNC would ideally be a consultancy role undertaking home assessments, referrals to mental health services, care planning, client advocacy, staff support, Centre-based education and role modelling for staff in relation to effective problem solving for clients with mental health issues. According to these participants, a Mental Health CNC would consult with staff regarding professional boundaries in care provision for clients with challenging behaviours and be available for secondary consultations with staff. Further, the Mental Health CNC would be involved in establishing relationships and facilitating communication with mental health providers.

## **1.3 Profile of RDNS Clients with a Mental Disorder**

The aim of the client profile is to describe client episodes where general health problems were co-morbid with mental health conditions over the 2004/2005 financial year. RDNS clients' demographic and service delivery data for the 2004/2005 financial year were retrieved from the client database (Camillus). The categories of mental health disorder were derived from the ICD-9 classification of mental disorders. In the ICD-9 classification of mental disorders, mental health conditions are those included in the range of codes between 290 and 319. Additional data comprised client characteristics including: gender, age, country of origin, language spoken at home, living arrangements, and carer availability; and service provision characteristics including: Centre / Region and program details.

Some of the key findings are:

- In the 2004/2005 financial year, a total of 34,269 client episodes were undertaken at Royal District Nursing Service (RDNS). Of these client episodes, 6,455 (18.8%) included a primary or secondary co-morbid mental disorder diagnosis.
- The most common mental disorders among RDNS clients are depression, dementia, alcohol use disorder, anxiety disorder and schizophrenia.
- Among Homeless Persons Program (HPP) clients, the most common mental disorders are substance abuse, psychosis and depression.
- Among HIV/AIDS clients, the most common mental disorders are depression, anxiety and substance abuse.

## **1.4 Screening for Depression**

Depression is known to be the most common mental disorder amongst older recipients of primary care services, including district nursing. A two-cycle feasibility study trialled a process for depression screening by using the 15-item Geriatric Depression Scale (GDS) with a sample of older RDNS clients at three Centres. An education session about depression and the use of the GDS preceded the screening process. The trial found that barriers existed amongst participant nurses regarding screening for depression, although generally they acknowledged depression as a common problem among older clients and most believed that

they had a potential important role in the identification and support of clients with this condition. Lack of knowledge emerged as a major constraint as did uneasiness about entering the mental health area, with some reluctance to use the GDS because of the type of questions included and not wanting to be intrusive regarding the 'emotional matters' of clients.

In summary, the trial found that nurse screening is feasible provided the following factors are put in place:

- The training provided to staff must contextualise the process of depression screening within the nurse's day-to-day clinical practice. The training should also emphasise the importance of attending to mental health issues in the provision of holistic care to the client.
- It should be acknowledged that not all nursing staff are adequately equipped and/or willing to screen their clients for depression. Only staff that have received appropriate training and are comfortable talking to their clients about their emotional problems should be expected to take part in the depression screening process.
- Nurses are not comfortable with routine screening and prefer to only screen clients if they are already exhibiting signs of depression. To maximise the accuracy of the screening process, training in the identification of the signs of depression is therefore necessary.
- Nurses prefer to use tools such as GDS only after a sufficient level of rapport has been established with the client. Screening of newly referred clients may therefore be problematic.
- The availability of a Mental Health CNC is important to ensure that appropriate follow-up is provided to clients who screen positive for depression.

## **1.5 Quantitative Evaluation**

The proposed Mental Health CNC role at RDNS encompasses mental health assessment, psychosocial/nursing interventions, liaison and collaborative care planning with community and mental health service providers in addition to supporting RDNS nurses in identifying and referring clients with potential mental health conditions such as depression. The Mental Health CNC role lies within the broader context of the Model of Mental Health Care at RDNS incorporating referral of RDNS clients to the Mental Health CNC, and liaison and referral between the Mental Health CNC and adult mental health services. Accordingly, the proposed trial and evaluation of the RDNS Model of Mental Health Care incorporating the Mental Health CNC role has two central aims as follows:

1. To establish a client profile in order to understand:
  - a. which clients use and benefit from the Mental Health CNC service;
  - b. what kind of mental health problems clients present with; and
  - c. the level of demand for a Mental Health CNC service at RDNS
2. To understand the effects of the trialled Mental Health CNC role on:
  - a. client outcomes including satisfaction with the service; and
  - b. RDNS staff at participating Centres including the feasibility of formal and informal referral and liaison systems developed during the trial of the role

The participants for the quantitative evaluation of the model included RDNS clients at Essendon, Sunshine and Altona Centres (participating Centres). All RDNS clients at participating Centres, irrespective of reason for referral to RDNS, were eligible for referral.

Some of the key findings are:

- Over a six month period working one day per week, the Mental Health CNC provided 151 secondary consultations.
- Approximately two-thirds of the secondary consultations involved assessment issues.
- Over the course of the project, 48 client visits and 152 client related contacts were conducted. These visits and contacts represented 78 individual clients.
- The most common reasons for referral to the Mental Health CNC were depression, anxiety and behaviour problems.
- The results of a satisfaction survey indicate that clients were mostly satisfied with the service they received from the Mental Health CNC with only a small number being dissatisfied with some aspects of the care provided.

## **1.6 Qualitative Evaluation**

The aims of the qualitative evaluation of the project were:

1. To ascertain participant nurses' viewpoints regarding the Mental Health CNC role and collaborative practice; and
2. To explore the perceived effect of the trialled Mental Health CNC role on client health and wellbeing.

Nine nurses from the three participating Centres who had made a referral to the Mental Health CNC were invited to participate in a semi-structured interview. The interviews were thematically analysed and the following themes were identified:

### ***Theme 1 – Effective Domiciliary Mental Health Nurse Consultancy***

Each interviewee commented on the ability of the Mental Health CNC to accept both verbal and written referrals for any RDNS clients with a mental health issues. Interviewees explained that the Mental Health CNC had undertaken home visits for the purpose of detailed mental health assessments from which recommendations regarding improved care planning, care management and referral of clients to appropriate services were made. Referral questions related to clients with signs and symptoms of depression (including those screening positive for depression on the GDS), anxiety, sleep disturbance, social difficulties, dementia, brain damage and where the nurse perceived the client to demonstrate challenging behaviours affecting care provision. Participant interviewees further commented on the ability of the Mental Health CNC to liaise with mental health services and GPs on behalf of clients and RDNS nurses, and assist RDNS nurses and clients to effectively negotiate mental health services such as referring a client to an Aged Psychiatry Assessment Team (APAT). In addition, the Mental Health CNC was noted by each interviewee to provide clinically relevant feedback regarding clients' mental health issues to the referring nurse, including recommended changes to care plans. Several interviewees noted that the Mental Health CNC assisted them to formulate achievable care plans specifying realistic goals, to provide more consistent care to their clients with mental health issues and to consider a broader range of care options in order to plan their care to meet their clients' mental health needs.

### ***Theme 2 – Mental Health CNC role was valuable***

All participants found the Mental Health CNC role was valuable due to the high quality of her mental health assessments and holistic approach to mental health care resulting in enhanced information, and improved mental health care planning for clients. The role was found to be particularly valuable for improving the quality and credibility of assessment information to provide to mental health services and GPs, and subsequently increased access for clients to mental health services in a timelier manner. Furthermore, participants found the role valuable as the Mental Health CNC had an extensive knowledge of mental health service systems. This was valuable in enhancing client outcomes as it allowed nurses to consider a broader range of potential interventions for clients such as referral to counselling. Thus interviewees found that the Mental Health CNC assisted them to negotiate the mental health service system on behalf of their clients.

### ***Theme 3 – Mental Health CNC role contributed to effective client outcomes***

Interviewees explained that the Mental Health CNC improved their understanding of their clients' mental health issues and their related behaviour which contributed to improved care planning and enhanced client outcomes including increased health monitoring.

### ***Theme 4 – Mental Health CNC role resulted in effective communication***

Interviewees commented that the Mental Health CNCs assessment, formulation of clients' mental health issues and suggested changes to care plans enhanced communication between nurses and clients. The Mental Health CNC communicated verbally (via phone and in face-to-face consultations with nurses), and included recommendations for care planning in her written assessments and progress notes including behaviour management strategies, and signs and symptoms of deterioration and/or relapse for which nurses should be monitoring clients. Importantly, interviewees explained that the Mental Health CNC preserved client confidentiality sending her written assessments and nursing reports directly to the client's primary nurse to read prior to storing them in the client's confidential file at the Centre.

### ***Theme 5 – Effective education***

The Mental Health CNCs role in education was an informal one at Centre level, focusing on the day-to-day management issues of clients who were referred to her. Interviewees, including staff members new to district nursing, commented that they learned about how psychiatric services such as APAT function and how to refer clients to these services, they learned about managing clients with challenging behaviours, and how to approach and effectively communicate with clients in the community with mental health problems as they gained greater understanding about mental health and clients' behaviour. Following involvement of the Mental Health CNC, interviewees reported enhanced understanding of specified mental health issues directly related to the client they referred. Interviewees explained that Centre staff were more aware of mental health issues following the trial of the Mental Health CNC role.

### ***Theme 6 – Limitations to the Mental Health CNC role as trialled***

Participant interviewees noted a number of limitations to the Mental Health CNC role as trialled. All commented on restricted access for both clients and nurses to the service as the Mental Health CNC worked one day a week for the duration of the trial. Working one day a week resulted in a delay of one week for assessment information to be relayed to the referring nurse. One day a week availability was also found to be problematic as it limited the ability to undertake double visits by the Mental Health CNC and primary nurse which would have

allowed the primary nurses to introduce the Mental Health CNC to the client and would have enhanced understanding of the Mental Health CNC role for the primary nurse. Several interviewees noted that a number of clients declined a visit from the Mental Health CNC due to their negative perception of her title as 'Mental Health Nurse' which clients believed implied that they were 'mad'. According to these interviewees, if the primary nurse had been able to accompany the Mental Health CNC and introduce her to the client, this would have been more acceptable to the client who trusted and had a therapeutic relationship with their primary nurse.

### ***Theme 7 – Improvements to the role (potential)***

All interviewees noted that if the Mental Health CNC worked more days during the week this would increase her availability for clients and staff. A number of interviewees believed that one Mental Health CNC employed on a full-time basis per RDNS Region would allow the role to be more fully developed in terms of undertaking more client assessments, more secondary consultations with staff, greater involvement in client care planning including managing clients with depression; brain injury; psychological problems; and assisting staff to provide more consistent care, and greater involvement in managing 'at risk' clients. Interestingly, a number of interviewees noted that it would be of benefit to clients and to the nurses providing care if the Mental Health CNC provided greater assistance in boundary setting; assisting clients to identify behaviour from the nurses which is acceptable to them and in assisting the nurses identify acceptable behaviour from clients.

## **1.7 Recommendations**

Overall, the findings of the project provide strong support in favour of the provision of a Mental Health CNC role within RDNS. Such a role has the potential to support staff and improve client outcomes in an area which is frequently neglected.

Based on the findings of the project, the following recommendations are made:

1. That RDNS management endorse a model of mental health care to benefit RDNS staff and clients as described in this report
2. That RDNS provide a Mental Health CNC to support clients in all practice areas and staff providing their care
3. That the role of the Mental Health CNC encompasses:
  - mental health assessment of referred clients
  - secondary consultation to RDNS staff, external service providers and families/carers
  - participation in the formulation of care plans in conjunction with the primary nurse or care manager
  - participation in the care coordination of clients with mental health issues
  - promotion of client advocacy and care continuity
  - referral to internal and external service providers, including GPs and mental health services
  - liaison with internal and external service providers

- provision of clinically-focussed education to RDNS staff, including processes for identifying clients with mental health issues, use of screening tools and the management of clients with mental health issues within a district nursing environment
  - provision of psychosocial and supportive interventions to clients with mental health issues
  - contribution to the conduct of mental health projects and research studies
  - compliance with the Mental Health Act and relevant privacy legislation including the maintenance of client confidentiality
4. That the Mental Health CNC receives clinical supervision by an appropriate external provider as needed
  5. That all Centre-based clinical staff receive information and education regarding the identification and management of clients with mental health issues from the Mental Health CNC
  6. That the use of mental health screening tools (e.g. GDS) by nominated staff is promoted within the RDNS model of mental health via the provision of relevant education
  7. That RDNS fund the development of a training package, including a video, for Centre-based clinical staff in the use of mental health screening tools
  8. That intake and referral processes be reviewed to ensure that adequate information is provided to RDNS staff in relation to clients with a history of mental illness
  9. That research studies concerned with improving the care provided to district nursing clients with mental health issues be continued
  10. That RDNS reviews and refines Camillus data and codes related to the activities of the Mental Health CNC
  11. That work be carried out to further develop the Draft Guidelines for Service Provision
  12. That RDNS reviews the model of mental health care within 12 months of its full implementation

## 2 Introduction

Royal District Nursing Service (RDNS) employs approximately 1,000 district nurses across the Melbourne metropolitan Region and the Mornington Peninsula. RDNS nurses visit clients in their own homes providing general nursing services including nurse assessment, wound care, aged care, diabetes care and medication assistance; and a range of specialist consultancy nursing services such as the Aged Care Consultancy, Cystic Fibrosis Home Support Team, Homeless Persons Program, HIV/AIDS, Diabetes, Haemophilia, Continence, Wound Care, Palliative Care and Stomal Therapy. In the 2004/2005 financial year, RDNS nurses provided 34,269 episodes of client care (Royal District Nursing Service, 2005). Given the high prevalence of RDNS clients with chronic illnesses and co-occurring mental health issues, the trial of a Model of Mental Health Care is a vital and timely addition to RDNS services.

### 2.1 Background

A substantial number of RDNS clients have co-morbid mental health conditions. Of the 34,269 client episodes contained in the RDNS client database for the 2004/2005 financial year, 19% included episodes with a co-morbid mental health condition.

RDNS clients experiencing an acute exacerbation of a pre-existing mental health condition or developing a mental illness for the first time in their lives may be eligible for mental health services (Victorian Department of Human Services, 1996). However, clients with a mental health condition who are unwell but not severely ill may not meet the intake criteria for specialised mental health services leaving them with unmet mental health care needs. In a recent study (Nunn & Flowers, 2003), 38% of older RDNS clients scored above the clinical cut-off on a validated screening measure of depression, the Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986), suggesting that a significant number of RDNS clients may benefit from more detailed mental health assessment and care plan development focused on management of their depression symptoms. The proposed Model of Mental Health Care at RDNS will address this gap in the service system with the introduction of nurse screening for mental health conditions and a Mental Health Clinical Nurse Consultant (MHCNC) who will undertake mental health assessment and care plan formulation with RDNS clients, and provide support and consultation to RDNS staff.

‘Nurse screening’ refers to the use of standardised and validated screening tools by field nurses to identify clients requiring more detailed assessment for mental health conditions such as depression. Currently at RDNS, two validated screening tools are already approved and available for staff use: the GDS (used to screen a client for depression symptoms) and the Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975) (used to screen a client for signs of cognitive impairment). Nurse screening is important in the identification of clients with potential mental health issues as mental health problems are not easily observable or identifiable by generalist nurses (Brown, McAvay, Raue, Moses, & Bruce, 2003). Following screening, a primary nurse, care manager or CNC may refer the client to a clinician skilled in more detailed mental health assessment such as the Mental Health CNC.

The Mental Health CNC role at RDNS will provide focused mental health assessment, psychosocial/nursing interventions including preventative interventions, liaison and collaborative care planning with community and mental health service providers in addition

to supporting RDNS nurses in identifying and referring clients with potential mental health conditions such as depression and dementia with psychotic features.

The Mental Health CNC role thus lies within the broader context of the Model of Mental Health Care at RDNS incorporating:

- Nurse screening of clients
- Nurse referral of RDNS clients to the Mental Health CNC
- Mental health assessment by the Mental Health CNC
- Secondary consultation with RDNS general nurses to advise on mental health problems and client care
- Care planning focused on mental health by the Mental Health CNC with the client's primary nurse and care manager
- Liaison with and referral to the client's mental health team such as their GP and local mental health services
- Education of RDNS general nurses to raise knowledge and awareness of mental health issues.

## **2.2 Literature Overview**

Mental health models are not well developed within Australian domiciliary nursing services. RDNS South Australia is an exception providing a mental health nurse consultancy which is currently undergoing an evaluation with a view to expanding the model (M. Tohl, personal communication, November, 2005). A search of the literature located few studies regarding mental health models within domiciliary nursing services. Therefore the following overview of the literature presents several studies investigating facets relevant to the proposed mental health model at RDNS including nurse screening for mental health conditions such as depression, and studies evaluating the effectiveness of community psychiatric nursing roles.

Past research on the role of community nurses in assisting clients with mental health issues remains largely exploratory due to the developing nursing role in primary care (Mead, Bower, & Gask, 1997; Miller, Garland, Ross, Kendrick, & Burns, 1999). However, according to some commentators (Bruno & Ahrens, 2003) nurse screening for mental health issues, in particular for depression, should be central to community and district nursing roles due to the high prevalence of diagnosed and undiagnosed depression in district nursing client cohorts and the serious consequences of untreated depression. Several investigators have noted the adverse impact of major and minor depression on chronic medical illnesses including increased patient suffering, slower improvement in recovery from illness and increased mortality (Katon & Ciechanowski, 2002; Katon, 2003). Katon and Ciechanowski (2002) reviewed studies investigating the effect of major depression in clients with chronic medical illness, including diabetes and coronary heart disease. They reported on multiple studies and concluded that co-morbid depression results in increased symptom burden, impairment of function, greater medical costs, less ability to self-care and poorer rates of adherence with medical treatments including medication management. Bruno and Ahrens (2003) recommend that district nurses receive training in the use of structured tools to screen clients for depression, that they screen their clients routinely for depression and have an available referral structure in place for referral of identified clients.

In past studies, district nurses have been found to have limited ability to identify depression in their clients suggesting that some district nursing clients with depression may not be

identified and therefore not appropriately referred for more detailed assessment and intervention. In one such investigation, Brown and colleagues (2003) surveyed 42 nurses about the presence of depression in a randomly selected sample of clients aged 65 years or older. In total, of the 403 patients who participated, 97 (24%) were independently diagnosed by clinical psychologists with either major or minor depression. Of these clients, the nurses correctly identified depression symptoms among 44 of the 97 (45%) people who were diagnosed with depression and they incorrectly identified depression symptoms among 230 of the 306 (75%) people who were not diagnosed with depression. These findings indicate that district nurses have difficulty identifying depression in their clients. In this study, one nurse characteristic, the extent of geriatric nursing experience, was found to be associated with more accurate assessment of depression. This suggests that increased exposure to older people with depression increases nurses' likelihood of accurately identifying depression in the aged indicating that increased education in depression may assist district nurses to accurately identify depression in their clients.

In another study investigating the prevalence of depression in RDNS clients, a sample of 148 clients 65 years or over were screened for depression using the GDS (Nunn & Flowers, 2003). In this sample, 38.5% of participants screened positive for depression on the GDS indicating that they required assessment by a mental health professional. However, although clients receiving treatment for depression were more likely to score higher on the GDS, overall only a small proportion of all clients in this sample were receiving interventions for their mental health condition. Clients in the study had been assessed by RDNS district nurses and were receiving RDNS ongoing care but only a small proportion were receiving care specifically for their mental health. This suggests that a significant number of RDNS clients with depression are neither identified nor treated for their mental health issues.

Under-recognition and under-treatment of depression in older people are frequently reported in the mental health literature (Mecocci, Cherubini, Mariani, Ruggiero, & Senin, 2004; Preville, Cote, Boyer, & Hebert, 2004). According to Mecocci and colleagues, this is due to: the belief by health professionals that depression is a normal characteristic of aging, the frequency of somatic symptoms characterising depression in older people, the frequency of co-morbid physical health problems in older people and a high prevalence of anxiety in this age cohort. However paradoxically, effective treatments for depression are readily available and include anti-depressant medication and psychological interventions such as cognitive behaviour therapy and interpersonal therapy (Mecocci et al., 2004).

Happell and Platania-Phung (2005) have criticised nursing for not adequately addressing clients' mental health needs despite a claimed focus on holistic health care; a philosophy in which the psychological, spiritual and physical domains of care are all considered to be central to adequate and effective health care of individuals. According to Happell and Platania-Phung, an integrated approach to mental and physical health by nurses is particularly relevant in 21<sup>st</sup> Century Australian health contexts due to the de-institutionalisation of people with mental health problems in the 1990s resulting in an increase in the number of people cared for by general nurses for with co-morbid mental health and physical health problems.

Hickie et al. (2005) note the central role played by primary health care in treatment and care of people with mental health issues and suggest a strengthening of this role is now needed. They recommend the stepped care approach to mental health whereby care is provided by a primary care multidisciplinary team who access specialist mental health professionals depending on illness severity and health needs of the client. The commentaries by Happell

and Platania-Phung (2005) and Hickie et al. (2005) highlight the increasing difficulties faced by people living in the community with mental health problems in accessing services, including quality nursing services, and note that mental health issues in older people are expected to rise rapidly over the next decade.

A number of authors (Haddad et al., 2005; Happell & Platania-Phung, 2005; Miller et al., 1999) suggest a multifaceted approach to improved nursing care for clients in the community with co-morbid mental and physical health problems including: improved mental health education for nurses, a structured approach to identifying clients with mental health issues and the introduction of psychiatry nurses into general health settings in order to provide consultation to generalist nursing staff.

The effectiveness of the Community Psychiatric Nurse role has been supported in past research. In one of these studies using a matched group design, Chan et al. (2000) found that community psychiatric patients cared for by community psychiatric nurses using a case management model had better outcomes in their mental status and functional level when compared with a control group. In a systematic review of randomised controlled trials assessing patient outcomes following community mental health nursing interventions in the UK, Brooker, Repper and Booth (1996) found support for the effectiveness of community mental health nurses on measures of client satisfaction, and improvements in depression and anxiety symptoms.

Promoting mental health in primary care settings is thus seen as vital to the effective health care of individuals in our community (Haddad et al., 2005; Mental Health Council of Australia, 2005). A number of authors have proposed that district nurses are in a prime position to provide mental health care to some of the most vulnerable people in the community, such as older people and those with chronic mental ill health (Haddad et al., 2005; Happell & Platania-Phung, 2005; Miller et al., 1999). District nurses are considered to be ideally placed to screen clients for mental health issues and make appropriate referrals.

The need for education to facilitate the competent use of validated screening instruments and encourage a more structured approach to the district nurse's role in mental health care has been stressed by several authors. Haddad et al. (2005) surveyed 217 district nurses in the UK and found that training and information regarding screening and identification of clients with potential mental health difficulties was their most frequently reported educational need. In another study, Jackson and Baldwin (Jackson & Baldwin, 1993), found that doctors and nurses were poor at detecting depression in older clients. They recommended that doctors and nurses receive training in basic psychiatric concepts and in the use of structured approaches to identifying potential mental health problems in their clients. Happell and Platania-Phung (2005) further note that nurses require training in mental health, at undergraduate level, and post registration. According to these authors, nurse education should incorporate the use of screening instruments for mental health problems and should promote understanding of the effect of mental illness on clients' physical health. In addition, the education should address any misconceptions the nurses may have about mental health and should facilitate a greater understanding of psychiatric issues relevant to their clients.

