

**THE ADVENT OF MENTAL HEALTH NURSES IN AUSTRALIAN PRIMARY
HEALTH CARE: A PRELIMINARY EVALUATION OF THE MENTAL HEALTH
NURSE INCENTIVE PROGRAM**

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Doctor of Philosophy

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DECLARATION

I certify that except where due acknowledgment has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

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OCTOBER 2013

ABSTRACT

Primary health care has been identified globally as the level of health care delivery that makes health care more accessible and affordable to a wider population. This is particularly relevant due to the global economic downturn currently facing most nations of the world. Any reform to the way care is delivered at the primary care level (or at any level) should involve nurses who represent the largest percentage of the health workforce and who are in direct contact with consumers of health care.

Access to specialist mental health care continues to be problematic and many people with serious mental illness still miss out on care, as they are sometimes considered ‘not sick enough’ to warrant secondary care input. There is a fragmentation in service delivery between the primary and secondary levels of care. General practitioners (GPs) remain the first point of contact for most people seeking help for mental health issues; however, GPs lack adequate skill and time to properly assess and provide on-going care to mental health patients.

Mental health nurses (MHNs) represent the largest professional group in the Australian mental health care system, and any major reform to the way mental health care is delivered would have to include input from MHNs. Mental health nursing in Australia has evolved over the years from custodial care in long-term psychiatric institutions to a unique specialty area with a defined role and function. Mental health nurses now utilise psychosocial interventions while caring for people with mental illness and are now even involved in prescribing medications. Until recently in Australia, MHNs have not had a formally recognised or structured role in primary health care settings as most MHNs in Australia work within the public mental health system.

The purpose of this study was to explore the current role and scope of practice of MHNs in the Australian primary health care in context of the Australian Government's Mental Health Nurse Incentive Program (MHNIP). This initiative introduced mental health nursing into Australian primary health care nationally. The study also offers some preliminary evaluation of MHNIP.

This was an explorative-descriptive study that consisted of three phases. Phase 1 of the study was a scoping exercise that involved semi-structured interviews with key stakeholders who were involved in the establishment of the MHNIP. The purpose of this phase of the study was to gain a better understanding of the reasons behind the establishment of the program as well as the expected outcomes for consumers of mental health care. The findings of the scoping exercise helped inform Phase 2 of the study, which involved the recruitment of mental health nurses working in various general practices across Victoria, Australia who participated in semi-structured interviews. The purpose of Phase 2 is to explore the characteristics of the MHNs currently working in primary health care – in particular, general practice. It also sought to explore how their role was being enacted and the facilitators and barriers to their role enactment. The impact of the role of the MHNs in general practice was also explored. The findings of Phase 2 helped inform the development of questionnaires for GPs and MHNs across Australia (Phase 3). The questionnaire explored in further detail why MHNs decided to take on the role and why GPs decided to engage the services of the nurses. It also explored the role of MHNs, the barriers and facilitators of role enactment, collaboration between MHNs and GPs, impact of the role, and the characteristics of client care, amongst others.

The study revealed that the guidelines for the role of MHNs were largely pre-determined by the Commonwealth Government, there was no evidence-based practice that informed the role of the MHNs. On their part, MHNs were quite pleased with the opportunity to work in general practice and GPs largely welcomed the presence of MHNs in their practice. The role

of the MHNs is similar to that of the case management role of community psychiatric nurses; however, the nurses are able to better utilise their clinical skills. The role of MHNs in primary health care can be further expanded to improve overall health care delivery for people with a severe mental illness. The MHNIP opens the way for a more effective delivery of mental health care in Australia.

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ABBREVIATIONS/GLOSSARY OF TERMS

ACMHN	Australian College of Mental Health Nurses
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Teams
CPN	Community Psychiatric Nurse
GP	General Practitioner
MHN	Mental Health Nurse
MHNIP	Mental Health Nurse Incentive Program
PHC	Primary Health Care
PN	Practice Nurse
SMI	Severe Mental Illness/Serious Mental Illness
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

DEFINITION OF TERMS

Primary Health Care- Primary health care is commonly viewed as a first level of care or as the entry point to the health care system for consumers. It can also be taken to mean a particular approach to care which is concerned with continuing care, accessibility, community involvement and collaboration between sectors. Primary care is often used interchangeably with primary medical care as its focus is on clinical services provided predominantly by GPs, as well as by practice nurses, primary/community health care nurses, early childhood nurses and community pharmacists.

Severe Mental Illness/Serious Mental illness/Severe and Persistent Mental Illness- used interchangeably refer to a diagnosis of nonorganic psychosis, functional disability in areas of social and occupational functioning, and a prolonged illness and long-term treatment. It includes many patients with schizophrenia, bipolar disorder, schizoaffective disorders, severe major depression, and, in some less frequently used definitions of SPMI, substance use and personality disorders.

CHAPTER 1

BACKGROUND AND STUDY AIMS

Hildegard Peplau, fondly remembered by nurses worldwide as the ‘mother of psychiatric nursing’, noted ‘*throughout history psychiatric mental health nursing has been modified in response to changing circumstances. Innovations in practice arise from the findings of nursing research, from changes within health care systems or from new demands in society*’ (Peplau, 1994, p3). The nursing profession is the backbone of most nations’ health care systems and any changes made to the way care is delivered would generally impact on the nursing profession. Nurses have often responded well to most of these changes in the health care system (Ellerbe & Regen, 2012).

This study explores one of such changes mental health nursing in Australia is currently experiencing. This is in response to changes in the way the Government delivers mental health care to the population. The study examines the role and scope of practice of mental health nurses in the Australian primary health care setting, in the context of a Commonwealth government initiative that aims to extend the delivery of better mental health care at the primary care level.

This chapter presents the background to the study; it examines key concepts pertinent to the study. The chapter also examines recent Australian Government policy that has led to the gradual introduction of mental health service provision in primary health care settings.

Burden of Mental illness

Mental illness in Australia accounted for about 30% of the non-fatal burden (dominated by years lost due to disability) and 13.3% of the total burden of disease and injury for the year 2003 (Australian Institute of Health and Welfare, 2007). The National Survey of Mental

Health and Wellbeing of Adults (NSMHW) in 2007 estimated that more than one million Australians suffer from a mental disorder with almost half a million of these affected long term (Australian Bureau of Statistics, ABS, 2008). The survey estimates that 45.5% of Australians aged 16–85 years (7.3 million people) experienced a mental disorder over their lifetime, while 20% (3.2 million people) experienced symptoms of a mental disorder over the 12 months prior to the survey (ABS 2008). Anxiety, affective and substance use disorders were experienced by 14.4%, 6.2% and 5.1% of the population respectively over the 12 months.

The 2010 National Survey of Psychotic Illness provides information on the prevalence of psychotic disorders and the number of people receiving treatment. It estimated that the 12-month prevalence of people with a psychotic disorder and who were in contact with public specialised mental health services was 4.5 cases per 1,000 population aged between 18 and 64 years, equating to almost 64,000 people nationally (Morgan et al., 2011).

The economic cost of mental illness in the community is high. Outlays in 2007–08 by governments and health insurers on mental health services totalled \$5.32 billion, and represented 7.5% of all government health spending. These figures reflect only the cost of operating the mental health service system. Many people with a mental illness depend on government for assistance that extends beyond specialist mental health treatment. They require access to a complex array of community services including housing assistance, community and domiciliary care, income support and employment and training opportunities. The costs associated with all these services represent a major component of total government outlays that are attributable to mental illness (Department of Health & Ageing, 2010).

From Institutions to Community: The Move towards Deinstitutionalisation

Deinstitutionalisation, the process of transfer of care of patients with serious mental illness from stand-alone psychiatric hospitals into the community, began in the early 1950s in most developed nations such as the USA and UK. In Australia, the movement gathered momentum in the 1960s; today, most people with serious mental illness live in the community. The population of patients in Australian psychiatric hospitals has declined from 281 per 100 000 in the early 1960s to 40 per 100 000 in 1992, which represents an 86% reduction (Newton, Rosen, Tennant, Hobbs, Lapsley & Tribe, 2000). However, as this population has been transferred to community-based services, this figure is questionable. One of the advantages of deinstitutionalisation is that patients who had hitherto been cared for as ‘long-stay patients’ now had the opportunity to live in the community and receive treatment in the community (Rosen, 2006). This change in treatment modality assumed that services would follow the mentally ill into the community. At this time, little effort was made to boost primary care services, such as enhancing general practitioner capabilities, to manage people with mental illness. This has resulted in a ‘gap’ in service provision to certain groups of patients (this will be discussed later).

According to Lapsley, Tribe, Tennant, Rosen, Hobbs and Newton (2000), the cost of hospital care for people with a mental illness was nearly twice as expensive as care in the community setting. Hence, deinstitutionalisation also had economic benefits for the nation as a whole.

Carr, Neil, Halpin, Holmes and Lewin (2003) reported on the cost of schizophrenia and other psychotic illnesses in urban Australia. They estimated the average societal cost per annum of treating a patient with psychosis is about \$46,200, which comprises of \$27,500 in lost productivity, \$13,800 in inpatient mental health care cost (hospital admission) and \$4,900 in other mental health and community costs. Hospital admission accounted for about 77% of

mental health costs, whilst outpatient or community mental health services accounted for only 9% of total cost and the mental health cost as a result of GP services was 1%. Hence, hospitalisation remains an expensive treatment option and provision of care at the primary care level would result in some savings to the nation.

Deinstitutionalisation has created a need to develop new and innovative services in the community. Australian Government policy has reflected a need to transfer care to a community setting with the expansion of treatment and support services to assist people affected by mental illness living in the community, which is a central aim of the Australian National Mental Health Strategy of 1997. The strategic role played by primary health care has also been noted by the Australian Government (Department of Health and Ageing, 2005). This has led to series of reforms aimed at responding to the health needs of people with a mental illness in a more accessible manner. In the period of 2010–11, there were over 7.1 million community mental health care service contacts for approximately 350,000 patients across Australia. There has been an average increase of about 3.2% per annum between 2006 and 2011. Involuntary patients accounted for 14.8% of the patients receiving care with about 85.5% of patients treated as ‘voluntary’ patients under the Mental Health Act (Australian Institute of Health and Welfare, AIHW, 2012). These are patients that could potentially receive treatment in the primary health care system through their GPs or private psychiatrist and thus reduce the overall health cost of the nation. The model proposed under the Mental Health Nurse Incentive Program (MHNIP), which is the focus of this present study, aims to cater for such patients.

Australian National Mental Health Plan

The need for a national approach to reform in mental health was formally acknowledged with the development in 1992 of the National Mental Health strategy. The First National Mental

Health Plan (1992–1998) concentrated on reform to specialist mental health services, increased the emphasis on community-based care, decreased reliance on institutional care and mainstreamed acute beds into general hospitals. Its major focus was the low prevalence mental illnesses such as psychosis and bipolar disorder. Hence, the priority of the first national plan was to transfer the care of people from institutions to community based services. Subsequent reviews of the plan indicate that commensurate levels of funding did not ‘follow’ patients discharged from institutions into the community. This created a system in which community-based mental health services struggle to provide adequate care to these groups of patients (Hickie et al., 2005).

The Second National Mental Health Plan, released in 1997, consolidated the reform activities of the first plan in addition to an emphasis on health promotion and prevention of incapacity due to mental illness. The need for the development of cross sector partnerships was prioritised as part of health service reform and strategies were implemented to improve outcomes in quality and effectiveness in service delivery. The focus of the Second National Mental Health Plan differed in that it extended to include high-prevalence disorders such as depression and anxiety disorders.

The Third National Mental Health Plan (2003–2008) had service responsiveness (access to timely care), quality care, research, innovation and sustainability as its priority themes. The plan was guided by the principle that all people in need of mental health care should have access to timely and effective services, irrespective of where they live. With regard to the issue of access to care, the plan noted that access to GPs was problematic. This was attributed to reductions in bulk-billing, a maldistribution of general practitioner workforce and lack of support for GPs to provide mental health care. This is in spite of the fact that GPs were often identified to be the first point of access for people with mental health problems and they

performed an important role in providing on-going physical and mental health monitoring and care. As part of its key directions, therefore, the plan sought to provide support for GPs and other primary care clinicians such as community nurses in providing mental health care to the community. The third plan aimed to foster the development of primary care programs in which GPs and mental health professionals (such as nurses) provide shared mental health care (Australian Health Ministers, National Mental Health Plan, 2003).

The Fourth National Mental Health Plan (2009–2014) echoes the need to strengthen the capacity of GPs to foster access to mental health services at the primary health care level (Australian Health Ministers, National Mental Health Plan, 2012). There has been a gradual reform of the Australian mental health system since the first national mental health plan and there has been a shift towards care that is not centralised at the specialist level. Primary health care has been gaining momentum as key player in the delivery of affordable and accessible mental health service. In all of the national mental health plans, no specific role was identified for mental health nurses, and most of the focus in primary care was largely directed towards GPs.

The Key Role of Primary Health Care

Primary health care plays a significant role in the health system of any nation. According to the World Health Organization, it forms an integral part of the country's health system – of which it is the central function and main focus – as well as the overall social and economic development of the community (World Health Organization, 1978). The Alma-Ata Declaration of 1978 defines primary health care as:

"... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in

the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination" (Alma Ata International Conference, 1978)

Primary health care is the first level of contact for individuals connecting them to the national health system, as well as bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process (World Health Organization, 2007). Primary health care incorporates primary care, but has a broader focus through providing a comprehensive range of generalist services by multidisciplinary teams. These teams include not only GPs and nurses but also allied health professionals and other health workers, such as multicultural health workers, indigenous health workers, and workers in health education, promotion and community development. Primary health care provides services for individuals, families and communities (WHO, 2007).

In Australia, there has been a growing emphasis on the role of primary health in the provision of mental health care. It has been argued that the primary care-based system is the only system that has the potential to reach the broader population (WHO 2008a). Australian primary care strategies will be discussed further in this chapter.

General Practitioners and Mental Health Care

In Australia, GPs provide services to their clients under a fee-for-service arrangement where a rebate up to a schedule is paid by Medicare Australia and any gap payment is borne by the consumer. Medicare was established as a means of providing medical care to all Australians irrespective of their socio-economic status. It is financed through progressive income tax and an income-related Medicare levy. Medicare provides access to free treatment for a public

(Medicare) patient in a public hospital, and free or subsidised treatment by medical practitioners including general practitioners, specialists, participating optometrists or dentists (for specified services only). As of 30 June 2011, there were over 22.5 million people registered for Medicare benefits and over 319 million services were processed in the July 2010–June 2011 period (Medicare Australia, 2011).

According to the Department of Health and Ageing (2006), 85 per cent of the Australian population sees general practitioners (GPs) every year and mental health is the second most common co-morbidity in general practice. GPs provide more than 10 million mental health consultations per year and 3.4 million of these are for depression. Most people requiring help with mental health issues will often seek such help from their General Practitioner with whom they are familiar (Robert, Robinson, Stewart & Smith, 2009). The estimated rate of mental health-related GP encounters per 1,000 population increased by an annual average of 4.8% between 2006–07 and 2010–11. The proportion of all GP encounters that are mental health-related has increased from 10.4% in 2006–07 to 11.7% in 2010–11 (Australian Institute of Health and Welfare, AIHW, 2012).

General practitioners have long been managing mental health presentations as best as they can. The Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity, carried out between April 2009 and March 2010, shows the most common form of management of mental health related problems by GP's was providing a medication prescription. The second most common form of management by GPs was provision of clinical treatment such as psychological counselling. Then, there was referral to other agencies (such as psychologist and psychiatrist), which indicates referral to services that were not available within the GP practice (Australian Institute of Health and Welfare, AIHW, 2012).

General practitioners were found to have had few tools to use in managing mental health presentations. They had limited training for their broad roles and often receive little or no support from specialist services (National Mental Health Strategy Steering Committee, 1997). A series of government initiatives (Better Outcomes and Better Access) were put in place to support the role of GPs in the management of people with mental illness at the primary care level (the structure and impact of these initiatives is discussed in detail later in this chapter). General practice in Australia is now considered an integral part of the mental health care system due to the potential that exists in care provision; this is in contrast to the earlier view that they were a group that required access to mental health training and referral pathways (Australian Ministers, Fourth National Mental Health Plan, 2012).

The National Primary Health Care Strategy

The Australian Government inaugurated an external reference group on 11 June 2008; its aim was to support the Government in developing a National Primary Health Care Strategy. The strategy is to look at how to deliver better frontline care to families across Australia with the following key priorities:

- Better efforts towards disease prevention
 - Promoting evidence based management of chronic disease
 - Supporting patients with chronic disease to manage their condition
 - Supporting the role GPs play in the health care team
 - Addressing the growing need for access to other health professionals, including practice nurses and allied health professionals
 - Encourage a greater focus on multidisciplinary team-based care
-

Many health care systems around the globe are confronting challenges in the face of dwindling health care funds, due to a downturn in the global economic outlook. There is a constant need for governments to seek alternate ways of providing health care to its population in a manner that is more affordable and sustainable. There is a great deal of emphasis being placed on continued cost reduction, and primary health care remains a viable and cost-effective means of lowering overall health care cost (WHO, 2008b).

Role of Nurses in Primary Health Care Delivery

Nurses play a significant role in the delivery of health care in Australia's health system in general and primary health care in particular and there is a move in most developed and developing nations to harness the role of nurses in the delivery of health care at this level. Nurses have long worked in primary health care with GPs as Practice Nurses.

In 2001, the Australian Government invested \$104.3 million in the Nursing in General Practice Incentive (NIGPI) program, which consisted of three components. One of these components is an \$86.6-million Practice Incentive Program (PIP) designed to encourage the employment of practice nurses and/or Aboriginal Health Workers through payment of incentives for general practices. One of the intended outcomes of this program was to improve consumer access and affordability of primary health care, assistance in the integration of primary care, and proactive contribution to the prevention and management of chronic diseases (Department of Health & Ageing, 2001). An evaluation revealed that the program improved the quality of the GP practice, had a positive impact on the management of chronic diseases and reduced waiting time. The program was found to increase the awareness of practice nurses and their role and also raised their profile in the community (Department of Health & Ageing, 2001).

There has been recent debate in Australia about expanding the role of nurses in primary care, in recognition of the skills and training that nurses possess and how this can be better utilised to improve access to health care by the general population (Roxon, 2008). While this move has been welcomed by peak professional and industrial unions representing nurses, there has been substantial resistance from the body representing GPs, the Australian Medical Association (AMA). In a statement following the constitution of an independent panel to advise the Australian Commonwealth Government on the matter by the Health Minister, the AMA suggested that expanding the current role of nurses in primary care will put patients' lives at risk (Capolingua, 2008). According to the AMA president at the time, Dr Rosanna Capolingua, nurses work well under medical supervision but did not have the training to be able to independently assess and diagnose patients.

Many countries are seeking to shift the provision of primary care away from doctors, giving nurses more responsibilities in order to reduce the demand for doctors and ultimately improve health care efficiency (Laurant, et al., 2008). The National Health Service (NHS) in England whilst facing rising demand for health care, pressure to constrain costs, poor access to services in deprived urban areas and medical workforce shortages has been pushing to extend the roles of nurses to areas previously controlled by doctors (Sibbald, Laurant, & Reeves, 2006).

The recognition of nursing as a professional group with the added autonomous practice status independent of the medical profession may still be a long way off in Australia, given the powerful influence and dominance of the medical profession.

Mental Health Nurses in Primary Mental Health Care

Mental Health Nurses represent 60% of the mental health workforce in Australia, and any plan to reform the delivery mechanism of primary mental health in the country will require

active participation of mental health nurses. Over the last 40 years according to Gillam (2005) and Wilkin (2001), the role of the community psychiatric nurse (CPN) has evolved from the psychiatrist's cat's paw (handmaiden) to a much more autonomous and skilled practitioner. The profile of the community psychiatric nurses has moved beyond that of a depot administrator to a more major role in the delivery of mental health care (Gillam, 2005).

Historically, community psychiatric nurses in Australia have worked as part of Community Mental Health Teams, which are usually part of a larger public general hospital where they deliver care to people with severe mental illness and other minor disorders such as anxiety and depression within a multidisciplinary team structure. There have been sporadic trials across the nation of community psychiatric nurses offering specialist consultations to GPs; however, the efficacy of having a community psychiatric nurse (CPN) situated predominantly in a primary care setting has not been researched in Australia. White (cited in Gournay & Brooking, 1994) reported significant changes in the working practice of CPNs in the UK, with almost 22.4% of the 4500 community psychiatric nurses surveyed in their study working in general practice. This is in contrast with Australia, where CPN services in general practice have not been implemented. The Australian Government's health policy aims to improve collaboration between mental health services and general practitioners in caring for people with serious mental illness. It is argued that mental health care needs are more appropriately met by GPs rather than long-term specialist care, and their involvement may also provide an opportunity to address unmet physical health needs. This may ultimately have an impact on the high rates of morbidity and mortality associated with major mental disorders (Robson & Gray, 2007; Howard et al., 2010). The lack of an effective collaboration mechanism between public mental health services and the private sector providers such as GPs has been documented in the literature (Pirkis et al., 2004). It has been reported that GPs were reluctant to deal with non-medical members of community mental health teams, including nurses; this

has been attributed to their limited understanding of the role of these nurses and insufficient knowledge about mental illness (Carr, Lewin, Walton, Faehrmann & Reid, 1997).

As previously mentioned, the Second National Mental Health Plan in Australia placed emphasis on partnerships between mental health services and general practitioners in improving mental health care delivery. However, the form this was to take was not well articulated, and this is possibly why there is no research into its effectiveness (Harmon, Carr & Lewin, 2000).

There is an increasing demand on the public mental health system, which often results in reduced capacity of CPNs working in community mental services to provide quality care to people with severe mental illness (King, Meadows & Le Bas, 2004). Caseload size has been an area of concern for these nurses; they often find it difficult to discharge clients who could otherwise be managed in primary health care if there was available specialist support for the GP.

The population of clients for whom mental health nurses provide care in the primary care setting has also been a subject of interest. Generally, people with a mental illness are classified into two broad categories: minor mental illness (depression, anxiety) and serious or severe mental illness (schizophrenia, bipolar affective disorder, and schizoaffective disorders). The noted common features of those with severe mental illness include: social disablement and loss of personal, family and wider social roles, which are all areas in the scope of mental health nursing care delivery.

The Senate Select Committee on Mental Health and the Council of Australian Government (COAG) Primary Care-Led Mental Health Service Reform

On 8 March 2005, the Australian Senate created a Select Committee on Mental Health to conduct a wide-ranging inquiry into the provision of mental health care in Australia. This was in response to growing community concerns about the state of mental health in Australia. Part of the terms of reference of the committee was to examine the role of primary health care in the promotion, prevention, and early detection of mental illness as well as chronic care management. The Committee also looked into the potential for new modes of delivery of mental health care (Senate Select Committee on Mental Health, 2006). The Mental Health Council of Australia (MHCA), the peak national non-government organisation representing and promoting the interests of the Australian mental health sector, recommended to the committee the need for better funding arrangements to improve models of primary and secondary care service delivery. This submission identified the need for health care provision that is local and more responsive to the needs of consumers and carers (Senate Select Committee on Mental Health, 2006).

In making its recommendations, the committee highlighted the need to devote resources to coordinating mental health care at a practical level in primary care. In the final report tabled before Parliament on 30 March 2006, the committee made 91 recommendations to the Council of Australian Governments (COAG) and the first was the need to focus on more community-based care. It suggested the Commonwealth establish new direct Medicare recurrent funded arrangements for employed or contracted mental health staff (such as mental health nurses) in community-based mental health centres (Senate Select Committee on Mental Health, 2006). The recommendation by the committee had some influence in the formulation of the Mental Health Nurse Incentive Program. The committee report was also

the only significant document publicly available that is pertinent to the MHNIP. This is further discussed in Chapter 4 of this study, under ‘Document Review’.

Council of Australian Governments (COAG) Primary Care-Led Mental Health Service Reform

In recognition of the increasing burden of mental illness and lack of accessibility of care by people with a mental illness, the Australian Federal Government, through the Council of Australian Governments (COAG) forum, announced in 2001 a range of funding aimed at reforming the mental health system in Australia.

In July 2006, COAG had endorsed a *National Action Plan on Mental Health (2006-2011)*.

Under the Plan, the Commonwealth was to implement 18 measures over five years to improve services for people with a mental illness, their families and carers, through:

- increasing clinical and health services available in the community and providing new team work arrangements for psychiatrists, general practitioners, psychologists and mental health nurses;
- providing new non-clinical and respite services for people with mental illness and their families and carers;
- providing an increase in the mental health workforce; and
- providing new programs for community awareness.

Better Outcomes in Mental Health Care Program

The Better Outcomes in Mental Health Care Program (BOiMHC) aimed to improve consumers’ access to high quality primary mental health care through a funding commitment of \$120.4 million announced in July 2001 with additional funding made available later. At the time, this was the largest single allocation of funding by the Australian Government for

mental health care reform (Hickie & Groom, 2002). The program consisted of five components which included: education and training for GPs, the GP Mental Health Care Plan (a three-step Mental Health Process), focused psychological strategies, access to allied psychological services (ATAPS) and access to psychiatric support (Fletcher, Pirkis, Kohn, Bassilios, Blashki & Burgess, 2007). The GP Mental Health Care Plan was to include the use of evidence-based outcome measures, patient psychoeducation, provision of a written mental health plan, planned review and others components of care that aimed to enhance patient outcomes. Since the introduction of the BOiMHC there has been more support for GPs to help them provide better mental health care to their consumers and the increased up-take of support programs by GPs suggests improved collaboration between GPs and other mental health professionals had commenced (Thomas, Jasper & Rawlin, 2006).

In the First Interim Evaluation Report of the Access to Allied Health Services Component of the BOiMHC, participating allied health professionals listed the following as some of the advantages of the program: an increased referral base, improved relationships with GPs, clinical supervision and opportunities to 'do something different'. On their part, consumers expressed increased satisfaction with care and the opportunity to access allied health professionals in their GPs' rooms was not only convenient but also reduced the stigma associated with seeking mental health care (Pirkis, Blashki, Headey, Morley & Kohn, 2003). An initial high up-take of the program was identified, with 80,000 services for the GP care plan items and 100,000 for psychological services by March 2007 (Medicare Australia, 2007).

Better Access to Mental Health Care

The Australian Government 2006–07 budget contained a commitment of \$538 million to provide better access for people living with a mental illness to psychiatrists, psychologists

and general practitioners through Medicare. The initiative, known as 'Better Access' to psychiatrist, psychologists and GPs through the Medicare Benefit Schedule (MBS) was developed as a core element of the Commonwealth of Australian Governments' (COAG) mental health package aimed at reforming Australia's mental health system. The Better Access to Psychiatrists, Psychologists and General Practitioners initiative (Better Access) was designed to improve access for people with high-prevalence disorders to a range of providers through a series of new Medicare Benefits Schedule (MBS) item numbers. Under the new item numbers, services of registered psychologists, selected social workers and occupational therapists were made eligible for rebate from Medicare. The psychologists can directly bill Medicare Australia or can bill the consumer who can then obtain a partial rebate from Medicare Australia (Fletcher, Pirkis, Kohn, Bassilios, Blashki & Burgess, 2007).

Mental health nurses had a very limited role in these initial two initiatives, i.e. BOiMHC and Better Access. In the first 14 months of operation of the Better Access initiative, more than 726,000 people living with a mental illness across Australia had accessed around 2.7 million Medicare subsidised primary care mental health services (Department of Health and Ageing, 2008).

The Australian & New Zealand College of Mental Health Nurses (now known as The Australian College of Mental Health Nurses), the peak body representing the professional interest of mental health nurses in Australia, issued a position statement following the release of the Better Access initiatives program. While the College welcomed the commitment the Australian Government had shown to the mental health reform agenda, it expressed its disappointment that nurses were not included in the new items provided for clinical psychologist and other allied health practitioners under the Better Access to Mental Health Care initiative. The College took the view that the exclusion of mental health nurses from equal provisions for service delivery under the Better Access to Mental Health Care initiative

indicates a lack of appreciation of the diversity of expertise, skill and experience that mental health nurses contribute to the mental health of the community. The college has vigorously campaigned to correct this perception of the mental health nursing profession (Ryan, 2010). The role of the college in the development of the MHNIP will be discussed in the findings chapter.

The Mental Health Nurse Incentive Program (MHNIP)

The inclusion of mental health nurses in the Australian Government's reform agenda included, amongst others, \$191.6 million of funding over five years for a Mental Health Nurse Incentive Program (MHNIP). This represented 10 per cent of the Australian Government's \$1.9 billion Better Access to Mental Health Services for Australia package. The incentive funded community-based general practices, private psychiatric practices and other appropriate organisations such as Aboriginal and Torres Strait Islander Primary Care Services to engage mental health nurses in the provision of coordinated clinical care for people with severe mental disorders (Department of Health and Ageing, 2007a). Other aspects of the mental health reform package that related directly to mental health nursing were the provision of additional education places at university, scholarships and clinical training in mental health, to address the workforce shortage (Department of Health and Ageing, 2007a).

According to a media release by the Parliamentary Secretary to the Minister for Health and Ageing, under the Mental Health Nurse Incentive Program, patients with severe mental illness will get the right services at the right time and unnecessary hospital admissions will be prevented due to the availability of specialist nurses providing and coordinating clinical care. In addition, patients will also benefit by receiving specialist care in more convenient locations such as clinics or their homes (Mason, 2007).

The Mental Health Nurse Incentive Program provides mental health nurses with a new career path and greater job opportunities by expanding the scope and autonomy of their clinical practice (Australian College of Mental Health Nurses, 2007a). It was anticipated by COAG that within five years of the program, more than 36,000 patients with severe mental illness will receive support from specialist mental health nurses each year (Abbott & Pyne, 2006).

The guideline for the initiative set out entry and exit criteria for consumers;

- The patient must have a diagnosis of mental disorder according to the criteria defined in the World Health Organization Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD 10 chapter V Primary care version, or the Diagnostic and Statistical Manual of Mental disorders- 4th Edition (DSM-IV);

AND

- The disorder causes significant disablement to the person's social, personal and occupational functioning;

AND

- The person has experienced at least one episode of hospitalisation for treatment of their mental disorder, OR is at risk of requiring hospitalisation in the future if appropriate treatment and care is not provided;

AND

- The person is expected to require continuing treatment and management of their disorder over the next two years;

AND

- The general practitioner or psychiatrist is principally responsible for the person's mental health care;

AND

- The patient provides consent to treatment from a mental health nurse.

The patient will be exited from the program when:

- The mental disorder no longer causes significant disablement to the person's social, personal and occupational functioning;

OR

- The patient no longer requires the clinical services of a mental health nurse;

OR

- The general practitioner or psychiatrist is no longer primarily responsible for the person's clinical mental health care. (Department of Health and Ageing, 2007b).

The client must have a mental health care plan that must include specific reference to the roles and responsibilities of both the nurse and the treating medical practitioner. Treatment must be provided according to the plan and the relevant clinical guidelines for the treatment of that disorder. It is expected that the GP or psychiatrist regularly review the plan in collaboration with the mental health nurse; where appropriate, the review should include input from other allied health professionals (Department of Health and Ageing, 2007b).

To be eligible to participate in the Mental Health Nurse Incentive Program, organisations must be community-based and have the services of a general practitioner with a Medicare Australia provider number or a psychiatrist registered with Medicare Australia. Divisions of

General Practice can contract the services of mental health nurses for use by general practitioners with a Medicare provider number. Eligible organisations were required to provide data about the organisation, care sessions and patient demographics to Medicare Australia.

The key requirement for mental health nurses to work under the MHNIP is that they must be credentialed by the Australian College of Mental Health Nurses (ACMHN) by 31 December 2008. Credentialing is a core component of clinical/professional governance or self-regulation, where members of a profession set standards for practice and establish a minimum requirement for entry, continuing professional development, endorsement and recognition. Registered nurses working in specialised fields and other disciplines have developed credentialing as a means to ensure standards of practice and competence within their specialist domain beyond entry to practice (Australian College of Mental Health Nurses, 2007b).

Being credentialed identifies the mental health nurse as having achieved a particular standard of practice expected from an experienced advanced practice clinician. It indicates to employers, professional peers, consumers, and other stakeholders, what might reasonably be expected from the MHN and that an evaluation of individual performance against the relevant practice standards has been undertaken (ACMHN, 2007b).

