1. Introduction

This chapter introduces the study, commencing with a broad overview and presentation of the research problem, question and objectives. Next, in order to provide understanding as to how this research project came about and my relationship to the study, I introduce myself. Definitions of key terms and classifications used in this study are then presented and explained. The chapter ends with an overview of the thesis structure, providing brief outlines of each chapter.

1.1 Broad overview of the study

As part of nationwide mental health (MH) reform in Australia, public sector service delivery has increasingly shifted away from inpatient care into community mental health (CMH) services and over the past 20 years the emergence of interdisciplinary, community mental health (CMH) teams has been observed. These teams are an important aspect of MH service provision in rural areas where there is generally a greater reliance on the public sector for health services. Health professionals working in these teams commonly hold generic case management positions.

Recruitment and retention in rural health services has been a major challenge for successive Australian state and federal governments, and workforce problems persist (Health Workforce Australia (HWA), 2013). Long-term unfilled positions are commonplace in many rural CMH services, particularly in more remote areas. These staffing shortages have been attributed to negatively influencing MH professionals' job satisfaction, contributing to burnout and resulting in high staff turnover (Drury, Francis, & Dulhunty, 2005; Perkins, Larsen, Lyle, & Burn, 2007).

The purpose of this thesis is to highlight how employment and rural-living factors impact the turnover intention of early career, rural-based CMH professionals in their first few years of working. Using a grounded theory (GT) methodology, the study aims to generate a substantive theory explaining this turnover intention phenomenon. It is anticipated that this theory could be relied upon for the development of policy and procedural responses to help address avoidable turnover among Australia's rural-based CMH professionals.

1.2 The research problem, question and objectives

People living in rural Australia who experience severe and persistent mental ill health rely heavily on public sector CMH services. These rural CMH services face severe staffing challenges in terms of both vacancies and turnover. A review of the research literature investigating factors impacting retention of rural CMH staff identified that little research had been undertaken on this particular workforce group. However, it is possible that different factors may impact the retention of this group of workers given the resourcing constraints of the rural public health service and the interdisciplinary and generic case-management approaches of CMH.

Drawing from the findings from the limited rural CMH literature available and supplementing it with findings from retention studies undertaken with other closely related workforce groups (for example, health professionals working in MH inpatient services and/or in metropolitan areas and other rural health services), the intention to stay or leave a rural health job was found to be influenced by a complex interaction of organisational, role and personal factors.

While having identified the research problem and a gap in the research literature, the findings from the literature review were not sufficient to frame the research question and determine the research design (such as where in rural New South Wales (NSW) to interview). To supplement the literature a pilot study[1] was undertaken to help build better understanding of the retention issue for rural CMH health professionals and also to check whether staff retention was an issue of concern in the field. This pilot study was undertaken with NSW Health service managers responsible for staffing and running rural-based CMH services. The pilot study confirmed that staff turnover was a major issue, and managers identified that high turnover among early career CMH health professionals was of particular concern. In addition, the pilot study indicated that little was known about this particular staff group's reasons for leaving (or for staying). Based on the findings from both the literature and the pilot study, the research question formulated for this study was:

> *How do employment and rural-living factors impact turnover intention among early career, rural-based community mental health professionals in their first few years of working?*

[1] The details of the pilot study are presented in Chapter 3: The Pilot Study

Choosing a GT approach to undertake this study meant, by implication, that the research question would be answered by developing *a substantive theory* that explained the impact of employment and rural-living factors on turnover intention among this group of health professionals (Study Objective 1). Given that the phenomenon under investigation was a process occurring over time and had an evolving nature, identification of the *basic social process*[2] at play would be used to assist theoretical conceptualisation (Study Objective 2).

1.3 Why am I here?

> People are often encouraged in career counselling to think of their work life as a linear progression, where each step takes them on a logical path to the top. But that is not how life unfolds. People's careers go up, down and sideways. They might set off in one direction, hit a wall or another opportunity beckons and they spin around to do something completely different. It's like a drunken man staggering around the world of work.
>
> Dr Jim Bright quoted in (Smith, 2011).

At this point of the thesis I would like to introduce myself, provide details of my background and present my own career journey that led me to being a PhD candidate and undertaking this investigation. I also think it is important to have some understanding of me and the worldview I hold, as this has implications for this study's research design and the analysis undertaken.

A few months before starting my PhD candidature in early 2012 I undertook a three-day professional development course on career counselling for youth. The training was part of the job I held at the time, working for a non-government organisation (NGO) brokering partnerships between high schools, business and community to strengthen youth attainment in education. The training was conducted by Dr Jim Bright and was entitled 'The postmodern global workplace'. It was during this training, in trying to emphasise the complexity and interconnectedness of modern work, that Dr Bright likened most people's careers to being more like a drunken man's stagger than a linear progression. I remember thinking: 'That's me!' My career has been one of stumbles, sideways moves and leaps into the unknown. My decision to do a PhD is just the most recent step, of many, made in my 'patchwork-ed' career.

[2] A basic social process is a theoretical code amenable to modelling that can account for the variation in time, context and behaviour of the phenomenon under investigation (Glaser & Holton, 2005).

I started my post-secondary school life by undertaking a Bachelor of Commerce and followed this by working for a multinational company in corporate taxation for four years. During those years I realised increasingly that I had made a really poor career choice – I hated the work, the corporate environment and its culture of greed. Eventually I resigned, intending never to return to this type of work, and set out to travel overseas for a year. On a bus in India in 1989, I remember making a firm resolution that from now on I would only ever do work that I considered ethical and altruistically motivated – work that was concerned with improving the world. This resolve has continued to act as my true north and has been behind every career choice made since. However, ethical concerns have not been the only influence on my career decisions. As I have moved through life and transitioned from being a single adult to being partnered and then to becoming a parent, my career choices have often been as equally influenced by my personal circumstances, the needs of my family and lifestyle aspirations.

It had never been part of my career plan to undertake a PhD. In fact, I remember making a deliberate note to self – when my oldest child was just a toddler and upon submitting the last essay to complete a Master of Arts in Development Studies – not to contemplate any further tertiary study until my children had grown up and left home. My experience of managing family life, working and tertiary studies had been a bit like water and oil: a combination that did not mix too well. Up until I started my PhD candidature three-and-a-half years ago, I had pretty much kept to this resolve, with the exception of taking a couple of single university subjects for very specific career-related reasons. However, in my late 40s, with my children by then in their teens, undertaking a higher degree in research had begun to very seriously enter my consciousness as a possible next career step or, in Dr Bright's parlance, the next in my drunken man's staggers in the world of work.

I do not think I would have ever seriously considered doing a PhD if I had not moved to live in rural Australia seven years earlier (in 2005). After working in the international aid sector for almost 15 years, I decided, after a posting to the Philippines with my family, that international development was too difficult a career to combine with raising a family. On return to Australia I segued into Australian-based community development, working on projects and programs targeting vulnerable population groups (for example, refugee women, people living with mental illness, disadvantaged youth). After a couple of years working in this capacity in Melbourne, my

husband and I had decided to move from the city to rural Australia, primarily for the purpose of raising our two sons who, at the time, were eleven and seven years old (now 22 and 17).

We moved from Melbourne Victoria[3], the city in which I was born and had lived most of my adult life to a small rural town with a population of 3,000 people located in the hinterland of the NSW mid-north coast. We chose this town not only because it was small and very picturesque, being surrounded by world heritage national parks, but also because it offered the range of schools, sports and cultural pursuits we were seeking for our children and ourselves. It was also well known for having an alternative culture, which we hoped would assist us to become accepted more quickly than is often the norm for outsiders moving to rural towns.

I remember soon after moving to the town being told: 'You'll have to earn your place in paradise' and not really understanding what that meant until 13 months later, during which time I had not found any work. In hindsight I now view that hard landing as experiencing the impacts of moving to a place in which we had no pre-existing social connections and living in an area in which there were few employment opportunities (as is commonplace throughout rural Australia). Eventually my employment drought broke and for the next six years I worked as a project manager and/or consultant in various local community development initiatives targeting vulnerable groups – in particular, people living with mental illness – as well as working as a research assistant at the local university for a couple of years.

Despite having been in back-to-back contract work since that initial period of unemployment, I have remained very conscious of the limited work opportunities in the area we live. I also observed that, because of this, it often acted as a motivating factor for people living in the area to undertake tertiary studies. So, over those six working years, PhD candidature increasingly came onto my radar, partly due to working as a university research assistant, and also from constantly hearing of friends and work colleagues undertaking and gaining their doctorates and from taking a weekly beach walk over a couple of years with a girlfriend who at the time was involved in writing up her PhD thesis and discussing her progress and the challenges she experienced.

[3] Located in the state of Victoria, Melbourne is the second largest city in Australia, with a population of slightly under four million people.

At the same time as this awareness of undertaking a PhD as a possible career step was growing, I was experiencing a growing weariness and frustration with my work. I found myself tiring of project work and the short-term nature of the project cycle and project-based funding. My interests were increasingly concerned with quality, wanting to build the evidence base of good-practice community development, to embed evaluation into project designs and to partner with universities to strengthen this work. Behind this, there was also a growing desire to think more deeply – to do less and think more. However, the reality was that most of my working time was spent on project management tasks: seeking funding, managing stakeholder relationships and writing reports. While I was fairly skilled at this and had become quite successful at gaining funding for often innovatively designed projects, increasingly these successes left me feeling empty. At the same time, as I was sitting in meetings negotiating with our university partners to undertake evaluation work, I began to feel that I would really rather be doing that work instead. So the stage was set for career change – and then an opportunity presented itself.

In the second half of 2011 I saw an advertisement for a PhD scholarship being offered by the University of New England (UNE) as part of a Collaborative Research Network (CRN) that was being established, funded by the Australian Federal Government to build the research capacity of rural universities. UNE's CRN was in the area of MH and wellbeing in rural communities and there were three thematic areas of research. Four PhD scholarships were being offered under Theme A, the thematic area of 'Self-care and MH within regional communities'. These lined-up with four major research programs: 1) building rural MH workforce capacity, 2) disability across the lifespan, 3) suicide in rural areas, and 4) MH resilience, self-care and social capital in rural areas. I was interested in them all but especially, given my background, in program four. However, because my Master of Arts degree had been by coursework, I was uncertain that I met the qualifications required. So I sent off an introductory email to Professor Rafat Hussain (Rafat) with low expectations of receiving a reply. But instead, it sparked off an email conversation lasting a couple of months and eventually led to face-to-face meetings with her and Associate Professor Myfanwy Maple (Myf). Both Rafat and Myf were very encouraging of my going forward with an application and agreed to be my thesis supervisors. My application for a PhD candidature and scholarship were both successful and in January 2012 I commenced my candidature.

The allocation of PhD candidates to the particular research projects under Theme A was undertaken after the four candidates had been selected and was decided upon by Rafat and Myf in consultation with the four of us. From the outset I had talked about wanting my research efforts to be of practical use, to conduct research in an area and on an issue that could possibly lead to new knowledge and improvements on the ground for people. I also wanted my research to be able to improve, directly or indirectly, the lives of people living with mental illness. On the basis of these aspirations, Rafat and Myf allocated research program one, building rural MH workforce capacity, to me. It was a research area of which I had only the very broadest knowledge. Admittedly, when I was first allocated it, I thought I had been given the least interesting topic, but this changed almost as soon as I commenced reading about Australia's rural MH workforce.

My interest was piqued because I found Australia's rural MH workforce was beset by complex problems resulting in very negative impacts for rural Australians living with severe or persistent mental ill health. While the research area was broadly defined (rural MH workforce) the study was to be entirely of my own choosing from an identified gap in the research. However, a couple of boundaries around the research area of rural MH workforce and the study location were decided from the outset. These decisions were a result of opportunities supported by the CRN, as well as the timing and funding constraints of this being a PhD study. The CRN had a number of partners, one of which was a Local Health District (LHD) of NSW Health. This partnership meant that the LHD would likely support and try to assist any research endeavours involving the LHD, as well as implying general support from NSW Health. I considered this a useful support for the study and thus decided to focus the research on workforce issues facing the NSW Health public sector: rural-based MH services. Any research would include this LHD, which was based in rural NSW. Also, given the time and funding constraints, it was decided that the study would be conducted only in rural NSW and not include sites in any other states.

The research topic that I eventually decided upon – the phenomenon of high staff turnover amongst early career, rural-based CMH professionals – was selected in part because, as well as it being a gap in the knowledge base, it was also well-placed to meet my desire to make a difference. I felt that the topic had potential to have a positive influence for practice and policy and also indirectly address issues of access and equity for people living with severe and persistent mental illness. However, while this motivation was strong and often voiced at the beginning of

my candidature, over the intervening three-and-a-half years, while I became immersed in learning the craft of research, this original altruistic motivation sometimes felt very distant from my research endeavours.

For what felt like the longest time, nothing was clear or appeared likely to be useful. It was therefore with some pleasure, when recently writing this thesis, I realised I had stayed true to this original motivation. In hindsight, I can see now that the study's findings, as a result of being grounded in the data, have given strong voice to both the work and living experiences of early career, rural-based CMH professionals. This PhD journey has also fulfilled my wish to be able to think deeply about an important and complex issue. As a constructivist researcher, it has also given me an opportunity to reflect on my own professional and personal experiences and to consider how these have guided and shaped the study design and my understanding of the study participants' lives.

1.4 Definition of key terms and classifications used

Australia's political framework and political parties

Australia's political framework is three-tiered, with the Commonwealth of Australia and a federal parliament, the operation of six state (NSW, Victoria, Queensland, South Australia and Western Australia) and two territory (Northern Territory and the Australian Capital Territory) governments as well as local government. Under Australia's constitution, both the Commonwealth and the states have rights to convene governments and make laws. Broadly speaking, the Australian Government (interchangeable with the term Federal Government) makes laws on matters which affect the country as a whole (for example, defence, immigration, financial regulation, taxation) while the state governments cover issues such as education, health and the operation of emergency services (Australian Government, no date). However, over the last century the scope of Commonwealth law making power has gradually increased and the Federal Government is now actively involved in law making in the areas of health, education and the environment (University of NSW: The Gilbert and Tobin Centre of Public Law, no date).

To help foster positive intergovernmental relations between these two tiers of government, the Council of Australian Governments (COAG) was established in May 1992. COAG's purpose is to

facilitate cooperation between all levels of government on policy areas of national significance. Since its establishment, COAG has played a pivotal role in implementing policy reforms in a range of areas, including MH reform under the framework of the National Mental Health Strategy, which commenced in 1992 and continues today (Australian Government: The Department of Health, 2014).

Australia is primarily governed under a two-party political model that includes the Australian Labor Party (ALP) and a coalition party comprised of the Liberal Party of Australia and the National Party of Australia, known as the Liberal National Coalition (LNC). Australia's Commonwealth governments are elected for three-year terms. Since 2000 the governing parties have been the LNC in 2001 and 2004, the ALP in 2007 and 2010 and the LNC again in 2013.

Rural and remote terminology

The study was undertaken in rural and remote NSW. The study area is defined drawing on the Australian Standard Geographical Classification–Remoteness Area (ASGC-RA), a geographical classification system developed by the Australian Bureau of Statistics (ABS) in 2001 to allow quantitative comparisons between city and country Australia. There are five remoteness areas (RAs): RA1 – Major Cities of Australia; RA2 – Inner Regional Australia; RA3 – Outer Regional Australia; RA4 – Remote Australia; and RA5 – Very Remote Australia (ABS, 2001). Remoteness is calculated using the road distance to the nearest urban centre. In this study the ASGC-RA remoteness areas include inner regional (RA2), outer regional (RA3) and remote Australia (RA4). For the purpose of this study, the term 'rural' is used to denote all three of these ASGC-RA areas. In instances when the term 'remote' or 'more remote areas' is used, it is generally referring to outer regional (RA3) and remote (RA4) areas. Figure 1.1 (below) visually presents these NSW remoteness areas (Australian Bureau of Statistics (ABS), 2006).

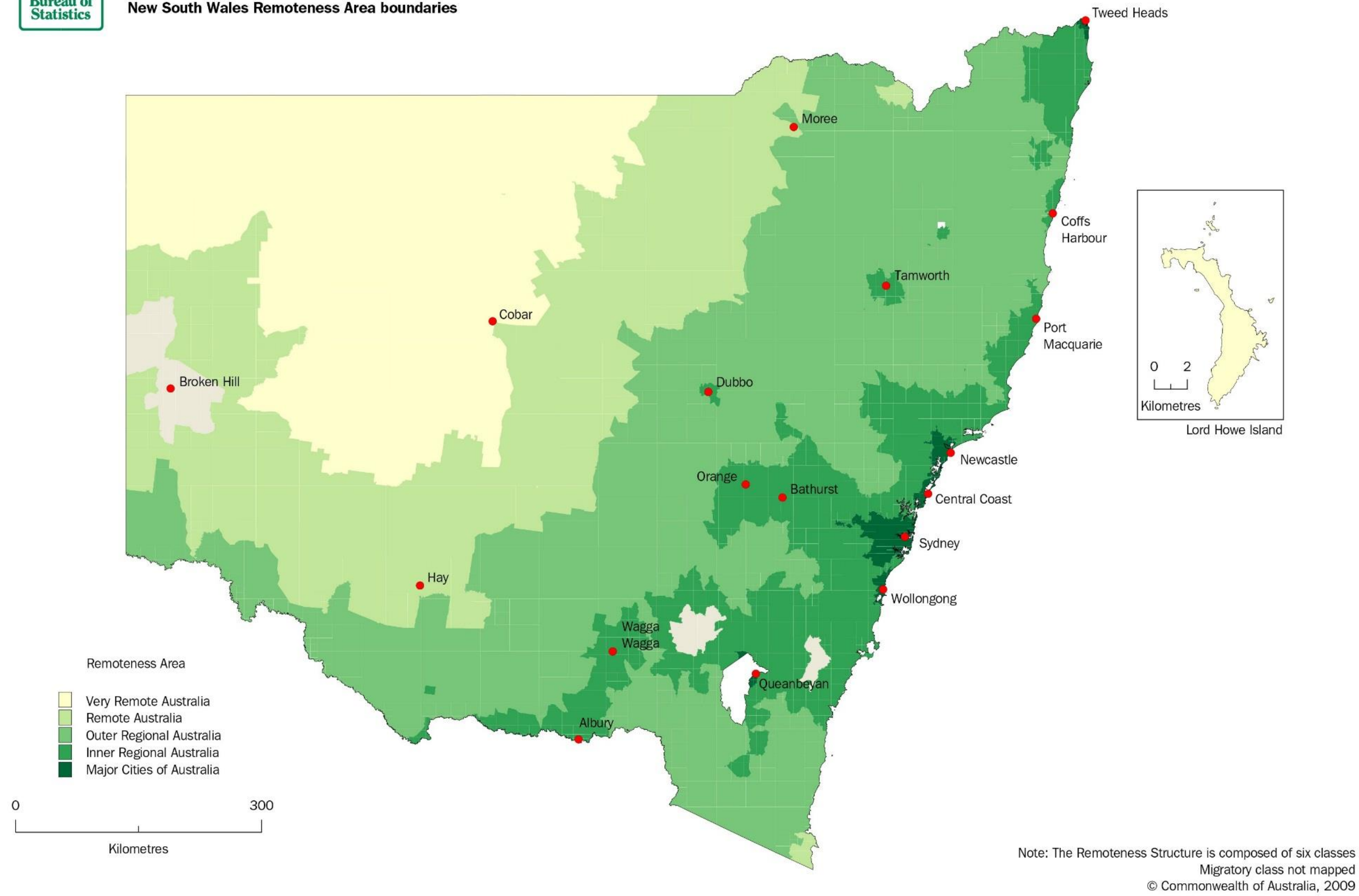

Figure 1.1 – Map of Australia illustrating ASGC-RA remoteness structure (Australian Bureau of Statistics (ABS), 2006)

Mental health services in Australia and the NSW Health structure

MH care in Australia is delivered through a mixture of health services covering primary health care and specialised services and is delivered by both public and private providers. The private sector includes Medicare subsidised health professionals such as general practitioners working in the primary care setting and specialists (psychiatrists and psychologists) accessed through the Federal Government's Better Access Program (Australian Government, 2010a). Of the Australians seeking help for a mental health issue 70% will consult their general practitioner (ABS, 2008). Australia's public sector MH services include both inpatient hospital-based acute services and community-based services. In rural Australia, inpatient MH services are commonly provided within large public hospitals and tend to be sited in larger rural towns, while CMH services are more widespread and operate in both large and small rural towns.

CMH services usually include services for Adult, Rehabilitation, Child and Adolescent Mental Health Services (CAMHS) and Specialist Mental Health Services for Older People. CMH professionals are usually assigned to one service area. In larger teams, staff may work in separate sub-teams with their own team leader and assessment and client allocation criteria. In smaller teams staff more commonly work as one team.

NSW Health (a department of the NSW State Government) is responsible for providing public health care to Australians living in the state of NSW. There are fifteen Local Health Districts (LHDs) supporting the delivery of health care – eight covering the metropolitan area of Sydney and the other seven covering the rest of NSW.

Community mental health teams' staffing and legislative framework

CMH positions are generally case management roles. In NSW Health these positions are mostly advertised as generic roles under the title of 'Mental Health Professional'. Eligible health professionals for these roles include: registered nurses (RNs), psychologists, occupational therapists (OTs) and social workers. RNs, psychologists and OTs are registered professions regulated under the Australian Health Practitioner Regulation Agency, while social workers are not a registered profession, but membership of the Australian Association of Social Workers is a requirement for practice and for working for NSW Health. In NSW, these health professionals are

paid under several different State-based Awards (such as the Public Health System Nurses' and Midwives (State) Award, the NSW Health Service Health Professionals (State) Award and the Health and Community Employees Psychologists (State) Award).

Aboriginal mental health workers (Aboriginal MHWs) are another key staff group in NSW CMH services, especially in rural areas. Aboriginal MHWs are either trainees or graduates of the NSW Aboriginal Mental Health Worker Training Program. This program commenced in 2008 and was developed in response to COAG's 'Closing the Gap' framework that established targets to address the disadvantage faced by Aboriginal and Torres Strait Islanders with respect to life expectancy, child mortality, education and employment (COAG, no date). NSW Health's commitment to closing the gap with respect to health outcomes includes an Aboriginal mental health workforce program that comprises strategies to support the development of a clinical and non-clinical Aboriginal health workforce. The NSW Aboriginal Mental Health Worker Training Program is one strategy of this workforce program (NSW Health, 2013).

Aboriginal MHWs are recruited at the LHD level. They are required to have kinship links to the local Aboriginal people living in that geographical area. Candidates selected for the program need to complete a three-year traineeship during which they work in a CMH service in the LHD under the supervision of senior staff while also undertaking a Bachelor of Health Sciences (Mental Health) degree at Charles Sturt University. On completion of this degree, they will be contracted into a full-time case management position (Watson & Harrison, 2009). Aboriginal MHWs are paid under the Aboriginal Health Education Officers Determination as either Aboriginal Health Education Officers – non-graduates or graduates.

In this study the term 'CMH health professionals' is used to denote a CMH workforce including both MH professionals and Aboriginal MHWs (both graduates and trainees). It is acknowledged that 'CMH professional' could have different meanings in countries other than Australia.

In terms of the composition of Australia's CMH workforce, there is no complete record available. However, it is possible, by drawing upon the 2008 workforce data included in the 2010 National

Mental Health Report (Australian Government) and Health Workforce Australia's (2013) inventory of Australia's MH workforce, to give rough estimates of the mix of each health worker group (although this data does not separate rural and metropolitan work settings). RNs (including mental health nurses who hold specialist qualifications in mental health nursing) comprise about three-quarters of Australia's CMH workforce and the allied health professions the other quarter. Within the allied health professions, psychologists and social workers comprise about one-third each of the CMH workforce and OTs one-sixth; the other one-sixth is drawn from range of allied health professions including counsellors, psychotherapists, family therapists and diversional therapists (Australian Government, 2010a).

Psychiatrists also play a key role in CMH teams. In rural CMH services, most psychiatrists are non-resident, and are fly-in, fly-out workers coming from capital or regional cities. Psychiatrists are usually designated the 'responsible clinician', having overall responsibility for CMH clients' care including admission, discharge, undertaking psychiatric assessments and medication reviews, and for overseeing the Community Treatment Order (CTO) provisions of the NSW Mental Health Act (MHA) 2007.

A CTO is a legal order made by the Mental Health Review Tribunal, providing for community-based treatment as an alternative to involuntary hospitalisation. It requires a person to accept medication, therapy, rehabilitation or other services for up to 12 months. The MHA makes provisions for the care of people who are admitted to hospital voluntarily (informal patient); are admitted to, or detained in hospital against their wishes (involuntary patient); are required to receive treatment under a CTO; and those who have committed a serious offence and are mentally ill (forensic patient). CMH services and the assignment of a case-manager is often the next step in care for informal and involuntary patients, and for persons on CTOs coming out of hospital. Most clients using CMH services are non-MHA clients and only a small number of clients are on CTOs.

Retention terminology

Recruitment is the process relating to the selection of staff to a particular service, team or role. Retention defines the length of time between commencement and termination of employment of

staff (Humphreys, Wakerman, Pashen, & Buykx, 2009; Humphreys et al., 2007). Turnover is commonly used to gauge retention and is a measure of staff terminations in a specified time period. The extent of staff turnover can also be seen as an indication of the extent of workforce flux (Rural Health West, 2013). An individual's thoughts about leaving and intention to quit – their turnover intention – have been found to be the strongest predictor of a decision to actually leave – turnover (Alexander, Lichtenstein, Oh, & Ullman, 1998). This group of retention-related terms is used interchangeably throughout this study.

Management terminology

In this study, participants primarily discussed management at one of two levels: either at the LHD/senior management level or at the service delivery level. In this study, the first group is described as senior management/managers and the latter group as service-level management/ managers.

Early career terminology

For the health workforce sector, an early career health professional has been defined by Eley et al. (2012) as the first five years of working in health after completing tertiary level qualifications. In this study the term 'early career' has been used to describe health professionals new to working in rural CMH services and pertaining to their work experiences in the first five years of holding such positions. This group may include: new health graduates and Aboriginal MHWs (both trainees and those qualified), health professionals with experience working in other areas of MH (for example in the private sector or public hospital MH inpatient wards), health professionals with experience working in clinical roles in fields other than MH and health professionals who have previously worked outside the health sector in non-clinical roles. There is no definition in common usage to cover this broad group of workers and so for this study, and in the interests of brevity for a key concept of the study, 'early career' was selected. Thus, when the term 'early career' is used it may refer both to health professionals who made a later career change into CMH as well as to new graduates starting their first health professional job in a CMH position.

Indigenous Australians – Aboriginal and Torres Strait Islander people

Indigenous Australians are people who identify as being of Aboriginal and/or Torres Strait Islander descent. In Australia, the term 'Indigenous' is primarily used by governments and for national data collection. In Australia's 2011 Census the Indigenous population was estimated to be 669,900, comprising three per cent of Australia's 22.34 million population (ABS, 2011). In NSW, Aboriginal people comprise nearly all (95 per cent) of the Indigenous people living in the state (ABS,2011). Many Aboriginal and Torres Strait Islander people are opposed to the term 'Indigenous', feeling that it generalises both cultures, as both have distinct histories and cultures (NSW Department of Community Services, 2009). For this study the term 'Aboriginal' is used unless quoting from or referencing a document where the term 'Indigenous' has been used.

1.5 Thesis structure

This thesis is structured into seven chapters. Chapter One provides an overview and sets the context for the study. It starts with an overview of the research problem and presents the study's research aims. I then introduced myself, including an account of my personal background and the career journey leading to undertaking this investigation. The chapter explains and defines terminology and classifications relevant to this study and concludes with this overview of the thesis by chapter.

Chapter Two introduces the context of the study. It presents the literature review. [Glaser and Strauss, the founders of GT in late 1960s, discouraged the conduct of a literature review before data collection. Arguing, from a positivist viewpoint, that by undertaking a literature review at the start of a research study, the researcher could potentially impose their preconceived ideas on the data and contaminate the emergence of an objective theory (Glaser & Strauss, 1967). Ramalho et al.'s (2015) paper argues that conducting the literature review prior to data collection in GT research is an epistemological stance. A constructivist GT methodological approach acknowledges the researcher's presence and accepts their subjectivity (Charmaz, 2014). Constructivist GT theorists argue that through the use of reflexive GT strategies, such as constant comparative method and memo writing, that the researcher will be able to prioritise the findings from the critical analysis undertaken over any prior assumptions the researcher holds such as those made resulting

from undertaking a literature review at the start of the study (Charmaz, 2014; Mills et al., 2006; Birks & Mills, 2011)].

The literature review undertaken comprises three areas: an overview of Australia's mental health workforce, factors impacting retention of Australia's rural-based CMH professionals, and key influences impacting turnover intention. It also explains the rationale for undertaking a pilot study.

Chapter Three discusses the pilot study undertaken with five NSW Health service-level managers running CMH services in rural towns in NSW. The publication paper entitled *Retention challenge facing Australia's rural community mental health services: Service manager's perspectives* (Cosgrave, Hussain, & Maple, 2015b) is included. The chapter contextualises the links between the existing literature, the findings from the pilot study, and the larger study that was undertaken.

Chapter Four introduces the theoretical orientation, methodological approach and research design used for this study. This chapter is divided into three sections, the first presenting the theoretical orientation underpinning the study, the second providing an overview of the methodological approach used, and the third concerning aspects and issues pertaining to the study's research design.

Chapter Five presents the findings in five sections. The first section deals with factors impacting the participants' professional satisfaction and the second with those affecting their personal satisfaction. The third section discusses the turnover intention of the participants. The basic social process identified is then presented in the fourth section and the chapter concludes with presentation of the substantive theory explaining turnover intention for this group of workers.

Chapter Six provides a discussion of the findings from the study. Two key findings areas are discussed with consideration to the existing research literature. These are the key factors identified as influencing the turnover intention theory and the factors identified as impacting retention of this group of workers.

Chapter Seven is the final chapter. It assesses whether the study answered the research question and study objectives and discusses the contribution the study makes to research and professional practice. It outlines a range of recommendations for reducing avoidable turnover of rural-based CMH professionals. The chapter concludes with an evaluation of the GT approach, discussion of the study's strengths and limitations and proposed future research directions.

2. Literature Review

This chapter is a review of the literature pertaining to the retention of rural-based CMH professionals and comprises three main sections: an overview of Australia's mental health workforce; factors impacting the retention of rural-based CMH professionals; and key influences impacting turnover intention identified from undertaking this study.

The review was undertaken over the three-and-a-half-year period of the PhD candidacy. The literature review included research reports and non-research based literature (grey literature). Specific inclusion and exclusion criteria were used to help focus and strengthen the review.

The overview of Australia's MH workforce mostly covered grey literature and included documentation that was published from 1993 to 2015. This period was selected to cover the period from the commencement of Australia's National Mental Health Strategy in 1993 and to allow for the inclusion of the findings from a report released in April 2015 from a comprehensive review of Australia's MH service system undertaken by National Mental Health Commission of Australia. The grey literature covered both Federal and NSW jurisdictions and included data, plans, reports, and evaluations from the Australian government, statutory bodies and Senate Committee reports.

The research literature on factors impacting the retention of Australia's rural-based CMH professionals' covered the period from 1993 to 2013 Given the paucity of literature found, the search was extended to include authors papers on retention of allied health professionals and RNs working in public health services in rural Australia.

The literature pertaining to the key factors identified in the turnover intention theory developed from the findings of this study covered the period from 1970 to 2014 and included both Australian and international authors. Table 2.1 (below) details these three sets of inclusion and exclusion criteria.

Table 2.1 Inclusion/exclusion criteria for research and non-research based literature

Non-research based literature: Australia's mental health workforce			
Restricted to Australia	Inclusion/exclusion criteria		Rationale
	Timeframe	1993-2015	This timeframe was decided on to capture the political and policy environment since the de-institutionalization of Australia's public sector MH service system
	Authors	1. Australian government 2. COAG 3. AIHW 4. ABS 5. NMHC 6. NSW MHC 7. AIHW 8. Senate papers	Relevant documents pertaining to the rural MH workforce

Research based literature: factors impacting retention of rural-based community mental health professionals			
Restricted to Australia	Inclusion exclusion criteria		Rationale
	Timeframe	1993-2013	A twenty year time period was thought relevant to capture the pertinent literature
	Authors	Published on factors impacting the retention of rural-based CMH professionals as well as allied health professionals and RNs working in rural public health services	Due to the paucity of literature by authors on factors impacting retention of rural-based CMH professionals, studies of allied health professionals and RNs were included as these groups of workers were considered likely to face many of the same challenges and thus help with identification of key impacting factors

Research based literature: aspects of turnover intention			
International and national research	Inclusion exclusion criteria		Rationale
	Timeframe	1970-2014	This time frame allowed for a broad reaching review of the literature
	Authors	Published on aspects identified as impacting turnover intention among rural-based CMH professionals	Studies relevant to the turnover intention aspects identified

2.1 Overview of Australia's rural mental health workforce

This section of the literature review presents an overview of Australia's rural MH workforce. It begins by outlining Australia's MH care system and the workforce including a review of Australia's federal and state governments' MH care and workforce policy approaches and the programs undertaken since 1993 under the framework of Australia's National Mental Health Strategy. The section concludes with an explanation of the CMH service delivery model and discusses the use of case management and interdisciplinary approaches.

Australia's mental health care system

Mental health care is a key component of Australia's health system. Australia's MH care system includes a broad range of services covering different life stages and levels of mental illness acuity involving a range of service focus points, ranging from prevention to intervention and recovery, delivered through hospital-based and in-community services (Australian Government: Department of Health and Ageing & PriceWaterhouse Coopers, 2011). A range of service providers operating in both the public and private sectors provide MH services. In the public sector, MH services include the provision of both inpatient and community-based services. Most in-patient services are delivered either in psychiatric wards in general public hospitals or, less commonly, in stand-alone psychiatric hospitals. Private sector MH services are delivered by psychiatrists, in private hospitals and through primary health care services provided by general practitioners (GPs).

Of the 38 per cent of adults and 25 per cent of children and young people in Australia seeking help for a mental disorder, the majority (77 per cent) will consult their GP; this will mostly relate to low acuity mental illnesses such as anxiety or depression (ABS, 2008). On the other hand, the public sector services are predominately used by people living with, or experiencing an episode of, high acuity mental illnesses such as schizophrenia, other psychotic disorders, bipolar disorders, other mood disorders and major depressions. Among this high acuity group, comorbidity is common and has been found to occur at higher rates in rural and remote areas of Australia (Australian Government: Department of Health and Ageing & PriceWaterhouse Coopers, 2011). A recent report produced by the Australian Institute of Health and Welfare (AIHW) on Australians' usage of MH services confirmed that rural Australians rely heavily on public sector CMH services (AIHW, 2014a). Aboriginal and Torres Strait Islander people access CMH services at a rate 3.2 times higher than the rest of the Australian population (AIHW, 2014b). This is not

surprising given that approximately two-thirds of Australia's Aboriginal people live outside its capital cities, with 22 per cent of Aboriginal and Torres Strait Islander people living in inner regional areas (147,700 people); 22 per cent in outer regional areas (146,100 people); eight per cent in remote areas (51,300 people) and around 14 per cent in very remote areas (91,600 people) (Australian Institute of Health and Welfare (AIHW), 2014b)

Mental health government policy and strategies

In late 1992 Australia's health ministers from the national, state and territory governments, working under the framework of the National Mental Health Strategy and the recently formed COAG, began collaborating to reform Australia's MH sector. Since then, this National Mental Health Strategy has 'steered a changing reform agenda over time, reflecting the evolution of MH policy considerations in Australia' (Department of Health and Ageing, 2010, p. 12). Under this strategy, four National MH Plans have been developed and endorsed by COAG's health ministers, the most recent being the Fourth National Mental Health Plan 2009–2014.

In 2006, in recognition of low rates of treatment for people with mental illness in Australia and the need to increase the capacity of treating services, COAG released a National Action Plan for Mental Health 2006–2011. Under this plan, COAG committed $1.9 billion over five years to implement 17 measures aimed at improving MH services. These measures included one program that specifically targeted rural and remote services (the Mental Health Service in Rural and Remote Areas Program) and others aimed at improving non-government, community-based services (the Better Access Program and the Mental Health Nurse Incentive Program). There were also a number of programs concerned with improving both the supply and quality of Australia's mental health workforce (for example, Additional Education Places, Scholarships and Clinical Training in Mental Health) (Australian Government, 2011).

In the last twenty years there has been much public discussion and media attention on the under resourcing of Australia's MH care system. In 2013 a group of MH sector experts produced a report arguing that, despite considerable investment by government in the MH service system over this period, the needs of people living with serious and/or persistent mental illness remain largely unmet (Mendoza et al., 2013). Public discontent has put pressure on the major political

parties to develop policies and to make budget pledges to improve MH services. Over the last ten years, when either party has been in government, steps have been taken to try to address many of the challenges and problems facing MH service provision by developing specific policies and budget allocations, as well as establishing commissions, advisory councils and working groups. For example, in 2011, the then ALP Australian Government formed the National Mental Health Commission (NMHC). The purpose of the NMHC was to monitor and evaluate Australia's MH system as a whole by working closely with consumers, carers and other stakeholders across all government jurisdictions (federal, states and the territories) (NHMC, 2015). To date, the focus of much of the NHMC's work has been on 'supporting individuals experiencing mental ill-health to lead a contributing life and to engage productively in the community' (NHMC, no date-b). To help progress this aim, in 2012 and 2013 the NMHC produced a national report card on mental health and suicide prevention in Australia entitled 'A Contributing Life' (NHMC, no date-a).

Health Workforce Australia (HWA) was also established by COAG in this period (in January 2011) as a Commonwealth Statutory Authority (HWA, no date). It was created to 'address the challenges of providing a skilled, flexible and innovative health workforce that meets the needs of the Australian community' (HWA, 2012, p. 32). One of HWA's strategic objectives was MH workforce reform and this involved three project areas: 1) mental health peer workforce project, 2) MH capabilities project, and 3) MH workforce study. Under the third project area, a MH workforce planning data inventory was developed (HWA, 2013). This inventory brought together data from a broad range of sources and attempted to provide the first comprehensive profile of Australia's MH workforce. A key purpose in developing this inventory was to better support MH workforce planning. In 2014, under the then newly elected LNC Federal Government, HWA was defunded and it officially closed down in August 2014, with essential functions being transferred over to the federal government's Department of Health.

More recently, the current government tasked the NHMC to conduct a national review of Australia's MH programs and services. Their report was submitted to the Federal Government in November 2014 and released in April 2015. The Review contained 25 recommendations across nine strategic directions to help guide reform of Australia's MH system over the next decade. While the report is comprehensive and its recommendations broad-reaching, some findings and

recommendations have particular relevance for this study and so are briefly discussed in the next paragraph.

The review found a high level of unmet need with respect to MH care in Australia's rural and regional communities and recommended addressing rural service inequities by supporting the development of innovative place-based models of care that can take into account community-specific issues (Recommendation10). The report found a significant MH gap between Aboriginal and Torres Strait Islander peoples compared to the general population and attributed this, in part, to MH services not being culturally appropriate. The Commission argued for more Aboriginal and Torres Strait Islander MH professionals and development of culturally appropriate services (Recommendations 18 and 21). The review attributed the skewed distribution of registered health professionals as contributing to the inequitable access to MH services in rural and remote Australia. It recommended the development of an expanded and more flexible workforce including clinical (medical and health professionals) and non-clinical staff and, in particular, the increased use of peer support workers. The Commission proposed that this expanded workforce be trained more extensively in MH knowledge and capabilities, and that service staffing be determined on competencies rather than professional categories.

Arguably the most significant recommendation in terms of impacts for Australia's rural CMH workforce was the proposal, using a staged approach, to reallocate $1 billion in Commonwealth acute hospital funding and to reinvest it in community and primary health care services. This recommendation was based on the Commission's identification of a 'missing middle' in MH service provision resulting from states and territories pulling back on their CMH service provision.

> The "missing middle" is causing enormous system failure, with people falling through the gap between GPs and primary health care on the one hand, and emergency departments and hospitals on the other hand.
>
> (NHMC, 2014, p. 33)

Subsequent to the release of the report, the Minister for Health, Sussan Ley, appointed a 13-member Expert Reference Group to guide the Australian Government in implementation of the report's recommendations. This group has been tasked to develop an action plan by October 2015.

The NMHC's review of Australia's MH services and programs perhaps also help to explain why a number of Federal Government and COAG MH plans are overdue and why no current workforce development strategies are in place at a national level. The search for a national document to use to compare the recommendations made in this study revealed that a key action under the Fourth National Mental Health Plan – to develop a National Mental Health Service Planning Framework – had not yet been completed. The most recent update concerning its progress was given in early 2014 by the project executive group tasked to develop the framework. This group advised that it was still waiting for the final report from NSW and, once received, expected it to take a further 6–12 months to finalise the framework (Senate Community Affairs Committee, 2014).

The fifth National Mental Health Plan has also been overdue since late 2012 when COAG released its 'Roadmap for National Mental Health Reform 2012–2022'. This roadmap outlines the reform directions Australia's governments will take over the next 10-year period and proposes six priority areas, including one relating to workforce development – Priority 5 (COAG, 2012). Priority 5 is concerned with improving access to high quality MH services and support, and includes two workforce development strategies – strategies 32 and 33. These workforce strategies concern: 1) improving the workforce service planning and capacity through the finalisation of the National Mental Health Service Planning Framework and by supporting this Framework as it evolves – Strategy 32; and 2) expanding the range of health professionals participating in the MH workforce and improving career pathways within the MH sector – Strategy 33 (COAG, 2012). A working group was established at the same time as the Roadmap was released and tasked to consider a successor for the Fourth National Mental Health Plan. This working group's findings were due to be given to the Federal Government in mid-2014, but at the time of writing this thesis have not yet been published, nor anything about their current status found.

With respect to the NSW government, it has its own state-based Mental Health Commission. In late 2013 this Commission released a strategic plan for MH in NSW entitled 'Living Well: A Strategic Plan for Mental Health in NSW 2014-2024'. The plan laid out the directions and principles for reform of the NSW MH sector (NSW Mental Health Commission, 2013). In this document, workforce development issues were only very broadly discussed and no other documents, reports or plans specifically dealing with MH workforce reform or development were identified for NSW.

Community mental health service delivery model

The de-institutionalisation of Australia's public sector MH services heralded significant changes in the MH service delivery model, including the closure of many stand-alone psychiatric hospitals and a general shift towards community-based service provision. This change impacted strongly upon the MH workforce, substantially changing its staff mix, work roles and relationships. With the reform of Australia's public sector community MH services, case management and interdisciplinary approaches to client care were adopted. These interdisciplinary and case management approaches are defined and explained in the following paragraphs.

An interdisciplinary approach involves health professionals drawn from a range of professions who work together to provide integrated care to meet the needs of clients (King, 2009). In particular, an interdisciplinary team approach involves health professionals contributing their profession-specific skills and knowledge to support clients to live as full and productive lives as possible – or, using the parlance of the NMHC, to have 'contributing lives' (Hall & Weaver, 2001). In Australia, the adoption of an interdisciplinary approach to CMH services saw the entry of university trained allied health professionals into CMH services, previously predominately the domain of hospital trained psychiatric nurses (Roche & Duffield, 2007).

Case management is the service approach used in Australia's public CMH services (King, 2009). A case management approach involves meeting the complex health and social care needs of CMH clients through the application of an interdisciplinary approach that 'cuts across professional affiliations to place the patient in the community as the focus' (Lloyd, King, & McKenna, 2004, p. 120). In Australia, CMH caseworker positions are held by a range of health professionals drawn from a broad group of disciplines including RNs, psychologists, social workers and OTs, as well as Aboriginal MHWs (HWA, 2013).Working in generic caseworker roles requires health professionals to work outside their area of professional knowledge and to develop MH knowledge and skills (Lloyd, King, & Bassett, 2002). This generic casework approach has been associated with role-blurring, skills generalisation and lack of validation and/or understanding of discipline-specific skills and approaches by other team members (Ceramidas, 2010).

CMH's interdisciplinary workforce and case management approach has been linked to some significant workplace and professional challenges including: conflicts over models of care and challenges to decision making (Ashby, Ryan, Gray, & James, 2013; Ziguras, Henley, Conron, & Catford, 1999); role confusion and de-specialisation of the health professions (Ceramidas, 2010; Gibb, Livesey, & Zyla, 2003; Lloyd, King, & Bassett, 2002; Scanlan, Still, Stewart, & Croaker, 2010); horizontal bullying, especially among nurses (Hazelton, Rossiter, Sinclair, & Morrall, 2011); and gaps in university training compared to the actual skills needed in the workplace (Roche & Duffield, 2007; Wynaden, Orb, McGowan, & Downie, 2000).

Section summary

This section aimed to set the scene by providing an overview of Australia's MH service system and the reform that has taken place over the last 30 years, especially with regard to workforce and, in particular, the CMH workforce. The interdisciplinary and case management approach used in CMH services were explained.

After undertaking a general review of the literature on Australia's rural mental health workforce, it was decided to focus this study on factors impacting retention among CMH professionals employed in Australia's rural public sector CMH services. This study topic was determined based on an assessment of its potential usefulness. It was thought that such a study could provide useful findings for a broad range of MH service stakeholders including clients, staff and public health sector providers. Factors taken into account included: 1) the heavy reliance upon community MH services in Australia's rural communities, particularly for those people living with serious and/or persistent mental illness; 2) the severe staffing challenges facing Australia's rural CMH services, in particular high staff turnover.

Having identified the research problem and a possible gap in the knowledge base, the next step was to undertake a more in-depth review of the literature. This was done by undertaking a systematic review of peer-reviewed literature on factors impacting retention of CMH professionals working in rural Australia, which is discussed in the next section.

2.2 Factors impacting retention of Australia's rural-based community mental health professionals

This section presents the literature on factors impacting retention of Australia's rural-based CMH professionals. The literature search commenced with a systematic review, followed by a snowballing and saturation approach. Five electronic databases were searched (CINAHL, MEDLINE, PsycINFO, Health and Medicine, and Health Collection) using the search terms 'mental health services', 'workforce/personnel', 'recruitment', 'retention' and 'Australia'. The search was restricted to peer-reviewed publications in academic journals with full-text availability. The search was also restricted to articles published in the English language, but was thought unlikely to impact the data yield given the focus was on the Australian context and most papers on the topic were likely to be in English. Where the databases allowed, the search was also restricted to publications in the geographical location of Australia/Australasia.

An initial search of the databases yielded 156 articles – 62 (CINAHL), 66 (MEDLINE), 4 (PsycINFO), 8 (Health and Medicine) and 16 (Health Collection) – and then four duplicates were removed, leaving 152 articles. Studies were then assessed against the eligibility criteria for inclusion. The criteria were: 1) the study reported on original research; 2) the study focussed on health professionals working in Australia's public sector CMH services (or included both inpatient and community based services); 3) the study focused on participants working in Australia's rural and regional areas (or national or state-wide studies that included rural and regional areas); and 4) the study focused on factors impacting on retention (or both recruitment and retention). These criteria were first applied to the title and abstract of each article, resulting in the exclusion of 127 articles. Full manuscripts of the remaining 25 articles were then read and assessed against the eligibility criteria, leaving six eligible articles (Ashby et al., 2013; Ceramidas, 2010; Henderson, Willis, Walter, & Toffoli, 2008; Moore, Sutton, & Maybery, 2010; Scanlan et al., 2010; Wolfenden, Blanchard, & Probst, 1996). Where an article's eligibility was uncertain, supervisors also checked it. Given the limited research found, a hand-search snowballing approach was followed commencing with the reference lists of the six papers identified. This yielded an additional eight papers (Crowther & Ragusa, 2011; Drury et al., 2005; Gibb et al., 2003; Lloyd, King, & Bassett, 2002; Perkins et al., 2007; Ragusa & Crowther, 2012; Scanlan, Meredith, & Poulsen, 2013; Ziguras et al., 1999), bringing the total number of eligible papers to 14 – drawn from 13 studies (see Figure 2.1: Flowchart of systematic literature review process).

This literature review complies with the PRISMA Statement (Moher, Liberati, Tetzlaff, & Altman, 2009) and was separately published (Cosgrave, Hussain, & Maple, 2015a) .

Given the paucity of literature yielded from this systematic review, it was decided to also include literature on factors impacting the retention of allied health professionals and RNs working in Australia's rural-based public health services. These two professional groups were thought likely to face many of the same challenges as the rural-based CMH professionals (Wright, Lavoie-Tremblay, Drevniok, Racine, & Savignac, 2011). From this expanded search, a further ten papers were identified from nine studies (Bragg & Bonner, 2014; Buykx, Humphreys, Wakerman, & Pashen, 2010; Gillham & Ristevski, 2007; Hegney, McCarthy, Rogers-Clark, & Gorman, 2002; Keane, Lincoln, & Smith, 2012; Lea & Cruickshank, 2007; Mills & Millsteed, 2002; O'Toole, Schoo, & Hernan, 2010; Stagnitti, Schoo, Dunbar, & Reid, 2006; Stagnitti, Schoo, Reid, & Dunbar, 2005).

The rest of this section presents the findings from these selected papers. The findings are presented under the categories 'organisational', 'role' and 'personal' and identified as being either a push and/or pull factor on deciding to leave or stay in a job. Before presenting the findings, the framework used to analyse and present these results will be discussed. This includes the source and basis for using the three categories (organisational, role and personal), the push/pull classification, the process used to determine the 13 broad themes identified and their categorisation under the three categories. The themes and their particular findings under each of the category headings are then discussed. Each category concludes with a summary table of the findings in the research literature.

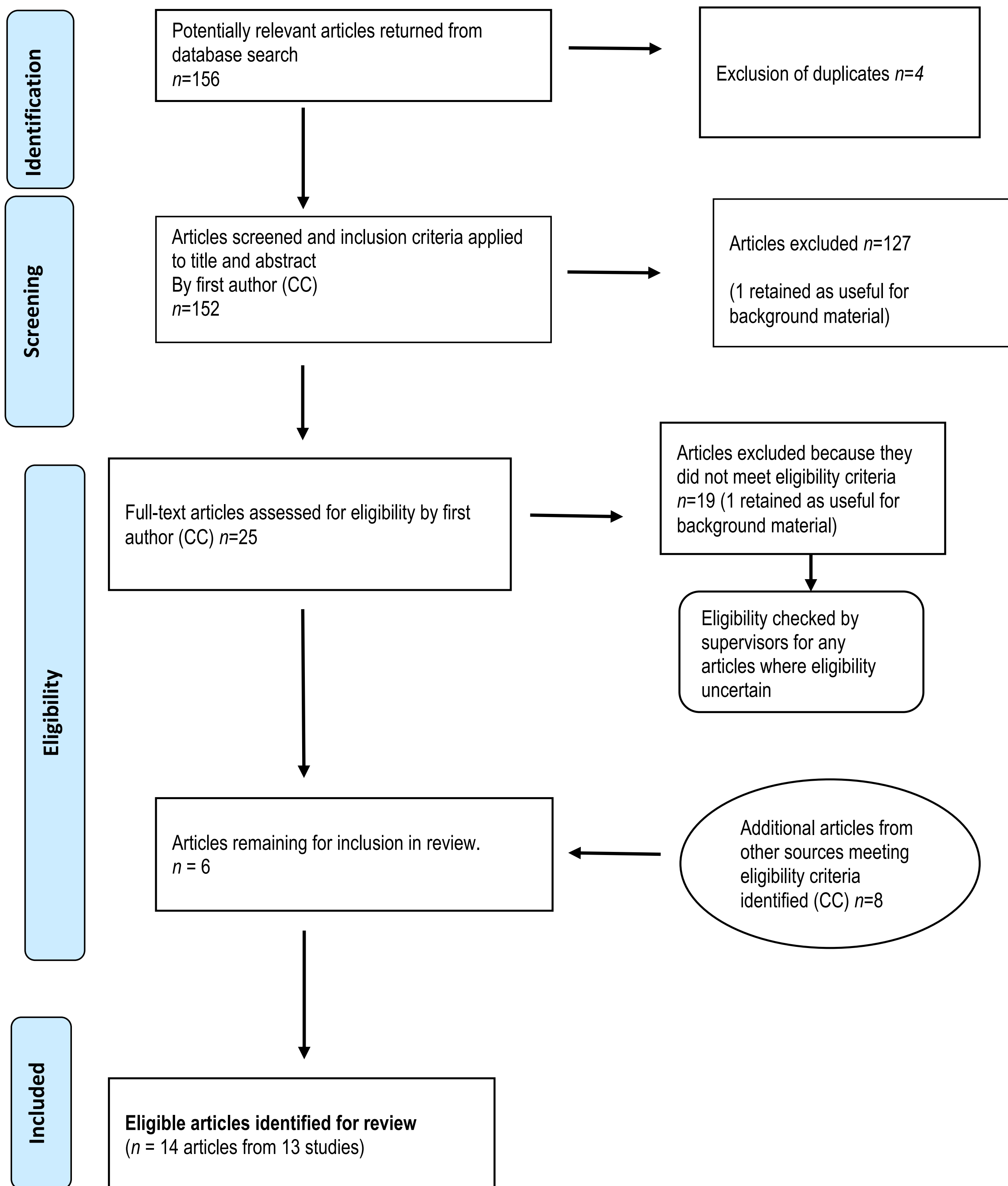

Figure 2.1 – Flowchart of systematic literature review process

Framework used to analyse and present findings

It is well established in health workforce studies that factors impacting retention of health professionals are multifactorial, involving both personal and work-related influences (Buykx et al., 2010; Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2005; WHO, 2010). The three categories used to synthesise and present the findings draw on the categories and definitions developed by Brown et al. (2013). They defined these categories as follows: organisational – variables within the organisation's power to change or influence their staff work-life; role – variables inherent in the health workers' role; and personal – considerations by the health worker relating to their beliefs, personal life and experience. Some health workforce studies investigating recruitment and retention categorise these impacting factors with respect to whether they are a 'push' factor to leave the job, or a 'pull' factor to take a job or stay in the job – for example, (Keane et al., 2012; Scanlan et al., 2010). This push/pull categorisation has also been used to assess and present the findings for this literature.