In the recent report '*Not for Service*', the Mental Health Council of Australia (2005) found that people with mental health issues continue to suffer from adverse health and social outcomes which are inadequately addressed by health services. This is largely due to the chronic under funding of mental health services by the State and Federal governments. The

report highlights the need for increased mental health services and a better quality of care across the board for these clients. The Mental Health Council of Australia identifies important issues regarding clients' difficulty accessing mental health services. The proposed RDNS Model of Mental Health Care aims to assist nursing clients, through nurse screening and Mental Health CNC assessment and intervention, to improve services and facilitate access to mental health services where required.

### **2.3 Project Aims and Objectives**

The proposed trial and evaluation of the RDNS Model of Mental Health Care incorporating nurse screening, the Mental Health CNC role, client care planning and liaison with and referral to external services, has three central aims:

1. To ascertain staff perspectives regarding mental health care at RDNS prior to the trial of the Model of Mental Health Care
2. To establish a profile of RDNS clients with co-morbid mental health conditions
3. To implement and evaluate a Model of Mental Health Care

Accordingly, the specific objectives of the RDNS Model of Mental Health Care Project are to:

1. Identify issues related to the provision of care to clients with mental health issues at RDNS by conducting focus groups with field nurses and nurse managers
2. Undertake a profile of RDNS clients with a co-morbid mental health diagnosis by using data collected over the 2004/2005 financial year in the RDNS client database to describe:
  - a. The characteristics of RDNS clients with co-morbid mental health conditions
  - b. The kinds of mental health conditions present in RDNS clients
3. Trial nurse screening for depression utilising the Geriatric Depression Scale at three participating RDNS Centres in the Western Region
4. Describe and understand the effects of nurse screening for depression on:
  - a. Referral systems (field nurses referring to the Mental Health CNC)
  - b. RDNS staff at participating Centres including the feasibility of nurse screening
5. Trial a Mental Health CNC role at participating Centres
6. Describe and understand the effects of the trialled Mental Health CNC role on:
  - a. Client outcomes including client satisfaction
  - b. RDNS staff at participating Centres including the feasibility of formal and informal referral and liaison systems, and care planning systems
7. Develop 'Guidelines for Service Provision' to support an ongoing model.

## **3 RDNS Staff Perspectives on Mental Health Issues**

As an early component of the Model of Mental Health Care, focus groups were conducted to identify some of the key issues and staff perspectives related to mental health and the provision of care by RDNS staff to clients with co-morbid mental health issues.

### **3.1 Method**

#### **3.1.1 Sample**

An invitation was sent to all RDNS Centres asking for volunteers to participate in the focus groups with the requirements that participants be field staff who have direct and regular contact with clients with mental health issues and/or consult with staff regarding client mental health issues. In total, 18 staff members volunteered to participate however seven subsequently withdrew or failed to attend. Six staff members attended the first group and five attended the second group. Participants included field nurses, clinical nurse consultants, liaison nurses and nurse managers.

#### **3.1.2 Data Collection**

Two focus groups were held at RDNS Head Office in September 2004. The focus groups were facilitated by Prof. Marilyn Annells (Director – LaTrobe University Postgraduate Clinical School of Community Nursing and RDNS Institute). Russell Nunn (Researcher, RDNS Institute) and Greg Reeve (RDNS Mental Health CNC – Western Region) also attended. Both focus groups were audio-taped with the permission of the participants.

#### **3.1.3 Data analysis**

To identify the main themes and sub-themes contained in the two focus groups, each focus group transcript was thematically analysed. Thematic analysis was undertaken using open coding to categorise participant viewpoints into common themes and sub-themes following the method identified by Strauss and Corbin (1998).

### **3.2 Results**

Findings from the collective two focus groups are presented to protect participants' anonymity. Nine themes were identified following thematic analysis of the two focus group transcripts:

1. Inadequate mental health care for RDNS clients with co-morbid mental health issues
2. RDNS staff concerns in caring for clients with co-morbid mental health issues
3. RDNS staff beliefs regarding the care of clients with co-morbid mental health issues
4. Mental health education needs for RDNS nurses
5. Need for guidelines for service provision regarding caring for clients with co-morbid mental health issues
6. RDNS nurse issues regarding screening clients for depression with the Geriatric Depression Scale (GDS)
7. The value of the RDNS Social Worker service for clients with co-morbid mental health issues

8. Improvements (potential) to RDNS service provision for clients with co-morbid mental health issues
9. RDNS Mental Health Clinical Nurse Consultant role (potential)

These themes and sub-themes are presented below with example quotes from the focus group transcripts.

***Theme 1 – Inadequate care for RDNS clients with co-morbid mental health issues***

Focus group participants expressed concern that there was no established process at RDNS to provide care to clients with co-morbid mental health issues and that this often resulted in a random approach to care. Care continuity was reported to be difficult as many clients with challenging mental health issues were moved from nurse to nurse in order to share their care among staff. Participants further explained that RDNS nurses had a limited understanding of mental health and mental health assessment. An additional constraint to providing effective mental health care for RDNS clients involved limited ability to undertake care, including the administration of psychotropic medication, over an extended period of time. The participants expressed a belief that this situation arose from funding difficulties and associated resource limitations.

Participants commented on difficulties accessing and communicating effectively with mental health services when attempting to refer a client, share relevant clinical information about a client's mental health and request follow up assessments for clients:

*“I feel like you contact the GP, it's not really their issue [the client] has just come out of hospital and you try and get something done back at the hospital level and they're well they're discharged so well it's really not our problem anymore. That's where I find it becomes the problem and I find that often when they do come out of hospital you haven't necessarily got all the information you need from that stage.”*

*“It's very difficult to get the GP to acknowledge that they need to be reviewed ... And even getting services like the Psychiatric Geriatric Assessment Team (PGAT) involved ... Like ringing up PGAT and saying we've got this lady who has you know she's depressed and we want a review and they are like what about the GP and what about the Aged Care Assessment Team (ACAT) and then you ring ACAT and they say what about PGAT, it seems to be going round and around in circles.”*

Participants noted that GPs provided limited medical services to clients with mental health issues and it was difficult to identify mental health care goals for clients with GPs. They explained that poor care coordination resulted from the difficulties in referring clients to mental health services, difficulties acquiring information from mental health services, the separation between general and mental health services, and differing priorities for physical health and mental health care from relevant services. In particular, focus group participants commented on the absence of services for older clients who were experiencing moderate depression, and grief and loss issues related to the loss of a spouse. According to participants, public mental health care was limited to treatment with psychotropic medication and did not provide adequate assistance to clients experiencing difficulty adjusting to life changes:

*“Unless the person can be treated with drugs then there is really nothing else out there for the public patient. Professional counselling for elderly people – there is nothing at all. A large proportion of our aged population clients who have lost a spouse and have unresolved grief for any amount of years and we expect them to be functioning like they were before.”*

### ***Theme 2 – RDNS staff concerns in caring for clients with co-morbid mental health issues***

According to focus group participants, many RDNS staff had concerns in sharing care with mental health services due to their lack of confidence in mental health services. They further explained that some RDNS staff felt unsafe caring for clients with schizophrenia who they believed were unpredictable and may physically threaten them. Participants commented on their lack of knowledge in mental health regarding crisis and risk management, cultural issues, day-to-day management of a person with schizophrenia or personality disorders, and their limited understanding of behavioural management strategies:

*“We seem to be getting a lot of younger people with schizophrenia diagnoses and we’re going in for medication management and field staff are feeling very uneasy about dealing with these people now because we don’t have much sort of education about these diagnoses and we’re going in there. Are they violent, are they surrounded by people who are violent ... if this person is having a crisis then what do we do ... ?”*

### ***Theme 3 – RDNS staff beliefs regarding the care of clients with co-morbid mental health issues***

Participants commented on a number of staff beliefs in relation to the care of clients with co-morbid mental health issues. Some staff did not wish to care for clients with mental health issues as they found them too challenging. Participants further explained that some staff feared clients with mental health issues, such as those with schizophrenia, as they believed they were potentially dangerous. Some RDNS staff were reluctant to explore mental health issues with clients as they believed that they were responsible for any associated psychological discomfort or distress the client may feel as a result. Participants noted that some RDNS nurses believed that their lack of knowledge about how to manage challenging behaviours was harmful to some clients as it reinforced the client’s challenging behaviours. The following quotes illustrate this theme:

*“I think there’s just a general fear. If you see on the sheet that this person has schizophrenia the nurse thinks they may have a knife and they might do this and they might be violent, people get really worked up about a situation before they even enter it.”*

*“I think that’s representative of our lack of knowledge in the area and lack of wanting to delve into that area. What are we going to deal with when we open up this box and all this stuff comes out ... ? ... and you get the run around from all the services out there who were supposed to be helping you but so it’s just like oh well skip him over this bit and hopefully we’ll be in and out quicker enough so we won’t have to deal with it.”*

*“[Nurses] are very afraid to do anything because I might do something that will cause it to be worse. I might get them to commit suicide if I say something. It’s better to ignore it. I don’t feel confident.”*

#### ***Theme 4 – Mental health education needs for RDNS nurses***

Participants noted that most RDNS nurses had no formal training in mental health and therefore mental health education was a requirement for all clinical nurses. They reported that education needed to target day-to-day care and management of clients with co-morbid mental health issues in the community, for example obtaining relevant information from referral sources, identifying mental health issues for clients and appropriate district nursing interventions, using screening tools and understanding how to interpret the results, identifying changes in clients’ behaviour and understanding how to manage challenging behaviours. According to participants, education needed to be Centre-based in addition to being provided at the Institute:

*“... out in the field, you need the skills to be able to identify or at least partially identify either a change in behaviour whether it’s ... bizarre behaviour ... developing those skills about identifying what the behaviours are.”*

*“Staff need to have mental health education - Centre-based education in mental health.”*

#### ***Theme 5 – Need for guidelines for service provision regarding caring for clients with co-morbid mental health issues***

Focus group participants identified the need for guidelines about providing RDNS services for clients with co-morbid mental health issues. According to these people, these guidelines should clarify criteria for RDNS to accept referrals for clients with mental health issues, they should provide guidance regarding the quality and type of information about a client’s mental health to obtain from a referral source and/or mental health service, and they should guide care coordination between RDNS and mental health service providers including the post discharge mental health care plan and the ongoing role of the mental health provider, GP and RDNS:

*“And I really feel like we do need some guidelines as well about what do we need to organise and when to accept them for RDNS as well, you know.”*

#### ***Theme 6 – RDNS nurse issues regarding screening clients for depression with the Geriatric Depression Scale (GDS)***

Participants described a variety of responses from RDNS nurses to the GDS: some staff liked to use it and other staff disliked using it. Many staff preferred to rely on their intuition and ‘gut’ feel while talking to the client. Participants commented that some nurses found the GDS questions open to interpretation and that nurses needed education regarding the use of the tool and interpretation of what the scores mean. The following quote illustrates this theme:

*“I think the questions can be interpreted in different ways ... it just gives you a scale and there is no room for comments you can’t put down what they feel I think*

*we should be out there talking to people and nurses need to trust their gut and their intuition a bit better than a scale.”*

***Theme 7 – The value of the RDNS social worker service for clients with co-morbid mental health issues***

Participants commented on the value of the social work service at RDNS in providing some support to RDNS clients in relation to their mental health issues. Social workers have training in mental health and assist clients by making referrals to GPs and to services such as ACAT regarding mental health problems. Participants noted that RDNS nurses referred some clients to social workers regarding behavioural issues as the nurses did not have a good understanding of clients’ behaviour.

***Theme 8 – Improvements (potential) to RDNS service provision for clients with co-morbid mental health issues***

Focus group participants commented on potential improvements to mental health care for RDNS clients: Mental Health Clinical Nurse Consultants (CNCs) at RDNS and resource nurses in mental health at RDNS Centres. They considered that the inclusion of one or two questions about mental health on the Preliminary Assessment Screening Tool would assist in phone screening clients. Participants explained that improved collaboration with mental health services, for example case discussion, and clarification of discharge plans and follow up by mental health services would improve care for RDNS clients with co-morbid mental health issues. They further noted that as an organisation RDNS needed to recognise that many of our clients have co-morbid mental health issues and ensure that the service provides equal and equitable service for all clients including those with mental health issues, clients with drug and alcohol issues and clients with challenging personalities:

*“I’d like to see mental health clients treated like everybody else. ... Status given to that whole area by having CNCs ... ongoing education and also to establish close relationships with the appropriate outreach psychiatric services in the area.”*

***Theme 9 – RDNS mental Health Clinical Nurse Consultant role (potential)***

Participants explained that a Mental Health CNC would ideally be a consultancy role undertaking home assessments, referrals to mental health services, care planning, client advocacy, staff support, Centre-based education and role modelling for staff in relation to effective problem solving for clients with mental health issues. According to these participants, a Mental Health CNC would consult with staff regarding professional boundaries in care provision for clients with challenging behaviours and be available for secondary consultations with staff. Further, the Mental Health CNC would be involved in establishing relationships and facilitating communication with mental health providers:

*“It would be public relations, getting links with the outreach services, education for the staff and consulting on complex clients.”*

### **3.3 Discussion**

The nine main themes emerging from the two focus groups suggest that a Model of Mental Health Care at RDNS would result in improved care for clients with co-morbid mental health issues. This indicates that a trial of a Model of Mental Health Care at RDNS, including an evaluation of effectiveness for clients and staff, is warranted.

Findings regarding ineffective mental health care for RDNS clients with co-morbid mental health issues reflect the general domiciliary nursing focus of care provision within RDNS and the separation between generalist and mental health services. Participants' comments suggest an absence of mental health care within the culture of RDNS. Indeed, RDNS which is predominantly financed under the Home and Community Care (HACC) Program is not currently funded to provide mental health care within a district nursing context.

These findings provide guidance regarding the components of a Model of Mental Health Care which are likely to be significant to both clients and staff. Participants' comments indicate that a Model of Mental Health Care at RDNS would ideally be supported by Mental Health CNC roles and resource nurses in mental health. These roles would incorporate nurse screening for mental health problems (e.g. depression), provide guidelines for service provision and include a strategy for staff education.

Importantly, these findings illuminate the need to engage staff in reconsidering mental health care for their clients and, for some staff, to change their beliefs regarding mental health in order to effectively identify and assist clients with co-morbid mental health issues. Thus, a change in RDNS care provision is necessary and would include mental health as a nurse consultancy specialty and require engagement of field nurses in processes to: screen clients for mental health issues, refer clients appropriately to specialist services including a RDNS Mental Health CNC, and address mental health issues in client care plans.

Themes identified by focus group participants suggest that a Model of Mental Health Care at RDNS would complement rather than replicate existing mental health services. Key foci of the Model of Mental Health Care would include identification of clients with mental health issues, following screening by field nurses; mental health assessment undertaken by a Mental Health CNC, and referral to appropriate services, such as GPs and mental health services. It is anticipated that RDNS staff, in collaboration with the RDNS Mental Health CNC, will undertake shared care planning, including goal setting in relation to mental health as it affects RDNS client care provision, with a client's GP and/or mental health services. In addition, this may be relevant for those clients for whom RDNS shares care with mental health providers, for example where RDNS field staff undertake medication management for clients with co-morbid major mental illnesses.

The need for education for RDNS staff in mental health emerged as a main theme from the two focus groups. According to participants, education in mental health would ideally be Centre-based and provided by a Mental Health CNC. It would target the day-to-day care and management of clients with co-morbid mental health issues in the community and the identification of significant changes in a person's behaviour and appropriate district nursing interventions such as referral to a mental health service and behaviour management strategies.

Focus group participants further commented on the potential Mental Health CNC role at RDNS. This would provide mental health assessments and interventions including referrals to

appropriate services, care planning, and a key role in education to staff and in establishing and maintaining links with mental health providers.

## **4 Profile of RDNS Clients with a Mental Disorder**

### **4.1 Introduction**

The aim of this client profile is to describe client episodes where general health problems were co-morbid with mental health conditions over the 2004/2005 financial year. As the development of more effective health care to RDNS clients with co-morbid mental health conditions is the aim of the RDNS Model of Mental Health Care, knowledge of the profile of this client group will be of assistance in defining the target group and in matching the strategies and guidelines proposed within the Model of Mental Health Care to clients' health care needs.

### **4.2 Method**

RDNS clients' demographic and service delivery data for the 2004/2005 financial year were retrieved from the client database (Camillus). As RDNS is a provider of general domiciliary nursing services, mental health disorders are typically recorded as secondary diagnoses. Therefore, diagnostic data presented in this client profile predominantly reflect secondary diagnoses.

The categories of mental health disorder were derived from the ICD-9 classification of mental disorders. In the ICD-9 classification of mental disorders, mental health conditions are those included in the range of codes between 290 and 319. These codes represent:

- Dementias
- Depressive Disorders
- Anxiety Disorders
- Schizophrenia and Psychoses
- Bipolar Disorder
- Mental Retardation
- Personality Disorders
- Drug and Alcohol Dependency and Abuse
- Mental Disorders Related to a Medical Condition
- Other Mental Disorders

It should be noted that although many varieties of dementia are included within the mental disorders sub-section of ICD-9, some dementias, including Alzheimer's Disease, are excluded.

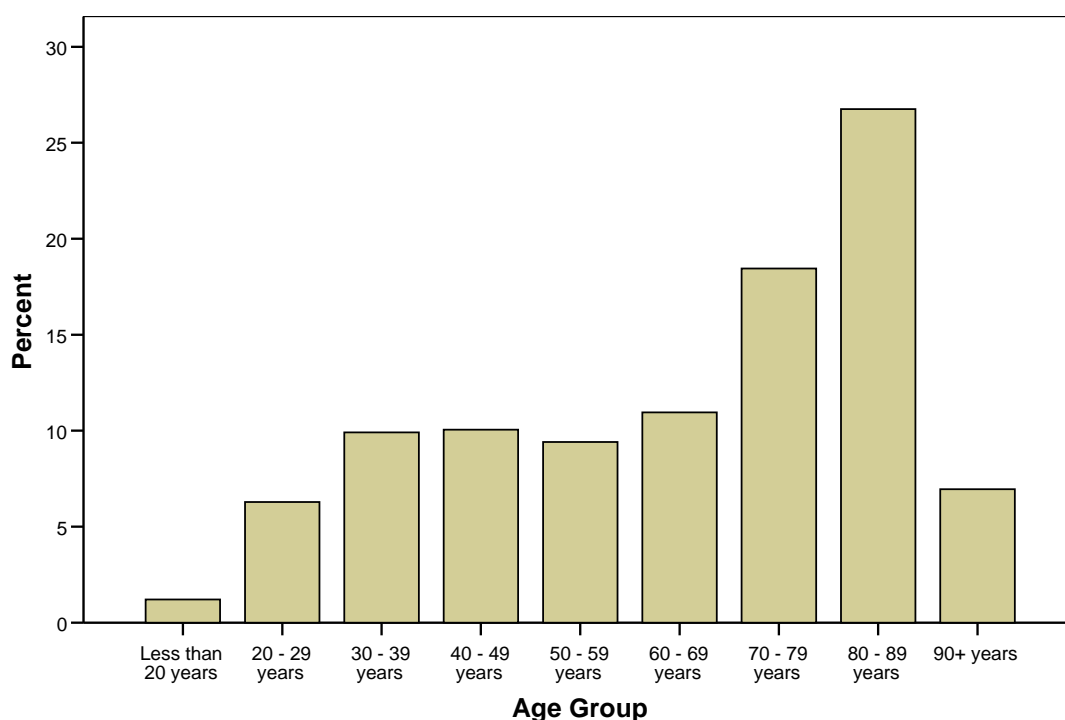
Additional data comprised client characteristics including: gender, age, country of origin, language spoken at home, living arrangements, and carer availability; and service provision characteristics including: Centre / Region and program details.

### 4.3 Results

In the 2004/2005 financial year, a total of 34,269 client episodes were undertaken at Royal District Nursing Service (RDNS). Of these client episodes, 6,455 (18.8%) included a primary or secondary co-morbid mental disorder diagnosis.

#### 4.3.1 Demographic Characteristics

The mean age of clients with a mental disorder was 64.7 years (sd=21.3, range=0-108) and 54.1% were female. Figure 4-1 shows the age distribution of clients with a mental disorder diagnosis.



**Figure 4-1 Age distribution of clients with a mental disorder**

Approximately two-thirds of client episodes where the client had a recorded mental health condition in the 2004/2005 financial year were born in Australia (see Table 4-1). Of the remaining episodes, Italy, England and Greece were the only countries of origin with a percentage greater than 2%.

**Table 4-1 Country of origin of clients with a mental disorder**

<b>Country of Origin</b>	<b>n</b>	<b>%</b>
Australia	4261	66.0
Italy	326	5.1
England	225	3.5
Greece	183	2.8
Other	1460	22.6
<b>Total</b>	<b>6455</b>	<b>100.0</b>

#### 4.3.2 Carer Availability and Living Arrangements

Table 4-2 presents carer availability data. Of these data, approximately one-third of clients with a mental health condition had a carer and almost one fifth were recorded as living alone with no carer. In slightly more than one-fifth of episodes, a carer was not considered necessary.

**Table 4-2 Carer availability of clients with a mental disorder**

<b>Carer Availability</b>	<b>n</b>	<b>%</b>
Lives with another, has resident carer	1600	24.8
Carer not needed	1480	22.9
Lives alone, has no carer	1215	18.8
Lives alone, has a carer	576	8.9
Lives in supported accommodation/institution	489	7.6
Lives in a mutually dependent situation	274	4.2
Lives with another, has no carer	242	3.7
Lives with another non resident carer	77	1.2
Missing	21	0.3
<b>Total</b>	<b>6455</b>	<b>100.0</b>

Table 4-3 displays the living arrangements of clients with a mental disorder. Of the client episodes involving a mental disorder, slightly more clients lived alone than with either family or others.

**Table 4-3 Living arrangements of clients with a mental disorder**

<b>Living Arrangements</b>	<b>n</b>	<b>%</b>
Lives alone	2494	38.6
Lives with family	2209	34.2
Lives with others	717	11.1
Lives in special purpose accommodation	514	8.0
Missing	521	8.1
<b>Total</b>	<b>6455</b>	<b>100.0</b>

#### *4.3.3 Treating Centre*

Client mental health episodes by RDNS Centre, excluding Homeless Persons Program (HPP) and RALLY Healthcare clients, are presented in Table 4-4. Percentages are based on the total number of episodes involving a mental disorder diagnosis. The top five Centres for the most frequent client episodes where the client had a mental health condition recorded were Caulfield, Moreland, Altona, Sunshine and Essendon Centres.