Role and Function of Mental Health Nurses Engaged Under the Mental Health Nurse Incentive Program

Mental health nurses engaged under the MHNIP, according to government guidelines, are expected to work closely with psychiatrists or GPs to facilitate the provision of coordinated clinical care and treatment of people with severe mental disorders. Services are provided in a

range of settings such as clinics or at patients' homes. The role and function of the MHN falls under two broad categories according to the program guidelines: provision of clinical nursing services for patients with severe mental disorders, which includes:

- Establishing a therapeutic relationship with the patient
- Liaising closely with family and carers as appropriate
- Regularly reviewing the patient's mental state
- Administering, monitoring and ensuring compliance by patient's with their medication and
- Providing information on physical health care to the patients.

AND

Coordination of clinical services for patients with severe mental disorders include:

- Maintaining links and undertaking case conferencing with general practitioners, allied health workers, psychiatrist, psychologists and key community workers;
 - Coordinating services for the patient in relation to general practitioners, psychiatrists and allied health workers, such as psychologists, including arranging access to interventions from other health professionals as required;
 - Contributing to the planning and care management of the patient;
 - Liaison with mental health personal helpers and mentors (a program that aims to create opportunities for recovery for people with a severe mental illness through increased social participation).
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Mental health nurses under the MHNIP are required to use the Health of the Nation Outcomes Scale (HoNOS) for each patient at entry to the program and subsequently measure changes in patients' symptoms and functioning using these tools every 90 days and at exit from the initiative. The Health of the Nation Outcomes Scale is the most widely used routine clinical outcomes measure in the United Kingdom's mental health services. It was developed in the mid-1990s as an inclusive and comprehensive instrument to measure patient outcomes in four main factors: behaviour, impairment, symptoms and social problems (Pirkis et al., 2005). While interest in the MHNIP was initially high amongst GPs and divisions across the nation, many of these eligible organisations were cautious in its up-take and took a 'wait and see' approach. This approach was due to the perceived barriers to implementing the program (Australian General Practice Network, 2007). The initial barriers anticipated by GPs and divisions of GP included:

- The use of the Australian Standards Geographical classifications to establish a claim for rural locality has disadvantaged a number of divisions and general practices.
- The retrospective payment system for eligible organisations has meant that divisions have need to draw on core funding to meet salary and infrastructure costs for a three-month period, which was promptly addressed to some extent through the introduction of a one off establishment fee,

and perhaps one of the most crucial barriers:

- The workforce shortage of suitably credentialed mental health nurses (Australian Division of General Practice, 2007).
-

The Private Practice Special Interest Group was set up by the ACMHN to promote the interest of mental health nurses working in private practice following the introduction of the MHNIP. The group held its inaugural conference 22–23 February 2008 in Canberra. Mental health nursing participants at the conference varied from those who had been in private practice prior to the introduction of the MHNIP, nurses currently engaged in the program as well as those considering working under the program (The Private Practice Special Interest Group Conference, 2008). While the participants acknowledged the potential benefits the MHNIP brings to the care of people with serious mental illness in the community, they were very critical of the current mode of operation of the initiative. The common theme that echoed amongst the participants was a lack of proper recognition by policy makers in Government of the important role that mental health nurses play in primary care and their ability to work autonomously.

Significance of the Study

Internationally, there has been interest for some time in an extension of the mental health nursing role into primary care. Development of specialist mental health nursing roles in primary health care is one of a range of initiatives necessary to extend the mental health services provided in the primary sector and to facilitate the transfer of mental health consumers to the primary sector (O'Brien, Hughes & Kidd, 2006). The MHNIP provides the opportunity for an expansion of the scope and autonomy of mental health nursing clinical practice. There is a need to understand the role and scope of practice of mental health nursing in primary care to achieve better outcomes for consumers of mental health services, through the provision of care at a level that is more accessible to the consumer.

This study is one of the first Australian studies to explore the role and scope of practice of mental health nurses working in primary care settings in the context of the Council of

Australian Government's Mental Health Nurse Incentive Program. Studies from outside Australia have examined the role and effectiveness of community psychiatric nurses working in the primary health care sector (Gournay & Brooking, 1995) however, studies from Australia have reported mainly on the emerging role and scope of practice of advanced practice psychiatric nursing in general, without specific emphasis on primary care (Clinton & Hazelton, 2000a; Elsom, Happell & Manias, 2005).

While analysing the development of the nurse practitioner role in Australia, Gardner and Gardner (2005) argued that there is a need to define the role within an evidence based research framework. This, according to the authors, will allow formal evaluation and inform the development of knowledge in this area of clinical practice. They stressed that research is needed as a basis for realising the full potential of Nurse Practitioners in health service delivery within Australia. There is also a need to situate the role of mental health nurses engaged under the MHNIP within a robust research context. This would help highlight the importance and value of nursing in promoting mental wellbeing at the primary care level, as well as to provide an evidence base for future government policy directions regarding mental health nursing roles. It will also provide a basis for a formal evaluation of the effectiveness of the mental health nurses' role in primary health care in Australia under the MHNIP.

The current study adds to the body of knowledge on the changing role of Australian mental health nurses in the delivery of mental health care at the primary care level. It will also inform future Government policy regarding the delivery of mental health services by mental health nurses in primary care. While a handful of mental health nurses have engaged in private practice for some time in Australia, no national study has been conducted to explore the role and scope of practice of these nurses. This study will explore and describe the

perceptions and scope of practice of mental health nurses working in primary health care within Australia.

According to the International Council of Nurses (2008), primary health care concepts and principles should be fundamental within the nursing curriculum, and nursing students need to be provided with high-quality clinical placements in primary health care settings. The Australian Nursing and Midwifery Advisory Council (ANMAC) is the peak national nursing and midwifery organisation established for the purpose of developing a national approach to nursing and midwifery. The body has developed national competency standards to assist nurses and midwives to deliver safe and competent care (Australian Nursing & Midwifery Advisory Council, ANMAC, 2012). Competency standards are industry-determined specifications of performance that set out the skills, knowledge and attitudes required to operate effectively in employment (ANMAC, 2012).

There are currently no national competency standards for mental health nurses working in primary health care in Australia. Results from this present study will be valuable in the development of national competency standards, as they will provide information on the current role and scope of practice of mental health nurses in primary health care across various settings in Australia. Development of such national competency standards would also assist tertiary education providers in establishing frameworks for course development for undergraduate and postgraduate nursing students.

The World Health Organization (WHO 2008a) has also endorsed the model of co-location of services, whereby mental health specialists work alongside primary health care staff.

According to O'Brien, Hughes and Kidd (2006), this pushes the boundaries of 'traditional working models' as it requires blurring of many traditional roles and systems. While several models of collaboration have been trialled in managing people with mental illness in primary

care, there is no evidence of the most optimal method (Keks et al., 2003). Mental health nurses are expected to work in collaboration with GPs and private psychiatrists outside of the public mental health system under the MHNIP. This is a new mode of service delivery in Australia that has not been evaluated. This study offers insight into the nature of collaborative practice that exists between mental health nurses, GPs and private psychiatrists in the primary care setting.

While the intention of this project is not to provide a full evaluation of the MHNIP, it does present the opportunity to provide preliminary data on the impact of the program from the perspective of some of the key participants. Pirkis et al. (2005) carried out an evaluation of the introduction by the Australian Government of new Medicare item numbers to facilitate greater collaboration between private psychiatrists and other health care providers through case conferencing. One of the inquiry strategies the study employed was the use of key informant perspectives (private psychiatrists) on their experiences under the program.

Coster et al. (2006) also conducted a study to evaluate the impact of the role of nurses, midwives and health visitor consultants on services and patient care across the UK.

According to the authors, it is possible to consider outcomes of a role as a series of direct or indirect impacts. They adopted the use of stakeholder perspectives in which they focused on the nurses themselves as key stakeholders.

Stakeholders are described by Koch (2000, p.121) as ‘those who have a direct involvement with the group or setting that is to be evaluated’, and it is the claims, concerns and issues of stakeholders that serve as the organisational foci for the study (Guba & Lincoln, 1989).

Consumers, carers, area mental health services, mental health nurses, GPs and private psychiatrists are all important stakeholders under the MHNIP. However, the evaluation of consumer, carer and area mental health services’ perspectives as well as outcomes is beyond

the scope of this present study. This will need to be examined in future research and as the MHNIP progresses.

In summary, this study will:

- Provide preliminary information on the scope of practice of mental health nurses working in primary health care in Australia;
- Highlight the key role that mental health nurses play in Australian primary health care and the potential available to enhance this role for more effective service delivery;
- Explore collaborative practice between mental health nurses and GPs/private psychiatrists in Australia;
- Provide initial data for the development and evaluation of competency standards for mental health nurses in primary care.

Purpose of the Study:

The purpose of this study is to explore the role and scope of practice of Australian mental health nurses working in primary health care settings within the context of the Australian Government MHNIP. This would offer preliminary evaluation of the MHNIP.

The following research questions will be addressed in order to achieve the overall aim of the study.

Research Questions

1. What were the drivers for the establishment of the MHNIP?
-

2. What are the reasons behind MHNs' desire to work in primary health care and also reasons why general practitioners engage the services of mental health nurses in their practice?
3. What role do MHNs play in the delivery of mental health care in primary health care settings?
4. What factors impact on the enactment of the role of the MHNs in the delivery of mental health care under the MHNIP?
5. What impacts has the role of MHNs had in primary health care?
6. What is the nature of collaboration between GPs and MHNs engaged under the MHNIP?

Thesis Structure

This chapter has introduced the current study by providing background information largely from government reports, and it has provided an overview of the research to be conducted, its significance and research questions. Chapter 2 presents a review of the current literature that focuses on the provision of mental health care in primary care; the role that nursing generally provides in primary care is contrasted with that of the mental health nurse. Most of the available literature arises from overseas studies or policy papers with a paucity of literature within the Australian context. Chapter 3 describes the methodological approach to the study; sampling, data collection and analysis are discussed. The ethical consideration for the study is also presented. In Chapter 4, results of Phase 1 of the study (which involved interviews with key stakeholders) are presented. Chapter 5 provides the findings from the Phase 2 interviews with mental health nurses, following an analysis of the transcripts of interviews using a framework analysis method.

Results of Phase 3 of the study involving a survey of mental health nurses and general practitioners are presented in Chapter 6. Finally, Chapter 7 discusses the findings from all the phases of the study in light of the research questions and draws comparisons with available literature. This chapter also discusses limitations, offers recommendations for practice, policy, education and research, and provides a conclusion to the thesis.

CHAPTER 2

LITERATURE REVIEW

The aim of this chapter is to situate the current study within the context of what is currently known about primary health and mental health care in the primary health setting in order to identify potential gaps in the literature. The chapter begins with an historical perspective of the concept of primary health care (PHC) and the strategic role that nursing has played in this area since its inception. The literature review provides an overview of the attempts, in various developed nations, towards integration of mental health into PHC and the role that mental health nursing has played within primary health care is also examined. The importance of stakeholder views in evaluation of programs is also highlighted. The notion of collaborative practice between nurses and medical doctors and the impact collaborative practice has on mental health consumer outcome is explored.

Literature Search Strategy

Involvement of mental health nurses in PHC in Australia is relatively new, and there is a paucity of Australian literature in this area. There was a great deal of difficulty finding literature that specifically examined the role of Australian mental health nursing in primary health care or general practice. At the beginning of this study in July 2008, there were no published works in Australia about the activities of mental health nurses in general practice. Since then, there have been five (5) published articles about the subject matter, including one by the researcher. These studies will be examined in the review. However, the majority of the cited works in this chapter are from overseas, particularly the United Kingdom. The literature utilised in this review was accessed from a variety of sources. The health electronic databases Web of Science, CINAHL Plus, Scopus, Medline, PubMed, Science Direct and PsycINFO

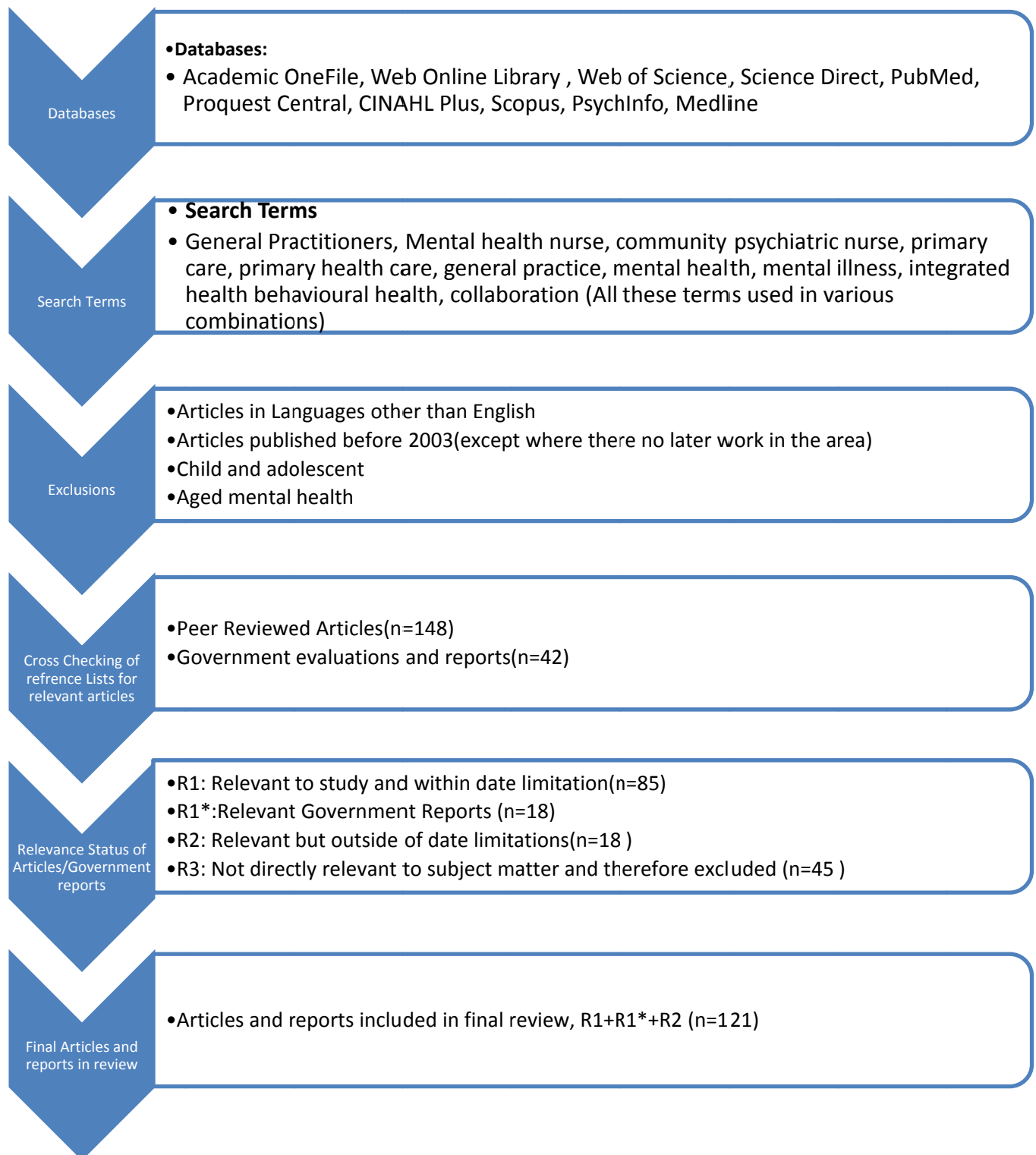
were accessed due to their coverage of mental health, primary health, psychosocial, medical and nursing contents using key terms. The search terms included: 'primary health care', 'primary mental health', 'mental health nurses', 'community psychiatric nurse', 'general practice', 'role and scope of practice', integration primary health and mental health. During the hand search of articles, the search terms or key words were refined as they were identified in relevant articles found.

Citations were limited to studies conducted in countries with a comparable health system to Australia such as the United Kingdom, New Zealand, the United States, Canada and Europe. The search was limited to studies published in English and in peer-reviewed journals.

Australian, New Zealand, United Kingdom and the United States government health websites as well as the World Health Organization and relevant nursing and medical organisation websites were also accessed to identify grey literature. The search period was limited to the period between January 2003 and December 2013, except in situations where there was no published work within that timeframe. In such cases, earlier work was utilised. For example, there has been no published work in Australia about the integration of primary and specialist mental health services since 1996; thus, earlier work was sought. Abstracts and titles were screened, and potentially relevant articles were retrieved and read. The research articles were selected for analysis if they had direct relevance to the subject matter, or had the potential to inform the study. The reference lists of some of the articles were also examined to see if any relevant articles could be found. The study commenced in 2008; hence the initial literature review needed to be updated at the conclusion of the study. Figure 1 gives an overview of the search strategy. There were a total of n=148 articles, including government reports included after duplicates were excluded. The peer reviewed journals were assessed at three levels of relevance, represented by R1/R1*, R2 and R3. Articles and government publications that were relevant to the subject matter and within the date limitation were classified as R1 and

R1* respectively. Articles that were considered relevant to the subject matter but outside of the date limitation were classified as R2. Articles were classified as R3 if they were not directly relevant to the subject matter.

Figure 1: Literature search strategy



The Primary Health Care Concept

Primary health care plays a major role in the health system of any nation. There has been increasing pressure upon most nations' health care systems to provide quality, cost-effective and equitable health care to its citizens, often with a reality of scarce resources (WHO, 2005). Primary care refers to a person's first point of contact with the health system and involves the management of a person's illness or disease. This first point of contact usually includes the general practitioner or family physician. The fact that 62% of people with a mental disorder in Australia do not access any form of mental health services means primary health care settings, such as general practice, are integral to early detection and intervention for those who would not otherwise seek help (Happell & Platania-Phung, 2005).

It is only recently that the Australian Government has started to place more attention to its primary health care sector, recognising that there was a need for reform, unlike countries such as New Zealand and the United Kingdom, who have long established frameworks for their primary health care sector. In 2008, the Australian Government announced the constitution of a stakeholder reference group to inform the development of a National Primary Health Care Strategy with the aim of building a stronger primary care system. The strategy placed a greater focus on keeping patients out of hospital and increased the focus of primary care teams on the provision of multidisciplinary care (Department of Health and Ageing, 2008). As the burden of disease has moved increasingly to chronic conditions, enormous pressure has been placed on the service system. Significant changes to the overall health system, including developments in the acute sector and in the provision of hospital care, have also placed additional demands on primary health care. These changes suggest the health system overall would benefit from a more systematic response from primary health care, together with efficient integration of other health sectors. Primary health care services have

historically been delivered in a relatively unplanned environment. Traditional organisational and funding structures are focused more towards treating episodes of ill health, rather than prevention and on-going management of disease.

Under the National Health Reform Agreement, the Australian Government is aiming to shift the focus of gravity of the health system from hospitals to primary health care. It has been acknowledged by the Government that a strong primary health care system helps prevent disease and assist people to manage their health conditions in the community, freeing up hospitals to look after those who need hospital care. The Government also aims to continue to invest significantly in primary health care infrastructure through the construction of General Practice (GP) Super Clinics and upgrades to primary health care facilities. The Government plans to strengthen its primary health care reforms and access to after-hours care through Medicare Locals. The national network of Medicare Locals will ensure primary health care services are more accessible and responsive to local health needs (Department of Health & Ageing, 2010). As stated earlier, similar primary health care strategies have existed in other countries.

New Zealand

The New Zealand Government had established a similar initiative in 2001, also known as the Primary Health Care Strategy. In addition, they also established the primary health care nursing expert group whose aim it was to advise on the implementation of the primary health care strategy (Hughes & Calder, 2006). A key component of the New Zealand government's primary health care strategy was the establishment of primary health organisations (PHOs). These organisations are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO. The vision and the new directions involve moving to a system where services are organised around the needs of a defined group of people (Hughes & Calder, 2006).

United Kingdom

In the United Kingdom (UK), primary care services have long been recognised as playing a pivotal role in the country's National Health Service (NHS). As a result, there has been increased government funding for primary care and it is now at the centre of the NHS (McKenna, Ashton & Keeney, 2004; McDonald, Davies, Cumming & Harris, 2007). In the UK, primary care trusts (PCTs) are in charge of primary care and have a major role around commissioning secondary care, providing community care services. They are central to the NHS and control 80% of the NHS budget. The 2012–13 PCT recurrent revenue allocations represent £87.5 billion. There are 58 mental health trusts in England. Primary Care Trusts are local organisations responsible for managing health services in the community (National Health Service, NHS, 2012).

Primary Health Care in Australia: Past, Present and Future

Australia, as a member state of the World Health Organization, signed up to the principles of primary health care at Alma-Ata in 1978. The Australian health system is characterised by two levels of government responsibility for policy, funding and organisation of health services. The Commonwealth Government has the major responsibility for general practice, and the state/territory governments have responsibilities for hospitals and the network of publicly funded community health services. Commonwealth and State/territory governments have set up their own arrangements for managing and supporting primary health care, and the only national set of primary care organisations is the Divisions of General Practice. Divisions of General Practice (DGP) are major players in Australian primary health care systems. The DGP was set up in the early 1990s as voluntary GP member-based and -led organisations. The aim of the organisation is to support the development of general practice in their catchment area by enhancing quality of care, improving access, encouraging integration and multidisciplinary care; focusing on prevention, early intervention and better management of

chronic diseases; and ensuring a growing consumer focus (Department of Health & Ageing, 2009).

According to Weller and Dunbar (2005), divisions of general practice have played a fundamental role in shaping Australian general practice. Divisions of general practice are relevant in the current study as they have the responsibility of engaging mental health nurses under the Mental Health Nurse Incentive Program and facilitating their operations at individual general practices. However, as part of the Government primary health care reforms of 2011, the Government is currently setting up Medicare Local Organisations (MLO), which is an equivalent of the New Zealand Government's Primary Health Organisations (PHO) and the UK's Primary Healthcare Trust (PHC).

Medicare Locals are primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps. The MLOs will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities. Medicare Locals have a number of key roles in improving primary health care services for local communities. The expectation is that MLOs will make it easier for patients to access the services they need, by linking local GPs, nursing and other health professionals, hospitals and aged care, Aboriginal and Torres Strait Islander health organisations, and maintaining up to date local service directories. The MLOs will also work closely with Local Hospital Networks to make sure that primary health care services and hospitals work well together for their patients. They will plan and support local after-hours face-to-face GP services, identify where local communities are missing out on services they might need, and coordinate services to address those gaps. They will support local primary care providers, such as GPs, practice nurses and allied health providers to adopt and meet quality standards. The MLOs will be accountable to local communities to make sure the

services are effective and of high quality. Medicare Locals will be independent organisations, and not government bodies (Department of Health & Ageing, 2010). The initial proposals to establish Medicare Locals were led by Divisions of General Practice in conjunction with key local partners. Medicare Locals will continue existing Divisions of GP activities but will expand their services to include a range of different functions. It is unfortunate that mental health care did not receive sufficient mention in how the Medicare Locals would operate. In the UK for example mental health trusts are funded by the NHS primary care trust. However, given the way the Australian primary health care reform seems to be closely following that of New Zealand and the UK, mental health care may eventually be heavily concentrated at the primary care level.

Another recommendation that arose from the external reference group for primary health care strategy established by the Government was the establishment of GP ‘Super Clinics’. The GP Super Clinics are facilities that support the delivery of integrated, multidisciplinary primary care services and the training and education of the future primary care workforce. They bring together GPs, practice nurses, visiting medical specialists and allied health professionals and other health care providers to deliver better primary health care, tailored to the needs and priorities of the local community (Commonwealth Government of Australia, 2010). No specific reference, however, was made to mental health care in the Government’s primary health care strategies.

Why Treat Mental Disorders in Primary Care?

There have been several arguments put forward as to why it is better to treat mental illness in the primary care setting. The World Health Organization (2007) identified certain rationales for integrating mental health into primary care. Due to the fact that PHC services are not associated with any specific health conditions, the perceived or associated stigma with

seeking help from specialised stand-alone services is less. Primary health care services are known to improve access to mental health services and treatment of co-morbid physical conditions by facilitating prevention and detection of mental disorders where they are appropriately resourced. In PHC, treatment is also provided closer to where the patient lives (WHO, 2007).

Cost of health care

Primary care for mental health is also said to be affordable and cost effective (WHO, 2007).

According to Lester, Glasby and Tylee (2004), patients have reported being more satisfied with their physical and mental health care being integrated in the primary health care setting.

In Australia, it has been estimated that mental health disorders result in a loss of \$2.7 billion in employee productivity and are the third largest contributor to the health burden (Hilton, Schuffman, Vecchio & Whiteford, 2010). It has been argued that a 2.5% reduction in hospitalisation – which amounts to about \$90 million savings to health costs – can be achieved by increasing efficiency in care delivery and new treatments for people with schizophrenia (Fitzgerald et al., 2007). About 1% of the Australian population or 220,000 are said to be suffering from schizophrenia. The cost of managing one patient with schizophrenia per year is about \$24,000 per episode with a minimum of one inpatient hospitalisation episode. An estimated 150,000 patients fall into the category of needing one inpatient hospitalisation per year which amounts to a direct cost of \$3.6 billion for patient care per year for this group (Fitzgerald et al., 2007). The bulk of the cost associated with providing mental health care for people with psychosis in Australia lies in inpatient hospitalisation, which accounts for 80% of such costs (Carr et al., 2003). Hence, any efforts aimed at reducing readmission, such as adequate support and treatment in general practice, which would prevent rehospitalisation, would be beneficial. One way that has been identified is adequate community follow-up for patients discharged from hospitals (Carr et al., 2003).

Stigma reduction

Mental illness has been reported as one of the most stigmatised conditions in society. People with mental illness are perceived to be dangerous and unpredictable (Corrigan & Powell, 2012). Stigma has a significant negative impact on the psychosocial functioning of people with mental illnesses, through both experienced and anticipated discrimination (Laurel & Link, 2003). Stigma has been linked to detrimental consequences such as negatively affecting the willingness of people with a mental illness to seek help (Henderson, Evans-Lacko & Thornicroft, 2013; Thornicroft, 2008).

Several measures have been identified in the literature as having the potential to reduce the stigma associated with mental illness in the society. Such measures include protest, education and contact (Couture & Penn, 2003). *Protest* is the attempt to suppress stigmatising attitudes and behaviours by directly instructing individuals not to consider or think about using negative stereotypes (Corrigan et al., 2007). The *education* strategy involves the provision of factual information to the general public about severe mental illness (Corrigan et al., 2007). The other strategy proposed in the literature is that of *contact*. The argument is that placing people in direct personal contact with the stigmatised group helps to dispel inaccurate and negative beliefs about mental illness (Corrigan et al., 2007). The situation whereby people with mental illness have their care concentrated in specialist mental health services does not provide opportunity to the public to have such contact. It has been argued that providing mental health care in a primary care setting has the potential to reduce the stigma often associated with a mental illness; this is because primary care services are not associated with any specific health condition (Lester, Glasby & Tylee, 2004).

Physical health of mental health patients

As stated earlier, another benefit that has been reported in treating mental health disorders in primary care is the improvement in physical health outcomes of mental health patients. The

poor physical health outcome for people with a severe mental illness has been well documented in the literature. It has been reported that people with schizophrenia, schizoaffective disorder and depressive disorders have a two to three times greater mortality rate compared to the general population (Brown, Miranda, Clemence & Hazel, 2010; DeHert et al., 2009). The mortality rates translate to a 13–30 year shortened life expectancy in people with a severe mental illness (DeHert et al., 2011).

Several factors have been identified as barriers to the recognition and management of physical illness in people with a severe mental illness. These factors have been grouped into patient- and illness-related factors, treatment-related, service-related, health professional-related factors (DeHert et al., 2011). One of the identified patient/illness-related factors is the fact that people with a severe mental illness do not seek adequate physical care due to the symptoms associated with their mental illness such as social isolation, cognitive impairment, suspicion or paranoia (Robson & Gray, 2007). People with a severe mental illness at times also lack social skills and experience difficulties communicating physical needs. Health risk and lifestyle factors such as poor diet, smoking, lack of exercise and unsafe sexual practices also contribute to their poor physical health outcomes (Lambert, Velakoulis & Pantelis, 2003; Robson & Gray, 2007).

Specialist mental health professionals such as psychiatrists often focus on mental health issues of the patients rather than also the physical health; there is infrequent baseline and subsequent physical examination of patients. In a study by Paton et al. (2004), the case notes of 606 inpatients with serious mental illness at two South London Trusts were reviewed to determine if weight, cholesterol and triglycerides had been measured at any point in their care. Only 113 (18%) of the patients had their weight recorded and 21 patients (3.5%) had their lipids monitored during their admission. The study, based in a large urban city, provides

no indication of the situation in more remote UK locations. There is often poor communication with patients and primary care health workers regarding physical health issues by specialist mental health professionals and also a lack of knowledge regarding physical health issues (Carson, Katz, Gao & Alegria, 2010).

Another very important factor that has been reported in the literature is the fragmentation or separation of medical and mental health system of care and lack of integrated services (Fleischhacker et al., 2008; Horvitz-Lennon, Kilbourne & Pincus, 2006). Most specialist mental health systems operate in silos; frequently, services for people with severe mental illness within specialist settings fail to fully incorporate or coordinate access to physical health care. Primary health care has been identified as a suitable place to ensure that the physical health needs of people with a severe mental illness are not neglected.

An Australian study by Hyland et al. (2003) examined the attitudes and practices of case managers working in Area Mental Health Service (AMHS) towards the physical health of people with chronic mental illness. This mixed-method study utilised focus groups and a questionnaire to seek the views of 32 case managers who were case-managing clients with a severe mental illness at an AMHS. The authors noted that a clear theme that emerged from the study was the lack of service delivery integration, which created a barrier to good physical health. The participants believed physical health issues of the clients were a shared responsibility between the patient, case manager, GP and psychiatrist. However, there was a lack of systematic process to ensure the responsibilities were translated into action. There were no processes in place to monitor and review the physical health of the clients. The authors noted that weak relationships between AMHS, GPs and hospital systems were a barrier to the provision of holistic care to the clients. This highlights the need for a liaison health worker such as a MHN to ensure seamless service delivery.

In the Australian study described in Chapter 1 that looked at the transfer of patients from Area Mental Health Service (AMHS) to GPs (CLIPP Model), 90 clients were followed up after 12 months of transfer of their care to the GP. There was a reported improvement in the physical health of about 60% of the patients transferred as a result of increased GP input. Also, the GPs reported newly diagnosed physical health issues in 20% of the transferred patients (Meadows, 1998). These patients may have otherwise not have had such illnesses detected without the input of the GPs. The focus in AMHS would often be the psychiatric symptoms the patients are presenting, and lesser attention to physical health concerns.

General Practitioners and Practice Nurses Managing Mental Health

Patients

In spite of the growing recognition of the primary care setting being a viable setting to manage people with a mental disorder, there are still certain barriers that exist. Thielke, Vannoy and Unutzer (2007) identified some of the barriers to treating mental health disorders in primary care to include: little monetary incentive for addressing and treating mental disorders, time constraints and limited follow-up availability. Others include limited capacity to provide evidence-based psychosocial treatments in primary care and limited access to mental health specialists. These barriers appear to be similar in most nations across the world with comparable primary health care systems.

Carr et al. (2004), in a quantitative study, examined the attitudes and roles of general practitioners in the treatment of schizophrenia. A cohort of 192 GPs from the Hunter Region of New South Wales (NSW), Australia was surveyed for the study. The participants noted that they had low levels of confidence in their clinical skills when it comes to providing care to people with schizophrenia. The GPs felt specialist mental health services were unhelpful in providing support when it comes to the care of patients with schizophrenia. The participants

for this study were drawn from a single geographical region (Hunter Region of NSW), which may impact its generalisation. General practitioners have expressed greater confidence in treating patients with common mental illness as opposed to those with a serious mental illness as they believe that people with a severe mental illness are too complex to care for in primary care (Fleury et al., 2012a).

Similarly, Clatney et al. (2008) surveyed 785 family physicians (FP) about the provision of care in a primary care setting. The most reported area of improvement identified by the participants when it comes to mental health care provision in primary care was access to mental health practitioners (MHP) such as psychiatrist and CMHNs. The FPs believed there was need to have an on-site or visiting MHP. The participants also stated they were interested in identifying or treating mental health problems, but considered the issue of access to specialist care as a major barrier. This is quite important as it impacts on the longer term willingness of FPs to accept patients with a mental illness and once again highlights the need to have specialist mental health professionals in primary care.