Content analysis was used to synthesise the papers' findings by categorising the identified factors impacting retention into broad themes and then grouping each broad theme with the three categories. Using this approach, thirteen broad themes concerning factors influencing retention of rural-based CMH professionals were identified. These included resourcing – fiscal and human; feeling valued and supported by management; rural service approach and career building opportunities; organisation – system, culture and values; workload; span of role; team values and culture; career planning and development; personal values, interests and life stage; work/life balance; social connections; kinship/family; and job satisfaction.

With regard to their categorisation, while some themes were conceptualised as being unique to one category (either organisational, role or personal), other factors were conceptualised as influencing retention in more than one category. For example, 'feeling valued and supported by management' was categorised as both an organisational and a role factor and 'job satisfaction' appeared under all three categories. Table 2.2 (below) provides a summary of the thirteen broad themes and their categorisation.

With respect to the push and pull categorisation, some factors were identified as having a positive pull effect and the opposite experience a negative push effect – for example, job satisfaction (pull) and job dissatisfaction (push). In these situations, the factors have been categorised as 'push/pull', and the negative experience denoted in brackets.

Table 2.2 – Broad themes identified in the literature and their categorisation

Theme no.	Broad themes	Categories		
		Organisational	Role	Personal
1	Resourcing – fiscal and human	✓		
2	Feeling valued and supported by management	✓	✓	
3	Rural service approach and career building opportunities	✓		✓
4	Organisation – system, culture and values	✓		
5	Workload		✓	
6	Span of role		✓	
7	Team values and culture		✓	
8	Career planning and development	✓	✓	✓
9	Personal values, interests and life stage			✓
10	Work/life balance			✓
11	Social connections			✓
12	Kinship/family			✓
13	Job satisfaction	✓	✓	✓

A summary table of the literature discussed in relation to each of the three category areas is included at the end of each section (Table 2.3 Organisational factors, Table 2.4 Role factors, Table 2.5 Personal factors. The listing indicates whether the factor was sourced from the papers selected from the CMH workforce literature or the more generalised rural health workforce literature. The purpose of the summary table is twofold: firstly to provide a concise listing of the key findings from the literature with respect to impacting factors on retention; and secondly to support the subsequent discussion that compares the findings from this study with the existing literature.

Organisational factors

Under this heading, the themes 1 – 4 will be discussed. These cover: 1) resourcing – fiscal and human; 2) feeling valued and supported by management; 3) rural service approach and career building opportunities; and 4) organisation – system, culture and values (Table 2.3 Organisational factors).

1. Resourcing – fiscal and human

Australia's rural health workforce is generally characterised as having inadequate resourcing (Keane et al., 2012) and experiencing widespread chronic staff shortages (Bragg & Bonner, 2014; Buykx et al., 2010). Recruitment and retention studies undertaken with staff working in Australia's rural health services reveal that these resourcing constraints often make it difficult to provide adequate clinical services to patients/clients (Ceramidas, 2010; Keane et al., 2012; Lea & Cruickshank, 2007). Rural CMH services have been identified as experiencing very severe workforce issues arising from both chronic staffing shortages and high staff turnover (Ceramidas, 2010; Henderson et al., 2008; Moore et al., 2010; Ragusa & Crowther, 2012). In Henderson and colleagues' (2008) study, undertaken with a group of South Australian CMH nurses, these chronic staffing shortages were identified as being a major issue impacting on workload. However, even though rural CMH services were greatly affected by resourcing constraints, rural positions were still viewed by health professionals as a good career-building opportunity (Perkins et al., 2007).

2. Feeling valued and supported by management

An often-identified factor for health professionals deciding to leave their rural job was if they did not feel valued and/or supported by management – at both the senior and service levels. Keane et al., (2012), defined the senior level of management as those people in the organisation responsible for resource management, setting the strategic direction of the service and determining the service model/approach taken. Keane and colleagues (2012) described the responses they received with respect to feeling supported by management from rural-based allied health professionals as being 'highly charged'. Feeling unsupported or not understood by management was described in various ways, but generally involved feeling that management did not understand the difficulties encountered operating in a rural service environment and, with respect to CMH workers, the demands of such jobs (Buykx et al., 2010; Gillham & Ristevski, 2007; Keane et al., 2012; Moore et al., 2010; O'Toole et al., 2010; Perkins et al., 2007; Stagnitti et al., 2006; Wolfenden et al., 1996). Keane et al. (2012) noted that rural allied health professionals often mentioned that a major source of their frustration with senior management was the restrictions they placed on the recruitment of vacant positions (due to the imposition of staffing freezes). Also identified in the rural health literature as being important for respecting their line manager were such things as respecting the clinical competency of the manager (Keane et al., 2012), being given an adequate orientation (Stagnitti et al., 2005), having a clear job description (Stagnitti et al., 2005), and access to the service manager being close – ideally on-site and face-to-face (Stagnitti et al., 2006).

There were a few factors consistently mentioned and emphasised in both the MH and rural practice literature with respect to health professionals feeling valued and supported by their line and/or clinical managers. These involved having the manager's support to undertake continuing professional development (CPD) and having regular clinical supervision and access to on-going professional support (Ashby et al., 2013; Buykx et al., 2010; Crowther & Ragusa, 2011; Drury et al., 2005; Keane et al., 2012; O'Toole et al., 2010; Perkins et al., 2007; Stagnitti et al., 2006; Stagnitti et al., 2005; Wolfenden et al., 1996).

Participants in Keane et al.'s (2012) study viewed management support for regular participation in CPD activities as being 'a proxy of overall management support' (p. 7). They found that even when line managers were supportive of their staff participating in CPD activities, rural resourcing constraints and staffing problems created major challenges. These difficulties were identified as including: not having sufficient budget allocation to pay for health professionals to attend CPD courses; and being unable to give staff time off to attend CPD because of staffing shortages and/or work demands.

3. Rural service approach and career building opportunities

Related to the fiscal and human resourcing constraints found in rural health services, health professionals working in these services described managing high levels of responsibility and having to build a broad base of skills to meet the wide range of patient/client demands. This resulted in the use of the term 'specialist generalist' to describe the unique skill set required by health professionals working rurally (Hegney, 1996). The opportunity to build these broad-based skills is often a key attractor for health professionals to take a rural health position, particularly among those early in their health careers (Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2005). This was highlighted by Keane et al. (2012) in their retention study conducted with allied health professionals working in rural NSW. They found that among those who were less experienced, a major motivation for them taking a rural position was the perceived opportunity to progress more quickly within NSW Health than in a metropolitan job.

Participants in two of the rural MH studies included (Drury et al., 2005; Perkins et al., 2007) described thinking that their rural jobs were harder than those of MH professionals working in metropolitan areas. This assessment can partly be attributed to the challenges of working in a rural environment. This includes such things as smaller team sizes (compared to metropolitan or larger regional centres) and a reduced range of professional disciplines within the teams.

In addition to the difficulties posed by the rural health service environment, CMH was found to have its own set of challenges and rewards impacting on the job satisfaction of its workers. The interdisciplinary and case management approach that underpins CMH service delivery was identified as an attractor for taking a CMH job (Ashby et al., 2013; Ceramidas, 2010; Scanlan et al., 2010). However, the interdisciplinary work model was also found to pose challenges. These were well described by a participant in the Ashby et al., study (2013) investigating professional resilience among OTs working in MH practice: 'We dilute our skills because we're actually trying to do our job and a range of other people's jobs at the same time' (p. 114). Given this service approach, CMH professionals described having to mostly work outside their discipline-specific viewpoint and skill set to perform a broad range of generic duties as well as having some, but significantly fewer, profession-specific responsibilities (King, 2009).

4. Organisation – system, culture and values

Another source of frustration, expressed by both MH and rural health professionals, was having to work in an environment that was impacted on by 'unending organisational change and restructuring' (Ziguras et al., 1999, p. 58). In developing their rural workforce retention framework, Buykx et al. (2010), emphasised the importance of health professionals feeling they were working in an effective and sustainable workplace and this required management to be visionary, strategic and efficient. Poor management communication was also often mentioned by health professionals as being a major factor contributing to their intention to leave (Bragg & Bonner, 2014; Buykx et al., 2010; Gillham & Ristevski, 2007; Hegney et al., 2002; Stagnitti et al., 2005). Perkins et al., (2007) investigated job satisfaction and retention among rural CMH professionals and found one of the lowest satisfaction scores was for 'the way the firm was managed' (p. 95).

Table 2.3 – Summary: organisational factors influencing retention of Australia's rural-based community mental health professionals

Broad theme no.	Broad themes	Findings no.	Push or pull effect	Particular Findings	Australian mental health workforce literature	Australian rural health workforce Literature
Category 1: Organisational factors						
1	Resourcing – fiscal & human	1	Push	Inadequate resourcing of clinical services.	(Ceramidas, 2010)	(Keane et al., 2012; Lea & Cruickshank, 2007)
		2	Push	Chronic staff shortages: unfilled positions, high staff turnover (a major contributor to job dissatisfaction).	(Ceramidas, 2010; Henderson et al., 2008; Moore et al., 2010; Ragusa & Crowther, 2012)	(Bragg & Bonner, 2014; Buykx et al., 2010)
2	Feeling valued and supported by management	3	Pull	Being given an adequate orientation.		(Buykx et al., 2010; Stagnitti et al., 2005)
		4	Pull	Having a clear job description.		(Lea & Cruickshank, 2007; Stagnitti et al., 2005)
		5	Pull (push)	Management providing/arranging clinical supervision and professional support (discipline-specific) for staff.	(Ashby et al., 2013; Crowther & Ragusa, 2011; Drury et al., 2005; Perkins et al., 2007; Wolfenden et al., 1996)	(Buykx et al., 2010; O'Toole et al., 2010; Stagnitti et al., 2006; Stagnitti et al., 2005)
		6	Pull (push)	Management supporting staff (or not) to undertake CPD and having networking opportunities.	(Ashby et al., 2013; Crowther & Ragusa, 2011; Drury et al., 2005; Perkins et al., 2007; Wolfenden et al., 1996)	(Buykx et al., 2010; Keane et al., 2012; O'Toole et al., 2010)
		7	Pull (push)	Management both senior and line manager having an adequate understanding of and respect for (or not) the rural operational context, work roles.	(Moore et al., 2010; Perkins et al., 2007; Wolfenden et al., 1996)	(Buykx et al., 2010; Gillham & Ristevski, 2007; Hegney et al., 2002; Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2006)
		8	Pull	Having on site or close access to line manager.		(Bragg & Bonner, 2014)

Broad theme no.	Broad themes	Findings no.	Push or pull effect	Particular Findings	Australian mental health workforce literature	Australian rural health workforce Literature
3	Rural service approach & career building opportunities	9	Push	Negative impacts resulting from generic casework approach. Working outside professional domain/role blurring/skill generalisation. Lack of opportunities to use/develop discipline specific skills and issues with role identity formation.	(Ashby et al., 2013; Ceramidas, 2010; Gibb et al., 2003; Lloyd, King, & Bassett, 2002; Scanlan et al., 2010; Ziguras et al., 1999)	(O'Toole et al., 2010)
		10	Push	Small team sizes – absence of other profession-specific peers, especially impacting allied health professionals.		(O'Toole et al., 2010)
		11	Pull	Opportunity to build/enhance clinical skills to step-up and take on greater responsibility by managing a broad caseload mix commonly found in rural settings – practicing as a 'specialist generalist'.	(Drury et al., 2005)	(Keane et al., 2012; O'Toole et al., 2010)
		12	Pull	Opportunity to fast-track career (accelerated promotion pathway for new graduates) or advance career by taking a more senior role.	(Perkins et al., 2007)	(Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2005)
4	Organisation – system, culture & values	13	Push	Constant organisational change/restructures.	(Scanlan et al., 2010; Ziguras et al., 1999)	(Bragg & Bonner, 2014; Keane et al., 2012)
		14	Pull (push)	Effective management (or lack of it) providing supportive structures, visionary leadership, strategic direction and a positive workplace culture. Importance of clear communication.		(Bragg & Bonner, 2014; Buykx et al., 2010; Gillham & Ristevski, 2007; Hegney et al., 2002; Stagnitti et al., 2005)
		15	Push	Poor integration of services between hospital departments (contributing to workload).	(Henderson et al., 2008)	

Role factors

The broad themes 5–7 will be discussed under this heading. These cover: 5) workload, 6) span of role, and 7) team values and culture (Table 2.4 Role factors).

5. Workload

The published literature reveals that CMH professionals' workloads are impacted upon by the nature of the work. Having to manage clients' disruptive behaviours –such as client aggression, poor insight, and poor compliance with treatment/medication and service avoidance – was mentioned as a factor that increased workloads (Henderson et al., 2008). Another commonly mentioned factor relating to the MH role was the heavy paperwork burden (Gibb et al., 2003; Henderson et al., 2008; Moore et al., 2010; Perkins et al., 2007). The more remote the CMH service, the greater many of these workload/work role challenges and, in the smaller and/or more remote services, CMH professionals described having to perform extra duties such as running outreach clinics, visiting clients in their homes (Henderson et al., 2008; Perkins et al., 2007); and/or performing MH assessments for the hospital's emergency department (Drury et al., 2005; Henderson et al., 2008). These big workloads commonly associated with rural CMH jobs were strongly linked to job dissatisfaction, burnout and high staff turnover (Ceramidas, 2010; Drury et al., 2005; Lloyd, King, & Bassett, 2002; Perkins et al., 2007).

6. Span of role

In the MH literature, three major role factors were identified as having negative impacts on the retention of rural CMH professionals. These were: the increased acuity and frequent comorbidity of rural clients (Crowther & Ragusa, 2011; Drury et al., 2005; Gibb et al., 2003; Henderson et al., 2008; Perkins et al., 2007; Ragusa & Crowther, 2012); the low level of other MH support services operating in rural areas (Crowther & Ragusa, 2011; Drury et al., 2005; Henderson et al., 2008; Perkins et al., 2007; Ragusa & Crowther, 2012; Ziguras et al., 1999); and having to manage heavy workloads (Crowther & Ragusa, 2011; Drury et al., 2005; Lloyd, King, & Bassett, 2002; Perkins et al., 2007; Scanlan et al., 2010).

High acuity and low levels of other support services places pressure on Australia's rural CMH professionals to provide clients with multifaceted care. As a participant in Crowther and Ragusa's (2011) study explained:

> We have a lot more social problems, complex diagnoses, mixed diagnoses, dual diagnoses, and limited services, and also … a lot of personality issues
> (p. 516).

Henderson et al. (2008) reported that CMH nurses discussed the complexity of care required to manage clients with dual diagnoses (for example, substance misuse, dementia, intellectual disability). CMH professionals working in smaller rural towns also described sometimes choosing to manage unwell clients in the community rather than admitting them if the admission involved travel, as that was often traumatising (Henderson et al., 2008). Henderson (2008) also identified having clients on CTOs created additional stress for CMH workers because these clients were often compliant resistant and involved additional paperwork. Ragusa and Crowther (2012) attributed this increased mental illness acuity of clients in the rural setting to increased workloads.

The resourcing constraints of rural service environments on the workloads of CMH professionals were also linked to new graduates feeling pressured to quickly take on full caseloads (Drury et al., 2005; Henderson et al., 2008); longer-term staff being expected to orient/supervise new team members (Henderson et al., 2008); and having to manage excessively large caseloads (Drury et al., 2005; Gibb et al., 2003).

7. Team values and culture

In managing the practice realities of rural CMH jobs – for example, heavy workloads, challenging clients and resourcing constraints – workers often stressed the importance they placed on having the support of colleagues and team cohesion (Ragusa & Crowther, 2012; Scanlan et al., 2010). The shared work experience was mentioned as a significant aspect of team cohesion, as explained by a participant in Ragusa and Crowther's (2012) study:

> Nobody understands this job except your colleagues. You can't share it with somebody who doesn't know what it's about
> (p. 49).

However, when team dynamics were experienced as dysfunctional (Scanlan et al., 2010) or workplace politics negative (Perkins et al., 2007) CMH professionals often gave these as a major reason for intending to leave the job.

The MH literature also identifies differences in workloads between the different professions that work in CMH teams. For example, in Henderson et al.'s (2008) study, nurse participants spoke of feeling that, because they could administer medications, they were given the more complex clients to manage compared to the allied health professionals in the team. The case management approach and interdisciplinary model were also described as negatively impacting on team dynamics. The literature published on this issue identified health professionals not feeling that other team members recognised or respected their specialist skill set or the approach of their particular profession – OTs in particular made mention of this (Ashby et al., 2013; Crowther & Ragusa, 2011; Lloyd, Bassett, & King, 2002).

Ashby et al. (2013) identified that, because of the interdisciplinary approach of CMH, OTs working in these services often felt pressured to adopt techniques and approaches that lay outside their specialities – for example, a bio-medical approach, psychological theories and occupation focussed models). This was found to negatively impact on a health professional's successful transition to the job as well as their longer term job satisfaction (Ashby et al., 2013; Ziguras et al., 1999).

Table 2.4 – Summary: role factors influencing retention of Australia's rural-based community mental health professionals

Broad theme No.	Broad theme	Finding no.	Push or pull effect	Particular Findings	Australian mental health workforce literature	Australian rural health workforce Literature
Category 2: Role factors						
5	Workload	16	Push	Pressure on new graduates to take on full caseload quickly.	(Henderson et al., 2008)	(Lea & Cruickshank, 2007)
		17	Push	Expectation to supervise/educate new team members.	(Henderson et al., 2008)	
		18	Push	Heavy workloads and burnout.	(Drury et al., 2005; Lloyd, King, & Bassett, 2002; Perkins et al., 2007; Scanlan et al., 2010)	(Keane et al., 2012)
		19	Push	Large caseload numbers.	(Drury et al., 2005; Gibb et al., 2003)	
		20	Push	Managing challenging clients.	(Henderson et al., 2008)	
		21	Push	Paperwork burden – extra requirements arising from legislative requirements, and managing litigation risk.	(Gibb et al., 2003; Henderson et al., 2008)	(Gillham & Ristevski, 2007; Keane et al., 2012)
		22	Push	Travelling required to service clients	(Henderson et al., 2008; Perkins et al., 2007)	(O'Toole et al., 2010)
6	Span of role	23	Push	Being the hospital 'go to' person for mental health issues.	(Drury et al., 2005)	
		24	Push	Low level of other support services.	(Crowther & Ragusa, 2011; Drury et al., 2005; Henderson et al., 2008; Perkins et al., 2007; Ragusa & Crowther, 2012; Ziguras et al., 1999)	
		25	Push	Managing increased client complexity/acuity role.	(Crowther & Ragusa, 2011; Drury et al., 2005; Gibb et al., 2003; Henderson et al., 2008; Perkins et al., 2007; Ragusa & Crowther, 2012)	

Broad theme No.	Broad theme	Finding no.	Push or pull effect	Particular Findings	Australian mental health workforce literature	Australian rural health workforce Literature
Category 2: Role factors						
7	Team values & culture	26	Push	Workplace hostility, staff bullying and horizontal violence.		(Lea & Cruickshank, 2007)
		27	Push	Differences between professions in case allocation/caseloads.	(Henderson et al., 2008)	
		28	Push	Dominance of a health model/service approach different from health professionals.	(Ashby et al., 2013; Ziguras et al., 1999)	
		29	Push	Lack of understanding/ respect of profession-specific approaches by other health professionals.	(Ashby et al., 2013; Lloyd, King, & Bassett, 2002)	
		30	Pull (push)	Team cohesion and support from colleagues.	(Ragusa & Crowther, 2012; Scanlan et al., 2010)	(Buykx et al., 2010; Stagnitti et al., 2005)

Personal factors

The broad themes 8-13 will be discussed under this heading. These cover: 8) career planning and development; 9) personal values, interests and life stage; 10) work/life balance; 11) social connection; 12) kinship/family; and 13) job satisfaction (Table 2.5 Personal factors).

8. Career planning and development

The literature identifies health professionals being drawn to CMH because they perceive the work as both interesting and rewarding (Ragusa & Crowther, 2012; Scanlan et al., 2010). In both the MH and rural practice literature, the most common reason given for leaving a rural position was lack of career opportunities in the rural practice environment (Buykx et al., 2010; Drury et al., 2005; Keane et al., 2012; Lloyd, King, & Bassett, 2002; O'Toole et al., 2010; Perkins et al., 2007; Scanlan et al., 2010; Stagnitti et al., 2006; Stagnitti et al., 2005). Wanting to have greater access to profession-specific CPD and more opportunities for networking with peers was also commonly cited as the reason for leaving a rural position (Mills & Millsteed, 2002).

9. Personal values, interests and life stage; 11. Social connection; and 12. Kinship family

In both the rural practice and MH literature, a major pull factor for a health professional to take a rural position is that they had extended family living in the town or other pre-existing personal connections. These connections continue to act as a strong pull factor for choosing to remain in a rural health job (Keane et al., 2012; O'Toole et al., 2010; Perkins et al., 2007; Stagnitti et al., 2005; Wolfenden et al., 1996). For those health professionals who move rurally to take up a health position, enjoyment of the rural lifestyle and environment have been found to be an initial pull factor (Keane et al., 2012; Mills & Millsteed, 2002; Perkins et al., 2007; Stagnitti et al., 2005; Wolfenden et al., 1996). Health professionals' life-stage/life experience, in particular wanting to raise a family or being young and single and wanting to travel and/or live elsewhere, were also identified as impacting retention (Keane et al., 2012).

The rural health studies show that, among the health professionals who have moved from elsewhere, as they become more embedded in the community and establish social connections in the town, this acts as a strong influence on their retention (Keane et al., 2012; O'Toole et al.,

2010). However, other health professionals associated the rural work experience with feelings of personal isolation, cultural strangeness and linked these with intending to leave a rural position (Lea & Cruickshank, 2007; O'Toole et al., 2010; Stagnitti et al., 2006). Lea and Cruikshank (2007) describe the impact of social cliques on new graduate nurses drawn from other places and working in rural-based public sector hospitals as follows:

> Staff in rural communities often have worked together for a number of years, may have trained together, may have partners who work together and even have children who play together, leading to social cliques forming around their work relationships. This unique element of rural nursing is uncommon in larger healthcare facilities
>
> (p. 5).

10. Work/life balance

Many studies investigating health professionals' reasons for leaving a rural position attribute personal commitments and/or family responsibilities as being a major push factor (Buykx et al., 2010; Hegney et al., 2002; Mills & Millsteed, 2002; Perkins et al., 2007). This includes the town or community not meeting the needs of other household members – in terms of such things as schooling, accommodation, spousal employment, and access to services, for example. (Buykx et al., 2010; Keane et al., 2012; Mills & Millsteed, 2002). The lack of anonymity and privacy arising from working in small health teams and living in small communities was also found to impact negatively on the retention of rural health professionals (Lea & Cruickshank, 2007).

13. Job satisfaction

The CMH literature identifies that health professionals value the opportunity to work closely with clients and their families and find it satisfying to play a hands-on role in clients' recoveries (Perkins et al., 2007). This commitment to the field of work appears to be enduring, and is often cited as being a key reason for CMH professionals staying in a rural position, as is the variety of work and autonomy in choosing the way of working (Perkins et al., 2007; Wolfenden et al., 1996). Therefore, despite the challenges of the job, most rural CMH professionals express enjoyment working in the field and experience high levels of job satisfaction (Scanlan et al., 2013).

Professional isolation was often mentioned by CMH professionals working in rural services, and especially by those working in the more remote services (Drury et al., 2005; Gibb et al., 2003; Moore et al., 2010; Wolfenden et al., 1996; Ziguras et al., 1999). Keane et al. (2012) found that the professional isolation of allied health professionals working rurally was addressed by regular access to CPD. However, the literature describes rural health professionals facing significant barriers in accessing CPD, given both practice and resourcing constraints. This lack of access to CPD among rural health professionals has been strongly linked to job dissatisfaction (Buykx et al., 2010; Drury et al., 2005; Gibb et al., 2003; Keane et al., 2012; Moore et al., 2010; Wolfenden et al., 1996; Ziguras et al., 1999).

Table 2.5 – Summary: personal factors influencing retention of Australia's rural-based community mental health professionals

Broad Theme no.	Broad theme	Finding No.	Push or pull effect	Particular Findings	Australian mental health workforce literature	Australian rural health workforce Literature
Category 3: Personal factors						
8	Career planning and development	31	Pull	Altruism – wanting to make a difference, interest in pursuing the field of work.	(Drury et al., 2005; Perkins et al., 2007; Ragusa & Crowther, 2012; Wolfenden et al., 1996)	(Keane et al., 2012)
		32	Push	Leaving because wanting greater support – more peers, more supervision and more professional development (issues of professional isolation).	(Crowther & Ragusa, 2011)	(Mills & Millsteed, 2002)
		33	Push	Leaving because of a lack of career opportunities/career structure. Wanting new opportunities.	(Drury et al., 2005; Lloyd, King, & Bassett, 2002; Perkins et al., 2007; Scanlan et al., 2010)	(Buykx et al., 2010; Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2006; Stagnitti et al., 2005)
9	Personal values, interests and life stage	34	Pull	Enjoy rural lifestyle/ environment.	(Perkins et al., 2007; Wolfenden et al., 1996)	(Keane et al., 2012; Mills & Millsteed, 2002; Stagnitti et al., 2005)
		35	Push	Leaving because wanting to travel, have new adventures, live in bigger social grouping.		(Keane et al., 2012)
		36	Pull	Rural environment conducive for raising a family.		(Keane et al., 2012)
10	Work/life balance	37	Pull (push)	Meeting (or not) needs of other household members – including childcare, spousal jobs.	(Perkins et al., 2007)	(Buykx et al., 2010; Hegney et al., 2002; Keane et al., 2012; Mills & Millsteed, 2002)
		38	Push	Lack of anonymity.		(Lea & Cruickshank, 2007)
		39	Pull (push)	Adequate (inadequate) remuneration – including affordable accommodation.	(Perkins et al., 2007; Wolfenden et al., 1996)	(Buykx et al., 2010)

Broad Theme no.	Broad theme	Finding No.	Push or pull effect	Particular Findings	Australian mental health workforce literature	Australian rural health workforce Literature
Category 3: Personal factors						
11	Social connection	40	Pull	Having strong social connections/friendships including with work colleagues.		(Keane et al., 2012; O'Toole et al., 2010)
		41	Push	Experiencing social isolation – cliquey rural communities and/or workplaces.		(Lea & Cruickshank, 2007; O'Toole et al., 2010)
12	Kinship/family	42	Pull	Family reasons and/or family relationships/ hometown – being close to extended family.	(Perkins et al., 2007; Wolfenden et al., 1996)	(Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2005)
13	Job satisfaction	43	Pull (push)	Enjoy the client group/ rewarding. Enjoy the challenge and variety of work. Professional pride in doing a difficult job (Emotional demands of the job (Hegney, 2002).	(Perkins et al., 2007; Ragusa & Crowther, 2012; Wolfenden et al., 1996)	(Keane et al., 2012)
		44	Push	Professional isolation issues because of (lack) of access to training, CPD and networking opportunities. Barriers to attending CPD include having to incur personal costs, difficulty taking time away from work to attend as no back-filling role, and workload demands.	(Drury et al., 2005; Gibb et al., 2003; Moore et al., 2010; Wolfenden et al., 1996; Ziguras et al., 1999)	(Buykx et al., 2010; Hegney et al., 2002; Keane et al., 2012)
		45	Pull (push)	Being a member of a supportive team/ unsupportive dysfunctional team or negative workplace politics.	(Perkins et al., 2007; Scanlan et al., 2010)	(Buykx et al., 2010)

Literature review discussion

Analysis of these 14 papers identified in the systematic literature review on retention of Australia's rural-based CMH professionals revealed that very few studies focussed exclusively on the rural CMH workforce (Crowther & Ragusa, 2011; Drury et al., 2005; Gibb et al., 2003; Perkins et al., 2007; Ragusa & Crowther, 2012; Wolfenden et al., 1996) and within this group only the studies by Perkins et al. (2007) and Wolfenden et al. (1996) specifically focused on recruitment and retention issues. Only three papers focussed exclusively on the CMH workforce (Drury et al., 2005; Gibb et al., 2003; Perkins et al., 2007). Of these three papers, only Perkins and his colleagues' paper (2007) was relatively recent and rural in focus. As a result, this paper has been strongly relied upon for this study. Given this reliance, it is important to note that the Perkins et al., (2007) study only involved health professionals from one LHD in one Australian state and was limited to allied health professionals.

These 14 papers also had design and focus limitations, reducing the confidence to generalise the findings. These limitations included the large number of studies undertaken with OTs (Ashby et al., 2013; Ceramidas, 2010; Lloyd, King, & Bassett, 2002; Scanlan et al., 2013; Scanlan et al., 2010), especially given that OTs comprise the smallest proportion of Australia's CMH workforce (HWA, 2013); the very small sample sizes of the studies by Gibb (2003), Drury (2005) and Ashby (2013); and the non-rural specific nature of the state-wide (Henderson et al., 2008; Scanlan et al., 2013) and nation-wide (Ceramidas, 2010; Lloyd, King, & Bassett, 2002) studies. Given the limitations of the systematic review, it was decided to supplement the findings by including research-based studies on allied health professionals and RNs working in public sector health in rural Australia.

The findings from these combined searches found that the intention or decision to stay or leave a rural CMH job is formed through a complex interaction of organisational, role and personal factors. These include that health professionals working in case management roles are required to carry out many demanding tasks and responsibilities. For those working rurally, resourcing constraints and small team sizes pose additional challenges for providing effective case management and interdisciplinary care for clients. These sector-specific challenges are additional to the well-acknowledged additional demands facing health professionals working in rural services (big workloads and high levels of responsibility). Given these pressures, rural CMH roles

are commonly described by the workers in them as demanding and stressful. Not surprisingly, rural-based CMH professionals emphasise the importance of having the support of management and working in a positive team to help them manage. Being able to handle such a challenging job is also a source of job satisfaction for many and is described as a strong pull factor for staying. On the other hand, the absence of management and/or collegial support is a significant push factor. In most studies, health professionals left or were intending to leave their rural positions because they wanted better career opportunities and were frustrated by a lack of opportunity for career advancement in rural services. Other major reasons for rural health professionals deciding to leave a rural CMH job were personal. These included such things as work/life balance issues, whether the town/community met theirs and any other household member's needs, as well as life-stage factors and the degree of social connection felt.

From this literature review, two particular findings influenced this study's design. These were: 1) that the reasons for rural-based CMH professionals deciding to stay or leave a job were complex and involved role, organisational and personal factors and thus suggested the use of a qualitative, in-depth approach to support a full investigation of impacting factors with study participants; and 2) that rural-based CMH professionals generally work in generic case management roles and thus, a multi-professional approach to participant selection was warranted.

While the literature review on Australia's rural MH workforce and factors impacting retention of rural-based CMH professionals allowed for an adequate understanding of the workforce issues to be developed and helped to identify the research problem, it was not considered sufficient to confidently frame the research question. Given the paucity of specific literature and the reliance on the broader MH workforce and rural health workforce research it was felt that only a partial understanding of the day-to-day operational realities of the CMH job and factors impacting retention had been achieved. Given this, the research question was unable to be clearly defined and key aspects of the research design to be decided upon. Also, given the importance to me of the study being useful, it was considered important to check first whether retention was a major issue. For these reasons, it was decided that the next step would be to undertake a pilot study with NSW Health service managers of rural-based CMH services. The pilot study's purpose was to try to address some of these gaps in knowledge and understanding as well as to check the perceived usefulness (or not) of a retention-focussed study. If it was considered useful by service managers,

data would be collected to help clarify the research question and determine the undecided aspects of the research design – this pilot study is discussed in Chapter 3 – Pilot Study.

2.3 Identified factors impacting turnover intention

In the final stage of this study, after the data had been analysed and the key findings identified with respect to factors impacting upon turnover intention among rural-based CMH professionals, a broad literature search was undertaken to situate the key findings in the literature. Its purpose was to help support identification of the basic social process and theory development and underpin the discussion component of the study. It commenced with a broad review of the international literature on factors impacting turnover intention. The key findings were then researched. These included: generic case management and forming a professional identity; social dynamics of rural communities; transition to rural working and living; transition to practice for newly qualified health professionals; team dynamics and organisational social capital; developing a sense of place and life stage; and the links between turnover intention and meeting expectations.

The search commenced with a review of the previous database searches that had been undertaken (ProQuest, MEDLINE, CINAHL and Health Collection) and the reference lists of selected articles, as well as drawing on Google Scholar. This phase of the review focussed on peer-reviewed papers in academic journals with full-text availability. This literature search included papers from Australia as well as other industrialised countries in North America, Europe and Australasia. When drawing upon these international papers, consideration was given to the country context and the degree to which it was similar to the Australian context in terms of rural geography, health service provision and political system. With this in mind, papers from Canada were given first preference, then New Zealand, United Kingdom, USA and other European countries. The findings from this research are presented in this section.

The international literature on factors impacting turnover

An extensive body of published literature on factors impacting the turnover of MH professionals outside Australia was identified. The starting point used to review the international research was to draw on two review articles: Barak et al.'s (2001) meta-analysis of 25 papers investigating contributing factors to turnover among human service employees – including CMH professionals, and Onyett's (2011) review of the international literature on job satisfaction, stress and burnout in CMH teams between 1997 and 2010.

Barak et al.'s (2001) paper commenced with a summary of the theoretical underpinnings of the research undertaken on staff turnover in the existing literature. They argued that theories regarding staff turnover predominately originate from the disciplines of psychology, sociology and economics and all three were necessary to fully explain staff turnover. They assessed the contribution of each domain as follows. Psychological theories included stress theories, personality and dispositional theories, learning theory and organisational theories and were based on individual behavioural responses and perceptions and attitudes to work. Organisational theories included social comparison theory, social exchange theory and social ecological theory and linked turnover to work-related rather than individual factors. Economic theories explained staff turnover on the basis of employees taking rational actions in response to economic and organisational conditions. The findings from the meta-analysis conducted on the 25 identified papers were then presented.

Barak et al.'s (2001) meta-analysis identified that the strongest predictor of turnover among human service health professionals was burnout, followed by job dissatisfaction, availability of employment alternatives, low organisational and professional commitment (defined as satisfaction with the workplace and profession), stress related to role ambiguity and role conflict, and lack of social support from co-health professionals and management. With the exception of burnout, the other factors all strongly correlated with the reasons given in other work sectors for staff turnover.

Geurts et al. (1998) also found burnout to be a major contributor to turnover intention among CMH professionals. Barak's findings were later confirmed in a study undertaken in the USA by Acker (2004) investigating job satisfaction and intention to leave among 259 social workers

working in mental health services. In her study, organisational conditions such as role conflict, role ambiguity and social support, as well as adequate opportunities for professional development, were all found to be significant factors. In a (1995) study undertaken by Onyett et al., the greatest sources of pressure in mental health professionals' jobs was attributed to lack of resources, work overload and bureaucracy. These stressors accord with those found in the Australian study by King et al. (2008) undertaken with nurses and allied health professionals working in mental health. Both groups ranked workload and lack of resources as the two main stressors, followed by organisational problems. In this study, allied health professionals also cited client-related difficulties as being a significant stressor for them.

Onyett (2011) found that most studies concerned with investigating stress and burnout among CMH professionals used Maslach's burnout inventory[4] (MBI) (Maslach & Jackson, 1981) as the measure. In reviewing these burnout studies, Onyett found that mental health professionals generally experienced high levels of emotional exhaustion and personal accomplishment and moderate levels of depersonalisation (Lloyd & King, 2004; Onyett, Pillinger, & Muijen, 1997; Prosser et al., 1996). Onyett explained this seemingly contradictory mix of stress levels as resulting from the field of work. That is, high levels of emotional exhaustion were experienced because CMH work was emotionally intense while personal accomplishment was high and depersonalisation only moderate because of the strong meaning and attachment professionals placed on their work (Aarons & Sawitzky, 2006; Onyett, 2011). Hence, CMH professionals' commitment to the clients and the work often causes them to stay working in environments that they experienced as pressured and difficult, contributing to burnout (Onyett, 2011; Paris & Hoge, 2010). In a Welsh study, also using the MBI measure, conducted with CMH nurses investigating burnout, lacking a supportive line manager was associated with high levels of emotional exhaustion (Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000).

[4] The MBI uses three measures to assess for burnout. These are: 1) emotional exhaustion – assessing feelings of being emotionally overextended and exhausted; 2) depersonalisation – gauging lack of feeling and impersonal response toward clients; and 3) personal accomplishment – measuring feelings of competence and achievement (Maslach & Jackson, 1981).

Drawing from the findings of these two review papers, the main factors impacting on turnover intention were found to be burnout and job (dis)satisfaction. These are each discussed further in the next two paragraphs.

With respect to the issue of burnout, Barak et al. (2001) posited that it particularly impacted human services health professionals because it was an emotionally intense field of work. It is a field of work in which health professionals' commitment and responsibility centres on clients rather than the organisation, as is more commonly the situation in other work fields. Barak et al. (2001) argued that, when negative organisational conditions (such as heavy workloads) combined with human service health professionals' high professional expectations there, is a conflict and burnout can result.

Onyett (1995), investigating the aspects that professionals viewed as rewards of CMH jobs (job satisfaction), identified the highest rated factors as: working in a team, interdisciplinary work, feeling effective clinically, and the clinical work generally. Teamwork was also found to act as a protective factor against burnout (Carpenter, Schneider, Brandon, & Wooff, 2003; Lloyd, King, & Chenoweth, 2002). Wilson and Crowe's (2008) qualitative study of twelve New Zealand CMH nurses working in the public sector identified that the therapeutic relationship with clients was their major source of job satisfaction. Their study found that this relationship could be positively or negatively impacted on by work and personal factors including the team dynamic, relationship with line manager and work/life balance issues. Scanlan et al. (2013) also identified the importance of feeling supported and valued by management as contributing to job satisfaction in an Australian study of MH OTs.

Generic case management and forming a professional identity

In their UK study examining the effectiveness of interdisciplinary work in adult CMH services, Peck and Norman (1999) found that problems were often experienced in establishing and sustaining interdisciplinary collaboration. They argued that it was professionals' strong adherence to their professional identity combined with the absence of a strong CMH philosophy that was the basis for these problems. They identified that each professional group had its own culture and specific values that originated during training and were maintained through ongoing socialisation

with discipline-specific professionals. Lloyd and his colleagues' (2004) survey, undertaken with 304 OTs and social workers working in MH in Australia, found that the work activities undertaken in case management roles were mostly generic in nature. Given the strong importance professionals' place on professional identity, there is an inherent tension with a generic case management approach. With the shift of MH service delivery from primarily hospital-based care to increasingly community-based services, this tension became the focus of much research in the late 1990s and early 2000s.

Onyett and colleagues (1997) United Kingdom (UK) study investigating job satisfaction and burnout among CMH professionals identified that generic case management put pressure on professionals to change their work practices, ideology and philosophy. Brown et al.'s (2000) UK study investigating the boundaries between professional roles in interdisciplinary CMH teams, argued that language used by professionals around professional identity and role boundaries was a form of social action and was about trying to find their place/position within the team. This tension between a generic case management role and adherence to professional identity was also attributed to erosion of professional skills and role blurring (King et al., 2002; Lloyd, King, & Bassett, 2002). Working in interdisciplinary teams, health professionals generally had less contact with discipline-specific professions and profession-specific departments in hospitals and thus, CMH professionals had less access to role models (Lloyd, King, & Bassett, 2002). This was identified as being a bigger issue in rural areas and presenting the most challenges for allied health professionals (Lloyd, King, & Bassett, 2002). The tension between generic case management and profession-specific training and identification also arose around the uni-professional undergraduate training approach taken in most western industrialised countries and how well (or not) it prepared professionals for both working in MH practice and an interdisciplinary teamwork approach (King et al., 2002; Lloyd, King, & Bassett, 2002; Peck & Norman, 1999).

Social dynamics of rural communities

Pugh and Cheers (2010) defined 'place' as referring to a particular geographical location area as well as to the social territory that exists within it. Sense of place is also about feelings of belonging and is linked to a person's identity and their social position. Cohen (1982) proposed that an individual's sense of belonging to a place was facilitated by their networks of kinship, neighbourhood, friendship, occupation and beliefs. Pretty et al.'s (2003) study of people living in

Australia's rural towns, proposed that a person's sense of place was determined by a mix of three factors: place attachment – the individualistic aspect imbuing a physical location with personal and social meaning; sense of community – the communal aspect involving processes of social identity from feeling a sense of belonging through caring for others and feeling cared for by other people; and place dependence – the goal-orientated behavioural aspect an individual's perception of the quality of life the town offers in terms of physical and social resources compared with other alternative places.

The literature investigating social dynamics of communities commonly makes distinctions between the experiences of insiders versus outsiders (or locals versus incomers). Jedrej and Nutall (1996) argue such terminology provides a powerful metaphor for people to express and give meaning to their experiences but may not accurately reflect the particular social dynamics of a community. Pugh and Cheers (2010) argue that an individual's social position in a community is not simply determined by their length of residence but instead is a process of 'fitting in', which involves both gaining social acceptance by others and the person's own self-identification. Relph (1976) posited that there were seven degrees of 'outsidedness' and 'insidedness': at one end uncomfortableness arising from the strangeness and alienation of living in an unfamiliar place and at the other end a deep un-self-conscious immersion in a place because of it being very familiar. For newcomers to fit in and feel like they belong, they must do the work that is needed to acquire an understanding of the community in which they are living. However, research has found that not all newcomers are interested in 'fitting in' and instead may focus their efforts on maintaining their own social network of family and established friends who are living elsewhere. Pugh and Cheers (2010) argued that fitting in and having a sense of place is never fixed or solely determined by an individual's length of residence or kinship ties. They argue that it is also dependent on the conduct of the individual and attitudes about that person by the community. If these become negative, a person may begin to feel like an outsider and this can be an issue for both locals and newcomers.

Transition to rural working and living

The most recent literature found concerning the adjustment process to rural practice and rural-living among professionals was undertaken in Canada by Gillespie and Redivo (2012a). Their research investigated levels of satisfaction with lifestyle and clinical practice among CMH professionals working in rural towns in the province of British Columbia. They found that health

professionals who relocated but had no prior rural-living experience faced the most challenging adjustment process. Gillespie and Redivo (2012a) posited that this was because this group of professionals had to make multiple and simultaneous adjustments – managing a new job, adapting to a rural practice setting, adjusting to a rural lifestyle, as well as making new social connections. They found that the group of professionals most likely to be satisfied with working in a rural position were those who already lived in the local town.

In investigating the most significant challenges professionals faced in the initial adjustment stage, both insiders and outsiders identified rural service constraints. These included having to operate with reduced resources, managing complex cases, and having limited access to clinical supervision. The next major challenge identified by both outsiders and insiders was balancing dual relationships and managing personal and professional boundary issues. Gillespie and Redivo (2012a) found that boundary issues posed larger challenges for insiders than for outsiders and were a significant contributor to initial and ongoing stress for them.

In another of their studies, Gillespie and Redivo (2012b) investigated satisfaction levels among professionals working in child and adolescent MH services in rural and remote settings, again in British Columbia. In this study they found that insiders generally had higher lifestyle and practice satisfaction levels than outsiders. This study also highlighted the impact of service setting and town size on professionals' satisfaction levels and found that professionals working in small remote communities, irrespective of whether they were an insider or outsider, experienced much lower levels of satisfaction across four areas (lifestyle, practice, preparation for practice, and fit of organisational standards) compared to professionals working in larger towns.

With respect to outsiders' transition experiences, research on urban-to-rural transition was investigated. Several studies undertaken in the USA during the 1980s and early 1990s were specifically concerned with the adjustment experiences of outsider MH professionals to rural areas (Miller, 1981; Reed, 1992; Sullivan, Hasler, & Otis, 1993). Miller's (1981) study drew on Burr's role transition theory (1972) and identified five key factors that either eased or made more difficult urban professionals' transition to a rural based MH positions. The first involved the degree of correct understanding the health professional had about the social expectations that

existed around the position. The second factor concerned role clarity and the extent to which the health professional and their employer's expectations matched or varied. The third factor concerned role strain and the extent to which the health professional was able to meet expectations. The fourth factor was the extent to which the position facilitated attainment of the health professional's personal goals and the fifth factor concerned the amount of normative change required to fit into the workplace and community. Studies later conducted by Reed (1992) and Sullivan et al. (1993) also identified the important role expectations and social adjustment played in the transition experience of outsiders.

These findings accord with the few studies found investigating rural transition in the Australian context. This research was undertaken by Lonne (1990, 2002) and Lonne and Cheers (2000, 2004). Their research focussed on the personal and professional adjustment experiences of new graduate social workers taking up positions in rural Australia. They were particularly interested in the experiences of professionals relocating from metropolitan areas. Lonne's (1990) study of this group of social workers identified that they went through a transition process that involved both adjusting to the job and the rural service environment, as well as to the different cultural milieu. Lonne proposed that this adjustment process usually took outsider new graduate social workers between 12–18 months. Later, drawing on a two-year longitudinal study of 123 social workers who had relocated to take up a job in rural Australia, collected as part of his PhD study (2002), Lonne identified that this adjustment process usually followed a U-curve. He explained the U-curve process as involving five phases: disorientation, honeymoon, grief and loss, withdrawal and depression, and reorganisation and adjustment. Lonne's adjustment process drew heavily upon Zapf's (1991) study of the adjustment of social workers in the Yukon Territory, Canada. Zapf conceptualised that the adjustment process for newcomers occurred over a twelve-month timeframe. He explained the process as having an initial impact stage, which he termed 'culture shock', followed by an outcome stage called 'recovery', during which the worker moved from being an outsider to becoming an insider. Zapf postulated that professionals' wellbeing decreased during the culture shock stage and increased in the recovery stage.

However, not all studies investigating transition to rural practice support Zapf's U-curve. Dollard and colleagues' (1999) study investigating the differences between social workers working in rural Australia (n=56) compared with those working in metropolitan areas (n=184) found that the

job satisfaction levels of rural health professionals, rather than improving after having adjusted, decreased over time. In attempting to explain this, they posited that it might be connected to the fact that the rural health professionals in the study had significantly less work experience compared to the metropolitan health professionals who participated. They also posited that rural health professionals might tend to stay in their jobs even after they have become dissatisfied because of a lack of other employment alternatives in rural towns as compared to metropolitan areas.

Transition to practice for newly graduated health professionals

In a Canadian study, Wright et al. (2011), investigating aspects of successful integration of new nurses into MH services, found that relational issues were the most important factor. This involved both nurses' connections with clients and the quality of the relationships between team members. They found that, when positive team relationships were not present, it contributed to turnover intention among the new nurses. These findings, in terms of the importance of working in a supportive team and its links to turnover intention, also accord with the Australian studies investigating the experiences of new graduates starting work in MH services (Hazelton et al., 2011; Lloyd, King, & Ryan, 2007).

Wright and colleagues' findings also resonate with the findings from Hurley and Lakeman's (2011) study exploring the process of identity formation among MH nurses in the UK. In that study, participants described the 'most powerful process' (p. 747) for forming and maintaining their MH nurse identity was through learning how to provide 'effective care provision' (p. 747). They identified that this was best done by watching 'experienced professionals work with service users, and through socialisation (p. 747)' with other MH nurses. Their study also identified that working with clients was a major influencing factor on professional identity formation. Similar findings were identified in Ashby and colleagues' (2013) Australian study of OTs working in MH services. They found that the work environment was important for providing opportunities for OT professionals in building their profession-specific practice skills as well as their professional identity. Ashby et al., (2013) found that new graduate OTs working in MH described the 'transition to practice time' as being their 'most vulnerable time' (p. 114), during which they felt pressure to quickly gain understanding of MH practice, consolidate their profession-specific skills and to develop a professional identity (Ashby et al., 2013).

Studies investigating the experiences of new nursing graduates identify that they go through a significant adjustment process when starting out. One of the leading theories on transition to practice experience for new graduate nurses is Duchscher's stages of transition theory (2008). Her theory focuses on the first twelve months of professional practice. Duchscher identified three stages of adjustment: doing – getting started; being – growing into the role; and knowing – feeling comfortable in the job (see Table 2.6 below for a summary of key adjustments at each stage). Duchscher described the adjustment process as a transformative journey that was not always linear, and that each stage required different types of skill building and emotional adjustments (Duchscher, 2008). At the doing stage, personal and professional adjustments were at their most intense, and she found at this stage that nurses often felt stressed 'about absolutely everything' (p. 444). Duchscher and Boychuck (2009) termed this stage 'transition shock'. In the being stage, the pace of change began to slow and the focus was on the job and gaining competency and building confidence. Duchscher (2008) found that many new graduate nurses in this stage feared they were not up to the demands of the job. In the knowing stage, nurses recognised that they had grown and changed and had begun to feel comfortable in the job. In this stage their focus began to move from the job to issues with regard to broader health organisation and strengthening relationships with work colleagues (Duchscher, 2008).

Table 2.6 – Duchscher's transition to practice theory for new graduate nurses

Period/milestone	Stage	Focus and adjustments
0–3–4 months	Doing – Learning how to do the job, building skills and forming relationships	Experiencing a gap between expectations about workplace/job and the reality. Learning the routines, practices and protocols. Trying to manage workload and responsibilities.
From 4–5mths	Being – Settling in	Forming professional identity. Building relationships with other health professionals. Seeking balance between personal and professional life.
Around 12 months	Knowing – Feeling comfortable	Increasingly seeking support from other work colleagues. Have time and headspace for personal matters. Now feeling able to help others.