**Table 4-4 Frequency of episodes involving a mental disorder by RDNS Centre**

<b>RDNS Treating Centre</b>	<b>n</b>	<b>%</b>
Caulfield	482	7.5
Moreland	388	6.0
Altona	358	5.5
Sunshine	353	5.5
Essendon	325	5.0
Diamond Valley	307	4.8
Box Hill	288	4.5
Heidelberg	276	4.3
Rosebud	215	3.3
Camberwell	209	3.2
Knox	209	3.2
Yarra	209	3.2
Springvale	192	3.0
Berwick	139	2.2
Lilydale	75	1.2
Cranbourne	41	0.6
Gisborne	10	0.2
<b>Total</b>	<b>4,076</b>	<b>63.2</b>

#### *4.3.4 RDNS Service Subtype and Funding Program*

Client mental health episodes by treating area are presented in Table 4-5. Although Homeless Persons Program (HPP) client episodes comprised approximately 10% of all RDNS client episodes in 2004/2005, just over one quarter of mental disorder episodes in this period involved HPP clients.

**Table 4-5 Frequency of episodes involving a mental disorder by Service Subtype**

<b>Treating Area</b>	<b>n</b>	<b>%</b>
General Nursing	4515	69.9
Homeless Persons Program (HPP)	1712	26.5
RALLY Healthcare	228	3.5
<b>Total</b>	<b>6455</b>	<b>100.0</b>

Table 4-6 contains a breakdown of client episodes with a mental health condition by specific funding program including DVA, palliative care and HIV/AIDS.

**Table 4-6 Frequency of episodes involving a mental disorder by funding program**

<b>Program</b>	<b>n</b>	<b>%</b>
Department of Veterans Affairs (DVA)	476	7.4
Palliative Care	152	2.0
HIV/AIDS	123	1.6

#### *4.3.5 Mental Disorder Diagnoses*

In total, 115 separate ICD-9 primary or secondary mental disorder diagnoses were assigned to RDNS clients during the study period. Table 4-7 displays the top 25 diagnoses with percentages expressed as a function of the total number of client episodes involving a mental disorder diagnosis, i.e. n=6,455. Depression and dementia are easily the two most common disorders. Other common mental conditions among RDNS clients include anxiety, substance abuse, psychoses and bipolar disorder.

Although dementia is included in this breakdown, it is often considered a neurological or age-related disorder rather than a mental disorder. It is included here as it falls within the Mental Disorders section of ICD-9 and because many dementias include behavioural or psychotic symptoms which may require an intervention by the Mental Health CNC.

**Table 4-7 Top 25 mental disorder diagnoses**

<b>ICD-9 Diagnosis</b>	<b>n</b>	<b>%</b>
Depressive disorder, NEC	1319	20.4
Senile dementia, uncomplicated	1203	18.6
Alcohol use disorder	654	10.1
Anxiety states	459	7.1
Unspecified schizophrenia	431	6.7
Organic personality syndrome	431	6.7
Other mixed or unspecified drug abuse	373	5.8
Unspecified intellectual disability	303	4.7
Unspecified psychosis	294	4.6
Unspecified transient organic mental disorder	203	3.1
Bipolar affective disorder, unspecified	157	2.4
Neurotic depression	127	2.0
Arteriosclerotic dementia	102	1.6
Other and unspecified alcohol dependence	102	1.6
Opioid use disorder	60	0.9
Opioid type dependence, unspecified	55	0.9
Panic disorder	51	0.8
Cannabis use disorder	48	0.7
Paranoid type schizophrenia	41	0.6
Drug withdrawal syndrome	39	0.6
Unspecified paranoid state	37	0.6
Paranoia	35	0.5
Senile dementia with depressive features	33	0.5
Schizoaffective type schizophrenia	33	0.5
Chronic schizophrenia	30	0.5

It can be seen that the most common mental disorders among RDNS clients include depression, dementia, substance abuse, anxiety disorders and psychoses.

To further explore the relationship between types of mental disorder and episode characteristics, ICD-9 diagnoses were collapsed into the following broad groups: mood disorders (including depressive and bipolar disorders); dementias; anxiety disorders; psychoses (including schizophrenia); substance abuse; mental disorders associated with a medical condition; and intellectual disability (including developmental disorders).

Dementia and mental disorder associated with a medical condition were most frequently observed in older clients while clients with substance abuse, psychotic disorders and intellectual disability tended to be younger. Consistent with the predominance of females among mental disorder episodes, most mental disorder groups contained more females than males, however for substance abuse and, to a lesser extent, intellectual disability, a higher percentage of males was observed.

**Table 4-8 Demographic characteristics by mental disorder groups**

<b>Mental Disorder Group</b>	<b>n</b>	<b>Mean Age</b>	<b>% Female</b>
Mood disorder	1790	65.4 (18.6)*	62.8
Dementia	1563	82.6 (7.5)	65.9
Substance abuse	1368	46.9 (17.5)	26.7
Psychoses	968	53.8 (19.2)	51.4
Mental disorder with medical condition	702	79.6 (12.1)	60.3
Anxiety disorder	614	63.3 (20.6)	63.8
Intellectual disability	353	45.7 (19.0)	43.9

\* Figures in parentheses are standard deviations

**Table 4-9 Mental disorder group by Service Subtype**

Mental Disorder Group	General Nursing		HPP		RALLY Healthcare	
	n	%	n	%	%	
Mood disorder	1438	32.1	301	17.9	51	22.6
Dementia	1447	32.3	12	0.7	104	46.0
Substance abuse	347	7.7	1000	59.5	21	9.3
Psychosis	501	11.2	443	26.4	24	10.6
Mental disorder with medical condition	659	14.7	19	1.1	24	10.6
Anxiety disorder	435	9.7	170	10.1	9	4.0
Intellectual disability	298	6.6	45	2.7	10	4.4
<b>Total</b>	4485	100.0	1681	100.0	226	100.0

**Table 4-10 Mental disorder group by funding program**

Mental Disorder Group	DVA		Palliative Care		HIV/AIDS	
	n	%	n	%	n	%
Mood disorder	122	25.6	55	36.4	74	61.2
Dementia	222	46.6	49	32.5	6	5.0
Substance abuse	26	5.5	16	10.6	17	14.0
Psychosis	13	2.7	9	6.0	9	7.4
Mental disorder with medical condition	88	18.5	17	11.3	11	9.1
Anxiety disorder	44	9.2	15	9.9	38	31.4
Intellectual disability	6	1.3	6	4.0	5	4.1
<b>Total</b>	476	100.0	151	100.0	121	100.0

Among General Nursing client episodes, mood disorder and dementia are the most prevalent disorders (see Table 4-9). Similarly, among RALLY Healthcare episodes, dementia is the most common mental disorder followed by mood disorder. However, the pattern of mental disorders among Homeless Persons Program episodes is very different. Almost 60% of HPP episodes involving a mental disorder have substance abuse as a diagnosis and over one-quarter have a psychotic disorder.

Table 4-10 displays the major mental disorder groups by RDNS program. Among DVA episodes, dementia is the most common mental disorder followed by mood disorder followed by mental disorder associated with a medical condition. Among palliative care episodes, mood disorders and dementia are the most prevalent mental disorders. In HIV/AIDS program episodes involving a mental disorder diagnosis, over 60% have a mood disorder and almost one third have an anxiety disorder.

#### **4.4 Discussion**

The profile of clients with a mental disorder diagnosis clearly shows that these conditions are highly prevalent among RDNS clients. Although the data shows that almost one in five RDNS clients has a known mental disorder, this is without doubt a substantial underestimate of the true prevalence. It is well known that high prevalence conditions such as depression and anxiety are only detected and treated in a minority of clients receiving primary care services. For example, the depression prevalence study of RDNS found that at least 30% of older RDNS clients have likely depression although only 10% of those clients were receiving treatment (Nunn & Flowers, 2003).

The age of clients with a mental disorder covers a wide distribution although the mean age of 65 years is somewhat younger than the mean age of RDNS clients in general. This may be due to the over-representation of HPP and HIV/AIDS clients with a mental disorder who tend to be younger than other RDNS clients.

In relation to carer availability and living arrangements, almost 40% of clients with a mental disorder live alone and one fifth live alone without a carer. The high number of clients without a carer may add to the challenge of providing care to this client group which needs to be considered when developing care plans.

Although depression, dementia and substance abuse are the most common diagnosed mental disorders among RDNS clients as a whole, there is a substantial amount of variation in the pattern of mental disorders across client subgroups. Among General Nursing Clients (funded under the HACC Program), Rally Healthcare (including DVA clients) and palliative care clients, depression and dementia are easily the most prevalent conditions.

The RDNS Annual Report for 2004/2005 (Royal District Nursing Service, 2005) noted that leg ulcers, urinary incontinence, wounds, malignant neoplasms, diabetes, Multiple Sclerosis, Alzheimer's Disease and Parkinson's Disease were the most frequently occurring diagnoses among RDNS clients. It is now well documented that there is a strong relationship between chronic illnesses and conditions such as these and the incidence and prevalence of mental health conditions such as depression (Cleary & Drennan, 2005; Rabinowitz, Shayevitz, Hornik, & Feldman, 2005). In the current mental health client profile, a large number of client episodes involved a diagnosis of depression. As clients are not referred to RDNS for

this reason, these figures reflect the high incidence of the co-occurrence of depression with chronic illness conditions.

In relation to the high prevalence of dementia, this is not surprising given the age distribution of RDNS clients, 70% of whom are aged 65 years and older.

There are a very high proportion of mental disorders in HPP clients and in clients enrolled on the HIV/AIDS program. Almost one quarter of HPP clients had a diagnosed mental disorder with the most common disorders being substance abuse followed by psychoses and depression. According to the research literature, people with homelessness issues very frequently suffer from co-morbid mental health conditions, including schizophrenia, depression and substance abuse (Rayburn et al., 2005). Therefore, the over representation of mental health diagnoses in HPP client episodes is consistent with the literature describing this client cohort.

The high number of co-morbid mental health conditions in people with HIV/AIDS is also not surprising and is consistent with the research literature. The most common mental disorders in this client group were depression and anxiety.

## 5 Screening for Depression

### 5.1 Introduction

The study described in this chapter was partially supported by seed funding from the beyondblue-funded diamond Consortium. The focus of the Consortium is on the management of depression that occurs within primary care and the interface between that care, the community and the public and private mental health services. The Chief Investigators of the study are Russell Nunn (RDNS Institute), Prof. Merylyn Annells (LaTrobe University and RDNS Institute) and Dr. Jane Sims (University of Melbourne).

Depression is a key contributor to the Australian burden of disease and a leading cause of loss of disability-adjusted life-years (DALYs) (Snow, Lascher, & Mottur-Pilson, 2000). In Victoria, it is the largest single cause of years lost due to disability (Victorian Government Department of Human Services, 1999). Depressed patients are commonly managed in the primary care sector. In general practice, 5% of patients have major depression and a further 5% less severe depression (Barry, Fleming, & Manwell, 1998; Britt, Sayer, & Miller, 1999). Prevalence of depression in older persons in the primary care setting is between 17 and 30% (Baldwin, Chiu, Katona, & Graham, 2002).

There is a clear need within Australia for research to be conducted focussing upon depression screening and assessment techniques, intervention strategies and referral processes to address depression amongst community-dwelling elderly people – and how community nurses can both facilitate and be part of these requirements.

In addition to their medical complaints, many of RDNS' clients are elderly, financially disadvantaged, isolated and housebound and are therefore at high risk for developing depression. A recent prevalence study (Nunn & Flowers, 2003) found that 38% of RDNS' elderly clients scored above the clinical cut-off on the 15-item Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986). Unfortunately, identification of depression in this population can be extremely problematic. Firstly, due to the stigma attached to mental illness, many elderly people are reluctant to discuss their emotional concerns with healthcare professionals. In addition, disentangling medical from mental health problems can be extremely difficult. Although the provision of mental health services is not typically associated with community nursing in Australia, the nursing staff of organisations such as RDNS that serve vast numbers of the elderly living in the community are in an ideal position to identify and facilitate appropriate intervention when depression is present.

The clients of RDNS are an ideal group with which to explore the nexus of community nursing screening and assessment for depression in community-dwelling elderly people and treatment interventions including those provided by general practitioners and/or mental health care professionals.

Although it is acknowledged that district nurses have the potential to play a key role in the identification of elderly people with depression (Hope, 2003; Piven, Lyons, & Titler, 2001), research has shown that many nurses have a limited understanding of depression (Bruno & Ahrens, 2003) and many have great difficulty in accurately identifying depression in their clients, particularly when subjective observational techniques are employed (Brown et al.,

2003). As appropriate and accurate assessment is the key to selecting necessary and available interventions, it was considered necessary in the current project to examine the feasibility of district nurses routinely screening for depression in their elderly clients.

Therefore, the primary aim of the proposed study was to:

- examine the feasibility of screening for depression in elderly district nursing clients.

To address the issue of developing an appropriate education strategy for RDNS nursing staff, a secondary aim was to:

- assess district nurses' knowledge, beliefs and attitudes with regard to depression.

## **5.2 Methods**

The depression screening study was conducted in two phases. In the first phase, a proposed methodology for identifying clients with depression was developed and trialled at one RDNS Centre (henceforth referred to as Centre A). The data obtained from this phase were then utilised to develop a modified depression screening methodology which was trialled at two further RDNS Centres (henceforth referred to as Centres B and C).

### **5.2.1 Phase 1**

The participants for Phase 1 of the study were RDNS field staff at Centre A and their older clients. Centre staff were invited to attend a two-hour training session at their centre on depression and the administration and interpretation of the Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986). In total, 25 staff attended one of three training sessions. At the beginning of each session, the nurses completed a questionnaire on their knowledge of depression and experience in identifying depression in their older clients, including familiarity with the GDS (see Appendix 2). Questions related to the nurses' knowledge and attitudes about depression were adapted from the Depression Attitudes Questionnaire (Dowrick, Gask, Perry, Dixon, & Usherwood, 2000) and a questionnaire developed by Naji et al (2004). Over the following three months, nursing staff were requested to administer the GDS during regular home visits with all new and existing clients who met the study eligibility criteria and who provided consent. To be eligible to take part in the study, clients must have been aged 65 years or older and be current clients at Centre A. Clients who had a diagnosis of dementia or who scored below the clinical cut-off on the Mini-Mental State Examination (MMSE) (Folstein & Folstein, 1975) or who were enrolled on a palliative care program were excluded.

Research over many years has shown that the GDS is an effective and valid screening tool for depression in older people (Scogin, Rohen, & Bailey, 2000). Although the GDS is already approved for use by RDNS staff, anecdotal evidence suggests that it is only used occasionally and that many staff are reluctant to use it because no training is provided in its' use and interpretation. For the purposes of this study, the GDS-5/15 (Weeks, McGann, King Michaels, & Penninx, 2003) was used (see Appendix 3). Unlike the regular 15-item GDS, the GDS-5/15 is administered in two steps. In the first step, the client is asked the first five questions. If two or more responses indicative of possible depression are elicited, the remaining 10 questions are asked. If the client provides less than two answers indicative of depression, the remaining questions are not asked.

Clients who scored above the clinical cut-off for probable depression on the GDS-5/15 (i.e. 8 or above) were referred to the Mental Health Clinical Nurse Consultant (MHCNC) for further assessment and referral if deemed necessary.

At the conclusion of the three-month implementation phase, a survey of all field staff at Centre A was undertaken. The purpose of the survey was to evaluate nurses' perceptions of the utility, acceptability and feasibility of routinely using the GDS with older RDNS clients. Post-implementation questionnaires were distributed to individual staff members via the RDNS internal mail system and were returned anonymously. Written informed consent was sought from all participating nursing clients whereas the completion and return of questionnaires from nursing staff was taken to constitute consent. In addition to the post-implementation questionnaire, eight staff members at Centre A took part in a Nominal Group Technique to identify the difficulties they had experienced during the course of the study. Nominal Group Technique is a structured group approach that is used for obtaining a consensus on a particular issue based on prioritising of issues and pooled judgements (Delbecq, VandeVen, & Gustafson, 1975).

### 5.2.2 Phase 2

Following the completion of Phase 1 of the study at Centre A, analyses of the data from the questionnaires and Nominal Group Technique were undertaken.

Anecdotal reports of resistance to using the GDS were apparent from the beginning with the number of GDS questionnaires being conducted with clients much lower than anticipated. The situation was further complicated by the resignation of the Mental Health CNC a few weeks after the commencement of the study which resulted in a temporary cessation of the study for approximately six weeks. At the conclusion of the GDS implementation phase, only 28 GDS questionnaires had been completed representing only five individual staff members. It should be noted that the number of nurses who used the GDS at Centre A may have been higher as some nurses may have failed to return the completed questionnaires to the project team.

A consultation meeting was held with representatives from the study Centres to review the findings from Centre A and to consider options for overcoming some of the difficulties encountered. As a result of the data analyses and subsequent discussions, the following modifications to the depression screening methodology were proposed for trialling in Phase 2 of the study at Centres B and C:

- The GDS would continue to be used to screen older RDNS clients for depression. However, greater emphasis would be placed in the pre-implementation training session for staff on the practical aspects of administering the GDS in a way that is acceptable to the nurses and is sensitive to the needs of the client. The training session would also incorporate a role play to provide participating nurses with an opportunity to practice administering the GDS. In addition, greater emphasis would be placed on contextualising the project within the nurses' day-to-day clinical practice and within the RDNS Model of Mental Health Care Project. The Mental Health CNC contracted to the Mental Health Model Project would assist with the delivery of the education session.

- Only staff involved in direct client care that may be in a position to screen their clients for depression as part of their role within RDNS would be invited to participate in Phase 2 of the study.
- The Centre Managers at the two participating Centres would nominate a ‘champion’ who would be familiar with the objectives and methodology of the study and whose role would be to provide support, information and encouragement to participating nursing staff throughout the study period, to ensure that all data was collected in accordance with the study protocol and also to liaise with study personnel as the need arose.
- Older RDNS clients would not be approached to participate in the study until the primary nurse felt that a sufficient level of rapport had been established.
- Nurses who volunteered to participate in Phase 2 of the study would be asked to sign a Consent Form accompanied by an explanatory statement to help ensure that they fully understood the study’s objectives, methodology and data collection requirements.
- This phase of the study would incorporate a one-month implementation phase (as opposed to three months at Centre A) during which all participating nurses would be encouraged to screen 5-10 clients each.

In total, 21 nurses participated in Phase 2 of the study (nine at Centre B and 12 at Centre C). The same pre-implementation questionnaire was used in Phase 2 as in Phase 1 however a slightly modified version of the post-implementation questionnaire was used.

## **5.3 Results**

### **5.3.1 Phase 1 Nominal Group Technique**

The results of the Nominal Group Technique with eight staff members at Centre A following the GDS implementation period are summarised below:

**Question:** *What Difficulties have you had with the Mental Health Project?*

1. The Absence of the Mental Health CNC (7 points)  
This point shared equal top rating with one other. The issues identified were that staff didn’t know what to do with the result of the GDS if it was positive. They felt a duty of care to follow up once problems were identified however participants believed they had no clear referral point or direction regarding consultancy. Therefore they were not willing to identify a problem in the first place.

The second issue relating to the absence of the Mental Health CNC was that this led to an “on again off again” process, and staff eventually lost interest or trust that the study was actually going to continue.

2. The Education Session/s (7 points)  
There were a number of views on the education delivered at the Centre. According to some participants, its content and quality was good, but some believed that the education did not give the right messages or targeted the right staff. The points raised are listed below:

- Only those staff who would be directly involved with the project should have been involved and not those who wouldn't be using the GDS. A counter view was that all staff needed to have information that the project was happening – but wouldn't necessarily have needed to get this information in the same way as those who needed instruction on how to use the GDS – in other words, 'horses for courses'.
- The education was confusing.
- It was too research focused and did not give any view that staff were to learn from it for their own clinical roles; only what they were to do in regard to the research.
- There was not enough context provided for the use of the GDS – only guidelines for the use of the tool. Staff said they did not realize that it was a part of a clinical model being developed to help them to make appropriate responses for their own clients with mental health / depression problems.
- There was no role play re how the GDS might be used and how the client might react or benefit and therefore staff didn't feel comfortable using it.
- As a separate point, the planning for the education session should have taken into account that the Aged Care CNC was not able to attend the proffered sessions. This was problematic because she could otherwise have been a resource for staff and could have supported the project had she been more involved from the outset.

### 3. Difficulties asking the GDS questions (4 points)

Further to the points raised above, there were some very specific issues related to the GDS itself:

- Participants explained that they did not like asking the questions in the GDS because they feared they might be seen as judgmental by the client because the questions would be perceived as intrusive and inappropriate.
- The questions seemed too repetitive.
- The question regarding whether clients felt their life was worthless was particularly unpalatable, especially for some of the clients whose situation was not good anyway. Staff wanted to re-word it but knew they could not. They also thought that there were too many possible answers to this question but only a 'Yes' or 'No' was allowed. In the end they might have avoided it altogether whereas if they had done a role play they might have received some guidance on how to approach the question and answers.

### 4. The Target Population (2 points)

- There were several comments that it was a pity the target population was so narrow – i.e., excluding palliative care and dementia clients who might well be depressed and needing this to be identified; and also non-English speaking clients.

### 5. "Felt like a Research Mule" (2 points)

Participants believed there was no purpose to what they were asked to do – it was just another task.

6. The personal nature of the GDS questions was challenging (1 point)

The above comment was made in the context of the participant's belief that the current RDNS environment is "task oriented" in which many staff feel they have been de-skilled in relating therapeutically with their clients at this level.

Some general positive comments about the study included:

- The division of the GDS into two halves – "... at least you could stop at five if there was no problem identified".
- Consciousness raising regarding depression as an issue.
- It is good that this has started at all (particularly relating to the Mental Health CNC position) which the participants said they had wanted for a long time.

Additionally, participants made the following comments:

1. Education session

- Keep the session brief
- Better explain the rationale for the use of the GDS
- Clarify the key differences between depression and dementia
- Clarify the use of the GDS including the process for using it and then what to do with the results
- Undertake role plays in order to better contextualise the use of the GDS
- Increase access to education to take account of the different shifts
- Provide several education sessions at different times so that nurses working across all shifts have an opportunity to take part

2. Other recommendations

- Explain the rationale for excluding clients with dementia from screening with the GDS
- Introduce a culturally appropriate depression screening tool for non-English speaking clients
- Separate the research component of the project from the clinical, possibly utilising two separate sessions
- Explain the rationale for the Mental Health Model Project and the context of the depression screening study within that project
- Only include small numbers of nurses in the screening study rather than all staff involved in direct client care

### 5.3.2 *Pre-Implementation Survey Findings*

In this section, the results of the GDS pre-implementation surveys at all three participating Centres are presented. Although Phase 1 of the study at Centre A was conducted prior to the Phase 2 at Centres B and C, the questionnaire was identical and was administered immediately prior to the depression education session. Therefore, the combined results for the three Centres constitute a useful baseline for comparisons with the post-implementation

surveys and can also be used to identify gaps in the nurses' knowledge of depression, thus helping to inform the development of future mental health training programs.

The sample for the pre-implementation survey was 46 nurses across the three centres. Twenty-five were based at Centre A, 9 were based at Centre B, and 12 were from Centre C. All nurses were involved in direct client care. Eighteen nurses were Grade 2 (39.1%), 18 were Grade 3 (39.1%) and nine were Grade 4 (19.6%).