In a study by Younes et al. (2005), 180 GPs in South Yvelines area in France were asked to complete two questionnaires; one was about their opinion on their patients with mental health problems compared to other patients. The other questionnaire explored the relationship of the GPs with mental health professionals compared to other physicians. The GPs in this study had a rather negative attitude towards their patients with mental health problems. The GPs noted that patients with mental health problems required more care, more time, and more frequent consultations and were more difficult to refer to secondary services than other patients. In addition, some of the participants also regretted having so many patients with mental health problems. This poses a challenge when it comes to addressing the issue of accessible mental health care and highlights the need to provide adequate support for general

practice in looking after people with a mental illness. General practitioners have a very important role to play when it comes to the delivery of mental health care at the primary care level. If according to the findings from Younes et al. (2005) study they have these concerns, then there are still real barriers to overcome in order to achieve the aspirations of quality mental health delivery in primary care.

Similarly, Lucas et al. (2005), in a qualitative study using semi-structured interviews, examined the attitudes of 25 British GP registrars all undertaking their vocational training scheme towards caring for mental health problems in primary care. While the GPs in that study reported that they understood the psychosocial nature of mental health problems, they were not confident in the management of the disorders. The reasons given for their reluctance similar to Younes et al. (2005) included inadequate time, lack of knowledge of referral pathways and local resources, and a limited understanding of the psychology of mental health problems. The study presented the views of GP registrars who have not had much experience in dealing with mental health patients. Nevertheless, it is still concerning that they have already formed such views at this stage of their training about people with mental health problems presenting to general practice.

There have been other studies that have explored the ability of GPs to provide care to people with either serious or minor mental illness. A study by Bindman et al. (1997) involving 90 GPs and 100 of their patients examined GPs' knowledge about care needed for people with serious mental illness. The majority of the GPs (n=64) regarded their role in caring for people with severe mental illness to be limited only to physical health care and prescribing, and said it was not uncommon to find a number of patients with severe mental illness receiving their long-term antipsychotic injections from their GPs or practice nurses (Bindman et al., 1997). The GPs were reluctant or not confident in engaging in actual assessment and treatment of

mental illness. In the Bindman et al. 1997 study while there was a high satisfaction rate 62(69%) among the patients on the physical health care they received from their GPs, the same could not be said of the mental health care. Only 39 (43%) of the patients rated the service for mental health as good or excellent, while the remaining patients 57% regarded the service as poor and did not believe the GPs were offering any mental health service to them. This could impact on the health seeking behaviours of people with mental health problems presenting to primary care. The authors noted though that the reliability of the instrument used for the study was not established.

Verdoux et al. (2006) explored GPs' (n=890) knowledge of symptoms and epidemiology of schizophrenia. The study noted a disparity between academic knowledge of symptoms and the actual ability of GPs to utilise appropriate interviewing techniques to adequately explore and identify symptoms.

Similarly, Kerwick, Jones, Mann and Goldberg (1997), in a study involving 273 GPs and 120 practice nurses, noted that fewer than 35% of GPs have understanding of any continuing education relevant to primary mental health and 98% of practice nurses have no specific mental health training. This partly explains the reluctance of many GPs to 'open their doors' to clients with a severe and enduring mental illness.

Apart from their skill/knowledge base, most GP practices are reluctant to take on mental health patients due to a lack of adequate financial incentives to do so. These practices operate as a business; most of the consultations that take place are very short and time-limited, with most running back to back.

In a study by Bushnell et al. (2005), the GPs surveyed were concerned about the impact mental health consultations could have on the waiting times for other patient groups and overall work load, hence their reluctance to involve themselves fully in mental health care. In

a study also known as the MaGpie study, 78 GPs from New Zealand were randomly selected to explore their attitudes and perceptions of barriers to providing mental health care. In terms of the financial implications of mental health consultations, approximately half of the GPs (54.3%) noted that they varied their consultation fees for patients with mental health problems with some writing off charges. In certain instances, the practices set up systems to help patients who may otherwise have difficulty in payment of consultation fees, such as deferred payment, automatic payment systems. One of the participants in the study expressed the frustration of having a forced choice between seeing patients with mental health problems at his own expense or having to give less time to their problems that was appropriate. Other barriers identified by the GPs include difficulty faced in accessing specialist services for patients, and their lack of adequate training in mental health interviewing techniques, a skill mental health nurses have perfected over the years (Bushnell et al., 2005). This study gives a good insight into the difficulties that exists between balancing economic realities of running a general practice business and the duty of care that GPs have towards people with mental health problems.

The findings of Bushnell et al. (2005) with regards to workload, contradicts those of Zantinge, Verhaak, Kerssens and Bensing (2005). Zantinge et al. (2005) study involving Dutch GPs (N =142), investigated whether the attention GPs paid to their patients' with mental health problems related to their subjective and objective workload. The authors utilised a questionnaire, log of GP's time during a week and an electronic medical registration system, including all patients' contacts during the year. The study concluded that GP's attention for a patient's mental health problems is not related to their workload. However, one assumption this study made was that GPs have fixed patient lists, which is not always the case.

It is important that general practice is strengthened to meet the needs of people with a mental illness seeking help at the primary care level. Indeed, patients with common mental health problems have expressed their preference in seeing a GP in primary care setting than being treated in specialist secondary care (Lester & Gask, 2009).

It has also been suggested that practice nurses be trained in delivering psychological interventions (Plummer & Haddad, 2009). However, there has been reluctance on the part of practice nurses to embrace mental health care as part of their role due to the lack of appropriate clinical skills in the area. Lester, Tritter and Sorohan (2005) noted that practice nurses largely believed that the care of people with SMI and to some extent, people with high-prevalence disorders was too specialized for their service.

Naji et al. (2004) carried out a postal survey of 442 practice nurses (PNs) from a one-in-two random sample of Scottish general practices to determine PNs' knowledge, attitudes, training and current practice with respect to depressed patients. Naji et al. noted that 82% of the PNs felt they lacked adequate knowledge and training to work with people with depression; only one in four PNs had attended post-qualification mental health training. The PNs also rated mental health training as a lower priority than areas of physical illness. The random sampling method utilised by the study adds to its strength. The study did not explore the attitude of GPs or their willingness to allow PNs to be involved in treatment of people with depression. In McKinlay et al.'s (2011) qualitative study, 16 GPs felt uncertain and sometimes ambivalent about the involvement of practice nurses in mental health care. Some of the GP participants in the study believed that the PNs were already busy enough with primary health care activities. Others were concerned that the PNs would take too long in mental health consultations. The former suggests mental health care is still not viewed by some GPs as part of the primary health care delivery package.

Primary care nurse practitioners (NPs) have also been noted to have inadequate academic preparation to intervene effectively with patients presenting with complex mental health needs (Lumby, 2007). This leaves a gap in terms of which professional group is best suited to provide care for people with a mental illness in the primary care setting.

Nursing in Primary Health Care

During the Alma Ata International Conference of 1978, nursing was recognised as the key to facilitating improved access to first level care and thus a reduction in health inequalities amongst citizens of any nation. This would ultimately lead to the provision of health care that improves population health in a way that is cost effective. The International Council of Nurses, ICN (2008) also argues that nursing is philosophically aligned to PHC and health promotion ideals. It describes nursing practice as the very essence of primary health care due to nursing education, experience and the settings in which they work. Nurses have historically been concerned with the broader determinants of health such as education, income, gender, social environment and family dynamics. Nursing practice extends to virtually all areas where people can be found, including schools, homes, homeless shelters, workplaces, and prisons as well as hospitals and research centres. Around most countries of the world, the nursing workforce still remains the largest in the health care system (ICN, 2008). Nurses have been noted to be vital to the training and supervision of other personnel and to the planning, organisation, monitoring and evaluation of Primary Health Care services (ICN, 2008). Nurses have also been noted to be effective care coordinators for people with chronic illnesses at the primary health care level and often are more cost-effective. A systematic review carried out by Laurant et al. (2008) concluded that appropriately trained nurses could produce equally high quality care as primary care doctors and achieve health outcomes for patients that are as good.

The International Council of Nursing (ICN) definition of nursing encompasses the autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It also includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Other nursing roles identified by the ICN include advocacy, promotion of a safe environment, research, participation in shaping health policy and patient health system management, and education (ICN, 2008). When it comes to the PHC model of care, there is a need for nurses to engage, lead and coordinate care for any form of progress to eventuate. The role of nurses in policy and provision needs to be seen as legitimate and essential in all areas (ICN, 2008).

Unlike the situation in Australia where the Government established a multidisciplinary reference group to inform its implementation of a National Primary Health Strategy, the New Zealand Government set up a specific Primary Health Care Nursing Advisory Group to advise it on the implementation of their PHC Strategy. This is particularly significant given the dominance of various levels of the health system by the medical profession and its hesitation to allow the expansion of the scope of practice of nursing (AMA, 2008). The New Zealand PHC Strategy required the Ministry of Health to ‘facilitate a national approach to primary health nursing which addresses capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangement’ (Ministry of Health, 2001).

The New Zealand Primary Health Care Nursing expert group defines primary health care nurses as registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. The scope of practice encompasses population health, health

promotion, disease prevention, wellness care, first-point-of-contact care and disease management across the lifespan (Ministry of Health, 2001).

In Australia, the available research findings on the nursing role in primary health care come mainly from the domain of practice nurses. A *practice nurse* is defined as a qualified nurse who provides nursing management in the general practice setting under some form of supervision from the employing GPs (Logan Area Division of General Practice, 2002). In comparison to countries such as the United Kingdom and New Zealand, the role of Australian practice nurses in the health system has not been clearly articulated (Halcomb & Davidson, 2006).

The development of the role of practice nurses in general practice settings has been faced with various challenges. According to Halcomb et al. (2005), some of the factors that influence the development of the practice nurse role include: the national health agenda, contemporary legal requirements relating to health care delivery, economic and social concerns, professional issues, knowledge development, consumer needs and workforce supply and demand (Halcomb et al., 2005). There are limited financial benefits for general practices to employ practice nurses, due to reported limited profit margins; some general practices would rather employ receptionists, who are considered a necessity as opposed to practice nurses (Halcomb et al., 2005). The medical control and the dominance of the biomedical approach to care within a general practice setting have also been identified as limiting the development of the practice nurse role (Halcomb et al., 2004).

Patterson, Del Mar and Najman (2000) sought to determine the extent to which receptionists working in general practices are undertaking clinical tasks traditionally the domain of nursing. Their quantitative study surveyed 164 GPs with a 55% response rate (n=84) about what factors influenced their employment of practice nurses, and the role receptionists played

in their practice, amongst others. The study reported that about 60% of the GPs surveyed did not employ a practice nurse due to financial constraints and a perceived lack of need. Some personnel employed as medical receptionists in some of the practices were undertaking direct patient assessment, monitoring and therapeutic interventions, despite the fact that they were employed primarily to undertake reception and clerical duties (Patterson, Del Mar & Najman, 2000). This raises the question of whether GPs were fully aware of the role and scope of practice of nurses. It also raises the question of the value placed on the skills of nurses, given the fact that some practices employed unqualified staff to undertake nursing roles. This current study by the author responds to this gap in the literature by examining the understanding of GPs about the role of mental health nurses in primary health care setting in the context of the MHNIP.

A study by Pascoe et al. (2005) described the workforce characteristics and current responsibilities of nurses working in Australian general practice settings. In the study, a convenience sample of n=222 nurses (which included registered and enrolled nurses) were recruited and required to complete a telephone survey combining qualitative and quantitative interviews. Survey questions were developed from published and unpublished research, undertaken in Australia and internationally, on the role and educational needs of practice nurses in general practice. The study identified that general practice nurses in Australia are likely to be registered nurses who work on a part-time basis. Most of the study participants (65.9%) have some form of post basic formal education and have participated in professional development in the past two years. The also identified 32 core activities performed by the nurses, as well as other activities which were not considered core but valuable activities. The study offered valuable information about the work of Australian practice nurses in general practice. The study concluded that nurses working in general practice are apparently no longer the 'handmaiden' to the doctors; rather, they are competent professionals who perform

a vast range of clinical, administrative and organisational responsibilities within general practice. The study, however, did not seek the views of the GPs with whom the nurses were working in order to capture the opinions of other key professionals. Data triangulation is important in further strengthening the study findings.

In spite of the fact that nurses have been working in general practices in Australia for several decades (Halcomb, Patterson & Davidson, 2006), it was not until 2001, when the Australian Government launched a series of initiatives to enhance the role of practice nurses, that greater attention was paid to their valuable contribution to the health system.

Meadly, Conway and McMillan (2004), in a mixed-method study using survey and focus groups, explored the demographics and diversity of roles and functions of 44 practice nurses across 180 general practices in New South Wales. They reported a lack of uniformity in role, functions and activities of practice nurses. The respondents also identified barriers to professional development such as limited access, GP reluctance to support them, competing priorities as well as demands and unrealistic expectations of the nurse. In the same vein, Halcomb, Davidson, Daly, Yallop and Tofler (2004) reported on their national study that utilised a postal survey of 284 practice nurses to investigate the demographics, current role and potential for role expansion of Australian practice nurses in relation to chronic disease management. The study identified barriers to role expansion, including: legal implications, lack of space, belief that the current role was appropriate as well as GP attitude towards the need for role expansion for practice nurses. It also identified facilitators to role expansion that included collaboration with GPs, education and training, opportunity to deliver primary health care, positive consumer feedback as well as high job satisfaction.

There have been reported benefits to the inclusion of practice nurses in general practice. An eleven-month trial of placing nurses from a community nursing organisation into four general

practices in Western Australia to increase clinical integration and professional partnerships was carried out by Lockwood and Maguire (2000). The study reported an improvement in patient access and quality of care, increased service provision and efficiency as well as improved knowledge about each other's profession (i.e. GP and practice nurse). There was also a high level of patient and GP satisfaction, however the nurses were less satisfied which was attributed to the 'gate keeping' role of GPs.

Consumers have expressed a lack of awareness and understanding about the scope of nursing roles in general practice. Consumers have also suggested extended roles for nursing including development of care plans, providing education and support, prescribing continuing medication as well as undertaking specific treatments (Cheek, Price, Dawson, Mott, Beilby & Wilkinson, 2002; Hegney, et al., 2004). Consumers, however, raised concerns about insurance and litigations; they also did not want nurses to substitute doctors, diagnose or contribute to increased cost. There is also the expectation for nurses and GPs to work as a team and present a united front (Cheek et al., 2002).

The case of practice nurses' role development is worth considering, as their scope of practice has been largely determined by general practitioners who are also their employers. General practitioners have also had a significant influence on the amount and type of continuing education practice nurses are able to access. This has been identified as a major impediment to the development of the practice nurse role due to the degree of control the GPs exercise (Patterson, DelMar & Najman, 2000).

Mental Health Nurses in Primary Health Care

There have been significant changes in the role of community psychiatric nursing over the last four decades. The role of the CPN has evolved from handmaiden to the psychiatrist to autonomous and skilled practitioner (Wilkin, 2001). Moving from the days of being merely

depot administrators and monitors of mood (Moore, 1961 cited in Wilkin 2001), CPNs have gradually positioned themselves as major players in the delivery of mental health care. There has also been an emergence of different aspects of the CPN, namely the community mental health nurse (CMHN), the primary mental health nurse (PMHN), the elderly specialist, the assertive outreach worker and the nurse for mentally disordered offenders (Wilkin, 2001). The PMHN is said to be an enfranchised practitioner no longer held down by the hierarchies and the legislation that still limit its CPN counterpart (Wilkin, 2001).

According to Wilkin (2001), mental health nurses have a central role to play in raising the profile of mental health within primary care, as well as educating other professions involved in this level of care about mental health. Mental health nurses are well positioned as a strategic group in the fabric of primary mental health care. In their study, Poynton and Higgins (1991) surveyed 369 GPs about their involvement with long-term mentally ill patients and their attitudes towards care in the South West Thames region in the UK. The study examined the number of people with a long-term mental illness that GPs have on their lists and also their willingness to take responsibility for them. About 84% of the respondents wanted community psychiatric nurses (CPN) to act as a key worker in the care of clients with long-term mental illness, coordinating different aspects of care. Very few GPs wished to take on this role and not many felt a social worker should act in the role. The preference for a CPN stems from the perception of GPs that CPNs were better linked with specialist psychiatric services and therefore better positioned to coordinate resources and care.

A comparative study by Bruce, Watson, Teijlingen, Lawton, Watson and Palin (1999) explored the impact of the employment of a CPN by a general practice in Aberdeen, Scotland on patient health outcome and mental health workload of the practices. The CPN was employed at the fundholding due to the perceived workload resulting from the management

of patients with a severe mental illness. There was a comparison made between a fundholding that employed the dedicated CPN and another that cared for mental health patients by traditional methods i.e. community mental health team (CMHT). The comparative study concluded that this model of care resulted in smooth transfer of care from long term institutionalised care to the community setting. There was little impact on patients' health outcome scores. While the study interviewed six GPs involved in the care, it provided no insight into how the CPN worked within this model. Only one CPN was used for the study, which makes it difficult to take into account factors such as skills and experience of the CPNs.

General practice settings are highly structured and there is often a great emphasis on multiple brief consultations. This is a huge barrier to the detection and management of mental disorders in the primary health sector (Dew et al., 2005) even though the majority of people with a mental illness consult their GPs as the first point of call – hence the argument to have dedicated mental health nurses with the required skills and training to provide specialist mental health care to these clients.

Gournay and Brooking (1994) had suggested in their controlled trial study that community psychiatric nurses (CPNs) should concentrate on providing care to people with severe mental illness as opposed to minor mental illness. The study set out to test the efficacy of CPN interventions in primary health care. The controlled trial involved 117 participants with many presenting with relationship/family problems, depressive or anxiety problems. Each was randomly allocated to GP care only, immediate CPN intervention or CPN intervention delayed by a 12-week waiting list. Central to the work carried out by the CPNs was counselling. Even though the results of the trial demonstrated that the participants' mental health improved on a range of outcome measures, there was no significant difference between

the group receiving CPN care and those receiving GP-only care. The question remains though about who can effectively provide care to these groups of patients who present to general practice with a depressive or anxiety disorder. Also, how can GPs be supported if they are to continue offering care to these patients.

Gournay and Brooking (1995) also examined the economic benefits of CPNs working with people with minor mental illness in the primary care setting. They concluded that it was an 'expensive luxury'. Whilst the patients receiving care from CPNs experienced less absence from work, resulting in a net benefit, the cost per adjusted life year for intervening in this group of patients was probably several times more than for intervening with the seriously mentally ill patients.

Kendrick et al. (2006) also suggested that GPs should not refer unselected patients with minor mental illness to specialist nurses, as this was not cost-effective. Kendrick et al.'s study was a randomised controlled trial involving 98 GPs who were asked to refer a total of 247 adult patients with anxiety and depression to either usual GP care, generic mental health nurse care and nurses trained in problem-solving treatment. At the end of the study period, there was a noted improvement in patients' mean symptom scores, social functioning and quality of life for all three groups. Although patients treated by nurses were significantly more satisfied than those randomised to usual GP care, this did not enhance recovery and therefore cannot be justified on cost-effectiveness grounds. The study had a good sample population and included patients in inner-city, suburban and rural general practices across a wide area of south-central England, which enhances generalisation. The results of the study are relevant to the present study, given the fact that one of the entry criteria for consumers to access the Mental Health Nurse Incentive Program (MHNIP) is that they have a severe mental illness. However, this criterion has not been well defined.

Richards, Rafferty and Gibb (2013) examined the benefits of the inclusion of MHNs in primary care mental health teams (PCMHTs) in Greater Glasgow and Clyde. The study asked 18 MHNs and nine team leaders from 10 PCMHTs about the value of the work of MHNs in PCMHTs using an eight-item questionnaire (for MHNs) and semi-structured interview for team leaders. The sample population was assessed through convenience sampling. The skills/attributes identified by the MHNs that they utilise in their work included: assessment skills, pharmacological knowledge and understanding of the spectrum of mental health problems. These are important skills that MHNs would normally utilise in specialist mental health services. The reported benefits of having a MHN in primary care include: reduced waiting times, reduction of cost in provision of care, and comprehensive health care provision. Unlike their

GP counterparts from other studies who did not have a good understanding of the skills of MHNs, the team leaders some of whom were occupational therapists, psychologists, and psychiatrists had similar views to the nurses about what their role was. This could be partly explained by the fact that MHNs have worked closely for a long time with these professionals as part of the community mental health teams. As MHNs make their advent into primary care settings, it is possible that GPs would gain better understanding about the skills and knowledge of MHNs.

Integration of Mental Health Care in Primary Health Care

Mental health care is a central part of the work of primary care in most developed nations of the world. In the UK for example, the majority of people with serious mental illness and common mental health problems are now registered with a general practitioner and 90% of patients with all mental health problems, including up to 30–50% of people with severe mental illness are seen only in primary care (Kingsland & Williams, 2007; Kendrick, Burns

& Garland, 2000). Comparable Australian data is not available, however, the rate of mental health encounters in general practice in Australia has been increasing (Britt et al, 2010).

Soon after the process of deinstitutionalisation, general practitioners have noted an increase in their workload in regards to providing care for people with serious mental illness.

However, GPs generally lack the adequate training to deal with mental illness beyond their undergraduate training and would often require more training to improve their skills in detecting and managing mental illness (Richards et al., 2004). Integrating collaborative mental health expertise into primary care is increasingly recognized as an essential tool toward improving the quality of care in these settings (Jenkins & Strathdee, 2000).

It is economically unviable for any country, no matter how rich, to be able to provide adequate, timely and equitable mental health care to its citizens with enduring mental illness solely within the confines of its secondary/tertiary specialist institutions (Jenkins & Strathdee, 2000).

Lipkin (1999) described psychiatry and primary care as two cultures divided by a common cause. There has always existed a dichotomy between mental health and primary care delivery systems. Attention to multiple medical issues, health maintenance, and structured diagnostic procedures are standard elements of primary care that are seldom incorporated into mental health systems while a multidisciplinary approach to treatment, group care and case management are common features of mental health treatment settings rarely used in primary health care (Thielke, Vannoy & Unutzer, 2007).

In Australia, there has been a growing emphasis on the role of primary health in the provision of mental health care. It has been argued that the primary care-based system is the only system that has the potential to reach the broader population. General practice is an important setting in primary mental care, as it presents an avenue for patients with a mental

illness to present at various stages of their illness. These stages include patients with first-episode psychosis to those in early stages of relapse, as well as those living with long-term enduring mental illness (Byng, 2005). According to Thielke et al. (2007), there is strong evidence that the best outcomes for treating common mental health disorders in primary care come from a 'collaborative care approach' in which primary care and mental health providers collaborate to provide care in an organised way to manage common mental illness. It provides a framework for establishing and sustaining effective communication between primary care providers, care managers and mental health providers. The care managers (i.e. MHNs) facilitate such collaboration, and support systematic diagnosis and outcomes tracking.

According to Kendrick (2007), about 30% of patients with a severe mental illness lose contact with psychiatric services and are looked after entirely by their GPs. Due to a high prevalence of co-morbidity in patients with a severe mental illness (such as respiratory diseases, obesity, diabetes as well as the presence of side effects as a result of psychotropic medications), a well-established link with general practice is essential. Rates of diabetes have been noted to be significantly higher in populations of people with a severe mental illness compared to the general population, which has been attributed to the diabetogenic effects of newer antipsychotics such as Olanzapine and Risperidone (Bushe & Holt, 2004; Osborn, Nazareth & King, 2006).

The National Institute of Clinical Excellence (NICE) guidelines for the treatment of schizophrenia and bipolar disorder recommend regular physical checks for diabetes, blood pressure, lipids, and fasting cholesterol, as well as weight and smoking status for these categories of patients (National Institute for Clinical Excellence, 2002). However, even though community mental health teams request their clients undergo these tests, the patients

often will forget or perceive it too laborious to attend a general practice, in addition to attending their specialist psychiatric appointments.

While the valuable role that is played by the primary care setting in the delivery of mental health care is not in doubt, there are some obstacles to providing such service in an optimal way. In Australia, remuneration of GPs who play a key role in primary health care is based on a fee-for-service system, and the fee structure for Australian general practice rewards high patient throughput. Given the fact that GP income is maximised through brief consultations, there is often insufficient consultation time to provide optimal care to 'complex cases' such as a severe mental illness. Primary health care has been described as a complex and difficult environment in which to work. There is significant time as well as workload pressures on GPs with patients presenting with symptoms ranging from coughs, colds, depression and heart problems (Lester, Glasby & Tylee, 2004).

A series of Government initiatives were put in place to support the role of GPs in the management of people with mental illness at the primary care level (as discussed in chapter 1). General practice in Australia is now considered an integral part of the mental health care system; this is in contrast to the earlier view that they were a group that required access to mental health training and referral pathways (Australian Ministers, National Mental Health Plan, 2012).

For a successful implementation of care for people with severe mental illness in the primary care setting, there has to be a shift in the way care is provided. Traditionally, general practice has always worked in a reactive manner, with GPs and practice nurses often waiting for patients to come and see them. It is assumed that if a patient does not return for a follow-up appointment it means they are well and not requiring service (Kendrick, 2007). This cannot be said of patients with severe mental illness, as often the patient might be experiencing a

relapse of their symptoms such as disorganisation and inability to self-initiate attendance. Almost all mental disorders involve impairment of functioning or self-care; many patients also have a sense of futility of treatment, especially suicidal patients, which emphasises the need for the practitioner to apply more skill and time to transition patients from diagnosis to successful treatment (Thielke, Vannoy and Unutzer, 2007). Mental health nurses are well placed in this area of assertive outreach to monitor for early signs of relapse as well as investigating reasons for non-attendance.

There are currently four main working models of mental health care at the interface of primary-secondary care, all modelled on secondary care services. They include: (i) the community mental health teams that provide increased liaison and crisis intervention; (ii) shifted outpatient clinics where psychiatrists operate clinics within health centres; (iii) the attachment model where mental health workers, usually community psychiatric nurses, are designated to work with patients with mental health problems in a primary care setting; and (iv) the consultation-liaison model where primary care teams are provided with advice and skills from specialist mental health services (Bower & Sibbald, 2000; Lester, Glasby & Tylee, 2004).

The MHNIP sets the stage for expanding the domain of practice of mental health nurses and thus opening up new career pathways. It also recognises the valuable role that mental health nurses play in the delivery of mental health care in both tertiary and primary health system. A closer working relationship between GPs and mental health nurses will help provide coordinated care for people with severe mental illness and a wider reach of services (Olasoji & Maude, 2010).

Integration models in Australia

There have been studies concerning some of the models in Australia including the use of psychiatric consultation-liaison (PCL). This model, which was originally established in the UK (Creed & Marks, 1989), has been trialled in Australia.

The North West Melbourne Area Mental Health Service established the Consultation Liaison in Primary Care Psychiatry (CLIPP) service model. Under this model, case managers within the area mental health service identify potential clients who are mostly clinically stable, without recent relapse, good insight and some social support. They are then referred to a CLIPP Nurse within the service who prepares the transfer of care management to a GP. A concise summary of diagnosis, history and treatment adherence is prepared from the case notes. Impediments to transfer are identified and acted upon where possible, and the outcome of this action is recorded. The CLIPP nurse also drafts a management plan and arranges a meeting between the GP, psychiatrist and the patient, at which stage a plan of continuing management is drawn up. The GP then takes over the primary responsibility for the care of the patient (Meadows, 1998). This provides an opportunity for clients who would otherwise have been receiving continuing care from Community mental health services to be managed by GPs. However, under this model the client does not receive any form of continuing care from the care coordinator, which means the GPs still takes on most of the care responsibilities.

A similar model to CLIPP was reported by McCann and Baker (2003) in a study carried out in New South Wales, Australia. The study reported on collaboration between community mental health nurses working as part of the community mental health team (CMHT) and local general practitioners. This qualitative study utilised interviews and participant observations to collect data from 24 community mental health nurses, purposeful sampling was used to access the population. The study was taken from a larger grounded theory study about how

community mental health nurses promote wellness with clients who are experiencing an early episode of schizophrenia. The authors identified two models of nurse and general practitioner collaboration: the shared care and the specialist liaison models. In the former, the nurses maintain close contact with GPs and discuss on-going care needs of the clients throughout the episode of acute care; in the latter, the CMHT assumes responsibility for care and treatment throughout the acute episode of the illness. The study did not examine the impact of the role of the nurses nor the interventions that they provided for the clients. The views of the GPs regarding collaborative service delivery were also not reported by the authors.

Other models of collaboration reported in the literature include the shifted outpatient's model where psychiatrists, mental health nurses and allied health workers hold clinics at general practice surgeries. In the liaison-attachment model, psychiatric multidisciplinary teams work from a general practitioner surgery base. The shared or collaborative care model involves GPs and psychiatric service providers formulating an agreed management plan for clients, which specifies the roles and responsibilities of various providers. A similar model to the MHNIP currently under investigation is the primary care team model. Under this model, multidisciplinary workers are employed by a general practitioner or a Division of General Practice, with vertical links to specialist services (Keks, Altson, Sacks, Hustig & Tanaghow, 2003).

Recent Australian studies on the MHNIP

Chamberlain-Salaun, Mills and Park (2011) conducted an exploratory descriptive study using semi-structured interviews with GPs (n=7) and MHNs (n=2) working under the MHNIP. Two themes emerged from the study relating to time and space. While the GPs in the study noted the difficulty they faced in allocating sufficient time to mental health consultations, the MHNs reported they were unconstrained by time. The MHNs in this study also described some of the difficulties they encountered in having access to suitable consulting room within

the practice. The guideline for the operation of the MHNIP makes the setting of care delivery flexible; the nurses noted they could see the patients in uncontrolled spaces such as their homes and cafés. This is a welcome development, as care is delivered as close as possible to where the patient lives. This study provided no information about other aspects of the role of the MHN participants and it was only able to recruit two MHNs from two general practices. All the participants (GPs and MHNs) were from one state in Australia.

Happell, Palmer and Tennent (2011) examined the skills and attitude of mental health nurses working under the MHNIP. Similar to the Chamberlain, Mills and Park (2011) study, participants were drawn from one state of Australia (Queensland). The study was an exploratory one involving 10 MHNs working under the MHNIP. The authors did not make it clear whether all the participants worked within general practice or other settings, such as with a private psychiatrist or a community-based organisation according to the MHNIP guidelines. The authors listed attitudes exhibited by the MHNs to include; assertiveness, valuing collaboration with clients and promoting holism. Items listed under skills included; adopting independent and collaborative approaches, educating others about the role, being autonomous and self-directed as well as good listening skills. The nurses reflected on how the role was developing and identified the provision of holistic care and collaborative work with other members of the multidisciplinary team including GPs as well as providing benefits to clients. The study did not explore the views of other major stakeholders such as GPs or private psychiatrists.

Lakeman (2013) reported on an online survey of 283 MHNs working under the MHNIP. Lakeman, through consultation with a group of MHNs working under the MHNIP, developed interview questions for the study. The questions were mainly open, allowing for descriptive narrative responses. The questions asked respondents to describe how they worked within the

program, how they worked with others, what education they had received which informed their role, and what on-going support or supervision they received. The MHNs were asked to describe the main outcomes of the MHNIP. The main patient-related themes reported in the study by the MHNs included: reduced symptoms, improved community participation, improved physical health, reduced use of hospitalisation and public mental health services. Others included: improved access or better use of services, managing risk and the promotion of independent living. The other aspect of the study was the use of the Health of the Nations Outcome Scale (HoNos) data which reported a reduction in score from admission and 12 months' follow up. The survey did not explore what interventions the MHNs utilised that resulted in the identified outcomes.

Clients accessing services through the MHNIP have also reported benefits from this model of service delivery. The clients have noted that the MHNIP offers flexible, holistic and affordable care. This has been reported in the study by Happell, Palmer and Tennent (2010). The benefits for the clients are consistent with the principles of primary health care.

On their part, Meehan and Robertson (2013) conducted a descriptive exploratory study in which they sought the perceptions of 25 GPs drawn from the West Moreton District of Queensland about the role of MHNs in primary care through semi-structured interviews. The GPs reported that the role of the MHNs through the MHNIP has resulted in more support and overall confidence in managing patients with mental illness. The GPs also acknowledged the skills and expertise of the MHNs and noted that it has helped them to keep up to date with mental health treatment. A number of the GPs from that study, however, did not fully understand the role of the MHNs or what they had to offer. This highlights once again the struggles that MHNs (and nursing in general) face when it comes to articulating their unique role within a multidisciplinary team environment. The findings from this study came from

one geographical region of Australia (Queensland), which might affect its generalisation to a wider population. Nevertheless, the use of semi-structured interviews by the authors, similar to the present study, provided rich qualitative data.