In their Australian study investigating the support needs of new graduate nurses working in rural services, Lea and Cruickshank (2015) drew on Duchscher's stages of transition theory as their

framework for analysing and presenting their findings. They found that while Australian rural nursing graduates' experiences generally accorded with those identified by Duchscher, they also faced additional difficulties arising from working in a rural service environment. These involved such things as resourcing constraints, management expecting them to take on big workloads soon after starting, managing high levels of responsibility and having poor levels of support. In Bennet et al.'s (2012) commentary paper investigating the needs of graduate nurses working in rural and remote Australia, working within the constraints of a rural service environment was found to reduce nurses' morale and negatively impact their intention to stay. In an earlier literature review undertaken by Bennett and colleagues (2010) identified that expectations played a major role in the transition process for new graduate nurses. They posited that there was often an expectations mismatch between management, who expected new graduates to be work-ready, and new graduates, who expected management to support them to get on top of the job (Lea et al., 2008).

Team dynamics and organisational social capital

Broadly, social capital can be defined as an asset deriving from social relations and networks. It is an umbrella concept used widely by researchers in the social sciences to investigate problems and explain collective behaviour (Putnam, 1995).

Leana and Van Buren (1999) defined organisational social capital as the asset arising from the character of the social relations within an organisation. They argued that individuals working for an organisation create this asset through the level of collective goal orientation (associability) and shared trust. 'Associability' refers to the willingness and ability of individuals to define and enact collective goals while 'trust' refers to the benefits of collaborating with known people being considered sufficient and predictable and, where staff are not known to them, that an organisation's social system is viewed as sufficiently strong to be able to confidently rely on other staff members. Leana and Van Buren (1999) posit that this associability and trust among workers is supported by the quality of the relationships workers have with each other and this is strongly impacted by an organisation's employment practices. Given this, they argue that organisational social capital can be built through encouraging workforce stability (through supporting high performance work by staff and investing in training and collaborative work); having an organisational philosophy that emphasises teamwork; and having clearly defined positions and employing workers who have the skills and experience to competently perform them. Leana and

Van Buren (1999) also contend that organisational social capital needs, like any other asset, regular maintenance to function well, requiring management to invest resources to ensure new staff are socialised ‘in the norms, values and ways of working inherent to the workgroup and the organization’ (p. 550). To maintain organisational social capital, management must also take an assets rather than a cost-based view to human management, valuing the individuals and interpersonal relationships. They also recognised that workers are involved in a process of continually assessing their commitment to the job/team/organisation and ongoingly recommitting.

Developing a sense of place and life stage

Erikson (1982) pioneered life stages over the life cycle and, with respect to adulthood, he identified three stages: young adulthood, middle adulthood and late adulthood. While there has been considerable debate as to the chronological ages relating to these adult life stages (Levinson, 1978; Sheehy, 1995; Valliant, 1993), there is generally agreement concerning the characteristics of each particular stage.

Of particular relevance for this study, given its focus on the experiences of early career health professionals, are the life stages of young adulthood and middle adulthood. Young adulthood is characterised by a focus on pair bonding (intimacy), building a livelihood and the pursuit of social activities, while middle adulthood focuses on work, family and stability (Erikson, 1982; Levinson, 1978; Valliant, 1993).

Erikson (1982) proposed that as a person nears the end of each life stage they go through a psychosocial crisis and progression to the next stage requires resolution of that conflict – for young adults it is intimacy versus isolation and for middle adulthood, generativity – wanting to make a difference to society versus stagnation. With respect to middle adulthood, Valliant (1993) viewed career consolidation as an important part of generativity. Valliant identified career consolidation as having particular characteristics – commitment, compensation and contentment – and concerned individuals wanting to do a job valued both by themselves and society.

Levinson (1978) argued that the major task of middle adulthood is settling down. Hay (1998), in his empirical study investigating the development of sense of place among original residents and persons who had moved from elsewhere from a geographical area of New Zealand, identified that a measure of entering middle adulthood was the desire to put down roots and that this often came with, or led to, the development of a sense of place. The desire to put down roots is usually very strong and as a result, place attachment might solidify towards the place the individual is living at the time. This place attachment is then further developed through the foci of middle adulthood, which concern building a strong social support system of family and friends, career consolidation and involvement in community activities (Hay, 1998). As a result of this very strong attachment in middle stage adulthood, many adults form a commitment to remain living in the particular place, at least until they retire and move into the late adulthood stage (Hay, 1998).

Links between turnover intention and meeting expectations

Porter and Steers argued that clarification of expectations between new staff and management was key to the reduction of turnover and they defined 'met expectations' as:

> the discrepancy between what a person encounters on the job in the way of positive and negative experiences and what he [sic] expected to encounter (p. 152).

Sutton and Griffin's (2004) longitudinal study investigating the determinants of job satisfaction among early career OTs in Australia used three measures of job satisfaction: pre-entry expectations, post-entry experiences and psychological contract violations (that is, the unmet explicit or implicit promise(s) made to an employee by an employer). Their findings were that, at commencement of a job, pre-entry expectations were positively related to job satisfaction, but over time they were increasingly influenced by post-entry experiences. They found that it was post-entry experiences and psychological contract violations that jointly predicted job satisfaction.

Geurts and colleagues' (1998) European study looking at burnout and intention to leave among 208 MH professionals put forward a conceptual understanding of turnover based on the sociological theories of social comparison, social exchange and equity. In particular, they drew upon social exchange theory and posited that individuals pursue equity in the relationship with their employers. They argued that the work relationship centres on employees agreeing to make

specific contributions (time, effort, experience) in exchange for their employer providing benefits (pay, conditions, a supportive workplace, career building opportunities) and there is an expectation that the contributions being made will be equitable.

Geurts et al. (1998) posited that this focus on expectations supports the notion of there being a psychological contract concerning employment matters in place between an employee and their employer. This psychological employment contract involves both explicit employment issues – such as pay, conditions and workload – as well as implicit employment matters – such as respect and support. Furthermore, if there was a perceived inequity or violation of the psychological contract – such as when the cost of the exchange with the organisation outweighs the benefits the employee receives – it will result in one of two forms of withdrawal: either psychological or behavioural.

Psychological withdrawal occurs in the form of emotional exhaustion – considered to be the key dimension of burnout using MBI as the measure, and behavioural withdrawal in terms of thoughts of leaving. In the same study, Geurts and colleagues (1998) also found that the more emotionally exhausted the employee, the more they tended to engage in negative communication with their colleagues, further strengthening their feelings of inequity. The authors argued that this could lead to a process of contagion of negative perceptions within teams.

2.4 Chapter summary

This chapter introduced the context of the study. It presented the literature review undertaken, which comprised three aspects: an overview of Australia's MH workforce, factors impacting the retention of Australia's rural-based CMH professionals and the key findings identified in this study with respect to factors impacting upon turnover intention. The reviews of the first two aspects were conducted before the research design was confirmed and data collection commenced. While establishing a broad understanding of Australia's rural MH workforce and rural health workforce issues, it was not considered sufficient to frame the research question. Given this, it was decided to undertake a pilot study with managers of rural-based CMH services to address the gaps in knowledge and understanding, help frame the research question and determine this study's research design (the pilot study is discussed in Chapter 3).

The literature review with respect to the key findings identified in this study was undertaken as part of theoretical coding stage to support development of the theory (Study Objective 1) and identification of the basic social process (Study Objective 2) and to underpin the discussion component of this study. The literature on these issues is merely presented in this chapter. How the literature links to this study's findings is introduced in Chapter 5 – Findings and then discussed in more detail in Chapter 6 – Discussion.

3. The pilot study

Chapter 3 is significantly shorter than all other chapters in this thesis, but a very important chapter nonetheless, contextualising the links between the literature and the larger study that was undertaken. The main body of this chapter is the publication *Retention challenge facing Australia's rural community mental health services: Service manager's perspectives* (Cosgrave et al., 2015b). The publication presents the findings from a pilot study undertaken with five NSW Health service-level managers responsible for running CMH services operating in rural towns in NSW.

The purpose of undertaking the pilot study was to collect data to help clarify the research question and determine aspects of the research design. As discussed in Chapter 2 – Literature review, a pilot study was decided upon because of the paucity of retention research found on Australia's rural CMH workforce, as well as believing I did not have sufficient understanding of the operations of rural CMH services given the lack of first-hand experience in this field of work. It also provided an opportunity to check with those who had responsibility for staffing of rural CMH services about the extent of the staffing issues they faced and whether they considered a future retention-focussed study would be a useful research endeavour. To assist the CMH services managers to elucidate on service operations and their experience of workforce issues, a semi-structured interview approach was selected.

Section 3.1 of this thesis has been published as:

Cosgrave, C., Hussain, R., & Maple, M. (2015). Retention challenge facing Australia's rural community mental health services: Service managers' perspectives. ***Australian Journal of Rural Health***, *23*(5), 272-276. http://dx.doi.org/10.1111/ajr.12205

Downloaded from e-publications@UNE the institutional research repository of the University of New England at Armidale, NSW Australia.

3.2 Chapter summary

The pilot study confirmed many of the findings in the literature, in particular that retention among CMH professionals working in rural services was influenced by a complex mix of professional and personal reasons. It confirmed that workers required a broad range of skills and a high level of clinical experience to be able to confidently manage the demands of a rural-based CMH case

management role, so most new graduates found the job very challenging. It verified that, because of chronic staffing shortages, the demands of a CMH job increased the more remote the service location.

These findings helped refine the focus of the research, develop the research question and decide on the study design. Given that most health professionals working in rural CMH services worked in generic case management positions, it was decided to take a multi-professional approach to participant selection and efforts would be made to recruit participants from every discipline eligible to work as CMH case managers for NSW Health.

The finding that most new graduates experienced the job as very challenging and that retention was a major issue for this group of workers was the basis for the decision to focus the study on turnover intention among early career CMH health professionals. However, given that much of the retention research undertaken on early career health professionals focused on their first year of work and their initial adjustment, it was thought important to try to go beyond this stage and explore the impacting factors on turnover intention after they had adjusted to the job but still in the first few years of working – a much less researched area. Also, given that the challenges of the job were known to increase the more remote the CMH services, it was considered important that early career CMH professionals were recruited from services operating in both large and small rural towns with different remoteness levels – the ASCGC-RA remoteness areas: inner regional (RA2), outer regional (RA3) and remote (RA4). Furthermore, as it was known that a range of professional and personal factors influenced the turnover intention of early career CMH professionals, a qualitative in-depth interview approach was selected. These decisions also supported the finalisation of the research question: *How do employment and rural-living factors impact turnover intention among early career, rural-based community mental health professionals in their first few years of working?* In the following chapter the research design used for this study is explained as is the theoretical orientation and methodological approach underlying the study.

3.3 Journal article format – Statement of authors' contribution

Journal-Article Format for PhD Theses at the University of New England

STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

	Author's Name (please print clearly)	**% of contribution**
Candidate	Catherine Cosgrave	60
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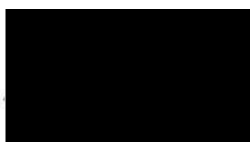
Name of Candidate: Catherine Cosgrave

Name/title of Principal Supervisor: Associate Professor Myfanwy Maple

28. 08.15

Candidate Date



2 Sept 2015

Principal Supervisor Date

3.4 Journal article format – Statement of originality

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STATEMENT OF ORIGINALITY

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	Page number/s
Publication Cosgrave, C., Hussain, R., & Maple, M. (2015). Retention challenge facing Australia's rural community mental health services: Service managers' perspectives. *Australian Journal of Rural Health, online*, 1-5. doi:10.1111/ajr.12205	1-5

Name of Candidate: Catherine Cosgrave

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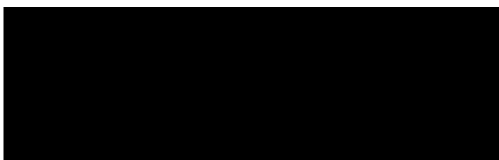

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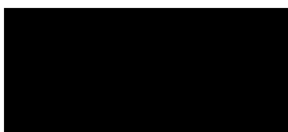

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4. Research Methodology

Chapter 4 explains the theoretical orientation, methodological approach and research design used for this study. The purpose of this research was to understand how job and rural-living factors impacted the turnover intention of early career, rural-based CMH professionals in the first few years of working. A qualitative study design was selected for this investigation. This chapter is divided into three sections. The first section presents the theoretical orientation underpinning the study. The second provides an overview of the methodological approach used, starting with a history of grounded theory (GT) and its different schools, then presenting GT methods, firstly those common to all GT schools, then methods linked to particular schools' approaches and ending with the methods chosen for this study. The third section concerns aspects and issues pertaining to the study's research design. These include participant selection and recruitment, ethical considerations, data analysis and reflexivity.

4.1 Theoretical orientation

The theoretical orientation of this study draws on a constructivist interpretivist paradigm, and a symbolic interactionist framework. As this study sought to understand factors impacting individuals' turnover intention and these involved issues of identity, work, agency and action, a symbolic interactionist framework was selected as an appropriate framework to guide the study. Each of these will now be discussed in turn, first providing an explanation and then further discussion on the rationale for their selection for use in this study.

A constructivist interpretivist paradigm

All research is impacted by the researcher's belief system or worldview, and these guide the investigation in ontologically and epistemologically fundamental ways (Guba & Lincoln, 1994). To support the development of a robust research design, the researcher must choose a research paradigm that accords with their beliefs about the nature of reality (Mills, Bonner, & Francis, 2006). A qualitative research approach helps to answer 'the whys and hows of human behavior, opinion, and experience' (Merriam, 2009, p. 1). As Merriam explains further:

> Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world.
>
> (2009, p. 13)

Guba and Lincoln (2000, 2005) propose that there are four interpretive paradigms that underpin all qualitative research: positivism, post-positivism, constructivism and critical theory; and they recently added a fifth – participatory (Lincoln, Lynham, & Guba, 2011).

Charmaz (2008) argues that constructivist grounded theory has its roots in social constructionism. While constructionism and constructivism are closely aligned, both sharing the view that knowledge is socially constructed. The difference between them is that constructivists believe that meaning is made through individuals' cognitive engagement with knowledge, while constructionists emphasise the creation of meaning though relationships and the social process (Young & Collin, 2004).

Constructivism–interpretivism is an approach that attempts to understand 'the world of human experience' (Cohen & Manion, 1994, p. 36). Constructivism is shorthand for social constructivism and is commonly combined with interpretivism (Creswell, 2003). Interpretivism has as its goal the understanding of the meaning of social phenomena. Both constructivists and interpretivists aim to make sense of the process by which meanings are created, negotiated, sustained or modified (Schwandt, 2003). As both participants and researchers co-create meaning and understanding within a constructivist research paradigm, a relativist ontology and a subjectivist epistemology is presupposed (Denzin & Lincoln, 2005). Two key assumptions underpin a constructivist-interpretivist perspective. These are: that individuals seek understanding of the world they live in and make meaning of their experience through their interactions with others – that is, reality is socially constructed, hence the use of the term 'social constructivism' (Mertens, 1998); and that the meanings developed by individuals are always subjective and so are varied and multiple. Individuals make meaning within the social, cultural, historical and temporal contextualities in which they live. Hence the constructivist researcher needs to explore how these processes interact and play out in the lives of their participants (Creswell, 2003). Thus, a constructivist-interpretivist research paradigm lends itself to taking a qualitative in-depth interview approach (Crotty, 1998). For this study, an in-depth interview approach was considered appropriate to support an in-depth

investigation with participants about how job and rural-living factors impact on them and influenced their turnover intention.

Researchers holding a constructivist-interpretivist viewpoint also need to hold true to the ontological politics of complexity (Landstrom, 2000). Thus, for this study, a theoretical framework was sought that would help grasp and interpret 'the complexities and heterogeneities of social life empirically' (Clarke, 2005, p. xxvi). Clarke (2005) argued that symbolic interactionism provides a framework for investigating such complex phenomena. A brief overview of symbolic interactionism follows.

A symbolic interactionist philosophical orientation

Symbolic interactionism is a theoretical perspective 'that assumes society, reality and self are constructed through social interaction and rely on language and communication' (Charmaz, 2014, p. 9). Symbolic interactionism emerged in the twentieth century in the USA from pragmatism and within the discipline of sociology. It drew on the works of the scholars Peirce, Dewey, Cooley, James and Mead (Denzin, 2004). Blumer, a student of Mead, regarded Mead as the principal originator of the perspective. It was Blumer (1969) who coined the term 'symbolic interactionism'. Mead taught at the University of Chicago from 1894 until his death in 1931 and his work focussed on the development of the self and the objectivity of the world within the social realm. A number of Mead's essays were published posthumously, the most recent in 1982 entitled *The Individual and the Social Self* in which he argued that 'the individual mind can exist only in relation to other minds with shared meanings' (Mead, p. 5).

Blumer posited that meaning-making comes before action and in order to understand the actions of an individual or a group it is necessary to understand the meaning that individuals or groups attach to things. Blumer believed that meanings arise from a process of social interaction, where things are defined and redefined through an interpretative process between individuals interacting with each other in a symbolic way. This social interaction is achieved through the use of symbols such as objects, tools and language, with language being the most symbolic system (Annells, 1996). Charmaz (2014) proposed that defining, labelling and naming are how individuals come to understand their situation – that is, people act according to how they define their personal

situation. The individual and the context within which the individual exists is central to symbolic interactionism. Thus, symbolic interactionism provides a framework to help support and guide research concerned with understanding human behaviour within a social context (Handberg, Thorne, Midtgaard, Nielsen, & Lomborg, 2014).

Handberg and colleagues (2014) argued that, because of the premises underpinning symbolic interactionism, it provides a useful theoretical framework for supporting a sound qualitative research design and the collection of rich data. These underpinning premises, originally proposed by Mead and later outlined by Blumer (1969), were that: 1) people act toward things and each other based on the meaning those things have for them; 2) meanings are derived through social interaction with others; and 3) meaning is dealt with and modified through an interpretative process. Coming from her 1970s work studying the social reality of death in contemporary USA, Kathy Charmaz (2014) has since built on Blumer's foundational principles by adding three further premises: 1) meanings are interpreted through shared language and communication; 2) finding meaning in social interaction is emergent and processual by its nature; and 3) the interpretative process of meaning-making becomes explicit when people's meanings or actions are problematic or their situations change. These six premises all draw upon self, identity, work, agency, and action and thus make symbolic interactionism well suited to studies concerned with understanding individuals and their actions (Charmaz, 2014; Handberg et al., 2014). Clarke (2005) contends that a constructivist-interpretivist epistemology underlies symbolic interactionism and GT and that both are co-constructed and non-substitutable. Charmaz (2014) proposes that 'Grounded theory…provides the methodological momentum for realizing the potential of symbolic interactionism in empirical enquiry' (p. 278). Thus, symbolic interactionism and GT theory are considered by some academics to be a strong theory/methods package useful for supporting the research of complex phenomena (Clarke, 2005; Star, 1989).

This section discussed the study's philosophical and theoretical underpinnings and explained and discussed why constructivism-interpretivism and a symbolic interactionist framework were chosen to guide this study. The next section presents GT, the methodological approach used for this study.

4.2 Methodological approach – grounded theory

The purpose of this section is to provide an overview of GT methodology, starting with a brief history, discussing the different variants that have emerged and outlining the constructivist approach selected for this study. Following on from this, GT methods will be discussed before presenting the coding approach and other methods chosen for this study.

A grounded theory methodological approach

Grounded Theory first came to public attention through Glaser and Strauss's seminal work, *The Discovery of Grounded Theory,* published in 1967. Glaser and Strauss presented a research method that could be used to generate theory from qualitative data. The work was published at a time when a positivist viewpoint predominated and quantitative research methods dominated. At this time qualitative research was criticised for its lack of rigour. Clarke (2005) described Glaser and Strauss's original GT approach as follows:

> Their emphases…were …on taking a naturalistic approach to research, have initially modest (read substantively focused) theoretical goals, and being systematic in…the interrogation of qualitative research data in order to work against… the "distorting subjectivities" of the researcher in the concrete processes of interpretive analysis
>
> (Original emphasis, p. 3).

Glaser and Strauss were both sociologists and were trying to develop a research approach for other sociologists to use to help explain social processes. Glaser was influenced by Columbia University's positivism while Strauss was shaped by the University of Chicago's pragmatism and symbolic interactionism.

Charmaz (2014) described Strauss as embracing Mead's views on 'action, process and multiplicity of perspectives' (p. 278). Charmaz (2009) argued that, from the outset, it was the union of these disparate traditions that placed GT on unsteady ontological and epistemological grounds and laid the seeds for the divergent directions that would later emerge. In the first chapter of *The Discovery of Grounded Theory: Strategies for qualitative research*, Glaser and Strauss (1967) invited researchers to use the GT strategies flexibly and for their own purposes. Many researchers accepted this invitation and since the publication of their seminal text, several different variants (schools) of GT have emerged, initially originating from Strauss himself (1987),

then later in his work with Juliet Corbin (1990, 1998) and then from other scholars – many of whom were students of Glaser and/or Strauss, including Charmaz, Clarke, and Morse (Allen, 2010). Charmaz (2014) argues that the ontological and epistemological basis of GT has continued to shift as each of these variants has emerged.

Today three generations, or schools, of GT are recognised and there are key scholars associated with each. Birks and Mills (2011) identify these scholars on the basis of their having written seminal GT texts/papers. The three schools, their key scholar(s), and the seminal papers/texts assessed by Birks and Mills (2011) are:

- Traditional or Glaserian GT refers to Glaser and Strauss's *The Discovery of Grounded Theory* (1967) and explicated since by Glaser (1978, 1992);
- Straussian GT initially advocated by Strauss (1987) and later in collaboration with his student Juliet Corbin (1990, 1998); and
- Constructivist GT as exemplified by Charmaz (1995, 2000, 2006) and Clarke (2005).

In 2005, Glaser claimed that any discussion about ontology and epistemology in respect to GT was moot because they were essentially neutral. While the symbolic interactionist philosophical underpinnings were implicit in Strauss and Corbin's first two editions of *Basics of Qualitative Research* (1990, 1998), their primary aim was to provide a how-to guide for researchers, so the methodological aspects were not explicated in any detail. As a result, GT is often viewed as not being a methodology but a package of methods providing strategies and techniques for data collection and analysis (Morse, 2009). Clarke (2005) suggests that it is because of this very 'shearing off of [its] epistemological and ontological roots' (p. 4) that GT has been able to travel beyond the discipline of sociology and have been so widely taken up by researchers from other disciplines, especially in health and the social sciences (Birks & Mills, 2011; Mills et al., 2006; Morse, 2009).

For this study I have relied on a constructivist GT methodological approach and the works of Kathy Charmaz (2003, 2005, 2014). In the next section, a brief overview of constructivist GT is presented.

A constructivist approach

Charmaz first proffered constructivist GT as an alternative GT approach in 1993 in a paper she presented at a qualitative research conference, which was later revised and published as a chapter in Denzin and Lincoln's book *Strategies of Qualitative Enquiry* (2000). While other scholars have followed suit, most notably Bryant (2002; 2007) and Clarke (2005), arguably Charmaz is constructivist GT's most well-known proponent and its most widely published.

The emergence of a constructivist GT approach reflects that qualitative research has gained increasing legitimacy since GT first emerged in the 1960s. Mills and colleagues (2008) argue that GT exists on a methodological spiral and each school reflects different epistemological underpinnings, commencing with positivist (traditional), post-positivist (Straussian) and leading to the current constructivist. Each school has contributed to this evolution of GT and each epistemological shift has been built on the arguments of earlier grounded theorists. In explaining constructive GT, Charmaz explicitly makes mention of this:

> Constructivist ground theory adopts the inductive, comparative, emergent and open-ended approach of Glaser and Strauss's (1967) original statement. It includes the iterative logic that Strauss emphasized in his early teaching, as well as the dual emphases on action and meaning inherent in the pragmatist tradition
>
> (2014, pp. 12-13).

Constructivist GT adopts traditional GT guidelines without subscribing to the positivist assumptions associated with traditional GT. Drawing upon the epistemological and ontological foundations of social constructivism, constructivist GT works from the assumption that research is a construction by both the researcher and their participants, as Charmaz explains:

> [constructivist GT] assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects' meanings
>
> (2003, p. 250).

Charmaz (2014) believes a constructivist GT approach to research provides many benefits including: fostering openness, encouraging empathetic understanding of participants' worlds and their actions, accounting for temporality, and having the potential to transform practice and social processes, and thus contribute to the making of a better world. Charmaz (2014) stressed that GT

methods should be viewed as flexible guidelines rather than as methodological requirements or rules. Charmaz (2014) posits that 'all variants of GT offer helpful strategies for collecting, managing and analyzing qualitative data' (p. 15). Charmaz (2014), Clarke (2003, 2005) and Bryant (2002) all contend that it is possible to mix and match methods from traditional and Straussian approaches with a constructivist approach.

The next section concerns GT methods and starts with an overview of the essential characteristics of GT, the approaches of the different schools and also presents the approach chosen and methods used in this study.

4.3 Overview of grounded theory methods

The aim of GT is to produce a substantive theory 'grounded' in the participants' data. GT has a number of particular characteristics that define it and are the basis for advancing theory development. These include: constant comparative method, concurrent data collection and analysis, theoretical sampling, coding and memo writing. In GT, coding helps advance the researcher's process of conceptual abstraction and is considered to be the principal method for transforming data from the descriptive into a substantive theory. Each of the three GT schools has its own coding approach and methods to support the development of a 'grounded' theory and each is discussed in this section, but before these coding approaches are presented, the particular coding approach and methods selected for this study will be introduced and explained.

In GT, theory generation occurs through a bottom-up, inductive reasoning process using methods involving the 'continual intermeshing of the data collection and analysis' (Glaser & Strauss, 1967, p. 73). The substantive theory – regarding a particular situational context involving a specific group and place, is grounded in the participant data[5] or, to quote Glaser's (2002) well-known dictum, 'all is data'(p. 1). This is achieved through constant comparative analysis.

GT's constant comparative method starts with the researcher breaking the data into discrete 'incidents' (Glaser & Strauss, 1967) and identifying concepts – that is, discrete happenings and

[5] In this study 'data' denotes the words gathered from interviews with participants.

events (codes) – as well as identifying the links and relationships between these codes (categorisation). Over time, the researcher's conceptualisation becomes increasingly abstracted and theoretical codes will emerge explaining the social phenomenon under investigation – this stage is defined as the point of theoretical integration. At this point, theoretical saturation is also usually reached – that is, when it is considered that no new properties or dimensions would emerge from any further coding or comparison of incidents (Holton, 2007). Charmaz (2014) contends that categories are theoretically saturated when they are theoretically abstract as well as substantively grounded.

Memo writing (also termed 'memoing') supports this process of constant comparative analysis. Strauss and Corbin (1990) define memoing as 'written records of analysis relating to the formulation of theory' (p. 197). Charmaz (2014) contends that it is the practice of memo writing that roots the researcher in analysis of the data and this leads to increasing levels of abstraction of the ideas underpinning theory development.

In GT, data collection (termed sampling) and analysis occur concurrently. Glaser and Strauss (1967) explain this concurrent process as the '*analyst jointly collects, codes, and analyses his* [sic] *data and decides what data to collect next and where to find them' (p. 45).* In GT, the sampling process occurs in stages and is always aimed at theory generation. Each sampling stage is driven by the findings/issues emerging from the constant comparative analysis of the data collected to date. Purposive sampling is the starting point for most GT studies and involves either collecting data from participants who have experienced the phenomena or from third parties with knowledge of the participants' experience of the phenomena[6]. As a GT study progresses, purposive sampling is gradually replaced by theoretical sampling.

The conceptualisation, coding and categorisation of data (all included in the term 'coding') is an 'essential aspect of transforming raw data into theoretical constructions of social processes' (Kendall, 1999, p. 746). Arguably, coding is the most important of the GT methods and this likely explains why the authors of each of the three GT schools propose their own particular approach to coding. While the GT scholars agree on many of the broad aspects of coding, such as developing

[6] As was the case for this study, undertaking a pilot study with CMH managers.

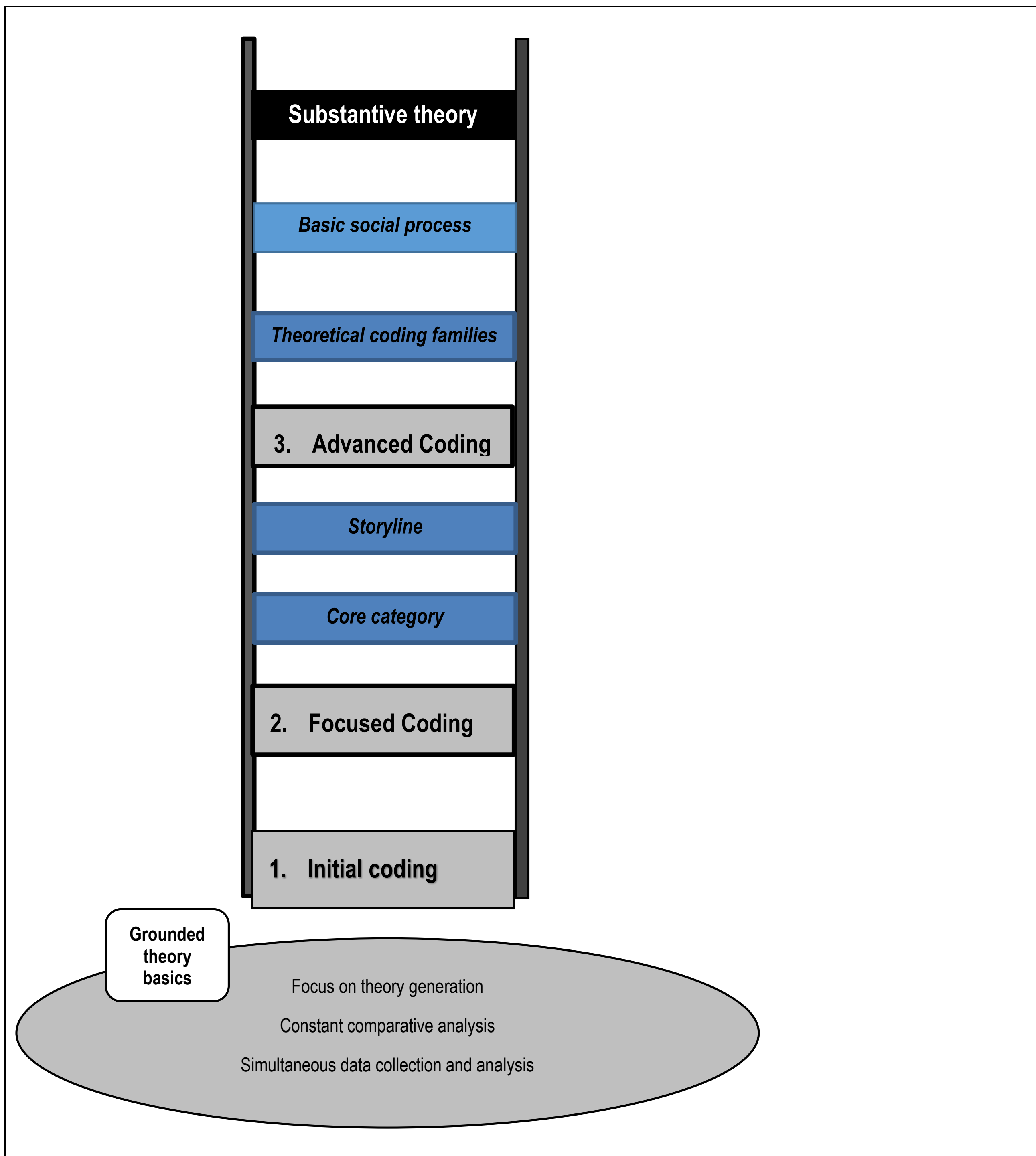
codes and categories and defining their properties, there are differences in the emphasis placed on these coding processes, the number of coding stages to use, and the terminology applied.

Coding and the methods used in this study

This study primarily followed the coding approach outlined by Charmaz (2014), which includes initial, focused and advanced coding. However, other methods, from both the traditional and Straussian schools of GT, were also drawn upon to help with the analysis and theory development. To explain the mix of approaches selected, I will use the metaphor of climbing a ladder, which is diagrammed in Figure 4.1. If theory development were a ladder, the ladder would be positioned on a non-slip rug comprising the basic GT methods used (such as constant comparative analysis) and then each rung of the ladder would represent increasing levels of conceptual abstraction. Charmaz's coding approach provides the main rungs supporting theory development in this study. However, there were points in the process when theoretical conceptualisation stalled and additional rungs were added to help the climbing to continue. These additional rungs drew on methods developed by and/or more closely associated with traditional and/or Straussian schools. The additional rungs included: identifying a core category; using a storyline to investigate the robustness of the core category proposed (Strauss & Corbin, 1990); and drawing on Glaser's theoretical coding families to help with theory development and identification of the basic social process.

Over the next few paragraphs, these coding approaches will be discussed in more detail commencing with a discussion of Charmaz's coding approach, then a brief description of the coding approach proffered by the other two schools and further explanation of the particular methods selected for use in this study.

Figure 4.1: Grounded theory methods used in this study



Charmaz (2014) argues for keeping the coding process simple and suggests that, for most research studies, a two-stage coding process (initial and focused) is sufficient. However, she also includes a third coding stage – advanced – if the researcher finds that additional support is required to reassemble the data and/or progress theory development. Charmaz's 'initial' coding stage commences with identifying important words or groups of words and labelling them. Charmaz (2014) stresses the importance of staying close to the data and suggests coding the data either word-by-word, line-by-line, or incident-by-incident. She also gives guidelines on how to perform initial coding, including: keeping the codes simple and precise, preserving action wherever possible, and moving quickly through the data. To help preserve participants' meaning and acknowledge the importance of the language being used, as well as supporting 'a strong sense of action and sequence', she suggests the use of *in vivo* codes and using gerunds – verbs used as nouns by adding 'ing' (Charmaz (2014, p. 120). In this study, the codes created in the initial coding stage have been called 'open codes', a term developed by Strauss and Corbin (1990, 1998).

Charmaz (2014) describes the 'focused' coding stage as being about removing duplication, trimming away excess, and focusing on and refining those open codes that have some degree of analytic power. She suggests that these focused codes may become the first tentative categories – as they did in this study. As the focused coding stage progresses, conceptual abstraction advances and some categories may be raised to theoretical codes and others subsumed under categories –the more minor categories have been termed sub-categories in this study. If an advanced coding stage is needed, Charmaz suggests drawing on Strauss and Corbin's conditional/ consequential matrix or Glaser's theoretical coding families. In this study, a third stage was required and some methods proposed by Glaser and Strauss and Corbin were used to help advance theory development. The coding approaches and methods particularly associated with these scholars and used in this study are discussed in the following two paragraphs.

Glaser (1978, 1992) suggested two coding stages: first, open coding then, once the core category explaining the basic social process has been identified, moving to selective coding. Strauss and Corbin (1990, 1998) propose a three-stage coding process: open, axial and selective. While they advanced a middle coding stage (axial), they also, in line with Glaser, supported the identification

of a core category to explain the central phenomenon[7]. Glaser and Holton (2005) described the core category as being the main theme or the main concern under investigation, or that which sums up what is happening in the data or the pattern of behaviour being observed. Glaser (2007) later added it as the 'something' that can be seen everywhere by the researcher. Strauss and Corbin (1990) described the core category as being 'the central phenomenon around which all other categories are integrated' (p. 116).

In regard to the basic social process, Glaser and Holton (2005) advanced that it is one type of theoretical code and its generation occurs around the core category. In 1978, Glaser defined it as being something that occurs and changes over time, with each stage having a discernible beginning and end and its own set of properties. Later, Glaser and Holton (2005) explained that, while a basic social process is one type of core category, not all core categories are basic social processes. They described the difference as being the processual nature of a basic social process – that is, that it has at least two stages while other types of categories do not. Identifying the basic social process was one of the two research objectives for this study.

Strauss and Corbin (1990, 1998) suggest that once the core category has been identified, the researcher draws on a range of methods such as storyline, axial and selective coding, and the use of the conditional matrix to help advance conceptual abstraction and theory development. However, Glaser (1978, 1992) recommends using theoretical families to achieve this. The remainder of this section will now explicate the particular approaches proposed by Strauss and Corbin and Glaser with respect to theoretical coding.

Storyline was presented in Strauss and Corbin's (1990) first text as a tool to support theoretical development. They defined storyline as being the 'descriptive narrative about the central phenomenon of the study' (p. 16). In 1992 Glaser published his rebuttal of Strauss and Corbin's GT approach, in which he criticised many of their suggested methods, including the use of storyline, arguing that it potentially forces the data into categories. Birks and Mills (2011) suggest that it was Glaser's criticism that resulted in its reduced emphasis as a method in the next edition

[7] Charmaz's (2014) coding approach does not include the identification of a core category, as she believes it is unnecessary and theoretical conceptualisation can advance without it.

of Strauss and Corbin's text. Birks and colleagues (2011; 2009), while agreeing with Glaser's criticism, suggest that storyline can still be a useful tool providing it is grounded in, and a true reflection of, the data. To help researchers achieve this, Birks and Mills (2009) developed some guidelines in the form of the mnemonic 'TALES', which represent:

- Theory takes precedence – that is, the theoretical constructs of categories and their relationships are given primacy;
- Allows for variation – that is, it incorporates the full range of variation including the negative cases;
- Limits gaps – it identifies gaps and limitations in the evolving theory;
- Evidence is grounded – the theory developed is a valid yet abstract account of the data; and
- Style is appropriate – the theory developed reflects the researcher's conceptual interpretation of the data.

Strauss and Corbin (1990, 1998) developed the conditional coding matrix as an extension of their axial coding process. Axial coding involves the core category being placed at the axis and the key relationships, with the categories and sub-categories delineated and the dimensions and properties of each category specified (Strauss & Corbin, 1990, 1998). Strauss and Corbin suggest using the conditional matrix to help view the phenomenon and its categories through different lenses: individual, group, family, community and national at either a late stage of axial coding or during selective coding. The conditional matrix has been criticised for being overly technical and making the process of theory development cumbersome (Robrecht, 1995). Kelle (2007) and Birks and Mills (2011) argue that the conditional coding matrix has many of the same elements as Glaser's coding families and similar intent. In this study, Strauss and Corbin's storyline was used to help with the identification of a core category and Glaser's theoretical coding families relied upon to support theory development. Glaser's coding families are explained in the next paragraph.

Glaser (1978) introduced theoretical coding families as a way of conceptualising how substantive codes relate to each other and can be used to develop a theory. Glaser (1992) argues his theoretical coding approach precludes the need for axial coding or the use of a conditional matrix because it is able to both bring the data back together and support theory development. As part of theoretical coding and drawing on sociological constructs, Glaser (1978) initially identified 18

theoretical coding families. In 1998, Glaser extended the list, adding another eight families by drawing on other disciplines. Charmaz (2014), while acknowledging overlap in many of Glaser's theoretical families, argues that, if used wisely, they can help specify and explain the theoretical relationships between the categories. Four of Glaser's coding families were determined as having relevance to this study as they named key processes occurring and/or influences upon participants' decision making regarding their turnover intention. These were: the six Cs, Process, Unit and Unit Identity. These four coding families are listed in Table 4.1 and relevant concepts highlighted under each family. These theoretical families were relied upon to help identify the basic social process and advance theory development.

Table 4.1: Glaser's coding families used in this study

Families	Codes/Descriptors
The six Cs (1978)	**Causes**, Context, Contingencies, Consequences, Covariance, **Conditions**
Process (1978)	**Stage**, Staging, Phases, Phasing, Progressions, Passages, Gradation, **Transitions**, Steps, Ranks, Careers, Ordering, Trajectories, Chains, Sequencing, **Temporalizing**, Shaping, Cycling
Unit (1978)	Collective, **Group**, Nation, **Organization**, Aggregate, Situation, Context, Arena, **Social world**, Behaviour pattern, Territorial Units, Society, **Family**
Unit Identity (1998)	**Professions**

This section has provided an overview of GT methodology and the constructivist approach and presented the methods selected for use in this study to help support theory development (Study Objective 1) and identification of the basic social process (Study Objective 2). The remaining part of this chapter will focus on the research design aspects of the study.

4.4 Research design

This section presents the research design used to investigate the turnover intention phenomena and discusses a range of pertinent issues including the sample selection and recruitment process, ethical considerations and the data analysis process, and concludes with reflexivity.

Participants

To help support the collection of information-rich data, a purposive sampling approach was chosen using a criterion sampling strategy for participant selection. The inclusion criteria were:

1) Currently works in, or has recently worked in, a NSW Health CMH service operating within the defined study area.
2) Meets the qualification criteria set by NSW Health to work as a CMH professional.
3) Has worked in the position for more than one year.
4) Has up to ten years' experience working in CMH.

Key aspects of these criteria not explained elsewhere are now discussed.

The defined study area

As discussed in Chapter 1, it was determined from the outset that the study would be situated in rural NSW, given the opportunity to leverage UNE's CRN partnership with a rural-based NSW Health LHD as well as the constraints of time and finances of being a PhD study. However, the study area was not defined any further until after the pilot study was undertaken.

A key finding of the pilot study was confirmation that staffing was a persistent challenge for rural CMH services, and particularly so for services in small towns in more remote areas. Given this, it was decided that the study area would include CMH services operating in rural towns of differing sizes: small, medium and large rural towns of varying degrees of remoteness. The defined study area covered a very large geographic area that included five of the seven LHDs operating in rural NSW. A large area was chosen as it was thought that difficulties might be encountered with respect to finding sufficient participants who met the inclusion criteria, knowing from the pilot study that long-term vacancies and high staff turnover were commonplace in rural NSW CMH services. In the end, this was not the case and sufficient participants working in CMH services in a range of different-sized towns were found in the first two LHDs selected, so the study ended up not extending beyond those two.

Drawing on the ABS's ASGC-RA classification of areas of remoteness, as well as the ABS 2011 census data on town or local government area (LGA) population size, a town type classification system was developed for this study. The ASGC-RAs included in this study were: inner regional (RA2), outer regional (RA3) and remote areas (RA4). Small towns were defined as having populations of less than 20,000, medium towns from 20,000-30,000 and large towns over 30,000

people. From these, four town type descriptors were developed. These were: 1) large rural town, inner regional area; 2) medium rural town, inner regional area; 3) small rural town, outer regional area; and 4) small rural town, remote areas. In total, nine rural towns were included in this study; an alphabetical letter was assigned to each town (A-I). In Table 4.2 (below) the nine towns have been sorted into the relevant town type and their population size (rounded) noted. The towns are referred to by both their alphabetical letter and descriptor elsewhere in this study – for example, 'Town E: large rural town, inner regional area'.

Table 4.2 – Town type classification

Town size	ASGC-RA remoteness areas	Town identifier	Population estimate[8]
Large rural town	Inner regional (RA2)	Town E Town F	47,500 39,000
Medium rural town	Inner regional (RA2)	Town G	23,0000
Small rural town	Outer regional (RA3)	Town A Town B Town C Town D	16,000 13,000 13,500 12,000
Small rural town	Remote areas (RA4).	Town H Town I	3,000 2,500

Brief profiles on each of these towns can be found at Appendix K.

Up to ten years work experience in community mental health

While the study was concerned with investigating job and rural-living factors influencing turnover intention among early career[9] health professionals in the first few years of working in CMH services, the inclusion criteria was extended to health professionals who had worked up to ten years in CMH – inclusion criteria 4. The rationale for extending the criteria to up to ten years was because of anticipated difficulties finding sufficient participants meeting the early career (0-5 years) criteria. Any participants recruited who had five years plus up to ten years work experience in rural CMH service(s) would be asked to reflect on their early job and rural-living experiences working in CMH in their first five years as well as the current experience.

[8] Population data is drawn from the ABS 2011 census. As most towns were also the local Shire capital, LGA data was used except for Town I. For Town I, town census data was used instead.
[9] Defined in Chapter 1 as being 0-5 years working in CMH.

Recruitment process

As current employees of NSW Health were the target participants, making contact with them first required gaining the approval and support of NSW Health at both senior and local management levels. Firstly, this involved seeking ethics approval and then obtaining the support of the service-level managers running the local CMH services targeted.

The service-level managers were first approached via email requesting their general support for the study and their assistance in promoting this study to their staff. This email (see Appendix A) also included, as an attachment, a formal letter outlining details of the study including information about both the UNE and NSW Health ethics approval(s) granted (see Appendix B and C). If a reply email or call was not received after a week, a follow-up phone call was made to determine their support. If the service-level manager agreed to support the study (and in all cases they did), a suitable upcoming team event was identified for making a presentation to staff. Once this date was decided on, the manager was asked to make staff aware of the up-coming presentation and to distribute the study's information sheet [10] (see Appendix D and E). Over the eleven-month data collection period from July 2013 to June 2014, seven service-level managers were approached and gave their support for a presentation to be made to their staff.

The service-level managers were also asked whether staff members who wanted to participate in the study could do so in work time and, if they chose, have their interview in the workplace. All seven managers agreed to this. To help protect the identities of the eventual participants, once the presentation had been made to staff, the managers had no further involvement in, or knowledge of, the recruitment process. In most cases, no further contact was made with the service-level managers expect for sending a thank you email to notify data collection in their CMH service had been completed.

[10] There was a separate information sheet for each LHD. The changes were made under the headings: Voluntary Participation and Approval & Complaints process, and related to the local counselling support contact details, ethics approval number and relevant contact person within the LHD.

Six group presentations to rural CMH staff were made, three of which were face-to-face and the other three presented using video-conferencing facilities. The presentation was approximately 15 minutes long and gave background to the study, discussed the need for, and importance of, the research and explained the inclusion criteria. Information sheets (Appendix D and E) were made available at these presentations either by myself or by the service-level manager if the presentation was video-conferenced. At the end of the face-to-face presentations, expression of interest forms (Appendix F) were circulated and any staff interested were asked to fill in a form. The form asked for name, role, professional group, contact details and preferred contact method. For those teams where the presentation was made by videoconference, interested persons were asked to email me.

This group recruitment approach worked well, with 34 staff expressing interest in participating in the study. Those people were contacted within five days, either by email and/or phone, whichever was their preferred method. In these communications, the inclusion criteria were reviewed and proposed interview dates discussed; this resulted in eight persons not proceeding further. These people were thanked for their interest and no further contact was made. Interview arrangements were made with the remaining 26 CMH staff members.

The interview dates were determined using a benchmark of a maximum of three interviews per day and days determined based on the number of participants in the CMH service. Once the interview time had been finalised, participants were sent an email confirming their scheduled interview time and asked to arrange a convenient, quiet space for the interview. The information sheet (Appendix D and E) and consent form (Appendix G) were attached to this email correspondence.

Twenty-five of the participants chose to have their interview conducted in their workplace, with the participants themselves organising the interview room (or in one case, video-conferencing facilities). The one non-workplace interview conducted was undertaken in the participant’s home.

Interview process

Each of the 26 participants was interviewed alone and, after gaining consent, the interview began by asking some general demographic questions to help develop a personal profile. This data included information regarding age, professional grouping, time since qualifying, time working in the role, time living in the town, if from elsewhere, where they were born and raised, where they completed their tertiary studies, and their relationship and family status.

After this, a short informal conversation ensued for the purpose of building rapport. At this point I usually made brief mention of my professional background and explicitly stated that I was not a health professional nor had I ever worked in MH services or for NSW Health. This was done quite consciously to highlight that no particular professional allegiances or viewpoints were held and to also lay the groundwork for me to feel comfortable asking participants to explain when I was unfamiliar with any terminology used or process discussed. Generally, most interviews followed a linear time approach, starting with the past and the participant's reasons for taking the job, then their initial, as well as current, experience of the job and living in the town and ending with the future and if they had made a decision yet about whether they intended to stay in or leave the current job.

The length of each interview varied, the longest being 2½ hours and the shortest 50 minutes, and on average taking 1 – 1¼ hours. The interview was usually drawn to a close once no new data was forthcoming. This point was usually signposted by information either being repeated or the conversation becoming more informal and chatty. Once this point was reached, the participant was given a signal that the interview was heading towards its end and a closing-type question such as: '*Finally, before we finish, is there anything else you would like to say?*' was asked.

Sampling

Participant recruitment was conducted on a service site basis and nine service sites were included, as listed above in Table 4.2. Interviews were conducted in two LHDs and undertaken in four batches. Batch 1 covered interviews 1-6 and included towns A-D, all of which were small rural towns located in outer regional areas. Batch 2 was a teleconferenced interview (Participant 7 – Natalie), who had left the job by the time of the interview but had previously worked in Town B. Batch 3 concerned interviews 8-13 and covered Town E, a large rural town, inner regional area.

Batch 4 covered interviews 14-26, which were undertaken in four towns: interviews 14-19 in Town F, a large rural town, inner regional area, interviews 20-22 in Town G, a medium rural town in an inner regional area, interviews 23 and 24 in Town H, a small rural town in a remote area, and interviews 25 and 26 in Town I, a small rural town in a remote area. Details of sampling by batches is presented in Table 4.3 (below).

Table 4.3: Sampling by batches

LHD no	Batch no.	Town	Interview no.
LHD 1	Batch 1	Town A small rural town, outer regional area	1 & 2
		Town B small rural town, outer regional area	3 &4
		Town C small rural town, outer regional area	5
		Town D small rural town, outer regional area	6
	Batch 2	Town B small rural town, outer regional area	7
LHD 2	Batch 3	Town E large rural town, inner regional area;	8-13
	Batch 4	Town F large rural town, inner regional area;	14-19
		Town G medium rural town, inner regional area	20-22
		Town H small rural town, remote areas	23 & 24
		Town I small rural town, remote areas	25 & 26

Each batch represented a particular sampling focus and or/investigation of particular issues emerging from the concurrent data analysis occurring. Batch 1 involved purposive sampling and was thought to be a good starting point for the study, as it was known (from the pilot study) that a number of early career CMH professionals were working in these services. Batch 1 interviews (1-6) were conducted over a four-week period with three separate trips being made. These interviews had particular focus on investigating the differences and/or similarities of the work experience between the professions. Specific mention needs to be made of Interview 6 (Madison) and Town D: small rural town, outer regional area. Madison had worked for over seven years in CMH and had recently commenced a job in a management role in Town C, a small rural town in outer regional area. However, the interview focussed principally on her experience in the previous five years, when she had worked as a CMH professional in a case manager role in a nearby town in the same LHD (Town D). While Town D is included as one of the nine service sites for this study, it should be noted that recruitment did not actually occur there and it is included because of the data drawn from Madison’s interview. Coding of interviews 1-6 and analysis of the data resulted in a descriptive account of the process leading to turnover intention and 129 open codes being created. The descriptive account was relied on to develop ten preliminary categories. The coding process is discussed in more detail in the section on data analysis.

Batch 2 (Interview 7, Natalie) took place seven weeks after the last Batch 1 interview. Natalie had worked in a CMH role in Town B for 3½ years, but during that time had also worked in the CMH services operating in Towns A and B. At the time of interview, Natalie had left this job a few months earlier to take up a senior social work position with NSW Health in a major regional city – the city where she had been born and raised and undertaken her tertiary studies. The key focus of this interview was to draw on Natalie's experience of working in Towns A, B and C, and test the validity of the preliminary categories so far developed. Figure 4.2 diagrammatically presents theoretical and purposive sampling undertaken in each interview batch.

Batch 3 (interviews 8-13) was undertaken in Town E (large rural town, inner regional area). The aim of this batch of interviews was to investigate the differences and/or similarities in the job and rural-living experiences between those early career CMH professionals working in large rural towns compared with those working in small rural towns in outer regional areas (Towns A, B, C and D). It was also thought that some of the issues identified in Batch 1 might be site-specific and other CMH sites were required to provide comparison data. By interviewing in a larger town, and by implication a larger CMH service and team, it was also anticipated that nursing professionals meeting the inclusion criteria would be found, as at that point only allied health professionals had been recruited. This was considered important because the study aimed to collect data from a representative sample of the range of health professionals working in CMH services and because nurses comprised the biggest professional group. Interviews were conducted with participants 8–13 over a three-day period and the participants included two nurses.