The mean length of time employed by RDNS across the three Centres was 17.8 years (sd=10.4). A comparison of the length of time employed revealed a difference which was close to statistical significance (F=3.13, df=2,41, p=.054). Post-hoc comparison using the Tukey test indicated that nurses at both Centre A and Centre B had been employed for a significantly longer period of time than those at Centre C (Centre A mean=20.8, Centre B mean=18.0, Centre C mean=11.9).

Across the three Centres, 29 nurses (63.0%) worked full-time and 16 (34.8%) worked part-time. Almost all (97.8%) worked day shift.

Table 5-1 shows the level of training and education that the nurses had received previously in mental health. Although somewhat more than a third of nurses had received some in-service training or undergraduate education in mental health, and about one-fifth had attended short courses, almost one third had received absolutely no prior education in mental health.

**Table 5-1 Level of previous education and training in mental health**

Type of Mental Health Education	N*	%
In-Service Training	18	39.1
Undergraduate	17	37.0
None	14	30.4
Short Courses	9	19.6
Other	2	4.3
<b>Total</b>	<b>46</b>	<b>100.0</b>

\* This is a multiple response question. Totals may add to more than 100%.

There was a considerable amount of variation in the nurse's estimate of the percentage of their older clients with depression. Estimates ranged from 1% to 90% and the mean estimate was 39.2%.

The vast majority of nurses stated that they were involved in the identification of depression in their older clients with only two nurses indicating that they did not identify depression. The most common method for identifying depression by a wide margin was subjective impression and opinion which was used by approximately three-quarters of the nurses in the study. Structured depression questionnaires were used by only five nurses (10.9%) (see Table 5-2).

**Table 5-2 Nurse's main method of identifying depression**

<b>Method of identifying depression</b>	<b>n</b>	<b>%</b>
Subjective impression/opinion	36	78.3
Depression questionnaire	5	10.9
Don't identify depression	2	4.3
Other	3	6.5
<b>Total</b>	<b>46</b>	<b>100.0</b>

Across the three centres, twenty-two nurses (47.8%) had used the GDS sometimes and three (6.5%) had used it often. Almost half of the nurses (45.7%) had never used the GDS. Among those who had used the GDS in the past, most found it somewhat useful (54.2%) or very useful (25.0%). About one-fifth of nurses who had used the GDS found it not very useful (20.8%).

In response to the question about whether the nurses believed there was a role for district nursing organisations in the routine screening of their older clients for depression, the overwhelming majority (84.8%) answered in the affirmative.

Table 5-3 lists the symptoms of depression according to the nurses participating in the study. Although most nurses were able to report at least some of the nine symptoms of depression according to DSM-IV criteria, many nurses failed to mention the two key symptoms of depression (depressed mood and anhedonia) and many listed symptoms which may indicate the nurses have difficulty distinguishing sadness from clinical depression.

**Table 5-3 Nurse identified symptoms of depression in older nursing clients**

<b>Depression Symptom</b>	<b>N*</b>	<b>%</b>
Insomnia / hypersomnia <sup>†</sup>	26	57.8
Weight loss / gain <sup>†</sup>	25	55.6
Depressed mood <sup>†</sup>	19	42.2
Social withdrawal / isolation / reclusive	17	37.8
Loss of pleasure / anhedonia <sup>†</sup>	16	35.6
Fatigue / loss of energy <sup>†</sup>	15	33.3
Poor motivation / lack enthusiasm / apathy	7	15.6
Personal neglect / unkempt appearance	7	15.6
Difficulty thinking / concentrating <sup>†</sup>	6	13.3
Thoughts of death / suicide <sup>†</sup>	6	13.3
Crying / tearful	5	11.1
Feelings of worthlessness / guilt <sup>†</sup>	3	6.7
Mood swings	2	4.4
Psychomotor agitation / retardation <sup>†</sup>	1	2.2
Flat affect	1	2.2
Feeling lonely	1	2.2
Anger / complaining / negativity	1	2.2
Missing	1	2.2

\* This is a multiple response table. Totals may add to more than 100%.

<sup>†</sup> DSM-IV symptom of major depression

Almost all nurses indicated that the most common causes of depression in their clients were social isolation, having an illness or disability and stressful events (see Table 5-4). Being in a caring role for someone with an illness was also identified as a common precursor for depression.

**Table 5-4 Nurse identified causes of depression in older nursing clients**

<b>Causes of Depression</b>	<b>N*</b>	<b>%</b>
Isolation	43	93.5
Illness/Disability	43	93.5
Stressful events	42	91.3
Caring for someone with an illness	38	82.6
Family problems	33	71.7
Family history	30	65.2
Cultural dislocation	29	63.0
Financial problems	26	56.5
Don't know	2	4.3
Other	1	2.2
<b>Total</b>	<b>46</b>	<b>100.0</b>

\* This is a multiple response question. Totals may add to more than 100%.

Although most nurses in the survey believed there is a role for district nurses in the identification of clients with depression, almost all (84.8%) did not believe they were able to deal effectively with depressed clients. The reasons for being unable to deal effectively with depressed clients are displayed in Table 5-5. The most common reasons were lacking adequate knowledge about depression, not having specialised training and not having enough time.

**Table 5-5 Reasons for not being able to deal effectively with depressed clients**

<b>Reasons</b>	<b>N*</b>	<b>%</b>
Lack adequate knowledge	35	89.7
Not had specialised training	20	51.3
Do not have enough time	19	48.7
Would not get adequate professional support	5	12.8
Not part of job	0	0
Other	1	2.6
<b>Total</b>	<b>39</b>	<b>100.0</b>

\* This is a multiple response question. Totals may add to more than 100%.

Nurses' responses on questions regarding to their knowledge and attitudes about depression are shown in Table 5-6.

In regard to treatment for depression, most nurses believed that antidepressants were effective however they were less certain about the effectiveness of counselling or psychotherapy. Most respondents considered depression to be a chronic condition which tended not to improve with treatment. Many nurses felt that depressed clients could be unpredictable and were difficult to deal with.

Many nurses were uncertain about whether depression was caused by biological or psychological factors and most found it difficult to distinguish unhappiness from clinical depression in their clients.

Almost all respondents agreed that depression was not a normal part of growing old and an overwhelming majority believed that district nurses had a role in supporting clients with depression.

**Table 5-6 Nurse's knowledge and attitudes regarding depression**

	Strongly agree		Agree		Neutral / Unsure		Disagree		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Should be offered antidepressants	11	24.4%	27	60.0%	3	6.7%	2	4.4%	2	4.4%
Antidepressants continued for at least 4 months	3	6.5%	14	30.4%	26	56.5%	2	4.3%	1	2.2%
Main treatment should be counseling	6	13.0%	13	28.3%	6	13.0%	18	39.1%	3	6.5%
Depressed people are unpredictable	5	10.9%	14	30.4%	9	19.6%	15	32.6%	3	6.5%
Counseling is effective for depression	8	17.4%	33	71.7%	4	8.7%	1	2.2%		
Depressed people are a danger to others			4	8.7%	7	15.2%	27	58.7%	8	17.4%
Depressed people need to pull themselves together			2	4.3%	2	4.3%	17	37.0%	25	54.3%
Tranquilisers are an effective treatment for depression			1	2.2%	10	22.2%	19	42.2%	15	33.3%
Antidepressants are an effective treatment for depression	5	10.9%	37	80.4%	1	2.2%	2	4.3%	1	2.2%
People with depression tend not to improve with treatment	1	2.2%	4	8.7%	5	10.9%	27	58.7%	9	19.6%
Antidepressants are drugs of addiction	2	4.3%	7	15.2%	8	17.4%	19	41.3%	10	21.7%

	Strongly agree		Agree		Neutral / Unsure		Disagree		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Depressed people are hard to talk to	2	4.3%	16	34.8%	2	4.3%	19	41.3%	7	15.2%
Seen increase in clients with depression	2	4.3%	25	54.3%	10	21.7%	9	19.6%		
Depression originates from client's misfortunes			7	15.6%	5	11.1%	27	60.0%	6	13.3%
Most depression improves without medication	1	2.2%	13	28.3%	8	17.4%	17	37.0%	7	15.2%
Biochemical abnormality is basis for depression	5	11.1%	19	42.2%	13	28.9%	7	15.6%	1	2.2%
Difficult to differentiate unhappiness from depression	1	2.2%	22	47.8%	5	10.9%	18	39.1%		
Two groups of depression: psychological and biochemical	2	4.3%	14	30.4%	24	52.2%	6	13.0%		
Depression is way of dealing with poor stamina			2	4.3%	5	10.9%	24	52.2%	15	32.6%
Depressed people experienced deprivation in early life			3	6.5%	11	23.9%	20	43.5%	12	26.1%
I feel comfortable in dealing with depressed people's needs			19	41.3%	6	13.0%	18	39.1%	3	6.5%
Depressions reflects response not amenable to change			2	4.4%	11	24.4%	24	53.3%	8	17.8%
Depression is natural part of becoming old							25	55.6%	20	44.4%

	Strongly agree		Agree		Neutral / Unsure		Disagree		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%	Count	%
District nurse useful to support depressed people	7	15.6%	37	82.2%			1	2.2%		
Working with depressed people is heavy going	4	8.9%	28	62.2%	4	8.9%	8	17.8%	1	2.2%
Little to be offered to depressed people who don't respond to medical treatment	1	2.2%	1	2.2%	12	26.7%	27	60.0%	4	8.9%
Rewarding to look after depressed clients	2	4.4%	19	42.2%	13	28.9%	11	24.4%		
Psychotherapy tends to be unsuccessful with depressed clients			2	4.4%	28	62.2%	11	24.4%	4	8.9%
Better with psychiatrist than GP if need antidepressants	3	6.7%	15	33.3%	9	20.0%	15	33.3%	3	6.7%
Antidepressants usually satisfactory in treatment of depression	2	4.5%	23	52.3%	13	29.5%	5	11.4%	1	2.3%
Psychotherapy for depression should be left to specialist	5	11.1%	25	55.6%	9	20.0%	6	13.3%		
If psychotherapy available, would be more beneficial than antidepressants	4	8.9%	11	24.4%	20	44.4%	9	20.0%	1	2.2%

### 5.3.3 Post-Implementation Survey Findings

As the education session for nurses at Centre A differed from the session provided to staff at Centres B and C, the results of the post-implementation surveys will be presented separately. Only the findings in relation to the acceptability and feasibility of using the GDS to screen for depression will be presented here. The results pertaining to the nurse's post-implementation knowledge and attitudes relating to depression are displayed in Appendices 6 and 7.

#### 5.3.3.1 Centre A

In total, 11 nurses from Centre A returned the post-implementation survey, thus giving a response rate of only 44%. Given the low response rate, these findings should be considered with some caution.

The sample comprised six Grade 2 nurses (54.5%) and five Grade 3 nurses (45.5%). No Grade 4 nurses returned the post-implementation survey form. Eight responders worked full-time (72.7%) and three worked part-time (27.3%).

With regard to the education session on depression, seven nurses (63.6%) rated the session as very useful and four (36.4%) rated the session as somewhat useful. Satisfaction with regard to how well the education session prepared them for using the GDS was somewhat lower with only three nurses (27.3%) rating the education as very adequate and eight (72.7%) giving a rating of somewhat adequate.

Only four of the respondents (36.4%) had used the GDS prior to the education session and seven (63.6%) had used it since the education.

Among those who had used the GDS in the past or recently, seven (87.5%) rated the GDS as somewhat useful and one considered it to be very useful (12.5%).

Table 5-7 lists the main benefits of using the GDS to screen for depression. More than half of the respondents believed that the GDS helped to uncover depression which would otherwise be overlooked.

Eight nurses listed some problems associated with using the GDS to screen for depression (see Table 5-8). The most common problems included a concern that the clients don't answer the questions honestly and that the GDS is not suitable for too many clients (e.g. those with dementia, non-English speaking clients).

In response to the question about whether they would feel comfortable using the GDS in the future, almost three quarters (72.7%) stated that they would be comfortable. A similar percentage (72.7%) believed that screening for depression should be part of the nurse's role at RDNS.

**Table 5-7 Benefits of using the Geriatric Depression Scale (GDS)**

<b>Benefits</b>	<b>n*</b>	<b>%</b>
Helps identify depression otherwise overlooked	6	60.0
Quick & easy to use	3	30.0
Effective screening tool for depression	2	20.0
Helps to quantify emotional state	2	20.0
Easy for client to understand	1	10.0
Other	1	10.0
<b>Total</b>	<b>11</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

**Table 5-8 Problems with using the Geriatric Depression Scale (GDS)**

<b>Problems</b>	<b>n*</b>	<b>%</b>
Clients don't answer honestly	4	50.0
Not suitable for too many clients	4	50.0
Questions too negative/depressing	3	37.5
Questions too non-specific/insensitive	3	37.5
Questions might make client feel worse	3	37.5
Questions need to be reworded	3	37.5
Questions too repetitive	2	25.0
Compromises clinical/therapeutic relationship	1	12.5
Don't feel comfortable asking clients about emotions	1	12.5
Don't like structured questionnaires	1	12.5
Prefer using observational skills	1	12.5
<b>Total</b>	<b>8</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

Only just over one third of Centre A nurses (36.4%) indicated that they are able to deal effectively with depressed clients. The reasons for not being able to deal with depressed clients are listed in Table 5-9. Lacking adequate knowledge and specialist training were the most common reasons.

**Table 5-9 Reasons for being unable to deal effectively with depressed clients**

<b>Benefits</b>	<b>n*</b>	<b>%</b>
Lack adequate knowledge	5	83.3
Not had specialised training	4	66.7
Would not get adequate professional support	3	50.0
Do not have enough time	1	16.7
<b>Total</b>	<b>6</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

### 5.3.3.2 Centres B and C

Sixteen nurses from Centres B and C returned the post-implementation survey, thus giving a response rate of 76%. Even though the response rate for this phase of the study was higher than at Centre A, the number of respondents is small and this should be taken into consideration when interpreting the findings.

The sample comprised five Grade 2 nurses (31.3%), six Grade 3 nurses (37.5%) and four Grade 4 nurses (25.0%). Twelve worked full-time (75.0%) and four worked part-time (25.0%).

With regard to the education session on depression, 11 nurses (68.8%) rated the session as very useful and four (25.0%) rated the session as somewhat useful. Only one nurse (6.3%) rated the content of the session as not being very useful. Satisfaction with regard to how well the education session prepared them for using the GDS was considerably higher than at Centre A with ten nurses (62.5%) rating the education as very adequate and six (37.5%) giving a rating of somewhat adequate.

Previous use of the GDS was higher at Centres B and C than at Centre A with 12 staff (75.0%) having used the GDS in the past. Subsequent to the education session, 10 nurses (62.5%) used the GDS at least once.

Among those who had used the GDS in the past or recently, six (40.0%) rated the GDS as somewhat useful and four (26.7%) considered it to be very useful. Five nurses (33.3%) felt that the GDS was not very useful.

Table 5-10 lists the main benefits of using the GDS to screen for depression. The pattern of responses is similar to that observed at Centre A with most of the respondents believing that the GDS helped to uncover depression which would otherwise be overlooked.

**Table 5-10 Benefits of using the Geriatric Depression Scale**

<b>Benefits</b>	<b>n*</b>	<b>%</b>
Helps identify depression otherwise overlooked	10	62.5
Quick & easy to use	9	56.3
Effective screening tool for depression	7	43.8
Helps to quantify emotional state	7	43.8
Easy for client to understand	4	25.0
<b>Total</b>	<b>16</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

In regard to problems with the GDS, the nurses at Centres B and C provided a similar pattern of responses to those at Centre A (see Table 5-11). In addition to the concern that clients do not answer the questions honestly, there was a concern that the GDS is not suitable for too many clients.

**Table 5-11 Problems with using the GDS**

<b>Problems</b>	<b>n*</b>	<b>%</b>
Not suitable for too many clients	13	81.3
Clients don't answer honestly	8	50.0
Questions too negative/depressing	7	43.8
Questions might make client feel worse	5	31.3
Questions need to be reworded	5	31.3
Questions too non-specific/insensitive	3	18.8
Questions too repetitive	2	12.5
Compromises clinical/therapeutic relationship	2	12.5
Don't feel comfortable asking clients about emotions	2	12.5
Don't like structured questionnaires	1	6.3
Prefer using observational skills	1	6.3
Don't like yes/no format	1	6.3
<b>Total</b>	<b>16</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

In response to the question about whether the nurses would feel comfortable using the GDS in the future, almost all (87.5%) stated that they would be comfortable and all but one respondent (93.8%) stated that screening for depression should be part of the nurse's role at RDNS.

At the conclusion of the GDS implementation phase, eight nurses (50.0%) at Centres B and C indicated that they felt they were able to deal effectively with depressed clients. The reasons for not being able to deal with depressed clients are listed in Table 5-12. As with the nurses at Centre A, lacking adequate knowledge and specialist training were the most common reasons.

**Table 5-12 Reasons for being unable to deal effectively with depressed clients**

<b>Benefits</b>	<b>n*</b>	<b>%</b>
Lack adequate knowledge	5	83.3
Not had specialised training	5	83.3
Do not have enough time	3	50.0
Would not get adequate professional support	1	16.7
<b>Total</b>	<b>6</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

## **5.4 Discussion**

Although the depression screening study involved a relatively small number of nurses at three RDNS centres, a number of useful findings were made and a feasible methodology for identifying older clients with depression has been formulated.

The pre-implementation survey revealed that only a few nurses had received training in mental health and most acknowledged that they had limited knowledge of mental health, including depression. This lack of knowledge emerged as one of the main barriers to nurses feeling able to deal effectively with depressed clients. Depression was acknowledged by most nurses to be a very common problem among RDNS clients and almost all believed that district nurses had the potential to play an important role in the identification and support clients with this condition.

Although a number of nurses had used the GDS in the past, it was only used occasionally and most nurses preferred to use subjective observation and opinion when identifying depression. On the positive side, the GDS was identified as a tool which helped to identify depression in those where it might be overlooked. The failure to use the GDS more regularly is likely to be partly due to the lack of training opportunities within RDNS in the use and interpretation of this tool. Additional reasons include the nurses concerns about the tool itself such as dissatisfaction with the GDS questions. It emerged several times during the study that there

was a desire to change the wording of certain questions and some nurses found a few questions too confronting to ask clients, e.g. do you feel pretty worthless the way you are now? There was also a concern that clients would not answer the questions honestly and there was a very valid concern that the GDS was not appropriate for clients with dementia or those from non-English speaking backgrounds. As many RDNS clients fall into these categories, alternative depression screening tools should be sought or developed for these client groups.

Most nurses expressed satisfaction with the education sessions however many at Centre A felt that it did not adequately prepare them for using the GDS. In comparison with nurses at Centre A, participants at Centres B and C reported greater satisfaction with the education session and they felt better prepared to use the GDS with their older clients. These findings may be explained by greater interest in mental health among the nurses at Centres B and C who were specifically selected because of their focus on their client's mental health. By contrast, all nurses at Centre A were invited to participate, irrespective of their areas of clinical interest.

Despite limited knowledge about mental health and the presence of some concerns about the GDS, almost all participants believed that district nurses should be involved in screening their older clients for depression.

Based on the initial data collected at Centre A and the subsequent trial at Centres B and C, the following factors are put forward as facilitators of the acceptance and feasibility of using the GDS as a screening tool for depression within a district nursing environment:

- The training provided to staff must contextualise the process of depression screening within the nurse's day-to-day clinical practice. The training should also emphasise the importance of attending to mental health issues in the provision of holistic care to the client.
- It should be acknowledged that not all nursing staff are adequately equipped and/or willing to screen their clients for depression. Only staff that have received appropriate training and are comfortable talking to their clients about their emotional problems should be expected to take part in the depression screening process.
- Nurses are not comfortable with routine screening and prefer to only screen clients if they are already exhibiting signs of depression. To maximise the accuracy of the screening process, training in the identification of the signs of depression is therefore necessary.
- Nurses prefer to use tools such as GDS only after a sufficient level of rapport has been established with the client. Screening of newly referred clients may therefore be problematic.
- The availability of a Mental Health CNC is important to ensure that appropriate follow-up is provided to clients who screen positive for depression.

## 6 Quantitative Evaluation

### 6.1 Introduction

As discussed in Chapter 3, a large number of RDNS clients have a diagnosed co-morbid mental health disorder. Although these figures are alarming in themselves, they clearly represent a substantial underestimate of the ‘true’ number of RDNS clients experiencing mental health issues. This is due to the large number of individuals whose mental disorders remain undetected and, as a consequence, untreated. Although RDNS clients experiencing an acute exacerbation of a pre-existing mental health condition or developing a mental illness for the first time in their lives may be eligible for mental health services (Victorian Department of Human Services, 1996), clients who are unwell but not acutely ill may not meet the referral criteria for specialized mental health services leaving them with unmet mental health care needs. Further, in a recent study (Nunn & Flowers, 2003), 38% of older RDNS clients scored above the clinical cut-off on a validated screening measure of depression, the Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986), suggesting that a significant number of RDNS clients may benefit from more detailed mental health assessment and care plan development focused on management of their depression symptoms. The proposed Model of Mental Health Care aims to address this gap by introducing a Community Mental Health CNC role at RDNS. This person will undertake mental health assessment and care plan formulation with RDNS clients and provide support and consultation to RDNS staff.

The proposed Mental Health CNC role at RDNS encompasses mental health assessment, psychosocial/nursing interventions, liaison and collaborative care planning with community and mental health service providers in addition to supporting RDNS nurses in identifying and referring clients with potential mental health conditions such as depression. The Mental Health CNC role lies within the broader context of the Model of Mental Health Care at RDNS incorporating referral of RDNS clients to the Mental Health CNC, and liaison and referral between the Mental Health CNC and adult mental health services. Accordingly, the proposed trial and evaluation of the RDNS Model of Mental Health Care incorporating the Mental Health CNC role has two central aims as follows:

3. To establish a client profile in order to understand:
  - which clients use and benefit from the Mental Health CNC service;
  - what kind of mental health problems clients present with; and
  - the level of demand for a Mental Health CNC service at RDNS
4. To understand the effects of the trialled Mental Health CNC role on:
  - client outcomes including satisfaction with the service; and
  - RDNS staff at participating Centres including the feasibility of formal and informal referral and liaison systems developed during the trial of the role

In this chapter, quantitative data related to the above aims will be presented and discussed. The results of the qualitative component of the evaluation are presented in Chapter 6.

## **6.2 Methods**

### **6.2.1 Participants**

The participants for the Project included RDNS clients at Essendon, Sunshine and Altona Centres (participating Centres). All RDNS clients at participating Centres, irrespective of reason for referral to RDNS, were eligible for referral to the Project. As the majority of RDNS clients are older adults, it was expected that the majority of Project clients would be older adults aged 65 years or over, living in the community with chronic and debilitating health problems and concurrent mental health issues.

As the Project involved the trial and development of a new clinical nurse consultancy role within RDNS, the number of clients participating in the Project would reflect the number of referrals received over the data collection period (June 2005 to January 2006). It was anticipated that the number of participants referred by the RDNS field nurses would initially be small and gradually build over the duration of the Project as a direct result of the development of the Mental Health CNC role.