The National Advisory Council on Mental Health (NACMH) undertook case studies across seven sites in Australia (Tasmania, South Australia, New South Wales, Victoria and Queensland) that were operating the MHNIP. A total of 19 MHNs were selected. The project was intended to inform the planned official evaluation of the program to be undertaken by the Department of Health and Ageing (NACMH, 2010). The key findings from the study include the fact that the MHNIP has received a wide acceptance amongst GPs, private psychiatrists, nurses, clients as well as non-governmental mental health service providers. Another significant finding relevant to this current study was the fact that the MHNIP was currently reaching a broader audience than what was described in the program guideline. One of the areas this thesis project examines is the type of clients MHNs are providing care to under the MHNIP.

Integration Models from Other Countries

Integration model in New Zealand

In 2004, the New Zealand Government requested primary health organisations (PHO) in the country to apply for funding in order to develop models of providing primary mental health care within their organisations. This was in recognition of the fact that there was a growing prevalence of mental health conditions in the New Zealand population, with projections of up to 46.6% of the population meeting the criteria for mental disorder sometime in their lives. It was also reported that 36% of people attending general practice had one or more of the three most commonly presenting mental disorders: anxiety, depression or substance use disorders. There was a need to strengthen the capacity of PHOs to cope with the increasing demand for services (Dowell et al., 2009).

The Primary Mental Health Initiatives (PMHIs) are similar to the Australian MHNIP described in this study. The initiative involves the employment of mental health staff (known as *clinical care coordinators*) or contracting of mental health services by PHOs to provide mental health care to people with mild to moderate mental health disorders (which is a different population compared to MHNIP). Even though the mental health staff involved in the initiatives could come from various disciplines, the majority were mental health nurses. A total of 26 initiatives were created. In 20 of those initiatives, the mental health care coordinator was a mental health nurse. Social workers and counsellors were engaged in the other six initiatives (Dowell et al., 2009). The MHN would normally have a small case load of more complex service users and they offered brief problem-solving therapy for some of the clients. Their role also included: needs assessment and service coordination, case management, building and strengthening networks between primary and secondary mental health services as well as advocacy for the service users. Another important role that the MHN was expected to fulfil was the mentoring of practice staff and undertaking interdisciplinary reviews. This role was not clearly highlighted in the Australian MHNIP but is quite important. The presence of a MHN in general practice has the potential to foster a greater awareness of mental health issues and knowledge sharing.

While evaluating the program, the New Zealand Ministry of Health chose not to utilise an experimental framework or methods in the design; instead, a mixed-method design was chosen, similar to what this current study adopted. Information was collected from stakeholders, clinicians and service users. The use of mixed methods according to Morse (Cited in Dowell, et al., 2009, p.27) is to obtain different but complimentary data on the same topic (an approach also adopted in this current study). It was noted that the PMHIs provided services to address the needs of service users with a wide range of symptoms and problems. Service users expressed satisfaction with the care received through the initiatives. While there

were variations across the sites, it was reported that initiatives that adopted co-location of the MHN within general practice appeared to have had more positive influence on teamwork.

The Australian MHNIP also utilises the co-location model of service delivery.

Integration models in Canada

In Canada, the Hamilton-Wentworth Ontario Health Service Organisation established a mental health program. The program involved the permanent attachment of mental health counsellors who are either psychiatric/mental health nurses or social workers, with many years of experience in general counselling or outpatient psychiatric services to primary care practices. Psychiatric consultants also visited for half a day every 1–3 weeks depending on the size of the practice and the demand (Kates, Craven, Crustolo, Nikolaou & Allen, 1997). The mental health counsellors provided care to people whom the family physician (GP) felt needed additional specialist input. Part of the role of the counsellors included making referrals to community programs and mental health services, which the family physicians found to be time-consuming (Kates et al., 1997). The program evaluation involving 87 family physicians in 35 practices by Kates et al. (1997) revealed that the program made mental health more available and accessible to the population. The evaluation also showed that there was continuity of care, additional support for family physicians and reduced utilisation of mental health services.

Haggarty et al. (2012) also examined the impact that the location of specialist mental health professionals within primary care had on wait time for services. The mental health clinical team consisted of two mental health counsellors and a psychiatrist. The authors conducted a chart review of referrals for mental health outpatient services before and after the introduction of the specialist mental health professionals. There was a noted decrease in the wait time for services; care was provided to patients in a more timely way. However, the study was within a single primary health care centre and it relied on retrospective file audit.

Also, the views of stakeholders such as the mental health professionals and GPs were not taken into consideration.

Integrated models in the United States

The American Academy of Family Physicians (2011), while recognising the increasing contact family physicians are having with patients with mental health issues, issued a position paper that outlined some of the changes they advocate in mental health care delivery. One such change was the allocation of adequate funding that would allow a system whereby specialist mental health professionals can be collocated at primary care physician offices. This is a similar measure to the Mental Health Nurse Incentive Program (MHNIP).

In the United States, increased demand for services and a dwindling numbers of providers has resulted in decreased access and satisfaction for both patients and providers. Moreover, the overwhelming majority of primary care visits are for behavioural and mental health concerns, rather than purely medical cases. There have been several integration models across different sites in the United States that are targeted primarily towards providing mental health services at the primary care level to people with high-prevalence mental health disorders (Butler et al., 2008; Brawer et al., 2010; Zivin et al., 2010; Davis et al., 2011; Vickers et al., 2013). Very few studies have examined integrated health care for people with severe mental illness (Marion, et al., 2004; McDevitt et al., 2005).

The Center for Integrated Health Care is a partnership between Thresholds (a psychosocial rehabilitation centre) and the University of Illinois College of Nursing faculty staff and students. It is a nurse-led clinic that provides mental and physical health care to people with a severe and persistent mental illness. The College of Nursing provided clinical equipment, clinical and office supplies, medications and clinical staff including family physicians (GPs) for consultation, referral and support (McDevitt et al., 2005). The program provides

psychosocial rehabilitation interventions/activities such as home visits, health promotions as well physical health assessment and treatments.

The DIAMOND (Depression Improvement Across Minnesota Offering a New Direction) project and the St. Louis Initiative for Integrated Care Excellence are some of the integrated models that exist in the United States. These initiatives, while promoting a greater degree of collaboration between primary care and specialist mental health services, are significantly different from the MHNIP. Unlike the MHNIP, mental health nurses are not the key specialist group embedded within the primary care setting.

The Minnesota DIAMOND Initiative is an evidence-based care management program that provides systematic and coordinated care for adult patients with major depression in primary care settings (Butler et al., 2008). Key care elements include assessment and monitoring, use of a registry for systematic tracking, formal stepped care protocols and relapse prevention. Nurses, medical assistants, or people with a clinical mental health background in a depression care manager role, perform the care functions, meeting weekly with a consultant psychiatrist for designated case review meetings. Specific duties of the care manager include patient education, self-management support, and coordination of care with primary care and behavioural health providers, and facilitating treatment changes identified by stepped care protocols. The care managers also facilitate communication between the mental health and primary care providers. Some care managers receive additional training to provide problem solving therapies (PST), a brief solution-focused treatment with efficacy for use in the primary care setting (Butler et al., 2008).

In 2007, the St. Louis Veterans Affairs Medical Center (VAMC) embarked on a mission to transform not only the way mental health services were provided, but also how health care as a whole was delivered to the veteran population. The St. Louis Initiative for Integrated Care

Excellence's (SLI(2)CE) goal was to provide a seamless integration of services based on a collaborative care model between mental health and primary care providers (PCPs). A total of seven psychologists were embedded within the system, with an additional nurse in a support/nonclinical role. There was evidence that the SLI(2)CE initiative had led to increased access to health care, and modified primary care practitioners' willingness to address mental health issues within the primary care setting. In addition, the study's data suggests strong support for a model of integrated-collaborative care that was previously successful (Brawer et al., 2010).

Another integrated model from the USA that involved nurses was the Northeast Clinic Coordinated Anxiety Learning and Management model (CALM). This program was developed as an evidence-based treatment for anxiety in the primary care setting. The interventions utilised by the CALM model included: medication and or brief psychotherapy for panic disorders, social phobia, post-traumatic stress disorder and generalized anxiety disorders. Therapists who were not previously experts in cognitive behavioural therapy (CBT) were trained to deliver the intervention (Vickers et al., 2013).

As part of their study, Vickers et al. (2013) carried out an evaluation on the impact of the CALM model of care. The mixed method study utilised semi-structured interviews with open-ended questions as well as rating scales to seek the views of 13 practitioners about the impact of the program. The practitioners interviewed were nurses and doctors. Data was collected before the introduction of the on-site system and repeated post the introduction of the system. The major themes that evolved from the data analysis were improved access to a greater breadth of mental health services on site in the primary care setting and better care availability for patients. The system also resulted in staff and provider satisfaction. The study however, did not examine patient satisfaction about the integrated model of care.

Integration models in the United Kingdom

Unlike Australia, community psychiatric nurses (CPNs) in the UK have been working in primary care since the early 1970s; by 1991 about 22.4% of UK's CPNs were based in general practice (Gournay & Brooking, 1994; Harker, Leopoldt & Robinson, 1976). A study by Harker, Leopoldt and Robinson (1976), which is the oldest study obtained on the link between primary care and specialist services, evaluated a scheme whereby three hospital-based community psychiatric nurses were attached to group practices to provide specialist care to people with a mental illness. The study examined the diagnosis of the patients referred to the CPN, the reasons for referral from general practitioners to CPNs, and the level of involvement CPNs had in the care of the patients. The evaluation reported a reduction in hospital referrals by practices, improved knowledge of mental health issues amongst the GP population as well as better utilisation of psychiatric medications. There was also a noted higher standard of care and treatment provided to patients. The GPs identified a considerable reduction in their workload (Harker, Leopoldt & Robinson, 1976). Even though this is a rather old study, the findings are relevant to present-day mental health care delivery and it is outstanding that this model of care is yet to be fully adopted across health care systems. The role of CPN or MHNs in a primary care setting, even in the 21st century, continues to be a subject of debate.

The NHS funded a cadre of Graduate Primary Care Mental Health Workers (PCMHWs) due to the growing concern that the demand for mental health resources continued to outstrip the supply. The NHS's long-term goal was to see primary care becoming the major arena for community mental health care as opposed to being merely gatekeepers to secondary mental health services (Strain, Hutnik, Gregory & Bowers, 2006). The role was also intended to help reduce the stigma associated with mental illness in the community. PCMHWs assist GPs in the management and treatment of patients with common mental health disorders through the

use of psychological interventions (Harkness, Bowers, Gask & Sibbald, 2005). Harkness et al. (2005) in evaluating the role of PCMHW, compared the results from survey of the first cohorts of PCMHWs (n=294) to the original policy goals and current treatment guidelines. The current study also examines the role of MHNs in light of government guidelines for the MHNIP.

Since 2008, initiatives such as Improving Access to Psychological Therapies (IAPT) have been adopted across several geographical locations in the UK as a model of mental health service delivery in primary care. The UK government initially committed £300 million for the first phase rollout of the program with an additional commitment of £400 million allocated in 2010 (Department of Health, 2012). IAPT services provide specific interventions and support for people with common mental disorders such as anxiety and depression (Currid et al., 2012; Richards & Borglin, 2011). The service delivers treatments that are recommended in the National Institute of Clinical Excellence (NICE) guidelines through its workforce of both psychological wellbeing practitioners (PWPs) and cognitive behavioural therapists (CBTs). It adopts a stepped-care model of care. The PWPs provide services to people with mild or moderate levels of distress, while the CBTs provide a more specialised service for those with more severe forms of depression and anxiety (Currid et al., 2012). Recently, the IAPT has been expanded to include access to psychological therapies for people with severe mental illness and personality disorders with the opening of a number of demonstration sites across the UK. Full evaluation of the program is yet to be carried out (Department of Health, 2012). However, there have been some pockets of evaluation in certain demonstration sites throughout the UK. These evaluations indicate that the talking therapies model can be effective in the treatment of depression and anxiety (Radhakrishnan et al., 2013). Whilst the IAPT model incorporates certain aspects of the MHNIP such as the use of talking therapies, it does not include psychosocial rehabilitations nor does it provide case

management for people with severe mental illness. Another significant difference is the fact that MHNs are not the primary care providers under the IAPT model, nor is a mental health qualification required for practitioners delivering the service (Richards, Rafferty & Gibb, 2013).

Case Management of People with Serious Mental Illness

A review of the case management model is important in the current study as mental health nurses working under the MHNIP operate as care coordinators or case managers for people living in the community, managed through the general practice setting. The program guidelines direct MHNs to link clients with available community resources as well as to provide overall coordination of their care.

During the process of deinstitutionalisation (a shifting of mental health care from hospital to community-based settings), it was recognised that many people with a serious mental illness needed some kind of coordinated approach to their care if they were to navigate their way through the fragmented array of mental health and social support services (Mueser, Bond, Drake & Resnick, 1998). In the UK, mental health services were mandated to introduce a 'Care Program Approach' (CPA) that would ensure that all people in contact with secondary mental health services received adequate follow-up and assessment and that they did not fall through the cracks of the system (Holloway & Carson, 2001). However, the CPA was based on case management developed in the USA, and has been widely criticised as being ineffective in meeting the needs of people with a severe mental illness.

Case management was seen as a model of care that could meet the on-going community follow-up needs of people with a severe mental illness. Case management has been described as the one of the most significant innovations in the delivery of mental health services since the rise of the asylums in the early 1800s (Holloway & Carson, 2001). It is said to form the

cornerstone of community care for mentally ill patients. Case management has been defined as a role of drawing together into one coherent system all services necessary to meet the needs of the service user (Rosen & Teesson, 2010). Some of the identified benefits of case management are preventing hospitalisation, improving the quality of life and functioning of the clients (Holloway & Carson, 2001). Several studies have reported on the effectiveness of case management in mental health service delivery for people with a serious mental illness (Mueser et al., 1998; Rosen & Teesson, 2010). There have been other studies that have been critical of the benefits of case management for people with a serious mental illness, suggesting it increases overall health cost (Marshall, Gray, Lockwood & Green, 2011). Overall, the literature suggests that there is evidence that case management in mental health care has the potential to reduce hospitalisation and improve the quality of life of people with a severe mental illness living in the community.

It is important to understand the activities or interventions that case management entails in the provision of service to people with a severe mental illness. The MHNIP guideline stipulates coordination of clinical services including linkage to social services as one of the key role and function of mental health nurses under the program. Further research would be needed to compare the interventions provided by clinical case managers in community mental health teams to that of MHNs under the MHNIP. However, this present study highlights activities of MHNs currently working under MHNIP.

Kudless and White (2007) examined the competencies and roles of mental health nurses working in community mental health centres. Their quantitative study utilised a survey instrument to sample 38 community mental health nurses who worked at a particular health organisation in the south-eastern United States. The mental health nurses worked as part a multidisciplinary team. The 163-item survey, which utilised Likert-type response scales,

canvassed the responses of the MHNs under two broad categories: direct care and indirect practice roles. Some of the activities reported by the respondents that they performed included case management services, such as linking clients to social services, psychosocial assessments, group, individual and family therapies. Other activities included medication monitoring and administration, conducting mental state and risk assessment, organising group programs.

In terms of how case managers allocated their time, the majority of the respondents reported spending more time in administrative duties and paperwork than in direct patient care. Of concern also was the fact that there was no allocated time for role development activities such as membership of professional organisations, attending conferences, peer supervision. Also, according to Simpson (2005), the value of the day-to-day work of community psychiatric nurses with their patients was diminished when it was restricted to the requirements of the nurses' coordinator/administrator role, a function that is given higher priority in today's health care systems.

This study offers insight into the role of community mental health nurses and how they allocate time to various activities. However, the study was conducted only within one particular health service, which might not take into account other factors that may affect the activities of the nurses.

The skills of MHNs could also be enhanced in the provision of psychosocial intervention. One of such training for skill enhancement was developed in UK. In the late 1990's, the Institute of Psychiatry in London developed the Thorn Nurse Initiative. This was a one-year training program that set out to produce specialist nurses dedicated to work with patients with schizophrenia. Training was skills-based, with a clinically focused and problem-oriented method of case management. It also involved training in contemporary psychosocial methods

including family management, cognitive-behavioural interventions with positive and negative symptoms, and prodromal and relapse strategies (Gournay, 1996).

Scope of Practice of Australian Mental Health Nurses

While analysing the development of the nurse practitioner role in Australia, Gardner and Gardner (2005) argued that there is a need to define the role within an evidence-based research framework. This, according to the authors, will allow formal evaluation and inform the development of knowledge in this area of clinical practice. They stressed that research is needed as a basis for realizing the full potential of nurse practitioners in health service delivery within Australia. In a similar vein, there is a need to situate the role of mental health nurses engaged under the Mental Health Nurse Incentive Program within a robust research context. This would help to highlight the importance and value of nursing in promoting mental wellbeing at the primary care level, as well as to provide an evidence base for future Government policy directions regarding mental health nursing roles. It will also provide a basis for a formal evaluation of the effectiveness of mental health nurses role in primary health care in Australia under the Mental Health Nurse Incentive Program.

Clinton and Hazelton (2000b), in their scoping of practice issues in the Australian mental health nursing workforce, noted certain restrictions to the scope of practice of mental health nurses, especially within health settings where there is greater multidisciplinary expertise. The authors identified, for example, that nurses with higher degrees in counselling are sometimes unable to utilise their skills – either because counselling is considered to be the domain of psychologists, or because they were saddled with other responsibilities that would not allow them to utilise such skills. In other areas such as family therapy, social workers are recognised as the ‘experts’. However, in services where there was difficulty in recruiting psychologist and social workers, there was an expectation that nurses would take up such role. Unfortunately, the advancement of mental health nursing (and indeed, nursing in

general) continues to be opportunistic whereby mental health nurses are asked to 'step up' into more advanced roles when there is a vacuum in service delivery and increasing public pressure and patient advocacy (Clinton and Hazelton, 2000b).

There has been reported dissatisfaction amongst mental health nurses, especially those working on the inpatient units about the gradual 'deskilling' of the mental health workforce and a continuous narrowing of nursing practice (Clinton & Hazelton, 2000c). According to Clinton and Hazelton (2000c), some service managers were not inclined to hire mental health nurses who have worked predominantly in large inpatient services due to the perception that those nurses may not function well in settings where more autonomous and higher standards of practice were required. It is important to distinguish, for the purpose of this current study, the various levels of mental health nursing practice that have been identified in the literature. This would help highlight what direction mental health nursing in a primary care setting ought to take.

Collaboration between Nurses and Doctors

One of the key elements of effective care delivery is appropriate collaboration between the multidisciplinary team (Richards, Bower & Gilbody, 2009). Collaborative practice issues, particularly focusing on nurse-doctor shared practice, have been the subject of discussion, debate and study for decades (Zwarenstein & Bryant, 2003; Whitecross, 1999). There are documented benefits of collaborative practice and the positive outcomes it has on patients (Hansson, Foldevi & Mattson, 2010). Martin-Rodriguez et al. (2005) claim that factors such as organizational structures and philosophy (including leadership) have an impact on the level of collaboration that could exist between nurses and doctors. The authors also noted systemic factors such as professional power, culture, and socialization as factors pertinent for successful collaboration. One of the key elements of effective delivery of care is effective collaboration amongst the multidisciplinary team (Richards, Bower & Gilbody, 2009).

There have been studies carried out to examine and measure the collaborative relationship between nurses and doctors. Jones and Way (2004) developed the Collaborative Practice Questionnaire (CPQ), a tool to measure the extent of, and satisfaction with, the collaboration between a family physician and nurse practitioner. The Collaborative Practice Questionnaire consists of two scales: the nine-item Measure of Current Collaboration Scale, and the 11-item Provider Satisfaction with Current Collaboration Scale. Secondary analysis of the nurse practitioner and physician data set was conducted by Opsteen (2007) to determine the psychometric properties of these scales and found that the scales have high internal consistency, are one-dimensional, correlate highly with one another, and demonstrate fair construct validity. This tool helped inform the section of the survey used in this current study that examined the relationship that exists between mental health nurses and general practitioners (this is further discussed in Chapter 3).

However, collaborative practice remains the exception rather than the dominant pattern within health care, especially between nurses and doctors (Keleher, 1998). This study has examined the collaborative practice that exists between mental health nurses and GPs/psychiatrists under the Australian Mental Health Nurse Incentive Program, and how this will enhance or limit the delivery of care under the program.

Stakeholder Views in Program Evaluation

While the intention of this project is not to provide a full evaluation of the Mental Health Nurse Incentive Program, it does present the opportunity to provide preliminary data on the impact of the program from the perspective of some of the key participants.

Pirkis, Headey, Burgess, Whiteford, White and Francis (2005) carried out an evaluation of the introduction by the Australian Government of new Medicare item numbers to facilitate greater collaboration between private psychiatrists and other health care providers through

case conferencing. One of the strategies of inquiry the study employed was the use of key informant perspectives (private psychiatrists) on their experiences under the program. The evaluation occurred in three stages. Stage one involved the review of Medicare records of patients who were provided service under the program. Stages two and three involved telephone interviews with 27 psychiatrists who had accessed the program. This current study also utilised key informant interviews in the first phase to identify issues, provide background and assist in the development of items for interviews and questionnaires.

Coster, Redfern, Wilson-Barnett, Evans, Peccei and Guest (2006) also conducted a study to evaluate the impact of the roles of nurse, midwife and health visitor on services and patient care across the UK. The multi-method evaluation combined focus groups, telephone interviews and a questionnaire survey of the nurses, midwives and health visitors (n=54) to explore the participants' perceived impact of their role on service and patient care. According to the authors, it is possible to consider outcomes of a role as a series of direct or indirect impacts; they adopted the use of stakeholder perspectives in which they focused on the nurses as key stakeholders.

Similarly, Woodward, Webb and Prowse (2005) in their study explored the work of nurse consultants in the UK, which at the time was a newly established role. A qualitative design was used, with in-depth interviews using a convenience sample of 10 nurse consultants. Data analysis of the interview was carried out using framework analysis; this resulted in the emergence of four major themes. These were characteristics of the post holder, role achievement, support systems and National Health Service influences.

This current study utilises a similar approach adopted by the Pirkis et al. (2005) and Coster et al. (2006) studies by using key stakeholders. It also utilises interviews and analyses data using framework analysis similar to Woodward et al. (2005).

Stakeholders are described by Koch (2000, p. 11) as ‘those who have a direct involvement with the group or setting that is to be evaluated’, and it is the claims, concerns and issues of stakeholders that serve as the organizational foci for the study (Guba & Lincoln, 1989).

Consumers, carers, area mental health services, mental health nurses, GPs and private psychiatrists are all important stakeholders under the MHNIP. However, the evaluation of consumer, carer and area mental health services perspectives and outcomes are beyond the scope of this present study. This will need to be examined in future research and as the MHNIP progresses.

Issues Pertaining to Mental Health in Primary Care in Published Work to Date: Gaps in the Literature

The way mental health care is delivered is rapidly changing across most nations of the world. There is a growing recognition of the need to drive and deliver care from the primary health care level. The role of primary health care is also changing from that of ‘gatekeeper’ of specialist mental health services to that of a viable setting where people can access mental health care. Nurses represent the largest professional group in mental health systems and have been playing a key role in this changing mental health delivery landscape.

A review of the literature reveals that while there have been early studies on trials of collaborative shared care between specialist mental health services and GPs/private psychiatrists in Australia (Meadows, 1998; Keks, Altson, Sacks, Hustig & Tanaghow, 1997), there are no reported studies on the role and scope of practice that mental health nursing plays in primary health care. While there have been trials of different models of MHNs working in primary health care in other countries, it is a relatively new concept in Australia. There are also no studies available on how mental health nursing can contribute to the delivery of care at the primary care level in Australia. The introduction of the Australian Government’s Mental Health Nurse Incentive Program created the opportunity for mental health nurses to

extend their practice into primary health care working alongside GPs and private psychiatrists. However, this initiative was established without any robust evidence-based research on how the role of mental health nurses in Australia is enacted.

While it has been documented in the literature that there exists a good correlation between patient outcomes and collaboration between nurses and doctors (Thielke, Vannoy & Unutzer, 2007), there is no Australian study that has examined the collaboration that exists or should exist between mental health nurses and primary care providers, such as GPs and private psychiatrists. The facilitators and barriers for such collaborative practice have also not been explored.

Chapter Summary

This review of the literature, which focuses on the role mental health nurses play in the delivery of care at the primary care level, has highlighted the issues pertaining to mental health care in primary care in published work to date. Most of the published work emanates from the United Kingdom, United States, New Zealand and Canada. At the time this study commenced, there was no published work on mental health nurses work in primary care setting. Since completion of the study, there have been four published articles including one by this researcher (Appendix A). The researcher also completed a book chapter in a psychiatric and mental health nursing textbook about mental health nurses working in primary health care setting, which would be a first in an Australian mental health nursing textbook (Appendix A). Unlike the Happell et al. (2010) and Chamberlain-Salaun, Mills and Park (2011) studies, this current study utilised a larger sample of MHNs and GPs, together with the use of a triangulation of methods to further strengthen the findings. The current study also included the views of key stakeholders who were involved in the set-up of the MHNIP.

CHAPTER 3

METHODS

This chapter describes the methodological approach undertaken for this three-phase mixed method, descriptive-explorative study of the role and scope of practice of Australian mental health nurses within the context of the Australian Government's Mental Health Nurse Incentive Program (MHNIP). It provides a justification for the use of a mixed-method design and offers a detailed description of each phase of the study, which are: formulation of interview scheduling, the process of instrument development, sampling method, data collection and the data analysis method utilised. It also presents the ethical considerations that were applied in the conduct of the study. Donabedian's structure, process and outcome model of quality care (Sidani & Irvine, 1999) as a framework for this study will be discussed. Donabedian's models also provide a framework for program evaluation.

The aim of this study is to describe the current role and scope of practice of Australian mental health nurses in primary health care as well as provide preliminary evaluation of the Australian Government's MHNIP which to date has not been formally evaluated by the Commonwealth Government of Australia.

Evaluating Effectiveness of Nursing Roles: Donabedian's (1980) Structure-Process-Outcome Model of Quality Care

In the face of dwindling health care resources and other competing needs facing most governments, there is a growing need to demonstrate that programs and initiatives lead to improved patient outcomes that is measurable. The escalating health care costs and the increasing consumers' demand for accountability have prompted changes in the delivery of health services (Sidani & Irvine, 1999).

The Nursing Role Effectiveness model was developed by Irvine, Sidani and McGillis (1998) to facilitate the identification and investigation of nursing-sensitive patient outcomes. It proposes specific relationships between the different roles nurses assume and the outcomes expected of nursing care, and by depicting the influence of structure on nurses' roles and outcomes.

According to Sidani and Irvine (1999), the structure consists of nurse, patient, and organizational variables that influence the processes and outcomes of care delivered. The nurse's experience, knowledge and skills are some of the nurse-related variables. Patient variables are those reflecting demographic characteristics such as age and gender, illness-related characteristics such as severity of illness; and physical and psychosocial function at the time of admission to health care. Organizational variables focus on measures of staffing patterns such as staffing mix and workload.

Process represents the independent, interdependent and dependent roles that nurses assume for delivering care. The *independent* role consists of the role functions and responsibilities for which only nurses are held accountable. These include activities initiated by professional nurses that do not require a physician's order, such as assessment, planning and implementing nurse-initiated treatments, monitoring the patient's condition, and evaluating outcome attainment (Sidani & Irvine, 1999). The *interdependent* role consists of activities that nurses perform that are partially or totally dependent on the functions of other health care providers for their accomplishment. The *dependent* role consists of the functions and responsibilities associated with carrying out medical orders. Process evaluation focuses on the program implementation process in order to analyse how things have been done and decide how they can be improved.

Outcome/impact includes nursing-sensitive patient outcomes, defined as patient states, behaviours or perceptions resulting from nursing actions. Outcome evaluations are widely used primarily to investigate how many of the planned activities of the program were carried out. However, it is becoming equally important in program evaluation that evaluations should also reveal, in more qualitative ways, the successes and problems encountered in the implementation process (Aubel, 1999). Outcomes/impact of a role can be considered as a series of direct or indirect impacts. The perspectives of key stakeholders such as care providers can be used to assess the role of health care professionals' impact on service provision and patient care. Guest et al. (2004) and Coster et al. (2006) examined the impact of the role of nurses, midwives and health visitor consultants in the UK. The evaluation utilised a multi-method approach involving interviews and survey of the health professionals rather than the patients in receipt of care (even though it was noted it would have been ideal to interview the patients as well). It was noted, however, that the practitioners were also well placed to provide an account of their work and its impact. Other studies such as Drennan, Goodman and Levenson (2004) and Abbott (2007) utilised similar methods. Drennan et al. (2004) reported on the evaluation of the primary care nurse consultants' role. The authors interviewed two chief executives, nursing directors, the nurse consultants as well as medical consultants to evaluate the role of the nurse consultants. Abbott (2007) utilised qualitative interviews with key stakeholders other than the care recipients to examine the evolution of the role of nurse consultants.

Program evaluation can be defined as a systematic way of collecting, analysing and using information to answer basic questions about programs (Reupert, McHugh, Maybery & Mitchell, 2012). It is often used to assess the appropriateness of a program's design and implementation methods in achieving specific objectives and results, both intended and

unintended, and to assess the factors impacting on these outcomes (Reupert, McHugh, Maybery & Mitchell, 2012; Trevisan, 2004).

Donabedian's structure-process-outcome model of quality care is utilised in this current study to explore what factors influenced the MHNs to take up such role, what categories of patients care is provided for (Structure), how the role of MHNs is being enacted and what barriers and facilitators impact on their role (Process) and what impact the role has on patient outcome from the perspective of the MHNs and GPs (Outcome).

Study Design

At the commencement of this study, there was no published data or research on the activities of mental health nurses working in primary health care in Australia. To date, there is a paucity of research on the subject matter. Hence, there was a need to initially obtain background information about the operation of the MHNIP at various local levels. The demographics and reasons why mental health nurses embraced this new role under the MHNIP were also unknown. According to Fowler (1995), it is essential that the design and choice of method in research reflect the core data requirements of the research questions.

A three-phase, descriptive-exploratory, mixed-method design was chosen in order to address the research questions, with each phase informing the other in a sequential manner.

Exploratory descriptive designs according to Brink and Wood (1998) are useful in answering questions about a particular population whose characteristics are unknown. A variable that may have been previously described in another population does not necessarily act or exist in a new population. Exploratory descriptive designs are most useful when there is little known about the phenomena of interest. Exploratory designs are useful in uncovering new knowledge, understanding meanings as related to particular subject matter – in this case, the role and scope of practice of Australian mental health nurses. While previous studies have

described the role and scope of practice of Australian mental health nurses across a variety of settings (Sharrock, Bryant, McNamara, & Foster, 2008; Wand & Fisher, 2006; Sands, 2004), there are no published studies about the characteristics of mental health nurses working in Australian primary health care settings in general or General Practice in particular.

Exploratory studies offer in-depth exploration and description of a single variable, process or phenomenon providing complete description and explication. They generate a great deal of useful data using triangulated methods and can generate the first stage of a planned long-term project (Brink & Wood, 1998). Exploratory designs are the method of choice in newly created programs due to the difficulties in conducting highly formal evaluations (Meadows, Singh & Grigg, 2007). For the purposes of this study, it was important to establish the background to the MHNIP and identify the barriers and facilitating factors to its up-take by GPs and MHNs.

Triangulation of Data

The researcher identified the need for both qualitative and quantitative data to adequately describe the role and scope of practice of mental health nurses under the MHNIP. The use of questionnaires and semi-structured interviews enabled the researcher to gather data by asking questions of research subjects (Fowler, 1995). Triangulation or mixed method strengthens a study by combining methods (Patton, 2002) and the use of multiple methods of data collection and sources of data according to Guba and Lincoln (1994) improves the probability that findings and interpretations will be credible. Triangulated research designs also enable the researcher to use information obtained from one data source to inform another (Breitmayer, Ayeres & Knafl, 2007). This idea has been utilised in this study by firstly conducting scoping interviews (Phase 1) of key stakeholders, which provided background information and access to policy documents and political positioning of relevant colleges involved in the establishment of the MHNIP. This phase then informed the second phase of the study, which involved interviews with MHNs and attempts to interview GPs (GP interviews were

unsuccessful). The final phase of the study (Phase 3) was informed by the results of Phase 2 and it involved the development of an instrument to obtain the views of both GPs and MHNs across Australia on issues relating to the role of MHNs in general practice. Another reason for mixing methods was to suit the large geographical distances in Australia (even within each of the states) and to engage busy GPs. The study employed both methodological and data triangulation. According to Patton (2002), methodological triangulation utilises multiple methods to study a single problem, while data triangulation draws upon variety of data sources to study a particular problem.