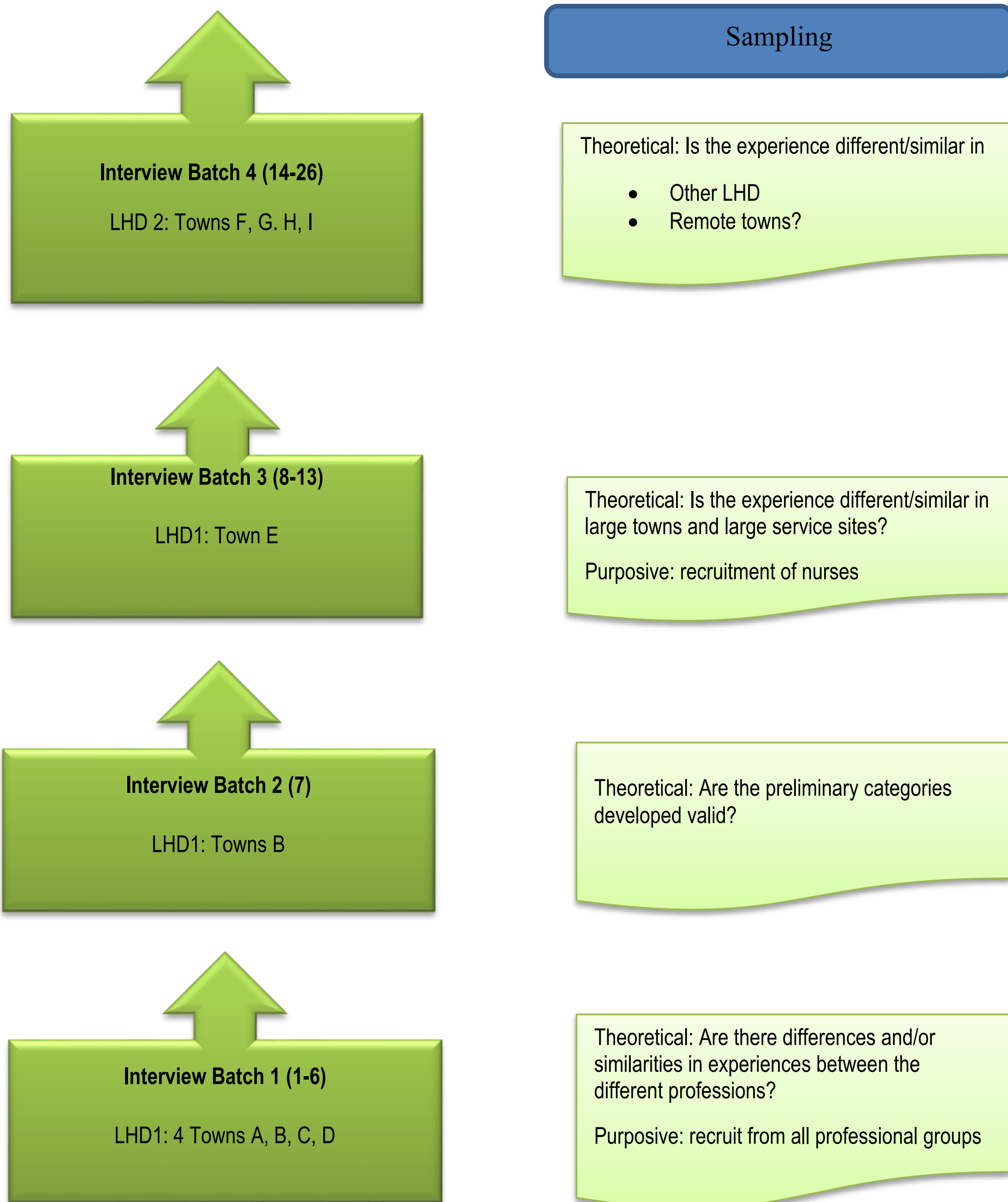
In Batch 3 particular mention needs to made of Jessica (Interview 15) who, after graduating from Applied Science in Leisure and Health, took a CMH position from 1998–2001 in Town E and then worked for the next eleven years in the private sector in non-MH roles before returning to work as a part-time vocational education and training consultant in CMH in 2012. At the time of interview she had been in this job for a just over two years. For the purposes of selection criteria 4 (duration of time in the position,) it was determined that Jessica had been working in rural CMH for over five years but less than ten years. Another participant, Amy (Interview 13) did not meet selection criteria 3 (duration of service), having only worked nine months at time of interview. During recruitment of participants for Batch 3, Amy approached me advising that she was keen to

participate. A preliminary discussion ensued revealing that, prior to her taking the CMH role, she had worked as a mental health support worker in a local NGO for a housing support program for some years, as well as an administrator for NSW Health, working with this particular CMH service. Thus, it was decided it would be useful to explore if and how her prior experience had impacted her experience of the job and the adjustment process.

After analysis of Batch 3 interview data it was still not possible to determine whether some issues were site-specific or were generalizable, so more sites were needed to provide further comparison data. The analysis also identified some gaps in sampling, including a continued under-representation of nurses and the omission of towns in remote locations. To address these sampling gaps, it was decided to conduct Batch 4 in another LHD and two LHDs were considered. The LHD selected was chosen because it included a CMH service operating in a large rural town in an inner regional area (Town F) and thus could provide a comparison site for Town E. It also had CMH services operating in small rural towns in remote areas (Towns H and I). It was known, again through data collected from the pilot study, that there was a CMH service operating in the LHD that had a cohort of nurses located in Town G, a medium rural town in an inner regional area, who might meet the inclusion criteria. Interviews were conducted with participants from these four towns over a ten-day period.

For the two remote towns (H and I) it was necessary to loosen the inclusion criteria to have any staff participate. This was because there were very few CMH professionals found to be working in these remote towns and hardly any that met the inclusion criteria. As it was a key aim of this study to include the experience of CMH professionals working in smaller services operating in remote areas, it was decided that collecting data from remote areas was more important than participants meeting all of the inclusion criteria, so the inclusion criteria were loosened. This resulted in three participants not meeting all of the inclusion criteria: Deborah – Participant 24, who was an Aboriginal MH support worker and did not meet the health qualifications criteria (2); Jacinta – Participant 26, who had over 30 years work experience in non-rural CMH but had only worked a few months in the role and so did not meet selection criteria 3 (minimum working time of one year) or selection criteria 4 (maximum of ten years' experience in CMH); and Bill – Participant 25, who had worked in Town I's CMH service site for over 20 years and for the last five in a management role, but also did not meet selection criteria 4.

Figure 4.2: Theoretical and purposive sampling issues by interview batches



Characteristics of participants

Table 4.4 (below) details the demographic details and personal circumstances of the 26 participants who participated in this study. Twenty-four of the 26 participants interviewed were currently working in a CMH role and two had recently left their positions. Participants ranged in age from 23 – 63 years and there were 21 female and five male participants. With respect to origins, 13 were born and/or raised in the town, three were from other rural towns (ASGC-RA 2-4), seven from metropolitan cities in Australia – either state capitals or major regional cities (ASGC- RA1), and three had moved to Australia from overseas in the last five years. At the start of working in the CMH service, 22 participants had 0-5 years' experience, two over five years (Madison – Participant 6 and Jessica – Participant 15) and two had over ten years' experience (Bill – Participant 25 and Jessica – Participant 26). Twenty-three of the participants held recognised tertiary qualifications for working in NSW Health CMH services and another two were currently undertaking recognised tertiary courses (Bede – Participant 16 and Alice – Participant 23). The participants were drawn from across the full range of eligible health professions including: social work (7), nursing (6), psychology (4) occupational therapy (3) and health sciences (5). Participants' experience working in CMH ranged from nine months to 30+ years.

Table 4.4: Study participants' demographic details and personal circumstances

Interview no.	Pseudonym	Age	Length of time living in the town	Personal circumstances	Batch/ Town letter	Town descriptor	Health profession /qualifications	Total years qualified	Relevant work experience at job commencement	Length of service in job
1	Zeena	51	1.5 yrs	Single with children. Has 3 children - 2 young adult children independent & living elsewhere & 1 primary aged child. Youngest child initially relocated to town but now living elsewhere with father	1 A	small rural town, outer regional area	Social work	1.5 yrs	0	1.5 yrs
2	Saskia	23	1.5 yrs	Partnered, partner relocated with her. No children.	1 A	small rural town, outer regional area	Social work	1.5 yrs	0	1.5 yrs
3	Clarke	29	Born & raised	Partnered, partner also born & raised in town. No children.	1 B	small rural town, outer regional area	Health Sciences in mental health	1 yr.	0	3 yrs
4	Mia	27	Born & raised	Single & no children.	1 B	small rural town, outer regional area	Psychology	3.5 yrs	2 yrs	1.5 yrs
5	Scarlett	30	2 yrs	Single & no children. From overseas on a working visa.	1 C	small rural town, outer regional area	Occupational Therapy	9 yrs	0	2 yrs
6	Madison	34	Born & raised	Single & no children but has commitments to a child in her extended family. Took job to be closer to family.	1 D	small rural town, outer regional area	Psychology	7 yrs	0	5 yrs
7	Natalie	27	3.5 yrs	Partnered, partner relocated with her. No children.	2 B	small rural town, outer regional area	Social work	3.5 yrs	0	3.5 yrs
8	Kalinda	32	Born & raised	Single has 2 school aged children living in town with father.	3 E	large rural town, inner regional area	Health sciences in mental health	1 yr.	0	4 yrs
9	Madeleine	42	4.5 yrs	Partnered since moving to town. Moved to town to be closer to her 2 school aged children who were living with father. Both children now finished school & living elsewhere.	3 E	large rural town, inner regional area	Nursing	17+ yrs	0	4.5 yrs
10	Georgia	33	9 yrs	Partnered with 2 preschool aged children, father is primary carer. Initially moved to town for work opportunities for both her & partner.	3 E	large rural town, inner regional area	Occupational therapy	12 yrs	0	8 yrs
11	Lowanna	28	Born & raised	Partnered with 3 children – 1 primary school aged and 2 preschool aged. Returned to home town to be closer to family after 5 years away.	3 E	large rural town, inner regional area	Health sciences in mental health	7 mths.	0	3.25 yrs
12	Jacob	23	2 yrs	Single & no children. From overseas on a working visa.	3 E	large rural town, inner regional area	Nursing (Psychiatric)	1.5yrs	0	1.5 yrs

Inter view no.	Pseud onym	Age	Length of time living in the town	Personal circumstances	Batch/ Town letter	Town descriptor	Health profession /qualificati ons	Total years qualifi ed	Relevant work experien ce at commen cement	Length of service in job
13	Amy	27	Born & raised	Partnered, partner also born & raised in town. No children.	3 E	large rural town, inner regional area	Social work	9 mths	0	9 mths
14	Emily	29	Raised	Partnered, partner born & raised in town. No children.	4 F	large rural town, inner regional area	Nursing	1.5 yrs	0	1.5 yrs
15	Jessica	37	16 yrs	Partnered, met in town both moved there for work. Now have 3 children – 1 preschool and 2 primary school aged.	4 F	large rural town, inner regional area	Applied Sciences in leisure and health	16 yrs	3 yrs	2 yrs
16	Bede	24	Born & raised	Single & no children.	4 F	large rural town, inner regional area	Social work	studyin g	0	4 yrs
17	Jade	27	1.25 yrs	Partnered, partner also from elsewhere. Planning to stay living in town long term and start a family.	4 F	large rural town, inner regional area	Psychology	2 yrs	0	1.25 yrs
18	Joseph	45	3.5 yrs	Partnered, partner also from elsewhere have 3 primary school aged. Family migrated to Australia 5 years ago on state sponsored visa.	4 F	large rural town, inner regional area	Social Work	24+yrs	0	2.75 yrs
19	Karen	53	20 yrs	Partnered, partner born & raised in town. Two adult children living elsewhere. Recently returned to home town to be closer to friends after 10 years away	4 F	large rural town, inner regional area	Nursing	30+ yrs	0	1.5 yrs
20	Katie	30	Born & raised	Partnered, partner born & raised in town. One child preschool aged.	4 G	medium rural town, inner regional area	Occupation al therapy	7 yrs	2 yrs	3 yrs
21	Lara	30	3 yrs	Partnered, partner also from elsewhere. Planning to stay living in town long term and start a family	4 G	medium rural town, inner regional area	Nursing	8 yrs	1 yr.	3 yrs
22	Charlie	53	Born & raised	Partnered, partner also born & raised in town. Five children – 4 independent adults , 1 at university & still dependent	4 G	medium rural town, inner regional area	Nursing	5 yrs	0	5 yrs
23	Alice	23	Born & raised	Partnered, partner born & raised in town. No children.	4 H	Small rural town, remote area	Health Sciences in mental Health	Studyin g	0	1.5 yrs
24	Debora h	45	Born & raised	Partnered, partner born & raised in town- 2 school aged children.	4 H	Small rural town, remote area	No health qualificatio ns	-	0	4.5 yrs
25	Bill	63	20 yrs	Single and no children.	4 I	Small rural town, remote area	Psychology	20+ yrs	20+ yrs	20+ yrs
26	Jacinta	53	Born & raised	Single & no children. Recently returned to home town to be closer to family after 30 years away	4 I	Small rural town, remote area	Social work	30+ yrs	30+ yrs	6mths

4.4.1 Ethical considerations

Ethics approval

Ethics approval for this research was first gained from UNE's Human Research Ethics Committee, initially for the pilot study in July 2012 – approval number HE12-131 (see Appendix H) and later for this, the main study in March 2013 – approval number HE13-022 (see Appendix B)[11]. Ethics approval was then sought from NSW Health for the five LHDs in the defined study area. On the basis of the study being low and negligible risk research, Hunter New England LHD's Human Research Committee reviewed the ethics application under an expedited process. Ethics approval was granted in April 2013, approval number LNR/13/HNE/115 (see Appendix C). Site-specific assessments were sought from the two LHDs where sampling was targeted. Ethics approval for the Hunter New England LHD site was granted by its Human Research Committee in April 2013 – approval number LNRSSA/13/ HNE/116 (see Appendix C) and for the Western NSW LHD site's Human Research Ethics Committee in December 2013, approval number LNRSSA/13/GWAHS/87 (see Appendix I).

Informed consent

Informed consent was obtained from all participants. Participants were sent a consent form (see Appendix G) and an information sheet (see Appendix E and F) as attachments in the email confirming the negotiated interview time. At the beginning of each face-to-face interview, participants were provided with a printed copy of both these documents. In these interviews, consent was sought by asking the participant to read through the consent form and answer all questions. If all questions were answered in the affirmative and the form was signed, they were deemed to have consented to participate in the research. All participants were over the age of 18 and had the capacity to give consent.

[11] In this application there was a second stage of the study described as group 2. This stage was to present the findings and recommendations to a group of NSW Health rural CMH managers and senior NSW Health management. In the ethics application made to UNE's Human Research Ethics Committee, it advised that the data collection methods for this stage of the study were not yet decided upon and an additional ethics application would be made and information sheet developed for group 2 at a later stage. Once data collection commenced for group 1 participants (the CMH professionals) it quickly became apparent that considerable time and effort would be required to ensure all factors impacting turnover intention were fully explored, a representative sample of the different types of health professionals working in CMH were interviewed and the interviews were conducted in a broad range of rural and remote service areas. Given this, it was decided that the group 2 component of study would not fit within the time constraints of the doctoral candidacy.

Confidentiality

Participant identifiability was considered to be an issue given the smaller teams operating in rural CMH services and of particular concern for those participants who were working in small rural towns in the outer regional and remote areas. All participants were informed of confidentiality and its limits. This was first mentioned in the information sheet (see Appendix E and F), which noted that participants might still be identifiable even though pseudonyms would be used in any documents drawn from the study. The issue of identifiability was also addressed in the consent form (see Appendix H), with participants being asked to consent to the research findings being published and to being quoted in those findings using a pseudonym and for their continued participation, even though they may be still be identifiable. Before data collection commenced, each participant was asked if they would like to choose a pseudonym. Only one participant chose to do so. For all other participants, pseudonyms were allocated at the time the interviews were transcribed.

To try to reduce the identifiability of participants, all information that could identify the rural town they worked in has been removed in quotes. Locations have been replaced with a town-type descriptor based on the classification system developed for this study. Any names identifying other people were also removed and replaced with a letter, for example ‘X said’. Any mention of the LHD was also deleted.

Duty of care to participants

It was generally considered there would be a low risk to participants from participating in this research. The inclusion criteria for participants was inclusive of Aboriginal people, and no particular impacts were envisaged due to their participation in the study. In the end, seven people who identified as Aboriginal participated. There were no participants from non-English speaking backgrounds. All participants were informed prior to interview of the anticipated interview duration (60-90 minutes) and were given the option to select two shorter interviews instead (no one took up this offer). Following ethical guidelines, participants were made aware, through the information sheet (Appendix E and F) and as part of the consent process that their participation was completely voluntary and they were free to cease their involvement at any time. Contact details of counselling and support groups/agencies relevant to each particular geographical area, as well as the NSW Health employee helpline were included on the information sheet.

One participant who became distressed during the interview was offered the option to cease the interview and reminded that support services were available. The participant declined both offers. At the end of this interview, I again reminded the participant of the availability of support services, but the participant said they were fine and firmly declined the offer of support. A few weeks later I sent an email thanking them for their participation and asking if they had any further questions or concerns. The participant replied that they were fine and at this stage had nothing more to add or any particular concerns.

Data Management

The data collected has been kept secure at all times. Interviews were recorded on three digital devices (a portable recorder, mobile phone and iPad) and then copied over onto to a password-protected computer after the interview. The data was then deleted from two of the recording devices, but the data recorded on the iPad device, which was password protected, was kept to assist with access, data immersion and the transcribing process.

Due to the number and size of the interview transcripts and the number of open codes created (129), it was not considered feasible to manage the data without the use of a data management software program. The software program chosen was QSR – NVivo Version 10 (QSR International, 2012). This software was used to help with coding of the data as well as organising and storing all the electronic data for the study.

All computer-entered data (transcripts, memos, NVivo 10 files and thesis drafts) were kept on a password-protected computer. Any hard copies of documents, including transcripts, were stored in a locked filing cabinet in my home throughout the study period. On the successful completion of this thesis, all hard copies and electronic files relating to the study will be handed to the study's principal supervisor (Associate Professor Myfanwy Maple). This data will be then be stored at UNE for at least five years from the return date, as per National Health and Medical Research Council ethical conduct of research guidelines (2007).

4.4.2 Data analysis

To distinguish between the sampling and coding processes undertaken, the reader is reminded that data collection and analysis occurs concurrently in a GT study. This section discusses the data analysis process undertaken, including the transcribing and coding processes. To recap, the coding approach selected for this study was Charmaz's (2014) three coding stages (initial, focused and advanced) and also drew on Traditional and Straussian GT methods in the later stages of coding.

Transcribing and coding approach used

Transcriptions of the interviews were verbatim and undertaken after each interview batch. The transcripts were coded before the next interview batch was undertaken. Coding of the first six interviews was done by hand and an initial list of 129 open codes (see Appendix J) created and ten preliminary categories developed. Thereafter, the coding of the transcripts was undertaken using NVivo 10. The list of open codes was entered into NVivo 10 as free nodes. In NVivo 10, free nodes are stand-alone nodes and have no clear connection or logic to any other nodes: they are generally the starting point of a coding process. The ten preliminary categories or, in NVivo terminology, 'tree nodes', were also entered. In NVivo 10, tree nodes are organised in a hierarchical structure and the free nodes grouped into categories.

When coding the transcripts in NVivo 10 coding, stripes were used to indicate what had been coded and into which nodes. This system was employed until each transcript had been fully coded. Revision of the codes continued in NVivo 10 using the constant comparative method, which involved examining the open codes and comparing them to other open codes within a transcript and between transcripts. Wherever overlapping codes were identified, they were subsumed and refining of the wording of the open codes continued throughout. The categories developed were also revised regularly. This ongoing refinement eventually led to the identification of the core category. How this occurred over the three coding stages – initial, focused and advanced – is now discussed and also diagrammatically represented in Figure 4.2.

Coding and categorising

Initial coding

An incident-by-incident approach was selected as the preferred unit size to analyse and code the transcript data. In line with the guidelines suggested by Charmaz (2014) when creating open

codes, wherever possible *in vivo* codes and gerunds were used. The following two excerpts from the first batch of transcribed interviews provide examples of how incidents were coded and types of descriptive names given to the open codes.

> *And then you step into this role as a clinician. And I remember my second or third day I was called to the emergency department, to go and see a young person and the person was suicidal and they were asking me questions. I done an assessment, which I knew how to do from my placement and things like that. I'd done the assessment and then the doctor and the nurses in the ED* [emergency department], *were asking me for a recommendation about the MH treatment. And I can remember thinking, I don't feel I'm the right person to be making those sort of decisions, just yet. I still felt like I was in that student mindset, I guess, and so I struggled with that for a little while.*
>
> [Natalie (7), 27 yrs, Social worker, Town B – small rural town, outer regional area]
>
> **Open Code 22: Being thrown in the deep end**

> *I guess with the worker who retired there have been some dynamic shifts around that. I had I had some problems with her, just not really respecting me as a person or a professional. She had this idea that I didn't know anything as a new grad. She had been nursing for 50 years, so "what could I tell her?" – sort of thing. So I was quite on edge around her and I have to tell you, I was quite relieved when she retired. I think there was a big shift in the dynamics and that tension went.*
>
> [Saskia (2), 23 yrs, Social worker, Town A – small rural town, outer regional area]
>
> **Open code 92: Working with difficult people – power plays, offloading, bullying, sabotaging**

In line with Charmaz's (2014) suggestion to move quickly through the data, I initially undertook the first batch of coding by hand, writing the open codes on the printout of each transcript. A coding list was developed and whenever a new open code was created, the list was updated. This coding list was then referred to as coding of subsequent transcripts occurred and if required, a new code was created and added to the list.

Analysis of interviews 1-6 transcript data using an incident-by-incident approach resulted in the creation of 129 open codes. In order to revise these open codes and try to make them more meaningful, they were typed into a Word document and sorted manually by cutting and pasting until groups of like codes were clustered together. As well as supporting refinement of the codes, this assisted with the development of a preliminary descriptive account of the process leading early career CMH professionals to stay or leave their jobs. This identified process was used to develop ten preliminary categories and each category was given a descriptor. These were: 1)

Making career plans, 2) Job seeking, 3) Weighing up the costs and benefits, 4) Arriving and finding one's feet, 5) Adjusting to rural-living – outsiders, 6) Making connections, 7) Doing a big job, long-term, 8) Working in a bureaucracy, 9) Finding your place in the team, and *10) Deciding to stay or leave.* These ten categories were preliminary only and considered weak in terms of their explanatory power and the linkages between them.

After completing Batch 2 (Interview 7 – Natalie) some more open codes were created and refinement and subsuming of the open code list continued. When coding was complete, the ten preliminary categories were revised. This resulted in the categories being subsumed down to eight: *1) Job seeking, 2) Taking the job – motivations, expectations and promises made, 3) Finding one's feet, 4) The importance of social connection, 5) Handling team dynamics and work relationships, 6) Working in an environment of change and uncertainty, 7) Doing a hard job, long-term, and 8) Deciding to stay or leave.*

After coding of Batch 3 (interviews 8 – 13) a few more open codes were created and refinement and subsuming of the open code list continued. The eight categories were also reviewed, this time focussing on processual issues and identifying sequential stages. The stages identified were: *Seeking, Landing, Adjusting, Connecting, Adapting, Managing* and *Deciding*. These were matched against the eight preliminary categories to reflect the processual nature of the phenomenon. At this point of categorisation, categories 5) *Handling team dynamics and work relationships,* and *6) Working in an environment of change and uncertainty* were subsumed into one category and renamed: 5) *Adapting – finding your place in the team and workplace*. This reduced the categories to seven: *1) Seeking – motives for taking the job, 2) Landing – finding your way, 3) Adjusting – finding your feet, 4) Connecting – to people and place, 5) Adapting – finding your place in the team and workplace, 6) Managing – doing a hard job long-term,* and *7) Deciding – to stay or leave.* Figure 4.3 diagrammatically presents this process of refining and subsuming the categories. At this point of the coding process the properties (characteristics) of the categories began to be defined. Strauss and Corbin (1998) described properties as defining and giving categories their meaning. Birk and Mills (2011) explained that properties need to be defined either in terms of their dimensions or their range of variance. In this study, the properties covered such things as time in the job; prior CMH work experience; prior rural Australia

exposure; staffing levels; and remoteness of town. These are listed under the relevant categories in Table 4.5.

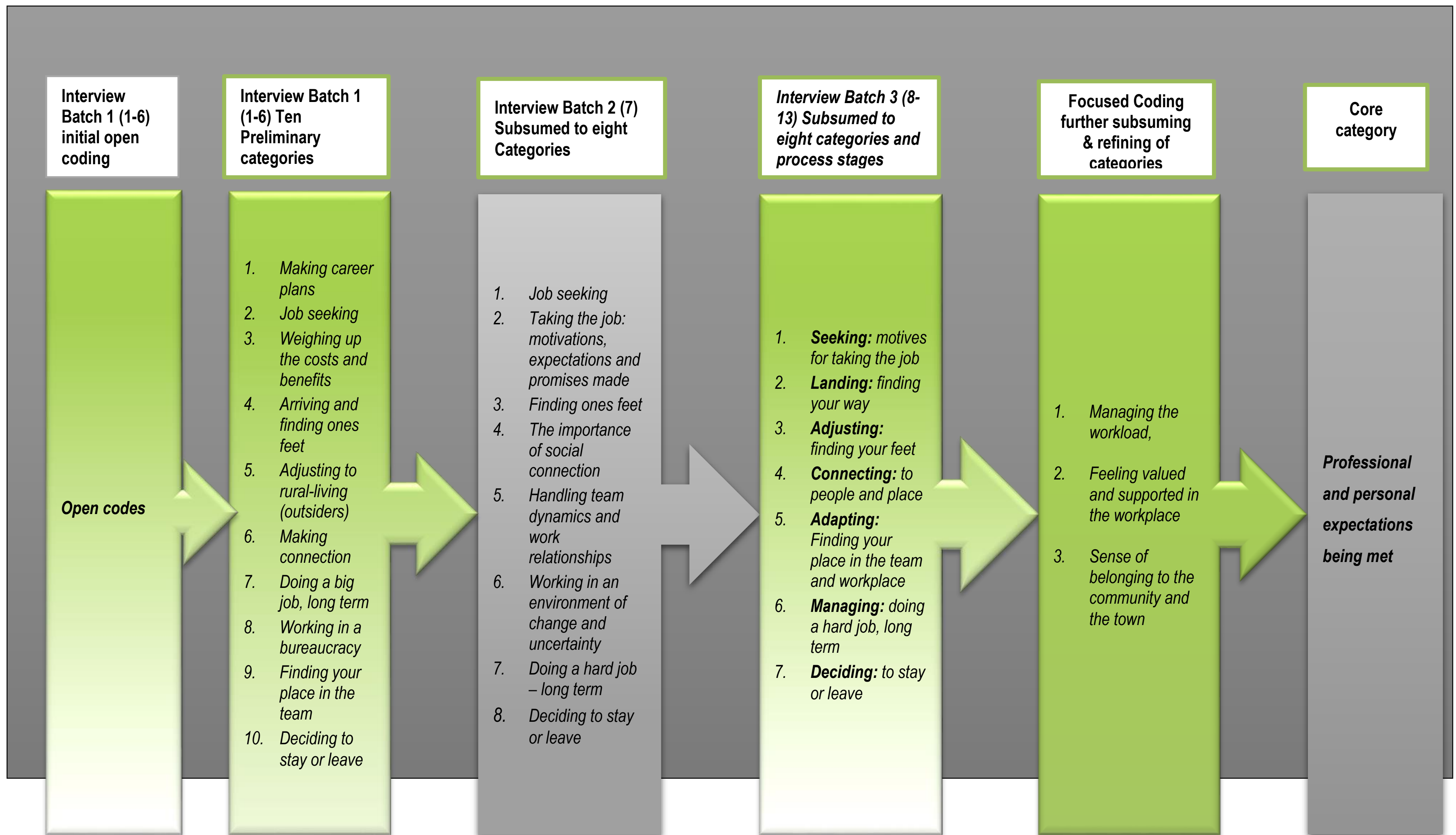


Figure 4.3: Development of categories and identification of the core category

Coding of Batch 4 (interviews 14 – 26) identified no new open codes and more data on the dimensions/variance of the properties. After coding this batch of interviews the open codes, properties and categories were all re-analysed to try to answer questions about the phenomenon under investigation. These included questions such as: when, where, why, how, who and with what consequences? At this point, open codes were further refined and grouped and subsumed into sub-categories or properties. At this stage of the categorisation there were 40 sub-categories under the seven categories. These are listed in Figure 4.3 (page 108).

Focused coding

At this stage of the coding process, the focus was on identifying the core category. To help with identification, large cardboard sheets and post-it notes were used to visually think through the categories and codes and how things were linked. Freehand diagramming was also extensively used at this stage. While these processes assisted in developing a better understanding of the relationships between categories, identification of a core category remained elusive. To help move through this impasse, the interview transcripts were re-reviewed and a series of memos entitled *Finding that elusive core category* were written. Through re-immersion in the transcript data and ongoing analysis of the categories, sub-categories and their properties, conceptual abstraction increased over time and a core category was eventually identified. The process of finding the core category involved several breakthroughs in reasoning. These are explained in the next few paragraphs and some of the key points from the memos written and diagrams drawn included.

The first important breakthrough came through memoing and from thinking about participants' turnover intention as involving them 'weighing up' a 'basket' of factors relating to their experience of the job and living in the town. The memo in which this was written is included below and the breakthrough idea underlined.

Extract from memo: Finding that elusive core category –'A good enough fit/ goodness of fit'

Another possible core category could be: 'A good enough fit' [...] which is about weighing up a basket of factors across the life domains and that each factor carries a weighting. This weighting depends on the particular characteristics of the individual (i.e. their degree of prior work experience, connection to the town and social supports in place). The weighting of some factors may lessen with time and in others get heavier with time. The greater the weight the harder it is to bear. Too much weight or too many negatively weighted factors the balance will be tipped towards the clinician deciding to leave. A clinician choosing to stay is when the

> *weight of the factors* [they are carrying] *is manageable and the clinician thinks the balance can be maintained.*

Reflecting on what might be in that 'basket of factors' led to further refinement of the seven categories. It became apparent that the category *1) Seeking – motives for taking the job* did not form part of this basket of factors. The coding and transcripts also showed that a major factor impacting retention of early career CMH professionals concerned *6) Managing – doing a hard job, long term.* Given this, it was considered reasonable to subsume categories *2) Landing – finding your way* and *3) Adjusting – finding your feet,* and to make them sub-categories of *6) Managing – doing a hard job, long term.* At this point the description for Category 6 was also re-termed *Managing the workload.* From this analysis, the categories were reduced to four and renumbered: *1) Connecting – to people and place, 2) Adapting – finding your place in the team and workplace, 3) Managing the workload,* and *4) Deciding – to stay or leave.*

A further analytical breakthrough came from reviewing the categories and their properties and memoing. This development started with identifying the importance – with respect to intention to stay or leave the CMH job – of participants' feeling supported and valued in their workplace (or not), as discussed in the extract from the following memo:

> **Extract from memo: Finding that elusive core category – Theory Development so far**
>
> *This morning as I yet again try to identify the core category and revisit the transcripts and coding, a new core category emerged: Feeling supported and perceiving a future. I realise this is what is at play from the outset for all early career CMH professionals, as they progress through various stages: adjusting, connecting and adapting. Choosing to stay is about feeling supported in the job and in the town and perceiving a future. Deciding to leave is when you don't feel supported and you can't see a future.*

It was apparent from this memo that the level of ease with which participants adapted and were able to manage their jobs was associated with the extent to which they felt supported and valued in the workplace as well as their sense of belonging to the town. Given this, it was decided to redefine the two categories: *1) Connecting – to people and place and 2) Adapting – finding your place in the team and workplace* to*: 1) Sense of belonging to the town* and *2) Feeling valued and supported in the workplace.* The four categories now became: *1) Sense of belonging to the town, 2) Feeling valued and supported in the workplace, 3) Managing the workload,* and *4) Deciding – to stay or leave.*

Table 4.5: Initial coding process (categories, sub-categories and properties)

Categories						
1. Seeking: motives for taking the job	***2. Landing: finding your way***	***3. Adjusting: finding your feet***	***4. Connecting: to people and place***	***5. Adapting: finding your place in the team and workplace***	***6. Managing: doing a hard job, long term***	***7. Deciding: to stay or leave***
Sub-categories						
Going where the job is	Encountering a *baptism by fire* (no orientation)	Adjusting expectations with reality	Maintaining ties to home	Importance the support of other team members	Having to do extra – the additional work posed by distance	Committed to staying in the town
Wanting to fast track career	Being shown the ropes (receiving orientation)	Getting comfortable with clients	BYO social supports	Navigating the team dynamics and finding your place	Coping with big workloads	Having access to training and professional development
Seeking work in *this* town	Feeling welcomed	Learning to live with risk	Starting out – making connections	Managing inter-professional tensions	Having to be self-reliant	Receiving regular clinical supervision
Seeking work in the area	Encountering hostility	Navigating skills and learning gaps	Already connected	Managing working in an environment of uncertainty	Coping with zero degrees of separation	Being supported to develop skills
Wanting to return home	Being thrown in the deep end	Learning to manage the paperwork burden	Navigating the terrain of making friends with work colleagues	Managing working in an environment of constant change		Having opportunities to step up and progress career
	Being gradually immersed	Understanding the MH system and NSW Health's framework	Experiencing the personal impacts of MH stigma			Having opportunities to link into profession-specific networks
	Feeling like a second class citizen					Having the support of first-tier management
Properties						
Prior rural Australia exposure prior CMH work experience	Time in the job, prior CMH work experience, staffing levels prior rural Australia exposure	Time in the job, prior; CMH work experience		Time in the job, staffing levels	Time in the job, staffing levels, team dynamic, remoteness of town	Time in the job

The analysis was beginning to indicate that the core category was about hope and deciding to leave a CMH job involved a loss of hope, which was an important aspect of the three categories underpinning turnover intention (deciding to stay or leave): *1) Sense of belonging to the town 2) Feeling valued and supported in the workplace,* and *3) Managing the workload*. As Category 4–*Deciding to stay or leave* was a direct consequence of the degree of hope a participant was experiencing with respect to the other three categories, it was decided it was an outcome of hope not an influencing factor and so was removed. This experience of loss of hope was also diagrammed and is included below in Figure 4.4.

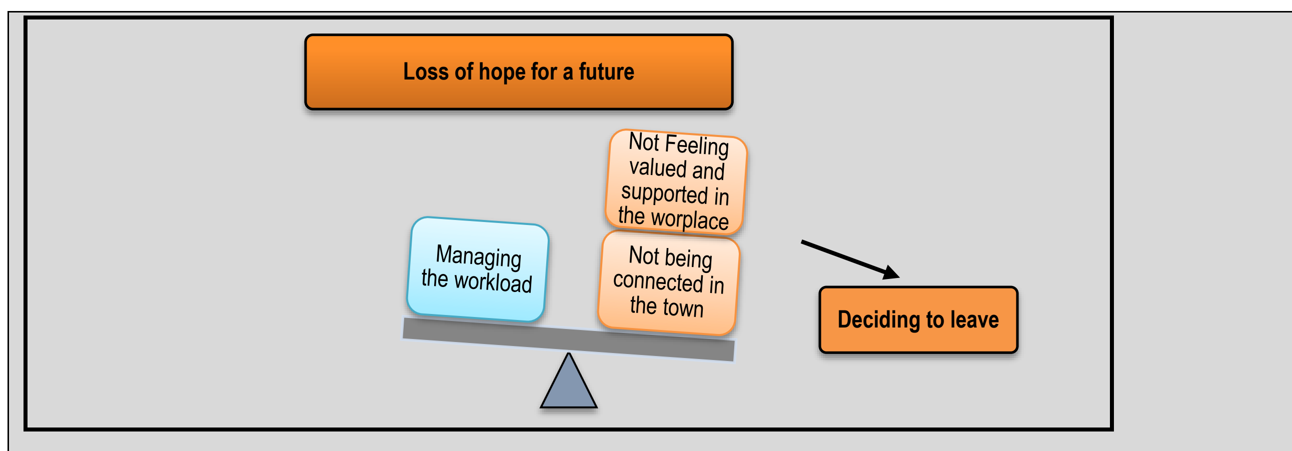


Figure 4.4: Finding that elusive core category – Perceiving a future – weighing things up

By this stage it had become clear that all three categories concerned the extent to which participants' professional and personal *expectations* and *aspirations* were *being fulfilled* by being in the CMH job and living in the town. To improve the core category's explanatory power, *aspirations being fulfilled* was subsumed into *expectations being met*, as both were considered to have similar meanings. The core category was *professional and personal expectations being met*.

At this point a storyline was written to articulate the relationships between the identified core category, categories, sub-categories and properties and the 26 transcripts reread. Comparisons were made with regard to the participants' experiences and their fit with the core category. The core category was found to account well with both the coding and categorisation developed and the experiences of CMH professionals outlined in the transcripts.

Advanced coding

At this point of the analysis, a further literature search was undertaken with respect to the key factors identified as impacting participants' turnover intention with the aim to situate the findings in the existing literature. This literature search highlighted that burnout and job (dis)satisfaction were the two main impacting factors on CMH professionals' turnover intention. In the research, burnout was linked to heavy workloads and CMH professionals having a very strong commitment to their clients and the work. Job satisfaction was associated with a broad range of factors involving the work role being performed, the organisation worked for, and the career opportunities available. Given the broad range of factors associated with job satisfaction, it was decided that it would be a fitting measure to use for the work role, organisational and career building aspects included in categories two and three: 2) *Feeling valued and supported in the workplace*, and 3) *Managing the workload*. As these categories included both employment and career building aspects, it was decided that a broader measure than job satisfaction would be appropriate, so *Professional satisfaction* was decided on as the umbrella measure to describe both satisfaction with the current job and career building satisfaction. It was also decided that *personal satisfaction* would be a suitable measure for the aspect identified as impacting individuals' personal expectations – that is, their *Sense of belonging to the community and the town*. From this, the categories of the core category were reduced to two: *1) Professional satisfaction with the current job and career building* and 2*) Personal satisfaction with the community and the town.* The core category and the categories, sub-categories and properties decided upon after theoretical coding are detailed in Table 4.6. These are fully explained in Chapter 5: Findings.

Glaser's (1978, 1998) theoretical coding families were also used to assist theory building for this study. Using the six Cs, Process, Unit and Unit Identity allowed for exploration of causes, conditions, stage, transitions, temporality, group, organisation, social world and professional identity, which assisted with the basic social process of change identified and the four stages: *initial adjustment, continuing adjustment, having adapted,* and *weighing it all up* and development of a grounded theory of turnover intention (*the reality gap*). The basic social process and the theory are also included in Chapter 5: Findings.

Table 4.6: Final core category, categories, sub-categories and properties

Core category	
Professional and personal expectations being met	
Categories	
1. *Professional satisfaction with the current job and career building*	2. *Personal satisfaction with the community and the town*
Sub-categories	
Relationships • Staffing issues • Team dynamic • Profession differences • Support from service-level manager • Organisational management and interface with senior management Role • Working with a demanding client group • Working with limited resources • Managing a big workload • Challenges of providing interdisciplinary care and generic case management • Safeguarding client privacy and confidentiality Career • Maintaining a professional identity • Receiving support for mental health skill building • Opportunities for career advancement	• Sense of belonging to community and/town
Properties	
• Extent of prior relevant work experience • Time in the job and degree of adjustment/adaption	• Extent of insidedness/outsidedness

4.4.3 Reflexivity

As a researcher's experiences and attitudes influence how the data is collected and the interpretation of that data, they must position themselves in relation to the research. That is, the researcher must critically reflect on how their background, experiences and assumptions will/has influence/d the research study.

Charmaz (2014) argues that, when using GT methods, it is the methodological frameworks used, as well as the underlying philosophies of the researcher that influence how the study is designed and the data gathered and analysed. This echoes Strauss's (1987) view that it is the researchers' biographies and experiences that influence the GT methods they choose and the way they are used and therefore they need to be accounted for and made explicit. This 'accounting for' is referred to as 'reflexivity' and involves an active and ongoing reflection by the researcher as to how their knowledge and personal experiences influence and shape the research design, data collection and analysis.

> Reflexivity is the process of reflecting critically on the self as researcher…it is a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself
>
> (Guba & Lincoln, 2005, p. 210).

Clarke (2005) describes the researcher's role as being one of 'actor, designer, interpreter, writer and constructer of the data, ultimate arbiter of the accounts proffered and as accountable for those accounts' (p. 12). So, to be consistent with a constructivist GT approach and to support quality in the research process, I tried to be aware of and transparent about my subjectivities and interpretations; that is, to understand myself and how my viewpoint, knowledge and experiences may have potentially impacted upon the study.

My reflexive process began with trying to understand the impact of my own values and experiences upon the research. The choice of a qualitative research approach reflects my personal affinity with storytelling and my world-view, which is that there is no one truth: that individuals construct their realities. The study has also been informed by my experiences as both a community development worker/project manager and researcher. It has also been influenced by my experience of moving from a capital city to live in a small rural town in NSW and, associated with that move, my experience of transition and changing sense of belonging, as well as experiences of navigating the realities of there being limited access to health resources in rural Australia. This study has also been influenced by the fact that I was not a health professional and had never worked in a rural CMH service or for NSW Health.

Clarke (2005) contends that 'reflexivities are needed that enhance our capacity to address all kinds of differences, certainly including those of power and authority' (p. 15). I recognised that my desire to make a difference could potentially lead me to side with the CMH professionals against management. Wherever possible I tried to be conscious of this and work to mediate its impacts. An outcome of the pilot study was that it helped build understanding from management's viewpoint. I recognised that my diverse work background gave me the confidence to interview participants from different cultural backgrounds, different ages, professional backgrounds, and political and social perspectives, making it relatively easy for me to establish rapport with participants and establish a relaxed environment for the interview, thus helping participants to delve deeply into their employment and personal experiences.

Clarke (2005) posits that all reports are deeply mediated by the researcher. Throughout the research process I often reflected on who I was giving voice to, and whether I was silencing or omitting anyone in this process. I tried to remain aware of the risk of presenting data that favoured one particular viewpoint or quieted a contradictory or outlying viewpoint. As the data collection progressed and the negative stories were mounting, managing this challenge grew, so I worked consciously to ensure both positive and negative experiences were explored with each participant. During this study I tried to ensure that the complexity of the participants' experiences was honoured and that the 'voice' given to participants was as close to their experience as I could make it.

This section presented the research design used for this study and discussed the participants, ethical considerations, data analysis leading to the identification of the core category and the basic social process and supporting theory development. It concluded with a discussion of the issue of reflexivity.

4.5 Summary

This chapter has focused on the theoretical orientation and the design of this study that relies on the theory/methods package of symbolic interactionism and constructive grounded theory to investigate how employment and rural-living impact the turnover intention of early career CMH

professionals in their first few years of working in a rural service. The following chapters detail the results and discussion about the findings from the interviews undertaken

5. Findings

This chapter presents the findings from the research study undertaken with 26 early career health professionals working in rural-based NSW Health CMH services. A qualitative approach was used to investigate the employment and rural-living factors impacting participants' turnover intention in their first few years of working. Using a grounded theory research methodology, the research question was answered through analysis and coding of the data, which led to the identification of a *basic social process* (Study Objective 2) and the development of a *substantive theory* (Study Objective 1) explaining the employment and rural-living factors impacting on early career CMH professionals' turnover intention (Research question). This chapter starts with a presentation of the findings from the analysis and coding process that was undertaken and then explains the *basic social process* and *substantive theory*.

By undertaking GT coding and identifying a core category and its underlying categories, sub-categories and their properties, turnover intention was found to be determined by the extent to which participants' professional and personal expectations were met (*the core category*) and these expectations were governed by a participant's level of professional and personal satisfaction (*categories*). Professional satisfaction was determined by factors involving relationships, the role and career opportunities while personal satisfaction was determined by the sense of belonging to the community and town (*sub-categories*). Participants' satisfaction levels were observed to vary and be affected by prior relevant work experience, time in the job and the extent of their felt insidedness – outsidedness. Figure 5.1 (below) shows the relationship between participants' professional and personal satisfaction levels and the extent to which their expectations were met and their turnover intention.

In this chapter, the findings are presented in five sections beginning with factors impacting participants' professional satisfaction, then those affecting personal satisfaction and then discussing the turnover intention of participants. The basic social process identified is then discussed and the chapter concludes with presentation of the substantive theory explaining turnover intention.

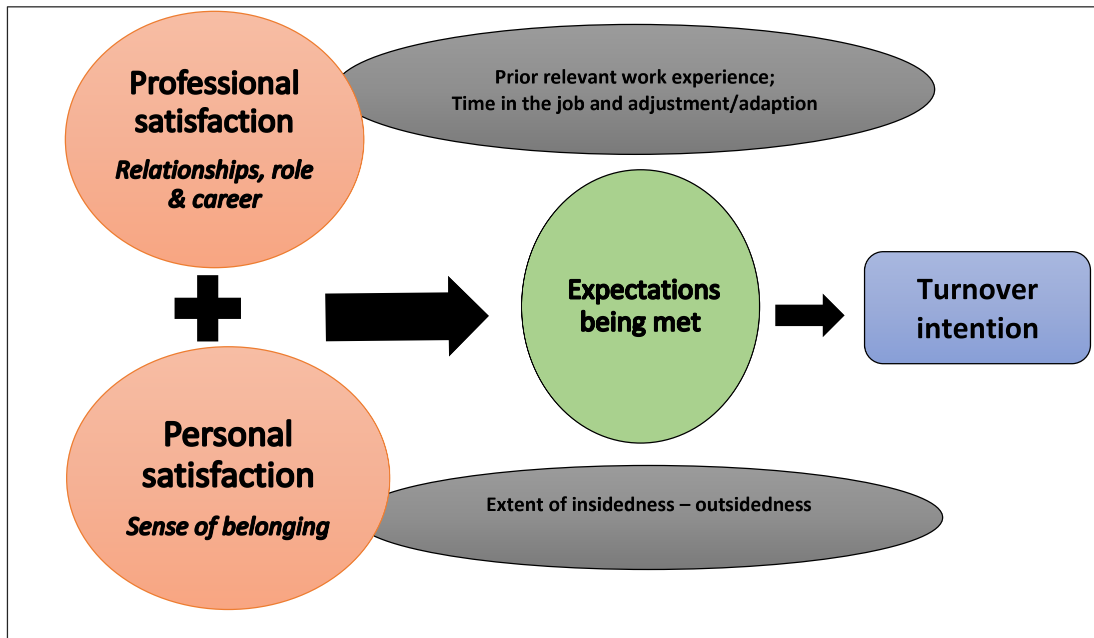


Figure 5.1 Factors influencing turnover intention and the causal relationship

5.1 Professional satisfaction

This section outlines the key aspects affecting the professional satisfaction of rural-based early career CMH professionals in their first few years of working. At this point the reader is reminded that, for this study a symbolic interactionist framework is being used. This means that individuals are considered to make meaning of their situation and experiences through their social interaction with others and that this process is emergent. To assist with the presentation of the analysis, relationships, role and career aspects of the job are separated but social and relational factors are felt to underpin them all. These are now presented separately below. This section concludes with discussion of the particular characteristics of the individual that intensify or reduce their professional satisfaction.

5.1.1 Relationships

Participants' professional satisfaction was found to be strongly influenced by the quality of the relationship they experienced with other workers and with the organisation generally, and that these 'work' relationships were affected by staffing issues, team dynamics, professional differences, the level of support felt from the service-level manager and the organisational culture and interface with senior management. These factors are discussed below.

Staffing issues

Participants commonly attributed chronic staffing issues to negatively impacting on both their workloads and job satisfaction. Chronic staffing issues were linked to both high staff turnover and long-term unfilled positions. High staff turnover was reported by nearly all participants as being a major issue affecting their service, as Natalie, discussing the staffing in the CMH services operating in towns A, B and C, highlights:

> *I could say, I was there for three and a half years and in the whole cluster there would probably be four staff that were* [still] there [from] *when I started,* [and that was] *across the three sites. And there's been times in* [Town C – small rural town, outer regional area] *when that* [service] *had seven plus clinicians.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

A range of reasons were proffered by participants to explain this high staff turnover, including: less experienced health professionals moving from elsewhere taking the job as a career stepping-stone and only ever intending to stay short-term; an increasing number of long-term staff members reaching retirement age; and resignations because of staff struggling to perform the job, and/or having issues with other team members and/or the service manager or having become disenchanted with the broader organisational management. In the two larger services (Towns E and F), participants observed that turnover rates across the different sub-teams often varied significantly and related this to there sometimes being issues with the particular client group or with a particular team leader. Joseph discussed how one team leader's approach to the work and their leadership style resulted in high staff turnover in his CAMHS team:

> *I have been in the service almost three years now and it's a long time, because there were a lot of changes in the team, a lot of staff have left the team because of some issues with management. Two left because of issues with management, no three, no four*
>
> [Joseph (18), 42 yrs, Social Worker, Town F – large rural town, inner regional area]

While high staff turnover was commonplace in the CMH services included in this study, there was one exception: Town G – medium rural town, inner regional area. This CMH service comprised a small team of approximately 13 full-time positions and had no staffing vacancies. Its last staff recruitment had been three years earlier with Lara (Participant 21). Participants explaining the team's stability (Katie – Participant 20, Lara – 21 and Charlie – 22) made mention of the team having very strong organisational social capital and striving for clinical excellence. Each participant discussed the team encouraging staff members to build up their MH skills as well as to

pursue an aspect of MH care that was of particular interest. They also discussed the town being a very 'liveable' place. As Lara, who moved from a regional city and subsequently decided to settle in Town G, explains:

> *But a lot of it is based on the quality of the place to live. Everyone will probably stay in the role because this is a great place to live. People have their family and friends here compared to someone like* [Town F large rural town, outer regional area] *(laughs).*
>
> [Lara (21), 30 yrs, RN, Town G – medium rural town, inner regional area]

Notably, Town G, compared to all the other CMH sites, was much closer to the coast and to several major regional cities and had a larger population base (23,000) than the other non-major rural towns included in this study.