Referral processes are central to the development of the Model of Mental Health Care at RDNS. Initially, the referral process was informal and local to each participating Centre. Over the first two to three months of the Project, the Mental Health CNC (Barbara Williams) and Project Coordinator (Jacqueline Allen) met with RDNS Care Managers, Assessment Nurses, Liaison Nurses and Clinical Nurse Consultants, as well as the nurses providing direct care to invite referral of prospective participants. It was anticipated that, as the field nurses gained experience making referrals to the Mental Health CNC, they would be encouraged to refer future clients for assessment and care planning.

### **6.2.2 Measures and Procedure**

For the duration of the Project, the Mental Health CNC was employed for one day per week. Mental Health assessment was undertaken by the Mental Health CNC as part of her clinical assessment of the client. All information collected was stored in the clients' confidential envelope at the Centre and photocopies of assessment information were made for data entry into the evaluation database and subsequent analysis.

The Mental Health CNC discussed the client's mental health issues with RDNS nurses who were providing care or relevant external service providers and recorded this information on a Secondary Consultation Form (see Appendix 8). Based on the information collected, a decision would be made as to whether the client was a suitable candidate for a full assessment. If it was felt that a mental health assessment was warranted, the Project would be explained to the client by the Primary Nurse. If the client was interested in participating, a home visit by the Mental Health CNC was arranged.

At the commencement of the home visit, the Mental Health CNC explained the Project to the client and their carer using the Plain Language Statement for Clients and Carers and, if agreeable, written consent to participate was sought using the Consent Form (see Appendix 9). With the client's consent, the Mental Health CNC would collect assessment information in the context of a semi-structured mental health interview.

Client mental health assessment information included data about clients' referral details, level of risk, and past and present mental health diagnoses and treatment. Assessment of clients'

mental health status involves inquiry and discussion of sensitive issues giving the client an opportunity to express their concerns with a mental health clinician with the required training and experience to undertake mental health assessment and a range of interventions including counselling, referral and follow-up. Inquiry and discussion of sensitive issues including clients' potential to harm either themselves or others is vital to accurate psychiatric nursing assessment and is part of standard psychiatric nursing practice (Fortinash & Holoday Worret, 2003). Therefore, an adaptation of the Risk Assessment – Mental Health in use at North Western Mental Health was used to assess clients' risk of harm to themselves and/or others. The Assessment - Mental Health and Risk Assessment documents are contained in Appendix 10.

Following collection of assessment data by the Mental Health CNC, the Project Coordinator entered the assessment data into the evaluation database. This data was then merged with client information contained in the RDNS client database (Camillus) for analysis. These data were used to obtain a profile of clients participating in the Mental Health CNC service, including demographics details such as age and gender, the type of mental health conditions and issues clients present with, and details about the clients' past treatment for mental health problems.

As part of the mental health assessment, clients were invited to complete the Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986) and the Mini-Mental State Exam (MMSE) (M. F. Folstein et al., 1975) in order to obtain an indication of their mood and cognitive status. The GDS and MMSE are currently used within RDNS and have been approved by the RDNS Forms Committee. An additional measure of clients' mental health symptoms, the Health of the Nation Outcome Scales (HoNOS) (Wing, Curtis, & Beever, 1996), was used to assess clients' mental health symptoms and their impact on the clients' functioning. The HoNOS was completed by the Mental Health CNC based on observation of the client.

Client satisfaction with the RDNS Mental Health CNC service was assessed two to three months following the initial Mental Health CNC home visit. The client satisfaction survey (Appendix 11) was mailed to the client and carer with a covering letter inviting the client to participate in the survey by completing the survey and returning it in the enclosed reply paid envelop. Each client satisfaction survey was coded with a separate list of codes and client UR numbers maintained by the Project Coordinator.

## **6.3 Results**

### **6.3.1 Secondary Consultations**

Over a six month period working one day per week, the Mental Health CNC provided 151 secondary consultations. One hundred and forty-six (96.7%) of these consultations were in relation to an existing RDNS client and only five (3.3%) related to a possible new referral. Eighty-three consultations (55.0%) were provided face-to-face and 57 (37.7%) were provided over the telephone. Approximately two-thirds of the consultations (67.5%) were with an RDNS nurse. The most frequent external consultations were with GPs (6.0%), Care Managers (5.3%) and Aged Care Assessment Services (ACAS) (4.0%). Thirteen (8.6%) consultations were with carers or other family members. The staff consulted with most often within RDNS were Primary Nurses (22.5%) and Aged Care CNCs (20.5%) (see Table 6-1).

**Table 6-1 Secondary consultations with RDNS staff**

<b>RDNS Staff Member</b>	<b>n</b>	<b>%</b>
Primary nurse	34	22.5
Aged Care CNC	31	20.5
Care Manager	9	6.0
HIV/AIDS CNC	9	6.0
Assessor	7	4.6
Assistant Centre Manager	6	4.0
Other CNC	5	3.3
Centre Manager	2	1.3
Homeless Persons Program	1	.7
Missing	47	31.1
Total	151	100.0

Table 6-2 displays the frequency of the types of secondary consultation provided. It can be seen that issues concerning assessment were the most common type of secondary consultation (65.3%). Other common types of secondary consultation were care plan issues (17.3%), advice on accessing external services (14.7%) and managing clients' challenging behaviours (12.7%).

As a result of the consultations, two clients with mental health issues were accepted as new RDNS clients and 48 referrals to the Mental Health CNC for existing RDNS clients were accepted.

**Table 6-2 Type of secondary consultation**

<b>Type of consultation</b>	<b>n</b>	<b>%</b>
Assessment	98	65.3
Care plan issues	26	17.3
Accessing external services	22	14.7
Challenging behaviours	19	12.7
Discuss referral to MH CNC	12	8.0
Care management issues	8	5.3
At risk issues	7	4.7
Informal debriefing/counselling	5	3.3
Discharge planning for RDNS clients	5	3.3
Psychotropic medication	4	2.7
Monitoring	4	2.7
Education for staff	2	1.3
Discharge planning for hospital clients	2	1.3
Education for clients/carers	1	0.7
Staff support	1	0.7

Note: This is a multiple response table. Totals may add to more than 100%.

### **6.3.2 Mental Health CNC Visits**

Data from the RDNS Client Database (Camillus) were extracted on the Mental Health CNC's visits and contacts during the course of the Project. As noted earlier, the recruitment period lasted from late June 2005 to early January 2006. The Mental Health CNC was available to provide consultation or visit clients one day per week during this period. In total, 48 client visits and 152 client related contacts (consultations etc.) were recorded. These visits and contacts represent 78 individual clients. The demographic characteristics of these clients are presented in Table 6-3.

In total, 141 hours of client visits and contacts were made during the period of the Project. The mean duration of visits and contacts for the 78 clients was 1.8 hours (sd=2.0, range=0.2–12.5).

**Table 6-3 Characteristics of Mental Health CNC client visits and contacts**

Age (years)	Mean =	69.1
	sd =	15.1
	Range =	17 - 96
Gender	Female	62.0%
	Male	38.0%
Country of birth	Australia	63.4%
Language spoken	English	77.5%
Living arrangements	Lives with family	51.1%
	Lives alone	40.7%
	Other	8.2%
Carer availability	Has residential carer	30.4%
	Lives alone, no carer	18.5%
	Lives alone, has carer	13.0%
	Carer not needed	13.0%
	Other	25.1%
RDNS Centre	Altona	36.7%
	Essendon	45.1%
	Sunshine	14.1%

Forty-eight clients were accepted for referral to the Mental Health CNC. The reason for referral is displayed in Table 6-4. It can be seen that depression, anxiety and behaviour problems are the most common reasons for referral.

**Table 6-4 Reason for referral to the Mental Health CNC**

Reason for referral	n	%
Depression	24	50.0
Anxiety	9	18.8
Behaviour problems	9	18.8
Dementia	4	8.3
Psychoses, delusions, paranoia	4	8.3
Grief	2	4.2
Other	6	12.5
Total	48	100.0

The primary ICD-9 diagnoses for the 78 Mental Health CNC client visits and contacts are shown in Table 6-5.

**Table 6-5 ICD-9 diagnosis of Mental Health CNC client visits and contacts**

<b>ICD-9 diagnosis</b>	<b>n*</b>	<b>%</b>
Diabetes Mellitus Without Mention of Complication	13	16.3
Ulcer Of Lower Limbs, Except Decubitus Ulcer	10	12.5
Human Immunodeficiency Virus (HIV) Disease	8	10.0
Varicose Veins of Lower Extremities with Ulcer	4	5.0
Organic Personality Syndrome	4	5.0
Senile Dementia, Uncomplicated	3	3.8
Alzheimer's Disease	3	3.8
Open Wound of Knee, Leg (Except Thigh), and Ankle, Without Complication	2	2.5
Urinary Incontinence	2	2.5
Depressive Disorder, NEC	2	2.5
Edema	2	2.5
Other	23	33.6
<b>Total</b>	<b>78</b>	<b>100.0</b>

\* This is a multiple response table. Totals may add to more than 100%.

### 6.3.3 Mental Health Assessment

Of the 48 clients referred to the Mental Health CNC, 21 (43.8%) consented to participate in the evaluation of the Project, possibly illustrating the sensitivities around information in this client group. The results of the assessment of these clients are presented in this section.

Most of the referrals came from the client's Primary Nurse (47.6%) or an RDNS CNC (42.9%). Twelve of the 21 clients (57.1%) had received treatment in the past for a mental health condition. Seven clients (33.3%) had received treatment for depression, three (14.3%) for anxiety and two for substance abuse (9.5%). Eight clients (38.1%) had received psychotropic medication in the past, three had received counselling or psychotherapy (14.3%) and two had received inpatient psychiatric treatment (9.5%). One client had received ECT in the past.

Thirteen clients (61.9%) were currently in receipt of treatment for a psychiatric condition. The most common reasons for treatment were depression (47.6%), anxiety (14.3%) and

dementia (9.5%). The most common type of treatment for a current mental health condition was psychotropic medication (66.7%) and only two clients (9.5%) were receiving counselling or psychotherapy.

As a result of the mental health assessment, five clients (23.8%) were referred to their GP, two (9.5%) to allied health and two (9.5%) to specialist mental health services. The most frequent interventions noted at the conclusion of the assessment were to monitor/review the client (55.6%), client/carer education (44.4%) and the development of a mental health care plan (22.2%).

**Table 6-6 Mental Health CNC interventions**

<b>Mental Health CNC intervention</b>	<b>n*</b>	<b>%</b>
Monitor/review client	10	55.6
Client/carer education	8	44.4
Care plan	4	22.2
Other	5	27.8

\* This is a multiple response table. Totals may add to more than 100%.

#### **6.3.4 Client satisfaction**

Two to three months following the mental health assessment, a satisfaction questionnaire was posted to all clients who consented to participate in the evaluation. Eleven questionnaires (52.4%) were returned. The results of the satisfaction survey are presented in Table 6-7. The results indicate that clients were mostly satisfied with the service they received from the Mental Health CNC with only a small number being dissatisfied with some aspects of the care provided. Unfortunately, the small number of respondents does not permit further interpretation or extrapolation.

**Table 6-7 Client satisfaction with the Mental Health CNC**

<b>Item</b>	<b>Very satisfied</b>	<b>Mildly satisfied</b>	<b>Neutral / unsure</b>	<b>Mildly dissatisfied</b>	<b>Very dissatisfied</b>
Satisfied with MH Nurse's explanation of care	7 (63.6%)*	2 (18.2%)		1 (9.1%)	1 (9.1%)
Satisfied that MH Nurse was competent and knowledgeable	7 (63.6%)	2 (18.2%)			2 (18.2%)
Satisfied that MH Nurse listened and understood problem	7 (63.6%)	2 (18.2%)		1 (9.1%)	1 (9.1%)
Satisfied with amount of help received from MH Nurse	8 (72.7%)	1 (18.2%)		1 (9.1%)	1 (9.1%)
Satisfied that MH Nurse helped you deal effectively with problems	8 (72.7%)	1 (9.1%)		1 (9.1%)	1 (9.1%)
Satisfied that service received from MH Nurse met your needs	8 (72.7%)	1 (9.1%)			2 (18.2%)
Satisfied that care received met expectations	7 (63.6%)	2 (18.2%)			2 (18.2%)
Overall satisfaction with service received from MH Nurse	7 (63.6%)	2 (18.2%)			2 (18.2%)

\* Row percentages

## **6.4 Discussion**

The data collected during the quantitative evaluation of the Project provide strong evidence in favour of the need for a Mental Health CNC role within RDNS to support clients with mental health problems and the nurses who provide care for them. Although the Mental Health CNC employed on this Project was only employed one day per week for six months and was providing coverage to only one RDNS Region, she provided over 150 secondary consultations which resulted in close to 50 referrals. Twenty-one clients subsequently consented to participate in the evaluation. During the project and in the interviews with staff, regular mention was made that the number of referrals would have been much higher had she been available full-time.

Most of the secondary consultations were with RDNS staff and most were related to assessment issues, care plan formulation and accessing appropriate external services. These are exactly the type of issues that had been identified in the initial focus groups with RDNS

staff as areas requiring urgent attention to support the provision of better care to clients with mental health problems.

As expected, most of the clients referred to the Mental Health CNC were older and, consistent with the demographic profile of RDNS clients in general, most were female. Approximately 40% lived alone and a substantial proportion lacked a carer.

In regard to the reason for referral to the Mental Health CNC, most were referred for depression, anxiety and behaviour problems. Depression and anxiety are known to be highly prevalent among recipients of primary care services, including district nursing, so this finding is to be expected. It should also be noted that the depression screening study ran concurrently with the main project and some referrals resulted from the nurses administering the GDS with their older clients. Those with behavioural problems may have been referred because they were making it challenging for the nurse to provide effective care to the client. Again, this was an issue that was raised in the initial staff focus groups.

Of the clients who consented to participate in the evaluation, more than half had received treatment in the past or were currently receiving treatment for mental health conditions. The most common reason for receiving treatment was depression. Although other conditions such as substance abuse and psychoses are common among RDNS clients (see Chapter 3), very few clients with these conditions were referred to the Mental Health CNC. Part of the reason for this may be that a substantial number of these are HPP clients and may already be receiving appropriate care both within RDNS and from external services. Nevertheless, there may have been a perception that the Mental Health CNC specialised in the assessment and management of depression rather than other conditions. The full-time presence of a Mental Health CNC within RDNS may help to better educate the staff about referral processes and the fact that support can be provided for clients with all types of mental health problems.

Overall, satisfaction with the Mental Health CNC role was very high. Around three-quarters of those who responded to the satisfaction survey were very or mildly satisfied with the Mental Health CNC. In view of the characteristics of some members of this client group, it is to be expected that there will be some level of dissatisfaction.

Although the number of clients who participated in the evaluation was small, it should again be stressed that the Mental Health CNC was only employed for six months and was only able to accept referrals and see clients one day per week. It is also important to note that although relatively few clients participated in the evaluation, the number of secondary consultations and referrals was substantially higher. There can be little doubt that there is a clear need for a full-time Mental Health CNC role covering all Regions to provide timely and appropriate assessment and care to clients with mental health problems, to liaise with and arrange referrals to external services (including GPs and specialist mental health services) and to support RDNS staff to provide better quality care to these clients.

## 7 Qualitative Evaluation

Qualitative data were captured from two data collection systems: semi-structured interviews and a Mental Health CNC journal. This resulted in two sections of the qualitative evaluation: semi-structured interviews and client case studies. The qualitative evaluation thus addressed the following aims:

3. To ascertain participant nurses' viewpoints regarding the Mental Health CNC role and collaborative practice; and
4. To explore the perceived effect of the trialled Mental Health CNC role on client health and wellbeing.

### 7.1 *Semi-structured Interviews*

#### 7.1.1 *Method*

##### **Sample**

In November 2005, clinical nurses from RDNS Altona, Essendon and Sunshine Centres who had made a referral to the Mental Health CNC were invited to participate in a semi-structured interview. The convenience sample included nine nurses, all female. The nine nurses included primary nurses, care managers and clinical nurse consultants. Interview guidelines are presented in Appendix 12.

##### **Data Collection**

Semi-structured individual interviews were undertaken by one researcher (JA) in November 2005 to ascertain participants' views regarding the Mental Health CNC role and collaborative practice. The interview guidelines were developed following consultation with experts in evaluation methods. Detailed notes were taken during all interviews. Interviews were of 15 to 20 minutes duration and were undertaken at RDNS Altona, Essendon and Sunshine Centres.

##### **Ethical considerations**

Organisational ethics approval was obtained to ensure that adequate consideration was given to ensuring the ethical rights of participants including participants' privacy, anonymity and their right to withdraw from the study. In accordance with Australian standards, as specified by the National Health and Medical Research Council criteria, participants were provided with a Plain Language Statement explaining the study, their participation in the study, and the voluntary nature of participation, prior to obtaining their written consent to be interviewed. All participants were interviewed voluntarily. A copy of the Plain Language Statement and Consent Form is contained in Appendix 13.

##### **Data analysis**

To identify the main themes and sub-themes contained in the interviews with the RDNS nurses, each interview transcript was thematically analysed. Thematic analysis was undertaken using open coding to categorise interviewee viewpoints into common themes and sub-themes following the method identified by Strauss and Corbin (1998).

### 7.1.2 Findings

To protect anonymity, findings from the collective nine interviews are presented as themes and sub-themes. Seven main themes were identified and included:

- Effective domiciliary psychiatry nurse consultancy
- Mental Health CNC role was valuable
- Mental Health CNC role contributed to effective client outcomes
- Mental Health CNC role resulted in effective communication between nurses and clients
- Effective education
- Limitations to the Mental Health CNC role as trialled
- Improvements to the role (potential)

These themes and related sub-themes are presented below with example quotations from the interviews.

#### ***Theme one – Effective Domiciliary Mental Health Nurse Consultancy***

Each interviewee commented on the ability of the Mental Health CNC to accept both verbal and written referrals for any RDNS clients with a mental health issues. Interviewees explained that the Mental Health CNC had undertaken home visits for the purpose of detailed mental health assessments from which recommendations regarding improved care planning, care management and referral of clients to appropriate services were made. Referral questions related to clients with signs and symptoms of depression (including those screening positive for depression on the GDS), anxiety, sleep disturbance, social difficulties, dementia, brain damage and where the nurse perceived the client to demonstrate challenging behaviours affecting care provision. Participant interviewees further commented on the ability of the Mental Health CNC to liaise with mental health services and GPs on behalf of clients and RDNS nurses, and assist RDNS nurses and clients to effectively negotiate mental health services such as referring a client to an Aged Psychiatry Assessment Team (APAT). In addition, the Mental Health CNC was noted by each interviewee to provide clinically relevant feedback regarding clients' mental health issues to the referring nurse, including recommended changes to care plans. Several interviewees noted that the Mental Health CNC assisted them to formulate achievable care plans specifying realistic goals, to provide more consistent care to their clients with mental health issues and to consider a broader range of care options in order to plan their care to meet their clients' mental health needs. The following quote from one interviewee illustrates these themes:

*“[The Mental Health CNC] can review the client...make recommendations regarding their psychiatric care. I've referred three or four clients....These clients had depression which we found after [the Mental Health CNC] saw them was related to isolation and then we got the client into the appropriate social and cultural groups. Another client I referred had frontal lobe problems. We don't know enough about that though, so it was after [the Mental Health CNC] went in that we could identify they had frontal lobe problems. [The Mental Health CNC] assisted us to adjust out care plan to better care for them.”*

The Mental Health CNC was also noted by several interviewees to provide effective secondary consultation resulting in the nurses' improved confidence to present information

about clients' mental health at case conferences and advocate more effectively for the client. Following secondary consultation with the Mental Health CNC, participants commented on their improved understanding of their clients' mental health issues and improved ability to maintain boundaries and manage clients with challenging behaviours.

Interviewees further explained that the Mental Health CNC was accessible and available to staff and clients on the one day of the week when she was working in the role and that she reviewed clients within one week of referral.

### ***Theme two – Mental Health CNC role was valuable***

All participants found the Mental Health CNC role was valuable due to the high quality of her mental health assessments and holistic approach to mental health care resulting in enhanced information, and improved mental health care planning for clients. The role was found to be particularly valuable for improving the quality and credibility of assessment information to provide to mental health services and GPs, and subsequently increased access for clients to mental health services in a timelier manner. Furthermore, participants found the role valuable as the Mental Health CNC had an extensive knowledge of mental health service systems. This was valuable in enhancing client outcomes as it allowed nurses to consider a broader range of potential interventions for clients such as referral to counselling. Thus interviewees found that the Mental Health CNC assisted them to negotiate the mental health service system on behalf of their clients. The following quote illustrates these themes:

*“Even for clients who were treated by psychiatry and then get discharged and [psychiatry] say “No”, they are OK. I can get [the Mental Health CNC] to give a second opinion.”*

Interestingly, participants commented on the value of the Mental Health CNC role in raising the profile of mental health issues for clients at each Centre increasing the awareness of and validating the importance of mental health issues for RDNS clients in the Western Region. In particular, interviewees explained that the Mental Health CNC role raised the need to provide some clients with informal counselling support. The following quote illustrates these themes:

*“This has opened up a whole range of issues - people here at the Centre are now talking about mental health...”*

*“If [the Mental Health CNC] is around then counselling is more likely to happen. This is because [the Mental Health CNC] specialises in depression, she would have more knowledge of the possible alternative treatments like counselling for clients. Counselling might get missed if there is no specialist involved.”*

### ***Theme three – Mental Health CNC role contributed to effective client outcomes***

Interviewees explained that the Mental Health CNC improved their understanding of their clients' mental health issues and their related behaviour which contributed to improved care planning and enhanced client outcomes including increased health monitoring. The following quote emphasises these themes:

*“[The Mental Health CNC] improved the care they received. Once we knew how a client was affected and what was underlying it we could direct our care better*

*... With one client we thought that he was depressed ... [The Mental Health CNC] went in and he opened up more for her and it was the social isolation that was causing problems for him not depression as such... Another client [following the Mental Health CNC visit] it increased our monitoring of her dementia.”*

One interviewee commented that following the Mental Health CNC assessment of one of her clients, the client reported feeling reassured:

*“...well [the client] just felt better after [the Mental Health CNC] had talked to him about it [as she] could tell him that he wasn’t mad.”*

All interviewees noted that a number of clients were referred to mental health services following the expert Mental Health CNC assessment prior to discharge of the client from RDNS. They explained that although they were aware of Aged and Adult Mental Health Services, they had a limited understanding of community mental health services available to provide social support to people with mental health problems. The following quote is an example of these themes:

*“We knew about her depression and how this was isolating her and now she is linked into outreach services which are age-specific. It has taken [the Mental Health CNC] a while to pull this together. It would not have been possible without [the Mental Health CNC] as I have no knowledge of available services and [the client] didn’t fall into the [local adult mental health service provider] demographic. [The client] needed to be taught the skills of getting out there. We had actually discharged [the client]... But because [the client] has attempted suicide in the past I wanted to be sure that [the client] was going to be OK, supported...[the client] was in for wound care.”*

Interviewees also noted that the Mental Health CNC referred both clients and family members to appropriate supports thus assisting to strengthen carers’ ability to continue caring.