There are many design possibilities available in mixed methods research including sequential or concurrent designs (Creswell, 2003; Morgan, 1998). In the sequential mixed method design as proposed by Creswell (2003) and Morgan (1998), one method is used first, followed by the other: for example, Qualitative→ Quantitative (where an initial qualitative method is used followed by a quantitative method) or Quantitative → Qualitative. This study employed the former in which an initial qualitative method (phase 1 and 2 – scoping of key stakeholders and interviews) was followed by a quantitative method (phase 3 – survey design). Patton (2002) suggested mixed methods were particularly useful in evaluation research. This study also offers preliminary evaluation of the MHNIP and it examines the structure, process and outcome of the program from the stakeholder's perspective. Structural measures include the characteristics of the MHN including education, experience, role expectations, the practice setting or organisational settings such as resources and provider relationships. The process measures explore the nature of the interventions and interactions with the patients and general practitioners by the MHNs under the program. Outcomes reflect the result of the structures and processes for the individual patients, families and the society (Lucille, 2004).

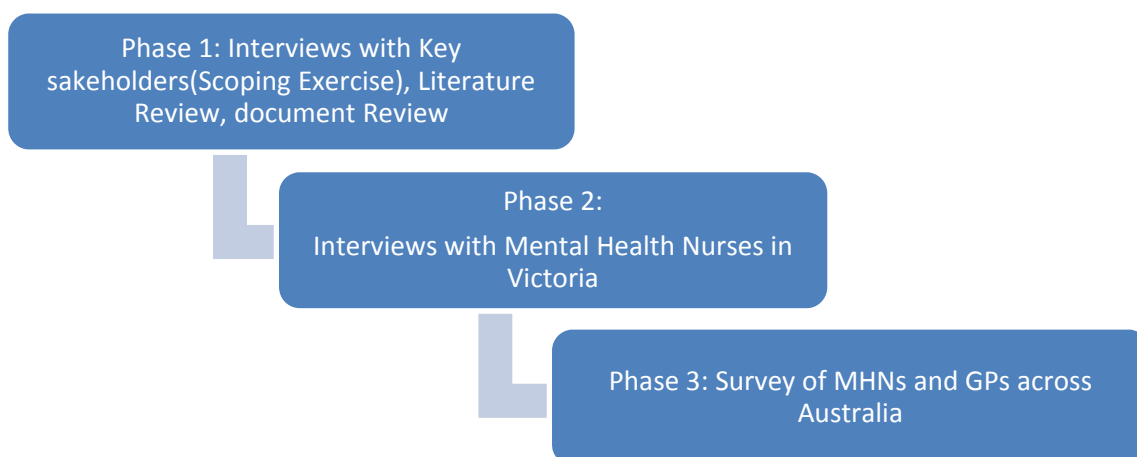


Figure 2: Overview of Study Phases

Phase 1 of the Study: Scoping Exercise

The purpose of this initial phase of the study was to gain better understanding about the key features of the MHNIP, which has enabled MHNs to work in general practice. At the time of commencing the study, there was very little known about the details of the program. There was a need to understand the drivers for the establishment of the MHNIP from the policy maker point of view; hence the researcher sought audience from the then Principal Medical Advisor (PMA, Mental Health and Workforce Division) to the Commonwealth Government in order to gain more in-depth understanding of the main reasons behind carving this new role for mental health nurses. The PMA was formerly the key adviser to the Government on how the program should be rolled out; hence, his views were highly significant to gain a better understanding of the MHNIP. The other key stakeholders identified were the Chief Executive Officer of the Australian College of Mental Health Nurses, who represented the interest of MHNs in the discussions leading up to the establishment of the program. The researcher also interviewed the President of the Royal Australian and New Zealand College of Psychiatrists

who represented the views of psychiatrists about the operations of the MHNIP. All of these individuals were engaged in a roundtable discussion with the government representatives about how the MHNIP should eventually develop. Equally important was the view of a representative of the Royal Australian College of General Practitioners (RACGP); however, there were unsuccessful attempts at interviewing any representative from the RACGP. A document review was also conducted as part of this initial scoping to inform and guide the interviews.

Prior to the interviews, the researcher developed a list of questions and prompts related to the study aims (Appendix H). The main issues that needed to be addressed were identified through the literature review and consultations with two project advisors. One of the project advisors had been the chief investigator in the national evaluation of the two previous programs established by the Australian Government (Better Access and Better Outcomes programs). She was engaged by the Australian Government to provide formal evaluation of the programs. She provided the researcher with expert advice and also identified the key Government contact who was interviewed by the researcher. The other project advisor was the previous President of the Australian College of Mental Health Nurses. He had good background knowledge about issues pertaining to MHNs scope of practice and roles as well as background information about the establishment of the MHNIP. He had also conducted a nationwide study of expanded role of community mental health nurses.

The scoping exercise provided valuable information about the key drivers for the establishment of the MHNIP and the context in which it was established. It also enabled the researcher to identify some of the key objectives that the program aimed to achieved as well as the role expected of the MHNs.

Sampling and Recruitment of Key Stakeholders in Phase 1

An e-mail (Appendix C) was sent to the PMA explaining the purpose of the study and an invitation to participate. He confirmed willingness to participate and a date and time was agreed upon for a telephone interview, which was tape-recorded with his permission. Due to the prominence and uniqueness of this role, it was not possible to conceal the identity of the participant; this was explained to him, and he consented. The interview lasted for about 30 minutes and an interview schedule was used (Appendix H). The interview schedule was sent to the PMA before the actual interview took place in order to gain richer responses.

Emails (Appendix C) were also sent to the Chief Executive Officer of the Australian College of Mental Health Nurses as well as the President of the Royal Australian and New Zealand College of Psychiatrists who both agreed to participate in the study. Both of these interviews took the same format as the interview with the PMA. Several documents cited by the key stakeholders, as well as others discovered by the researcher that related to the MHNIP, were also reviewed. These included press releases, Australian Senate deliberations (Hansard records), newspaper articles, and newsletters by various organisations of interest.

Document Review

Document review is a way of collecting data by reviewing existing documents. A range of documents relating to the Mental Health Nurse Incentive Program were reviewed. These documents included ministerial press releases, newspaper articles, stakeholder press releases and job descriptions posted by Divisions of General Practice in their advertisements. Local policies and procedures about the operation of the MHNIP were also reviewed when they were available. This review involved detailed reading of the documents and highlighting specific issues that provided further insight into the subject matter explored during the interviews. One of the aims of the document review was to determine whether the initial purpose of the program corresponded to the way the program was implemented. The initial

scoping exercise involving interviews with key stakeholders was useful in determining where to locate relevant documents concerning the MHNIP for review.

Phase 2 of the Study: Interviews with Mental Health Nurses

The purpose of the second phase of the study was to gather preliminary data from mental health nurses currently working under the MHNIP through semi structured interviews about their current role and scope of practice in general practice under the MHNIP. There was an exclusion criterion set for the MHN participation. The interviews were limited to MHNs that worked in general practice and those that worked with private psychiatrists were excluded from the study.

Sampling and recruitment for Phase 2

The establishment in July 2007 of the Australian Government MHNIP created a new cohort of mental health nurses in Australia, i.e. mental health nurses in general practice. The initiative is still in its early stages; there are no national or local bodies that specifically represent the interests of mental health nurses in general practice like those that represent practice nurses, such as the Australian Practice Nurses Association. There are pockets of groups providing *ad hoc* forums for the nurses working in this area. The Australian College of Mental Health Nurses established a Private Practice Special Interest Group in December 2007 to bring together and provide support for mental health nurses working in private practice across the country especially under the auspices of the MHNIP. The researcher attended the inaugural conference of the special interest group in February 2008 with the view to meeting mental health nurses working under the MHNIP. However, the mental health nurses at the conference were a heterogeneous group that comprised a proportion of mental nurses working in general practice, those working with private psychiatrists and those who have their own private practice in line with the guideline of the MHNIP. As stated earlier, this study set an

entry criterion to only include mental health nurses working in general practice, as general practice is often identified in health care policy as the key site for primary health.

One of the organisations trying to provide a forum for mental health nurses in general practice under the MHNIP is General Practice Victoria. The researcher contacted General Practice Victoria, which is the peak body for all Victorian Divisions of General Practice, to gain access to mental health nurses working in general practice. In Victoria, 90% of GPs are members of the 29 divisions across the state. As mentioned in Chapter One of this thesis, Divisions of General Practice support the development of general practice within their catchments areas by enhancing quality of care, improving access, encouraging integration and multidisciplinary care, focusing on prevention, early intervention and better management of chronic diseases such as mental illness (Department of Health & Ageing, 2009). General Practice Victoria (GPV) organised an inaugural forum with the aim of gathering together mental health nurses working under the MHNIP across various divisions of general practice under the MHNIP as a means of providing collegial support. The researcher attended this forum; a short presentation about the project was made and expressions of interest in the study distributed to all the mental health nurses present with the contact details of the researcher.

Potential participants who contacted the researcher were then sent the Plain Language Statement of the study (Appendix D), a consent form (Appendix G) and a date was set for the interviews. Once access to mental health nurses was established, their assistance was then sought to recruit the GPs they were working with. A total of 14 mental health nurses were recruited across six divisions of general practice in Victoria, plus two mental health nurses who are directly employed by the general practice as opposed to working through the local division. Interviews were conducted with a total of 16 mental health nurses working with GPs across various divisions of general practice in Victoria. At the time of conducting the study,

there was an approximate total of 85 mental health nurses employed under the MHNIP across Victoria. This was a convenience sample of mental health nurses that indicated their willingness to participate in the study. All of the interviews took place at the participants' workplaces and at a time that was convenient for them. The interviews lasted for between 45–60 minutes and questions were asked using a schedule of interview (Appendix I). The interviews were recorded using a digital recorder. In addition, the researcher also jotted notes of some of the responses provided by the participants. The purpose of the study was explained to the participants before the beginning of the interview and the necessary consent form was signed. The researcher made the participants aware of their right to terminate the interview at any time if they wished, and that their confidentiality would be protected through the use of de-identified data. The participants were asked questions according to the interview schedule; however, if there was a particular area they wanted to emphasise, they were given the opportunity to do so. In semi-structured interviews, the interviewer has a pre-defined set of questions; however, the interviews were conducted without following a particular or rigid manner (Polit & Beck, 2004).

With regard to the GPs, the initial plan was to conduct face-to-face or telephone interviews similar to those used for the mental health nurses. It was difficult, however, to get the time space in the GPs diary to conduct these interviews due to the busy nature of general practice. Grbich (1999) reported on the difficulty of recruiting or accessing medical practitioners for studies involving interviews. This is because they are often very busy, they distrust researchers (especially qualitative researchers) and often interviews are interrupted by other activities going on in the busy practice. The researcher was only able to facilitate one telephone interview with a GP; this was only possible because the GP came in on her day off to attend a practice meeting. In view of the intentions of the researcher to carry out a wider survey of GPs in Phase 3 of the study, it was decided to seek the views of the GPs only in

Phase 3. There was a limited sample population of GPs whom the researcher was able to include in the study, hence the decision to survey GPs in Phase 3 so as not to lose potential participants. This was a pragmatic consideration especially in light of the fact that the researcher did not have the funding to reimburse GPs for their time to participate in the study.

Semi-structured interviews with mental health nurses: Phase 2 of Study

Semi-structured interviews have been reported as a very powerful data collection method whereby the researcher asks the participant questions, or conducts an in-depth interview about a specific research topic (Nieswiadomy, 2008). In semi-structured interviews, the researcher utilises scheduled standardised interview questions for every respondent without necessarily following the same order; it provides the opportunity for re-phrasing/clarifying questions with the respondents (Polgar & Thomas, 2000). Semi-structured interviewing was chosen as the most appropriate method for this study as it enabled the researcher to ask the respondents the same set of questions while at the same time offering the flexibility to vary the order of questions and further clarify the responses provided. This approach is different from highly structured interviews in which the researcher uses the same set of questions and does not vary the wording or order of questions across the interviews (Polgar & Thomas, 2000).

The questions for the interview schedule (Appendix I) were developed using findings from the scoping exercise, findings from the literature and consultations with the project supervisors who had expertise in the area, as discussed previously. The process enabled the researcher to identify the main issues to be addressed in the interviews. The questions were refined through these 'experts' for clarity, their ability to be understood and elicit the information sought.

Phase 3 of the Study: Survey of General Practitioners and Mental Health Nurses

The purpose of the third phase of the study was to gather descriptive statistics to contribute to the overall definition of the role and scope of mental health nurses in primary health and also elicit the views/perspective of GPs working with mental health nurses. It provides information about the structure, process and outcomes of the MHNIP. The findings from Phase 1 and 2 of the study as well as other instruments available in the literature (this is further explained below under instrument design) informed the instrument design of phase 3 of the study.

Sampling and recruitment for Phase 3 of the study

In consultation with mental health nurses across the division and the researcher's supervisors it was agreed the use of surveys would be a more viable option to increase participation by GPs. Hence, a questionnaire was developed using the findings of similar studies carried out in the UK and Canada involving mental health nurses in general practice and the role of nurse practitioners in primary care (Harkness, Bower, Gask & Sibbald, 2006; IBM Business Consulting Services, 2003). The questionnaire was sent to a general practitioner who was also in academia, for validation and to consider its appropriateness for use with the GP population. It was also reviewed by the principal supervisors to ensure its validity. Another person that reviewed the questionnaire was a psychologist who worked as a statistics consultant for RMIT University. These individuals made valuable contributions to the design of the instrument. Due to the limited sample population it was not possible to conduct a pilot of the GP questionnaires.

GP recruitment for Phase 3

Participating mental health nurses were asked to identify GPs they were working with under the MHNIP. The GPs could either complete a paper-based or on-line questionnaire (the majority completed the on-line survey). A total of 125 GPs were invited to participate in the

study; in total there were 63 completed surveys, giving a response rate of 50.4%. A response rate of about 48% according to Thorpe et al. (2009) has been associated with GP/physician studies. The response rates have been reported to go higher when financial incentives are added (Barclay et al., 2002). The researchers' details with a web link were sent through the MHNs to the GPs. The option of paper-based questionnaires (Appendix E) was also provided for the GPs. Overall, 10 GPs completed the paper-based survey while the remainder completed the on-line survey. A detail of the study was provided in the cover letter sent by the researcher as well as through the e-mails.

Mental health nurses' recruitment for Phase 3

The Australian College of Mental Health Nurses (ACMHN) had set up a list of credentialed MHNs nationally. Looking through their profile as at the time of sending out the surveys, about 227 nurses indicated they were working under the MHNIP. Of this number, some of the MHNs (n=87) were working with private psychiatrists, who were not considered in this study. Of the number of MHNs working with GPs across Australia, only 128 had accessible contact details on the register. An e-mail (Appendix F) was sent to all members on the register who indicated they were working under the MHNIP. The researcher also contacted officials at ACMHN to seek permission to send generic emails to a newly created primary mental health care e-list, which consisted of most members that were available on the public register. This was done to maximise participations. Several MHNs who were working with private psychiatrists contacted the researcher to clarify the entry criteria; these potential participants were advised that the study was limited to only MHNs that were working with GPs. 128 surveys were distributed with 79 returned. Reminder e-mails were sent to the potential participants to increase participation; this had some effects, generating nine more responses, bringing a total of 88 (69% response rate). Voluntary return of the questionnaire implied

consent. Participants were also advised to contact the researcher directly to receive further details of the project should they wish.

Instrument Design

The lack of an existing instrument that examines the role and scope of practice of Australian mental health nurses working in the primary health care setting necessitated the development of a new instrument. Two questionnaires (Appendices K & L) were developed which utilised some items from previously published British questionnaires about the role of mental health nurses (MHN) and Graduate Primary Health Care Workers (GPHCW) in primary health care settings as well as researcher-designed items generated from the literature review (Gournay & Brooking, 1994; Strain, Hutnik, Gregory & Bowers, 2006). The design was also influenced by a Canadian study that evaluated the integration of primary health care nurse practitioners (NP) into Ontario's health care system. (IBM, Business Consulting Services, 2003). The instrument for both studies had undergone validity and reliability testing. The study sought the views of NPs and GPs; it examined the factors that influenced the enactment of the role of the NPs. See Table 3.1 for a full list of which study of findings influenced each item. The analysis of data from the second stage of the study also helped inform the development of the study, as the MHN participants provided useful insights into how their role was being enacted under the MHNIP. According to Tashakkori and Teddlie (1998), researchers may start with qualitative data collection and analysis on a relatively unexplored topic, using the results to design a subsequent quantitative phase of the study. The first phase of a new instrument development might involve using semi-structured interviews or focus groups to establish the issues to be addressed in a large-scale questionnaire survey. This method was adopted in the current study. This is a useful feature of methodological triangulation in that information gained from one method can be used to inform the other. Many of the items in the questionnaires were common to both questionnaires; this was to provide the opportunity for comparison to be

made between the GPs' and mental health nurses' responses. Each questionnaire elicited the following: demographic information, current work practices of mental health nurses, the respondents' views on how the role is impacting on patient care and outcome, what factors have contributed to the enhancement of the role and what factors have hindered the role enactment. The GP questionnaires also included specific questions directed to them on how the presence of a mental health nurse has impacted on their work practice and what their views were about expanded scope of practice for MHNs in the future. The questionnaires were designed to provide further insight into the role of the MHN, elicit data that would give information about the type of practice models that exist across different sites that engage MHNs. Part of the questions in the instrument used open-ended questioning; this was because it was difficult to predict the possible answers the participants would give (Pallant, 2011). For example, one such question asked the participants the reasons why they decided to work in the primary health care setting.

Table 3.1: Item generation

Item Number	Study Influence/Source
C04, C05, C06, C07, C08, C12, C13, F54, F57, F58	Primary Health Care Nurse Practitioners (NP) Survey
D17, D18, E32, E37	Graduate Primary Care Mental Health Workers Survey
All other items	Generated from analysis of Phase 1 and 2 of the study and review of the literature

Instrument Description

The MHN survey consisted of a total of 83 Items including demographic questions while the GP survey consists of 52 items including demographic questions. The demographic section of the questionnaire included questions about the participant's age, sex, location of practice, how long in practice, how long working under the MHNIP as well as academic qualifications.

Section A requested the participants (MHNs) to allocate the time they spent on various activities as well as the percentage of clients with different diagnosis that they provide care for, i.e. schizophrenia, bipolar disorder etc.. The participants were also asked to state their core activities under the program. The section also consisted of open-ended questions, asking the participants to state the reasons why they decided to work under the MHNIP for the MHNs and the reasons MHNs were engaged (for the GPs).

Section B also consisted of open-ended questions that asked both GPs and MHNs to state the impact the role of the MHN has had on the general practice and patient outcomes.

Section C (Factors impacting on the role) consisted of 12 Items for the MHNs asking to what extent certain factors impacted on the enactment of their role.

Section D (Mental healthcare provision in primary health care) consisted of 11 items that asked both GPs and MHNs about the provision of mental health care to mental health patients in primary health care.

Section E1 (Role and impact of the MHN) consisted of 12 items for both MHNs and GPs asking about how the abilities of MHNs to look after people with mental illness.

Section E2 (Scope of practice) consisted of 13 items for both MHNs and GPs. These set of questions sought the key elements of the role of the MHNs, what duties they are expected to undertake.

Section F (Collaboration between GPs and MHNs) consisted of seven items common for both GPs and MHNs exploring the nature of collaborative practice that exists between the two groups. The last Section G explored what aspects of the MHNs' role satisfied them and what aspects they were not satisfied with; it consisted of 15 Items.

Key elements of the Phase 1 and Phase 2 interviews that influenced instrument design

Analyses of data from Phases 1 and 2 of the study revealed certain issues that were further explored in the 3rd phase of the study. These issues were within the overall aim of the study. Some areas explored during the interviews that the participants did not rate as a concern were subsequently not included in the questionnaire. For example, participants were asked to state the negative impact of their role on patient outcome during the interviews (Appendix H, Question 10) but none was identified by any of the participants. This was not explored further in the questionnaire. Some of the issues raised by the key stakeholders in Phase 1 and the MHNs in Phase 2 included:

- The factors that influenced MHNs to decide to work in primary health care setting
- The impact of the role of the MHNs on patient outcome
- The core roles that the MHNs are performing in general practice
- Their relationship with the GPs

Instrument reliability

Factor analysis and Cronbach's alpha can be used to test the reliability of an instrument. In order to conduct a reliable factor analysis, the sample size needs to be big enough. The general rule of thumb is that the researcher would need 10–15 participants per item. This is not possible in the current study as the available sample population is small (Pallant 2011).

Hence, reliability testing for the instrument used in this study was carried out through SPSS version 20, which revealed good internal consistency. According to Pallant (2011), the most common indicator for internal consistency is the Cronbach's alpha coefficient. It refers to the degree that all items are equivalent and measure the same underlying construct or the degree to which all the items that make up a scale 'hang together' (Cohen & Swerdlik, 2005; Pallant,

2011). The statistic used in a Cronbach's alpha measures the correlations between items. Correlations measure how dependent two variables (items) are; that is, the score on one item should be able to predict to a certain extent the score on another item designed to measure the same attribute (Pallant, 2011). Cronbach's alpha coefficients that exceed 0.70 are considered acceptable whilst coefficients greater than 0.80 are considered high (DeVellis, 2003). The Cronbach's alpha coefficient for this instrument for the non-demographic items ranged from 0.752–0.825. The Cronbach's alpha coefficient values are presented in Table 3.2 below.

Table 3.2: Reliability Analysis of questionnaire

Sub-Scale	Item Nos	Cronbach's Alpha
Factors Impacting on role	5	0.752
Ability of MHNs to look after SMI	4	0.814
Positive aspects of the MHN role	6	0.782
Treating mental health patients in PC	3	0.780
Role of MHN in PC	7	0.814
Collaboration between GPs and MHNs	7	0.825

Instrument validity

Psychometric validation is the assessment of the agreement between hypothesised factors that make up the measures and scales designed to assess them (Pallant, 2011). According to Neuman (2006), when a researcher says an indicator is valid, it is valid for a particular purpose and definition. The same indicator may be less valid or invalid for other purposes. Neuman (2006) identified four types of validity measurement: face, content, criterion and concurrent validity.

Face validity is a judgement by the scientific community that the indicator really measures the construct, and addresses the question: Do people believe that the definition and method of

measurement fit on the face of it?" *Content validity* addresses the question: Is the full content of a definition represented in a measure? *Criterion validity* uses some standard or criterion to indicate a construct accurately. The fourth type of validity measurement is *construct validity*, which is for a measure with multiple indicators. It addresses the question: If the measure is valid, do various indicators operate in a consistent manner (Neuman, 2006)? According to Kimberlin and Winterstein (2008), because there is no statistical test to determine whether a measure adequately covers a content area or adequately represents a construct, content validity is usually achieved through the judgement of experts in the field.

The instrument design for the current study was a one-off instrument whose aim was to examine the evolving role of mental health nurses in Australian primary health care system. Face and content validity were sought during this study. Face and content validity are determined by a review of the items and not through the use of statistical analyses. An expert panel of four very experienced clinicians (mental health nurse, registered nurse, general practitioner, and psychologist/statistician) assessed the instrument for face and content validity. The experts assessed the language, grammar and readability of the questionnaire items. Following the review process/feedback mechanism, certain items were reworded and others deleted.

Pilot Testing of Survey Instruments

Following the completion of the process of reliability using Cronbach's alpha and content validation of the instrument, the surveys were entered into an online survey website known as Survey Gizmo. The population of MHNs and GPs working under the MHNIP was quite limited at the time; hence, it was not possible to do a large-scale pilot survey. Nevertheless, the survey website generated the pilot questionnaire which was sent to 10 MHNs who had at least five years of experience in mental health nursing. The MHNs were asked to provide the researcher with feedback about the questionnaire regarding the questions, ease of completion

and any unclear elements of the survey instrument. There was a general consensus amongst the participants that the survey was too easy to understand and complete. The participants also provided useful feedback about terminology and minor editorial adjustments (see Appendix L for a sample of feedback received).

Piloting is useful in helping the researcher not only with wording of questions but also with the sequence of the questions and reduction of non-response rates (Oppenheim, 1992). The individuals that participate in a pilot test are not able to participate in the actual survey by virtue of the fact that they have been exposed to the questions (Sue & Ritter, 2007).

Data Analysis Phase 1 and 2 (Qualitative data)

The interview transcripts from the semi-structured interviews were given to professional transcribers for transcription. Upon obtaining copies of the transcripts, the researcher made three copies of each transcript. One was kept in a secured locker at the university to provide a backup of data in case of an adverse event such as electronic data corruption, and back-up copies of the electronic data were also created (Sandelowski, 1994).

Graneheim and Lundham (2004) as well as Taylor-Powell and Renner (2003) identified four broad approaches to qualitative data analysis and the choice is often influenced by either a theoretical perspective or whether the researcher seeks an objective or subjective positioning in relation to the data. The four broad approaches are: *enumerative*, which is typified by content analysis of documents; *investigative*, in which the researcher probes beneath the words to uncover hidden meanings; *iterative*, which involves collection of data through observation or interview and the detection of emerging themes; and *subjective*, in which the researcher is deliberately enmeshed with either the subjects or the data.

In analysing qualitative data, there is a need to establish trustworthiness, which is a key concept in qualitative research according to Graneheim and Lundham (2004). The authors

describe the concepts of credibility, dependability, and transferability as aspects of trustworthiness that are used specifically in qualitative research. *Credibility* addresses the extent to which the data and analysis processes address the intended research focus, the choice of suitable meaning units (for example, paragraphs or sentences), and ensuring that no meaningful data is excluded and no irrelevant data is included by choosing inappropriate themes or categories. This can be addressed by using representative quotations to illustrate the themes and by seeking consensus between co-researchers.

Dependability, according to Graneheim and Lundham (2004), refers to the degree to which data change over time and the alterations made in the researcher's decisions during the analysis process. They suggest that such changes, which evolve naturally during the course of a study, can be addressed through open dialogue amongst the research team members.

Transferability is the qualitative equivalent of generalizability and it refers to the extent to which the findings may be applicable to other groups or settings. It may be facilitated through rich presentation, including illustrative quotations and clear descriptions of participants and data, and methods of data collection and analysis.

The analysis of data from this present study was achieved using a framework suggested by Ritchie and Spencer (1994), known as *framework analysis*. Framework analysis has become hugely popular as a way of conducting analysis of primary qualitative data and in particular, health care areas with policy relevance (Dixon-Woods, 2011). Although framework analysis may generate theories, its main goal is to describe and interpret what is happening in a particular setting (Ritchie & Spencer, 1994).

Framework analysis involves five key stages: familiarisation, identifying themes, identifying a thematic framework, indexing, charting and mapping and interpretation. The audio tapes of the interviews were transcribed verbatim by professional transcribers prior to analysis and the

data for each participant was analysed separately. The researcher achieved familiarisation by listening to the audio taped interviews and reading the type-written transcripts. Through this process, any errors in the process of transcription were corrected. Gaps in the transcripts were also identified and corrected. The researcher also went through notes/jottings made during each of the interviews. During this process, the researcher noted key ideas or recurring themes. The second stage of identifying the thematic framework was informed by the original research questions. The items listed in the interview schedule and emergent themes from the interview transcripts. Indexing involved systematically applying the thematic framework to all of the interview data for each participant. The charting stage involved developing an overall picture of the data by lifting them from their original context and rearranging them under thematic headings derived in the previous stage. Mapping and interpretation, which is the final stage of the framework approach, involved comparing and contrasting the data collected from each participant and searching for patterns, connections and explanations.

In order to ensure credibility was achieved, samples of the interview transcripts were independently analysed using the framework approach by the PhD candidate and the candidate's supervisors. The findings obtained were extensively discussed until consensus was achieved.

McSherry, Mudd and Campbell (2007), in their descriptive qualitative study evaluating the perceived role of the nurse consultant through the experiences of health professionals, utilised a semi-structured interview framework to undertake interviews. A thematic analysis was then used to decipher interview data which revealed nine primary themes. This current study utilised a similar approach to data collection and analysis.

Data Analysis Phase 3 (Quantitative Data)

Each completed questionnaire was assigned a unique identifying number once they were received. A data file was created using Statistical Package for Social Science (SPSS) version 20 (SPSS Inc., Chicago, IL, USA). Data was then entered directly from the questionnaires into SPSS; no calculations or reverse scores were done during this stage to minimise entry errors. The researcher was able to read the comments provided by the participants at the same time as entering the quantitative data into the database. Following data entry, descriptive data analysis was conducted using SPSS. Once the descriptive statistical analysis was completed, where necessary, scale responses were reverse scored in order to give numerical scores which corresponded to the qualitative response; that is, the greater the rate, competency, importance, or agreement, the higher the numerical score. The chi-square test (or independent samples t-test for strongly original data) was used to compare the doctors' and nurses' responses.

Time Frame

Data collection for the study occurred between June 2009 and April 2011.

Ethical Considerations

The RMIT University Ethics Committee for Human Research granted permission for the study (Appendix B) to be undertaken. The study was conducted in accordance with the National Statement on Ethical Conduct in Research Involving Humans. Letters were also written to the Chief Executive Officers of the Divisions of General Practices seeking their permission to undertake the research in their various practices. The interviews were tape-recorded; however, every reasonable effort was made to ensure confidentiality as stated in the Plain Language Statement (Appendix D) given to every participant. The names of the participants were deleted from the transcripts and replaced with pseudonyms. Due to the high-profile nature of key stakeholders interviewed in Phase 1, it was difficult to ensure anonymity.

This was explained to all the stakeholders prior to the commencement of the interviews and they agreed to have their status identified.

The protocol for data storage was also followed. Data was electronically stored and password-protected with access only to the researcher according to the ethics committee requirements.

The disposal of any material would take place after five years of storage at the School of Health Sciences, RMIT University.

Chapter Summary

This chapter has provided a description of the research design and method used for the study to answer the research questions. It has provided the sampling/recruitment strategy, the instrument development for the questionnaires as well as the interview schedule. The chapter also provided the data analysis method for all stages of the study. The chapter has also highlighted the ethical considerations for the study. The next three chapters (Chapters 4, 5 & 6) will present the findings of the study.

CHAPTER 4

SCOPING STUDY FINDINGS

This chapter presents the findings of the interviews with key stakeholders involved in the initial setting up of the MHNIP. This program formally engaged MHNs in Australian primary health care settings including general practice. Prior to the establishment of the program, no clear roles were identified for MHNs in the Primary Health Care settings of Australia's health care system. It was therefore important to examine views of key individuals involved in the establishment of the program in order to gain better understanding of the factors that influenced the program development. This is especially in view of the fact that the role and scope of practice of MHNs in Australian primary health care has changed and evolved as being able to make a significant contribution from this Government initiative.

The stakeholders interviewed included the then Principal Medical Adviser to the Australian Government, the Chief Executive Officer of the Australian College of Mental Health Nurses as well as the President of The Royal Australian and New Zealand College of Psychiatrist (RANZCP). Unsuccessful attempts were made to interview the representative of the Royal Australian College of General Practitioners (RACGP). However, some of the views of the RACGP issued through press releases and position statements are presented in the document review included in this chapter. The views of the three stakeholders were represented as follows: Principal Medical Adviser to the Commonwealth Government (PMA), the Chief Executive Officer of the Australian College of Mental Health Nurses (ACMHN) and the President of The Royal Australian and New Zealand College of Psychiatrists (RANZCP).

The chapter provides an overview of the reasons behind the establishment of the Mental Health Nurse Incentive Program which has seen an extension of the scope of practice of

MHNs into the primary health care setting; it also examines the expected outcomes of the MHNIP from the point of view of the stakeholders. The chapter also discusses additional factors which were considered during the establishment of the program.