As well as experiencing high staff turnover, many participants spoke of their service experiencing frequent changes of their service-level manager and/or the clinical coordinator and periods when these positions were unfilled, leaving the staff feeling unsupported, as Natalie's experience highlights:

> *I had been there the longest out of the clinicians that are in there at the moment. So I have experienced a variety of managers […]. When I first started there was no service manager, it was the clinical coordinator doing everything. And then X was stepped into the service manager role and we hardly ever saw her, she would just nod her head and say: 'Yes' to everything. But really we had no [management], it was again that sort of surface superficial involvement. There was no real substantial involvement in anything. So […] it still felt like we didn't really have a service manager*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

The effect of this high turnover among service-level managers often resulted in procedural change being fairly constant as new managers made their mark. Some participants described this as making the work environment unsteady, as Bede explains:

> *We haven't had a permanent manager for who knows how long. We have already been through a few and every new manager that comes in wants to try something different and it makes the whole place a little bit unstable. We are not really sure in what direction the workplace is going in*
>
> [Bede (16), 24 yrs, Aboriginal MHW trainee, Town F – large rural town, inner regional area]

As well as generalised high staff turnover, participants often mentioned their CMH service having long-term unfilled positions. Not surprisingly, with increasing remoteness (in the outer regional and remote areas), participants described unfilled positions as being both highly prevalent and protracted. In the two remote service sites (Towns H and I), staffing vacancies were so severe that agency nurses were permanently relied upon, as Alice describes:

> *Because we have no full-time staff, no Adult staff, no full-time clinicians, there are just agency nurses, they come for three months and then they are gone again. They work full-time while they are here, but every three months we are getting a new worker. They just can't fill actual clinician roles and they haven't since we have been here. So we have seen six or seven different agency nurses* [since starting].
>
> [Alice (23), 23 yrs, Aboriginal MHW trainee, Town H – small rural town, remote area]

As well staffing shortages being more severe in the remote sites, there were also greater difficulties experienced retaining any recruited staff. Madison observed that, during her five years working in Town D as a sole clinician, all the staff who were recruited left within a fairly short time frame, as she explains:

> *There was only a CAMHS worker* [herself] *because they couldn't successfully recruit and fill the two vacant positions there* [Adult roles]. *They'd occasionally have people pop in, and they would last maybe two or three months, but mostly they* [those positions] *were vacant for the five years I was there.*
>
> [Madison (6), 34 yrs, Psych, Town D – small rural town, outer regional area]

Several participants attributed this 'revolving door' phenomenon among newly recruited staff to the additional challenges of taking up a long-term vacant position. This included such things as facing a backlog of unattended community need, as well as there often being no one to give them a handover or orientate them into the job. Zeena, who took up one of these long-term vacant positions, discussed how she felt under-prepared to meet the demands of the role:

> *I've had some really tough things happen […] I have been working in mental health for older persons and that was tough because no one did the job before I started. So I had no handover, it was vacant for over two years. And it used to be in a nurse-specified role, and I can understand why now, because older people have a lot of complex medical medication issues.*
>
> [Zeena (1), 51 yrs, Social Worker, Town A – small rural town, outer regional area]

Clarke felt that in the service he worked, the reclassifying of several previously nurse designated positions to MH professional roles was an attempt by management to try to fill the many long-term vacancies, as he explains:

> *It's funny, because we do have designated positions for the cluster but I think they are changing that because a lot of the time we haven't been getting nurses when nursing positions come up. So* [now they are] *advertising it as being a mental health professional, so they are just opening it up to all mental health workers. They are probably just chasing the best candidates, hopefully. Because a lot of times they've recruited over the years and never had any interest because they were specifically related to disciplines.*
>
> [Clarke (3), 29 yrs, Aboriginal MHW graduate, Town B – small rural town, outer regional area]

Chronic staffing shortages were also attributed to having to manage high levels of responsibility and, in the more remote areas, this was also often without much access to senior MH professionals, as Natalie's experience undertaking MH assessments attests:

> *If I was to assess someone in our assessment centre* [large regional city]*, I would see them, then possibly a nurse […] and then a psychiatrist would see them and then a decision will be made based on everyone's assessment and recommendations about what the plan is for the person. So there is no individual accountability, I guess. Whereas in* [Town B – small rural town, outer regional area] *I would see them and I would be the only person with any mental health knowledge being asked to make a call about whether they should be allowed to go home […] and if you wake a psychiatrist up or interrupt the on-call psychiatrist when they are in the middle of something, they're not usually too happy about it.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Team dynamic

The team dynamic and relationships with other team members were discussed by all the participants and described as being a critical factor influencing their job satisfaction and their turnover intention, as Kalinda's response highlights:

> [The team] *does function. We are lucky here and I think that's why I stay because I love everybody here in this team. I've got a good team. I could leave this role, and even though the job could be good somewhere else, I could end up in a team full of arseholes. You know what I mean?*
>
> [Kalinda (8), 32 yrs, Aboriginal MHW graduate, Town E – large rural town inner regional area]

Participants discussed the team dynamic being influenced by a range of factors including: the mix of experience levels; the professions represented; the range of ages; and, gender balance. In the larger services in the inner regional areas (Towns E and F), a few participants spoke of there being negative undercurrents and tensions between the sub-teams. In particular, several participants discussed having difficulties interfacing with staff from the CAMHS team. Several participants described the CAMHS team as working quite separately from the other sub-teams. Madison (Participant 6) explained that this perception of CAMHs sitting apart was probably accurate and related to CAMHs workers in rural NSW Health being managed from a central base in a major regional city. In the smaller teams operating in the outer regional and remote areas, sub-team dynamics were less of an issue as the small team sizes meant the team mostly operated as one, as Katie explains:

> *[Interviewer] So you've got CAMHS, older persons mental health, adult mental health, how do you work together?*
>
> *[Participant] We pretty much function as one team.*
>
> *[Interviewer] Do you think that's because you're a small team/service?*
>
> *[Participant] I think it is, and the two drug and alcohol workers are very closely linked with the mental health team as well.*
>
> [Katie (20), 30 yrs, OT, Town G – medium rural town, inner regional area]

In some services, the mix of staff was described as being very limited and nearly always so in the smaller teams operating in outer regional and remote areas. Participants working in those teams described the staffing mix as mostly comprising newly graduated staff from the allied health professions and a few long-term, very experienced hospital-trained psychiatric nurses. Several of the newly graduated participants working in those teams described feeling bullied and sabotaged by the older, very experienced nurses when they started in the job, as Natalie describes:

> *And the nurse that I was with, the nurse that was working there, was someone that was quite* [pauses] *manipulative and a bit of a bully. And so it made it really difficult for me to ask questions and feel like I was getting the accurate answer. Rather than, when it came down to it, that person felt threatened. I guess. By having someone new in the service that presented a different opinion. So there were times when I was given misleading information to sort of steer me down the wrong path.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

However, this experience may be an issue, particularly for newly graduated allied health professionals given their professional identities were still developing and they would be unlikely to have the confidence to argue a different therapeutic approach with more experienced team members from other health disciplines. Two other participants (Madison – Participant 6 and Jacob – Participant 12) described really appreciating having older nurses on the team and feeling they offered valuable clinical experience and leadership to other team members. Notably though, this was discussed in the context of supporting newly graduated nurses entering CMH, as Madison's comments highlight:

> *The two nurses that we've had on our team have been around for the last decade in mental health, so they are really, really super experienced. So what that means for us, is that we have this great fount of knowledge that our new nursing staff are able to access.*
>
> [Madison (6), 34 yrs, Psych, Town D – small rural town, outer regional area]

The degree to which participants felt they worked in a supportive team environment was also described as being highly sensitive to staffing changes. In particular, participants working in the smaller CMH teams often described feeling that even a single staff member leaving or joining the team affected the dynamic, either positively or negatively. However, the opportunity to significantly change the dynamic was welcomed by some, as Saskia explains:

> *I have to tell you I was quite relieved when she retired* [a long-term psychiatric nurse]. *I think there was a big shift in the dynamics and that tension went. Because there's been changes with staff, myself and another staff member started at the same time and then there was another one towards the end of the year. And then X came back from maternity leave. And then Y started in May. So there's been these changeovers and every time that happens the team shuffles a little bit. It is not necessarily good or bad it is just different. But I'm definitely enjoying it more now.*
>
> [Saskia (2), 23 yrs, Social Worker, Town A – small rural town, outer regional area]

Profession differences

Although nearly all participants were recruited as generalist caseworkers and, in the main, were expected to perform the same job, in reality this was not always the case. Madeleine explained that as an RN she had responsibility for administering intravenous medications to all the service's clients but that her caseload allocation was the same size as that of the allied health professionals working in the team. She discussed being expected to carry out this *medical stuff* on top of an

already full caseload, which resulted in her instituting rules about when and how she would provide the service, as she explains:

> *The service manager […] asked me to change my study day because there was several people in the team that found it difficult that there was no available RN on a Friday afternoon. And I was livid for so many different reasons. One it was because they* [other team members] *have people drop in for an* [unscheduled] *injection and there was nobody to give them one. And it's kind of that expectation that I'll be sitting around waiting to jab people!* [Like] *that's what we do, like we don't have a caseload, you don't have anything else on your agenda! We've got a clear diary and that's it. I just think that there was that lack of professional respect there.*
>
> [Madeleine (9), 42 yrs, RN, Town E – large rural town inner regional area]

Mia, a clinical psychologist, described feeling that she was often allocated the more difficult and complex clients as a matter of course and felt this was unfair and negatively impacted on her professional satisfaction.

> *I don't know whether it's just expected or it's within my role. I know that I see a lot more crisis clients or clients with severe symptoms as compared to an OT or mental health nurse. They see clients with mild to moderate symptoms. So I'm picking up a lot more challenging and difficult clients and that in itself weakens the multidisciplinary approach. There are huge inequities in that, then. It leaves you feeling on a personal level: 'What the hell I am doing? Why am I doing this for, if no one else on the team is stepping up and dealing with it? Where do I fit in with that?'*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Participants also described feeling aggrieved because, despite all being recruited to perform the same generic case management job, they were not paid the same, being employed under different Awards. In particular, nearly all of the Aboriginal MHWs discussed feeling resentful about the substantial pay differential that existed between them and the other CMH professionals in the team, as Kalinda's response highlights:

> *I'd like to get paid like a social worker because I do the same thing as a social worker. That would be nice.*
>
> [Kalinda (8), 32 yrs, Aboriginal MHW graduate, Town E – large rural town inner regional area]

Support from service-level manager

All participants felt that feeling valued by their service-level manager was an important contributor to job satisfaction. They explained that 'feeling valued' by their manager involved believing their manager understood the challenges and demands of their job and appreciated their efforts. Participants discussed a range of ways their manager demonstrated (or not) their support and appreciation. Consulting with staff and taking into consideration staff's clinical expertise and on-the-ground operational understanding before implementing any procedural/system changes was often mentioned.

Several participants felt that the relationship with their service-level manager had been affected by the promises made to them during recruitment and whether these were delivered. Jacob (Participant 12) described appreciating that the manager who had recruited him had been honest and up-front about the fairly limited financial support he could expect to receive for undertaking CPD activities. Other participants described their service-level manager making false promises to them, particularly in regard to the level of clinical support they would receive on the job, the career advancement opportunities and, for a few, about the rural-living experience, as Mia discusses:

> *When I was recruited into the team, I was promised all kinds of things, here's the silver platter: 'We've got this to offer you and this to offer you and this to offer you. And it's fantastic to work out in* [Town B –small rural town, outer regional area]. *And you'll be working in a well-supported team' and all these kinds of empty promises.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

The participants who felt that recruitment promises had been made and broken described feeling ongoing resentment to the manager. However, not all participants responded to broken recruitment promises like this; their response appeared to be related to the degree of mismatch between their expectations about the job and the reality they met. Natalie (Participant 7) is a good case point. While she also described having had exaggerated promises made to her during recruitment, she had not expected they would ever be delivered and so did not experience any disappointment. She described having a fairly open and positive relationship with her service manager over the three-and-a-half years she worked.

The difference expectations play is exemplified by comparing Natalie's response with Zeena's. Zeena had taken up the job on the basis of promises made to her regarding the opportunity to fast-track her career in NSW Health by working in a rural service for a few years and then being able to apply for a re-grading of her position. She described that the anticipated pay rise associated with this advancement was also an influencing factor in taking the job. When she realised that this process had been misrepresented to her and would be extremely difficult, if not impossible, to achieve, she described being very disappointed and feeling that her service-level manager needed to make amends:

> *I've said to* [service-level manager], *I feel like you owe me a career path now because that didn't come through* [re-grading and pay rise] *and I sort of felt that I made a sacrifice to come and be here.*
>
> [Zeena (1), 51 yrs, Social Worker, Town A – small rural town, outer regional area]

The participants working in understaffed teams were asked to suggest ways of reducing staff turnover in rural CMH services. Not surprisingly, several made mention of the importance of the service-level manager being 'straight up' during recruitment. This was discussed as being particularly important for those interviewees who had little or no CMH experience and/or experience of rural-living, as Jacob, who had recently qualified and was from the UK, explains:

> *[Interviewer] And what's that being honest about, which bits?*
>
> *[Participant] Just about how remote and rural we really are here. Being honest about training opportunities and supervision opportunities and professional development opportunities and growth opportunities, that type of thing. Because you start to feel that you've been done-over when you find this stuff out for yourself. I think that leads to a lot of resentment and frustration.*
>
> [Jacob (12), 23 yrs, RN (Psychiatric), Town E – large rural town, inner regional area]

Feeling supported by the service-level manager was also described as relating to the staffing choices they made. Some participants described facing increased workloads and responsibilities as a direct result of their manager recruiting ill-suited and/or poorly skilled health professionals to perform the job, as Mia describes:

> *When the new clinician came into the team, that clinician was found not to have the abilities or capabilities [...] or even the understanding of what it's like out here in*

> *a rural area. Then that impacted on us because we had to pick up that caseload too and dissolve it back into our caseloads. It was just a nightmare!*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Some participants felt that these poor staffing choices were because of the difficulties the service-level managers experienced trying to recruit appropriately skilled staff to work in rural services. However, others believed that the poor staffing choices stemmed from the manager: *having* [a] *bums on seats, tick and flick* approach to recruitment (Clarke, Participant 3). A couple of participants discussed preferring to have to manage a bigger workload than to deal with having ill-suited people as team members. Some of the participants who described having big caseloads to manage because of severe staffing shortages and feeling stressed as a result also described forming unrealistic expectations on the capabilities of new staff. A few felt that their service manager also fanned these raised expectations. Natalie explained how having such unrealistic expectations on new staff had negative impacts on all the staff as well as for the team dynamic:

> *For months we were aware that she was coming and she was built up, as […]* [having] *a lot of mental health experience and […] would hit the ground running. Because we were so overwhelmed with work and we were really desperate for another clinician, and so all of the staff thought: 'You beauty, she is going to come in, get an orientation, and she should be able to start doing assessments and start taking on clients', because we were all just at breaking point. The reality […] was […] she needed a lot more orientation than what was set up […]. And so, she ended up feeling like she wasn't meeting the expectations that everyone had of her and everyone else was frustrated because they were expecting something that didn't sort of happen.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Feeling valued and supported by one's manager was particularly difficult for those who thought that their manager had inadequate clinical skills and/or showed poor leadership. Those participants who described not respecting their service manager mostly discussed relying on their team for clinical direction and support, as Lara reveals:

> *I had been quite used to people who gave structure and guidance and being able to trust the leader. As you turn to your manager for guidance and support when you feel out of your depth. I don't have that here, I turn to the team. We discuss everything that we are concerned about […] I don't go to the manager.*
>
> [Lara (21), 30 yrs. RN, Town G – medium rural town, inner regional area]

Some participants working in CMH services in the outer regional areas did not have a service-level manager on site or one regularly visiting and found this made it difficult for the manager to understand the realities of their jobs and respond in a timely way to problems when they arose and was also detrimental to building a good relationship. Mia's situation exemplifies how, over time, this contributed to her growing resentment and job dissatisfaction:

> *But in terms of managing of the front line and issues and struggles with high caseloads, clinical reviews, intake allocations meetings – on the ground stuff. I feel we are not supported to the potential that we could be supported. I feel as though there is an impression that we are quite disposable. 'Not to worry, if you leave someone else will fill your position anyway.' So you're not really an asset as such to the team. I find that quite difficult, given how much study I have done and that I've worked really hard to get here.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Organisational culture and interface with senior management

In respect of organisational management, many participants described feeling that the decision making of senior NSW Health management was very removed from the day-to-day realities of their working lives. A few participants thought that senior management had little understanding of the high levels of responsibility involved in rural CMH positions and this was exemplified by the determinations they made on grading of positions, particularly with respect to jobs in more remote areas, as Jacinta's recruitment experience as a CAMHs sole clinician in a remote town highlights:

> *There needs to be a real awareness… How this position could be Level II is beyond me. This is a sole practitioner job, how is it Level II? I do not know how they came to that conclusion. If you look at the social work levels II, Level III and Level IV, it should not be a Level II […]. So how they ever got the idea* (it was a Level II) *is beyond me. It makes me think they undervalue the work and what is required. The difference is, I think they really need to acknowledge the isolation and the different theories and practitioners who are in more isolated areas like this.*
>
> [Jacinta (26), 53 yrs, Social Worker, Town I – small rural town, remote area]

In trying to explain this perceived lack of effective management, Jacinta attributed it to inflexibility and disconnections in the system rather than the skill levels of people in those roles:

> *The number of different people that I have talked to about my position, they were all trying to be helpful, they actually were. But it's like when you have a locum doctor, the client goes to see six different doctors and you know you are not going to get the same answer are you? You're not going to get the same three, even if they looked at the record. I have seen that with the care here, if people see different*

> *doctors there is going to be disjunctions, there is going to be things that don't work out, and that's what happened to me in my position.*
>
> [Jacinta (26), 53 yrs, Social Worker, Town I – small rural town, remote area]

However, some participants argued the opposite and attributed the poor decision making by senior management to their having low skill levels and suggested their appointments were not necessarily merit-based, as Charlie expressed:

> *Big systems: the less educated you are, the bigger bully you are, and the further you go. That's how it works or that's what I think.*
>
> [Charlie (22), 53 yrs, RN, Town G – medium rural town, inner regional area]

Charlie went on to explain that the longer she worked in NSW Health, the more the bureaucratic culture got her down. Those participants who had worked for NSW Health in different roles and/or other service areas for a long time fairly commonly expressed a high level of cynicism about the organisation (such as Jessica – Participant 15; Karen –19; Charlie – 22; Deborah –24; Bill – 25; and Jacinta – 26). This group mostly described senior management as being self-serving and feeling frustrated by the constant cycle of restructuring (at the state, LHD and service levels). They discussed the pain associated with such changes rarely resulted in any improvements in the operation of the service. As a result, most participants in this group spoke of trying to ignore management as much as they could and just ride out any restructuring, as both the responses from Charlie, who had worked for over 20 years in NSW Health, first as an EN in community health prior to upgrading her nursing qualifications, and then taking a position in CMH, and Jessica, who had previously worked a few years in CMH for NSW Health after graduating, highlight:

> *I never get too caught up in it* [the changes being made]. *They* [senior management] *go: 'These people here and here, and so on. So swap with this job.' But I never try and keep up with it because they swap their jobs around all the time and are always acting, acting, acting* [laughs].
>
> [Charlie (22), 53 yrs, RN, Town G – medium rural town, inner regional area]

> *I think too, that I 've realised if you just sit and ride it out with Health that it will ride out [...] People get anxious or get cross because they take so long to make a decision. But I think, because I've experienced it before, I think they do take forever to make a decision, so don't worry about it, it will happen in the end, it's just Health* [s' process]. *I keep saying, they are putting all these people off and in couple of years' time they will be going: 'We need to recruit again' and everyone will be coming back again.*
>
> [Jessica (15), 37 yrs, Diversional Therapist, Town F – large rural town inner regional area]

Some participants acknowledged that management faced some challenges that would make it hard to ever meet staff expectations and described a 'them-and-us' culture existing between senior management and staff. Clarke's response exemplifies this culture when asked whether he was interested in moving into management:

> *[Interviewer] What about working in a management role in the future?*
>
> *[Participant] No, I just see how much our team and everyone else complains about management* [laughs]. *I don't want to be that person who gets complained about all the time.*
>
> [Clarke (3), 29 yrs, Aboriginal MHW graduate, Town B – small rural town, outer regional area]

Joseph observed that the 'them-and-us' attitude was widespread in the CMH service he worked in and that it was often accompanied by staff resisting changes proposed by management, as he explains:

> *The managers will have a meeting, and they will be talking about how to run the program or reducing the staff or something like that and if that information is not passed onto the staff. They will be thinking they are doing some conspiracy against the staff. But I think basically the workers don't want any change, they like things the way they are and that is a big thing. No one wants to, change is always a threat, even if management is working for more output, more services, better service delivery, workers don't want to be disturbed. That's part of the problem.*
>
> [Joseph (18), 42 yrs, Social Worker, Town F – large rural town, inner regional area]

This 'them-and-us' culture and a widespread resistance among staff to organisational or procedural change was discussed by several participants as arising from staff feeling frustrated by, and exhausted from, working in an environment of constant change. Participants described feeling

that many of the changes implemented were made without consultation or, if they were consulted, their recommendations were ignored. They described feeling that many of the changes made by management were often ill considered and/or unnecessary. The sense of frustration and exhaustion by staff is apparent in the following responses from Jessica and Jade:

> *I got an email from* [senior manager LHD level] *or whatever his name is a little while ago, and it said: 'Yes, I have been consulting with staff' [...]. I thought that's such a wank, telling us that you've been consulting with staff, when I've never seen him? Do you know, I think they* [senior management] *just get so caught up in their 'making changes' and 'wanting to show what they've done'. I think that they need to see services and see how they are working and recognise if they are working well then leave them alone [...] and not have to change everything.*
>
> [Jessica (15), 37 yrs, Diversional Therapist, Town F – large rural town inner regional area]

> *I think the instability* [change of staffing in service-level manager position] *has created a lack of motivation and a lack of uptake of changes by clinicians. Because it has been so unstable and the changes have been happening quite regularly, rather than a new management coming in and saying: 'This is what we are doing now'. It's not been met with resistance but it's been met with an ambivalence: 'What's the point? We will do this, this week but we know it is going to change next week.'*
>
> [Jade (17), 27 yrs, Psychologist (intern), Town F– large rural town, inner regional area]

The quality of the relationships early career CMH professionals have with other team members at work, their service-level manager and senior management and the attitude they have to the organisation and its culture were all found to impact strongly on job satisfaction. These relationship factors were often heightened in the smaller teams operating in the small towns in outer regional and remote areas. Role factors are also important and are discussed next.

5.1.2 Role

The role they performed was found to strongly influence participants' professional satisfaction. Key aspects of the job included: working with a demanding client group; working with limited resources; managing a big workload; challenges of interdisciplinary care; generic case management; and safeguarding client privacy and confidentiality. These are discussed below.

Working with a demanding client group

Most participants described their clients as having very high levels of mental illness acuity and were mostly people recovering from an acute episode of serious mental illness or living with chronic mental illness. Bede attributed the high acuity of illness among CMH clients to the limited funding and staffing of rural services and that low acuity people, if seen, were generally referred on to other services/providers:

> *Pretty much, with our staffing limits versus NGOs, we are only following up the chronic people. If adults come through with anxiety or depression, they can see the psychiatrist and have an assessment done but […] more than likely they will be referred back to their GP to manage medication for depression or anxiety and they can get involved in programs run by NGOs. So we can have people with schizophrenia and psychosis and they are the sort of ones that we keep. So there are no undemanding clients* [laughs].
>
> [Bede (16), 24 yrs, Aboriginal MHW trainee, Town F – large rural town, inner regional area]

The predominance of high acuity clients was also attributed to CMH staff generally being reluctant to arrange involuntary admissions under the MHA if it involved their client having to leave town, and this was the case for all those working in CMH services in the outer regional and remote areas, as Bill explains:

> *We try to keep them out of hospital […]. To get a client from here* [Town I – small town, remote area] *to* [large rural town, inner regional area] *is traumatic for them and traumatic for us. Often the ambulances won't take them, and they have to be 'specialled*[12]*' overnight. And they* [the hospital] *are* [usually] *short-staffed, so they bring in Health's security assistants or something.*
>
> [Bill (25), 63 yrs, Psychologist, Town I – small rural town, remote area]

The client group was commonly described as having challenging behaviours and complex life situations, making it difficult to support them at times, as Natalie explains:

> *We work with a client group that are unpredictable and quite chaotic at times and crisis driven.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Some participants also mentioned that learning to manage and cope with suicidality risk was hard to deal with and not something they ever became fully comfortable with. Joseph described

[12] Assigned an individual staff member to provide one-on-one care

observing himself and other team members being professionally and personally affected whenever their clients had poor outcomes (such as self-harming, suicide attempt and inpatient admission/ readmission), as he explains:

> *Those complex cases affect us. If we have done a counselling session, and the next day we are hearing from the mother that he did self-harming or he tried to kill himself [...]. One of the first things that would be going through our mind is that I'm not a good enough clinician, it must be my fault. […] There is always this guilty feeling we are worrying about it. Did I document that properly, does the documentation protect me? All these thoughts. […] So we are carrying all of this into our personal lives and if you have three or four complex cases, then you won't be happy on weekends* [laughs].
>
> [Joseph (18), 42 yrs, Social Worker, Town F – large rural town, inner regional area]

Clients who were on CTOs were described by a couple of participants as being particularly demanding and significantly adding to their workload, as Mia relates:

> *Our CTO clients, obviously the majority of them are non-compliant with medication. So according to the Mental Health Act, we have to follow certain procedures and protocols with that. And on a day when they are overdue with their medication, we would liaise with the police and ambulance to come with us to find this client out in the community somewhere. That could take six–seven hours of an eight-hour day and you've still got to fit in everybody else in that day as well.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

The stress of working with the client group appears to increase with time and was often linked to burnout (actual and anticipated) as Lowanna explains:

> *It's just the whole dynamics of their whole situation, which can be really frustrating. Sometimes you have to invest so much time into one particular person and it just feels like you aren't getting anywhere. That's draining. That leads to that burnout sensation, the feeling that you just can't give any more.*
>
> [Lowanna (11), 28 yrs, Aboriginal MHW, Town E – large rural town, inner regional area]

Nearly all the participants expressed an awareness of the potential for burnout and the need to take care of themselves and watching out for any early warning signs. A few participants considered CMH to be a short-term career step only, a good place to start their careers and build skills and gain experience, but too stressful to work in for the long-term, as Clarke's response highlights:

> *I'm working here and it's such a stressful environment and you can get paid the same amount of money to mow lawns [...]. Working for council, a person gets paid the same amount of money as I do for trying to prevent someone from committing suicide or trauma or abuse, and all this complex stuff that's going on. And the more it goes on. I think I could just have a simple mediocre kind of job and go there, do the job and get paid the same amount of money and go home and my job stays at work.*
>
> [Clarke (3), 29 yrs, Aboriginal MHW graduate, Town B – small rural town, outer regional area]

While participants often experienced the clients as demanding, they also spoke of being strongly committed to them and drawing much job satisfaction from working with a challenging client group, as Mia explains:

> *I like working in mental health – I like my job a lot. I like being a psychologist. I like the clients, even though they drive me up the wall some days. I've had all kinds of things thrown at me and said to me in ED* [emergency department]. *And that's fine, I can deal with that. That's easy.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Working with limited resources

Most participants made mention of the challenges of working in a resource-constrained environment and discussed the difficulties this presented for them in terms of carrying out their jobs and its negative impacts on the quality of the service provided to client. Staffing shortages/turnover and poor quality and/or ill-suited physical equipment and financial constraints were all mentioned as negatively impacting on workload and, by implication, on the CMH professionals' job satisfaction. Human resourcing constraints were discussed earlier under relationships while physical and financial are discussed here.

Many participants in one LHD mentioned physical resources, and the work inefficiencies caused by having to use an out-dated database software system. Jacinta (Participant 26), who worked in a remote CMH service, spoke of feeling shocked that the tele-conferencing equipment did not work for months. Most participants made mention of experiencing recent cost-cutting and budget tightening and described it as making it increasingly difficult to provide quality client care, as Mia describes:

> *While* [colleagues working in metropolitan areas] *also have issues with the* [NSW] *Health system around funding and resources, it doesn't seem to be to quite the same extent as it is out here and it's been slowly getting worse. I would say things have been becoming more difficult, particularly since the end of last year. That is, in terms of the system, our resources, funding being cut, staffing numbers dropping, caseloads increasing and some difficulties with management as well.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

A staffing freeze imposed in one LHD was described by several participants as negatively impacting on the workloads of the remaining staff. However by far the most mentioned and most strongly felt budget cuts were those on the budget for staff continuing professional development (CPD)[13]. This widespread and intense negative reaction can partly be explained as resulting from unmet expectations. Many participants, particularly in one LHD, had anticipated receiving some financial support for CPD, either because they had received CPD funding before or because promises had been made to them during their recruitment. As Zeena's situation highlights:

> *Here we run on the smell of an oily rag. We don't have any money for training. In my first year I was actually able to go to a conference in Cairns and that was paid for. Now there is nothing, there is no training unless it's being run in-house or someone is running it for free.*
>
> [Zeena (1), 51 yrs, Social Worker, Town A – small rural town, outer regional area]

The issue of CPD is discussed further below in the section on career aspects affecting professional satisfaction.

Managing a big workload

Most participants spoke of their jobs involving big workloads. Some participants talked about feeling their workloads were much larger than their metropolitan CMH colleagues, given that working in rural services usually involved providing additional services (such as conducting emergency department MH assessments if there was no designated CMH staff member to perform that role and/or running outreach clinics). These duties often required travelling by car and driving considerable distances. For example, Madeleine (Participant 9) spoke of running an outreach clinic for a region covering around 5,000 square kilometres, involving two hours' driving on the

[13] In Australia OTs, nurses, psychologists and social workers are required to spend a minimum number of hours every year on approved learning activities to maintain their registration under APHRA or, for social workers, their membership of AASW, and this is commonly termed continuing professional development (CPD).

clinic day. Zeena, in her specialist role covering towns A, B and C, was responsible for a geographic area of 35,000 square kilometres and travelled once a week to either town B or C. This involved between 3-5 hours' driving on the day[14]. Thus, performing these additional duties took up substantial amounts of time. Mia discussed how she was expected to fit such extra tasks into her already full workdays:

> *A typical day is that I arrive here around 8.00-8.30am and then you could be faced with a number of difficulties in terms of ED* [emergency department] *presentations for mentally unwell, suicidal, homicidal clients. We start the day dealing with what's happened overnight. […] I am also giving therapy to over 30 clients at the moment and obviously you have to deal with emergency department on top of your clients. ED involves* [three service sites in small rural towns, outer regional area] *as well and dealing with hospital staff and management within the hospitals as such. This is all before lunch. Today I've just had lunch now* [it was 4.00pm]. *And it just rolls on and on and on.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Paperwork and entering statistics was mentioned by most participants and described as burdensome and taking up far too much time. When asking Karen what she thought her time split between seeing clients and doing paperwork was, she suggested that it probably should be 50/50 but as she always prioritised clients over paperwork, she found it difficult to keep up:

> *It does take a long time to write up assessments, you might see them for an hour or two, for initial assessment but it could take you two or three hours to write it up. And you won't have two or three hours spare that day, because you've got more clients. So then you put it down to finish another time and sometimes that other time maybe next week and I think bloody hell!*
>
> [Karen (19), 53 yrs, RN, Town F – large rural town inner regional area]

In one of the CMH services, when it lost its fly-in, fly-out psychiatrist and so did not have a 'responsible clinician' to review and sign off on clients' discharge plans, the paperwork requirements for staff were described as significantly increased because reporting and statistics were still required, even though the clients were not active, as Madeline explains:

> *There was a lot of people in that group* [clinical review team] *who had huge caseloads because we weren't discharging people. And if you're not discharging them, even though you may not be seeing them, you may not need to see them,*

[14] Again, for comparative purposes, noting that the geographic area of Tasmania, Australia's island state, is 90,758 square kilometres.

> *you've still got to do all their paperwork, you know. And their stats still keep coming up all the time*
>
> [Madeleine (9), 42 yrs, RN, Town E – large rural town inner regional area]

Several participants spoke of having to manage growing caseloads due to staff leaving and/or there being long-term vacancies and feeling that their workloads were unmanageable and contributing to their job stress and job dissatisfaction, as Madeleine's response highlights:

> *I was very stressed, that's why I was looking for other jobs* [laughs]. *I wasn't really looking for other jobs though, I think I was looking for distractions, just something to kind of take the pain away* [laughs]. *[...]. I think it was just the time management, you know, doing all of the groups, as well as the paper work, like all the computer work and the stats and seeing clients and fitting everything into a really limited kind of time frame.* [As well as having] *at one point [...] 40 clients.*
>
> [Madeleine (9), 42 yrs, RN, Town E – large rural town inner regional area]

While accepting that client numbers are a crude indicator of workload, there is still some value in discussing caseload sizes. King (2009) determined, after surveying 180 case managers working in Victoria, that the mean caseload for full-time Adult case managers was 20 clients, although his study did not differentiate the type of client care being provided (such as whether it was active or ancillary care, or clients were being treated under the MHA or not). So, while being cautious about comparisons, given that some participants working as Adult case managers advised having caseloads that were, at times, over double that size (Madeleine – 40+; and Karen – 48), it is reasonable to argue that their caseloads were large. While not having any research papers on the median caseload size for CAMHS workers, but by drawing on King's median caseload size, the average caseload size of 15-20 proposed by Madison seems plausible. Based on this average case size, Joseph (41) and Madison (40-45) were also managing very large caseloads. These four participants all made mention of feeling overworked and stressed and experiencing difficulties managing the client numbers and associated paperwork and that this had a very negative impact on their job satisfaction. Joseph and Madeleine both noted that they had considered in the recent past – or were currently considering – leaving their positions. Madison described her caseload, when she worked as a case manager in Town D, as being *ridiculou*s.

In summary, in a CMH case management role it is usual to have to manage a large amount of paperwork. However, for those working in rural services, there are often other pressures on their

time arising from performing additional tasks such as: emergency department MH consults; providing outreach services; and the travel associated with being responsible for large geographic areas. The staffing shortages and high staff turnover that are commonplace in rural Australia also mean that some rural-based CMH professionals are managing very large caseloads for extended periods. The study participants attributed these factors to workload stress and job dissatisfaction. In particular, having to manage large caseloads for an extended time was described as influencing team members' decision to leave, as Bede explains:

> *To think back about why people have been leaving. […]. People are leaving because they are overworked. But if we had a full team I think it would be different. Before we were understaffed people left because they were moving from town not because of the job. […] But that's what happens* [now] *when you are dealing with 30 or 40 […]* [clients] *because you don't have enough staff and that number is getting bigger whilst our staff is getting smaller.*
>
> [Bede (16), 24 yrs, Aboriginal MHW trainee, Town F – large rural town, inner regional area]

Challenges of interdisciplinary care and generic case management

The interdisciplinary care model aims to address the clinical and psychosocial needs of clients by having professionals from a range of disciplines work as a team. Most participants described being really supportive of the interdisciplinary care approach and believed it offered clients holistic MH care. The usual way that interdisciplinary care in rural CMH teams occurred was through clinical review meetings, which occurred at least once a week at most sites. Less formal approaches, such as drawing on the expertise of other team members from different professions as and when required, were also discussed.

However, to be able to provide effective interdisciplinary care, team sizes needed to be large enough to have a mix of professions. In the smaller teams in the more remote towns, where long-term psychiatric nurses were described as often working in CMH, the medical model was explained as dominating the care approach taken, as Saskia's experience at the start of working exemplifies:

> *Starting in a workplace where you are working with nurses who have an idea that everybody does the same job. There were three fulltime RNs that I was working with at the time […]. It was quite challenging – well it still is challenging – trying to find out where I fitted as a social worker. […]. On one of my first days I said to one of the nurses: 'So, is every client here on medication?' She looked at me kind of weirdly and said, 'Well yeah!' And I'm thinking, 'What do you mean?' Those*

> *kind of ideas of a really strong medical model were really challenging. I felt this pressure to kind of conform to that.*
>
> [Saskia (2), 23 yrs, Social Worker, Town A – small rural town, outer regional area]

Natalie discussed the very negative impacts on interdisciplinary care from working in a team of just two people and where the other staff member – also a psychiatric nurse and long-term CMH staff member – did not value the approach:

> *It's really about how* [much] *the individual clinician values the input from the team member, or that holistic approach and I guess if they are open to feedback. The nurse, that I mentioned, that I worked with first, she would present someone […] in clinical review, and she would just rattle off what the issues were, what she's done and then she'd say: 'Right,' and close it* [the file]*, and we'd move onto the next person. She was very closed to any sort of discussion about: 'Have you considered this? Have you tried this? This could be an option you know?' She was very closed,* [so] *in those cases, in those mental health client's care, there was no real multidisciplinary input, apart from the nurse and the doctor.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Mia discussed how relational issues and a lack of professional respect between team members affected the ability of the team to provide interdisciplinary care:

> *If you don't like someone, you don't like them. How are we expected to respect them and hear their feedback if you don't like them? Or you don't trust them or you don't believe they are a capable or competent clinician, how do you take that on board? You don't. So again it's not a multidisciplinary team, it's just a team with different disciplines in it!* [laughs].
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

The ability to provide quality interdisciplinary care was considered by some participants to be negatively impacted by the constraints and demands of the rural CMH work environment combined with the generic case management approach. The impact of staffing shortages and high demand for services in rural services meant that client allocation was mostly determined based on a staff member's current caseload and trying to share the client load equally rather than matching client's needs to the most appropriate team member, as Natalie explains:

> *There's a big crossover, in the rural environment, between disciplines I guess, or the functions of clinicians. If someone specifically needed a type of psychological therapy they would ideally be allocated to X, because she's the psychologist. If someone specifically needed something that I was more able to support them with*

> *or if someone was Aboriginal and wanted specifically to see an Aboriginal worker, you know, they would be allocated accordingly. But if at those times when, you know, if I have 30 clients, and someone else only had 10, that person that needed a social work service might be allocated to the person with the smaller caseload. In which case that person might consult with me about things, but would essentially perform a pseudo social work function with the client.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Further to client allocation, Mia described feeling frustrated because she only got to use her psychology skills with the clients she was allocated and not more broadly across the team. She described this as being a *huge downfall* of working in a rural service. She believed it was something particular to rural practice and that it did not occur in metropolitan services, as she describes:

> *I've talked to my supervisor in* [a regional capital city] *and other colleagues as well and we talk about the psychologists working in teams outside of this area. Whilst they still work in multi-disciplinary teams too, within them it's very clear what the role of an OT, social worker, or psychologist is within that team. Rather than being seen as being just like everybody else and doing the same work as everyone.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

However, despite the challenges of working in generic roles, several participants described working in a generic role as really stretching them, broadening their skills and clinical understanding far beyond their own profession-specific knowledge and skill base, as Natalie describes:

> *I think it has, because I have an understanding of those processes and of the different roles. And* [now] *I've got skills in areas, I've got knowledge about medication and about things that ordinarily nurses would be involved with. But I learnt about because I had to, because the client needed that from me, so that's what I provided.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Safeguarding client privacy and confidentiality

All MH roles involve ensuring the privacy and confidentiality of the clients. Most participants spoke of finding this a challenge in rural towns, given that relationships and roles often overlapped. This challenge increased the smaller the town and/or the better-known the health professional in the community. So, for those who had lived in a small town for a long time and/or

had deep connections, safeguarding client privacy and confidentiality was described as particularly challenging, as Lara discussed:

> *It's harder to maintain the privacy and confidentiality like in terms of people go: 'Oh how do you know him?' or 'How do you know that person?' or 'Do you know them?' Because it is a small town everyone kind of knows everyone, so people kind of figure it out.*
>
> [Lara (21), 30 yrs, RN, Town G – medium rural town, inner regional area]

Privacy and confidentiality posed particular challenges for the Aboriginal MHWs, as personal and professional boundaries were not the cultural norm, as Kalinda explains:

> *As Aboriginal mental health workers…we just don't knock off at 4.30-5 o'clock at the end of the day. If we see a community member, we can't say, 'No sorry, it's five o'clock'. That stuff doesn't fly in Aboriginal communities, you don't say no to people and expect them to be okay about it. You've got to give them something, you know, or help in some way*
>
> [Kalinda (8), 32 yrs, Aboriginal MHW graduate, Town E – large rural town inner regional area]

Aboriginal family grouping and family 'business' with other families/clans was also discussed by the Aboriginal MHWs as creating demands and expectations on them and impacting client allocation, again highlighted by Kalinda's experience:

> *You'll have family members of clients say: 'But they won't speak to anyone but you'. I've got three people in the one family, a brother, a cousin and a sister. The sister is 15, and she won't speak to anyone but me. But I am on the Adult team, so if I don't talk to her, she is not going to talk to anybody and she's suicidal. So what do you do about that? Do you say: 'Oh sorry, you don't meet my criteria, I'm on the Adult team and I can't help you'?*
>
> [Kalinda (8), 32 yrs, Aboriginal MHW graduate, Town E – large rural town inner regional area]

On the other hand, Aboriginal family business can sometimes create the opposite situation, with a whole section of an Aboriginal community not feeling comfortable to access CMH services because of the family grouping of an Aboriginal MHW. Most of the Aboriginal MHWs spoke of having found strategies to manage family and cultural expectations and this involved being upfront in client allocation meetings about potential conflicts/issues and also giving Aboriginal clients choice over their caseworker. Given the constraints in rural areas to be able to allocate a

particular caseworker based on clients' needs as discussed above, it is unlikely that Aboriginal MHWs have much capacity to offer Aboriginal clients choice, especially in the smaller service sites.

In the main, while maintaining client confidentiality and privacy is an ongoing issue for rural CMH professionals, participants indicated that it was most problematic at the start of their employment and described it getting easier to handle with time and as they developed strategies and found ways to manage. This involved such things as deciding how to manage situations when people they knew were on the client allocation list and deciding what to do or say (or not) if they saw a client on the street or in a social situations.

In summary, the need for CMH professionals to safeguard client privacy and confidentiality poses additional challenges for those living in small rural towns and/or who are well known in the community and there are also cultural factors that the Aboriginal MHWs must navigate. While safeguarding clients' privacy and confidentiality is ongoing, in terms of having a negative impact on professional satisfaction, it is mostly experienced at the start of employment.

The role early career CMH professionals have to perform and particular aspects with respect to the clients, resourcing, workload and the approach to client care were all found to impact on job satisfaction. Some role aspects that had a negative impact on job satisfaction reduced over time while others increased with time. Support for career building was also identified as an important aspect of professional satisfaction and is discussed next.

5.1.3 Career building

While participants' professional satisfaction was strongly influenced by their work relationships and the role they performed, it was also affected by career building factors. The key factors of career building were: maintaining a professional identity; support for MH skill building; and opportunities for career advancement. These are discussed below.

Maintaining a professional identity

Most participants identified strongly with their specific professional group and considered it important to be able to maintain their professional identity even though they were working in generic roles. Some participants described feeling pressured from management and/or the team to view themselves as CMH professionals and to give up, or significantly lessen, their attachment to their profession-specific identity, as Natalie describes occurring during her recruitment interview:

> *And I remember in my interview I said something like: 'In a social work role, this is what I envisage I would be doing and whatever,' and she* [the service-level manager] *said: 'You don't do social work role here, you do a mental health role and you do everything.' And that really sort of sums it up, I guess.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

To maintain their professional identity, many participants described it as being important that they had regular opportunities to network and exchange ideas with other people from their profession. This was described as occurring in a variety of ways in the larger services, where there were generally more senior health professionals on site, through the provision of both formal and informal mentoring and support, as Amy's experience highlights:

> *So here in* [Town E – large rural town, inner regional area] *I guess one of the positive factors in my retention, would be that I've always had someone with whom I can physically walk two steps to get to their office and say: 'This just happened'. Or even times, when I've had a client with me, I've left and just walked out and ran something by someone. And I've also had access to other social workers like X and Y, like people in this actual building and I could just walk to their office.*
>
> [Amy (13), 27 yrs, Social Worker, Town E – large rural town, inner regional area]

For those working in the smaller teams, access to people from their profession was described as occurring mostly through clinical supervision or by attending profession-specific network meetings run regularly at the LHD level, and for some by attending CPD activities. Those participants who were the only team member from that discipline in the team emphasised the importance of attending network meetings and/or CPD courses, as Saskia's and Jacob's experiences highlight:

> *Last year I relied on a monthly social work meeting that we have. It's like a peer supervision. That was another saving grace, getting to go to that once a month and being with people who think like me and feel like me. It has really helped to keep me going*
>
> [Saskia (2), 23 yrs, Social Worker, Town A – small rural town, outer regional area]

> *Yep. I took that opportunity* [to undertake professional training courses in a capital city]. *The good thing about it was, at these trainings, there was usually a lot of other RNs, who worked in CAMHs. And so, it was my only chance to meet other RNs who worked in CAMHs. Because there simply was none here.*
>
> [Jacob (12), 23 yrs, RN (Psychiatric), Town E – large rural town, inner regional area]

Receiving support for mental health skill building

Nearly all participants made mention of feeling that having opportunities to develop their MH skills was important for their job satisfaction. This included such things as: receiving an adequate orientation at the commencement of employment; having regular clinical supervision; and opportunities to participate in CPD activities. These are discussed below.

Receiving an adequate orientation

Many participants mentioned feeling they needed to receive an in-depth orientation at the start of their employment and, among those who had only recently graduated, the need for mentoring was also often brought up. However, most participants described receiving little of either and more commonly described finding they were expected to just get on with the job. There were a couple of participants who felt they had been well supported at the start and that their workload and responsibilities had been gradually increased in line with their confidence growing. This support had mostly been given by team leaders and informally rather than through a formal orientation program. Among the participants for whom this was their first job working as a health professional, some expressed astonishment at the level of neglect they experienced, as Emily expresses:

> *My start to mental health was shocking. I had no mentor, no nothing. So I pretty much just sat in my office for maybe three months just researching. [...] I had been to my team leader numerous times: 'Help me, help me, I am new grad, I'm enthusiastic, I want to learn', but nothing.*
>
> [Emily (14), 29 yrs, RN, Town F – large rural town, inner regional area]

In trying to explain the general lack of formal support they met with, some participants believed it was not intentional but a consequence of working rurally and resourcing constraints. Madison believed it was a State issue and related to NSW Health's having a culture of staff neglect, as she reflected on the differences working in public sector health in Queensland:

> *I remember I kept on saying to people, and remember this was the first time I'd worked for NSW Health. And coming from Queensland and working for two different government departments it was very structured around the expectations of roles. And they had a lot of best practice guides and resources to shape your practice. There was nothing like that here. It was just: 'Off you go'* [laughs].
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area]

Other participants believed it related to a general lack of interest in the welfare of staff by service-level managers once they had recruited a staff member, as Clarke discusses:

> *Once you're recruited here I don't think there's any follow-up stuff around retention. There is a big focus around recruitment but* [not] *the retention side of things. I think once they* [management] *think they've got them* [here] *that nature will take its course and they will stay here or they will just go.*
>
> [Clarke (3), 29 yrs, Aboriginal MHW graduate, Town B – small rural town, outer regional area]

In the absence of a formal orientation process and support, a few participants spoke of relying on the team's clinical review meetings to help orientate them and learn the requirements of the job. Given most participants described receiving limited or no formal orientation, during their interview they were asked to suggest ways that future staff could be better supported at commencement of the job. This resulted in three general recommendations being made: 1) the need for a structured orientation program; 2) the assignment of a dedicated mentor/buddy for the first 3-6 months, especially for those who had recently graduated and for whom this was their first health professional job; and 3) opportunities to undertake regular CPD specifically focussed on building MH skills and understanding of the therapeutic approaches in use.

Of particular note in regard to the orientation received was the experience of the Aboriginal MHWs at the start of their traineeships. All but one spoke of finding no planning in place for their orientation or ongoing support. They also described management and other CMH staff having little or no understanding about the Aboriginal MHW trainee program and what the trainee roles involved. Because of this, they all encountered difficulties finding their place in the team, as Lowanna's description of her and Kalinda's (Participant 8) experience at the start of their traineeships, highlights:

> *In the beginning […] we weren't included, we sat upstairs in an office separately. […] now when I think about it because we were up there, we were isolated, away from everyone and a lot of the time we were left twiddling our thumbs. So a lot of that feeling came out of boredom. Some people love to come to work get paid and do nothing. But I was here to learn and half the time, by the time we came downstairs, and tried to put ourselves out there by saying: 'Can we come with you?' or 'Can we do this?' I think the feeling might have been a bit mutual: they were not sure what we could do either.*
>
> [Lowanna (11), 28 yrs, Aboriginal MHW graduate, Town E – large rural town, inner regional area]

Regular clinical supervision

In accordance with the National Standards for Mental Health Services (Australian Government, 2010b), service-level managers of CMH services are committed to and responsible for ensuring the provision of clinical supervision for staff. In NSW Health this is usually provided internally and the supervisors are mostly senior health professionals working in NSW Health. Clinical supervision generally involves a staff member meeting regularly with their supervisor to reflect and review on the clinical situations that have arisen at work, as well as to support their professional development. The amount of supervision a staff member receives can vary, but generally NSW Health policy proposes that new graduate health professionals receive one hour per week and more experienced staff one hour per month (NSW Health, 2007).

Among the participants, most spoke of their service-level manager making efforts to arrange clinical supervision for them at the start of their employment. However, several discussed having issues with the supervisor allocated in terms of either their suitability and/or availability and as a result, a few ended up receiving very limited supervision, as Natalie's experience highlights:

> *Unfortunately, the person who was selected as my clinical supervisor initially was based in* [Town E]*, and she didn't have the same value or idea about how clinical supervision should work as I did. And so for my first twelve months that I was there, I might have had supervision three times.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Access to CPD

Despite budget cuts for CPD, most participants' spoke of their service-level manager being supportive of their undertaking CPD and their applications for paid leave being nearly always

approved. However, they all stated that they were expected to meet the associated costs of undertaking a CPD activity. Several participants discussed this expectation to self-fund CPD (or pay upfront and hope to be reimbursed later through a successful scholarship application) made it either prohibitive or involved considerable personal sacrifice for them to attend. This was because most courses were run in metropolitan areas and so, as rural workers, they had to cover travel and accommodation costs in addition to the course fees, as Natalie explains:

> *We are looking at a group of people that are more isolated, that have less exposure to opportunities for training and networking and feeling included or part of the service. And then when the service says will give you the time and you can take the car but you need to pay the fee for the course, which might be $1,000 as well as your accommodation which might be another $500 or $600. Especially when you're on a new* [graduate salary] *[…]. When I first started out there I might just clear […] $800 a week, […]. So if you were on your own and you were earning that sort of money and having to pay bills and that sort of thing as well. You know, to fork out money for training like that, it's a big expense*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Some participants discussed being unable to meet this level of costs and instead relying on NSW Health's in-service training and/or any relevant training being run locally by other services for no or minimal cost. Such opportunities were more commonly available to those participants working in the larger rural towns (Towns E and F). In the services operating in the more remote areas, participants spoke about trying to develop town-based solutions to bring affordable MH training to the area, as Mia describes:

> *A number of ideas have been put forward to management. Like, well, if we can't go to training let's bring training to us. And we've even approached a number of training academies such as the post-traumatic centre, and they've been agreeable to come here, obviously at a cost. We brought that to management and said: 'How could we make this work? Do we invite NGOs to participate? Invite other clusters?'*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Mia also spoke of feeling that rural-based CMH professionals' ability to access CPD was further compromised because of staffing shortages, which meant there was often no staff available to back-fill essential services, thus making it very difficult to take time out to attend CPD, especially if it were being run in a metropolitan area, as she explains:

> *I know we keep talking about lack of training and the funding and lack of resources and all that kind of stuff and that's a built in thing with us; it's something we deal with every single day. But if you were to live in* [major regional city] *you would be able to take the afternoon off and go to training and it not cost you anything. And not have to worry about that this client is in crisis because they'd go to the crisis care team not CMH.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Most participants thought the loss of a CPD budget was likely to continue and this would make it even more difficult to attract health professionals to work rurally and to be able to retain early career staff, as Georgia explains:

> *Our new grad social worker is very motivated and she is exemplary, she has stepped up into* [undertaking] *training this year, which she has funded all herself. But unless you are willing to do that, I think it's going to be a real disincentive and I think we will lose people over it. They won't come or they will come, realise what it's like and not stay. I'm not sure if it's being spoken about at recruitment.*
>
> [Georgia (10), 33 yrs, OT, Town E – large rural town, inner regional area].

Opportunities for career advancement

Many participants made mention of there being opportunities for career advancement as important to their job satisfaction. This involved such things as opportunities to advance in grading level, to act in more senior roles and for there being senior roles to aspire to. These are discussed below.