Two interviewees explained how the Mental Health CNCs assessment and secondary consultation had assisted in improving the risk management of two clients. For one client, the Mental Health CNCs understanding of the mental health service system resulted in a timely and appropriate referral to APAT and a well coordinated application for Guardianship. For a second client, the Mental Health CNCs consultation to nursing staff regarding boundary setting resulted in improved management of the client-nurse relationship and the client having their care needs met. The following quotes illustrate this theme:

*“With [the Mental Health CNCs] help we could act quickly and get APAT in quickly. And get them involved. So the process to get the Guardianship application was quicker and actually happened too. So the ‘at risk’ management of the client was sorted out more quickly...”*

*“...because there was an incident with a nurse when I was on a day off...[the client] was a bit upset...there was this meeting about getting all these other things in place...But I knew that if we had too many people it is just going to make it worse...So I just talked to [the Psychiatry CNC] about it...[the client] just needed some boundaries and some consistency...[The Mental Health CNC]*

*agreed with me... she reinforced that that was the best way to go with someone like that...If they had decided to go that way then I would have decided to pull [RDNS] out because I knew that it was not workable that way..."*

#### ***Theme four – Mental Health CNC role resulted in effective communication***

Interviewees commented that the Mental Health CNCs assessment, formulation of clients' mental health issues and suggested changes to care plans enhanced communication between nurses and clients. The Mental Health CNC communicated verbally (via phone and in face-to-face consultations with nurses), and included recommendations for care planning in her written assessments and progress notes including behaviour management strategies, and signs and symptoms of deterioration and/or relapse for which nurses should be monitoring clients. Importantly, interviewees explained that the Mental Health CNC preserved client confidentiality sending her written assessments and nursing reports directly to the client's primary nurse to read prior to storing them in the client's confidential file at the Centre. The following quotes illustrate this theme:

*"Another client [following a visit from the Mental Health CNC] we could re-direct her from her paranoia. She would say that the family is all against me, but after [the Mental Health CNC] went in and assessed it was found that it was not her family but her paranoia. We didn't know what to think before. So, we could re-direct her and then she was happier and could know that the family were not out to get her."*

*"[The Mental Health CNCs] communication works well, she writes up detailed notes, they are in the internal mail and the primary nurse reads them before they go into the confidential envelope for filing."*

#### ***Theme five – Effective education***

The Mental Health CNCs role in education was an informal one at Centre level, focusing on the day-to-day management issues of clients who were referred to her. Interviewees, including staff members new to district nursing, commented that they learned about how psychiatric services such as APAT function and how to refer clients to these services, they learned about managing clients with challenging behaviours, and how to approach and effectively communicate with clients in the community with mental health problems as they gained greater understanding about mental health and clients' behaviour. Following involvement of the Mental Health CNC, interviewees reported enhanced understanding of specified mental health issues directly related to the client they referred. Interviewees explained that Centre staff were more aware of mental health issues following the trial of the Mental Health CNC role. They further commented that Centre staff were thinking about mental health differently:

*"...the project has made better awareness...and made the nurses recognise things and just think a bit more outside the square."*

#### ***Theme six – Limitations to the Mental Health CNC role as trialled***

Participant interviewees noted a number of limitations to the Mental Health CNC role as trialled. All commented on restricted access for both clients and nurses to the service as the

Mental Health CNC worked one day a week for the duration of the trial. Working one day a week resulted in a delay of one week for assessment information to be relayed to the referring nurse. One day a week availability was also found to be problematic as it limited the ability to undertake double visits by the Mental Health CNC and primary nurse which would have allowed the primary nurses to introduce the Mental Health CNC to the client and would have enhanced understanding of the Mental Health CNC role for the primary nurse. Several interviewees noted that a number of clients declined a visit from the Mental Health CNC due to their negative perception of her title as 'Mental Health Nurse' which clients believed implied that they were 'mad'. According to these interviewees, if the primary nurse had been able to accompany the Mental Health CNC and introduce her to the client, this would have been more acceptable to the client who trusted and had a therapeutic relationship with their primary nurse. The following quotes illustrate this theme:

*"Working one day a week has been very limiting. If she was available more often then we could get more work done and she could do more consultations."*

*"It's been difficult to get prompt follow up from [the Mental Health CNC] as she's only here one day a week and can't talk to the staff until the week after her assessment of the client."*

*"With my client who refused, maybe this was because they didn't know [the Mental Health CNC]. Maybe if the Mental Health CNC doesn't know the client it would be of assistance if the primary nurse accompanied the Mental Health CNC to make the client feel at ease a bit more."*

Participants also found that the Mental Health CNC was less available due to the requirements of the project which required her to undertake more formal assessments and extensive data collection. They reported that these project activities limited the availability of the Mental Health CNC for secondary consultations and education.

Several interviewees explained that they had found the scope of practice of the Mental Health CNC unclear and this had been a difficulty for them when explaining the role to clients in considering a referral to the Mental Health CNC. According to one interviewee, the Mental Health CNCs role was unclear in regard to psychiatric diagnosis, shared care with psychiatric services, crisis management and her ability to liaise with psychiatric services following their discharge of a client. Further, according to several interviewees, some staff at participating Centres were not aware of the Mental Health CNC role. Several interviewees also commented on their difficulties accessing the Mental Health CNC as she did not have the same mobile phone each shift due to resource limitations.

Other interviewees reported that a limitation of the Mental Health CNC role was related to the culture at the three participating Centres where mental health has not been a priority for nurses due to RDNS providing general domiciliary nursing care. They also commented on a number of staff finding it difficult to provide care to clients with mental health issues:

*"...this client's psych issues weren't seen as a priority, the wound was the focus and once the wound was healed she was discharged and didn't continue on with her depression or mental health issues. The Care Manager acknowledged that she found caring for people with mental health issues difficult and it isn't part of the culture of the agency."*

Several interviewees believed that the Mental Health CNC role as trialled did not fully reflect the role's potential as the Mental Health CNC was contracted from an external agency and was therefore not a 'part' of RDNS. According to these interviewees, the Mental Health CNC was operating as an external consultant providing services focused on mental health assessment to RDNS clients and this limited her ability to be seen by staff as a part of the agency. These people considered that this limited the staff in utilising the Mental Health CNC for more informal consultations including undertaking joint visits with primary nurses on a more informal basis.

### ***Theme seven – Improvements to the role (potential)***

All interviewees noted that if the Mental Health CNC worked more days during the week this would increase her availability for clients and staff. A number of interviewees believed that one Mental Health CNC employed on a full-time basis per RDNS Region would allow the role to be more fully developed in terms of undertaking more client assessments, more secondary consultations with staff, greater involvement in client care planning including managing clients with depression; brain injury; psychological problems; and assisting staff to provide more consistent care, and greater involvement in managing 'at risk' clients. Interestingly, a number of interviewees noted that it would be of benefit to clients and to the nurses providing care if the Mental Health CNC provided greater assistance in boundary setting; assisting clients to identify behaviour from the nurses which is acceptable to them and in assisting the nurses identify acceptable behaviour from clients. One interviewee explained that for some clients, for example clients with challenging personalities, a highly structured approach to care, such as nurses adhering to a behavioural management strategy that has been agreed to by both parties, reduces clients' anxiety associated with social interactions, for example nurses visiting them in their own home to provide care.

Participant interviewees noted that greater awareness among staff of the availability of a Mental Health CNC and clarification of their role in terms of the scope of their practice and how they are able to assist staff identify and manage clients with mental health issues would improve the role and increase utilisation of the role by field staff. Further, if the Mental Health CNC was available more days of the week this would, according to interviewees, increase her ability to undertake double visits with staff and demonstrate her interviewing style and the use of screening tools.

Interviewees also explained that the role could be enhanced if the Mental Health CNC were able to undertake Centre based education. Several participants considered that Centre based education could include the Mental Health CNC leading care team meetings to brainstorm strategies and client care planning in regard to clients with challenging behaviours and provide education to Centre staff about screening clients for depression and anxiety, the use of screening tools and how to make referrals to mental health services. According to one interviewee, Centre based education could focus on the 'basics' of managing clients with mental health issues; including de-escalating clients who are becoming angry or agitated, client advocacy and facilitating a greater understanding by staff of depression.

The following quotes illustrate this theme:

*“We would like to see the role developed with greater psychiatric nursing input regarding nursing care plans as a big number of our clients suffer from depression or post stroke or have psychological problems.”*

*“The Mental Health CNC service would be of great benefit if we could have more of it. Psychiatric care is difficult to plan ... I want to see my client get proper and appropriate care and this is where [the Mental Health CNC] would be of great help and assistance.”*

### **7.1.3 Discussion**

Interview findings suggest that the trialled Mental Health CNC functioned as a nurse consultancy role providing effective domiciliary mental health assessments, secondary consultations and recommendations to care planning which assisted interview participant nurses in the Western Region to provide better health care to clients. Interviewees found the role of value due to expert mental health assessment information and advice which assisted them to communicate more effectively with GPs and more effectively access mental health services on behalf of their clients.

Interview findings regarding client outcomes are of interest as they suggest that the Mental Health CNC role complemented existing mental health services rather than replicated their service. According to interviewees, the Mental Health CNC undertook expert assessment and subsequently made recommendations regarding care plan changes focused on referral to mental health services, including those providing rehabilitation and social support, improved monitoring of clients’ mental health by RDNS nurses, improved liaison with clients’ GPs regarding their mental health, and improved risk management for clients. The Mental Health CNC role was thus one which focused on strengthening domiciliary nursing care of clients with co-morbid mental health conditions by detailed mental health assessment and consideration of available options for interventions both within RDNS and within mental health services.

The limitations associated with the Mental Health CNC role identified by interviewees highlighted issues related mostly to the ‘trial’ of the role. These included clinical availability confined to one day a week and the data collection requirements of the project. The detailed and the formal nature of the client assessments, which were time consuming, interfered with her availability to undertake less formal client assessments, undertake visits together with primary nurses, provide secondary consultation and deliver education to staff. A number of interviewees commented that they did not clearly understand the scope of practice of the Mental Health CNC role suggesting that the role is a developing one within a health care culture with limited understanding of community psychiatric nursing.

Findings from interviewees on the limitations to the Mental Health CNC indicate that the role as trialled within the requirements of the project was an ‘underestimation’ of the potential role. Interviewees’ comments on potential improvements to the role also suggest a developing change in interviewees’ perceptions of and understanding of the possibilities for an effective Model of Mental Health Care within the RDNS context further indicating a developing ‘cultural’ change for this sample of primary nurses, care managers and clinical nurse consultants providing clinical care.

Overall, the positive findings including criticisms of the Mental Health CNC role suggest even greater benefits for RDNS clients with mental health issues, including enhanced client outcomes and more consistent nursing care provision, with the full implementation of a Mental Health CNC role in each of the four Regions within RDNS.

## **7.2 Client Case Studies**

### **7.2.1 Method**

#### **Sample**

The sample included four clients selected by the Project Coordinator and the Mental Health CNC as these clients represented a range of mental health issues, nursing interventions, and collaboration with RDNS nurses and mental health service providers. The convenience sample of four case studies is presented in order to illustrate the diversity of clients referred to the Mental Health CNC and provide examples of the complexity of providing care to RDNS clients with co-morbid mental health and physical issues.

#### **Data Collection**

The Mental Health CNC maintained a journal over the duration of the qualitative data collection phase of the project from June to November 2005 containing details regarding clients referred to her and regarding client assessments including information about client outcomes.

#### **Ethical Considerations**

Organisational ethics approval was obtained to ensure participant clients' and their carers' privacy, anonymity and their right to withdraw from the study. Participants and their carers were provided with a Plain Language Statement explaining the study, their participation in the study, and the voluntary nature of participation, prior to obtaining their written consent or the written consent of their carer to have their health care story presented as a case study upon the condition of the de-identification of all data. Each of the four clients presented in the client case studies agreed voluntarily to have their story included in the study. Written consent to participate in the evaluation was obtained from carers and clients for those clients with impaired cognitive function. To preserve client anonymity, clients' names have been changed and the details of their family and/or carers and specific diagnoses have been referred to in a general rather than detailed manner.

#### **Data Analysis**

The Mental Health CNC was interviewed regarding the client scenarios contained in the case studies. The resulting client stories were coded into themes and sub-themes which were subsequently drafted into brief case studies.

### **7.2.2 Findings**

#### *Case Study One: Grace*

Grace was an older adult living with family who were concerned about her rapid deterioration in her ability to take care of her activities of daily living and the sudden onset of bizarre behaviours and rapid deterioration in her memory. Grace had recently been prescribed

psychotropic medication and as she was unable to administer this to herself, RDNS nurses were visiting for medication management. Grace was referred to the Mental Health CNC by her RDNS primary nurse who was concerned about Grace's rapidly deteriorating memory. Following her assessment, the Mental Health CNC found that Grace had well functioning social skills however there was clinical evidence of severe memory difficulty.

The Mental Health CNC undertook a comprehensive mental health nursing assessment including the Mini-mental State Examination, appraisal of the client's social skills, mood and mental state examination. In addition, the Mental Health CNC consulted with the client's family about her ability to function with her activities of daily living, for example cook a meal independently and her safety in continuing to drive her car. Subsequently, the Mental Health CNC consulted with the client's GP and a referral was made to a psychiatrist who specialised in cognitive disorders and general psychiatry.

Grace was admitted to a specialist unit for further assessment. She was diagnosed with an early onset and rapidly progressive dementia, her medication was changed and Grace and her family were advised about the prognosis of her illness and how they might best care for Grace. This enabled the family to better plan Grace's care.

RDNS nurses had intended to refer Grace to another service and discharge her as they believed that RDNS was not an appropriate service to undertake her medication management. Following the involvement of the Mental Health CNC and with a greater understanding of Grace's diagnosis and the likely course of her illness, RDNS nurses remained involved in care provision to Grace and her family assisting with medication management, health monitoring, support and education.

#### *Case Study Two: Brenda*

Brenda is a middle aged woman living with family. Brenda has several chronic physical health problems resulting from a severe accident many years ago which have left her largely immobile and in chronic pain. In addition, she has a history of conflict with her family and drug and alcohol problems. Brenda also has a history of major mental illness. RDNS nurses have been visiting Brenda for wound care and referred her to the Mental Health CNC regarding their concerns about Brenda's expressed wish to die and her social isolation.

Following her assessment, the Mental Health CNC was concerned about Brenda's social isolation and difficulties getting out of the house. She consulted with Brenda's GP and a referral was made to a private psychiatrist who agreed to bulk bill her for psychiatric assessment and provide counselling. The Mental Health CNC also referred Brenda to a psychiatric disability rehabilitation service for socialisation.

At the time of writing this case study, Brenda had the letter of referral to the psychiatrist from her GP and she was to commence visits from the psychiatric disability rehabilitation service.

Upon wound healing, RDNS nurses expect to discharge Brenda.

#### *Case Study Three: Megan*

Megan is a middle aged woman living with her family. She has a history of multiple chronic physical illnesses including diabetes and related health complications. RDNS nurses visit her

to undertake wound care. Megan was referred to the Mental Health CNC about concerns regarding blackouts related to anxiety episodes.

The Mental Health CNC undertook a mental health assessment and found that the client had been experiencing conflict with family and increasing episodes of anxiety. Megan's blackouts had been assessed by medical practitioners who had found them to be related to anxiety. The Mental Health CNC spent time with Megan and her family providing them with education about the warning signs of anxiety episodes and breathing and relaxation techniques to use when experiencing these symptoms. The Mental Health CNC invited the family to consider contacting a community counselling service regarding obtaining assistance in managing anger and conflict.

Megan and her family were provided with information regarding improved management of Megan's anxiety, conflict and management of anger.

Upon wound healing, RDNS nurses expect to discharge Megan.

#### *Case Study Four: Peter*

Peter is an older adult living on his own. He has family who live interstate. Peter has diabetes and chronic health problems related to the complications of diabetes. RDNS nurses assist him with managing his diabetes. Although Peter only scored 1 out of 15 on the Geriatric Depression Scale, his primary nurse was concerned as he was experiencing frequent tearfulness for no apparent reason. She referred him to the Mental Health CNC for a more detailed assessment.

The Mental Health CNC visited Peter in the community and undertook a mental health assessment. Upon reflection with Peter, they agreed that his tearfulness was related to his bereavement in the last 12 months of his wife. As Peter did not wish to take medication for depression, he agreed to the Mental Health CNC's suggestion of referral for counselling.

At the time of writing this case study, Peter's GP had referred him for counselling at a local community service. Peter reported that he felt better in himself after speaking to the Mental Health CNC.

There were no direct effects on RDNS service provision.

### **7.2.3 Discussion**

The four client case studies were purposively selected to illustrate the diverse and complex nature of many RDNS clients with co-morbid mental health issues who were visited by the Mental Health CNC over the duration of the project. Each case study highlights the Mental Health CNC role as complementing RDNS domiciliary nursing care, and mental health services including GPs. This further reflects that the Mental Health CNC role provided a service focused on mental health assessment, case formulation and referral to appropriate services, which differed from services in either Adult or Aged Mental Health Services. Further, according to the Mental Health CNC, none of the clients presented in the case studies would have accessed Adult or Aged Mental Health Services as they were not severely unwell. This indicates that in each of the case studies presented the Mental Health CNC role bridged a gap in the service system as clients with mental health issues who did not meet the

referral criteria for Adult or Aged Mental Health Services had their mental health issues addressed.

## 8 Recommendations

Based on the findings of the project, the following recommendations are made:

1. That RDNS management endorse a model of mental health care to benefit RDNS staff and clients as described in this report
2. That RDNS provide a Mental Health CNC to support clients in all practice areas and staff providing their care
3. That the role of the Mental Health CNC encompasses:
  - mental health assessment of referred clients
  - secondary consultation to RDNS staff, external service providers and families/carers
  - participation in the formulation of care plans in conjunction with the primary nurse or care manager
  - participation in the care coordination of clients with mental health issues
  - promotion of client advocacy and care continuity
  - referral to internal and external service providers, including GPs and mental health services
  - liaison with internal and external service providers
  - provision of clinically-focussed education to RDNS staff, including processes for identifying clients with mental health issues, use of screening tools and the management of clients with mental health issues within a district nursing environment
  - provision of psychosocial and supportive interventions to clients with mental health issues
  - contribution to the conduct of mental health projects and research studies
  - compliance with the Mental Health Act and relevant privacy legislation including the maintenance of client confidentiality
4. That the Mental Health CNC receives clinical supervision by an appropriate external provider as needed
5. That all Centre-based clinical staff receive information and education regarding the identification and management of clients with mental health issues from the Mental Health CNC
6. That the use of mental health screening tools (e.g. GDS) by nominated staff is promoted within the RDNS model of mental health via the provision of relevant education
7. That RDNS fund the development of a training package, including a video, for Centre-based clinical staff in the use of mental health screening tools

8. That intake and referral processes be reviewed to ensure that adequate information is provided to RDNS staff in relation to clients with a history of mental illness
9. That research studies concerned with improving the care provided to district nursing clients with mental health issues be continued
10. That RDNS reviews and refines Camillus data and codes related to the activities of the Mental Health CNC
11. That work be carried out to further develop the Draft Guidelines for Service Provision
12. That RDNS reviews the model of mental health care within 12 months of its full implementation

## References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Baldwin, R., Chiu, E., Katona, C., & Graham, N. (Eds.). (2002). *Guidelines on depression in older people: Practising the evidence*. London: Martin Dunitz Ltd.
- Barry, K. L., Fleming, M. F., & Manwell, L. B. (1998). Prevalence of and factors associated with current and lifetime depression in older adult primary care patients. *Family Medicine*, *30*, 366-371.
- Britt, H., Sayer, G. P., & Miller, G. C. (1999). *General Practice activity in Australia 1998-1999* (No. AIHW Cat No GEP 2). Canberra: Australian Institute of Health & Welfare.
- Brooker, C., Repper, J., & Booth, A. (1996). Examining the effectiveness of community mental health nursing. *Mental Health Nursing*, *16*(3), 12-15.
- Brown, E., McAvay, G., Raue, P., Moses, S., & Bruce, M. (2003). Recognition of depression among elderly recipients of home care services. *Psychiatric Services*, *54*(2), 208-213.
- Bruno, L., & Ahrens, J. (2003). The importance of screening for depression in home care patients. *Caring*, *22*(11), 54-58.
- Chan, S., Mackenzie, A., Ng, D., & Leung, J. (2000). An evaluation of the implementation of case management in the community psychiatric nursing service. *Journal of Advanced Nursing*, *31*(1), 144-156.
- Cleary, J., & Drennan, J. (2005). Quality of life of patients on haemodialysis for end-stage renal disease. *Journal of Advanced Nursing*, *51*(6), 577-586.
- Delbecq, A. L., VandeVen, A. H., & Gustafson, D. H. (1975). *Group Techniques for Program Planners*. Glenview, Illinois: Scott Foresman and Company.
- Dowrick, C., Gask, L., Perry, R., Dixon, C., & Usherwood, T. (2000). Do general practitioners' attitudes towards depression predict their clinical behaviour? *Psychological Medicine*, *30*(2), 413-419.
- Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, *12*, 189-198.
- Fortinash, K. M., & Holoday Worret, P. (2003). *Psychiatric mental health nursing*. San Diego, CA: Mosby.
- Haddad, M., Plummer, S., Taverner, A., Gray, R., Lee, S., Payne, F., et al. (2005). District nurses' involvement and attitudes to mental health problems: A three-area cross-sectional study. *Journal of Clinical Nursing*, *14*, 976-985.
- Happell, B., & Platania-Phung, C. (2005). Mental health issues within the general health care system: Implications for the nursing profession. *Australian Journal of Advanced Nursing*, *22*(3), 41-47.

- Hickie, I., Groom, G., McGorry, P., Davenport, T., & Luscombe, G. (2005). Australian mental health reform: Time for real outcomes. *Medical Journal of Australia*, 182(8), 401-406.
- Hope, K. (2003). A hidden problem: Identifying depression in older people. *British Journal of Community Nursing*, 8(7), 314-320.
- Jackson, R., & Baldwin, B. (1993). Detecting depression in elderly medically ill patients: The use of the Geriatric Depression Scale compared with medical and nursing observations. *Age and Ageing*, 22, 349-353.
- Katon, W., & Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*, 53(4), 859-863.
- Katon, W. J. (2003). Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. *Biological Psychiatry*, 54, 216-226.
- Mead, N., Bower, P., & Gask, L. (1997). Emotional problems in primary care: What is the potential for increasing the role of nurses. *Journal of Advanced Nursing*, 26(5), 879-890.
- Mecocci, P., Cherubini, A., Mariani, E., Ruggiero, C., & Senin, U. (2004). Depression in the elderly: new concepts and therapeutic approaches. *Aging Clinical And Experimental Research*, 16(3), 176-189.
- Mental Health Council of Australia. (2005). *Not for Service*. Canberra: Author.
- Miller, E., Garland, C., Ross, F., Kendrick, T., & Burns, T. (1999). Practice nurses and the care of patients receiving depot neuroleptic treatment: Views on training, confidence and use of structured assessment. *Journal of Advanced Nursing*, 29(6), 1254-1461.
- Naji, S. A., Gibb, J., Hamilton, R. J., Lawton, K., Palin, A. N., & Eagles, J. M. (2004). How ready are practice nurses to participate in the identification and management of depressed patients in primary care? *Primary Care Mental Health*, 2(1), 47-54.
- Nunn, R. J., & Flowers, C. (2003). *The prevalence of depression in elderly domiciliary nursing clients*. Melbourne: Royal District Nursing Service Helen Macpherson Institute of Community Health.
- Piven, M. L. S., Lyons, S. S., & Titler, M. G. (2001). Detection of depression in cognitively intact older adult protocol. *Journal of Gerontological Nursing*, June, 8-14.
- Preville, M., Cote, G., Boyer, R., & Hebert, R. (2004). Detection of depression and anxiety disorders by home care nurses. *Aging & Mental Health*, 8(5), 400-409.
- Rabinowitz, J., Shayevitz, D., Hornik, T., & Feldman, D. (2005). Primary care physicians' detection of psychological distress among elderly patients. *American Journal of Geriatric Psychiatry*, 13(9), 773-780.
- Rayburn, N., Wenzel, S., Elliott, M., Hambarsoomians, K., Marshall, G., & Tucker, J. (2005). Trauma, depression, coping, and mental health service seeking among impoverished women. *Journal of Consulting & Clinical Psychology*, 73(4), 667-677.
- Royal District Nursing Service. (2005). *Annual Report 2004/2005*. Melbourne, Australia: Author.