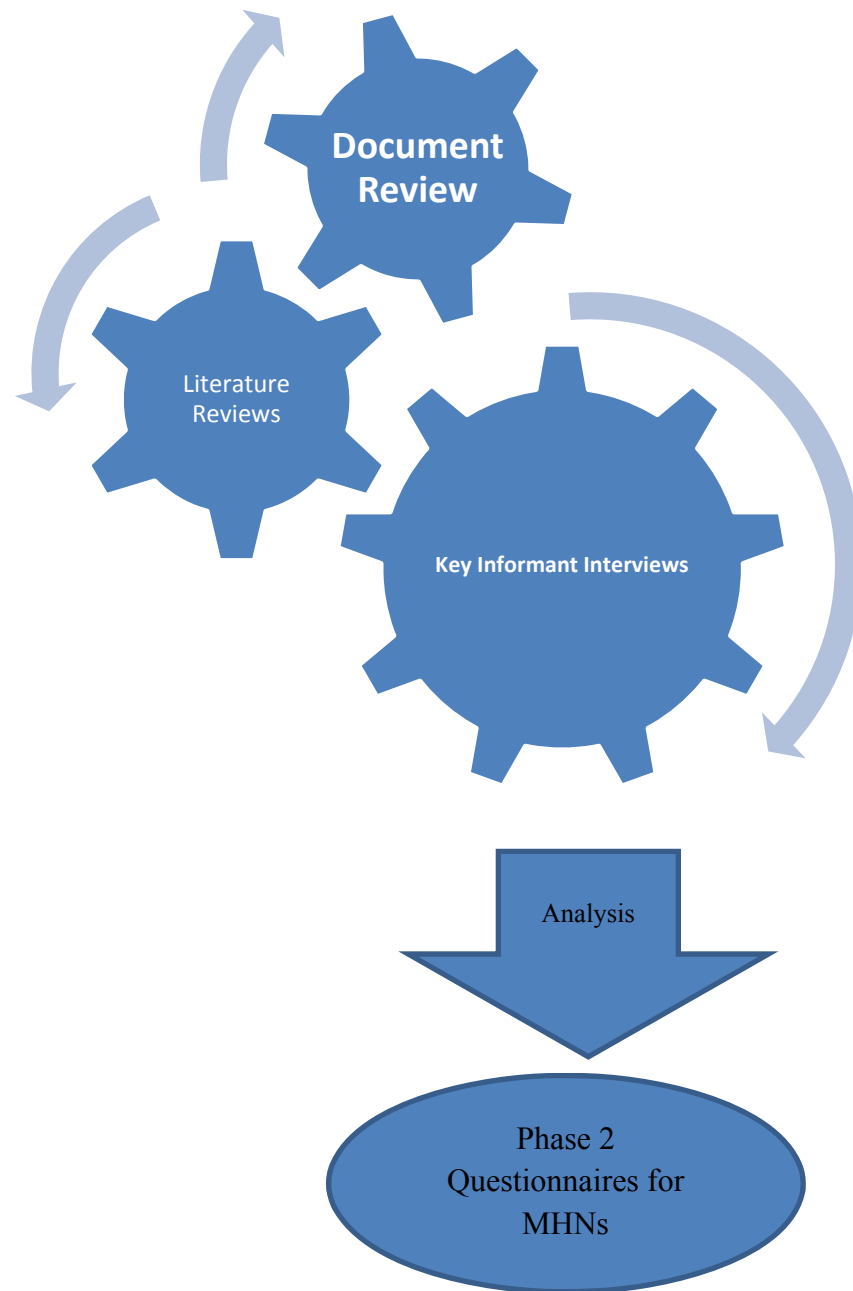


Figure 3: Phase 1 design

Stakeholders' Involvements

Each stakeholder was asked to explain their role and level of involvement at the time of the establishment of the MHNIP. These individuals represented the key professional bodies that provide mental health care in Australia as well as a government adviser who informs the Commonwealth Government on key policy issues affecting mental health care. Each of the stakeholders had a significant role in the delivery of mental health care in Australia and their comments represented those of the members of the professional bodies that they each represent. Mental Health Nurses have traditionally worked closely with the Psychiatrist in multidisciplinary teams in acute hospitals and community mental health teams and, to varying degrees, in private mental health hospitals. Hence the views of the College President of the RANZCP were important in trying to understand how the guidelines around the MHNIP evolved. In addition to working with GPs (see background Chapter One. Under the MHNIP, Psychiatrists are also able to engage the services of MHNs to provide care to people with a severe mental illness. It was important to interview the Commonwealth Government advisor who was involved in the crafting of the program before the consultations with key professional groups occurred. Finally, the Chief Executive Officer of the Australian College of Mental Nurses represented the views of the mental health nurses during the consultations. Each of the participants summarised their involvement as follows:

I'm talking in my role as Specialist Medical Advisor with the Royal Australian and New Zealand College of psychiatrist and at the time of all of this going on, I was on the Executive of the College as the President (RANZCP).

At the time of establishing the Mental Health Nurse Incentive I was representing the Australian College of Mental Health Nursing in my capacity as the Chief Executive Officer (ACMHN).

I speak in my capacity as the Principal Medical Adviser to the Commonwealth Government of Australia in Mental Health & member of the National Health Committee and I was involved in the set-up of the program as an advisor to the commonwealth (PMA #1).

Establishing a Reference Group on Mental Health Issues

According to the participants, the Commonwealth Government had set up a reference group consisting of the key professional groups involved in the delivery of mental health care at the primary care level as part of the initial implementation of the MHNIP. Workforce issues were identified as a major area that needed to be addressed in order to increase capacity and accessibility of mental health care for consumers at the primary care level. There was a recognised need to restructure the workforce to meet the needs of the consumers in a timely and accessible manner. In order to achieve this, all parties involved had to agree on how best to target or restructure the workforce distribution.

The Government set up an expert reference group which included the colleges and the Department of Health and Ageing. They had already developed the guidelines and how they saw the program working. Then we basically just continued to tweak, I suppose, what it was they had in terms of the guidelines in relation to it (ACMHN).

But that was our thinking, that we would work out what our areas of common interest were, and try and lobby government, and we decided that workforce issues, which meant a workforce who met an adequate number, but also, of mental health professionals, as well as adequately trained and adequately distributed, not just a number, it was training and distribution (RANZCP).

All the stakeholders interviewed had input to some extent in the initial set up of the program; however, there were reservations from one of the stakeholders about the level of consultation.

Participant ACMHN was of the view that the nurses were called in after the program guidelines had been established but the ACMHN had some input in the final details.

We just continued to give our input into how that would look and what some of the words were in relation to it and what we thought was a reasonable period of time for this and what were the entry points and the exit points to the program. So, the college did not make any submissions prior to the establishment of the program (ACMHN).

There was a series of events that also led to the establishment of the program from the Government's point of view. These included consumer and carer advocacy to increase capacity of primary health care providers to ensure people with mental illness were not missing out on care. Also, the Australian Select Senate Committee on Mental Health identified access to specialist mental health care in the primary health care setting as problematic (Senate Select Committee on Mental Health, 2006). Following deliberation, the committee came up with a series of recommendations, one of which was for the Commonwealth to establish new direct Medicare recurrent funded arrangements for employed or contracted mental health staff (such as psychiatric nurses) to enhance the provision of care in primary care settings.

There was limited support for people receiving care from their GP and private psychiatrist. Consumer and carer groups were also advocating for the establishment of such a system to cater for the need of clients in this category. The Mental Health Council of Australia's 'Not for Service Report' as well as the findings of the Senate Select Committee on mental health added to the need for establishing the program (PMA).

The program was setup to cater for the need of people with a severe and persistent mental illness, this is not limited to disorders such as schizophrenia and it can also apply to high prevalence disorders depending on the impact it has on the patient (PMA).

Evidence-Based Research and Program Establishment

During the establishment of the Mental Health Nurse Incentive Program, there was no reference to similar models of care from other countries such as the United Kingdom, which had implemented a similar program as alluded to in Chapter Two of this study. Hanney, Gonzalez-Block, Buxton and Kogan (2003) argued that research-informed policies would lead to better outcomes as research exposes policy-making to a wider range of validated concepts and experiences than those drawn from the normal time-limited and politically constrained process. Also, Whiteford (2005) noted that evaluating approaches used by others to solve similar problems might facilitate the generation of credible options in policy development. The MHNIP, according to one of the stakeholders, was born out of ‘political expediency’ as opposed to the utilisation of evidence-based research. Other stakeholders noted demand by various interest groups advocating for better access to mental health care for people suffering from a mental illness and best available practical measure as reasons for the program establishment. The stakeholders also noted that they did not examine similar types of programs running in other countries, nor was there a benchmark established at the outset of the program for evaluation.

There was no real influence from any similar program overseas on the establishment of the program; rather it was guided by a move towards the best available clinical practice (PMA).

‘Did we look at the UK and do research? No’, there was need for political expediency, there was money on the table and we all wanted to get this done and dusted, there was no evidence based research from overseas that was influencing the set-up of the program, because when the Prime Minister decides something’s going to happen and put money on it people don’t stop and say ‘Is that a good idea, where’s the research?’, one has to be somewhat opportunistic and say ‘We’ll make the best of it that we can and we’ll sort it out a bit later on, if we have to’ (RANZCP).

While Hanney et al. (2003) admitted that evidence-based policy may be difficult to achieve at times, it is nevertheless a necessary step if the final outcomes of health, health equity, and social and economic gain are to be achieved. As stated above, policy-making based on research output can help identify pitfalls to avoid during the implementation of programs. In the case of the MHNIP, findings from studies carried out in the UK on a similar type of program had identified that due to lack of proper coordination and firm guidelines, there were cases of community psychiatric nurses based in primary care becoming isolated from mental health teams and who had taken on patients with minor disorders from general practitioners at the expense of patients with severe mental illness (Kendrick et al., 1993). A critique of UK policy by Gournay and Brooking (1994) suggested that by not focusing on having mental health nurses working with people who have serious mental illness, a misdirection of resources occurred. Kendrick et al.'s (2006) randomised control trials concluded that GPs should not refer unselected patients with common mental disorders to specialist mental health nurses.

Even though the guidelines set out by the Australian Government for the operation of the MHNIP stated that the program was designed for patients with a severe mental illness, there was no clear direction from the program guideline as to what constitutes these categories of patients or what GPs are to do with patients presenting with a common or highly prevalent mental disorder. The economic impact of having MHNs provide, as part of their role, care for people with high-prevalence disorder under the MHNIP would need to be further explored in light of the fact that studies from the United Kingdom identified no real economic benefits. In fact, the UK National Health Service (NHS) moved to a system of recruiting graduate primary care mental health workers to provide counselling and other therapy to patients with high-prevalence disorders, while community psychiatric nurses focused on people with serious mental illness (Bower, 2002; Farrand, Duncan & Byng, 2007). Exploring the economic

impact of MHNs providing service to people with high-prevalence disorders is beyond the scope of this current study.

The Need to Enhance Accessibility

According to the stakeholders there was a recognised need that general practitioners, who are the first point of call for people seeking help for mental health related issues, needed assistance to deliver quality and affordable mental health care. General practice operates on a business model and consultations are often quite time-limited, based on an economic model to ensure general practice establishments are financially viable. This is particularly a problem for mental health clients who often require longer consultation time due to the nature of their sometimes-complex psychosocial issues, which GPs are often not well equipped to address (Verdoux et al., 2006). This view was expressed by all the stakeholders and encapsulated in the following comments by Stakeholder ACMHN:

Another driving force behind setting up the program was the fact that general practitioners, in essence their consultation time with people is somewhere between 5 minutes to 15 minutes and 20 minutes if it's complex, but people with a mental illness obviously require a longer intervention with a practitioner. You can't address the needs of a person with a complex mental health problem in five minutes (ACMHN).

There was also a sense that public mental health systems had limited capacity to cater for the needs of all individuals with a severe mental illness, and access to care for consumers was still problematic. Consumers are often deemed to be not 'sick enough' to access services due to limited ability of the system to cope. Health funding over the years has not caught up with the increasing demands for services. Of particular note are the effects of the process of deinstitutionalisation, a process that saw the closure of large psychiatric institutions, resulting in the setting up of community mental health teams to cater for the needs of people with

severe mental illness. However, rhetoric about people being transitioned into the community was not matched with appropriate levels of funding. Most of the community mental health teams continued to struggle over the years with increased case loads, often resulting in increased staff turnover and the incidence of clinician burnout, especially for community mental health nurses whose caseloads often have a greater proportion of consumers with complex care needs. According to Doessel, Scheurer, Chant and Whiteford (2005), there was little evidence suggesting that resources followed patients into the community following the process of deinstitutionalisation.

The program was set-up as a result of the deficiencies identified in the system related to mental health services for people with a severe mental illness, limited options available for certain consumers within the system and the limited capacity of public acute mental health services to cope with the provision of care (PMA).

Back when they closed a lot of the large institutions in relation to mental health care there was a lack of services provided at that time in the community for people with mental illness. One of the groups of people that continued to fall through the gaps in terms of service provision were those with, as they deem it, serious or complex mental illness. They did need to set up a process in the community whereby outside the community health teams that were already stretched with massive caseloads how they were going to - the Commonwealth was going to provide some support in terms of provision of care to people with mental illness. So they looked at this program, to provide services (ACMHN).

Workforce Issues/Concerns

There were concerns expressed by the stakeholders during the establishment of the MHNIP. The main concern was the lack of experienced mental health nurses to take on the role. There was also a sense of fear that the MHNIP had the potential to ‘bleed’ the public mental health

system of experienced mental health nurses, especially if the remuneration and opportunities were attractive enough. This last point seems to have influenced the funding arrangement of the program. This view came across from the stakeholder interviewed:

The Government had a dilemma, on the one hand they had to pay enough so that people (MHN) would want to use this initiative, but on the other hand their concern was about the State Government and that people would leave the public sector, which of course they didn't want to happen, and the Liberal Commonwealth Government didn't want to be accused of damaging a predominantly Labour State Government public sector (RANZCP).

Some of the challenges during the formulation of the program include: the ability to get the right type of mental health nurse to work in this role, the ability to get enough nurses who are credentialed to take up this role. The suggestions that this type of program will suck up/bleed nurses out of the public health system, however anecdotal evidence suggest that some nurses like the mix of public/private work. For the nurses the challenge is the ability to access adequate level of support compared to working within a public community mental team structure (PMA).

Stakeholder ACMHN stated there was a need to ensure the employment arrangement was right for the MHNs going into the program and reflected the need to define the employment status of the nurses in such a way that they would be seen as independent practitioners as opposed to employees of general practitioners or psychiatrists; hence the term 'engaging mental health nurses' which was used in the program guidelines.

One of the things, when we started was that they stated that the nurses had to be employed by the psychiatrist or GP but we strongly advocated for the fact that they could be engaged. So, that was one thing that we did in relation to setting up the guidelines (ACMHN).

The College of Mental Health Nurses strongly argued that there were many mental health nurses, and that there was capacity, if there was a proper financial structure, that the workforce would be available. That's what they said in a convincing way, and XXX and I still have a chuckle over that from time to time because it didn't happen (RANZCP).

Another concern was whether adequate supervision support would be available to MHNs in light of the fact that they would be working in a relatively isolated setting compared to the team structure that exists within public community clinics. Mental health nurses extending their scope of practice into general practice thus provided opportunity as well as a need to work in a more somewhat autonomous capacity.

Availability of adequate supervision and support for the nurses was also of concern (PMA).

The issue of adequate supervision was also raised by mental health nurses during the interviews with them. This is discussed further in Chapter Five of this study.

Funding Arrangements

Stakeholder ACMHN had raised concerns during the establishment of the program about the funding arrangement put in place, and would like to see a restructuring of the program such that mental health nurses were the eligible organisations under the MHNIP; this would mean even more flexibility. Under the current system, GPs are recognised as the eligible organisations; hence the funding for the program is paid directly to the GP to engage the services of a MHN. This means that the MHN takes referrals from a limited number of GPs. The maximum number of sessions a mental health nurse can take up under the program is 10 per week. The maximum number of referrals is also 10, and this is supported by the following statements:

I think one of the impediments to the program is the fact that nurses currently are not able to be eligible organisations. The reason I say that is because a lot of times the feedback I get from nurses working with particular individual GPs, is that they'd be very happy to have a nurse, but they actually don't want to administer the program (ACMHN).

So I remember that we all lobbied to say that there needs to be a model to get right what is the costing model with the Government so it was very hard to work out the right funding model, and the Government were just adamant it would not be fee for service. So the GP or the psychiatrist had to sign up to the program, the Commonwealth decided to benchmark it against community mental health clinics in Canberra, that's how they did their costing, what it cost to employ a MHN in Canberra; that was silly (RANZCP).

I remember that we all lobbied to say that there needs to be a proper model of funding. The government had a dilemma, on the one hand they had to pay enough so that they could attract the right people to work under this initiative, but on the other hand their concern was (and that of the State Government) people would leave the public sector, which of course they didn't want to happen, and the Commonwealth didn't want to be accused of damaging the public sector (RANZCP).

Most of the mental health nurse participants interviewed for this study also commented on the current funding arrangement of the MHNIP and their views will be presented in the next chapter of this study.

Expected Outcomes

The stakeholders were asked what the expected outcomes were for the MHNIP. According to the stakeholders, it was expected that the MHNIP would improve access to mental health care; ease the burden faced by general practitioners in the provision of mental health care; as

well as reduce the rate of hospital admission amongst consumers of mental health services. General practice still remains the initial point of contact for people seeking mental health care, and mental health consultations continue to increase in general practice. In 2009–10, an estimated 11.4% of GP encounters were mental health-related and there has been an annual average increase of 5.7% (AIHW, 2010). General practitioners also had very limited interventions they could provide to people with severe mental illness who often require referrals to other agencies to assist with complex social issues resulting from their illness. The BEACH (Bettering the Evaluation and Care of Health) 2009–10 survey of general practice activity rated medication prescription as the most common form of intervention provided by GPs to mental health-related presentations (Britt et al., 2010).

It was the aim of the program that the right clientele access the program that such clients receive coordinated care to ensure they avoid unnecessary hospital admissions. It was also hoped that the program would reduce the work load on private psychiatrists and GPs. Also that the consumers would report a service that is more beneficial with quicker access (PMA).

There were expectations that general practices engaging the services of a mental health nurse could somewhat replicate the model of care in community mental health clinics through the provision of case management to consumers with a severe mental illness. The case manager is often a resource person that coordinates the care of the individual receiving it. Also, because these individuals often have complex care needs, it was virtually impossible for GPs and psychiatrists to provide such care to them without the assistance of specialist mental health nurses.

The thinking was that both psychiatrists and GP's could do more with a funding model that allowed something like a community clinic with case managers, and that would allow to move more to a consultation model and see more people. Okay so it was to allow increased access

to specialist mental health assessments, increase capacity for the private sector to manage people, or people with a higher level of severity to be treated in a private sector. So the general inking was, people who were very sick will go to the public health system (RANZCP).

Flexible Service Delivery

The flexibility that the role of the MHN brings into care delivery was identified as a major benefit. Referral to a MHN means there is increased accessibility to mental health care for the patients within a primary care model. Under the current system of community-based mental health care, people with a severe mental illness are required to live within certain catchment areas to access public health services located within their catchments. Sometimes the difference could literally be a matter of streets apart; if the patient were to move, he or she would need to be referred to a different service. The introduction of the MHNIP has brought a more flexible approach to care and basically the patient is able to stay with the same GP or MHN regardless of where they lived. The overarching principle of primary health care delivery is to bring health care as closely as possible to where an individual lives. For a long time, access to specialist mental health service has lain in the domain of the tertiary health care system. The MHNIP offers an opportunity for individuals to be able to access specialist services in general practices. The other aspect of the delivery mode that is beneficial to the patient is the ability to choose their own GP who has engaged the services of a MHN. This is empowering for the patient and goes to the heart of improving collaborative care delivery with patients. However, with the current up-take of the program currently being in its infancy, not all GPs are engaging a MHN. One of the stakeholders commented on the increased options available to people with a mental illness receiving care in general practice:

It gives the patients more treatment options in that they have the option of having their medical mental health care choice, they can choose which GP or psychiatrist they see, whereas at a public community mental health clinics they don't (PMA).

This was further corroborated by another stakeholder:

Access to specific mental health treatment is currently determined based on where an individual lives, hence if a person relocates to a different geographical location they would have to transfer their care to the Area Mental Health Service that covers the new area. Under the MNHIP there is continuity of care and the patient is able to continue with the same GP regardless of their geographical location (RANZCP).

The above view is supported by Jenkins and Strathdee (2000), who noted that an important reason for integration of mental health with primary care was that general practitioners are well placed to provide long-term follow-up and support without frequent changes of personnel.

It has been noted that multidisciplinary primary health care teams are becoming more or less an integral part of the general practice landscape. This has benefits for population health by improving chronic disease management, promoting a preventative health approach as well as addressing workforce shortages (Yates, Well & Carnell, 2007). There is a growing body of evidence-based research about the physical health issues faced by people with a severe mental illness and a variety of factors play a role in individuals with a mental illness having poor physical health outcomes. Mental health nurses working in collaboration with GPs are well placed to improve the physical health outcomes of consumers with a severe mental illness. According to Yates, Well and Carnell (2007), an integrated care approach is a good way of meeting the physical health care needs of consumers with a severe mental illness. The presence of mental health nurses in general practice under the MHNIP was identified by the

stakeholders as an effective way of fostering the integrated care approach within service delivery.

One of the key benefits of this program is that it enables consumers to have access to a 'one stop shop' where they get not only their physical health care needs addressed but also have access to specialist mental health care (PMA).

Looking into the future, the stakeholders would like to see a greater role for mental health nurses; however, from the policy maker's point of view, there were no plans at the setting up of the program to extend the MHN role under the MHNIP to a nurse practitioner type of role.

The scope of practice of mental health nurses under the MHNIP was designed to fit with the current scope of practice mental health nurses working in community mental health clinics currently operate under. There was no immediate push towards expanding this role to a nurse practitioner type of role (PMA).

This offers a good career path for people that have got a good level of autonomy and independence in their practice and are skilled mental health nurses. They can move on to this new world in primary healthcare and feel that they're making a big difference. So I think there are some real benefits to the program, not only to the consumers but also to the mental health nurses and the profession in itself (ACMHN).

The work itself is interesting and rewarding, but the structure around it, where it's all heading onto the future, is pretty unclear (RANZCP).

Future Role for Mental Health Nurses

The stakeholders agreed that mental health nurses were a valuable addition to general practice and had a significant role to play in the overall delivery of mental health care at the primary

care level. It was clear that even though the MHN role was valuable, it was not well understood by other mental health professionals such as GPs and allied health.

I believe mental health nurses have a huge role to play in mental health care at the primary care level; however there is a need for MHN to articulate itself more clearly in terms of what their unique roles are (PMA).

This view was echoed by participant ACMHN, who noted that during the discussion phase of the setting up of the MHNIP, there was a need to reiterate what MHNs are able to uniquely contribute to mental health care, as opposed to other professional groups such as psychologists.

Probably earlier on some of the challenges were probably people trying to define the difference between what a mental health nurse could bring to service provision, as opposed to a psychologist, and whether psychologists felt threatened by nurses coming into that primary healthcare space was probably something more than any of the GPs or psychiatrists had a problem with (ACMHN).

I still think this is a good model. I think the idea of having included nurses in the private sector is good. My personal view is that we do better work in collaboration, we see more patients and we provide more services by having a team. I believe mental health nurses have a valuable contribution to make in the delivering of health care in the primary care sector (RANZCP).

Document Review Incorporating the Views of the RACGP

During the interviews with the stakeholders, they were asked if there were any significant policy documents that the researcher could access in order to gain a better understanding of the set-up of the MHNIP. The only publicly available document then was the report of the

Senate Select Committee on Mental Health (Senate Select Committee on Mental Health, 2006). The senate report arose out of an inquiry instigated by the then Australian Democrat political party (ADP). The researcher then accessed newsletters, advertisements and press releases that related to the MHNIP. These grey literature, were assessed for relevance to the study, information and opinions of key stakeholders about the MHNIP. The main themes identified are summarised below.

The need for a new approach

The ADP criticised the lack of commitment from the Government to moving from hospital-based acute care to prevention and strategic early intervention delivered through multidisciplinary, community-based care and general practice settings (Australian Democrats, 2007). The ADP recognised the role played by nurses at the primary care level and had called for their inclusion in the redesigning of mental health care delivery.

We remain convinced that community based, primary mental health centres staffed by skilled multidisciplinary teams would improve expertise and responsiveness to immediate needs (ADP, 2007, para. 4).

The Australian Senate Select Committee on Mental Health Report (2006), previously discussed in the first chapter of this study, made recommendations which include the strengthening of mental health delivery through the primary care level.

In spite of this call, it took some time before the Government of the day established the MHNIP.

Potential benefits of the MHNIP

Even though it was not possible to interview a representative of the professional body representing general practitioners, a number of press releases and position statements were issued by the Australian Medical Association and the Royal Australian College of General

Practitioners (RACGP). The RACGP believes the MHNIP would improve patient care through collaborative practice with MHNs. The college encouraged its members to utilise the services of MHNs in improving the care given to their patients with a mental illness.

‘This exciting program gives patients with severe mental disorders access to clinical care during periods of significant disability, delivered in the community setting by an experienced mental health nurse who works collaboratively with the general practitioner’ (RACGP, Mental Health Review, 2008).

‘Patients can now receive case management services through their GPs without resorting to the public mental health services’ (RACGP, 2008).

The RACGP also believes the MHNIP has the potential to reduce the overall workload of GPs and other practice staff while increasing capacity of the general practice to coordinate care to people with a severe mental illness. Similar views through media releases were also expressed by the then Parliamentary Secretary to the Minister for Health and Ageing, Senator Mason at the time of announcing the commencement of the MHNIP.

‘General Practices that engage or retain a mental health nurse under the MHNIP will have increased capacity to directly provide and coordinate services for people with severe disorders in the community and services provided by the mental health nurse may also reduce workloads for GPs and other practice staff’ (RACGP, 2008).

In addition, the program will take pressure off privately practising GPs. It will allow them to spend time on more complex care (Mason, 2007, para.3).

The workload issues were further examined in the third phase of this study through the survey of GPs across Australia.

The RACGP also sees a number of benefits for the patients that access the MHNIP. There are benefits around access, comprehensive and coordinated care.

The MHNIP will benefit patients in a number of ways including; providing access to clinical care by a mental health nurse in the community, continuity of care, provision of multidisciplinary, community based care through one practice, additional assistance with medications and the benefit of having a single person coordinating both clinical care and liaising with other serviced providers (RACGP, 2009).

Various divisions of general practice through newsletters and annual general reports highlighted the initial benefits of the MHNIP. One of such was the Peninsula GP network that engaged the service of six MHNs across various sites. The GP feedback highlighted the skills and expertise of the MHNs as well the making mental health care provision timely.

At Peninsula Family General Practice, we have been very fortunate indeed to have a mental health nurse on a sessional basis. She has proven to be highly successful and effective for patients (and doctors) and closes many gaps in provision of timely, appropriate services (Peninsula GP Network, 2010).

We wish to emphasise that the strength of this initiative (MHNIP) is in grounding mental health nurse care in the general practice setting, which empowers generalists to do more for their patients with serious mental illness, not just with respect to their mental, but also their considerable physical health needs,' (Dr Marles, President, RACGP, 2013).

With respect to the credentialing process, the RACGP was pleased with the fact that standards will be in place to determine MHNs that were eligible to work within the MHNIP.

'The RACGP recognises that the Australian College of Mental Health Nurses credentialing program will be the standard qualification for mental health nurses working under this

initiative (MHNIP), and supports the ACMHN's role in setting the standards for the profession'. The RACGP believes the credentialing process is important as it provides patients and the GP with the measure of certainty about the skills and knowledge of the person who will contribute to their care (RACGP, 2008).

The credentialing is particularly important for the RACGP as the organisation was not familiar with qualifications and skills of MHNs.

Expected role and function of the mental health nurse

There were various job advertisements by different organisations for a MHN to work within general practice. The required role of the MHN was consistent with the program guideline set out by the Government. The initial media release about the program briefly outlined the expected role to be carried out by the MHNs.

Mental health nurses would work with doctors to provide services such as periodic reviews of patients' mental states, medication monitoring, and information for patients on their physical health care (Senator Mason, 2007, para.3).

Most of the organisations listed the role expected of the MHN to include: coordination of clinical care for patients with a mental illness, patient assessments, interagency liaison and medication monitoring. Other organisations included the provision of education and training as required.

Chapter Summary

This chapter has examined the events leading up to the establishment of the MHNIP, an Australian Government program that has brought about an extension to the scope of practice of Mental Health Nurses into primary care settings. The chapter presented findings from three stakeholders involved in the initial setting up of the program. All the stakeholders were asked

if there were any considerations from previous research or similar programs overseas that informed the establishment of the MHNIP. From the findings, there was little consideration given to evidence-based research or similar programs from other countries as a means of informing the establishment of the program. Instead, it was borne out of political necessities and in response to calls by consumers, carers and key stakeholders in the mental health arena for a need to redesign mental health care delivery. The Government was being pressured to do something about the issue of making access to mental health care easier for patients and their families. However, according to the stakeholders, there was recognition that MHNs had a role to play in the delivery of a more accessible, flexible and comprehensive mental health care in primary care settings. There were concerns raised around the funding arrangements and the fact that it was tied to the GP engaging the mental health nurse as opposed to a system where the nurses themselves accessed the funding directly.

The document review was useful in highlighting some of the events that led to the establishment of the MHNIP as well as the views of GPs on the potential benefits of the program. There was a positive sense of satisfaction from the GPs about the presence of a MHN in general practice. The roles expected of a MHN as set out by the government were consistent with what most eligible organisations required.

The issues raised during this phase of the study were further explored in Phase 2 of this study, involving interviews with MHNs who are working under the MHNIP. The findings from Phase 1 of the study helped inform the development of the interview schedule utilised in Phase 2 along with literature and document reviews. Through a series of semi-structured interviews, the views of MHNs about how the program was being implemented, the benefits their role had in overall care delivery were also explored. This is presented in the next chapter of this thesis.

CHAPTER 5

PHASE TWO: QUALITATIVE FINDINGS

This chapter presents the study findings arising from the data analysis of the semi-structured interviews with mental health nurses working under the Mental Health Nurse Incentive Program (MHNIP). Donabedian's (1980) structure-process-outcome model guided the questions and presentation of the findings. It explores the reasons why the participants decided to work under the MHNIP and invariably in the primary health care setting (structure). How the role of the MHNs is being enacted, the perceived barriers and facilitators to the role as well as the nature of collaboration with GPs and the impact of their role in general practice is also described (process). The impact of the role of MHNs in primary care setting is also presented (outcomes). The schedule of interview questions was developed following the literature review and the analysis of data from Phase 1 of the study involving interviews with key stakeholders about the MHNIP as well as a review of documents publicly available that relates to the MHNIP.

The participants were drawn from various general practices across Melbourne Victoria. This study provides preliminary data on how the role of MHNs working under the MHNIP in general practice is being enacted. A brief description of the participants in the study will be provided, including summary of basic demographics such as age, sex and years of working experience. A total of 16 mental health nurses (MHNs) were interviewed during this phase of the study. Themes were produced using the words of the participants. Participant's views/comments are presented in the following format: Participant number- Par #..., e.g. Par #1 means participant number 1.

Chapter Five will present demographic characteristics of the sample followed by a presentation of the findings under emergent themes.

Characteristics of the Sample and Practice Settings

A total of 16 mental health nurses (MHNs) were interviewed, including 11 female and five males. The participants were asked to state their ages, years of experience, settings worked and their working arrangements.

The average age was 47 years; they had an average of 22 years' experience in nursing and had worked in a variety of clinical settings prior to working in general practice. These settings included: acute in-patient units (adult & adolescents), community mental health clinics, drug and alcohol services as well as private psychiatry. The majority of the mental health nurses (n=14) were hospital trained. Others (n=2) obtained their training through the university sector; however all but two of the participants had a post-graduate degree in Mental Health Nursing. Only one of the participants had worked as a mental health nurse in general practice prior to the establishment of the MNHIP. This participant worked as a GP Liaison MHN employed by a community mental health service and his role was to coordinate discharge of patients to GPs who then took over the on-going care role from the Mental Health Community service. This is a similar model to the CLIPP program described earlier, (Meadows, 1998). The primary care setting is a relatively new specialty area within mental health nursing in Australia; hence not many of the participants have worked previously in this setting. The participants worked in a variety of medical practices ranging from solo practices to small and large group practices. A number of the nurses (n=10) worked through Divisions of General Practice, four worked through Practices not affiliated with Divisions of General Practice, while three worked in community-based clinics. This is consistent with the guideline of the MHNIP, which stipulates the type of organisations that are eligible to engage the services of a MHN (for further discussion, see Chapter 1).