Many participants discussed having opportunities locally to pursue their professional interests as being important to their job satisfaction and their intention to stay, as Lara's current assessment of her job attests:

> *This is probably the only place that I could see myself staying. Everywhere else that I* [have] *worked, I couldn't see staying beyond three years at all, I'd then need to move and had to do something different. But I have much more opportunity here to do things in my role like, I can work on different projects. I get to do education and training and I still get to see my clients, my mix in my role is good here.*
>
> [Lara (21), 30 yrs. RN, Town G – medium rural town, inner regional area]

Among those participants who had already been working in CMH for a few years, many expressed the importance of seeing there were opportunities for career advancement. These opportunities included such things as: occasions for secondment to other positions, including

acting in senior positions; providing clinical supervision to other staff; and, chances for promotion and/or re-grading, as Charlie highlights when discussing her recent re-grading:

> *And now I have just got a re-grading, so* [now] *I'm actually a clinical nurse specialist, and I'm a little bit chuffed about that [...] you actually have to step up, you are meant to run projects, show a leadership role. So it's the next level up, a higher level of skill and the clinical nurse specialist is in mental health, which is my area of specialty.*
>
> [Charlie (22), 53 yrs, RN, Town G – medium rural town, inner regional area]

Some participants thought resourcing in general for rural CMH services was likely to contract even further and so considered the future employment prospects in rural CMH looked bleak. A couple of participants thought that NSW Health's rural CMH services were currently on a trajectory that would see them severely reduce in their size and scope, as Madison explains:

> *The risk that I see is that all the other ancillary professions, like my own, will give way to just having mental health nurses again. So it goes back to being a medical model of mental health. You can have access to a psychiatrist for medication review and all other services are through the community. I think there is a real risk of that. I think it's a dreadful thing if that were to happen. It's likely to happen; not only because of workforce issues, but because of the way funding is moving.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area]

In summary, early career CMH professionals' job satisfaction was found to be impacted upon on by the CMH service having career building opportunities including such things as being able to maintain professional identity, develop MH skills and for there to be opportunities for career advancement. Opportunities and support for career building were always important and, for some, increased over time. The individual characteristics of early career CMH professionals were also found to be important for professional satisfaction and this is discussed next.

5.1.4 Factors intensifying or lessening CMH professionals' experience of the work

Particular characteristics of the individual participants, beyond the issues raised above, were identified as either intensifying or reducing professional satisfaction. These involved the extent of their prior work experience as a health professional and the duration of their employment in the CMH service. These factors are discussed below.

Extent of prior relevant work experience

Among the participants who had worked as health professionals in other capacities in Australia before starting work in the CMH service (such as Madeleine – Participant 9, Jessica – 15, Karen – 19, Katie – 20, Lara – 21 and Charlie – 22), their adjustment was generally less difficult and occurred more quickly than those who had no or very little prior experience working as a health professional before commencing the CMH job. Karen demonstrated the benefit of having prior clinical work experience as well as having previously worked for NSW Health in her quick and relatively smooth adjustment into CMH after a long career in rural-based general nursing:

> *I really didn't have that many* [adjustments to make]*, it was only learning the procedures that was the hardest thing, like where to find things and I'm not that au fait with computers even still, but I am getting there. I found that people responded to me and I was getting good results, so I was pretty happy.*
>
> [Karen (19), 53 yrs, RN, Town F – large rural town inner regional area]

Almost all those participants who had no or little prior experience working as a health professional described having a difficult transition and struggling with both learning to do the job and adjusting to the organisational culture. Having had little prior clinical experience was very common among these early career participants, either because they had recently graduated from a health course (Zeena – 1, Saskia – 2, Natalie – 7, Jacob –12, Amy – 13, Emily – 14, Jade – 17), or were a health professional who had previously been working in non-clinical roles (Scarlett – 5, Georgia – 10, Joseph –18), or were lay people joining the Aboriginal MHW trainee program (Clarke – 3, Kalinda – 8, Lowanna – 11, Bede – 16 and Alice – 23).

Saskia – 2, Amy – 13 and Emily – 14, who had earlier worked in administrative roles for NSW Health, felt this also helped them in their adjustment as they had less of a cultural adjustment to make. Among the recently graduated participants, nearly all[15] described feeling that their university training had under-prepared them for working in CMH and having to make a big leap to become a competent MH professional. This was even the case for those who had undertaken CMH placement(s) as part of their course. Saskia's experience of the job highlights this perception of the new graduates feeling ill prepared:

[15] The exception being Jacob (12) who trained as a psychiatric nurse in the UK.

> *I had to learn all this information and I had to be able to do these things, almost feeling like everything that I'd been trained to do wasn't relevant*
>
> [Saskia (2), 23 yrs, Social Worker, Town A – small rural town, outer regional area]

The new graduate participants commonly described it taking them at least a full year before they started to feel comfortable in the job, as Amy's experience exemplifies:

> *I think my learning has gone on a massive curve ball in the first twelve months and in that time it's just been constant.*
>
> [Amy (13), 27 yrs, Social Worker, Town E – large rural town, inner regional area]

The group of participants who had not worked in clinical roles before described their initial adjustment as being difficult too. Georgia (Participant 10), who had worked for four years as an OT in insurance before starting work in CMH, described her start in the CMH as the *rabbit in the headlights type daunting*. However, although the initial adjustment was often intense for this group of workers, it usually took them a shorter time than the new graduate workers to adjust – around three months. Arguably, it was the Aboriginal MHWs who encountered the hardest initial adjustment experience of all the participants interviewed (discussed above under career building).

Time in the job and degree of adjustment/adaption

As well as an initial phase of adjusting, participants described a second stage of adjustment that involved them learning the job sufficiently to be comfortable. To be comfortable in the job required the participant having developed the necessary MH work skills, understanding and confidence to perform the work, as Joseph's description of his first two years in the job highlights:

> *I'd say after about a year I became really confident doing assessment before that I was really panicking. I was not given much assessment initially, probably just one or two in a fortnight. But now I'm getting almost four or five in a week. So most of the time* [in the beginning] *I was doing the case management and the not very complex clients ones, the light ones. […] but now they're very complex,* [although] *not all of them are complex. I feel like the team is now confident about my ability to deal with complex ones, so I'm getting them.*
>
> [Joseph (18), 42 yrs, Social Worker, Town F – large rural town, inner regional area]

This second phase of adjustment involved mastering the duties and responsibilities of the job and this generally took those participants who had some prior relevant experience 12-18 months, as explained by Madison:

> *And I remember having several conversations just saying: 'I don't feel like I'm doing a good job, but I don't even know what a good job would look like'. I had nothing to guide me, so it probably took a good 18 months for me to really find my feet.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area].

Among those who had very limited or no prior clinical experience, getting to the point of feeling comfortable in the job took them longer – for some, up to two years in the job.

After having got comfortable in the job, participants' focus began to shift away from performance of the job to considerations about management and the organisational culture and career building opportunities. This trajectory from adjusting to having adapted is well reflected by Madison's explanation about organisational psychology and her own experience of adjusting/adapting to the job:

> *The theory in organisational psych is that it takes 18 months to 2 years* [to feel] *that you've got a job down. And then 2 to 4 years it's sort of getting a sense of competency. And then 4–5 years a sense of mastery. I would suggest that my own experience would bear that out as a truism. It kind of felt that way, the first couple of years was really just establishing my sea legs and finally I felt like I had some sense of what I needed to be doing. Years 2–4 were there was not so much chasing my tail all the time. I could start to put some things in place that made things better.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area].

In summary, early career CMH professionals have individual characteristics such as the extent of their prior work experience as a health professional and the duration of their employment in the CMH service that can intensify or reduce their experience of the job and impact their professional satisfaction.

5.1.5 Section summary

In summary, relationships with others, the work role and the career building aspects of the job were all identified by participants as impacting on their professional satisfaction in their first few years of working. The influence of relationships and role aspects on professional satisfaction was found to vary with time, either decreasing or increasing, while career-building aspects were consistently important and increased with time for some. Particular characteristics of the service setting and/or the individual were found to affect professional satisfaction. For example, in the smaller teams operating in the outer regional and remote areas, the negative aspects of relationships and role were generally heightened. Prior relevant work experience and the duration of their employment and stage of adjustment or adaption were also found to impact on professional satisfaction. The degree of professional satisfaction early career CMH professionals have regarding the job is one of two major aspects impacting their turnover intention. The other is their degree of personal satisfaction living in the town and this is discussed next.

5.2 Personal satisfaction

This section outlines the key aspects affecting the personal satisfaction of rural-based, early career CMH professionals in their first few years of working. In the main, a participant's personal satisfaction is determined by their sense of belonging. It was found that each participant's sense of belonging differed depending on their perceived level of 'insidedness' or 'outsidedness'. This section begins by defining the insidedness – outsidedness spectrum of belonging and goes on to discuss the range of belonging expressed by the participants under the categories of outsiders and insiders.

5.2.1 Extent of insidedness – outsidedness

Participants' sense of belonging to the physical place and to the community of the town the lived in was found to differ significantly depending on how long they had lived in the town. While accepting that belonging is not a fixed state but a spectrum of experience, nor is it solely determined by an individual's length of residence, it was still thought useful to draw on Relph's (1976) concept of 'outsidedness' and 'insidedness' to discuss the range of belonging expressed by participants. Pretty et al. (2003) also argued, in the context of Australia's rural towns, that belonging also involves a behavioural aspect that they termed 'place dependence' – where

individuals assess whether their future life aspirations can be sufficiently met by the town compared to other places.

For this study, the insidedness – outsidedness spectrum of belonging has been defined as follows. At the insider end of the spectrum, the individual is usually comfortable in, and very familiar with, both the place and the townspeople and feels a strong sense of community through the social connections they have. The place is usually also imbued with personal and social meaning for them. Such a strong sense of belonging is usually expressed by people who were born and/or raised in the town and who are, as Relph (1976) describes, unselfconsciously immersed in both the place and the community.

At the other end of the spectrum are outsiders, those individuals who feel very unfamiliar with both the place and its people. They are likely to have no, or very few, social connections in the town and thus feel little sense of community. The place may also feel alien to them. In respect of place dependence, at this end of the belonging spectrum the individual is likely to assess their future life aspirations as being better met by living elsewhere. Figure 6. 2 (below) shows this spectrum of belonging between insiders and outsiders.

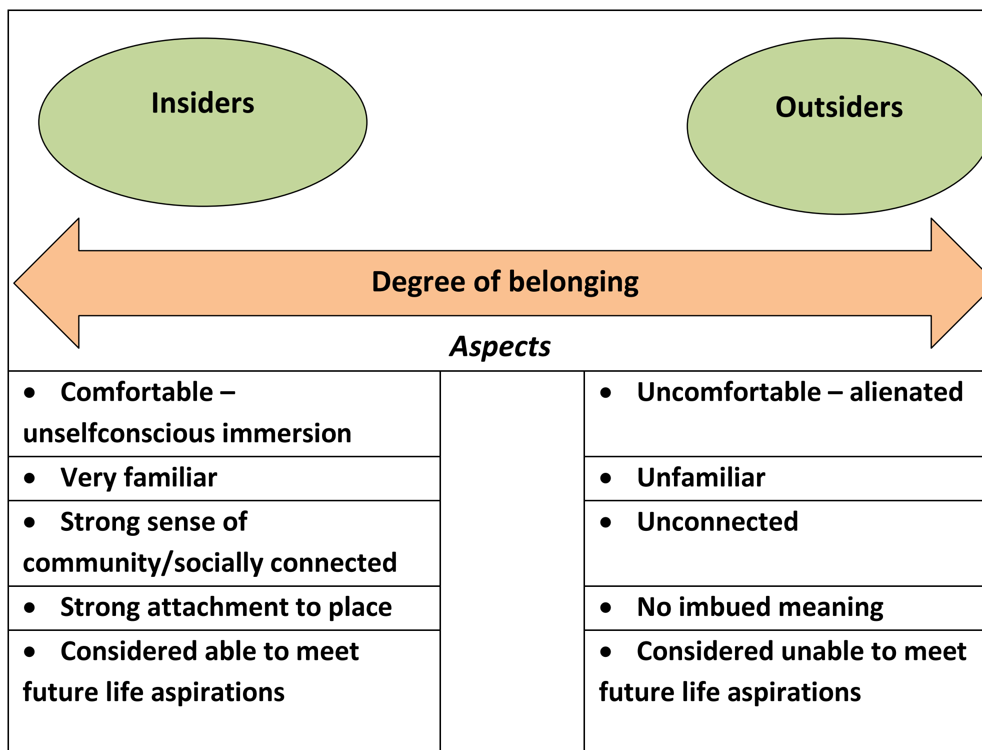
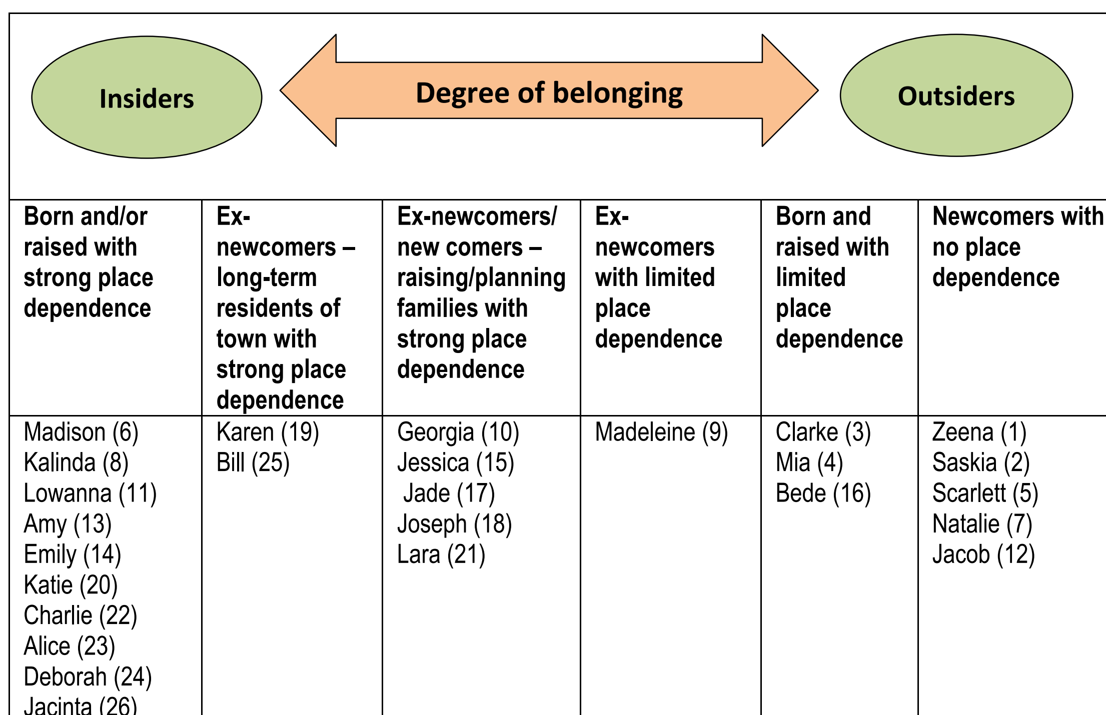


Figure 5.2 Spectrum of belonging

The experiences of participants on this outsider/insider spectrum are now discussed. Table 5.1 (below) presents this in a table form.

Table 5.1 Participants' degree of belonging on insider/outsider spectrum



Born and/or raised with strong place dependence	Ex-newcomers – long-term residents of town with strong place dependence	Ex-newcomers/ new comers – raising/planning families with strong place dependence	Ex-newcomers with limited place dependence	Born and raised with limited place dependence	Newcomers with no place dependence
Madison (6) Kalinda (8) Lowanna (11) Amy (13) Emily (14) Katie (20) Charlie (22) Alice (23) Deborah (24) Jacinta (26)	Karen (19) Bill (25)	Georgia (10) Jessica (15) Jade (17) Joseph (18) Lara (21)	Madeleine (9)	Clarke (3) Mia (4) Bede (16)	Zeena (1) Saskia (2) Scarlett (5) Natalie (7) Jacob (12)

Outsider-newcomers

The level of prior experience of the social dynamics and culture of Australia's rural towns was found to affect the degree of outsidedness that newcomers felt at the outset of moving to a town. For Georgia (Participant 10) and Madison[16] (Participant 6), who both had rural upbringings, their adjustment was less intense than that described by those who were from metropolitan areas of Australia (capital cities or major regional cities) or from overseas. However, Madeleine's easy adjustment to moving to live in Town E suggests that prior experience of moving to new places and having to make new friends can also lessen the intensity of the adjustment experienced, as she describes:

> *[Interviewer] How was moving to Town E?*
>
> *[Participant] Oh look I've moved so much in my life, it was no big deal. I'm pretty flexible, so I've lived in the mountains, I've lived at the beach, middle of the city, middle of the suburbs. So I really enjoyed it, I love the area, the drive here was a pleasure. No problems, whatsoever.*
>
> *[Interviewer] What about making friends?*

[16] In respect of her move from her hometown (Town D) to Town C to take up a CMH management position: the towns were about two hours' drive apart and were both small rural towns in outer regional areas.

> *[Participant] Um, making friends, same thing, I think, I don't tend to make a huge amount of friends when I move, I pick friends from everywhere, I've still got friends back in Sydney and I've got friends here, but probably more workmates.*
>
> [Madeleine (9), 42 yrs, RN, Town E – large rural town inner regional area]

The study participants who were recent newcomers were either from metropolitan areas (Zeena – Participant 1, Saskia – 2, Natalie – 7, Jade – 17) or from overseas (Scarlett – 5 and Jacob – 12) and none had prior experience of living in rural Australia. All described feeling particularly alienated and socially disconnected in the first year of living in the town. Madison argued that the level of alienation experienced by newcomers occurred because they often had an idealised view of rural-living and communities, making it difficult for their expectations to be met, as she explains:

> *I can think of a fairly recent experience, where we had a staff member come interstate with the idea that they were going to be able to live out in the bush. And everybody is going to be really lovely and so welcoming and they are going to embrace you in a big warm hug. I am going to be able to walk around the streets and not have to lock up my house at night and all those kinds of things. And that obviously isn't the reality, which is really confronting for people.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area]

All participants, irrespective of their background, described the rural towns they were working and living in as being slower-paced, conservative, church-going, predominately a white Anglo community with a smaller cohort of Aboriginal people (and, in those towns with a mining industry, having new residents from elsewhere and/or fly-in, fly-out workers), very sporting-focussed and the pub being the hub of much of the town's social activity. When the cultural milieu and social activities of the town coincided with the interests of the newcomer, the adjustment process was often fast, smooth and enjoyable, as Lara describes:

> *I love the sense of community here, so people are so welcoming in terms of sporting clubs. I joined the tennis club not long after I moved here and everyone was really welcoming and so happy for me to be involved in that. So I've played tennis ever since I moved here basically.*
>
> [Lara (21), 30 yrs, RN, Town G – medium rural town, inner regional area]

However, newcomers who had little or no prior exposure of 'rural Aussie' culture often experienced culture shock, as exemplified by Jacob, who had recently migrated from a UK metropolitan city, on his arrival to Town E:

> *You know in a town like* [Town E] *it's very difficult if you're not from here or brought up here or you don't know much about country Australia when you arrive. I was shocked when I arrived here and there was dogs on the back of utes and cowboy hats, it was like Texas to me. It was just so: 'Oh my god, where am I?' type of thing*
>
> [Jacob (12), 23 yrs, RN (Psychiatric), Town E – large rural town, inner regional area]

Zeena, although raised in Australia, also described experiencing a difficult adjustment culturally because her interests lay more with an alternative lifestyle. She described finding it hard to find anything of interest to do or to link up with any like-minded people, as she explains:

> *I found it really difficult to start off with [...]. The things I was into in Sydney like permaculture and more fringe activities and everything I suppose. There's just not, not that choice of people here for that.*
>
> [Zeena (1), 51 yrs, Social Worker, Town A – small rural town, outer regional area]

Saskia reported experiencing a honeymoon phase of adjustment when she and her husband relocated to Town A, and at first being excited by and enjoying the differences and new experiences the town offered them, as she describes:

> *You feel welcome, it's a clean town. When* [partner's name] *and I first came here, one of the shops has a massive blank wall and no graffiti, and we thought that back in* [a major regional city] *that would be covered. The rubbish people go around and pick up the rubbish everywhere they really care for the town. And that's something. [...] You do get that community feel* [here] *people knowing my name at netball* [but] *I have no idea who they are.*
>
> [Saskia (2), 23 yrs, Social Worker, Town A – small rural town, outer regional area]

While nearly all newcomers (except Jade – 17) expressed some degree of alienation in the first year of moving to the town, those who came with partners (Saskia – 2, Natalie – 7, Madeleine – 9, Jade – 17, Lara – 21), or relocated with family members (Georgia – 10 and Joseph – 18) appeared to be buffered to some extent from the loneliness and vulnerability of having no or few friends in town. Having partners and children also broadened the social net from which to make friends, as Lara acknowledges:

> *So I have met friends through* [partner's name] *work because a lot of the wives of people that have moved out here for the mines don't work as such. But they do lots of social things together, so I am very included in all of that and stuff.*
>
> [Lara (21), 30 yrs, RN, Town G – medium rural town, inner regional area]

Those newcomers who moved to the town as a single people (Scarlett – 5, Jacob – 12, and Zeena[17] – 1) each described really struggling to make friends and feeling lonely, especially in the first year, as Zeena's experience highlights:

> *I found it really difficult to start off with, because people are friendly and they are nice but they weren't really inviting me into their homes. So I was sitting at home quite a lot by myself with my son. So after my son left I was pretty lonely, because I didn't have local friends and stuff.*
>
> [Zeena (1), 51 yrs, Social Worker, Town A – small rural town, outer regional area]

However, after the first year of living in the town, most newcomers described feeling more comfortable and being more socially connected, as Zeena's experience attests:

> *More recently I got involved with the community garden and that's been really good because it's got like-minded people into organic and sustainability. So that's been great for me and I've made friends.*
>
> [Zeena (1), 51 yrs, Social Worker, Town A – small rural town, outer regional area]

For some others their personal satisfaction may have derived from lowering their expectations about belonging and deciding to be content with having only a few social connections. This attitude was expressed by Zeena – 1, Saskia – 2, and Natalie – 7, who had all moved to the town for career reasons, so felt little or no place dependence on the town, as Natalie's experience emphasises:

> *And then* [after 12 months] *it got easier, because I kept sight of the three years* [planned time of stay] *[…] I went to Hawaii for a holiday and that was a good reward. […] I have supervised some new graduate social workers […] and one of the things I said to them as advice was, what I think helped me, about keeping sight of your goals and planning things in the short term to keep you going. Like having a weekend away in the month, so that you are working towards something or you're going away for three days or you're going on holiday or whatever. Just having something to look forward to or keep you focused I guess.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

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[17] After her primary school-aged son returned to Sydney to live with his father.

Ongoing challenges making friends

Making friends remained challenging for all participants who were from elsewhere, even among those who had been living in the town for some years. This was attributed to their mostly making friends with people who were outsiders and thus, their sense of community was always vulnerable to people leaving, as Jessica, who had been living in Town F for 16 years, explains:

> *What we've really noticed is that though people leave a lot. Because all our friends, […] it's funny all our friends are from out of town. And it's still true, a lot of our friends aren't from* [Town F]. [Town F] *can be very insular.*

She also discussed being quite deliberate about her efforts to make new friends because of always losing friends through their leaving town:

> *I reckon, every couple of years I think: 'Right, I need to make a bit of an effort* [with making friends] [laughs] *because we are on the low side.'*
>
> [Jessica (15), 37 yrs, Diversional Therapist, Town F – large rural town inner regional area]

This heavy reliance by newcomers on making friends with other outsiders was also attributed to locals not being very interested in making new friends. While nearly all newcomers spoke of experiencing local people as friendly and feeling that they lived in a supportive community, their interactions with local people generally went no further than surface level exchanges. This was credited to most locals already having well-formed social connections and their feeling little need to step outside of those, as Saskia explains:

> *It's actually a lot like that*, [Town A] *and probably other places too. Everyone has their friendships established,* [so] *I think they take that for granted and don't think that new people need to be invited to things.*
>
> [Saskia (2), 23 yrs, Social Worker, Town A – small rural town, outer regional area]

Madison discussed the perception that in rural communities it was generally well acknowledged that newcomers often experienced them as closed. She believes that if rural communities want to have essential services staffed in their town, the community needs to work to support outsider-newcomers to make friends and that local councils should take some ownership of the issue, as she explains:

> [Town D] *is known as a closed community and people say it's really hard to get a leg in there socially. Then perhaps you reap what you sow, if you are a closed community you going to have trouble keeping people around. In* [Town D] *we had an open night charity thing, open to everybody but particularly for doctors and teachers and ambos, police. And every month, we'd have a trivia night, a way to meet like-minded professionals. They were brilliant nights, lots of fun and a way to get to know people outside the work context.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area]

As MH professionals, the responsibility to safeguard client privacy and confidentiality and maintain boundaries between personal and professional worlds was also often mentioned by newcomers as having negative social impacts, as Natalie explains:

> *But it was hard to make those more genuine sort of friendships with people, […] because in the sort of work that I was doing, […] I was having contact with a good majority of the community in one way or another so, that did make it hard to make friends. Because you don't sort of want to cross that line, I guess. It would be difficult to make friends with the sister of someone who I counselled or provided support to after their baby had passed away, that would be really difficult.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

Madison viewed this professional/social conflict as something that particularly impacted those working in rural areas, given there was often little or no anonymity available, as she explains:

> *I think if you are new in the city then if you have interests you can very easily find something outside of work. Here you can run into clients just when you go out to dinner, which can be awkward. So when you live in a place with a very small population sometimes it can be a better idea not to go out. It is just about adapting. And if you don't have things external to work, then your focus can be on the importance of those relationships within the work environment* [and these can] *become overinflated. Then what happens when things happen* [go wrong] *in those relationships it can feel like your whole life isn't working.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area]

A few participants thought the social constraints of living rurally and working in MH were made worse because of the high level of stigma existing in rural communities, as Mia discusses:

> *Also there is still the stigma around mental health and you're pretty scary still. Even though we treat pretty much everybody* [laughs] *including people that have high paying jobs or are senior members within the community, people behind the bar and coaches. We've seen them all, we treat them all, we see their families, and*

> *we've seen them all at their worst. But there's still that stigma: 'Watch out for mental health* [people]*'.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Given the challenges posed by the role and boundary issues and experiencing disinterest from locals in making friends, several newcomers described focussing their friendship efforts in the workplace, as Scarlett's experience highlights:

> *Now being in a rural area, you have to understand that* [Town C] *is a small place and if you go to the pub you are very likely to see your clients there. Which you don't want to do. I am not a very 'pub-y' person either. So I guess looking at any social stuff you will run into your clients. So you're tending to be more social then with work people. So now* [at work] *you have four people from different countries on work visas, so you have a lot in common. So X, Y, myself and Z* [other CMH work colleagues] *would sometimes, at least once a week, meet up somewhere and have dinner. We had that friendship circle going, so that was good. You also got an opportunity to debrief as well because, at the time, I didn't have a supervisor.*
>
> [Scarlett (5), 30 yrs, OT, Town C – small rural town, outer regional area]

Newcomers' experiences of making friends with work colleagues varied widely: while for Natalie (Participant 7) they ended up forming the core of her social group for the three-and-a-half years she was living in Town B and was a positive experience, Saskia struggled with several of her work friends leaving town after a period, Jacob (Participant 12) described the friendships he made with his work colleagues as being unsatisfying and feeling bored by their focus on work matters, and Scarlett's eventual fallout with several work colleagues caused her to feel excluded and isolated both at work and socially, as she explains:

> *I realise, very soon, that X is now friends with Y and Z* [three CMH work colleagues]*. You know, when you are walking through town and you see your colleagues together having dinner and you realise you haven't been invited. Ok I think: 'I don't know what that's about' but I just leave it, respect it. Then I start distancing myself from all of them at work, trying to keep strictly to my work and getting other friends outside of work, which I had* [already] *been working on.*
>
> [Scarlett (5), 30 yrs, OT, Town C – small rural town, outer regional area]

Outsider-stayers

Among the participants there were ex-newcomers who had been living in the town for the medium to long term (over three years – hereafter termed 'outsider-stayers') (Madeleine –

participant 9, Georgia – 10, Jessica – 15, Joseph – 18, Karen – 19, Lara – 21), Bill – 25 and Jade[18] – 17), they all described feeling a sense of belonging to the community and to the town but there were notable differences expressed depending on their length of residence.

For Karen (Participant 19) and Bill (Participant 25), both had lived in their towns for over 20 years and their attachment to the place and the community was very strong. They both discussed wanting to stay living in the town indefinitely. Their sense of belonging was very similar to that expressed by locals, as Karen's experience of walking down the main street of Town F (large rural town inner regional area) after ten years living on the coast attests:

> *I just feel less remote here because when I go to downtown there are people that I will run into that I know. People will come up to me and say: 'You fixed my leg thirty years ago' and I'm thinking: 'I don't remember you'* [laughs].
>
> [Karen (19), 53 yrs, RN, Town F – large rural town inner regional area]

While outsider-stayers who had lived in town for a shorter period (between three and 16 years) also reported feeling a sense of belonging, it was not as strongly felt as that described by Karen and Bill. Among this group of participants, belonging was less about having a strong sense of community and attachment to place and more about place dependence, and this was closely associated with their current life stage. This group of participants were either actively involved in raising a family (Georgia – Participant 10, Jessica – 15, Joseph – 18) or, in the cases of Lara (21) and Jade (17), planning to start a family soon or, drawing on Erikson's (1982) eight life stages, they were in or entering mid-adult stage and primarily concerned with family and stability. Among these participants, place dependence was either a very conscious decision about choosing the town to live in and to raise their family, as it was for Georgia – 10, Lara – 21, and Jade – 17 or was circumstantial, occurring because of happenstance, as was the case for Jessica – 15 and Joseph – 18. This conscious decision making versus circumstantial events is highlighted by the different responses from Lara and Jessica explaining their reason for living in the town:

> *Well, we only intended to move out here for two years, that was* [her partner's] *goal with work. Come out here for two years then move back. […]. After the two years had gone past, we didn't really realise that it had been two years already, and we weren't prepared to move or anything like that.* [But]*, just in the last 12 months*

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[18] While a recent newcomer, having lived in the town only 2¼ years, she and her partner had decided within the first year of living in the town to settle there for the long-term to start a family.

> *we've really made the decision* [to stay in Town G]. *We are ready to have kids now, that's why we got married last year – to settle down and have kids.*
>
> [Lara (21), 30 yrs, RN, Town G – medium rural town, inner regional area]

> *I quite liked it* [when first moved to Town F]. *I didn't mind it, I lived at the nurses' quarters for a few weeks and then moved in with some girls. I didn't mind it really […]. We did talk about going back to Sydney but we never really, I think we both* [she and her partner] *didn't want to live in Sydney and we didn't really have anywhere else to go I suppose. We never really looked for other jobs.*
>
> [Jessica (15), 37 yrs, Diversional Therapist, Town F – large rural town inner regional area]

Madeleine's (Participant 9) experience highlights the importance of life stage on place dependence. She had moved to Town E (large rural town, inner regional area) four-and-a-half years ago in order to be closer to her two high school-aged children who had moved to the town with their father. Her children had now finished school and left town and she moved out of middle-adulthood into late-adulthood. She reported being in a process of re-assessing her place dependence and was considering moving elsewhere in the short to medium term, either to be closer to her boys and/or to advance her career.

Insider-locals

The participants who were born and/or raised in the town or the local area (Clarke – Participant 3, Mia – 4, Madison –6, Kalinda – 8, Lowanna – 11, Amy –13, Emily –14, Bede –24, Katie – 20, Charlie – 22, Alice – 23, Deborah – 24 and Jacinta – 26) (hereafter termed 'locals') rarely discussed their social experience of the town or their sense of belonging unless specifically asked. Instead, information about their sense of belonging was mostly gleaned from interview questions around their perceptions about newcomers' adjustment experiences or concerning their future life plans. Arguably, belonging was not discussed among this group because their sense of belonging was strong or, as Relph (1976) posits about locals, they tended to be unselfconsciously immersed in the place and the community.

Without exception, all local participants expressed a strong sense of belonging through their comments about the place, their kinship ties, feeling part of a community and participating in the lifestyle and activities of the town, as Mia's, Madison's and Jacinta's responses all highlight:

> *Out here in* [Town B] *there is a great group of younger people in their 20s. But you have to know those people or know someone from that group to break into that group. Or have some interest, out here it's very sporty people play rugby, netball, tennis, touch football and people also drink a lot out here. If you don't play those, I don't know what you'd do out here. Over summer, my family has a ski boat, so we go out water skiing and wet boarding and camping and we bring people with us to do that.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

> *So coming from a community that I grew up in and know every second person or their parents or you know somebody that's related to them, it makes it very easy. Whatever's on you hear about it over dinner. I have a very big family in* [Town D], *so it just wasn't hard, you just kind of knew everything that was going on, so stuff just flowed naturally.*
>
> [Madison (6), 34 yrs, Psychologist, Town D – small rural town, outer regional area]

> *Can I just say that there are things about the country for which I'm really glad to be home for. The people, because they know my family, have been really helpful to me. They have helped me out, they have bent over backwards. I have been a bit surprised about how helpful people have been. But that's what it's like in the country, people will support you. So that's the good side about living in the country.*
>
> [Jacinta (26), 53 yrs, Social Worker, Town I – small rural town, remote area]

While most locals expressed strong place dependence and were intending to stay living in the town for the foreseeable future, in many cases this was also linked to their current life stage. Most of these participants were either involved in raising a family (Katie – 20, Charlie – 22, Deborah – 24, Madison – 6, Kalinda – 8, Lowanna – 11) or were in a committed relationship and considering starting a family soon (Amy – 13, Emily – 14 and Alice – 23), with Jacinta (Participant 26) being the exception: she was older and single and had recently returned to her hometown to work part-time for NSW Health and pursue creative pursuits after 30+ years living away.

The role of life stage in place dependence among locals is highlighted by the fact that those locals who were in what Erickson (1982) termed the young adult stage (Clarke – Participant 3, Mia – 4, and Bede –16) and were more focussed on intimate relationships, career and social life issues, all expressed having plans in place to leave the town in the near future. Mia and Clarke both intended to travel for an extended period, although Clarke expected he would return when he and his partner wanted to start a family. In Bede's (Participant 16) case, he planned to relocate to another

rural town in the same region where he also had strong kinship ties upon completing his Aboriginal MHW traineeship.

5.2.2 Section summary

In summary, participants' personal satisfaction was determined by their sense of belonging to the town. Participants' sense of belonging primarily concerned the extent to which they felt connected to the place, considered themselves to be part of the community and whether they believed the town would be able to meet their and other family members' future life aspirations (termed place dependence).

These three factors were found to vary depending on the extent of an individual's 'insidedness' or 'outsidedness', which at one end had outsider-newcomers and at the other insider-locals. Outsider-newcomers generally had little attachment to place, few or no social connections and no place dependence, while newcomers who stayed (outsider-stayers) experienced a growing sense of belonging in terms of attachment to place and connection to people, and this increased the longer the time spent living in the town. However, for many outsider-stayers, their place dependence was connected to their current life stage of middle-adulthood and being primarily concerned with raising a family, which generally prioritised stability in terms of place. The insider-locals had generally expressed the strongest sense of belonging in terms of place attachment, social connection and place dependence. However, again life stage impacted and those insider-locals who were in the early-adult stage had reduced place dependence and all had plans to leave the town; for some, this was thought to be only temporary while for others it was considered permanent. An individual's level of professional and personal satisfaction was found to determine the extent to which they felt their professional and personal expectations were being met and this was found to govern their turnover intention, as is discussed in the following section.

5.3 Turnover intention

Nearly all of the participants involved in this study described having reached the stage in the job where they were now comfortable (the only exception being Jacinta – Participant 26, who at the time of interview had only been in the position for six months) as well as expressing some degree

of belonging to town and community. By the time of the interview, the majority of participants had already made a decision regarding whether they intended to stay or leave their CMH job.

Eight intended to leave the job and the town in the near future (Zeena – 1, Clarke – 3, Mia – 4, Scarlett#[19] – 5, Madison##[20] – 6, Natalie# – 7, Jacob# – 12 and Bede –24) (this group is termed 'leavers'), fourteen intending to stay for at least the next few years and most for the foreseeable future (Madeleine – 9, Georgia – 10, Amy –13, Emily –14, Jessica – 15, Jade –17, Karen – 19, Joseph – 18, Katie – 20, Lara –21, Charlie –22, Alice – 23, Deborah –24, and Bill – 25) (this group is termed 'stayers'), and at the time of interview four were undecided (Saskia – 2, Kalinda – 8, Lowanna – 11 and Jacinta –26). Among those who were undecided, Saskia and Kalinda were subsequently found to have left their CMH positions, adding them to the leavers group brings the total of leavers to ten.

Analysing intention to stay or leave on the basis of their level of belonging (outsider-newcomers, outsider-stayers or insider-locals) highlights that those who intended to stay were mostly the outsider-stayers or the insider-locals. This data is tabulated in Table 5.2 (below). Undertaking an analysis of each of these groups, the major reasons for intending to stay or leave can be identified. This analysis concerns identifying the professional and personal factors that most strongly impacted on the participants in making their decision to stay or leave the job.

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[19] # At time of interview had already left or were about to leave the job to take up employment in metropolitan areas of NSW.

[20] ## Refers to Madison leaving her CAMHS position in her hometown, Town D, to take up management role in CMH in Town C, which she was in at the time of interview.

Table 5.2: Deciding to stay or leave – extent of belonging to town

Extent of belonging	Intending to stay (n=14) 54%	Intending to leave/left (n=10) 38%	Undecided (n=2) 8%
Recent newcomers	Jade (17)	Zeena (1) Scarlett (5) Natalie # (7) Jacob# (12) Saskia (2)	
Outsider-stayers	Lara (21) Madeleine (9) Georgia (10), Jessica (15) Karen (19) Joseph (18) Bill (25)		
Locals	Amy (13) Emily (14) Katie (20) Charlie (22) Alice (23) Deborah (24)	Clarke (3) Mia (4) Madison (6) Bede (24) Kalinda (8)	Lowanna (11) Jacinta (26)

Reasons for staying

Insider-locals and outsider-stayers mostly chose to stay in the job because they had high levels of personal satisfaction living in the town, felt a strong sense of belonging and believed the town in the medium to long-term (place dependence) would be able to meet theirs and family members future needs. Among this group, most felt that their CMH job was the best job available in the town (particularly with respect to remuneration and employment conditions). Among the allied health professionals who were stayers, many made mention of there being very few other employment options for them in the town/area either in the public or private sectors, and that NSW Health offered significantly better remuneration and employment conditions than jobs in the private sector, as Georgia describes:

> *I think, even though* [Town E] *is a bigger country town, there is a lack of equally remunerated positions available outside of Health […] and that is the thing that makes you stay. That may not be a positive thing but it is a factor as people get used to, and budget around, what they are earning.*
>
> [Georgia (10), 33 yrs, OT, Town E – large rural town, inner regional area].

Given the limited employment prospects available in rural towns, this can potentially result in staff working in CMH teams for the medium to long-term who are professionally dissatisfied but

continue working in the job regardless (hereafter termed 'dissatisfied stayers'). While none of the participants in this study were dissatisfied stayers, given the identified importance of a positive team dynamic for staff job satisfaction, a team that has long-term dissatisfied staff working in it is likely to negatively impact on the job satisfaction of other staff members and possibly be a major factor in their decision to leave. The potentially negative effects of having dissatisfied long-term staff on the team are highlighted by Jessica's assessment of her team's dynamic:

> *I think it's really good now* [the team dynamic]*, even maybe a year or so ago it wasn't. We had a couple of older ladies who had been there for a long time, from when I was there before. People who are just stale, just don't want to be there, who are negative. You'd suggest something new and they say: 'Oh, oh, that could never work, oh, no.'*
>
> [Jessica (15), 37 yrs, Diversional Therapist, Town F – large rural town inner regional area]

Reasons for leaving

Most of the outsider-newcomers and some of the insider-locals (those who were young and independent, such as Clarke – 3, Mia – 4 and Bede – 16) did not assess the town as being able to meet their needs in the medium to long-term and so felt no or very limited place dependence, as Natalie's and Clarke's (Participant 3) responses both highlight:

> *I think you know the reason that we didn't stay was because it's not our base, our base is in* [major regional city] *and that's why we left.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area]

> *I think whilst I will always remain passionate about mental health and the* [Town B] *community, I think at the moment I'm probably looking elsewhere in terms of career pathways, just probably for a short term to change up, to regenerate the batteries and do a little bit of travelling as well.*
>
> [Clarke (3), 29 yrs, Aboriginal MHW graduate, Town B – small rural town, outer regional area]

Among this group of leavers there were also aspects of the job they were dissatisfied with, and these acted as push factors (Scarlett – 5, Jacob – 12, Mia – 4, and Kalinda – 8). For Natalie (7) and Madison (6), pull factors were at play and they left their jobs primarily for career advancement reasons, as Natalie explains:

> [I was] *contacted by head of discipline* [NSW Health service operating in major regional city] *and was asked to apply for a level IV position, which is a senior role. I am responsible for about 10 other social workers here.*
>
> [Natalie (7), 27 yrs, Social Worker, Town B – small rural town, outer regional area

For Madison (Participant 6), in addition to career advancement reasons, taking up the management position in Town C let her move closer to her parents to support them with raising her nephew.

5.3.1 Section summary

By the time of the interview, the majority of participants had made a decision regarding whether they intended to stay or leave their CMH job. There were strong pull aspects for continuing to live in the town and stay working in CMH and/or NSW Health among the stayers. Most stayers were either insider-locals or outsider-stayers and were in the mid-adult stage of life and assessed the town as being able to meet their and other family members' future life aspirations (place dependence). Staying in the CMH job was related to the good employment conditions offered by NSW Health and the limited other employment opportunities in the town, especially for allied health professionals.

For those intending to leave or who had already left, push and pull factors were at play. Most leavers were those in the early-adulthood – and this included both insider-locals and outsider-newcomers – who wanted to make changes in their living situation. Among this group, pursuing career-building opportunities was also an important factor (pull factor). The substantive theory explaining turnover intention drawn from these findings will now be discussed, commencing with identification of the basic social process.

5.4 The turnover intention theory

Drawing on the findings from the analysis and coding of the data led to the identification of the *basic social process* (Study Objective 2), which was then brought together to develop the *substantive grounded theory* (Study Objective 1). The *substantive grounded theory* answers the research question concerning how employment and rural-living factors impact the turnover

intention of early career CMH professionals in their first few years of working in rural services. This section starts with an explanation of the basic social process identified and then presents the turnover intention theory.

The basic social process – adjustment, adaption and assessment

The interaction between the two categories identified *(professional and personal satisfaction*) and the contextual conditions that intensified or lessened these experiences *(prior relevant work experience, time in the job, extent of insidedness – outsidedness),* as discussed earlier in this chapter, resulted in the identification of the basic social process. To recap, a basic social process is a part of GT coding and is a theoretical code amenable to modelling that can account for the variation in time, context and behaviour of the phenomenon under investigation (Glaser & Holton, 2005).

Data analysis revealed that the basic social process experienced by the participants concerned dealing with change and involved a process of adjustment, adaption and assessment. The four stages of this process were: *initial adjustment, continuing adjustment, having adapted,* and *weighing it all up*. How well participants managed change, and what point they were at in that process of adjusting affected the degree to which they assessed their professional and personal expectations as being met (*core category*). Glaser and Holton (2005) emphasised that it was important that a basic social process emerged from the data. The key professional and personal factors that led to the identification of the basic social process of adjustment, adaption and assessment are now discussed.

In respect of professional factors, all early career CMH professionals were found to go through an initial difficult stage of adjustment upon starting the job: *rabbit in the headlights type daunting* (Georgia – Participant 10). For those who had some prior relevant work experience, this stage (*initial adjustment*) usually lasted a few months and, for those who had little or no prior relevant work experience, more often up to 12 months. This was followed by a less intense but still challenging stage of adjustment *(continuing adjustment)* during which gaining mastery of the job was the main concern. In this stage, having prior relevant work experience continued to reduce the amount of time it took to gain the competencies required. Those participants who had some prior

relevant experience generally took around 12 months to gain mastery, while those who had little or no prior relevant experience could take up to two years. Once having learnt to perform the job competently, most early career CMH professionals described feeling comfortable in the job *(having adapted)* and from this stage onwards prior relevant work experience had less influence on job satisfaction. Instead, the main influencing factors became the quality of the relationships with others in the workplace, the ongoing demands and rewards of performing the role and opportunities for career building.

With respect to personal satisfaction, the extent to which an early career CMH professional felt a sense of belonging to the town was the key influencing factor. This was determined based on their sense of insidedness versus outsidedness. Those who were newcomers and from elsewhere (outsider-newcomers), especially if they had very limited or no prior experience of rural 'Aussie' (Australian) culture at the start of working (*initial adjustment*), often felt alienated and socially disconnected. However, after about twelve months most outsider-newcomers had made some friends in the town and began to feel some sense of belonging to the town. From this time onwards, the longer the outsider lived in the town, the greater their sense of belonging grew and it was possible for them to feel a sense of belonging as strong as that of locals, but generally this took a long time – 20 plus years, going by Bill's (Participant 26) and Karen's (19) experiences. Generally, outsider-stayers had smaller social networks than insider-locals and as a result their sense of belonging did not match the levels of belonging experienced by locals.

The need to safeguard client privacy and confidentiality was identified as posing additional challenges because of heightened boundary issues in rural towns. This required them to develop an understanding of their role and the personal and professional boundaries required and to develop strategies to manage the issue. Until these were in place, a rural CMH worker's professional and personal satisfaction was negatively impacted upon. These adaptions were usually made in the first year or two in the job, during the adjustment stage.

During the process of adjustment and adaption most participants were found to be continually assessing whether the job and living in the town was meeting their professional and personal expectations. On reaching the stage of having adapted, the participant had often already decided

about whether the job and/or the town were able to meet their (and any other family members') future professional and personal needs (*weighing it all up*).

The four stages of the basic social process and key relevant factors are presented in Table 5.3 (below).

Table 5.3 Basic Social Process – adjustment, adaption, assessment and the relevant factors

Basic social process	Relevant factors		
	Professional	Personal	Both
Initial adjustment 3-12 months *Feeling seasick*	• *Rabbit in the headlights type daunting* [Georgia – Participant 10] • Hardest/longest for those with little, no prior relevant work experience	• Impacts on outsider-newcomers – alienated, socially disconnected	• Identifying issues and learning to manage professional/ personal boundaries
Continuing adjustment 12-24 months *Finding your sea legs*	• Learning to do the job • Hardest/longest for those with little, no prior relevant work experience	• Outsider-newcomers – becoming familiar, starting to make connections	
Having adapted Within 12-24 months in the job/living in the town *Managing to sail in permanently choppy waters*	• Being comfortable doing the job • Prior relevant experience begins to matter less	• Outsider-newcomers – having made friends, feeling sense of community	• Strategies developed and in use to manage professional/ personal boundary issues
Weighing it all up After 12-24 months in the job/living in the town *Deciding whether to continue the voyage*	• Weighing up professional satisfaction being in rural CMH job against future career aspirations	• Weighing up personal satisfaction living in this rural town against future life aspirations • Assessment of place expectations – this town versus other places	

In summary, the basic social process experienced by the participants involved dealing with change and a process of adjustment, adaption and assessment. The four stages of the process were: *initial adjustment, continuing adjustment, having adapted,* and *weighing it all up*. The basic social process and the findings are now brought together to formulate the turnover intention theory.

The turnover intention theory – the reality gap

The substantive GT theory formulated to explain turnover intention is labelled 'the reality gap'. The reality gap theory explains the impact that employment and rural-living factors had on the turnover intention of early career CMH professionals in their first few years of working. The theory posits that employment and rural-living factors influence a CMH professional's turnover intention depending on how manageable the gap is between their professional and personal expectations and the reality of their employment/living experience – termed the reality gap. The gap is gauged by the individual's current level of professional and personal satisfaction.

This reality gap turnover intention theory will now be explained using the metaphor of an individual taking an ocean voyage on sailing a boat. The boat is the individual and their sailing skill level is about their ability to handle an ocean voyage. The ocean symbolises the employment and rural-living circumstances that the individual encounters. The challenges and demands of a CMH role and living in a rural town are captured by the perpetual choppiness of the waters.

Using this metaphor, the four stages of the basic social process can described as: *feeling seasick, finding one's sea legs, managing to sail in permanently choppy waters* and *deciding whether to continue the voyage,* and narratively described as follows:

> *At the start of the sea journey, the experience is new for everyone and so all sailors will struggle to find their sea legs. The degree and duration of an individual's seasickness will depend on their familiarity with the ocean environment. That is, whether they have any prior experience of sailing and taking ocean voyages and, if they do, whether they learnt to sail in perpetually choppy waters. As the individual becomes more familiar with handling the boat and ocean sailing, they will get over their seasickness and increasingly be able to keep their balance while standing on the boat. By the time the sailor has gained some mastery of the boat and understanding of the permanently choppy sea conditions they will have usually decided whether this voyage is one they want to continue on or not.*

Table 5.4 (p. 177) details other key aspects of the reality gap turnover intention theory using this sailing metaphor.

Arguably, almost all rural CMH professionals will experience a reality gap to some extent because of the harsh realities of the rural CMH service environment. Most CMH professionals

working in rural services perform their job in a constrained resource environment, have big workloads to manage, limited access to professional development and career building opportunities, and are time-pressured because of carrying out additional duties and needing to travel to reach clients. These pressures are generally heightened for those working in the remote areas because of the smaller team sizes and a higher proportion of staffing shortages to be found.

These harsh, ever-present realities of the rural CMH service environment mean most staff who stay working beyond the first year (that is, get through the seasickness and gain their sea legs) will also have accepted that their professional expectations are unlikely to ever be fully met working in a rural CMH role – that is, they accept that the ocean will always be choppy – so they adjust their professional expectations downwards, and their expectations met are likely to be sitting at an acceptable, but not optimum, level. Most CMH professionals, while accepting some compromise in having their professional expectations met, will also have a point at which they will not accept their job satisfaction dropping any further: any further negative pressures in the job (bad weather events), such as a change in the team dynamic, restructuring or increased caseload may push their professional expectations being met beyond their minimum acceptable level. If bad weather occurs for a sustained period, it is often a significant factor in the individual deciding to leave.

As well as organisational aspects of rural CMH services, workers' individual characteristics impact on the size of the reality gap experienced. This covers four key aspects:

- Extent of prior relevant work experience and/or having a well-formed professional identity
- Whether they are an outsider-newcomer
- The sense of place dependence towards the town
- The person's life stage.

Table 5.4 Key aspects of the reality gap theory explained using metaphor

Stage	Sailing a boat on an ocean voyage	Key impacts on professional and personal satisfaction
Initial adjustment 3-12 months *Feeling seasick*	*Those who have no or very little experience of the ocean environment or of sailing a boat on a long voyage or navigating choppy waters will experience the most intense seasickness and for the longest duration.*	Having limited or no relevant prior work experience and being an outsider-newcomer impacts very negatively.
	The less boats on the ocean, the more likely the feeling of isolation and alienation and the greater the seasickness.	The smaller the team, the greater the initial adjustment required and the greater the negative impacts.
Continuing adjustment 12-24 months *Finding one's sea legs*	*The individual's boat will also be a particular colour. They will feel less seasick if they can see other boats of the same colour and heading in the same direction out on the ocean.*	At the outset, developing/maintaining a professional identity is important and having access to others from same profession impacts positively.
	Those who have a crew on the boat or are in constant radio contact will be able to cope with the seasickness better than those making the voyage solo or without any radio contact.	Feeling a sense of belonging to the place and the community and having an intimate personal relationship or children all impact positively.
	In addition to choppy seas there can be big waves caused by bad weather.	Staffing changes (including service-level management), staffing shortages and their effects on workload heighten negative impacts.
Having adapted Within 12-24 months in the job/ living in the town *Managing to sail in permanently choppy waters*	*The colour of other boats will begin to matter a little less, but it is important that there are some other boats out there.*	Maintaining a professional identity remains important throughout. Working in small teams continues to increase the risk of negative impacts.
	The sailing experience is never easy and thus requires constant surveillance of the weather and adjustments to the positioning of the boat's mast, sails and rudder.	A rural CMH job is always demanding and challenging.