- Scogin, F., Rohen, N., & Bailey, E. (2000). Geriatric Depression Scale. In M. E. Maruish (Ed.), *Handbook of psychological assessment in primary care settings* (pp. 491-508). Mahwah, New Jersey: Lawrence Erlbaum Associates.
- Sheikh, J., & Yesavage, J. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist*, 5, 165-173.
- Snow, V., Lascher, S., & Mottur-Pilson, C. (2000). Pharmacological treatment of acute major depression and dysthymia. *Annals of Internal Medicine*, 132, 738-742.
- Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory* (2nd ed.). London: Sage Publications.
- Victorian Department of Human Services. (1996). Victoria's Mental Health Service: The Framework for Service Delivery Aged Persons Services. Retrieved 1 February, 2005, from [www.dhs.gov.au](http://www.dhs.gov.au)
- Victorian Government Department of Human Services. (1999). *The Victorian Burden of Disease Study: Morbidity*. Melbourne, Victoria: Epidemiology Section, Health Intelligence and Disease Control, Public Health and Development Division.
- Weeks, S. K., McGann, P., King Michaels, T., & Penninx, B. W. (2003). Comparing various short-form Geriatric Depression Scales leads to the GDS-5/15. *Journal of Nursing Scholarship*, 35(2), 133-137.
- Wing, J., Curtis, R., & Beevor, A. (1996). *HoNOS: Health of the Nation Outcome Scales: Report on Research and Development*. London: Royal College of Psychiatrists.

## **Appendices**

## Appendix 1

### Mental Health Model Focus Group Questions

1. Can you tell me about some of your experiences working with RDNS clients who have mental health problems?
2. What are some of the main issues confronting RDNS field staff when providing care to clients who have mental health problems?
3. (a) Based on your experience, how *common* are mental health problems in RDNS clients?  
  
(b) What *types* of mental health problems are experienced by our clients and which are most prevalent?
4. In your opinion, how much *knowledge* do RDNS field staff have of:  
  
(a) the prevalence, type and causes of mental health problems experienced by our clients;  
(b) techniques for identifying the signs of mental health problems in our clients; and  
(c) the mental health service system and how to access relevant external services?
5. What initiatives should RDNS take to improve the knowledge of RDNS field staff in relation to mental health issues?
6. In general, what role do you believe RDNS field staff should play in relation to the identification and care of clients with mental health problems?
7. When a client is referred to RDNS, do we receive sufficient information on the client's mental health history?
8. In your opinion, how comfortable are RDNS field staff when talking to clients about their emotional and mental health?
9. Based on your experience, do RDNS field staff feel fearful or at risk when attending to clients with an established history of mental illness?
10. How do RDNS field staff normally respond when they observe a change or deterioration in a client's mental or emotional state?
11. At present, what are some of the main barriers to RDNS field staff providing care to clients with mental health problems?
12. In your opinion, what initiatives should RDNS take to improve the quality of care it provides to clients with mental health problems?

## Appendix 2

### Study on Screening Older RDNS Clients for Depression Pre-Implementation Staff Survey

#### PART A – YOUR DETAILS

1. Which of the following best describes your role within RDNS?
- RN Grade 4 .....  1  
RN Grade 3 .....  2  
RN Grade 2 .....  3  
Other (*please specify*) .....  0  
.....
2. Are you involved in direct client care? Yes .....  1  
No .....  2
3. In what year did you first qualify as a Registered Nurse? .....
4. How long have you been employed by RDNS?
- Less than 1 year .....  1  
1–2 years .....  2  
3–5 years .....  3  
6–10 years .....  4  
More than 10 years .....  5
5. What hours do you work?
- Full-time .....  1  
Part-time .....  2  
Casual .....  3
6. What time of day do you *usually* work?
- Day time .....  1  
Evening .....  2  
Other (*please specify*) .....  0  
.....
7. What level of education and training have you received *in mental health*? (*Please tick all that apply*)
- None .....  1  
Undergraduate .....  1  
Postgraduate .....  1  
In Service Training .....  1  
Short course(s) .....  1  
Other (*please specify*) .....  1  
.....

**PART B – DEPRESSION IN YOUR CLIENTS**

8. Based on your experience, what percentage of your older clients (aged 65 years and above) suffer from a depressive illness? ..... %

9. How do you *usually* identify depression in your older clients? (*Please tick one only*)

Don't identify depression .....	<input type="checkbox"/>	1
Depression questionnaire.....	<input type="checkbox"/>	2
Subjective impression/opinion.....	<input type="checkbox"/>	3
Other ( <i>please specify</i> ) .....	<input type="checkbox"/>	0

.....

10a. How often do you currently use the Geriatric Depression Scale (GDS) to assess depression in your older clients?

Never .....	<input type="checkbox"/>	1
Sometimes.....	<input type="checkbox"/>	2
Often.....	<input type="checkbox"/>	3

10b. If the answer to the previous question is **SOMETIMES** or **OFTEN**, how useful have you found the Geriatric Depression Scale?

Not very useful .....	<input type="checkbox"/>	1
Somewhat useful.....	<input type="checkbox"/>	2
Very useful.....	<input type="checkbox"/>	3

11. In general, do you believe district nursing organisations such as RDNS should be involved in the *routine* identification of older clients with depression?

Yes .....	<input type="checkbox"/>	1
No .....	<input type="checkbox"/>	2
Don't know.....	<input type="checkbox"/>	3

12. What are the main signs/symptoms of depression? (*Please list all that you can think of*)

- a. ....
- b. ....
- c. ....
- d. ....
- e. ....
- f. ....
- g. ....
- h. ....
- i. ....

13. What do you consider to be the most common causes of depression amongst your older clients? *(Please tick all that apply)*
- Social isolation .....  1
  - Illness/disability .....  1
  - Family problems.....  1
  - Financial problems.....  1
  - Caring for someone with an illness.....  1
  - Stressful events e.g.. death of spouse.....  1
  - Family history of depression .....  1
  - Cultural dislocation.....  1
  - Don't know .....  1
  - Other *(please specify)*.....  1
- .....

- 14a. Do you feel able to deal effectively with older clients with depression? Yes .....  1  
 No.....  2

- 14b. If the answer to the previous question is NO, what are the reasons? *(Please tick all that apply)*
- You lack the adequate knowledge.....  1
  - Dealing with depression requires specialised training which you have not had .....  1
  - You do not feel that dealing with depression is part of your job.....  1
  - If you tried to deal with it you would not get adequate professional support .....  1
  - You do not have enough time.....  1
  - Other *(please specify)*.....  1
- .....

**PART C – YOUR VIEWS ON DEPRESSION**

15. We would like to know your views on depression. Please indicate how much you agree or disagree with each of the following statements by placing a tick in the appropriate box. In completing the items, please consider as depressed those clients in whom you recognise depression to be a significant part of the clinical picture, not just those who happen to be seeing a mental health specialist, e.g. a psychiatrist.

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
People with severe depression should be offered anti-depressants.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants should be continued for at least 4 months after recovery.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The main treatment for severe depression should be counselling .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are unpredictable .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling is an effective treatment for depression .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
People with severe depression are a danger to others .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression need to pull themselves together.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers are an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants are an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression tend not to improve with treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants are drugs of addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are hard to talk to .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the last 5 years, I have seen an increase in the number of clients presenting with depressive symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The majority of depression originates from clients' recent misfortunes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most depressive disorders improve without medication.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An underlying biochemical abnormality is at the basis of severe cases of depression .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is difficult to differentiate whether clients are presenting with unhappiness or a clinical depressive disorder that needs treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is possible to distinguish two main groups of depression: one psychological in origin and the other caused by biochemical mechanisms....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming depressed is a way that people with poor stamina deal with life difficulties .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed clients are more likely to have experienced deprivation in early life than other people .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel comfortable in dealing with depressed clients' needs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression reflects a characteristic response in clients which is not amenable to change .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming depressed is a natural part of being old .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
The district nurse could be a useful person to support depressed patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with depressed clients is heavy going .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is little to be offered to those depressed clients who do not respond to medical treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is rewarding to spend time looking after depressed clients .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy tends to be unsuccessful with depressed clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If depressed clients need antidepressants, they are better off with a psychiatrist than with a general practitioner .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants usually produce a satisfactory result in the treatment of depressed clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy for depressed clients should be left to a specialist .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed clients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please feel welcome to add any comments about your experience working with older RDNS clients with depression.

.....

.....

.....

.....

.....

**Thank You**

## Appendix 3 - Geriatric Depression Scale (GDS-5/15)

- This scale is to be read in conjunction with the client's most recent general assessment.
- This scale should not be used with clients who score lower than 23 on the MMSE.

Attach client label if available

**Name:** \_\_\_\_\_

**UR:** \_\_\_\_\_

**PART A - Choose the best answer for how you felt during the past week.**

1. Are you basically satisfied with your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
2. Do you often get bored?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
3. Do you often feel helpless?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
4. Do you prefer to stay home, rather than going out and doing new things?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
5. Do you feel pretty worthless the way you are now?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
<b>TOTAL PART A =</b>		
<b>PART B</b>	<b>If the client scores <u>2 or more</u> on PART A, continue with the remaining 10 questions:</b>	
6. Have you dropped many of your activities and interests?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
7. Do you feel that your life is empty?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
8. Are you in good spirits most of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
9. Are you afraid that something bad is going to happen to you?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
10. Do you feel happy most of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
11. Do you feel you have more problems with memory than most people?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
12. Do you think it is wonderful to be alive now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
13. Do you feel full of energy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
14. Do you feel your situation is hopeless?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
15. Do you think that most people are better off than you are?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
<b>TOTAL PART B =</b>		
<b>TOTAL GDS-15 SCORE (PART A + PART B) =</b>		

**SCORING:** Tick the appropriate box. Answers indicated by a \* count as 1 point.

Whilst the Geriatric Depression Scale is an effective screening tool, it does not replace skilled clinical evaluation.

If the client receives a TOTAL GDS-15 score of **5-7**, they possibly have depression. Monitor the client at regular intervals for any deterioration in their mood.

If the client receives a TOTAL GDS-15 score of **8 or more**, they are likely to be experiencing depression. Refer the client to your CNC - Aged Care, CNC - Mental Health, ACAS or the client's doctor.

This scale is adapted with permission from:

- Weeks, S. K. et al (2003) Comparing various short-form Geriatric Depression Scales leads to the GDS-5/15, Journal of Nursing Scholarship, 35, 133-137; and
- Sheikh, J.L. & Yesavage, J.A. (1986) Geriatric depression scale (GDS): Recent evidence and development of a shorter version, Clinical Gerontologist, 5, 165-173.

## Appendix 4

### Study on Screening Older RDNS Clients for Depression Post-Implementation Staff Survey – Centre A

#### PART A – YOUR DETAILS

1. Which of the following best describes your role within RDNS?      RN Grade 4 .....  1  
RN Grade 3 .....  2  
RN Grade 2 .....  3  
Other (*please specify*) .....  0  
.....
2. Are you involved in direct client care?      Yes .....  1  
No .....  2
3. In what year did you first qualify as a Registered Nurse? .....
4. How long have you been employed by RDNS?      Less than 1 year .....  1  
1–2 years .....  2  
3–5 years .....  3  
6–10 years .....  4  
More than 10 years .....  5
5. What hours do you work?      Full-time .....  1  
Part-time .....  2  
Casual .....  3
6. What time of day do you *usually* work?      Day time .....  1  
Evening .....  2  
Other (*please specify*) .....  0  
.....

#### PART B – DEPRESSION IN YOUR CLIENTS

- 7a. Did you attend the education session on depression at your Centre in November 2004?      Yes .....  1  
No .....  2  
Not sure .....  3

**IF you answered “YES” to Q7a, please answer Q7b, Q7c and Q7d.**

7b. Overall, how useful was the content of the education session?
   
Very useful .....  1
   
Somewhat useful .....  2
   
Not very useful.....  3

7c. How adequately did the education session prepare you for using the Geriatric Depression Scale (GDS) with your clients?
   
Very adequate .....  1
   
Somewhat adequate .....  2
   
Not very adequate .....  3

7d. If you feel that the content of the education session was not very useful or that it did not prepare you adequately for using the GDS with clients, do you have any suggestions for improving the education session?

.....

.....

.....

8a. Prior to attending the education session on depression in November, how often did you use the Geriatric Depression Scale (GDS) to assess depression in your older clients?
   
Never .....  1
   
Sometimes.....  2
   
Often.....  3

8b. Since attending the education session on depression in November, how often have you used the Geriatric Depression Scale (GDS) to assess depression in your older clients?
   
Never .....  1
   
Sometimes.....  2
   
Often.....  3

8c. If the answer to Q8a or Q8b is SOMETIMES or OFTEN, how useful have you found the Geriatric Depression Scale (GDS)?
   
Not very useful .....  1
   
Somewhat useful.....  2
   
Very useful.....  3

8d. If you have **not** used the Geriatric Depression Scale (GDS) since attending the education session last November, what are the main reasons? (*List all that apply*)

- a. ....
- b. ....
- c.....
- d. ....
- e. ....

9. What, if any, do you consider to be the benefits of using the Geriatric Depression Scale (GDS)?  
(Please tick all that apply)
- Quick and easy to use.....  1
  - Easy for client to understand.....  1
  - Believe GDS is an effective screening tool for depression .....  1
  - The GDS helps to quantify a client's emotional state .....  1
  - Helps identify depression in clients that might otherwise be overlooked ..  1
  - None of the above .....  1
  - Don't know.....  1
  - Other (please specify) .....  1
  - .....

10. What, if any, do you consider to be the problems or challenges associated with using the Geriatric Depression Scale (GDS)? (Please tick all that apply)
- Questions too negative / depressing .....  1
  - Don't like yes/no format.....  1
  - Clients don't answer honestly.....  1
  - Clients don't cooperate.....  1
  - Questions too non-specific / insensitive ..  1
  - Questions too repetitive.....  1
  - Too long / time consuming .....  1
  - Questions might make clients feel worse / depressed .....  1
  - Questions need to be reworded .....  1
  - Compromises clinical / therapeutic relationship with client.....  1
  - Don't feel comfortable asking clients about their emotional state.....  1
  - GDS not suitable for too many clients, e.g. those with dementia .....  1
  - Don't like using structured questionnaires.....  1
  - Prefer to use observational skills to identify depression .....  1
  - Don't like treatment options for depression, e.g. anti-depressants.....  1
  - None of the above.....  1
  - Don't know .....  1
  - Other (please specify).....  1
  - .....

11. Do you have any suggestions for improving the process of identifying depression in RDNS clients?

.....

.....

.....

12. Would you feel comfortable using the Geriatric Depression Scale (GDS) in the future?
- Yes .....  1
  - No .....  2
  - Don't know.....  3

13. What are the main signs/symptoms of depression? *(Please list all that you can think of)*

- a. ....
- b. ....
- c. ....
- d. ....
- e. ....
- f. ....
- g. ....
- h. ....
- i. ....

14. What do you consider to be the most common causes of depression amongst your older clients? *(Please tick all that apply)*

- Social isolation .....  1
- Illness/disability .....  1
- Family problems.....  1
- Financial problems.....  1
- Caring for someone with an illness.....  1
- Stressful events e.g.. death of spouse.....  1
- Family history of depression .....  1
- Cultural dislocation.....  1
- Don't know .....  1
- Other *(please specify)*.....  1

15. Do you feel that screening for depression in your older clients should be part of your role at RDNS?

- Yes .....  1
- No.....  2

16a. Do you feel able to deal effectively with older clients with depression?

- Yes .....  1
- No.....  2

16b. If the answer to the previous question is NO, what are the reasons? *(Please tick all that apply)*

- You lack the adequate knowledge.....  1
- Dealing with depression requires specialised training which you have not had .....  1
- You do not feel that dealing with depression is part of your job.....  1
- If you tried to deal with it you would not get adequate professional support .....  1
- You do not have enough time .....  1
- Other *(please specify)*.....  1

## PART C – YOUR VIEWS ON DEPRESSION

16. We would like to know your views on depression. Please indicate how much you agree or disagree with each of the following statements by placing a tick in the appropriate box. In completing the items, please consider as depressed those clients in whom you recognise depression to be a significant part of the clinical picture, not just those who happen to be seeing a mental health specialist, e.g. a psychiatrist.

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
People with severe depression should be offered anti-depressants.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants should be continued for at least 4 months after recovery.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The main treatment for severe depression should be counselling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are unpredictable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling is an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are a danger to others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression need to pull themselves together.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers are an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants are an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression tend not to improve with treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants are drugs of addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are hard to talk to.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the last 5 years, I have seen an increase in the number of clients presenting with depressive symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The majority of depression originates from clients' recent misfortunes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most depressive disorders improve without medication.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An underlying biochemical abnormality is at the basis of severe cases of depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is difficult to differentiate whether clients are presenting with unhappiness or a clinical depressive disorder that needs treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
It is possible to distinguish two main groups of depression: one psychological in origin and the other caused by biochemical mechanisms....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming depressed is a way that people with poor stamina deal with life difficulties.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed clients are more likely to have experienced deprivation in early life than other people.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel comfortable in dealing with depressed clients' needs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression reflects a characteristic response in clients which is not amenable to change.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming depressed is a natural part of being old.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The district nurse could be a useful person to support depressed patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with depressed clients is heavy going.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is little to be offered to those depressed clients who do not respond to medical treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is rewarding to spend time looking after depressed clients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy tends to be unsuccessful with depressed clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If depressed clients need antidepressants, they are better off with a psychiatrist than with a general practitioner.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants usually produce a satisfactory result in the treatment of depressed clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy for depressed clients should be left to a specialist.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed clients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank You**



7b. Overall, how useful was the content of the education session?
   
Very useful .....  1
   
Somewhat useful.....  2
   
Not very useful.....  3

7c. How adequately did the education session prepare you for using the Geriatric Depression Scale (GDS) with your clients?
   
Very adequate .....  1
   
Somewhat adequate .....  2
   
Not very adequate .....  3

7d. If you feel that the content of the education session was not very useful or that it did not prepare you adequately for using the GDS with clients, do you have any suggestions for improving the education session?

.....

.....

.....

8a. Prior to attending the education session on depression in October, approximately how many times did you use the Geriatric Depression Scale (GDS) to assess depression in your older clients? .....

8b. Since attending the education session on depression in October, approximately how many times have you completed the Geriatric Depression Scale (GDS) with your older clients? .....

8c. Overall, how useful have you found the Geriatric Depression Scale (GDS)?
   
Not very useful .....  1
   
Somewhat useful.....  2
   
Very useful.....  3

8d. If you have **not** used the Geriatric Depression Scale (GDS) since attending the education session last October, what are the main reasons? (List all that apply)

- a. ....
- b. ....
- c. ....
- d. ....
- e. ....

9. What, if any, do you consider to be the benefits of using the Geriatric Depression Scale (GDS)? *(Please tick all that apply)*
- Quick and easy to use.....  1
  - Easy for client to understand.....  1
  - Believe GDS is an effective screening tool for depression .....  1
  - The GDS helps to quantify a client's emotional state .....  1
  - Helps identify depression in clients that might otherwise be overlooked ..  1
  - None of the above .....  1
  - Don't know.....  1
  - Other *(please specify)* .....  1
  - .....

10. What, if any, do you consider to be the problems or challenges associated with using the Geriatric Depression Scale (GDS)? *(Please tick all that apply)*
- Questions too negative / depressing .....  1
  - Don't like yes/no format.....  1
  - Clients don't answer honestly.....  1
  - Clients don't cooperate.....  1
  - Questions too non-specific / insensitive ..  1
  - Questions too repetitive.....  1
  - Too long / time consuming .....  1
  - Questions might make clients feel worse / depressed .....  1
  - Questions need to be reworded .....  1
  - Compromises clinical / therapeutic relationship with client.....  1
  - Don't feel comfortable asking clients about their emotional state.....  1
  - GDS not suitable for too many clients, e.g. those with dementia .....  1
  - Don't like using structured questionnaires.....  1
  - Prefer to use observational skills to identify depression .....  1
  - Don't like treatment options for depression, e.g. anti-depressants.....  1
  - None of the above.....  1
  - Don't know .....  1
  - Other *(please specify)* .....  1
  - .....

11. Do you have any suggestions for improving the process of identifying depression in RDNS clients?

.....

.....

.....

12. Would you feel comfortable using the Geriatric Depression Scale (GDS) in the future?
- Yes .....  1
  - No.....  2
  - Don't know.....  3

13. What are the main signs/symptoms of depression? *(Please list all that you can think of)*

- a. ....
- b. ....
- c. ....
- d. ....
- e. ....
- f. ....
- g. ....
- h. ....
- i. ....

What do you consider to be the most common causes of depression amongst your older clients? *(Please tick all that apply)*

- Social isolation .....  1
- Illness/disability .....  1
- Family problems.....  1
- Financial problems.....  1
- Caring for someone with an illness.....  1
- Stressful events e.g.. death of spouse.....  1
- Family history of depression .....  1
- Cultural dislocation.....  1
- Don't know .....  1
- Other *(please specify)*.....  1

15. Do you feel that screening for depression in your older clients should be part of your role at RDNS? Yes .....  1  
 No.....  2

16a. Do you feel able to deal effectively with older clients with depression? Yes .....  1  
 No.....  2

16b. If the answer to the previous question is NO, what are the reasons? *(Please tick all that apply)*

- You lack the adequate knowledge.....  1
- Dealing with depression requires specialised training which you have not had .....  1
- You do not feel that dealing with depression is part of your job.....  1
- If you tried to deal with it you would not get adequate professional support .....  1
- You do not have enough time .....  1
- Other *(please specify)*.....  1

## PART C – YOUR VIEWS ON DEPRESSION

17. We would like to know your views on depression. Please indicate how much you agree or disagree with each of the following statements by placing a tick in the appropriate box. In completing the items, please consider as depressed those clients in whom you recognise depression to be a significant part of the clinical picture, not just those who happen to be seeing a mental health specialist, e.g. a psychiatrist.