Hours worked per week

Under the guideline for the MHNIP, a full-time MHN can work up to 35 hours per week which equates to 10 sessions per week. Each session last for 3.5 hours and within the session the MHN must have a minimum of two clients; this can be divided into face-to-face and non-face-to-face activities. Most of the participants worked an average of about six sessions per week, which amounts to about 21 hours/week. The participants noted that the session times were also used to catch up with GPs to discuss patient on-going care. There have been arguments against the current funding arrangements, which are said to limit the number of sessions the MHN is able to undertake. This concern will be discussed later in this chapter.

Location of care delivery

The care provided by the MHN participants occurred at various settings depending on patient need. Some went on home visits and found this to be an essential part of the role. Others practiced from the GP clinic only. One of the key benefits of the home visits is to bring care as close as possible to where the clients live. It also gives an opportunity for the MHN to assess what happens at home with the client and their families/carers. Some clients have difficulties due to their symptoms attending clinic-based appointment, hence a need for more flexible service delivery. The following are the comments by the participants:

I do a couple of home visits. I make sure that I know who's there and everything. So I'll suss out the situation with that but only under very limited criteria. They have to be sort of pretty much physically isolated in the house through physical disorder or whatever. Yeah, so I will do the home visits. (Par #4)

Well, in this role there's certainly more of an outreach component. You can actually get out there and meet the clients in their homes. (Par #3)

I have been on a home visit a couple of times because the clients wanted me to see how they live, or I wanted to go and have a look. A couple of clients are on anti-psychotics and have put on significant weight. So we've talked about diet. So as part of that I'll go out to their house, have a look in their fridge and then we might go shopping. And I've done that just a few times just as part of on-going management. (Par #13)

The location of the care being at the client's home puts the client firmly in charge, allowing him or her to take lead at every turn. Most often than not, the nurse will have to use strategies of persuasion and negotiation during such interactions and this can be empowering for the client.

Findings

The following themes emerged from the views and comments made by the participants during the interviews. Themes arise from the experience and comments of the participants in response to each of the questions posed by the researcher. For a subject to be considered a theme, it must have arisen consistently across at least two-thirds of the interview transcripts and reflect the experiences of at least a third of the participants (Highet et al., 2004).

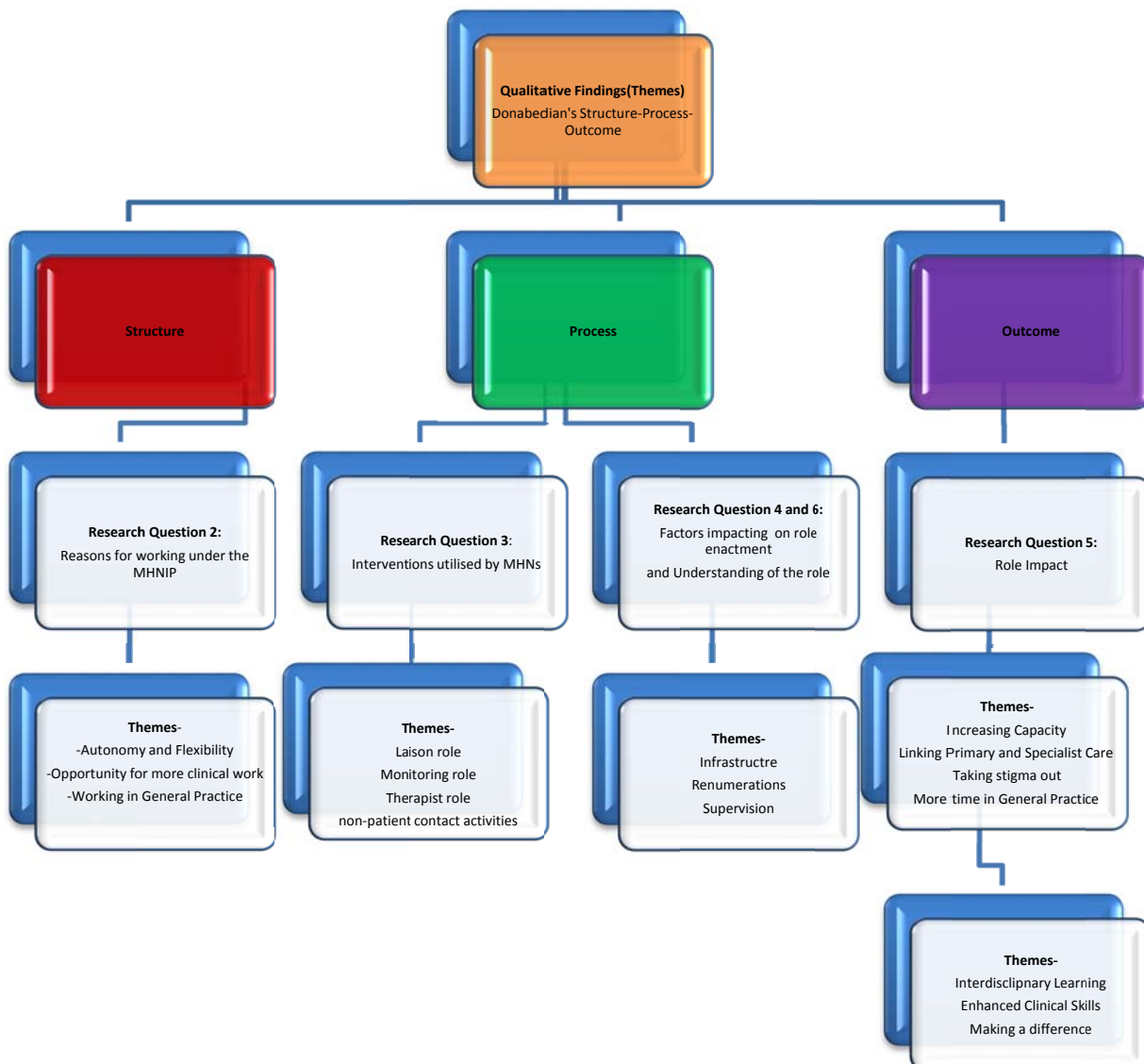


Figure 4: Interview process and emerging themes

Credentialing Experience (Structure)

In order to be eligible to work under the Mental Health Nurse Incentive Program, mental health nurses had to be credentialed by the Australian College of Mental Health Nurses. Participants were asked to share their experience of the process of being credentialed. The credentialing process gives recognition to the experiences of mental health nurses and it helps to set a standard for all MHNs who plan to work in general practice under the MHNIP. Prior to the establishment of the MHNIP, most of the participants had not gone through the credentialing process. Credentialing was not a prerequisite to working in other specialty areas of mental health.

The process was considered by some of the participants to be beneficial, as it offered an opportunity to reflect on their clinical practice while recognising their skills and experience.

The actual process itself was quite anxiety provoking, but I think that in all it's been a positive experience because it has really recognised our advanced experience and training and things like that. So above all I feel quite positive about it (Par #14).

Some of the participants, however, were critical of the process in that it only recognises or gives Continuous Professional Development points to learning achieved three years prior to the application for credentialing.

The other issue identified by participants was the amount of time it takes to gather the evidence required for the application and putting it together. Hence, some of the participants noted that they paid a consultant to assist them in completing their application.

Just finding the time that's quite demanding, yes and then work, you know there's always reading and different things to do for work, so yes it's the time (Par#11).

I basically paid someone to do it because I couldn't be bothered (Par #6).

Profile of clients under MHNIP

Participants in this study were asked to provide basic demographics about their current client groups, keeping in mind that the MHNIP was targeted towards individuals with severe mental illness. The age group seems to vary from adolescent to the aged (i.e. 16 to 86 years); however, the majority of the clients were between the ages of 16-65yrs, there was a mix of both male and female clients. Most of the participants however have a mix of people with severe mental illness such as schizophrenia, bipolar disorder, schizoaffective disorder and people with common or high-prevalence disorders such as depression, anxiety, and obsessive-compulsive disorders.

In terms of mixture of client diagnostic group per participant, there is a consistent high proportion of people with depression and anxiety compared to severe mental illness such as schizophrenia and bipolar disorder. There are a lot of patients with co-morbid drug and alcohol issues; there are also patients with forensic histories. Participants also reported having patients with domestic violence, personality disorders and situational crisis. This diverse mix of clientele will require a lot of skill, flexibility and clinical experience on the part of the MHN.

I guess at any point in time roughly a third of my clients would have schizophrenia or bipolar disorder as a diagnosis and most of the rest of them are depressed in some form, with the odd, very odd things thrown in (Par #4).

Most of my clients are in the younger end of the spectrum in their 20s. I've got a high number of anxiety/depression, personality disorder the rest, bipolar and schizophrenia (Par #5).

There are clients who have not had recent contact with psychiatric services who are being picked up at the general practice.

I am looking after XXX who is a long-standing schizophrenic (sic) never been admitted, still on Stelazine [older anti-psychotic], I'm trying to take him off it (Par #3).

There does not seem to be clarity about the program guideline regarding the term 'severe mental illness'. There is a mix of various client groups that are receiving care from the mental health nurses under the MHNIP. There seems to be some ambiguity around what is termed severe mental illness. The participants noted a blurring about what is traditionally considered to be a severe mental illness and the types of clients that are referred to them.

What is a severe mental health disorder? I'm actually thinking about that a lot and then a lot of people I'm getting with drug and alcohol as well as depression with suicidality, chronic suicidality or even active fits into severe; heavily disabled OCD that doesn't get a look at in Area mental health at all. Domestic violence, there's a lot more in this than in area mental health services, so is that a severe mental illness? (Par #18)

So the term 'severe' and 'what's not' is a bit tricky. (Par #4)

Reasons For Choosing to Work Under the MHNIP and Understanding of the Role

Participants were asked to state the reasons why they decided to work under the MHNIP. The MHNIP has created an extension to the scope of practice of mental health nurses into general practice in Australia. A range of views were expressed by the MHNs as to why they decided to work under the MHNIP. The view of the participants was that this was a very exciting area of specialty that has given them more autonomy, flexibility and exposure to what happens in the so-called 'GP Land'. Most of the participants also compared their role under the MHNIP to that of working in acute public and private psychiatry, which were the only two major areas that have been previously available for mental health nurses. There was a sense that this area

of specialty offered better opportunity to be engaged in more clinical work with clients and most found the notion of working in general practice a great career opportunity.

Autonomy and flexibility

Most of the participants viewed their work in general practice as offering them a degree of autonomy and flexibility that they did not fully enjoy while working in other mental health settings. The ability to work autonomously within clinical settings has implications when it comes to on-going retention and recruitment of mental health nurses in the face of a declining workforce. Some of these reasons were also alluded to by participants in the quantitative part of the present study; this is presented in Chapter 6.

The following participants expressed this view as follows:

The autonomy was a big driving factor for me. The opportunity to try something different, so I have worked extensively in the public mental health system for a long time, all different settings, but always in public mental health. This role gives me the opportunity to work more independently (Par #9).

The main reasons for me I guess was [sic] wanting more autonomy in my practice (Par #10).

So a lot of what we do is really sort of we have that flexibility because of the nature of the service where we can do outreach if we need to. If we need to do intensive support two or three times a week, we can do that. If we want to run groups with clients, we can do that. So it gives us a lot of scope for our practice (Par #14).

The autonomy and flexibility it offered were good (Par #13).

I've certainly enjoyed the change. It seems to give you a bit more freedom to be more creative, be creative with your clients than being, you know, desk bound so to speak, or limited to meeting them at the service (Par #3).

Others talked about flexibility in care delivery that their role under the MHNIP offers. These included flexibility of work hours, flexibility of mode of service delivery and the ability to work around the needs of the clients.

I suppose the flexibility, wanting to work with clients individually in the clinic and seeing results. Also the fact that I can plan my own time and work around the needs of the clients that was very exciting (Par #11).

You are sometimes constrained in public system as to how you can respond to client needs; I find that I can be more flexible with my time in this role (Par #3).

Opportunity for more clinical work

The participants reported that their role offered greater opportunity to spend more time in providing clinical services as opposed to working in public mental health services or community mental health services.

Because I like doing clinical work and this position, it's very clinically focused, I have one meeting a month. It was quite a shock apart from the supervision I get, the focus on the clinical work in primary care is there which doesn't exist in public mental health. Public mental health is trying to make the system work and the best you could ever get was about 40 per cent clinical whereas now I'm up to, I think I worked it out at something like 95 per cent clinical (Par #12).

There are less paper work and more client work (Par #7).

In an area mental health service I don't think your skills are valued, I think the system overtakes the clinical needs, it's very focused on doing everything on the cheap and the minimum, there seems to be a whole of lot attentions paid to those patients who are involuntary (Par # 12).

Participants in this study have noted that their role gives them the opportunity to be able to spend time with the patients. Participants also noted that their role, under the MHNIP, has given them opportunity to also be engaged in more preventative health promotion activities compared to working in public mental health systems.

For me I think it's an opportunity to bring together all of my past skills into one area which is not necessarily focused on medical intervention, although that's part of it. This program has offered the opportunity to engage more in mental health promotion activities (Par #1).

I am able to spend some time with my clients and provide health education, lifestyle teachings and healthy lifestyle issues, generally how to look after themselves (Par #10).

And also having the ability to sort of be in that primary health care role. So actually being able to help people with prevention of relapse and things so that they're not readmitted into hospital (Par #10).

This view was further corroborated by another participant:

Because I just see the public health system as drowning, and I very much believe in prevention, having worked on the mother and baby unit for six years, you know, we have to try and educate people and in managing better.... (Par#9)

Excitement of working in general practice

The opportunity to work in general practice was considered by the participants as being professionally rewarding. Most of the nurses stated they had the opportunity to provide care to

some of the clients that would not necessarily have made it into the public health system. General practice offered an extension of their scope of practice bringing with it a sense of excitement and challenge. Many saw it as a good career option and a chance to make a difference in facilitating access to care for people with a mental illness living in the community. The opportunity to experience a different clinical setting where the skills of MHNs can be effectively utilised has implications for recruitment and retention into the workforce.

I was very excited about the program itself, just this new idea of having mental health nurses in that setting and supporting GPs was for me a good opportunity. (Par #10)

I had been very interested, when I heard that you could work as a mental health nurse in private practice I thought it was a good career opportunity, that there potentially would be the scope in the future of having even more independent practice than even this program. (Par #13)

Even though mental health nurses working in general practice is quite new and has its own challenges and difficulties, it does come with many opportunities and possibilities for the mental health nursing profession. MHNs occupy an important part of the overall delivery of mental health services. By extending their scope of practice into the primary health system as specialist practitioners, MHNs have the opportunity to increase their role within the mental health care delivery system.

In addition to the exciting challenge of working in general, most of the participants expressed displeasure for public mental health system as another reason why they decided to work under the MHNIP. They noted the nature of work within the public system was crisis-driven with a lot of emphasis on risk aversion.

I think, that's right my experience of being a case manager is that there are many things that I am doing right now in this role that I wanted to do as a case manager, and knew it would be great if I could do them, you know, that's evidence-based practice, but there was no time and it really was crisis-driven work, whereas now in this role it feels like there is much more time to plan appropriate therapy sessions and interventions (Par #10).

In the public health system you lurch from crisis to the next literally every day, every minute, its one crisis to the next. You know, I managed a psych ward for 10 years and that's just what you do (Par #9).

Nurses' Understanding of Their Role

Participants were asked to state their understanding of what their current role entails. They also reflected on the huddles of transiting into the role such as the credentialing process. Some of the questions the researcher sought to answer included; do the MHNs have an understanding of what their role is?, are other members of the practice aware of the role of the MHNs, do the MHNs have enough time to carry out the duties that are expected of them in their role?

Specialist care coordinators

The participants were asked about their understanding of the role of a mental health nurse under the MHNIP. Most of the participants were fully aware of the guidelines of the MHNIP and viewed their role as a MHN as one of providing specialist services to support the general practitioners in caring for people with a severe mental illness. The nurses also viewed their role as a significant part of the general practice; not only do they have the ability to reduce GP consultation times, they also make it possible to provide a more comprehensive mental health treatment for clients with a severe mental illness, who often require much longer consultation time than can be offered by GPs. These views are consistent with the program guidelines set

out by the Government when the MHNIP was established. There was a sense among the participants that their role was also a consultative one in which they are able to provide secondary consultations to the GPs. Participants also highlighted the fact that their role was to provide preventative health care to people with a serious mental illness, with a view to preventing hospitalisation when it was possible.

The following two participants talked about their role in terms of working alongside GPs as well as the client group they cared for:

So my understanding of the role of the mental health nurse is to aid the GP by reducing the time that they need to spend with mental health clients so that they [GPs] can see more patients. But the clients that are appropriate for the MHNIP are people with chronic mental health problems, needing more input and more support, that aren't part of the public mental health system. That's my understanding (Par #13).

To work with the GPs, taking referrals from the GPs so that its shared care or the GP maintains the key responsibility, and to do things like monitor medication, some psychotherapeutic interventions depending on the needs of the client, to liaise with other agencies, and try and access other agencies as developing and maintaining a rapport with clients who are seen by their GPs to try and maintain their wellbeing and kind of get in early with early warning signs and stuff for those who are at risk of relapsing (Par #1).

However, even though most of the participants are aware of the program guideline (which will be discussed later in this chapter), some of the services they provide under the program do not actually fit the guidelines in terms of client groups, i.e. people with a severe mental illness.

Most of the participants reported that their role was largely understood by other members of the general practice. However, in certain instances they have had to reiterate the things they can or cannot do to other health care professionals in general practice. According to one of the participants in a particular instance, practice nurses encountered an expectation that they would be present at the clinic at all times to deal with patients in crisis. They had to reiterate the fact that they were not a crisis service.

Working in GP Land: a learning curve

The transition for most Mental Health Nurses from public health to General Practice presented a huge learning curve. The changing landscape of health care delivery is seeing the need for the nurse to preserve relevant skills and knowledge from the past in addition to incorporating new skills and knowledge to enable them to function in the new environments. Most of the participants came from a public mental health system background where the focus was more about the provision of nursing care without a great deal of consideration for business cost analysis. For example Participants One and Five suggested the nature of general practice as a business:

But I'm aware that time is restricted, mainly because it's kind of small business as well as a health zone (Par #1).

Look, one of the big lessons for me was that general practitioners are actually small business owners or holders and I didn't have that in my head at all before this job so that's been very interesting because one of the biggest responses I had when I was going around selling the whole thing was, 'Well, what's in it for me?' and I'd sort of think, 'What? What are you talking about? We need to look after these unwell people' (Par #5)

One of the challenges that MHNs face when entering general practice is adapting to work in this new clinical setting. The current undergraduate and post-graduate mental health training

in Australia does not prepare students for work as a MHN in primary health care settings. For example, one participant commented that as recently as year 2010, there were no mental health placements in general practices.

No, nothing in the curriculum really prepares you to work in a GP Practice (Par #7)

You do need to be prepared to work independently and be self-motivated. A lot of people like a team around them; you need experience to work in general practice (Par #9)

I suppose in my ignorance with GPs as well, I mean that's been one of the good things about it (MHNIP), is to actually find out more about what happens out in GP land. (Par #1)

Look, I've certainly got a better all-round respect for general practice. I certainly see how busy they are out there. I used to be critical of the short time that they would give people, but when you see the constant flow, and it's not just any doctor, it seems all GP practices are the same, they don't get a minute. And they are all under the pump (Par #2).

There were issues raised by the participants around the availability of time within the funding structure of the MHNIP for clinical supervision.

The way the program is designed getting supervision within the allocated time is difficult and I have had to make my own arrangements outside of the allocated time (Par #2)

One of the concerns that had been raised by a key stakeholder during the set-up of the MHNIP was that of support and supervision for mental health nurses working under the program, given the fact that traditionally MHNs have been used to working in a multidisciplinary mental health team. So while the participants did not see working alone in general practice as a major issue, they were however keen to ensure they had time and opportunity for adequate clinical supervision.

Working with general practitioners: communication and collaboration

Participants were asked about the nature of collaboration that exists between them and the GPs they work with, the frequency of communication and the nature of such communications. There was a sense that the expertise and skills of the mental health nurse were appreciated and respected. The GPs were respectful of the skills of the nurses and valued their level of expertise/clinical experience. It was noted by the participants that their clinical skill was acknowledged and respected by the GPs they were working with. The following are statements by some of the participants:

The most striking thing is the incredibly high level of respect for my clinical expertise (Par #11).

Some doctors have commented that they're kind of astounded at the depth of my skills (Par #5).

Never in my professional life have I ever felt so respected and valued (Par #11).

Most of the participants describe a good and cordial working relationship with the GPs in which there was a level of collaboration when it came to patient care.

I do have a good relationship with the GPs that I work with. If I see a patient and I need just to collaborate with them I can just knock on their door. Even if they're seeing another patient they'll come out and they'll talk with me about it. Or they will see that patient the same day within the next one or two consultations. They're happy to do that for me (Par #13).

So I've got a very good working relationship with all of my referring GPs. And so very often we are liaising together and liaising with the patient as well, which is good (Par #10).

Other participants noted it took some time before they were able to strike a balance in terms of collaborative practice; often, the MHN had to be assertive in terms of ensuring collaboration occurred.

Look, I have had a few GPs who have needed to be trained on how to communicate with me about their clients in relation to making medication changes and things like that and not actually informing me, but that was really pretty much in the initial stages of starting (Par #14).

We don't have any further information from the GP unless we go in and say, 'Look, Mary's turned blue' and they say, 'Yes, I've painted her with blue paint' you just don't know nothing about what's going on (Par #4).

Overall, it is good to see that a good level of collaboration exists between nurses and doctors in providing patient care.

There were, however, difficulties regarding the frequency of communication about patient care. The communication varies from *ad hoc* to a more structured form. There are also a number of opportunistic communication events that took place. The difficulty has been around the way general practice operates; due to time constraints, there does not seem to be time set aside for proper joint reviews by the GP and the MHN. According to the participants, the funding available for the program leaves very little room for the GP and MHN to engage in adequate clinical reviews. The extent of collaboration seemed to vary at times depending to the level of interest the GP has in mental health issues. Some of the participants talked about how some GPs would actively inquire about patient progress, while others operate on a need-to-know basis.

It varies a bit on GP practice to GP practice. So it's usually a matter of throwing yourself across the corridor and not letting them get past (Par #5).

I try and get face to face contacts with the GP and sometimes find that difficult. And it's in stark contrast to somewhere like a community mental health team where you have a daily update and then a weekly opportunity for clinical review (Par #1).

Collaboration with patients: the recovery framework

In terms of engagement with the clients, the participants noted they were able to work more collaboratively with the clients within a recovery framework. One of the criteria for the MHNIP is that patients have to engage voluntarily. The clients were involved in decisions regarding the frequency of contacts and overall need for on-going treatment. The participants noted the patient care plan was not necessarily driven by the clinicians, but rather set around the expressed needs of the clients. They noted their clients felt empowered through this process.

I'm very much patient-driven so they set the agenda and if the agenda changes from their perspective then we move to a new agenda (Par #2).

I say to a number of people, 'You tell me when you don't want to come anymore, that's how we'll measure it' (Par #3).

...a lot of my clients express satisfaction due to their having the ability to determine how their treatment is delivered (Par #14).

And I guess my philosophy too is that if the clients want to come and see you they can. They don't have to, it's a totally voluntary program (Par #8).

There is a greater push across mental health services to have consumer-driven care and a greater level of collaboration between health care professionals and consumers and carers. MHNs working under the MHNIP are adopting the recovery-oriented care model.

Impact of the Role of Mental Health Nurses in General Practice

Increasing capacity and accessibility: the ‘non-squeaky wheels’

The introduction of the MHNIP has increased treatment service options for people with a severe mental illness. Access to specialist mental health care remains an on-going issue for people suffering from a severe mental illness, and often consumers of mental health services have to be deemed quite unwell in order to access services. Consequently, a number of people are ‘falling through the cracks’ when it comes to access to specialist services. Participants in this study noted that they are providing care to individuals who would otherwise not have ‘qualified’ for entry into public mental health services and are described by one of the participants as the ‘non-squeaky wheels’. They noted the difficulties often encountered by patients as well as GPs in navigating the specialist public mental health services.

So it’s a different cohort completely. And they’re often people who fit into that 60% of the literature which says that never go near mental health services. And in some ways they are what have been termed the ‘non-squeaky wheels’ (Par #12).

A participant described the case of a mental health client who suffers from schizophrenia but has had no contact with mental health services for over 20 years. This client has on-going symptoms that affect his quality of life, but he has never really had cause to be picked up by acute mental health services despite his on-going symptoms. He has been receiving care through his GP focusing mainly on physical health concerns.

He’s now 160 kilos and has to turn sideways to get into the caravan. So he has no showering facilities, no washing facilities, very little kitchen and he wasn’t the kind of person to go back

to the emergency housing service and say 'okay where do I go next'? So I've used my knowledge about PDRSS (Psychiatric Disability Rehabilitation and Support Services) and started to link him in with that. He's got lots of unremitting symptoms, quite profound, last week he went to Westgate [a large bridge in Melbourne famous for suicide], but he decided he wasn't going to jump (Par #8).

Basically there's a huge gap between the people who are eligible and access the public mental health system and the general community. And obviously only the more severe end of the spectrum actually gets into the public system and often after struggling for a long period of time in the community with a prodromal syndrome or the build-up. It's usually only after some event occurs that they get picked up by the public mental health system, I am picking up some of these people through MHNIP (Par #5).

Participants also noted that their role under the MHNIP has also resulted in some pressure being taken off community-based mental health services struggling with increasing case loads.

We're obviously helping the case managers to discharge clients, to keep clients moving through, to reduce their case loads. I mean, some of the case managers would have 30- 35 clients. You know what I mean by that. So we're pretty popular at the Area Mental Health Services (Par #3).

These clients never get into public health, they can't afford to go and see a psychologist once a week for 10 weeks under the better access program because sometimes the gap payment they have to pay is all they actually live on (Par #5).

Hence, when looking at the issue of increased capacity and access, the presence of MHNs in general practice not only facilitates access to specialist care in a primary care setting, it also

frees up capacity in tertiary care to take on more clients. The service delivery, which is not based on the client's geographical location, has also been reported as being useful. Also, the service is not time-limited for the clients compared to previous initiatives by the Commonwealth Government such as the Better Access initiative. Under Better Access, the client has access to up to 10 sessions per year to see a clinical psychologist. The following is a comment by one of the participants:

We're not inhibited by having a limited number of sessions and lots and lots of patients say, 'How many more sessions have I got left?' 'Well, how long do you think I'll live?', I tell them. They expect to be chopped off at the knees and it's really useful for them when they aren't. We don't have that very strict living – where-you-live criteria or if you move to the other side of the road you we don't own you anymore (Par #15).

The missing link: connecting primary and specialist care

General practitioners are usually the first point of contact for people seeking help with mental health related disorders but often the GPs are reluctant to refer on to specialist services mainly due to difficulty in accessing services. The participants stated they were able to liaise with specialist mental health services, such as the crisis and assessment team, in a language they are able to understand. Participants in this present study viewed their role as providing a much-needed link between general practice and specialist services. This view is echoed by the following participants:

So I find that I'm doing work with one of the GPs that doesn't have as much experience with mental health, the work I'm doing is directing him in all the right places because he identifies my knowledge as an overall understanding of how the system work, because he says he doesn't have a clue. And he said, 'If you could just write it all in a manual it might help another GP down the road.' (Par #13)

I've started to liaise more with area mental health services, I've just done a case conference with a case manager to transfer the care of a person who wanted to come to one of our doctors (Par #8).

Early recognition of signs of mental health problems have also occurred as a result of the mental health nurse role within the practice. Some of the participants noted that they have begun to identify individuals with emerging mental health issues such as early psychosis and were referring them on for treatment in a timely manner.

The young guy who I involved with Mental Health Services, and that's clearly what he needed. He was very unwell and prior to doing the job that I've been doing now I had been working for a specialist early psychosis service and many clients that were coming to us had been floating about for months and months unwell before anybody picked up on the fact that they were psychotic and they needed treatment, and you know, this kid came and saw me and within that day he was seen by CATT, within the next day, he was hospitalised and he's now better. He's now asymptomatic, he's been discharged from hospital and he will be seeing me again on a regular basis. So to me being able to provide someone with the support, but also to ensure that you can get someone referred and seen, you know, to me that's a success as well (Par #10).

One of the significant impacts of the role of the MHN under the MHNIP is the detection of relapse symptoms of severe mental illness. This is captured by the comments of the following participant:

I received a referral for a woman who has schizophrenia, has never needed an admission, has always seen her GP for care, had not been well for the last two years, having command hallucinations in the last 6 months. At this point she did sort of start to talk to her GP about her concerns but prior to that she'd been attending for her depot every fortnight for years,

didn't often ever speak to the doctor, didn't really have a relationship with him. I discussed with the GP that this woman actually needs further treatment and I was able to link her up with a psychiatrist who reviewed her care and made adjustments to her treatment (Par #5).

Another point commented on by the participants was the difficulty some GPs face in referring people with mental illness even to a private psychiatrist who has the capacity to provide on-going care and recommendations. One of the benefits of having a MHN in the practice is the ability to link the clients to an appropriate private psychiatrist.

And also the doctors don't have as an extensive network with private psychiatrists as I thought they would do (Par #12).

The Mental health Nurses are also using their knowledge of the way public mental health services operate to facilitate admissions for their patients taking the pressure off GPs.

I have had to admit a client into hospital. I was actually really surprised As soon as you say you're a mental health nurse, all the barriers, well I found, they dropped away (Par #8)

And it's knowing what to say, and it's being respected by triage and triage looking at my notes and going 'oh this clinician clearly knows what she's talking about', you know? As opposed to a GP saying 'OK, this person is a bit odd, here's some Zoloft' (Par #9).

The linkage role of the MHN goes beyond the mental health needs of the patients. The participants reported that the physical health care needs of the patients are also being assessed and met. Often the patient requires follow-up specialist care such as dental, optical etc. and the MHNs are ensuring this follow-up occurs. Several factors affect the overall poorer physical health outcome of people with a mental illness. One of these factors is the difficulty the patients' experience in going through with follow-up appointments due to the impact of their illness, which can include disorganisation and social isolation. According to the

participants in this study, they are ensuring that patients are receiving the necessary follow-up appointments with other specialist services. Below is a statement by one of the participants:

I think we're like God sent to them (GPs), that we can come in and spend a certain amount of time with the clients. And just sorting out certain clients who have chronic schizophrenia and who would never go to their regular eye appointments, or their diabetic appointments and now the GPs know now that we'll get them there (Par #2).

Taking the Stigma out of Mental Illness

Participants in this study have noted that patients found it more comfortable receiving care through their GPs and are willing to engage with the MHN at the general practice setting. One participant describes how her client responded to her:

I've found they're more willing to come and see you in a community health center here actually. There is less stigma coming here as opposed to Mental Health Service, so they're getting seen by the GP, so people just see them in that way too (Par #7).

They see them as part of that team, they think 'I trust my GP, if you are working with my GP I trust you (Par #9)

But those that are quite worried about the stigma and stuff, when they sit down I usually allow them to understand the difference in my role versus the hospital role, and how we are independent from the hospital and that we are not the CATT team. Their anxieties are normally alleviated a little bit (Par #6)

There is need to increase awareness about mental health issues presenting to general practice and improve health outcomes for people living with mental illness. The potential is available

through the MHNIP to improve access to supportive services among the population around mental health issues. As noted by one of the participants:

It's interesting you say about the stigma, because I had someone actually in the waiting room, like they weren't one of my patients, but they said 'what do you do here?' You know, and I said 'I'm a counsellor' and they went into the doctor and said 'I want some of that.' (Par #12)

More time for GPs

According to the participants, the addition of the mental health nurses into general practice has increased capacity and freed up GP consultation time. It has also made possible the detection of underlying mental illness such as psychosis. Most clients with mental illness often present with complex care needs that require more time than the standard consultation time, which was almost impossible for their GP to offer. The mental health nurse participants in this study reported that they are providing service users more consultation time, detecting mental illness more readily and freeing up GP consultation time. This participant talked about a client she saw at the GP clinic who has been seeing the GP for a while. However, the GP has not been able to detect that the client had a psychotic illness. Another participant talked about a certain client who had a depressive disorder. Prior to the establishment of the MHNIP, this client would make up to three appointments in a week to see their GP; now this has dropped off to once a fortnight since they are seeing the MHN.

They just haven't got the time. And I got to see him for three X one-hour appointments, and usually a GP sees him for 15 minutes, you just think 'Is this person a bit odd, or is there something a bit deeper?' GPs don't have time. You need the three X one-hours. By the end of the three, one-hour sessions I realised this boy's got psychosis. If I had three 15-minute sessions like the GPs, I don't think I would have picked that up (Par #5).