Stage	Sailing a boat on an ocean voyage	Key impacts on professional and personal satisfaction
Weighing it all up After 12-24 months in the job/ living in the town *Deciding whether to continue the voyage*	*By the time the sailor has gained some mastery of the boat and understanding of the 'usual' weather conditions, they have often decided whether this voyage is one they want to continue on.*	Assessments about professional personal satisfaction are made continually and by the stage of having adapted, most workers will have decided, or will soon do so, whether they intend to stay/leave. Those who chose to leave are generally either outsider-newcomers or insider-locals at the early-adulthood stage and with limited or no place dependence to the town. Those who chose to stay are either insider-locals or outsider-stayers at the middle-adulthood life stage with moderate to strong place dependence to the town.
	A few will have chosen to take the journey because they viewed it as 'good for learning' but never intended to continue journeying in such choppy waters (working in MH) and will leave in search of smoother waters (other health fields). *Some others will decide that, while the sailing experience is for them (they want to stay working in mental health), this particular ocean voyage is not (rural-based CMH work), and they will choose to stop this particular voyage (resign) and continue the voyage elsewhere, either in a bigger sea (taking a CMH job in a metropolitan area) and/or sailing in waters where there is more reliable radio contact (returning to the town/city where they feel a sense of belonging).* *A few will just want to stop the voyage for a while and dock their boat to pursue other adventures (such as travelling)* *These choices are often made by those who have not been on the journey very long (newly graduated and or young) and/or have been journeying solo and feel able to manage, and sometimes even excited by, the prospect of more change.*	The leavers will all have limited/no place dependence but their reasons behind this are different • Among the outsider-newcomers some never intend to stay longer than short-term: they moved to town solely for career reasons, to build professional experience and skills. • Some outsider-newcomers and insider-locals in early-adulthood view MH as a short-term career only, a good field to build up their professional skills and experience but too stressful to work in for the medium-long-term and when they enter middle-adulthood. • Having a sense of belonging to the town is very important in the middle-adulthood life stage and many outsider-newcomers intend to return to their home when they reach this life stage. • Some insider-locals in young-adulthood will have reduced place dependence for their home, either temporarily or permanently.

	For those who are travelling in a boat with a crew or have decided to add one, sailing a straight and steady course is usually more the main goal, and so they will choose to continue sailing on this particular voyage, providing they know that they and their crewmembers will have reliable radio contact.	Outsider-stayers and insider-locals at the middle-adulthood life stage most commonly choose to stay. Being concerned with starting or involved in raising a family increases place dependence for self and others, and at this stage of life place stability is often prioritized.
	Among those sailors who have good radio contact (outsider-stayers and insider-locals) but have been journeying for a while (in mid or late career) and feel themselves tiring from having to always sail in choppy waters, most will stay on this particular voyage until the journey is complete (retirement).	Having chosen to stay living in town, the insider-locals and outsider-stayers are likely to stay working in public sector health given limited employment options in rural towns and that the public sector offers the best employment conditions available, especially if an allied health professional.
	For this group of sailors, it is important they feel that they chose to stay rather than it arose because of there being no other sailing options on this ocean (limited employment choices in rural towns). If they feel they had no choice, they risk becoming 'sea blind' and not being able to sail straight and becoming a hazard to other boats in the water, especially to those sailors just setting out.	Limited employment options in rural towns mean's workers will generally stay in their CMH job although they can have low levels of professional satisfaction (dissatisfied stayers) – and this potentially can have negative effects on team dynamics.

These factors influence at different points in the individual's stage of adjustment/adaption to the job. In the adjusting stages *(feeling seasick, finding one's sea legs),* the reality gap for early career CMH professionals is generally most strongly impacted on by professional aspects. Most early career CMH professionals are likely to experience a very significant reality gap because of the job being largely unknown to them and given the negative pressures operating in the rural health service environment. This reality gap will be reduced for those who, at the commencement of the job, had some prior relevant work experience and/or an already well-formed professional identity. Those CMH professionals who are also outsider-newcomers and having to adjust to living in the town as well are likely to experience the largest reality gap during the adjusting stage.

However, once having adjusted *(managing to sail in permanently choppy waters),* the reality gap is likely to be more strongly impacted on by personal factors. The most significant factor contributing to experiencing a reality gap at this stage is whether the early career CMH professional has a sense of place dependence towards the town, and this is most strongly influenced by their current life stage. The reality gap will be heightened for those in the early-adulthood life stage including both outsider-newcomers and insider-locals, as they will feel little or no place dependence. This group is especially sensitive to bad weather events in the workplace or offers to make alternate voyages, and when these factors combine it can push an individual's reality gap below their minimum acceptable level of meeting their professional expectations. At this stage the reality gap is reduced for those who are in their middle-adulthood life stage; this includes both outsider-stayers and insider-locals. Because they want stability, this group often have strong place dependence towards the town for the medium to long term. While most workers in the mid-adult life stage will feel their professional expectations are being met to an acceptable level, there will be some for whom they have fallen below their minimum acceptable level. However, because at this life stage meeting personal expectations is the predominant concern, this level of professional dissatisfaction will not elicit the usual turnover intention (dissatisfied stayers).

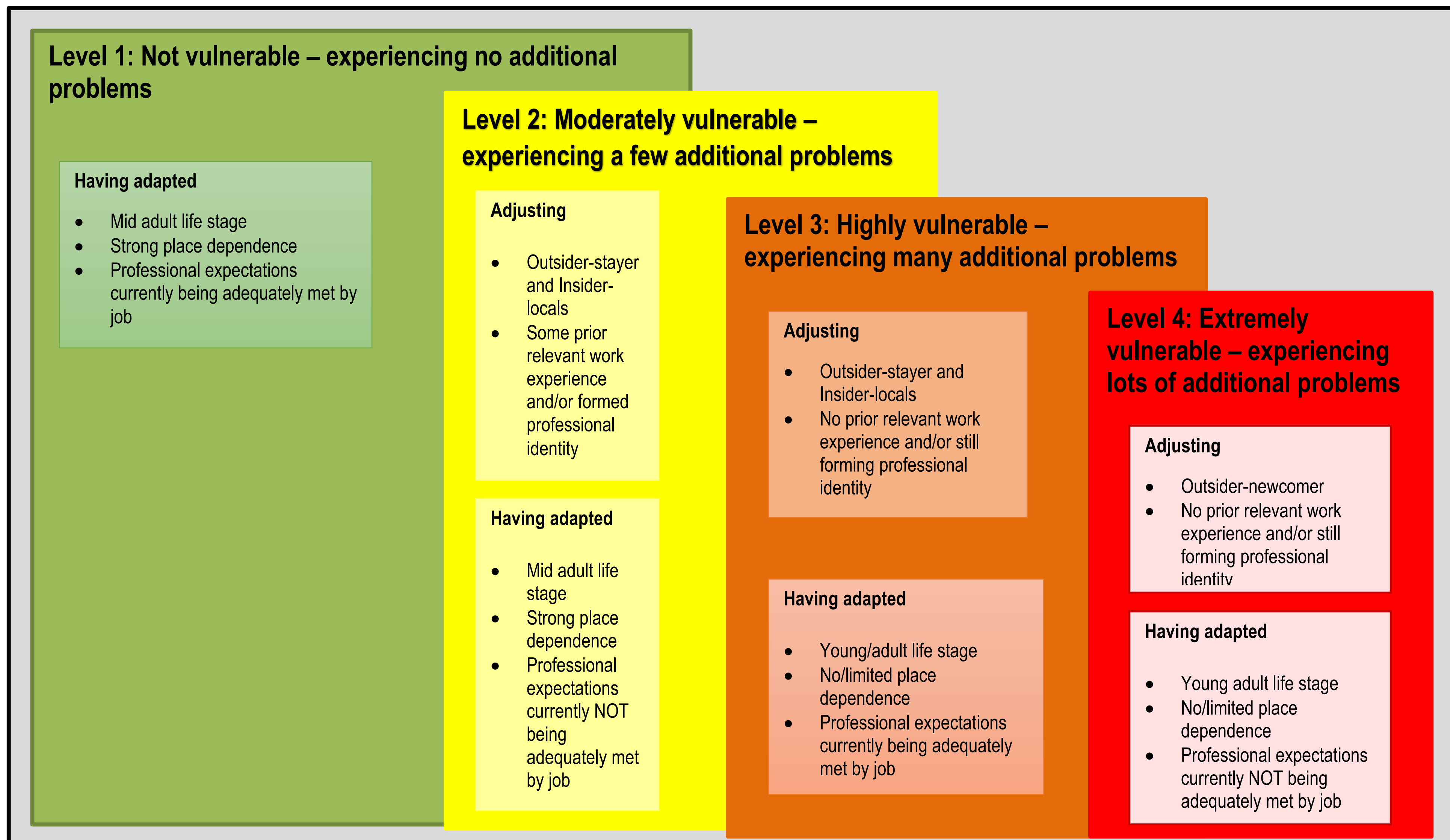
Drawing on a matrix developed to assess the vulnerability of young people by the Victorian Government (2010), the level of risk for experiencing a reality gap can be reckoned based on an individual's current stage of adjustment/adaption and their individual characteristics with respect to the four identified influencing aspects. Working in a small CMH team in a remote area further

increases an individual's risk vulnerability. There are four risk levels, ranging from extremely vulnerable (Level 4 – red), highly vulnerable (Level 3 – orange), moderately vulnerable (Level 2 – yellow) and minor vulnerability (Level 1 – green). As discussed, the risk vulnerability is never reduced to zero given the negative pressures arising from working in a rural CMH service environment.

During the adjusting stages, those early career CMH professionals who will be extremely vulnerable to experiencing a reality gap (Level 4) will be those who have little or no experience sailing in choppy waters. They will be the outsider-newcomers in the initial stages of adjustment to the job *(feeling seasick or finding one's sea legs)*, who will have had very limited or no prior relevant work experience and will still be forming their professional identity. The Level 3 group will be either outsider-stayers or insider-locals who also have limited professional experience but their vulnerability is reduced because of their sense of belonging to the town. A Level 2 vulnerability risk relates to outsider-stayers or insider-locals who have some relevant professional experience and/or an already formed professional identity at the commencement of the job.

After adapting to the job, Level 4 risk is for any CMH professionals (outsiders and insiders) who are in young-adulthood and feel limited place dependence to the town and/or are experiencing bad weather in the job and/or being made career building offers to make alternative voyages. Level 3 risk is for the same group of early career CMH professionals, but whose professional expectations are being adequately met by doing the rural CMH job. Level 2 risk is for those in middle-adulthood who have strong place dependence to the town; they are usually outsider-stayers or insider-locals but are experiencing bad weather in the job and/or being made enticing (career building) offers to take alternative voyages. Level 4 is the same group as Level 3 but whose professional expectations are being adequately met by doing the rural CMH job. These levels of risk are presented diagrammatically in Figure 5.3 (below).

Figure 5.3 Levels of risk for experiencing a reality gap and factors making early career CMH professionals vulnerable at each level



5.5 Chapter summary

This chapter presented the major findings from the research study undertaken with 26 early career health professionals working in rural-based NSW Health CMH services. Through analysis of the data using a GT coding process, turnover intention was found to be determined by the extent to which participants' professional and personal expectations were being met and these were governed by participants' individual professional and personal satisfaction levels.

This chapter presented the major factors influencing professional satisfaction (relationships, role and career building) and personal satisfaction (sense of belonging to the town) and those aspects that intensified or lessened the level of satisfaction experienced (prior relevant work experience, time in the job and degree of insidedness – outsidedness). Bringing together these findings with the basic social process of adjustment, adaption and assessment, a substantive theory on turnover intention was developed. The reality gap turnover intention theory answers the research question concerning how employment and rural-living factors impact the turnover intention of early career CMH professionals in the first few years of working in rural services.

In the following chapter, key features of this turnover intention theory will be presented and discussed in terms of how they are situated within the research literature.

6. Discussion

The previous chapter presented the findings from a GT analysis of the employment and rural-living experiences of early career CMH professionals in their first few years of working and how these impacted on their turnover intention. This grounded theory explained the influencing factors on, and the process leading to, turnover intention among this group of workers and was developed from the findings of the analysis. To recap, the theory posited that employment and rural-living factors influence the turnover intention of early career CMH professionals depending on how manageable the gap is between their professional and personal expectations and the reality of their employment and living experience. A number of key factors influencing turnover intention were identified in the development of this substantive theory:

- stages of adjustment and adaption
- extent of insidedness versus outsidedness
- extent of prior relevant work experience and formation of a professional identity
- town size and remoteness
- place dependence and life stage
- expectations being met

These issues are discussed in this chapter in relation to the existing literature. The chapter concludes with a comparison of the factors identified in this study as impacting the retention of early career CMH professionals with those discussed in the existing literature.

6.1 Key concepts of turnover intention

Stages of adjustment and adaption

The adjusting *(feeling seasick and finding one's sea legs)* and having adapted (*managing to sail in permanently choppy waters)* stages identified in this study accord closely with those outlined by Duchscher's (2008) stages of transition theory for new graduate nurses to professional practice. Duchscher's stages were: doing – getting started; being – growing into the role; and knowing – feeling comfortable in the job. Duchscher's 'doing' and 'being' equate strongly with experiences described by study participants in the adjusting stage, and her 'knowing' stage with their experiences in the adaption stage.

Duchscher (2008) described the doing stage as being very intense for the new graduate nurses and they were often stressed about everything – leading to the term 'transition shock' being coined to describe this stage; the being stage as slightly less intense and mostly focussed on gaining mastery of the job; and the knowing stage as generally more calm and when the nurses begin to look outwardly and become more concerned with organisational issues and focussed on building quality relationships with their work colleagues (Duchscher, 2008; Duchscher & Boychuk, 2009). However, the timeline that Duchscher posits for the transition of new graduate nurses to professional practice does not accord as well with the findings from this study.

Duchscher's transition theory covered a twelve-month process. She proposed that the doing stage occurred in the first 3-4 months, the being stage from 4-5 months and the knowing stage around 12 months in the job. Duchscher's timeline matches participants in this study who had some prior relevant work experience and/or an already formed professional identity but not with those who did not. In this study, the adjustment process generally took longer for the early career CMH professionals who, at the start of their employment, had no prior relevant work experience and were still concerned with forming their professional identity, for them the doing – *feeling seasick* stage – sometimes took up to 12 months and the being – *finding one's sea legs* stage – up to 24 months.

Lea and Cruickshank's (2015) study investigating the adjustment of Australian rural-based new graduate nurses also has relevance for the findings in this study. They used Duchscher's stages of transition theory as their framework and their findings concurred with Duchscher's stages and timeline. However, they found that rural new graduate nurses generally had a harder adjustment experience. Lea and Cruickshank (2015) attributed this to the impact of the rural work environment and the additional work demands placed on nurses working in rural services. Their findings accord with this study's findings with respect to the rural CMH service environment posing extra challenges for health workers generally, but particularly so for those who have no prior relevant work experience and/or were still forming a professional identity at commencement of the job.

Extent of insidedness versus outsidedness

The more intense adjustment experience for outsider-newcomers compared with those who already had some sense of belonging to the town (insider-locals and outsider-stayers) is well supported by Gillespie and Redivo's (2012a, 2012b) research findings from two studies investigating factors impacting the retention of MH professionals working in rural Canada. Their studies identified that the professional and lifestyle satisfaction of MH professionals working in rural areas was strongly linked. They also found that health professionals who were recruited from within the community (insider-locals and outsider-stayers in this study) had much higher levels of professional and lifestyle satisfaction compared to those recruited from outside the community (outsider-newcomers).

Among the group recruited from outside the town, satisfaction with the rural lifestyle differed depending on whether they had any prior exposure to rural-living. For those who did have some prior experience living in a rural town, their professional and lifestyle satisfaction levels were much closer to those recruited from within the town. This accords strongly with the reported experiences of the participants in this study who were outsider-newcomers but had some prior rural-living experience (Madison[21] – Participant 6, Madeleine – 9, Georgia – 10, Jessica – 15 and Lara – 21). They all reported a much easier adjustment experience to living in the rural town than those who had no prior rural-living experience (Zeena – Participant 1, Saskia – 2, Scarlett – 5, Natalie – 7, Jacob – 12).

Gillespie and Redivo's (2012a) study undertaken with 44 CAMHS workers found, as did this study, that safeguarding clients' privacy and confidentiality posed additional challenges for those recruited from within the community (insider-locals and outsider-stayers) as compared with those recruited from outside the community (outsider-newcomers). However, unlike this study where boundary stresses were found to reduce for all CMH health professionals after the individual had adapted to the job, Gillespie and Redivo's study found that among those who had been recruited from the community, boundary issues remained an ongoing and significant stress.

[21] With respect to her later move from Town D to Town C, both small rural towns in outer regional areas.

This more difficult adjustment to the job and rural-living for people recruited from elsewhere compared to those recruited from the community was also supported by the findings in Lonne's (2002) PhD study investigating the adjustment experience of 123 social workers who relocated from elsewhere to take up social work jobs in rural towns in Australia. While his study included experienced and inexperienced social workers and around 75 per cent had at least two years prior rural-living experience, he found that all the outsider-newcomers encountered an initial intense adjustment period typically taking 12-18 months – this accords with the minimum 12-month adjustment period identified in this study for outsider-newcomers who had no prior rural-living experience.

Lonne (1990, 2002) proposed a U curve of adjustment over 12-18 months, with five phases (disorientation, honeymoon, grief and loss, withdrawal and depression, reorganisation and adjustment). In the first 6-9 months new workers experienced low levels of job satisfaction and sense of belonging, with these gradually increasing over the next 10-18 months, with job satisfaction eventually levelling off and a steady increase in belongingness to the community. These phases accord closely with many of the experiences described by outsider-newcomers in this study, although arguably the fall was faster and sharper as the honeymoon stage was not always experienced – (only described by Saskia – Participant 2 and Lara – 21).

Extent of prior relevant experience and formation of a professional identity

In the literature, successful adaption to working in the health sector by early career health professionals was strongly associated with the formation of a professional identity and this was linked to socialisation with, and support from, other team members of the same profession (Ashby et al., 2013; Hurley & Lakeman, 2011; Wright et al., 2011). Ashby et al.'s (2013) study of Australian OTs working in MH services found that the initial adjustment stage for new graduates was a very vulnerable time for them given they faced the dual demands of needing to build up their MH skills and form a professional identity. In this study, among those who had recently graduated and for whom this was their first professional health job, most described feeling underprepared to perform the role as well as to work within an interdisciplinary approach.

Lloyd (2002) found that OTs working in MH roles generally had less contact with and support from health professionals from the OT discipline. Peck and Norman (1999) identified a negative impact on interdisciplinary care in CMH services because of workers strongly identifying with their professional discipline, making it difficult for them to understand and support other clinical approaches. This was also found to be the case in this study, with most participants thinking of themselves in terms of their professional identity rather than as generic mental health caseworkers. Many participants described feeling a constant tension between working in their case management position and trying to form or maintain their professional identity. This was also supported by Lloyd's (2002) findings regarding the negative impact on job satisfaction of rural CMH workers due to reduced ability to connect with discipline-specific professionals.

Town size and remoteness

In their study of the factors impacting the recruitment of CAMHS professionals living and working in rural Canada, Gillespie and Redivo (2012b) found that, those who worked in the smaller, more remote towns were the least satisfied group of workers, generally experiencing much lower levels of satisfaction with respect to both professional satisfaction and rural lifestyle. With respect to professional satisfaction, this accords with this study, which found that with increasing remoteness, professional dissatisfaction increased. In this study, this was associated with the more remote services having smaller teams combined with chronic staffing shortages that intensified the negative aspects of workplace relationships (poor team dynamic) and challenges of performing a rural CMH job (resourcing constraints, extra duties).

Gillespie and Redivo (2012b) posited that the most dissatisfied workers in remote towns were those recruited from outside the community (outsider-newcomers). This also accords with the findings from this study, which found that in the more remote services (outer regional and remote areas) the newcomer-outsiders were the most personally dissatisfied (Zeena – Participant 1, Saskia – 2, Scarlett – 5, Natalie – 7 and Jacob – 12). However, this study's findings also suggest that remoteness is not always associated with having lower levels of personal satisfaction: it is also affected by the extent of belonging felt to the town and community. For the workers in the more remote services who had some sense of belonging to the town at the start of the job (for example, Clarke – Participant 3, Mia – 4, Deborah – 24, Bill – 25 and Jacinta – 26), their personal

satisfaction was close to, or the same as, those who were living/working in towns in the inner regional areas (for example, Kalinda – 8, Emily – 14, Charlie – 22).

Place dependence and life stage

This study found that after having adjusted to the job, the major influence on early career CMH professionals' turnover intention shifted from primarily professional concerns to issues related to their (and other family members') personal satisfaction. This was found to link to participants' sense of belonging to the town, which was strongly influenced by their current life stage. Those participants who were in middle-adulthood or entering middle-adulthood were identified as the most likely group to decide to stay living in the town and working in the CMH job. This finding is well supported in the literature explaining life stage and the development of place dependence.

Erikson (1982), the pioneer of life stages over the life cycle, associated middle-adulthood with stability, the focus being on family and work and wanting to make a difference (generativity). Valliant (1993) associated this generativity with career consolidation and posited that people in middle-adulthood wanted to work in a role that was valued by themselves and society. These characteristics of middle-adulthood all resonate strongly with the participants in this study who were involved in raising families or were planning to start one in the near future.

Levinson (1978) suggested that the major task of middle-adulthood was settling down. Hay's (1998) study concurred with this and he argued that the desire to put down roots was also associated with place attachment. Hay (1998) observed, in his study of people living in a particular area of New Zealand, that a person's place attachment considerably strengthened at the beginning of middle-adulthood and was often linked to the place the person was living in at the time. He found that this was a strong influence for both locals from the area (insider-locals) and those who had come from elsewhere (outsider-newcomers and outsider-stayers). Hay's findings help explain the very fast and easy adaption to rural-living that Jade (Participant 17) experienced despite her being a newcomer with no prior rural-living experience. Jade and her partner had decided they were ready to start a family and they assessed Town F as meeting their needs. This desire to put down roots as one enters middle-adulthood – making the decision to settle down and start planning a family – also helps to explain other outsider-newcomers choosing to stay on

living in the town (Jessica – Participant 15 and Lara – 21) and the reasons for staying living in the town and in the CMH job given by some of the younger insider-locals (Emily – Participant 14 and Amy – 13).

Moving out of the middle-adulthood stage into late-adulthood also explains the ties to the town beginning to loosen for outsider-stayer Madeleine (Participant 9) since her grown-up children had left town and for Bill (Participant 25) as he approached retirement, and for the shifts back to their respective hometowns made by Karen (Participant 19) and Jacinta (Participant 26).

Expectations being met

This study found that after CMH professionals had adjusted (*managing to sail in permanently choppy waters*), personal factors were the main influence on their turnover intention and that life stage and place dependence were the main influencing factors. However, among those CMH professionals who decided to leave (mostly those in the young-adulthood life stage and who had limited place dependence), professional dissatisfaction was also found to be a contributing factor. Geurts and colleagues' (1998) study investigating the reasons for turnover intention among European MH professionals posited that when a MH employee assessed the cost of their exchange with their employer as outweighing the benefits, they would either decide to leave the job or withdraw psychologically.

Geurts et al. (1998) found that those CMH professionals who decided to stay in the job but psychologically withdrew often engaged in negative communication with other team members, causing their negative perceptions to spread throughout the team. This resonates with the study's finding regarding professionals in middle-adulthood whose professional expectations had fallen below their minimum acceptable level, but decided to stay in the job (termed 'dissatisfied stayers'). Several participants discussed the damaging impact on team dynamics and work morale that occurred when there were long-term staff in the team who were very negative and who they perceived as not wanting to be there (most likely dissatisfied stayers).

Section summary

This section discussed the key concepts of the reality gap turnover intention theory in relation to the existing literature. The existing literature supports the concept of stages of adjustment to a new health professional's job. The literature also highlights that the adjusting stage of a MH job is difficult and job satisfaction is often at low levels in this stage, particularly for those who have limited or no prior relevant work experience and/or are still forming their professional identity. The importance of having a strong sense of belonging to the town was supported by the existing research and identified as being an issue that particularly impacted the personal satisfaction of outsider-newcomers. The issue of boundaries for MH workers in rural towns was well supported in the literature. With respect to turnover intention, the roles of expectations being met, life stage and place dependence/attachment were also supported by the research. Generally, the key concepts of the reality gap turnover intention theory were well supported in the existing research

However, there were some aspects of the theory's concepts that could not be identified within the existing literature. These related to the duration of stages of adjustment and adaption, and to the observed closing of the gap in the satisfaction levels of staff after having adapted to the job and to living in the town. That is, the point where people were recruited from and/or how much experience they have matters much less.

As well as supporting the development of a substantive theory explaining turnover intention, the findings identified key factors impacting the professional and personal satisfaction of early career CMH professionals and these are discussed next with respect to the existing research.

6.2 Factors impacting retention

This study's findings identified key employment and rural-living factors impacting on the retention of rural-based early career CMH professionals. These factors were presented under two main categories – *professional* and *personal satisfaction* – and key aspects discussed (relationships, role and career building, and sense of belonging). An analysis was undertaken comparing the factors identified in the present study against the 12 broad themes identified in the existing literature (and originally listed in Table 2.2). This analysis is highlighted in Table 6.1 (below), which matches the 12 broad themes with the key factors identified in this study as

impacting the retention of rural-based early career CMH professionals. This is then followed on by a discussion of the analysis under each of the theme headings.

Table 6.1 Broad themes in existing literature compared with key findings from this study

Theme no.	Broad themes identified in existing literature (from Table 2.2)	Key findings from this study		
		Professional satisfaction		Personal satisfaction
1	Resourcing – fiscal and human	Role	Working with limited resources	
		Relationships	Staffing issues	
2	Feeling valued and supported by management	Relationships	Support from service level manager	
		Career Building	Support for MH skill building	
3	Rural service approach and career building opportunities	Role	Challenges of interdisciplinary care and generic case management	
		Career Building	Opportunities for career advancement	
4	Organisation – system, culture and values	Relationships	Organisational culture and senior management interface	
5	Workload	Role	Managing a big workload	
			Working with limited resources	
6	Span of role	Role	Working with a demanding client group	
7	Team values and culture	Relationships	Team dynamic	

Theme no.	Broad themes identified in existing literature (from Table 2.2)	Key findings from this study			
		Professional satisfaction		Personal satisfaction	
			Professional differences		
8	Career planning and development	Career building	Opportunities for career advancement		
			Maintaining a professional identity		
9	Personal values, interests and life stage			Belonging	Place dependence
10	Work/life balance			Belonging	Place dependence
11	Social connections			Belonging	Community links
12	Kinship/family			Belonging	Community links

1) Resourcing – fiscal and human

The dual challenge of chronic staffing shortages and high staff turnover, which was the situation in all but one of the CMH services in this study, and its negative impact on staff workloads and job satisfaction, as was experienced by the majority of study participants, have been well identified in both the Australian MH and rural health workforce literature (Buykx et al., 2010; Ceramidas, 2010; Henderson et al., 2008; Moore et al., 2010; Ragusa & Crowther, 2012). Inadequate resourcing of rural health services and the challenge of providing adequate clinical services are also often discussed in the Australian rural health workforce literature (Keane et al., 2012; Lea & Cruickshank, 2007).

2) Feeling valued and supported by management

In the health workforce retention literature, feeling supported by management was a major factor identified as impacting health professionals' job satisfaction and was described as relating to management understanding the challenges of the role being performed and the additional demands of working in rural services (Buykx et al., 2010; Gillham & Ristevski, 2007; Hegney et al., 2002;

Keane et al., 2012; Moore et al., 2010; O'Toole et al., 2010; Perkins et al., 2007; Stagnitti et al., 2006; Wolfenden et al., 1996). Nearly all study participants spoke of feeling that having management support was important to their job satisfaction. A new aspect not outlined elsewhere in the research was describing management support to mean their taking into consideration service constraints and the needs of existing staff when recruiting new staff. The importance of respecting the manager's clinical competence (Keane et al., 2012) and having the manager physically on site (Stagnitti et al., 2006) was also reported by some study participants. Several participants made mention of broken recruitment promises negatively impacting on their relationship with their service manager and this was also a new aspect of feeling supported by management that was not identified in the existing literature.

In the research, feeling supported by management was linked to receiving an adequate orientation, having opportunities to participate in CPD activities and receiving regular clinical supervision (Ashby et al., 2013; Buykx et al., 2010; Crowther & Ragusa, 2011; O'Toole et al., 2010; Perkins et al., 2007; Stagnitti et al., 2005; Wolfenden et al., 1996). All of these aspects were strongly emphasised by this study's participants. Keane et al. (2012) described receiving management support for CPD as being a gauge for management support generally, and this was also found to be the case in this study, highlighted by the strong negative reaction many participants had to the cuts incurred in their service's CPD budget. The study also confirmed another finding identified by Keane et al. (2012) regarding the additional difficulties that rural resourcing constraints pose for health professionals working in rural services being able participate in CPD activities and receive clinical supervision.

3) Rural service approach and career building opportunities

The rural health workforce literature suggests that a key attractor for taking up a rural position is the opportunity to develop broad-based clinical skills and it being especially attractive to those in the early years of their health careers (Keane et al., 2012; O'Toole et al., 2010; Stagnitti et al., 2005). This finding was also supported in this study, with three participants (Zeena – Participant 1, Saskia – 2 and Natalie – 7), all recent graduates and outsider-newcomers, explaining that skill building and career advancement had been their major motivation for taking their rural-based CMH position.

The workforce literature on retention in CMH services found that, while an interdisciplinary care and a generic case management approach were often attractors in taking a CMH job, they also had negative impacts on job satisfaction. This was associated with health professionals' discipline-specific skills becoming diluted and experiencing difficulties forming or maintaining a profession-specific identity (Ashby et al., 2013; Ceramidas, 2010; King, 2009; Scanlan et al., 2010). It was also found that these risks were intensified in a rural service environment, given its smaller teams and potentially a more limited number of professional disciplines on staff (Drury et al., 2005; Perkins et al., 2007). The present study supported these findings and highlighted how the resourcing constraints in rural CMH services can further limit the ability of CMH staff to use their discipline-specific skills, as there was little or no capacity to match clients' needs with the most appropriately skilled staff person.

4) Organisation-system, culture and values

Buykx et al. (2010) found that retention of the rural health workforce relied on staff perceiving the organisation as being managed efficiently and strategically. Furthermore, Perkins et al. (2007) identified that among rural CMH staff 'the way the firm was managed' (p. 95) was an important aspect of job satisfaction and was often what staff were least satisfied with. Ziguras (1999) identified that MH staff frequently expressed frustration about having to work in an organisational culture of constant restructuring and change. In the rural health workforce literature, poor communication by management was commonly identified as contributing to staff dissatisfaction and turnover (Bragg & Bonner, 2014; Buykx et al., 2010; Gillham & Ristevski, 2007; Stagnitti et al., 2005).

All these findings were well supported in the present study, with almost all participants expressing frustration with, resistance towards, and growing cynicism about having to work in an environment characterised by constant change. This was discussed as occurring at the service level with regard to changes in procedures due to frequent turnover of managers and their wanting to make their mark. It also was reported occurring at the LHD level with respect to organisational restructures, which were described as being protracted and creating uncertainty and stress among staff. Participants also described a 'them and us culture' existing between management and staff and this being widespread. Many participants spoke of feeling that management had little or no real understanding of their workplace realities and the level of responsibility their positions

involved. This study also found that the longer health professionals had worked for the organisation, the greater their cynicism towards management and the greater their tendency to devalue any change being implemented by management.

5) – 6) Workload, Span of role

The demanding nature of the mental health clients, identified in this study as being a key factor impacting on participants' job satisfaction, was also identified in the existing literature. All study participants discussed managing clients with high levels of mental illness acuity and generally linked this with the scarcity of MH resources available in rural areas (Crowther & Ragusa, 2011; Drury et al., 2005; Henderson et al., 2008; Perkins et al., 2007; Ziguras et al., 1999). Some participants associated the demanding nature of the clients with having to manage clients on CTOs, particularly those who were compliance-resistant (Henderson et al., 2008). A couple of participants associated the high level of mental illness acuity among clients as being related to their preference to manage their acutely unwell clients in the community rather than admit them if it involved the client having to leave the town (Henderson et al., 2008).

Gibb et al. (2003) and Drury et al. (2005) identified the negative impacts of unlimited or excessive caseloads on workload and job satisfaction. In this study, the major factor attributed to having a big workload arose from the size of the caseload they had responsibility for and the associated paperwork. A number of participants had caseloads that were well above the recognised average caseload size and described these as resulting from high staff turnover and/or long-term staffing vacancies in their service. The participants in the study for whom this was their first professional job since graduating also attributed staffing shortages to their receiving a poor orientation and being expected to quickly take on a full caseload (Henderson et al., 2008; Lea & Cruickshank, 2007).

Other aspects contributing to workload identified by the participants were the demanding nature of the client group (Henderson et al., 2008) and having to perform additional duties and travel significant distances to see clients (Drury et al., 2005; Henderson et al., 2008; Perkins et al., 2007). In addition, the participants in this study often mentioned the heavy paperwork required in

performing a MH role (Gibb et al., 2003; Henderson et al., 2008; Moore et al., 2010; Perkins et al., 2007).

7) Team values and culture

Team dynamics and relationships with other team members were mentioned by all the participants and discussed as being a critical factor influencing their job satisfaction. The importance of team cohesion and support from colleagues has been well identified in the health workforce literature (Buykx et al., 2010; Ragusa & Crowther, 2012; Scanlan et al., 2010; Stagnitti et al., 2005). Several participants discussed in detail the adverse impact working in a team with a negative dynamic had on their job satisfaction. This was also reported in the existing CMH workforce literature (Perkins et al., 2007; Scanlan et al., 2010).

This study confirmed the findings in the existing literature with respect to the reduced standard of interdisciplinary care and the risk of a single model approach arising from the smaller team sizes and a more limited mix of professions found in rural services (Ashby et al., 2013; Ziguras et al., 1999). Furthermore, the lack of respect and understanding that could operate between staff members from different disciplines (Ashby et al., 2013; Lloyd, King, & Bassett, 2002) and how it sometimes resulted in less experienced staff being the targets of workplace hostility and bullying by older, long-serving staff members (Lea & Cruickshank, 2007) was also highlighted in this study.

While all the rural CMH participants were employed in generic case management positions, their professional discipline was associated with impacting their workload and case allocation, with nurses (and, in this study, also the clinical psychologist) stating that they were required to perform additional duties and feeling they were allocated the more complex clients compared to allied health professionals (Henderson et al., 2008). The issue of pay differences between the professional disciplines and the general lack of understanding and respect felt by the Aboriginal MHWs discussed in this study were not mentioned in the existing literature and are most likely an issue specific to NSW Health.

8) Career planning and development

The literature identified altruistic motives as being an important aspect for wanting to work in MH and having ongoing influence on professional satisfaction (Drury et al., 2005; Perkins et al., 2007; Ragusa & Crowther, 2012; Wolfenden et al., 1996). This finding was supported in this study, with many participants linking their sense of professional satisfaction to their clients and, while often describing them as demanding, they were reported as the main reason they found their job satisfying.

Having opportunities to build and advance one's health career was mentioned by most participants in this study, especially those who were in the early career stage and this also correlates with the existing literature (Drury et al., 2005; Lloyd, King, & Bassett, 2002; Perkins et al., 2007; Scanlan et al., 2010). However, this study found that career advancement was more nuanced than just leaving the job for a new position (pull factors). This study identified that career advancement was of particular concern for those in the early-adulthood life stage. This study found that career advancement (pull factors) was not usually the only reason for rural-based early career CMH professionals deciding to leave their job: they also usually involved some level of professional dissatisfaction with the job (push factors).

This study found, as did the rural health workforce research, that discipline-specific professional identity was, and remains, very important for health professionals, and having regular opportunities to participate in CPD activities and to network were an important aspect of professional satisfaction (Crowther & Ragusa, 2011; Mills & Millsteed, 2002).

9) – 12) Personal values, interests and life stage, work/life balance, social connections, kinship/family

The importance of feeling a sense of belonging to the town and building or having an established social network/kinship ties in the town are all identified factors in the literature and linked with personal satisfaction. These factors were also all supported in this study's findings (Keane et al., 2012; Lea & Cruickshank, 2007; O'Toole et al., 2010; Stagnitti et al., 2005; Wolfenden et al., 1996). The existing literature identifies personal interests and/or family responsibilities as being an influencing factor on health professionals' decision to stay or leave a rural health job (Buykx et

al., 2010; Keane et al., 2012; Mills & Millsteed, 2002; Perkins et al., 2007). This study's findings correlate with this but again provide a more nuanced understanding, identifying that personal interests and concerns are a major factor in turnover intention, but the aspects and degree of influence differs depending on an individual's life stage, which in turn influences their degree of place dependence.

Weak or no place dependence was found among participants who were in young-adulthood and intending to leave their position. Having strong place dependence was associated with participants in or entering middle-adulthood who were primarily concerned with family matters and work stability. While Lea and Cruickshank (2007) identify lack of anonymity as an issue impacting turnover intention of rural-based health professionals, this study's findings expand on the issue with regard to the additional difficulties posed for health professionals working in MH.

Section summary

This section presented the findings from analysis that compared the key themes identified in the existing literature regarding factors impacting the retention of health professionals working in rural Australia with the findings from this study. Overall, almost all of this study's findings regarding factors impacting retention were already identified in and well supported by the existing research. There was only one aspect of the study's findings that was not found in the existing research. This related to the additional challenges CMH professionals working in the rural service environment faced with respect to having to safeguard client privacy and confidentiality, but this is linked with difficulties regarding personal anonymity and living in a rural town which has been researched (Lea & Cruickshank, 2007).

6.3 Chapter summary

This chapter reviewed the major findings of the research study undertaken with 26 early career health professionals working in rural-based NSW Health CMH services and their place within existing literature. Two key findings areas were examined: firstly, the key concepts of the reality gap turnover intention theory; and secondly, the identified factors impacting retention. The key concepts of the reality gap turnover intention theory brought together a broad range of employment and rural-living concepts and all of these were well supported in the existing

research. With respect to the analysis undertaken, the factors identified as impacting retention were also well supported in the existing research. The contribution of this study to existing literature is discussed in next and final chapter.

7. Conclusion and recommendations

This chapter is the final chapter of the PhD thesis. It begins with an assessment of whether the study answered the research question and met its objectives. It then progresses to the study's contribution to research and professional practice. Recommendations arising from the research are outlined and analysed with reference to the existing literature. The grounded theory approach is then evaluated. The chapter concludes with a discussion of the study's strengths and limitations and proposed future research directions.

7.1 Contribution of the research

CMH teams and case management services delivered by health professionals in rural Australia are an important public sector MH service, heavily relied upon by people who are living with serious and/or persistent mental ill health. Chronic staffing shortages are widespread within these rural CMH services, arising from both long-term vacancies and high turnover of new staff.

The aim of this study was to investigate how employment and rural-living factors impact the turnover intention of rural-based, early career CMH professionals in their first few years of working (the research question). Using a constructivist grounded theory methodology, the study aimed to develop a substantive theory explaining the turnover intention phenomenon for this group of workers (Study Objective 1) and to assist with theoretical conceptualisation to identify the basic social process (Study Objective 2).

Twenty-six in-depth interviews with rural-based early career CMH professionals working for NSW health were undertaken. Through analysis of the interview data using a GT coding approach, turnover intention was found to be determined by the extent to which an individual's professional and personal expectations were being met and this was governed by their levels of professional and personal satisfaction.

The quality of relationships an individual had with their work colleagues, their experience of the work role and opportunities available for career building were all found to impact professional satisfaction. Personal satisfaction was affected by the extent to which an individual felt they

belonged to the town and the community. The level of satisfaction experienced intensified or lessened depending on whether the worker had any prior relevant work experience, the length of time they had been in the job and their feeling of insidedness/outsidedness with respect to the town and the community. The data analysis identified that the basic social process involved change and encompassed four stages: *initial adjustment, continuing adjustment, having adapted,* and *weighing it all up*. The degree to which a worker assessed their professional and personal expectations as met was affected by how well they adjusted and adapted and what point they were at in the change process.

The grounded theory explained the influencing factors on, and the process leading to, turnover intention among rural-based early career CMH professionals. The theory proposed that employment and rural-living factors influenced worker's turnover intention depending on how manageable an individual found the gap between their professional and personal expectations and the reality of their employment and living experience (*the reality gap*). This turnover intention theory was further explained by using the metaphor of an individual taking an ocean voyage on sailing a boat. The four stages of the basic social process were likened to: *feeling seasick, finding one's sea legs, managing to sail in permanently choppy waters* and *deciding whether to continue the voyage.*

Given the harsh, ever-present realities of the rural CMH service environment (*permanently choppy waters*) most early career staff who stayed in the job beyond the adjusting stages of *seasickness* and *finding their sea legs* had accepted that their professional expectations were unlikely to ever be fully met working in a rural CMH role and, at best, would reach an acceptable level. These service constraints intensified the more remote the service location, given the heightened staffing shortages found in those services. This study also found that the decision to stay or leave a rural job is generally made early on and often in the adjustment stage.

In addition to a worker's professional satisfaction being impacted upon by working in *permanently choppy waters*, it was found that professional expectations were affected by individual characteristics of the worker. These characteristics included: whether they had any prior relevant work experience and/or an already well-formed professional identity starting the

job; whether they were an outsider-newcomer; the extent of their place dependence towards the town; and their current life stage. These characteristics were found to have different influences depending on the individual's stage of adjustment/adaption to the job.

It was found that the reality gap was most strongly impacted on by professional aspects in the adjusting stages and that most early career CMH professionals initially experienced a large reality gap due to being unfamiliar with the job and having to manage the challenges of working in a resource-constrained service environment. In this adjusting stage, the reality gap was lessened for those who had some prior relevant work experience and/or an already formed professional identity. Those most likely to experience the largest reality gap were those who were inexperienced and had been recruited from outside the town (outsider-newcomers).

Once an early career CMH professional had adjusted *(managing to sail in permanently choppy waters),* personal factors were found to impact more strongly on the reality gap. At this stage, the reality gap was heightened for individuals who were in the early-adult life stage and who felt little or no place dependence towards the town. This group were also more sensitive to bad weather events in the workplace and/or offers to make alternate voyages. On the other hand, individuals who were in the middle-adulthood life stage and focussing primarily on raising a family and having stable work usually felt strong place dependence towards the town for the medium to long term. They also tended to assess their professional expectations as being reasonably met by the job. However, because of a lack of alternative employment opportunities in rural Australia, some individuals in this middle-adulthood life stage continued to stay working in the CMH job despite their professional expectations having fallen below their minimum acceptable level – the study suggests that these dissatisfied stayers have negative impacts on the team dynamic and on the professional satisfaction of other staff.

For research

Generally, the key concepts of the reality gap turnover intention theory (which included stages of adjustment and adaption, extent of insidedness versus outsidedness, extent of prior relevant work experience and formation of a professional identity, town size and remoteness, place dependence and life stage and expectations being met) were all well supported in the existing research.

However, a few of the aspects of some of the key concepts differed to the findings in the existing literature. These were:

- The differences in duration in the stages of adjustment and adaption to the job between health professionals who, at the start of employment, had some prior relevant experience and/or an already formed professional identity and those who did not.
- After having adapted to the job, whether job satisfaction levels between health professionals who had some prior relevant work experience and those who did not continued to be different or became the same.
- After having adapted to living in the town, whether the personal satisfaction levels of outsider-newcomers continued to be different or became the same as those who were recruited from the town.

Further research is required to verify these findings.

With respect to this study's findings regarding factors impacting retention, almost all of the factors identified were supported by the existing research. There was only one aspect of the study's findings that was not found in the existing research. The study's major contribution was to build understanding regarding how these factors particularly impacted on rural-based early career CMH professionals working in generic case management roles.

For professional practice

The turnover intention theory brought together a broad range of employment and rural-living concepts. It is also thought likely that the matrix and recommendations will have relevance for other Health departments in other states of Australia and internationally that want to improve avoidable staff turnover among early career CMH professionals working in rural service settings.

While this theory was developed based on the rural work and living experience of CMH professionals, given it concerns early career adjustment and adaption, it is thought likely to have relevance for other early career human service employees working in public sector services, such as teachers, child and community support workers, policemen, and ambulance workers. As Barak and colleagues (2001) identified in their investigation of the antecedents of turnover in the human

service workforce, human service workers operate in emotionally intense fields of work and generally feel a strong commitment to their clients and the work, making them susceptible to burnout and resulting in turnover. Thus, it is likely that human services workers will generally, in their first few years of working, be vulnerable to experiencing a gap between their expectations concerning their employment and the reality of the job they are working in. So this turnover intention theory may have application for early career human service workers. Given this, it also likely that the vulnerability risk matrix developed and the following recommendations will have utility for management of human service public sector organisations trying to address turnover among staff working in rural services.

7.2 Recommendations from the research

The findings from this study all strongly point to the need to stabilise the team and the work environment in order to reduce avoidable staff turnover among early career health professionals working in rural CMH services. To achieve this, efforts need to be made to help ensure the recruitment of appropriate staff and encourage staff retention by adequately supporting new staff at the outset and trying to meet their career aspirations in the medium to long-term. This study identified many negative experiences encountered by rural-based early career CMH professionals in the stages of adjusting (*feeling seasick* and *finding one's sea legs*), adapting (*managing to sail in permanently choppy waters*) and assessing (*deciding whether to continue the voyage)* that can inform policy and procedural effort aimed at improving retention among this group of health professionals.

The following recommendations are based on a number of the key factors identified in this study as influencing turnover intention including: stages of adjustment and adaption, insidedness versus outsidedness, prior relevant work experience and extent of professional identity formation, place dependence and life stage, and professional expectations being met. Thirteen recommendations have been developed based on the key issues identified by participants with respect to staff recruiting and to difficulties faced and supports required to help new staff in adjusting and adapting to the job/town and assessing these both for the future. These recommendations all aim to help *calm the choppy waters* and help individuals gain mastery in sailing their boat sooner. These recommendations are aimed at both levels of NSW Health's management: the service and

senior levels (including LHDs and the State). The recommendations are listed below in Table 7.1 under the stages of recruitment, adjusting, adapting and assessing. A discussion of each recommendation then follows.

Table 7.1: Recommendations from this study's findings

Recommendations	
Recruitment	
1	Aim to recruit staff who have a reduced vulnerability risk of experiencing a reality gap
2	Ensure the needs of existing staff and the team dynamic are considered when recruiting any new staff
3	Aim to encourage early career staff in the young-adult stage to stay for the medium term by offering an early career 3-5 year program
4	Ensure service managers have sufficient authority and independence to implement place-based responses to staffing needs and their performance on staffing is assessed on retention (or job satisfaction measures), not recruitment
Adjusting – *feeling seasick* and *finding one's sea legs*	
5	Ensure new staff receive adequate orientation and ongoing discipline-specific support for the duration of their adjustment at a level commensurate with their level of experience on entry
6	Train new staff in strategies to manage role boundary issues and to safeguard client confidentiality and privacy
7	Work with local Council and other community organisations to provide a 'Welcome program' for outsider-newcomers to help them become familiar with the town and establish social connections
Adapting – *managing to sail in permanently choppy waters*	
8	Ensure all staff have regular access to clinical supervision and discipline-specific networking opportunities and provide financial support to help them to regularly undertake CPD activities (recognizing that maintaining professional identity is of ongoing importance to all staff)
9	Support staff to undertake any organisational opportunities that support them in building their clinical and/or management skills or to experience or pursue a senior management position
Assessing – *deciding whether to continue the voyage*	
10	Ensure staff workloads and caseloads are reasonable by engaging agency staff to fill long-term vacancies and promptly recruiting any new vacancies that arise
11	Encourage stability in staffing by offering incentives that encourage medium-term commitment from service-level managers
12	Work to minimise unnecessary change at both service level (procedural) and organisation level (restructuring)
13	Work to understand the team dynamic and identify any dissatisfied staff and work with them to address their issues

Recruitment

Recommendation 1: ***Aim to recruit staff who have a reduced vulnerability risk of experiencing a reality gap***

This study identified that individual personal characteristics of early career CMH professionals heightened or lessened their risk vulnerability of experiencing a reality gap. Service level managers could use this knowledge to inform their recruitment selection. Whenever the choice is

available, it is recommended when choosing staff that preference is given to those applicants who are insider-locals or outsider-stayers and/or those who have some relevant prior experience and/or an already-formed professional identity. In addition, managers should be aware of the greater likelihood of the medium to long-term retention of staff who are in their mid-adult life stage and involved in raising a family or planning to start one in the near future.

Recommendation 2: ***Ensure the needs of existing staff and the team dynamic are considered when recruiting any new staff***

This study identified that a positive team dynamic was an extremely important factor for health professionals with respect to their job satisfaction. It found, because of the smaller-sized teams operating in rural areas, that the team dynamic was very sensitive to staff changes. A change of just one staff member had the potential to alter a team dynamic from positive to negative and vice versa. In the remote services (outer regional and remote) this was particularly the case given the big workloads and high levels of responsibility staff held, leaving them with reduced capacity as individuals and/or as a team to accommodate any ill-suited or poorly skilled new staff member. In these small teams, poor staffing choices could result in the whole team (or a sub-team in the larger services) becoming dissatisfied and lead to existing staff deciding to leave.

Recommendation 3: ***Aim to encourage early career staff in young-adult stage to stay for the medium term by offering an early career 3-5 year program***

This study found that health professionals who were in young-adulthood (both outsider-newcomers and those who were insider-locals) often had reduced or no place dependence and as a result were the most likely group among the early career CMH professionals to choose to leave the job and town.

The duration of stay in the job was often very short (18-24 months) within this group among the outsider-newcomers. However, this group were generally very career-focussed and, while it may be difficult to influence health professionals in young-adulthood to stay in the job and town long-term, it might be possible to encourage them to make a longer-term commitment to a rural CMH job (say 3-5 years) if career advancement was seen as a likely outcome. This could be encouraged

by offering a program that includes MH skill building, discipline-specific clinical supervision, support for participating in regular CPD activities and, at the program's end, giving workers assistance/support to obtain more senior positions in NSW Health.

Recommendation 4: ***Ensure service managers have sufficient authority and independence to implement place-based responses to staffing needs and their performance on staffing is assessed on retention (or job satisfaction measures), not recruitment***

This recommendation concerns the importance of giving service-level managers sufficient authority (budgetary and decision making) to allow them to respond appropriately to local circumstances with respect to recruitment of staff. This concerns such things as being able to take into consideration: the needs of existing staff, the size of the team and the town's level of remoteness. Ideally, this flexibility should allow the service manager to decide on the grading level of positions, to develop job descriptions for positions and set location-specific performance indicators for the staff. Service-level managers should also have sufficient authority to offer staff retrenchment packages to allow them, if required, to respond to negative staff members (dissatisfied stayers) whose ongoing presence is destabilising the team.

Also, given the high risk of staff turnover in rural CMH services, service-level managers' performance with respect to staffing should ideally be measured with respect to the job satisfaction level among existing staff and not based on recruitment measures.

Adjusting – feeling seasick and finding one's sea legs

Recommendation 5: ***Ensure new staff receive adequate orientation and ongoing discipline-specific support for the duration of their adjustment at a level commensurate with their level of experience on entry***

This recommendation concerns the known negative influences on early career CMH professionals' job satisfaction during the adjustment stage. All new staff should receive a formal orientation and have their clinical supervisor allocated and supervision sessions begin as soon as possible. New staff may also benefit from being allocated a mentor from within the existing staff. Additional support should be on offer for the more experienced new staff member for at least 12

months from starting and for those with little or no prior relevant experience and/or those still forming their professional identity. Such extra supports should be in place for up to 24 months.

Recommendation 6: ***Train new staff in strategies to manage role boundary issues and to safeguard client confidentiality and privacy***

An important new finding from this study was the negative impact professional/personal boundary issues and the challenges of safeguarding client confidentiality in a rural town had on job satisfaction for new staff, especially in the first year of working. Support to manage this issue could be given as in-house training to new staff as part of orientation and throughout the first year of working. Other staff who have been working in CMH and living in the town for a few years will likely be able to offer valuable strategies to manage and should be involved in training. Given the additional and very culturally specific challenges Aboriginal MHW face, additional training and/or separate training should be considered.