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
People with severe depression should be offered anti-depressants.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants should be continued for at least 4 months after recovery.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The main treatment for severe depression should be counselling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are unpredictable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling is an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are a danger to others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression need to pull themselves together.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers are an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants are an effective treatment for depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression tend not to improve with treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants are drugs of addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People with severe depression are hard to talk to.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the last 5 years, I have seen an increase in the number of clients presenting with depressive symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The majority of depression originates from clients' recent misfortunes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most depressive disorders improve without medication.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An underlying biochemical abnormality is at the basis of severe cases of depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Strongly Agree</b> 1	<b>Agree</b> 2	<b>Disagree</b> 3	<b>Strongly Disagree</b> 4	<b>Neutral/ Unsure</b> 5
It is difficult to differentiate whether clients are presenting with unhappiness or a clinical depressive disorder that needs treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is possible to distinguish two main groups of depression: one psychological in origin and the other caused by biochemical mechanisms....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming depressed is a way that people with poor stamina deal with life difficulties .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed clients are more likely to have experienced deprivation in early life than other people .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel comfortable in dealing with depressed clients' needs .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression reflects a characteristic response in clients which is not amenable to change .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming depressed is a natural part of being old .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The district nurse could be a useful person to support depressed patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with depressed clients is heavy going .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is little to be offered to those depressed clients who do not respond to medical treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is rewarding to spend time looking after depressed clients .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy tends to be unsuccessful with depressed clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If depressed clients need antidepressants, they are better off with a psychiatrist than with a general practitioner .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants usually produce a satisfactory result in the treatment of depressed clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy for depressed clients should be left to a specialist .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed clients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix 6

### Post-Implementation Knowledge and Attitudes about Depression – Centre A

	Strongly agree		Agree		Neutral/Unsure		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%
Should be offered antidepressants	<i>1</i>	<i>11.1%</i>	<i>8</i>	<i>88.9%</i>				
Antidepressants continued for at least 4 months			<i>6</i>	<i>66.7%</i>	<i>3</i>	<i>33.3%</i>		
Main treatment should be counselling	<i>1</i>	<i>10.0%</i>	<i>3</i>	<i>30.0%</i>	<i>5</i>	<i>50.0%</i>	<i>1</i>	<i>10.0%</i>
Depressed people are unpredictable	<i>1</i>	<i>10.0%</i>	<i>4</i>	<i>40.0%</i>	<i>5</i>	<i>50.0%</i>		
Counselling is effective for depression	<i>1</i>	<i>10.0%</i>	<i>8</i>	<i>80.0%</i>	<i>1</i>	<i>10.0%</i>		
Depressed people are a danger to others					<i>6</i>	<i>60.0%</i>	<i>4</i>	<i>40.0%</i>
Depressed people need to pull themselves together					<i>1</i>	<i>10.0%</i>	<i>9</i>	<i>90.0%</i>
Tranquilisers are an effective treatment for depression					<i>6</i>	<i>60.0%</i>	<i>4</i>	<i>40.0%</i>
Antidepressants are an effective treatment for depression	<i>2</i>	<i>20.0%</i>	<i>6</i>	<i>60.0%</i>	<i>2</i>	<i>20.0%</i>		
People with depression tend not to improve with treatment					<i>7</i>	<i>77.8%</i>	<i>2</i>	<i>22.2%</i>
Antidepressants are drugs of addiction			<i>1</i>	<i>10.0%</i>	<i>5</i>	<i>50.0%</i>	<i>4</i>	<i>40.0%</i>
Depressed people are hard to talk to	<i>1</i>	<i>11.1%</i>	<i>4</i>	<i>44.4%</i>	<i>4</i>	<i>44.4%</i>		
Seen increase in clients with depression	<i>1</i>	<i>10.0%</i>	<i>4</i>	<i>40.0%</i>	<i>5</i>	<i>50.0%</i>		
Depression originates from client's misfortunes					<i>9</i>	<i>90.0%</i>	<i>1</i>	<i>10.0%</i>
Most depression improves without medication			<i>2</i>	<i>20.0%</i>	<i>7</i>	<i>70.0%</i>	<i>1</i>	<i>10.0%</i>

	Strongly agree		Agree		Neutral/Unsure		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%
Biochemical abnormality is basis for depression	2	22.2%	1	11.1%	6	66.7%		
Difficult to differentiate unhappiness from depression			2	20.0%	8	80.0%		
Two groups of depression: psychological and biochemical			3	30.0%	7	70.0%		
Depression is way of dealing with poor stamina			2	20.0%	4	40.0%	4	40.0%
Depressed people experienced deprivation in early life			2	20.0%	7	70.0%	1	10.0%
I feel comfortable in dealing with depressed people's needs			2	20.0%	7	70.0%	1	10.0%
Depressions reflects response not amenable to change			1	11.1%	6	66.7%	2	22.2%
Depression is natural part of becoming old					5	50.0%	5	50.0%
District nurse useful to support depressed people	1	10.0%	7	70.0%	2	20.0%		
Working with depressed people is heavy going			8	80.0%	2	20.0%		
Little to be offered to depressed people who don't respond to medical treatment			1	10.0%	9	90.0%		
Rewarding to look after depressed clients			3	30.0%	6	60.0%	1	10.0%
Psychotherapy tends to be unsuccessful with depressed clients			1	10.0%	9	90.0%		
Better with psychiatrist than GP if need antidepressants	1	10.0%	2	20.0%	7	70.0%		
Antidepressants usually satisfactory in treatment of depression	1	10.0%	7	70.0%	2	20.0%		

	Strongly agree		Agree		Neutral/Unsure		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%
<b>Psychotherapy for depression should be left to specialist</b>	2	20.0%	5	50.0%	3	30.0%		
<b>If psychotherapy available, would be more beneficial than antidepressants</b>	2	20.0%			8	80.0%		

## Appendix 7

### Post-Implementation Knowledge and Attitudes about Depression – Centres B & C

	Strongly agree		Agree		Neutral/Unsure		Disagree		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Should be offered antidepressants	5	31.3%	9	56.3%					2	12.5%
Antidepressants continued for at least 4 months	3	18.8%	5	31.3%	6	37.5%	1	6.3%	1	6.3%
Main treatment should be counselling	1	6.3%	8	50.0%	4	25.0%	3	18.8%		
Depressed people are unpredictable	1	6.3%	6	37.5%	2	12.5%	7	43.8%		
Counselling is effective for depression	3	18.8%	11	68.8%	2	12.5%				
Depressed people are a danger to others			1	6.3%			13	81.3%	2	12.5%
Depressed people need to pull themselves together			1	6.3%	2	12.5%	7	43.8%	6	37.5%
Tranquilisers are an effective treatment for depression					3	18.8%	8	50.0%	5	31.3%
Antidepressants are an effective treatment for depression	5	31.3%	9	56.3%	1	6.3%			1	6.3%
People with depression tend not to improve with treatment	1	6.3%			3	18.8%	11	68.8%	1	6.3%
Antidepressants are drugs of addiction			4	25.0%	2	12.5%	7	43.8%	3	18.8%
Depressed people are hard to talk to			5	31.3%			10	62.5%	1	6.3%
Seen increase in clients with depression	1	6.3%	12	75.0%	2	12.5%	1	6.3%		
Depression originates from client's misfortunes			5	31.3%	6	37.5%	5	31.3%		
Most depression improves without medication					4	25.0%	12	75.0%		

	Strongly agree		Agree		Neutral/Unsure		Disagree		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Biochemical abnormality is basis for depression	3	18.8%	4	25.0%	4	25.0%	4	25.0%	1	6.3%
Difficult to differentiate unhappiness from depression			8	50.0%	3	18.8%	5	31.3%		
Two groups of depression: psychological and biochemical			3	18.8%	8	50.0%	2	12.5%	3	18.8%
Depression is way of dealing with poor stamina					2	12.5%	10	62.5%	4	25.0%
Depressed people experienced deprivation in early life			1	6.3%	5	31.3%	9	56.3%	1	6.3%
I feel comfortable in dealing with depressed people's needs			9	56.3%	3	18.8%	2	12.5%	2	12.5%
Depressions reflects response not amenable to change			1	6.3%	2	12.5%	11	68.8%	2	12.5%
Depression is natural part of becoming old	1	6.3%					10	62.5%	5	31.3%
District nurse useful to support depressed people	3	18.8%	13	81.3%						
Working with depressed people is heavy going	2	12.5%	10	62.5%	1	6.3%	3	18.8%		
Little to be offered to depressed people who don't respond to medical treatment			3	18.8%	3	18.8%	10	62.5%		
Rewarding to look after depressed clients	1	6.3%	8	50.0%	5	31.3%	1	6.3%	1	6.3%
Psychotherapy tends to be unsuccessful with depressed clients					7	43.8%	7	43.8%	2	12.5%
Better with psychiatrist than GP if need antidepressants	4	25.0%	3	18.8%	3	18.8%	6	37.5%		
Antidepressants usually satisfactory in treatment of depression	2	12.5%	9	56.3%	5	31.3%				

	Strongly agree		Agree		Neutral/Unsure		Disagree		Strongly disagree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Psychotherapy for depression should be left to specialist	<i>4</i>	<i>25.0%</i>	<i>11</i>	<i>68.8%</i>	<i>1</i>	<i>6.3%</i>				
If psychotherapy available, would be more beneficial than antidepressants	<i>2</i>	<i>12.5%</i>	<i>5</i>	<i>31.3%</i>	<i>7</i>	<i>43.8%</i>	<i>2</i>	<i>12.5%</i>		

## Appendix 8

### Secondary Consultation Record

Please tick the relevant box (☑) for each question.  
Complete one Secondary Consultation Record per consultation

<b>1. Referral status of client</b>			
Referral to RDNS	<input type="checkbox"/>	Existing client	<input type="checkbox"/>
<b>2. Mode of consultation</b>			
Phone	<input type="checkbox"/>	Face-to-face	<input type="checkbox"/>
Case conference	<input type="checkbox"/>	'At risk' conference	<input type="checkbox"/>
<b>3. Who is the consultation with?</b>			
Internal provider	<input type="checkbox"/>	External provider	<input type="checkbox"/>
Both	<input type="checkbox"/>		
<u>Nursing</u>			
Primary nurse	<input type="checkbox"/>	Assessor	<input type="checkbox"/>
Care manager	<input type="checkbox"/>	Liaison	<input type="checkbox"/>
Aged care CNC	<input type="checkbox"/>	HIV CNC	<input type="checkbox"/>
Other CNC	<input type="checkbox"/>	HPP	<input type="checkbox"/>
ACM	<input type="checkbox"/>	CM	<input type="checkbox"/>
<u>Allied health</u>			
Social worker	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>
OT	<input type="checkbox"/>	Other	<input type="checkbox"/>
<u>Medical</u>			
General practitioner	<input type="checkbox"/>	Other	<input type="checkbox"/>
<u>Other provider</u>			
Aged Care Assessment Service			
Aged Psychiatric Assessment Service	<input type="checkbox"/>	Community Health Centre	<input type="checkbox"/>
Case Manager	<input type="checkbox"/>	Council staff	<input type="checkbox"/>
Family/Carer	<input type="checkbox"/>	Other	<input type="checkbox"/>
<b>4. What is the consultation about?</b>			
Psychotropic medication	<input type="checkbox"/>	Care management issues (mental health)	<input type="checkbox"/>
Assessment (mental health)	<input type="checkbox"/>	Care plan issues (mental health)	<input type="checkbox"/>
Monitoring (mental health)	<input type="checkbox"/>	Education for clients/carers	<input type="checkbox"/>
Education for staff	<input type="checkbox"/>	Staff support	<input type="checkbox"/>
'At risk' issues	<input type="checkbox"/>		
Challenging behaviours	<input type="checkbox"/>	To discuss referral to RDNS mental health nurse	<input type="checkbox"/>
Accessing external services	<input type="checkbox"/>	Informal de-briefing/counselling	<input type="checkbox"/>
Discharge planning for clients in hospital	<input type="checkbox"/>		
Discharge planning for clients receiving RDNS	<input type="checkbox"/>		
<b>5. What is the outcome of the consultation?</b>			
Referral accepted to RDNS	<input type="checkbox"/>	Referral accepted to RDNS MHN	<input type="checkbox"/>
Other (specify)			
-----			
-----			
-----			

## Appendix 9

### **PLAIN LANGUAGE STATEMENT- Clients and Carers Caring for your Mental Health Needs**

Royal District Nursing Service (RDNS) are conducting a project to help clients who may be experiencing mental health issues. This project aims to improve community mental health services by developing, implementing and evaluating a community model of mental health within RDNS. My name is Jacqueline Allen and I am the Project Officer responsible for the evaluation of this project.

If you agree to participate, the RDNS Consultant Mental Health Nurse will visit you at home and undertake a nurse assessment. The nurse assessment involves talking to the Consultant Mental Health Nurse about any mental health concerns you may have. Following the assessment, the Consultant Mental Health Nurse will consider available care and service options together with you and your carer. With your permission, the Consultant Mental Health Nurse may talk to your doctor or other health professional about your treatment needs. The assessment is expected to take from one to two hours. With your permission, your health care story may be included as a case study in the final report. If you agree to take part in the project, you will be asked to sign a consent form. By signing the consent form you indicate that you understand this information and that you give your consent to participate in the project.

All information you provide to us will be treated as strictly confidential. Your name or identifying details will not be presented on any reports or case studies. Names or incidents that make identification possible will not be included in any material available to anyone else outside the project team. Participation is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw at any stage and any data collected about you will be destroyed. If you choose not to participate, this will not affect the care you receive from RDNS.

If you have any questions about the project, please feel welcome to call me on 9536 5335.

Yours faithfully

Jacqueline Allen  
**Project Officer**

**CONSENT FORM - Clients and Carers  
Caring for your Mental Health Needs**

**Name of project:** Caring for your Mental Health Needs

I (*insert your name in capital letters*)..... hereby consent to participate in the above project.

- The details of this project have been explained to me verbally, and
- I have received a copy of the Plain Language Statement, and
- Any questions I have asked in regard to this project have been answered to my satisfaction.

I agree to participate in this project realising that I may withdraw at any time. I agree that data provided by me may be used in a thesis, presented at conferences or published in journals on the condition that neither my name nor any other identifying information is used. I understand that any information I provide will be treated with the strictest confidence.

**Your Name:**.....

**Your Signature:**.....**Date:**...../...../.....

**Name of Witness:**.....

**Witness Signature:**.....**Date:**...../...../.....

## Appendix 10

### Assessment – Mental Health

**Date of assessment:**

#### Referral source

Internal: Primary nurse  Assessment nurse  Care manager  RDNS Liaison   
CNC  Allied health  External (specify) \_\_\_\_\_

#### Presenting problem/s

Onset date

Client's/carer's understanding of reason for Psychiatric CNC assessment

What changes were noticed (if relevant)?

What does the client/family think is causing the problem/s?

Adapted from Fortinash & Holoday-Worret,

## **History**

### **Family and social networks**

Genogram (note the client's support systems)

### **Social**

What social activities/activities does the client participate in?

### **Pre-morbid**

Note the client's medical history, and the effect on the client's current problem? (consider information in General Assessment contained in the client's history)

Has the client received treatment in the past for a mental health issue?  √='Yes'

What was the reason for the client's past mental health treatment? **(tick all relevant boxes)**

Depression  Anxiety  Psychosis including schizophrenia  Bipolar

Substance abuse  Intellectual disability  Dementia including Alzheimers

Other

What type of treatment did the client receive? **(tick all relevant boxes)**

Counselling/psychological therapy  Psychotropic medication

Inpatient psychiatric treatment  ECT  Other

### Psychiatric

Is the client currently receiving treatment for a mental health issue?  √='Yes'

What is the reason for the client's current mental health treatment? **(tick all relevant boxes)**

Depression  Anxiety  Psychosis including schizophrenia  Bipolar

Substance abuse  Intellectual disability  Dementia including Alzheimers

Other

What type of treatment is the client currently receiving? **(tick all relevant boxes)**

Counselling/psychological therapy  Psychotropic medication

Inpatient psychiatric treatment  ECT  Involuntary admission

Community Treatment Order  Other

### Medication Management

(Consider information in the client's most recent General and Medication Assessments)

Complete 'Medication management table' as required

Does the client/family show evidence of difficulty managing their medication?  √='Yes'

### Symptoms

(Describe type of symptoms, their frequency, severity and duration)

### Recent stressors/Losses (complete if relevant)

Has the client experienced any recent stressful life events and if so specify?

**Legal History including Guardianship and Administration Orders (complete if relevant)**

Has the client ever been in trouble with the law, if so specify?

**Alcohol and Drug usage (complete if relevant)**

Does the client show evidence on a dependence on alcohol, illicit or prescription drugs, if so specify?

**Education**

What level of education did the client complete (**tick relevant box**)

Primary School       Some Secondary School       Completed Secondary School   
Tertiary Education       No formal education

**Mental status exam**

**Appearance** (for example: dress, personal hygiene)

**Behaviour** (for example: motor activity, social manner)

**Speech** (for example: rate, quality, quantity, volume, tone)

**Mood** (for example: sad, fearful, depressed, angry, anxious, grandiose, restricted)

**Affect** (for example: blunted, flat, labile)

**Perception** (for example: hallucinations, illusions, phobias)

**Thought stream** (for example: flight of ideas, loosening of associations, tangential thinking, thought insertion/withdrawal)

**Thought content** (for example: delusions, obsessions, passivity phenomena)

**Cognition** (for example: orientation, attention span, remote and recent memory)

**Judgement** (for example: understanding consequences of behaviour, decision making)

**Insight** (understanding of illness, own and other's situation)

## Assessment summary

General comments:

Client referred to external service providers: **(tick all relevant boxes)**

Mental health services  GP  APAT  ACAS

Allied health/OT/SW

Mental Health CNC CNC interventions: **(tick all relevant boxes)**

Monitor/review client  Liaison with MH case manager

Case conference  Family conference  Care plan

Client/carer education  Use of interpreter  Other

## References

Fortinash, K., Holoday-Worret, P. (2000). Psychiatric Mental Health Nursing. St Louis: Mosby.

Registered Nurses Association of Ontario. (2003). Screening for delirium, dementia and depression in older adults. Retrieved March 8<sup>th</sup>, 2004 from the World Wide Web: <http://www.rnao.org>

## Appendix 11

### Caring for your Mental Health Needs Satisfaction Survey

Your Name: ..... Date: .....

**Please tick the relevant box (☐) for each question.**

	Satisfied 1	Mostly satisfied 2	Mildly dissatisfied 3	Very dissatisfied 4	Neutral/ Unsure 5
1. How satisfied are you with the RDNS Consultant Mental Health Nurse's explanation of your care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How satisfied are you that the RDNS Consultant Mental Health Nurse was competent and knowledgeable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How satisfied are you that the RDNS Consultant Mental Health Nurse listened to you and understood your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with the amount of help you received from the RDNS Consultant Mental Health Nurse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How satisfied are you that the RDNS Consultant Mental Health Nurse helped you to deal more effectively with your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How satisfied are you that the service you received from the RDNS Consultant Mental Health Nurse's met your needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How satisfied are you that the care you received met your expectations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Overall, how satisfied are you with the service you received from the RDNS Consultant Mental Health Nurse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix 12

### **MODEL OF MENTAL HEALTH CARE INTERVIEW GUIDELINES FOR RDNS STAFF**

- 1) What is your understanding of the role of the RDNS Mental Health CNC?  
*Interviewer prompt*  
*Referral processes (within RDNS and external)*  
*Case conferences (internal to RDNS and external)*  
*Staff information and support*
  
- 2) What is your understanding of the role of the RDNS Mental Health CNC in collaborative care planning?  
*Interviewer prompt*  
*With RDNS clinical nurses and allied health staff*  
*With the mental health and community teams*
  
- 3) How available and accessible was the Psychiatric Nurse CNC?  
*Interviewer prompt*  
*To RDNS clinical nurses and allied health staff*
  
- 4) In your opinion, how does the Mental Health CNC affect communication between RDNS clinical nurses/allied health staff and any external individuals/organisations?
  
- 5) Was your understanding of mental health changed in undertaking client care with the RDNS Mental Health CNC, and if so, what changed and how did this change occur?
  
- 6) In your opinion are there any limitations in working with the Psychiatric Nurse CNC in providing client care and if so what were they?
  
- 7) What could be done to improve collaboration with the Mental Health CNC in providing client care?
  
- 8) Do you have any suggestions on how the role could be further developed?
  
- 9) What effect did the Mental Health CNC have on client outcomes?

## Appendix 13

### **PLAIN LANGUAGE STATEMENT- RDNS Staff Model of Mental Health Care**

RDNS is conducting a project to explore the role of a community psychiatric nurse. The aim of this project is to develop, implement and evaluate a Community Psychiatric Nurse Consultant role within RDNS. Royal District Nursing Service Executive Management has approved the project. My name is Jacqueline Allen and I am the Project Officer responsible for the evaluation of this project.

If you agree to participate, you will be interviewed about your experience working with the RDNS Psychiatric Nurse Consultant. The interview will take approximately 20 minutes and will be conducted in the place of your choice, and, with your permission the interview will be audio-taped.

If you agree to take part you will be asked to sign a consent form. By signing the consent form you indicate that you understand this information and that you give your consent to participate in the project.

All information you provide to us will be treated as strictly confidential. Your name will not be recorded on any documentation. Any information that may make identification possible will not be included in any material available to anyone else outside the project team.

Participation is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw at any stage and any data collected about you will be destroyed.

Please feel welcome to call me on 9536 5335 if you have any questions about the project.

Yours Faithfully

Jacqueline Allen  
**Project Officer**

Should you have any concerns or complaints about the conduct of this research project please contact:

Mark Smith, Chair, RDNS Research Ethics Committee  
Helen Macpherson Smith Institute of Community Health  
Royal District Nursing Service  
31 Alma Road, St Kilda, Victoria, 3182  
Ph: 9536 5382, Fax: 9536 5300

**CONSENT FORM - RDNS Staff  
Model of Mental Health Care**

**Name of project:** Development and Evaluation of a Model of Mental Health Care at RDNS

I (*name of participant in block letters*).....  
hereby  
consent to participate in the above project.

- The details of this project have been explained to me verbally, and
- I have received a copy of the Plain Language Statement, and
- Any questions I have asked in regard to this project have been answered to my satisfaction.

I agree to participate in this project realising that I may withdraw at any time. I agree that data provided by me may be used in a thesis, presented at conferences or published in journals on the condition that neither my name nor any other identifying information is used. I understand that any information I provide will be treated with the strictest confidence.

**Name of Participant:**.....

**Signature of Participant:**.....**Date:**...../...../.....

**Name of Witness:**.....

**Signature of Witness:**..... **Date:**...../...../.....