Recommendation 7: ***Work with local Council and other community organisations to provide a 'Welcome program' for outsider-newcomers to help them become familiar with the town and establish social connections***

This study identified that those who were outsider-newcomers experienced a very high-risk vulnerability of experiencing a reality gap, in particular those who had relocated to the town for the job and were living as a single person. The study found that making friends, especially outside the workplace, was often extremely challenging for outsider-newcomers. It is recommended that the service level manager work with local community organisations to develop a welcome program to assist all outsider-newcomers filling professional roles (teachers, ambulance officers, police, etc.) to adjust to the town and make social connections with both other outsider-newcomers and insiders.

Adapting – managing to sail in permanently choppy waters

Recommendation 8: ***Ensure all staff have regular access to other discipline-specific health professionals and provide the level of support required to assist staff to regularly undertake discipline-specific CPD activities (recognising that maintaining professional identity is of ongoing importance to all staff)***

This study found that, for all CMH health professionals, maintaining their profession-specific identity was important and impacted their professional satisfaction. Both NSW Health and service-level managers need to work to reduce the current barriers that exist (budgetary, time, staffing constraints) for rural staff to regularly attend discipline-specific CPD activities. NSW Health must recognise and accept that rural-based health professionals face more barriers to undertaking CPD activities and thus need to provide additional budgetary resources to rural services to help staff overcome these difficulties. Rural staff should also be given regular opportunities, both formal and informal, to link up and network with other discipline-specific health professionals including senior clinicians and peers working in NSW Health.

Recommendation 9: ***Support staff to undertake any organisational opportunities that support them to build their clinical and/or management skills or to experience or pursue a senior management position***

This study found that all early career CMH professionals sought opportunities to build their clinical skills in both MH and their specific discipline and also some management skills. Service level managers should work to identify opportunities internally and externally that may assist to build the skills sought by their staff to help them to advance their careers.

Assessing – deciding whether to continue the voyage

Recommendation 10: ***Ensure staff workloads and caseloads are reasonable by* engaging *agency staff to fill staffing vacancies and promptly recruiting any new vacancies that arise***

This study found when staff in rural services left positions their caseloads were usually taken over by existing staff. Rural recruitment difficulties meant that these existing staff often found they had to manage these increased caseloads for indefinite periods and this contributed to stress and job

dissatisfaction. NSW Health and service managers should avoid this practice and, as much as possible, engage agency nursing staff to fill any staff vacancies as well as, work to shorten the duration of the recruitment process.

Recommendation 11: Encourage stability in staffing by offering incentives that encourage medium-term commitment from service-level managers

This study found that staff feeling supported and understood by the service level manager was an important aspect of their job satisfaction and was negatively affected by high turnover of service-level managers. NSW Health should identify ways to encourage service-level managers to increase their commitment and stay in the position for the medium-term (3-5 years). The increased authority (budgetary and decision making) suggested under Recommendation 4 is one possible approach and offering financial incentives for each year of service is another. Turnover of management is also related to the organisational culture of change that characterises large public institutions like NSW Health. This is a complex issue that needs addressing, but solutions are outside the scope of this study.

Recommendation 12: ***Work to minimise unnecessary change at both service level (procedural) and organisational level (restructuring)***

The negative impacts on the job satisfaction of CMH professional resulting from working in an environment of continual change were also highlighted in this study. NSW Health and service-level managers should be aware of this issue and, wherever possible, work to minimise change. However, as mentioned in Recommendation 11, this issue also relates to the culture of change that characterises NSW Health and solutions are outside the scope of this study.

Recommendation 13: ***Work to understand the team dynamic and to identify any dissatisfied staff and, wherever possible, work with them to address their issues***

This study identified that after adjusting to the job, issues of personal satisfaction were the main influencing factor on CMH professionals' decision to stay. Those who were in middle-adulthood

and involved in raising families or planning to start one were usually concerned with having stability and because of this, generally expressed strong place dependence. While many in this group were satisfied with the job, the limited employment opportunities to be found in rural Australia meant that some staff members who stayed in their position were not satisfied with the job (dissatisfied stayers). The existing literature identified that these staff members could have very negative impacts on other staff and the team dynamic. The importance of having and maintaining a positive team dynamic has been emphasised as a key factor for staff retention. Thus, service-level managers should prioritise trying to gain understanding of any dissatisfied staff grievances and, if possible, work to address them. Linked to Recommendation 4, service-level managers should ideally have the authority to offer staff retrenchment packages if found necessary.

7.3 Comparison of recommendations with the existing literature

As discussed in the literature review, a number of key planning documents with respect to Australia's mental health services sector and workforce development issues were overdue: these include COAG's National Mental Service Planning Framework and the fifth National Mental Health Plan. Arguably, these delays were thought to be related to the recent national review of MH services and programs undertaken by the NMHC and the current action plan being developed based on the 25 recommendations they made. While the NMHC's recommendations confirm the workforce difficulties faced by Australia's rural MH services and encourage the expansion of CMH services and a broadened CMH workforce, they do not specifically address the issue of retention of rural-based CMH professionals. Furthermore, no NSW MH workforce development planning documents were identified. Thus, there was no government documentation identified that was available to draw on to use to analyse the recommendations made in this study.

Given this, the literature reviewed in this study was examined to see if there were any papers that could be used instead. From this process, it was decided to rely on the framework for rural and remote workforce retention developed Buykx et al. (2010), which was a systematic review of the international literature over the period 2000-2009, including 15 studies assessed as relevant to the Australian rural and remote health context. While the Buykx et al. (2010) review was not MH-

specific, the framework developed was considered relevant to the more generalised retention recommendations made[22].

The Buykx et al. (2010) paper was one of the studies selected for identifying factors impacting retention among Australia's rural-based CMH professionals and it is discussed in the literature review and discussion chapters. However their framework, which addresses factors known from the existing research to contribute to avoidable turnover of rural and remote health workers, has not yet been presented. The framework presents six suggestions to improve retention. These are: 1) maintaining adequate and stable staffing; 2) providing appropriate and adequate infrastructure; 3) maintaining realistic and competitive remuneration; 4) fostering an effective and sustainable workplace organisation; 5) shaping the professional environment that recognises and rewards individuals making a significant contribution to patient care; and 6) ensuring social, family and community support. These suggestions were compared with the recommendations made in this study and Suggestions 1, 4, 5 and 6 were found to support the recommendations made. These are explained in more detail below.

Buykx et al.'s (2010) Suggestion 1 (to maintain an adequate and stable staffing) was described as involving recruitment of the right person and having adequate staffing to ensure burnout among existing staff is avoided. The authors based this suggestion on the research identifying job dissatisfaction among existing staff, with staffing shortages and high staff turnover generally, as well as early exits being commonplace among new recruits. Their suggestion corresponds with the overall recommendation made in this study for the need to stabilise rural CMH teams and their work environment. It specifically relates to the recruitment recommendations made (Recommendations 1-4) and also to the assessing recommendations (10, 11 and 13) concerning staffing measures to help support team stability and reduce job dissatisfaction and/or burnout among staff.

Buykx et al.'s (2010) Suggestion 4 (to foster an effective and sustainable workplace organisation) was described as involving good communication and strong leadership by management and providing new staff with orientation. This suggestion was based on existing literature identifying

[22] Recommendation 6 – regarding training of new staff to assist them to manage role boundary issues – was considered to be MH-specific and so was not included in the analysis undertaken.

efficient management as necessary for effective workplaces and that employees want to work for successful organisations – vision and strategic leadership are key features of this. The importance of providing staff orientation is based on research that the turnover intention can be decided based on a health worker's initial entrée to the job. Suggestion 4 corresponds with this study's Recommendation 4 regarding providing an adequate orientation and ongoing support commensurate with experience level and with Recommendation 12 with respect to working to minimise unnecessary change at both the organisation and service levels.

Buykx et al.'s Suggestion 5 (to shape the professional environment to recognise and reward staff contributions from staff members) included factors such as the importance of working in a supportive team as well as having opportunities to attend CPD activities and for career advancement. The latter two aspects were linked to research identifying links to professional satisfaction, and this accords closely with this study's Recommendations 8 and 9.

Buykx et al.'s (2010) Suggestion 6 concerned social, family and community aspects. While they emphasised family aspects, this study's Recommendation 7 (regarding working as a community to develop a welcome program for outsider-newcomers to help them socialise) is considered to fit well under this suggestion. From this analysis we conclude that the study's recommendations accord very strongly with those developed by Buykx et al. based on the existing research.

7.4 Strengths and limitations of the current research

The research design chosen for this study, like any research design, has weaknesses and strengths. One strength was the in-depth interview approach used, which gave the early career CMH participants sufficient time and space to discuss their adjustment and adaption experiences and their thoughts about the future. Also, by explicitly stating that the study was interested in exploring both employment and rural-living aspects, participants were free to focus on or highlight whichever aspects affected them most. By taking such an approach, the different adjustment experiences of outsider-newcomer participants, compared to those who had been recruited from the town, emerged early on in the study to be an important factor.

Another strength of the study was limiting early career participants to those who had been working for a minimum of twelve months, thus allowing for the exploration of experiences after they had adapted to the job to be captured and to explore what factors influenced turnover intention at this stage – this period of the working lives of early career health professionals is relatively unexplored in the research. However, this working duration minimum also posed limitations for the study, in particular regarding how employment and rural-living factors impacted upon those who worked for less than 12 months and had already left or were intending to leave.

The decision to set the study area in rural and remote NSW, as discussed in Chapter 1: Introduction, was decided upon from the outset due to a LHD of NSW Health being a partner of UNE's CRN, as well as the timing and funding constraints imposed by this being a PhD study. By limiting the study area to rural and remote NSW, the representativeness of the findings with respect to rural-based early career CMH professionals working in other states in Australia is not verifiable. While some NSW Health state-specific factors have been identified in this study (such as pay differences between the professions), there may be others and the study would need to be extended to other states to help determine this.

The recruitment challenges experienced and discussed in this study with respect to the remote service areas resulted in the inclusion criteria having to be loosened, and resulted in not all participants from the remote areas (RA4) being in the early career stage. It also meant that the number of participants from remote areas included in the study was small. While the findings from study supported the existing research that factors negatively impacting job satisfaction were heightened for those working in outer regional and remote areas, confidence in the findings would be strengthened by the study having had additional early career CMH participants from remote areas.

Another strength of the study was the use of a symbolic interactionist theoretical framework. This guided both the interview questions asked and the analysis undertaken and these both prioritised the individual participant's social interactions with others. This approach helped to identify the particular meaning each individual attributed to their work role, the importance they attached to

their professional identity, their sense of agency with respect to the employment and personal choices they made, and how they understood and operationalized belonging to a place and a community. In particular, it encouraged the analysis to be focussed on action and the continual reciprocal processes occurring between individuals, their workplace and the community in which they lived; this assisted with identification of the core category, the basic social process and eventually led to the development of the turnover intention theory.

7.5 Future research

There are a number of recommendations for future studies that emerge based on this study's findings.

An important next step would be to undertake research to investigate whether the findings are similar among early career CMH professionals working in other states of Australia. This research would be very amenable to using a semi-structured survey approach and drawing on accepted measures and tools for gauging influencing aspects such as job satisfaction and work stress/burnout. If the results of this nationwide survey support the findings from this study, this would strengthen the substantive nature of the turnover intention theory. This survey suggestion would also provide a way to investigate the discrepancies discussed above between this study and Duchscher's (2008) proposed duration of adjustment and adaption stages for new graduate nurses and with Gillespie and Redivo's (2012a, 2012b) studies concerning professional and personal satisfaction levels among different types of workers.

More research is also required on those rural-based early career CMH professionals who worked for less than 12 months and had left or were intending to leave their job. While it is reasonable to assume that this group experienced many of the same employment and rural-living factors identified as impacting the professional and personal satisfaction of participants in this study, to what extent these factors contributed to their decision to leave, and if there were any other factors involved, cannot be determined from this study. This is considered an important area for future research to ensure that existing research has comprehensively investigated turnover intention for rural-based, early career CMH professionals.

This study's identification of a group of CMH professionals in their middle-adult stage of life who had adapted to the job and whose professional expectations appear not to be satisfactorily met but chose to stay working regardless (dissatisfied stayers) is an important finding, particularly because of the very negative impacts, identified by Geurts and colleagues' (1998) study, that dissatisfied stayers could have on team dynamics. Trying to better understand this group and their experience of professional and personal satisfaction is an important area for future workforce research. It is acknowledged that there may be challenges in recruiting this group of CMH professionals. However, dissatisfied stayers are an issue in most workplaces, so any research on this group of workers is likely to make an important contribution to both research and practice.

As the impact of employment and rural-living aspects on turnover intention of early career CMH professionals were the focus of this study, the influence of personality traits and values of the individuals were not considered. However, it was apparent from the interview data that these factors also influenced CMH professionals' expectations and the reality gap they experienced. This would be a useful area for further research within the discipline of psychology.

The fly-in, fly-out psychiatrists providing clinical services to these rural CMH teams may also be able to provide an interesting 'outsider-insider' perspective on CMH team dynamics and impacting factors on turnover among staff.

7.6 Evaluation of the grounded theory approach

Consistent with using a constructivist GT approach, a researcher's findings will always be constructed truths and the degree to which they are defensible is whether they have been presented to the audience in a new and meaningful way (Thorne, Kirkham, & O'Flynn-Magee, 2008). An evaluation of this study has been undertaken using four criteria proposed by Charmaz (2014). These criteria are: credibility, originality, resonance and usefulness. Credibility refers to conceptual grounding and logic, originality to the significance of the study in terms of new insights and new concepts, resonance as to whether the study reflects the full experience of participants and broader links can be drawn, and usefulness as to whether the study contributes to

new knowledge and has practical application (Charmaz, 2014). With regard to these four criteria, Charmaz posits that a ‘strong combination of originality and credibility increases resonance, usefulness, and the subsequent value of the contribution’ (2014, p. 338). Charmaz also proposed a series of questions for each criterion. These were drawn upon to assist in this evaluation.

Credibility

The aim of this study was to investigate how employment and rural-living factors impacted on turnover intention among rural-based, early career CMH professionals in their first few years of working. This research question was investigated by undertaking 26 interviews with CMH professionals working for NSW Health. Charmaz (2014) posits several indicators of credibility. These include whether the research achieved familiarity with the topic and/or setting and if the data was sufficient to merit the claims made. In this study, familiarity and data sufficiency were achieved through the use of an in-depth interviewing approach that helped to support the full exploration of the employment and rural-living aspects of participants’ lives. The inclusion criteria developed and sampling approach taken helped to ensure that the study included participants from all the relevant professional groups and from different sized rural towns and services.

Charmaz (2014) also posits that credibility relates to the rigour applied in the coding process. She suggests that rigour is achieved when the comparisons made between codes and categories are systematic; the categories developed cover a wide range of empirical observations; and the links made and the argument and analysis given are logical. The coding process used for this study aimed to be systematic and logical by employing constant comparative analysis throughout. The analysis aimed to include the full range of empirical observations by consistently returning to and checking with the interview transcripts throughout the coding process. Memo writing, diagramming and story-lining were used to help ensure that conceptualisation of the data was logical and consistent.

Charmaz (2014) argues that, for a study to have credibility, it must include sufficient evidence so that any reader assessing the claims made would agree with them. A key aim of this thesis, and the thesis structure developed, was for this purpose. To ensure the reader was provided with

sufficient information to understand how the substantive theory was developed, the coding process used was outlined and each of the steps taken towards increasing abstraction (open coding, categories, core category, theoretical coding, basic social process, and substantive theory) have been fully explained.

Originality

Charmaz (2014) advances that originality concerns whether the study provides new insights or fresh understanding on an issue, and whether the theory has significance in terms of contributing to the broader research and better understanding of the subject. This study identified how employment and rural-living factors impact the turnover intention of rural-based, early career CMH professionals in their first few years of working. In the main, the study's findings were found to support the existing body of knowledge concerning factors impacting turnover of health professionals working in rural service settings and added new insights into how these factors affected this particular group of workers. The most original aspect of this study was the turnover intention theory that was developed, which brought together aspects impacting both professional and personal satisfaction, the concept of expectations being met, and identified both organisational and individual characteristics that heightened or reduced the reality gap. This understanding allowed for the development of a vulnerability risk matrix outlining which type of early career health professionals – and at what point in time – will be vulnerable to experiencing a reality gap between their expectations and their experience and thus are at heightened risk of leaving the CMH job.

Resonance

Charmaz (2014) suggested that resonance concerns such thing as: whether the study reveals the liminal meanings, identifies links between participants' lives and larger collectivities, and whether it can provide deeper meaning to the subjects of the study. Through the identification of the basic social process in this study, the liminal meanings were identified and explained. The findings and the theory developed recognise the links between the participants' experience with larger collectivities (workplace, organisation, community). The theory's identification of a group of characteristics that heighten CMH professionals' vulnerability risk for experiencing a reality gap potentially helps build understanding about the likely employment and rural-living experience that an early career health professional considering a rural CMH position could utilise.

Usefulness

Charmaz (2014) posits that a study's usefulness involves several aspects. These include: whether analysis can be of practical use in the everyday lives of people; whether the analysis suggests a generic process that may have broader application; if it inspires research in other substantive areas; and whether it makes a contribution to knowledge and contributes to making a better world.

With respect to this study's contribution to practice, as discussed elsewhere, the reality gap turnover intention theory and vulnerability risk matrix both potentially have broad application for other rural-based early career human service work groups in the public sector. The recommendations made may also have utility for management of other public sector rural-based human service organisations, helping them to develop effective policy and procedural responses to address avoidable turnover among their early career staff.

The need for further research to continue to build understanding on turnover intention among rural-based early career CMH professionals to explore the generalizability of the theory developed has been suggested and discussed.

7.7 Chapter summary

The focus of this study was to explore how employment and rural-living aspects impacted on the turnover of early career CMH professionals in their first few years of working in a rural position. The challenging and demanding nature of a rural-based CMH job has been well established through this investigation. Given the resourcing constraints operating in Australia's public sector rural health services, combined with the heightened illness acuity of rural clients and the very large workloads experienced in a rural CMH position, we can conclude that a rural-based CMH job is a difficult job at any career stage. Mia succinctly sums up the challenges of performing a rural CMH role:

> *It's a really hard job out here. It's exhausting. You're the expert out here. You're in charge. And you've got to have that ability and accountability in that position to manage that.*
>
> [Mia (4), 27 yrs, Psychologist, Town B – small rural town, outer regional area]

Not surprisingly then, for early career health professionals who have little prior experience working as health professionals and/or are still forming their professional identities taking up rural-based CMH positions, learning to find their sea legs on a boat they don't yet know how to sail and being on an ocean that is always choppy is a very hard start to the career voyage. For those recruited from outside, the sailing experience is even harder as very few aspects of the ocean will be familiar.

While this study found that once an early career CMH professional had learnt to sail comfortably *in the permanently choppy waters* related to performing a rural CMH job, life stage and personal factors began to impact more strongly than professional factors on the turnover intention. This study also found that early career CMH professionals often made their decision to stay or leave a rural job much earlier and usually while they were learning to sail the boat and manage the choppy waters. So given this, if avoidable turnover of this group of workers is to be reduced, it is essential for public sector management to work to ensure these new staff workers are very well supported in the initial adjustment stage. Public sector health management needs to understand and acknowledge that early career health professionals taking up rural-based CMH positions encounter large and difficult initial challenges that require them to change and adapt in many ways, both personally and professionally. Managing big changes such as these is always difficult and support must be given wherever and however possible. The final words are left to Jeannette Winterson and her contemplation on change and the inevitable difficulties it brings and how these are a normal part of the human condition:

> When we make a change, it's so easy to interpret our unsettledness as unhappiness, and our unhappiness as the result of having made the wrong decision. Our mental and emotional states fluctuate madly when we make big changes in our lives, and some days we could tight-rope across Manhattan, and other days we are too weary to clean our teeth. This is normal. This is natural. This is change.
>
> Jeanette Winterson (2002)

References

Aarons, G., & Sawitzky, A. (2006). Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(3), 289-301. doi:10.1007/s10488-006-0039-1

Acker, G. (2004). The effect of organizational conditions (role conflict, role ambiguity, opportunities for professional development, and social support) on job satisfaction and intention to leave among social workers in mental health care. *Community Mental Health Journal, 40*(1), 65-73. doi:10.1007/s10488-006-0039-1

Alexander, J., Lichtenstein, R., Oh, H., & Ullman, E. (1998). A causal model of voluntary turnover among nursing personnel in long-term psychiatric settings. *Research in Nursing & Health, 21*, 415–427. doi:0160-6891/98/050415-13

Allen, L. (2010). A critique of four grounded theory texts. *The Qualitative Report, 15*(6), 1606-1620. Retrieved from http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1365&context=tqr

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research, 6*(3), 379-393. doi:10.1177/104973239600600306

Ashby, S., Ryan, S., Gray, M., & James, C. (2013). Factors that influence the professional resilience of occupational therapists in mental health practice. *Australian Occupational Therapy Journal, 60*, 110-119. doi:10.1111/1440-1630.12012

Australian Bureau of Statistics. (2011). 3238.0.55.001 – Estimates of Aboriginal and Torres Strait Islander Australians, June 2011. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3238.0.55.001Main+Features1June%202011?OpenDocument

Australian Bureau of Statistics (ABS). (2001). *ASGC remoteness classification: Purpose and use*. (03/01).

Australian Bureau of Statistics (ABS). (2006). Australian Standard Geographical Classification – Remoteness Structure (ASGC-RA). Retrieved from http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/DC74D8E8C0C777C8CA25796B0015019B/$File/1216015003_asgc_2006_ra_nsw_map.pdf

Australian Bureau of Statistics (ABS). (2008). *National survey of mental health and wellbeing 2007: Summary of results* (Cat. No. 4326.0). ABS. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0.

Australian Bureau of Statistics (ABS). (2011). *Census of population and housing: Socio-economic indexes for areas (SEIFA)*. ABS. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2033.0.55.0012011?OpenDocument.

Australian Government. (2010a). *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008.* Canberra, ACT: Commonwealth of Australia.

Australian Government. (2010b). *National standards for mental health services*. Canberra, ACT: Commonwealth of Australia.

Australian Government. (2011). Commonwealth's component of the COAG National Action Plan on Mental Health (2006 – 2011). *Mental health & well being*. Retrieved from http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/summary-of-programs-1

Australian Government. (no date). Our Government. Retrieved from http://www.australia.gov.au/about-australia/our-government

Australian Government: Department of Health and Ageing, & PriceWaterhouse Coopers. (2011). *Mental health service in rural and remote areas program evaluation: Final evaluation report*. Canberra, ACT: Commonwealth of Australia. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mhsrraev.

Australian Government: The Department of Health. (2014). National Mental Health Strategy. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-strat

Australian Institute of Health and Welfare (AIHW). (2014a). *Australia's health 2014: 7.1 Profile of Indigenous Australians*. (AIHW Cat. no. AUS 178). Retrieved from http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547770

Australian Institute of Health and Welfare (AIHW). (2014b). *Mental health related services provided in Australia: State and territory community mental health care services*. AIHW. Retrieved from http://mhsa.aihw.gov.au/services/community-care/

Barak, M., Nissly, J., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and meta-analysis. *Social Service Review, 75*(4), 625-661. Retrieved from http://www.jstor.org/stable/10.1086/323166

Bennett, P., Barlow, V., Brown, J., & Jones, D. (2012). What do graduate registered nurses want from jobs in rural/remote Australian communities? *Journal of Nursing Management, 20*(4), 485-490. doi:10.1111/j.1365-2834.2011.01254.x

Bennett, P., Brown, J., Barlow, V., & Jones, D. (2010). What do new graduate registered nurses say they want from jobs in remote communities? *Australian Journal of Rural Health, 18*(5), 212-213. doi:10.1111/j.1440-1584.2010.01157.x

Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide*. Thousand Oaks, California: Sage Publications.

Birks, M., Mills, J., Francis, K., & Chapman, Y. (2009). A thousand words paint a picture: The use of storyline in grounded theory research. *Journal of Research in Nursing, 14*(5), 405-417. doi:10.1177/1744987109104675

Blumer, H. (1969). *Symbolic interaction: Perspectives and method*. Englewood Cliffs, New Jersey: Prentice-Hall.

Bragg, S., & Bonner, A. (2014). Degree of value alignment: a grounded theory of rural nurse resignations. *Rural and Remote Health, 14*(2648). Retrieved from http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=2648

Brown, B., Crawford, P., & Darongkamas, J. (2000). Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health & Social Care in the Community, 8*(6), 425-435. doi:10.1046/j.1365-2524.2000.00268.x

Brown, P., Fraser, K., Wong, C., Muise, M., & Cummings, G. (2013). Factors influencing intentions to stay and retention of nurse managers: a systematic review. *Journal of Nursing Management, 21*(3), 459-472. doi: 10.1111/j.1365-2834.2012.01352.x

Bryant, A. (2002). Re-grounding grounded theory. *Journal of Information Technology Theory and Application, 4*(1), 25-42. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/docview/200016135?accountid=17227

Bryant, A., & Charmaz, K. (2007). Introduction – Grounded Theory Research: Methods and Practices. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 1-28). London, UK: Sage Publications.

Burr, W. (1972). Role transitions: A reformulation of theory. *Journal of Marriage and Family, 34*(3), 407-416. doi:10.2307/350436

Buykx, P., Humphreys, J., Wakerman, J., & Pashen, D. (2010). Systematic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy. *Australian Journal of Rural Health, 18*(3), 102-109. doi:10.1111/j.1440-1584.2010.01139.x

Carpenter, J., Schneider, J., Brandon, T., & Wooff, D. (2003). Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health care. British Journal of Social Work, 33(8), 1081-1103. doi: 10.1093/bjsw/33.8.1081

Ceramidas, D. (2010). A case against generalisation of mental health occupational therapy in Australia. *Australian Occupational Therapy Journal, 57*(6), 409-416. doi:10.1111/j.1440-1630.2010.00876.x

Charmaz, K. (1995). Grounded theory. In J. Smith, R. Harré, & L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 83-122). London, UK: Sage Publications.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed.). Thousand Oaks, California: Sage Publications.

Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 249-292). Thousand Oaks, California: Sage Publications.

Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 507-535). Thousand Oaks, California: Sage Publications.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage Publications.

Charmaz, K. (2008). Constructionism and the grounded theory. In J. Holstein & J. Gubrium (Eds.), *Handbook of constructionist research*. New York, USA: Guilford Press.

Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. Morse, P. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-154). Walnut Creek, California: Left Coast Press.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London, UK: Sage Publications.

Clarke, A. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/docview/60476590?accountid=17227

Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, California: Sage Publications.

Cohen, A. (1982). *Belonging: Identity and social organisation in British rural cultures*. Manchester, UK: Manchester University Press.

Cohen, L., & Manion, L. (1994). *Research methods in education* (4th ed.). London, UK: Routledge.

Cosgrave, C., Hussain, R., & Maple, M. (2015a). Factors impacting on retention amongst community mental health clinicians working in rural Australia: A literature review. *Advances in Mental Health* 13(1), 58-714. doi:10.1080/18374905.2015.1023421

Cosgrave, C., Hussain, R., & Maple, M. (2015b). Retention challenge facing Australia's rural community mental health services: Service managers' perspectives. *Australian Journal of Rural Health, online*, 1-5. doi:10.1111/ajr.12205

Council of Australian Governments (COAG). (2012). *The roadmap for national mental health reform 2012-2022*. COAG. Retrieved from http://www.coag.gov.au/node/482

Council of Australian Governments (COAG). (no date). Closing the gap in Indigenous disadvantage. Retrieved from https://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage

Creswell, J. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). Thousand Oaks, California: Sage Publications.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, NSW: Allen & Unwin.

Crowther, A., & Ragusa, T. (2011). Realities of mental health nursing practice in rural Australia. *Issues in Mental Health Nursing, 32*(8), 512-518. doi:10.3109/01612840.2011.569633

Denzin, N. (2004). Symbolic Interactionism (B. Jenner, Trans.). In U. Flick, E. von Kardorff, & I. Steinke (Eds.), *A companion to qualitative research*. London, UK: Sage Publications.

Denzin, N., & Lincoln, Y. (2005). *The Sage handbook of qualitative research.* (3rd ed.). Newbury Park, California: Sage Publications.

Dollard, M., Winefield, H., & Winefield, A. (1999). Burnout and job satisfaction in rural and metropolitan social workers. *Rural Social Work, 4*, 33-43.

Drury, V., Francis, K., & Dulhunty, G. (2005). The lived experience of rural mental health nurses. *Online Journal of Rural Nursing and Health Care, 5*(1), 19-27. Retrieved from http://go.galegroup.com.ezproxy.une.edu.au/ps/i.do?id=GALE%7CA174057709&v=2.1&u=dixson&it=r&p=PPNU&sw=w&asid=447248a132f4d53eb1ebbcadfd805b90

Duchscher, J. (2008). Process of becoming: The stages of new nursing graduate professional role transition. *Journal of Continuing Education in Nursing, 39*(10), 441-452. doi:10.3928/00220124-20081001-03

Duchscher, J., & Boychuk, E. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing, 65*(5), 1103-1113. doi:10.1111/j.1365-2648.2008.04898.x

Eley, D., Synnott, R., Baker, P., & Chater, A. (2012). A decade of Australian rural clinical school graduates: Where are they and why? *Rural and Remote Health, 12*(1937), 1-12. Retrieved from http://www.rrh.org.au/Articles/subviewnew.asp?ArticleID=1937

Erikson, E. (1982). *The life cycle completed: A review*. New York, USA: W W Norton.

Geurts, S., Schaufeli, W., & De Jonge, J. (1998). Burnout and intention to leave among mental health-care professionals: A social psychological approach. *Journal of Social and Clinical Psychology, 17*(3), 341-362. doi:10.1521/jscp.1998.17.3.341

Gibb, H., Livesey, L., & Zyla, W. (2003). At 3 am who the hell do you call? Case management issues in sole practice as a rural community mental health nurse. *Australasian Psychiatry, 11*(Suppl. 1), 127-130. doi:10.1046/j.1038-5282.2003.02005.x

Gillespie, J., & Redivo, R. (2012a). Personal–professional boundary issues in the satisfaction of rural clinicians recruited from within the community: Findings from an exploratory study. *Australian Journal of Rural Health, 20*(1), 35-39. doi:10.1111/j.1440-1584.2011.01249.x

Gillespie, J., & Redivo, R. (2012b). Type of community as confounding variable in the satisfaction of rural child and youth mental health clinicians: Implications for evidence-based workforce development. *Journal of Mental Health Training, Education and Practice, 7*(1), 20-32. doi:10.1108/17556221211230561

Gillham, S., & Ristevski, E. (2007). Where do I go from here: We've got enough seniors? *Australian Journal of Rural Health, 15*(5), 313-320. doi:10.1111/j.1440-1584.2007.00900.x

Glaser, B. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, California: Sociology Press.

Glaser, B. (1992). *Basics of grounded theory analysis: Emergence vs. forcing*. Mill Valley, California: Sociology Press.

Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, California: Sociology Press.

Glaser, B. (2002). *Constructivist grounded theory?* Paper presented at the Forum Qualitative Sozialforschung / Forum: Qualitative Social Research. http://nbn-resolving.de/urn:nbn:de:0114-fqs0203125

Glaser, B. (2007). *Doing formal grounded theory: A proposal*. Mill Valley, California: Sociology Press.

Glaser, B., & Holton, J. (2005). Basic social processes. *Grounded Theory Review, 4*(1), 1-27.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, Illinois: Aldine.

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, California: Sage Publications.

Guba, E., & Lincoln, Y. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed., pp. 163-188). Thousand Oaks, California: Sage Publications.

Guba, E., & Lincoln, Y. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, California: Sage Publications.

Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: A long and winding road. *Medical Education, 35*(9), 867-875. doi:10.1046/j.1365-2923.2001.00919.x

Handberg, C., Thorne, S., Midtgaard, J., Nielsen, C., & Lomborg, K. (2014). Revisiting symbolic interactionism as a theoretical framework beyond the grounded theory tradition. *Qualitative Health Research*, *online* 1-5. doi: 10.1177/1049732314554231

Hannigan, B., Edwards, D., Coyle, D., Fothergill, A., & Burnard, P. (2000). Burnout in community mental health nurses: Findings from the all Wales stress study. *Journal of Psychiatric and Mental Health Nursing, 7*(2), 127-134. doi:10.1046/j.1365-2850.2000.00279.x

Hay, R. (1998). Sense of place in developmental context. *Journal of Environmental Psychology, 18*(1), 5-29. doi:10.1006/jevp.1997.0060

Hazelton, M., Rossiter, R., Sinclair, E., & Morrall, P. (2011). Encounters with the 'dark side': New graduate nurses' experiences in a mental health service. *Health Sociology Review, 20*(2), 172-186. doi:10.5172/hesr.2011.20.2.172

Health Workforce Australia (HWA). (2012). *Health workforce 2025: Doctors, nurses and midwives – Volume 1*. Adelaide, SA: HWA Retrieved from https://www.hwa.gov.au/resources/publications.

Health Workforce Australia (HWA). (2013). *Mental health workforce planning data inventory*. Adelaide, SA: HWA Retrieved from https://www.hwa.gov.au/resources/publications.

Health Workforce Australia (HWA). (no date). About us. Retrieved from https://www.hwa.gov.au/about-us

HealthStats NSW. (no date). Socioeconomic Indexes For Areas (SEIFA) by Local Government Area. Retrieved from http://www.healthstats.nsw.gov.au/Indicator/soc_seifa_lgamap/soc_seifa_lgamap

Hegney, D. (1996). The status of rural nursing in Australia: A review. *Australian Journal of Rural Health, 4*(1), 1-10. doi:10.1111/j.1440-1584.1996.tb00180.x/epd

Hegney, D., McCarthy, A., Rogers-Clark, C., & Gorman, D. (2002). Why nurses are resigning from rural and remote Queensland health facilities. *Collegian, 9*(2), 33-39. doi:10.1016/S1322-7696(08)60414-X

Henderson, J., Willis, E., Walter, B., & Toffoli, L. (2008). Community mental health nursing: keeping pace with care delivery? *International Journal of Mental Health Nursing, 17*(3), 162-170. doi:10.1111/j.1447-0349.2008.00528.x

Holton, J. (2007). The coding process and its challenges. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 265-290). London, UK: Sage Publications.

Humphreys, J., Wakerman, J., Pashen, D., & Buykx, P. (2009). *Retention strategies & incentives for health workers in rural & remote areas: What works?* Canberra, Australia: Australian Primary Health Care Research Institute. Retrieved from http://files.aphcri.anu.edu.au/research/international_retention_strategies_research_pdf_10642.pdf.

Humphreys, J., Wakerman, J., Wells, R., Kuipers, P., Jones, J., Entwistle, P., & Harvey, P. (2007). *Improving primary health care workforce retention in small rural and remote communities: How important is ongoing education and training?* Canberra, Australia: Australian Primary Health Care Research Institute. Retrieved from http://aphcri.anu.edu.au/projects/network/improving-primary-health-care-workforce-retention-small-rural-and-remote.

Hurley, J., & Lakeman, R. (2011). Becoming a psychiatric/mental health nurse in the UK: A qualitative study exploring processes of identity formation. *Issues in Mental Health Nursing, 32*(12), 745-751. doi:10.3109/01612840.2011.609634

Jędrej, M., & Nuttall, M. (1996). *White settlers: The impact of rural repopulation in Scotland*. Luxembourg: Harwood Academic Publications.

Keane, S., Lincoln, M., & Smith, T. (2012). Retention of allied health professionals in rural New South Wales: a thematic analysis of focus group discussions. *BMC Health Services Research, 12*(175), 1-11. doi:10.1186/1472-6963-12-175

Kelle, U. (2007). The development of categories: Different approaches in grounded theory. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 191-213). London, UK: Sage Publications.

Kendall, J. (1999). Axial coding and the grounded theory controversy. *Western Journal of Nursing Research, 21*(6), 743-757. Retrieved from http://wjn.sagepub.com.ezproxy.une.edu.au/content/21/6/743.full.pdf

King, R. (2009). Caseload management, work-related stress and case manager self-efficacy among Victorian mental health case managers. *Australian & New Zealand Journal of Psychiatry, 43*(5), 453-459. doi:10.1080/00048670902817661

King, R., Lloyd, C., & Holewa, V. (2008). Can identified stressors be used to predict profession for mental health professionals? *Australian e-Journal for the Advancement of Mental Health, 7*(2), 97-103. doi:10.5172/jamh.7.2.97

King, R., Yellowlees, P., Nurcombe, B., Spooner, D., Sturk, H., Spence, S., & Le Bas, J. (2002). Psychologists as mental health case managers. *Australian Psychologist, 37*(2), 118-122. doi:10.1080/00050060210001706756

Landstrom, C. (2000). The ontological politics of staying true to complexity. *Social Studies of Science, 30*(3), 475-480. doi:10.2307/285812

Lea, J., & Cruickshank, M. (2007). The experience of new graduate nurses in rural practice in New South Wales. *Rural and Remote Health, 7*(814), online. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_814.pdf

Lea, J., & Cruickshank, M. (2015). The support needs of new graduate nurses making the transition to rural nursing practice in Australia. *Journal of Clinical Nursing, 24*, 1-13. doi:10.1111/jocn.12720

Lea, J., Cruickshank, M., Paliadelis, P., Parmenter, G., Sanderson, H., & Thornberry, P. (2008). The lure of the bush: Do rural placements influence student nurses to seek employment in rural settings? *Collegian: Journal of the Royal College of Nursing Australia, 15*(2), 77-82. doi:10.1016/j.colegn.2008.02.004

Leana, C., & Van Buren, H. (1999). Organizational social capital and employment practices. *Academy of Management Review, 24*(3), 538-555. Retrieved from http://www.jstor.org/stable/25914

Levinson, D. (1978). *The seasons of a man's life* (1st ed.). New York, USA: Knopf.

Lincoln, Y., Lynham, S., & Guba, E. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 97-128).

Lloyd, C., Bassett, H., & King, R. (2002). Mental health: How well are occupational therapists equipped for a changed practice environment? *Australian Occupational Therapy Journal, 49*(3), 163-166. doi:10.1046/j.1440-1630.2002.00332.x

Lloyd, C., & King, R. (2004). A survey of burnout among Australian mental health occupational therapists and social workers. *Social Psychiatry and Psychiatric Epidemiology, 39*(9), 752-757. doi:10.1007/s00127-004-0808-7

Lloyd, C., King, R., & Bassett, H. (2002). A survey of Australian mental health occupational therapists. *British Journal of Occupational Therapy, 65*(2), 88-96. doi:10.1177/030802260206500207

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health, 11*(3), 255-265. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2003015905&site=ehost-live

Lloyd, C., King, R., & McKenna, K. (2004). Generic versus specialist clinical work roles of occupational therapists and social workers in mental health. *Australian & New Zealand Journal of Psychiatry, 38*(3), 119-124. doi:10.1080/j.1440-1614.2004.01316.x

Lloyd, C., King, R., & Ryan, L. (2007). The challenge of working in mental health settings: Perceptions of newly graduated occupational therapists. *The British Journal of Occupational Therapy, 70*(11), 460-470. doi:10.1177/030802260707001102

Lonne, B. (1990). Beginning country practice. *Australian Social Work, 43*(1), 31-39. doi:10.1080/03124079008550054

Lonne, B. (2002). *Retention and adjustment of social workers to rural positions in Australia: Implications for recruitment, support and professional education.* (Phd), University of South Australia, Adelaide, South Australia.

Lonne, B., & Cheers, B. (2000). *Personal and professional adjustment of social workers to rural and remote practice: Implications for improved retention*. Paper presented at The International Conference [on] Rural Communities & Identities in the Global Millennium, British Columbia, Canada.

Lonne, B., & Cheers, B. (2004). *Practitioners speak: Balanced account of rural practice, recruitment and retention.* Paper presented at the International Rural Human Services Conference: Beyond Geographical and Disciplinary Boundaries, Halifax, Canada.

Maslach, C., & Jackson, S. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99-113. doi:10.1002/job.4030020205

Mead, G. (1982). *The individual and the social self – Unpublished essays by G. H. Mead* (D. Miller Ed.). Chicago, Illinois: University of Chicago Press

Mendoza, J., Elson, A., Gilbert, Y., Bresnan, A., Rosenberg, S., Long, P., . . . Hopkins, J. (2013). *Obsessive hope disorder: Reflections on 30 years of mental health reform in Australia and visions for the future*. Moffat Beach, Queensland: ConNetica Consulting.

Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, California: Jossey-Bass.

Mertens, D. (1998). *Research methods in education and psychology: Integrating diversity with quantitative & qualitative approaches*. Thousand Oaks, California: Sage Publications.

Miller, R. (1981). Successful urban-to-rural professional role transition. *Community Mental Health Journal, 17*(2), 143-152. doi:10.1007/BF00754361

Mills, A., & Millsteed, J. (2002). Retention: an unresolved workforce issue affecting rural occupational therapy services. *Australian Occupational Therapy Journal, 49*(4), 170-181. doi:10.1046/j.1440-1630.2002.00293.x

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), 25-35. Retrieved from http://ejournals.library.ualberta.ca/index.php/IJQM/article/viewArticle/4402

Mills, J., Francis, K., & Bonner, A. (2008). Walking with another: Rural nurses' experiences of mentoring. *Journal of Research in Nursing, 13*(1), 23-35. doi:10.1177/1744987107078907

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine, 151*(4), 264-269. doi:10.7326/0003-4819-151-4-200908180-00135

Moore, T., Sutton, K., & Maybery, D. (2010). Rural mental health workforce difficulties: A management perspective. *Rural and Remote Health, 10*(4), online. Retrieved from http://www.rrh.org.au/articles/subviewaust.asp?ArticleID=1519

Morse, J. (2009). Tussles, tensions and resolutions. In J. Morse, P. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 13-19). Walnut Creek, California: Left Coast Press.

National Health and Medical Research Council. (2007). *National statement on ethical conduct in human research incorporating all updates up to May 2015*. Canberra, ACT Retrieved from https://www.nhmrc.gov.au/guidelines-publications/e72.

National Mental Health Commission. (2015). About us. Retrieved from http://www.mentalhealthcommission.gov.au/about-us.aspx

National Mental Health Commission. (no date-a). Our national report cards. Retrieved from http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards.aspx

National Mental Health Commission. (no date-b). Review of mental health programmes and services. Retrieved from http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx

National Mental Health Commission (NMHC). (2014). *Report of the national review of mental health programmes and services, Volume 1-4:* Retrieved from Sydney, NSW NMHC: http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx

NSW Department of Community Services. (2009). *Working with Aboriginal people and communities: A practice resource*. Ashfield, NSW: NSW Department of Community Services. Retrieved from http://www.community.nsw.gov.au/docswr/_assets/main/documents/working_with_aboriginal.pdf.

NSW Health. (2007). *Drug and alcohol clinical supervision guidelines*. Sydney, NSW: Department of Health, NSW.

NSW Health. (2013). Aboriginal Health employment and training opportunities. Retrieved from http://www.health.nsw.gov.au/aboriginal/Pages/employment-and-training.aspx

NSW Mental Health Commission. (2013). Strategic plan – Living well: A strategic plan for mental health in NSW 2014-2024. Retrieved from http://nswmentalhealthcommission.com.au/our-work/strategic-plan

O'Toole, K., Schoo, A., & Hernan, A. (2010). Why did they leave and what can they tell us? Allied health professionals leaving rural settings. *Australian Health Review, 34*(1), 66-72. doi:10.1071/AH09711

Onyett, S. (2011). Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health, 20*(2), 198-209. doi:10.3109/09638237.2011.556170

Onyett, S., Heppleston, T., & Muijen, M. (1995). *Making community mental health teams work*. Retrieved from London, UK:

Onyett, S., Pillinger, T., & Muijen, S. (1997). Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health, 6*(1), 55-66. doi:doi:10.1080/09638239719049

Onyett, S., Standen, R., & Peck, E. (1997). The challenge of managing community mental health teams. *Health & Social Care in the Community, 5*(1), 40-47. doi:10.1111/j.1365-2524.1997.tb00097.x

Paris, M., & Hoge, M. (2010). Burnout in the mental health workforce: A review. *The Journal of Behavioral Health Services & Research, 37*(4), 519-528. doi:10.1007/s11414-009-9202-2

Peck, E., & Norman, I. (1999). Working together in adult community mental health services: exploring inter-professional role relations. *Journal of Mental Health, 8*(3), 231-242. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/docview/215282899?pq-origsite=gscholar

Perkins, D., Larsen, K., Lyle, D., & Burn, P. (2007). Securing and retaining a mental health workforce in far western New South Wales. *Australian Journal of Rural Health, 15*, 94-98. doi:10.1111/j.1440-1584.2007.00860.x

Porter, L., & Steers, R. (1973). Organizational, work, and personal factors in employee turnover and absenteeism. *Psychological Bulletin, 80*(2), 151-176. doi:10.1037/h0034829

Pretty, G., Chipuer, H., & Bramston. (2003). Sense of place amongst adolescents and adults in two rural Australian towns: The discriminating features of place attachment, sense of community and place dependence in relation to place identity. *Journal of Environmental Psychology, 23*(3), 273-287. doi:10.1016/S0272-4944(02)00079-8

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P., & Thornicroft, G. (1996). Mental health, burnout and job satisfaction among hospital and community-based mental health staff. *The British Journal of Psychiatry, 169*(3), 334-337. doi:10.1192/bjp.169.3.334

Pugh, R., & Cheers, B. (2010). *Rural social work: An international perspective*. Bristol, UK: Policy Press.

Putnam, R. (1995). Bowling alone: America's declining social capital. *Journal of democracy, 6*(1), 65-78.

Ragusa, A., & Crowther, A. (2012). 'I think it is the best job… I love it!' Engendering workplace satisfaction in rural and remote Australian mental health nursing. *Rural Society, 22*(1), 45-58. doi:10.5172/rsj.2012.22.1.45

Ramalho, R., Adams, P., Huggard, P., Hoare, K (2015) Literature review and constructivist grounded theory methodology. *Forum Qualitative Social Research*, 16 (3), article 19. http://www.qualitative-research.net/index.php/fqs/article/view/2313.

Reed, D. (1992). Adaptation: The key to community psychiatric practice in the rural setting. *Community Mental Health Journal, 28*(2), 141-150. doi:10.1007/bf00754281

Relph, E. (1976). *Place and placelessness*. London, UK: Pion.

Robrecht, L. (1995). Grounded theory: Evolving methods. *Qualitative Health Research, 5*(2), 169-177. doi:10.1177/104973239500500203

Roche, M., & Duffield, C. (2007). Issues and challenges in the mental health workforce development. *Contemporary Nurse, 25*, 94-103. doi:10.5172/conu.2007.25.1-2.9

Rural Health West. (2013). *Critical success factors for recruiting and retaining health professionals to primary health care in rural and remote locations: Contemporary review of the literature*. Nedlands, Western Australia: Rural Health West. Retrieved from http://www.ruralhealthwest.com.au/docs/publications/rhw_uwa_cucrh-contemporary-review-of-the-literature-f-lr.pdf?sfvrsn=2.

Scanlan, J., Meredith, P., & Poulsen, A. (2013). Enhancing retention of occupational therapists working in mental health: Relationships between wellbeing at work and turnover intention. *Australian Occupational Therapy Journal, 60*(6), 395-403. doi:10.1111/1440-1630.12074

Scanlan, J., Still, M., Stewart, K., & Croaker, J. (2010). Recruitment and retention issues for occupational therapists in mental health: Balancing the pull and the push. *Australian Occupational Therapy Journal, 57*(2), 102-110. doi:10.1111/j.1440-1630.2009.00814.x

Schwandt, T. (2003). Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In N. Denzin & Y. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed., pp. 292-331). Thousand Oaks, California: Sage Publications.

Senate Community Affairs Committee. (2014). *Budget estimates 2014-2015, Answers to estimates questions on notice health portfolio*. Canberra, Australia: Parliament of Australia Retrieved from

http://www.aph.gov.au/~/media/Committees/clac_ctte/estimates/bud_1415/DoH/answers/SQ14-000963.pdf.

Sheehy, G. (1995). *New passages: Mapping your life across time*. Toronto, Canada: Random House.

Smith, F. (2011). How to get luck on your side. *Financial Review*. Retrieved from http://www.afr.com/news/policy/education/how-to-get-luck-on-your-side-20111024-jjfwe

Stagnitti, K., Schoo, A., Dunbar, J., & Reid, C. (2006). An exploration of issues of management and intention to stay: Allied health professionals in south west Victoria, Australia. *Journal of Allied Health, 35*(4), 226-232. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/docview/210975376?accountid=17227

Stagnitti, K., Schoo, A., Reid, C., & Dunbar, J. (2005). Retention of allied health professionals in the south-west of Victoria. *Australian Journal of Rural Health, 13*(6), 364-365. doi:10.1111/j.1440-1584.2005.00732.x

Star, S. (1989). *Regions of the mind: Brain research and the quest for scientific certainty*. Stanford, California: Stanford University Press.

Strauss, A. (1987). *Qualitative analysis for social scientists*. New York, USA: Cambridge University Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, California: Sage Publications.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, California: Sage Publications.

Sullivan, W., Hasler, M., & Otis, A. (1993). Rural mental health practice: Voices from the field. *Families in Society, 74(8),* (8), 493-502.

Sutton, G., & Griffin, M. (2004). Integrating expectations, experiences, and psychological contract violations: A longitudinal study of new professionals. *Journal of Occupational and Organizational Psychology, 77*(4), 493-514. doi:10.1348/0963179042596487

Thorne, S., Kirkham, S., & O'Flynn-Magee, K. (2008). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1), 1-11.

University of NSW: The Gilbert and Tobin Centre of Public Law. (no date). Federalism – Frequently Asked Questions. Retrieved from http://www.gtcentre.unsw.edu.au/resources/federalism/frequently-asked-questions

Valliant, G. (1993). *The wisdom of the ego: Sources of resilience in adult life*. Cambridge, Massachusetts: Harvard University Press.

Victorian Government. (2010). *Positive pathways for Victoria's vulnerable young people: A policy framework to support vulnerable youth*. Melbourne, Victoria: Department of Human Services.

Watson, C., & Harrison, N. (2009). *New South Wales Aboriginal mental health worker training program: Implementation review*. Darwin, NT: Cooperative Research Centre for Aboriginal Health and NSW Department of Health.

Wilson, B., & Crowe, M. (2008). Maintaining equilibrium: A theory of job satisfaction for community mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 15*(10), 816-822. doi:10.1111/j.1365-2850.2008.01319.x

Winterson, J. (2002). Column July 9th, 2002. Retrieved from http://www.jeanettewinterson.com/

Wolfenden, K., Blanchard, P., & Probst, S. (1996). Recruitment and retention: Perceptions of rural mental health workers. *Australian Journal of Rural Health, 4*(2), 89-95. doi:10.1111/j.1440-1584.1996.tb00194

World Health Organization (WHO). (2010). *Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations*. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/hrh/retention/guidelines/en/

Wright, D., Lavoie-Tremblay, M., Drevniok, U., Racine, H., & Savignac, H. (2011). Relational dimensions of a positive integration experience for new mental health nurses. *Archives of Psychiatric Nursing, 25*(3), 164-173. doi:10.1016/j.apnu.2010.07.008

Wynaden, D., Orb, A., McGowan, S., & Downie, J. (2000). Are universities preparing nurses to meet the challenges posed by the Australian mental health care system? *Australian and New Zealand Journal of Mental Health Nursing, 9*(3), 138-146. doi:10.1046/j.1440-0979.2000.00175.x

Young, R., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of vocational behavior, 64*(3), 373-388. doi:10.1016/j.jvb.2003.12.005

Zapf, M. (1991). Cross-cultural transitions and wellness: Dealing with culture shock. *International Journal for the Advancement of Counselling, 14*(2), 105-119. doi:10.1007/BF00117730

Ziguras, S., Henley, K., Conron, W., & Catford, N. (1999). Social work in mental health services: A survey of the field. *Australian Social Work, 52*(2), 53-59. doi:10.1080/03124079908414125