One of the reasons GPs shy away from mental health consultations is the fact that in some cases, to fully cater for the needs of the individual, there may be need for multiple agency referrals. One of the major impacts of the role of the MHN under the MHNIP is the ability to take this pressure off the GP as the MHN does the linkages required for the client. The following participants speak of the ways their role has been able to free up GP consultation time in the practices:

Well I think the GPs love us because we save so much time for them. Like we do the legwork, they love that, doing the referrals to other services. Complementing the assessment, quite often a lot of the clients need to come in and talk to somebody for an hour, and they just can't do that, they just don't have the time, or necessarily the skill or the expertise (Par #7).

Most GPs don't have the time to look after people who are depressed; they have the time to say, 'Hi, good day, how're you going? Okay, here's your script, see you next time' and it's unrealistic because a person with depression really needs to spend time to tell you the whole story, get the support and so on (Par #4).

Interdisciplinary learning

According to the participants, the MHNIP has offered an opportunity to make available to other members of the general practice team, especially GPs and practice nurse's knowledge about mental health care. One of the key roles of MHNs in primary health care is as an educator, to provide opportunity for other members of the multidisciplinary team to gain a better understanding of mental health issues. It also presents an opportunity for MHNs themselves to gain a better understanding of general practice. The following participant captured this view with the following statement:

There were a lot of GPs there who didn't have the expertise in mental health care because they'd never really required to have anything beyond a fundamental understanding of mental

health issues and be able to recognise, however they are now more aware of the complex nature of mental illness (Par #4).

In the GP practice I complete a mental health plan for the GP. The GPs have even commented and said, 'This is your expertise. You've clearly seen a lot more psychiatric patients than we have. Your assessments are more complex and more skilled.' (Par #13)

Mental health nurses have reported a greater awareness of the workings of general practice and its team members. This would ultimately contribute to a greater degree of interdisciplinary collaboration and improved patient outcome.

And everybody thinks they know how a GP works because they all go to one but once you get behind the desk and see how it actually works and how they move from patient to patient and why GPs aren't going to sit on the phone and chat to a case manager for half an hour about some case (Par#5).

Enhanced clinical skills

Working under the MHNIP is an extension of practice for mental health nurses; the participants were asked how this new role has impacted on their own clinical skills/professional development. Working in a more autonomous environment has given the nurses opportunity to better utilise their clinical skills. There has been a shift towards custodial care at the expense of other valuable nursing roles such as health promotion, illness prevention, patient education and rehabilitation.

Well I've picked up my game considerably, I'm much more adept at doing mental state exams, I've improved on history taking, I've improved on formulation and there's lots of, found lots of areas for improvement, there's lots of stimulation in terms of people who come with a particular disorder that I have to revisit (Par #14).

For me I think it's an opportunity to bring together all of my past skills into one area which is not necessarily focused on medical intervention, although that's part of it. But opportunity to meet with clients at their own level, at their own place, a more comfortable environment for them. And the health promotion side as well, opportunities for health promotion through that, yes (Par #1).

Making a difference

Participants were asked to reflect on successful stories that their role has produced. There is a great sense among MHNs that their role is making a difference on a number of fronts in the lives of individuals with a mental illness. This feeling of making a difference adds to the overall sense of job satisfaction.

And the patients do acknowledge that seeing us is making a difference in their lives (Par # 8).

So it feels like very valuable work to be not only providing this great service one on one to the client, but to be supporting GPs. I find that really meaningful for me (Par #11).

I've got patients who, when I first met them were so disabled by their anxiety and their depression they weren't leaving the house. Now, I'm not saying that we are responsible for fixing them but certainly some of the work we do, some of the cognitive behavioural therapy does make a difference (Par #6).

And I've got patients with lots of issues who used to go to the doctor twice a week with various complaints but since we've been involved that's dropped right off (Par #10)

There is also a sense that the presence of a MHN in general practice has made a difference to the way mental health patients are both viewed and cared for.

And there are quite a number of GPs out there that are more than happy now to work with clients with our support. I think that's made a big difference. (Par #2)

There are a number of clients in another practice that the doctors are astounded that the patients come repeatedly come back to me because they've never been able to find somebody that they could connect with (Par #16)

Factors Impacting on Role Enactment

Infrastructure in general practice

General practices are run as a business enterprise and as such each consulting room is expected to generate income to sustain the viability of the practice. Even though there is flexibility in the MHNIP allowing for the delivery of care both at the client's home and general practices, there were still times in which meeting the client at the GP clinic was a more appropriate setting. This is usually in situations where the client is not yet well known or there are safety concerns with regard to doing home visits. There is also the issue of non-availability of fleet cars to facilitate such visits in certain instances.

Organising face-to-face case conferencing with other agencies can also sometimes be a challenge when it comes to finding office space and given the nature of mental health care, there is often the involvement of multiple agencies in patient care.

There is a need to look at how practices engaging a MHN under the current structure of the program can make the provision of adequate space a priority for the nurses.

And that's generally because they don't have function or space for me, or they want to charge exorbitant prices for me to use that space. So the majority of the clients I see here or I do home visits (Par #14).

There is a notion in GP practices that each GP room has to earn an income per hour. We're seen as an add-on service that out of the goodwill of the GPs they'll find a space for us (Par #7)

I guess availability of practice rooms is another barrier. Some practices don't have room. And we don't have offices here either (Par #2)

Support and supervision

Another barrier in the role enactment expressed by the participants was the lack of funding within the program structure to allow for clinical supervision. This issue was also raised by some of the key stakeholders during the setting of the MHNIP. Most of the participants highlighted the importance of clinical supervision as it provided a reflective space for them with regard to their practice. It also gave them opportunity to have access to an external clinician for support.

The way the program is designed getting supervision within the allocated time is difficult and I have had to make my own arrangements outside of the allocated time (Par # 4).

So the content of the program needs to be looked at, supervision provides support for nurses and gives a valuable opportunity to bounce off ideas with someone else (Par #14).

In recognition of the value they place on clinical supervision the participants had to make their own individual arrangements to obtain supervision.

I have my own private super that I have on a sort of regularly, fortnight to monthly basis. So I have that myself which is good and that's actually with a psychiatrist (Par #15).

Lack of career progression

Even though they are excited about the opportunity to change their practice scenery to general practice, participants were quite disappointed that there is a lack of career progression in terms of remuneration once you are working in general practice. It is worth noting that since the establishment of the MHNIP, the funding available per session for MHNs has remained unchanged. Some of the participants reported a drop in their income coming into the MHNIP.

They noted that for future recruitment efforts for experienced MHNs entering the field, the pay might be an issue.

Well it was a drop of pay for me, I've calculated that, it was a significant drop of pay; significant drop in conditions because I don't get sick leave, I don't get holiday leave, I don't get paid if I'm not here (Par #2).

I do it not for the money. The money's actually less because I don't have penalties. I do it because it's enjoyable. I've had a lot of opportunity whilst I've worked in the profession, while I've worked at the mental health practice. It's good for my professional development. However financially I've made sacrifices for it (Par #13).

There were suggestions to maybe include an incremental salary structure for MHNs working under the program; however, this would be at odds with the desire to have MHNs being able to directly bill Medicare for their services.

So maybe there should be a pay structure to involve another couple of year levels, or something like that too. Because once we're here at this level, that's it (Par #7)

Interventions Provided by MHNs under the MHNIP

The role of the mental health nurses in general practice under the MHNIP varies from that of care coordinator, clinician, and or educator. The participants were asked to identify the core role that they perform under the MHNIP. The participants also reflected on the type of activities in which they engage, which is broadly divided into patient and non-patient contact activities. They noted their role was similar to that of case management.

Liaison role

Liaison work was identified as one of the key roles/duties performed by MHNs in general practice. This aspect of their role involves making referrals to psychosocial rehabilitation

services, personal helpers and mentors program. They also linked patients with governmental and non-governmental agencies. This was noted as services to which GPs have had difficulties in the past referring patients.

Their liaison role also involves at times the need to act as advocates for patients in the court systems, as well as a liaison with the Department of Human Services for child protection issues. Patients with severe mental illness often require input from multiple agencies, which they find difficult to navigate at times. Even though the liaison work may not involve face-to-face patient contact, it remains vital behind-the-scenes work needed to maintain the patient's wellbeing. This is a role consistent with clinical case management available in specialist mental health services, and the ability to harness various services in order to support the clients was vital in maintaining their overall wellbeing.

It is also a linkage role as well, making appropriate referrals to other services, services such as the personal helpers and mentors program, local community health centres and support groups (Par #10).

I think practically every patient I've got requires some form of link-in to other services and I'm fortunate in that I used to work in PDRSS services so I have a better understanding of the resources (Par #4).

The mental health nurse participants were involved in linking consumers with services in the community and assisting with accommodation needs. Several participants spoke about finding consumers living in unsuitable accommodation and needing relocation as part of their overall care plan. Problems with housing could be physical in nature such as inadequate cooking facilities, or social in nature such as exposure to substance use. Due to the fact that people with a severe mental illness often struggle to navigate the raft of community services

available, this role of psychosocial rehabilitation being undertaken by the MHNs under the MHNIP is quite vital when it comes to improved outcomes for the patients.

And the psycho-social stuff as well, there's a lot of housing issues and I make referrals to the PHaMs program [Personal Helpers and Mentors] (Par #4).

I guess it's doing the bio psycho-social assessment; it's looking at people holistically around the issues that impact on their mental health. So that's actually everything but it's – our mandate is mental health so we've got to think about, 'Well, is this person in accommodation that endangers them?' obviously you can't have good mental health if you're living in high-risk accommodation. Are they able to care for themselves? Are they able to eat sensibly, not be involved in massive substance abuse and so on (Par #5).

I like the fact that you're working with people on their lives, in their lowest points; you're almost a life coach with some of these people. We're also averting admission a lot of the time and, if they do require admission, you can set up proper communication lines and make sure that the patient clearly understands how this is going to work, it's more real (Par #4).

It has been noted in the literature that caring for a relative diagnosed with schizophrenia can be stressful and may result in increased burden for carers in meeting the needs of their relatives. Behaviours contributing to this burden included such things as withdrawal, violence, paranoid suspiciousness and poor self-care (Ferriter & Husband, 2003).

One of the key liaison roles undertaken by MHNs is that of working with families and carers of their clients. Participants in this study noted that they were engaged in family work more so than they had been whilst working in public mental health systems. They were liaising directly with family members and also providing necessary support. They noted the burden of care expressed by carers and how important it was to include support for carers as part of their

care plan. They have had to identify support services available in the community for carers and make appropriate referrals when required.

The approach to families is quite noticeably different because often the family members are also patients of the clinic so they have equal standing. So it's very different to 'the identifying patient in an area mental health service is this and okay we'll only involve the family if they're in danger, despite all the rhetoric they are secondary whereas in here they are equal (Par #3).

So I have also managed to take pressure off a lot of carers for these particular people because I think quite often these people will get the care, but the carers don't get the care, or they don't get the input that's required. So I am also very mindful that a lot of the work that I do is actually with the carers of those people as well and being able to teach people how to reinforce boundaries and things like that (Par #14).

Another factor that comes into play, according to some of the participants, is the level of relationship that often exists between the family of the clients and the GPs.

The knowledge of the GPs of the families is astounding compared to Area Mental Health because they've often cared for the family over generations and so they've been around when the kids are babies, they've seen them grow up; they know the extended family if they live in the area. They even know the neighbours (Par #4).

I link a fair bit to family counselling and stuff through Anglicare so I don't do that myself unless necessary (Par#5).

I do a lot of work with families and loved ones and often they will attend sessions and so sometimes we are able to talk about trying to do family therapy in a sense of good communication skills and problem-solving skills, so that they can hopefully go home and

implement those in their own home and not have to rely on somebody else to be able to help facilitate appropriate communication and problem-solving (Par #11).

Monitoring role

The MHNs identified, as one of their key roles, conducting initial and on-going patient assessment, including risk assessment. Assessment is a key part of mental health nurses' role. It provides the basis for on-going treatment. Assessment of psychiatric symptoms can be quite complex at times and requires competent skills to undertake. The participants noted that they obtained the psychiatric history of the patients and in some cases had to liaise with external services with the permission of the clients to obtain further histories. Mental health nurses, by virtue of their role, often have the ability to conduct holistic assessments as they have additional time to go into detail. According to the participants, the assessment data they obtain from the patients is quite valuable in the formulation of their care plan. The following participants describe their roles:

The interventions can be monitoring mental state; monitoring the effect of the medication; support while people are starting new medications, they can be identifying areas of need with a similar process to the...what's it called...assessment they use in the Area of mental health? I can't think of the name of it but covering all areas (Par #2).

My weekly chores consist of going out and doing assessments, doing mental health care plans and then working out what best to do with that person, be it refer them on to a psychologist, maybe to primary mental health team, maybe back to their GP (Par #10).

I tend to go into in-depth details when it comes to doing my assessments and sometimes I have had to speak to area mental health services to obtain further information, of course that is if my client consents (Par #14).

In some instances, according to the participants, they have been able to avoid hospital admission due to early detection of relapse signs through assessment, which has led to appropriate early interventions.

Mental health nurses were involved in various aspects of medication management ranging from monitoring to education about side effects. The nurses reported this as an important aspect of their role. They particularly noted the need to educate the clients about the possible side effects of their medication and how the patients can be involved in minimising the impacts of the medication side effects on their overall wellbeing.

I do lots and lots of psycho education and medication, antipsychotics and stuff like that. That's pretty much standard of what I do with everybody (Par #14).

Providing information about medication side-effects, psycho-education about the medications and how they may or may not work. Also teaching the patients to be in control of their own health (Par #7).

Apart from monitoring and educating patients about their medications, some of the participants also reported some advocacy role when it comes to medication management. The nurses reported that they might make recommendations with the treating GP or private psychiatrists around the dosing and efficacy of the patient's medication regime.

Therapist role

Most of the participants reported using particular therapies drawn from a number of intervention models. Through the process of engaging with the clients and undertaking assessment, the MHNs were able to determine the clients' need for psychotherapy. The participants noted the use of brief solution-focused therapy (BSFT) and cognitive behavioural therapy (CBT). They noted that at times this involved problem solving with the clients. There was a reported flexibility with the role of the MHNs which made the use of such therapeutic

interventions possible. The participants noted that this was in contrast to their work in public mental health services, where such roles were often the domain of clinical psychologists.

Most of the participants had undertaken training in psychotherapy as an adjunct or part of their initial nursing training.

Most meta-analyses agree that expert CBT is beneficial in the management of residual symptoms, poor insight and poor adherence to treatment regimes in schizophrenia (National Institute for Clinical Excellence, 2002). The following participants describe their use of psychotherapy:

I provide individual therapy and tailoring that to the client's needs. I help the clients develop problem-solving skills and improve their communication so that they are communicating more effectively, and spend time educating them about their illnesses (Par #11).

So the work I'm doing with him, I'm looking at doing harm minimisations, motivation interviewing around his alcohol abuse, which is what he wants to do. I have utilised brief solution focused therapy and provide supportive counselling (Par #7).

I tend to use CBT a lot and it's good to have the opportunity to use these skills (Par #9).

Given the evidence to support the efficacy of interventions such as CBT and BSFT, the presence of MHNs at the primary health care level has the potential to improve outcomes for people with a severe mental illness accessing mental health care at this level.

Non-patient face-to-face contact activities

The work that mental health nurses took on for GPs took a great deal of time between seeing new consumers. Following up via phone and arranging referrals to other services are examples of tasks that GPs would have needed to do for themselves before the MHNIP.

Having a MHN to be able to facilitate such activities is a welcome addition to general practice.

So there's a lot of time spent in tracking down and organising referral spots. A lot of time writing your reports and progress notes of the regular visits that you do (Par #2).

Yes, you do spend a lot of time on the phone, be it trying to contact the GPs, or the patients, or psychologists (Par #6).

Some of the time spent during this role includes spending time in the office on the phone to various agencies to provide support to the patient (Par #10).

Part of the time spent in the role also includes other activities such as professional development, attending meetings, documentation and other housekeeping measures.

Expectations for the Future

Given the way their role had evolved and some of the difficulties they have encountered whilst carrying out their role, the participants were asked to identify what changes, if any, they would like to see in the way their role under the MHNIP is enacted. The participants noted they would like to see a change in the way the MHNIP is currently funded. They also expressed the desire to see an expansion of the program to include such models as nurse-led clinics.

Nurses becoming eligible organisations

There has been an argument around the current arrangement for the way the funding of the MHNIP is administered. Currently, funding for the program is made through Medicare Australia to eligible organisations – which have been limited to GPs, private psychiatrists or community-based organisations. There is a sense that the expertise and professional competence of MHNs is somewhat discounted. Other allied health professionals such as

psychologists, social workers and occupational therapists are able to provide a wide range of services under the Government's Better Access to Mental Health Care program and they receive a rebate directly from Medicare following referral from GPs. The participants felt their professional skills and expertise were not being adequately recognised by program policy makers. The following participants passionately defend the need for MHNs to have their own provider number under the MHNIP:

Because it's about acknowledging and respecting the professions equally, and even though the GP, I sort of consult with them, a lot of what I do, they're not there holding my hand. And I'm quite sure that psychologists have to refer back to the GPs at times, Occupational Therapists, Social Workers, whoever else have got provider numbers. So yes, I think we should have our own number (Par #7).

If I had an opportunity to change, that we would have our own provider number, that we'd have clear biller items through Medicare so that our scope of practice could be complementary but independent (Par #11).

Giving us a provider number doesn't mean that we're going to practice outside our scope because there's a clear difference between what a GP does and what a mental health nurse does (Par #13).

We (MHNs) need to be recognised to the level of being able to function as a registered organisation under Medicare so we can service a range of clinics across the communities that we service. It allows more flexibility and options for clients of our service (Par #2).

Mental health nursing is well placed to increase accessibility and affordability of mental health care in the primary health care setting. Psychology, as a professional group, has established itself over the years as a key player in the delivery of mental health care in

primary care. Traditionally, GPs have been the first point of contact for most patients experiencing a mental illness; perhaps it is time to shift the pendulum towards MHNs who have the appropriate skills and expertise.

Expansion of the MHNIP

In Australia, there have been suggestions to establish nurse-led mental health clinics as part of an extension of the role of Mental Health Nurse Practitioners into primary care (Wand & White, 2007). Participants in this current study, however, argue that this should not be limited to mental health nurse practitioners and there is a huge potential to expand the MHNIP to operate such nurse-led clinics.

I feel that it's the way of the future, that public community mental health clinics will probably soon be a thing of the past and all clients will be treated within their home setting with the GP as the primary carer. And we will be like case managers from the general practices, or mental health practice nurses the same as they have their diabetes practice nurses (Par #2).

There needs to be more of us. And I would also like to see a situation in which each general practice has a resident practice mental health nurse just like they have practice nurses (Par #15).

Now, I think we have become adept at practice nurses managing patients' diabetes, they are managing patients' asthma, they're doing wounds, so that all, you know, some of them are even doing plastering, to take that pressure of managing those chronic patients with GPs. I don't believe that mental health should be any different. And so if you had a resident mental health nurse in all of the GPs practices GP has a conversation with the mental health nurse straight away, can you see this person, bang and it can be done (Par #14).

As previously mentioned, the Commonwealth Government recently established GP Super Clinics across Australia. It is disappointing that there was no due consideration given to

mental health care through these clinics, given that the MHNIP could be expanded and well utilised at these centres.

Chapter Summary

This chapter has presented findings from interviews with 16 MHNs working in general practice under the MHNIP. The findings describe the characteristics of MHNs working in general practice, reasons why they chose to work in general practice and how well they understood their roles. It also presented how their role is being enacted and their collaboration with GPs. It also presented the category of patients they provide care for under the program.

Most of the participants working under the MHNIP were female and the average age was over 47 years with an average of over 22 years of experience working in mental health. As part of the requirement for working under the MHNIP, all the participants were credentialed MHNs.

Autonomy, flexibility, the opportunity to engage in more clinical work and health promotion activities were some of the reasons that influenced their decision to work in general practice.

Another factor that attracted them to this area was the actual excitement of working in general practice, which is new to mental health nursing practice in Australia.

The participants had a good understanding of what their role was under the MHNIP and most viewed their role as care coordinators for people with mental illness being looked after in general practice. Working in general practice was a learning curve to the MHNs and they had to adapt quickly to the new environment. Lack of availability of office spaces at the practices, as well as a lack of adequate career/remuneration structure, indicated some of the barriers they experienced in their role.

There was a wide range of patients for whom the MHNs were providing assessment and care in general practice; this ranged from those with severe mental illness to others with high-

prevalence disorders. There was lack of clarity from the program guidelines as to what constitutes a severe mental illness.

The presence of MHNs in general practice had a lot of impact on the overall delivery of mental health care in the primary health care setting. There was a freeing-up of GP consultation time, increased capacity and better accessibility to mental health care. It has improved mental health consumer access by reducing stigma surrounding mental illness and the MHN has provided the much-needed link between primary and secondary care systems. There was also an exchange of learning between MHNs and other members of the practice team, especially GPs and MHNs.

Interventions /activities in which MHNs engaged within general practice ranged from assessments, care planning, medication monitoring, and linkage to services, psychosocial interventions and family work. Some MHNs could see ways to expand their role even further. A great deal of time was spent on paper work, following up referral agencies and seeking people on the phone to link consumers with services; roles that the GP previously needed to do for themselves.

Looking into the future, the participants would like to see a restructuring of the way the MHNIP is run. Some of the changes they noted included a need for MHNs to have their own provider numbers in order to become eligible organisations. MHNs would also like to see an expansion of the program to all GP clinics.

Overall, analysis of the data arising from the semi-structured interviews offered valuable insight into how the MHNIP is being implemented and the issues that are pertinent to the MHNs working under the program. This data was utilised in the development of the questionnaire utilised in the third phase of the study. The next chapter presents findings of the

third phase of the study, which involved a survey of MHNs and GPs working under the MHNIP.



CHAPTER 6

PHASE 3: QUANTITATIVE FINDINGS

This chapter presents the results from the survey of mental health nurses (MHN) working under the Mental Health Nurse Incentive Program (MHNIP) and general practitioners (GPs) that engage their services across various states in Australia (Phase 3 of the study). It provides demographic data about the participants and their perception about the provision of mental health care in general practice settings by MHNs. It also reports on the activities of the MHNs, the client diagnosis, the reasons why they chose to work in general practice as well as the impact of their role. The views of GPs and how they view the impact of the presence of a MHN in their practice are presented along with perceptions of collaborative practice between GPs and MHNs. Separate instruments were used for the GPs and MHNs; however, the majority of items were the same to allow for comparative analysis. Clarification of items used for comparison between GP and MHN populations is included in the introduction to each section of this chapter. The Chapter is divided into two sections. Section 1 provides the demographics of the participants as well as open-ended questions exploring the impact of the MHN role, the activities of the MHN, patient categories, and time allocation to duties.

Section 2 contains results from Likert Scale response type questions on the factors that impact on the role of the MHNs, suitability of mental health care in primary health care settings, key elements of the role of a MHN in primary health care setting, impact of the role as well as collaboration between GPs and MHNs.

Sampling

The Australian College of Mental Health Nurses (ACMHN) established a list of credentialed MHNs nationally. This list was used as a profile and contact identification summary at the

time of sending out the surveys, with 227 nurses indicated they were working under the MHNIP. Of this number, some of the MHNs (n=87) were working with private psychiatrists. These were excluded from this study as the inclusion criteria required participants to be working in a GP practice. Of the number of MHNs working with GPs across Australia, only 128 had accessible contact details on the register. This resulted in 128 surveys being sent out with 88 returned (69% response rate).

MHN were asked to identify GPs they were working with under the MHNIP and the GPs could either complete a paper-based or on-line questionnaire (the majority completed the on-line survey).

A total of 125 GPs were invited to participate in the study and the total completed surveys were 67, giving a response rate of about 50.4%.

SECTION 1

Demographic Data

This section presents the results of demographic data collected from both GPs and MHNs who participated in the study. Table 6.1 shows the frequency and percentage of demographic variables by profession. The age distributions were similar for mental health nurses (MHNs) and general practitioner (GPs). For both MHNs and GPs, the majority of participants were over 50 years old. It is worth noting the ages of the MHNs in this study as this has implications for future workforce sustainability for the MHNIP. Majority of the MHNs were over the age of 50, which is also a reflection of the workforce distribution of mental health nurses; most of the experienced MHNs are aged 50 years and above. There was a significant difference in gender composition between MHNs and GPs, $\chi^2(2) = 32.26, p < .001$. The majority of MHNs were female and the majority of GPs were male. There was a significant

association between state and profession, $p = .036$. For example, 41.8% of GPs were from Victoria but only 33.3% of MHNs were from Victoria; 20.7% of MHNs were from Queensland but only 9.0% of GPs were from Queensland. There was also a significant association between education and profession, $p < .001$. While MHNs held education qualifications from Bachelors to Doctoral, all the GPs had a post-graduate diploma. In this sample, MHNs had significantly longer time in practice than GPs, $t(150) = 3.68$, $p < .001$. Most of the MHNs (45.9%) have been working over two years under the MHNIP while 55.3% of GPs have worked with a MHN over two years under the MHNIP.

Table 6.1: Frequency and percentage of demographic variables by profession.

	Mental Health Nurse		General Practitioner		χ^2
	n	%	n	%	
Age					
26-35 years	5	5.7	3	4.5	4.31
36-45 years	15	17.2	14	20.9	
46-50 years	11	12.6	16	23.9	
50 years and over	56	64.4	34	50.7	
Gender					
Male	23	26.4	50	74.6	32.26***
Female	64	73.6	17	25.4	
Total	87	100.0	67	100.0	
State					
VIC	29	33.3	28	41.8	N/A ^a
NSW	27	31.0	22	32.8	
QLD	18	20.7	6	9.0	
SA	3	3.4	3	4.5	
WA	4	4.6	8	11.9	
TAS	6	6.9	0	0	
Years worked under the MHNIP					
One year or less	22	25.3	4	6.0	10.17**
One to two years	25	28.7	26	38.8	
Over two years	40	45.9	37	55.3	
Education					
Bachelors/MBBS	6	6.9	67	100.0	N/A ^a
Post Graduate Diploma	34	39.1	67	100.0	
Masters	36	41.4	0	0	
Doctorate	3	3.4	0	0	
Hospital Based Training	7	8.0	0	0	

Others	1	1.1	0	0	
	M	SD	M	SD	t
Years in practice	21.97	10.35	16.79	7.06	3.68***

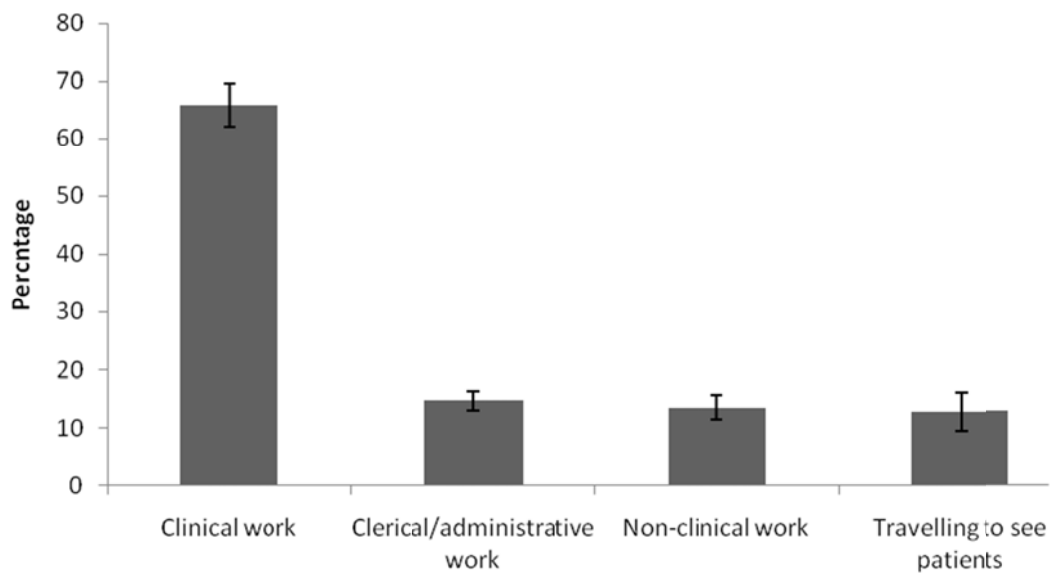
^a Assumption of χ^2 test was violated due to small cell sizes. Fisher's exact test was used instead.

Time Allocated for Duties

MHN participants were asked to allocate the percentage of time they devoted to the following activities: clinical work, clerical/administrative duties, non-clinical work, travelling to visit patients. Table 6,2 and Figure 5 show the percentage of time allocated to duty for MHNs. The percentage of time allocated on clinical work was much higher than all other duties and this indicated that, on average, MHNs allocated a significantly higher percentage of time on clinical work than other duties ($p < .05$). All other duties were largely overlapping and this indicated that there was no significant difference in time allocated to clerical/administrative work, non-clinical work and travelling to see patients ($p > .05$). As stated in interviews from Phase 2 of this study, most of the participants stated they were keen to work in general practice as it offers them opportunity to do more clinical work as opposed to being saddled with administrative burdens. From the responses of the participants of the survey, it seems the MHNs are achieving this desire to do more clinical work.

Table 6.2: Percentage of time allocated to duty for MHN

	N	Mean	Std. Deviation	Median	IQR
Clinical work	85	65.84	17.76	70.00	22.5
Clerical/administrative work	85	14.68	7.52	15.00	10.0
Non-clinical work	85	13.49	9.68	10.00	10.5
Travelling to see patients	85	12.81	15.51	5.00	19.0

Figure 5: Percentage of time allocated to duty for MHN with 95% confidence intervals.

Categories of Patients

MHN participants were asked to indicate the percentage of patients in different diagnostic categories that were present in their case load. Table 6.3 and Figure 6 show the percentage of patients categories reported by MHNs. The category of major depressive disorder patients (30.45%) was significantly higher than all other categories except anxiety disorder patients. The second highest percentage was anxiety disorder patients (24.36%). The percentages of other patient categories were below 20%. Diagnosis such as schizophrenia, schizoaffective disorders and bipolar disorders often classified as severe mental illnesses (Fleury et al., 2012b) accounted for about 33.54% of the patient category. As mentioned earlier in Chapter 5 of the study, there is a need to look more closely at the category of patients that are accessing the MHNIP and who MHNs were caring for.

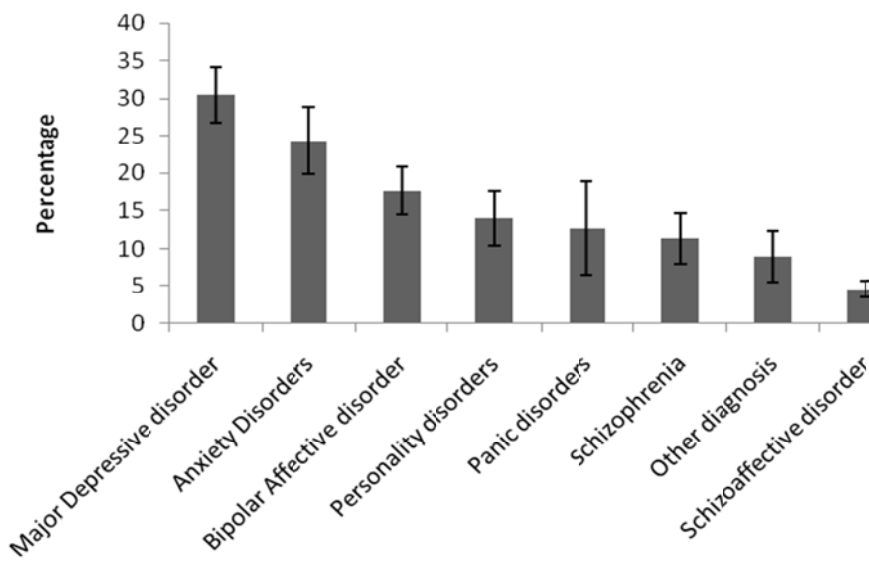
It is therefore surprising to note that during the conceptualisation of the Australian MHNIP, there was no consideration given to evidence-based research from other countries who have implemented similar programs and at the moment the criteria of patient entry into the program is very fluid. Even though the program guideline continues to mention that it was for patients

with a severe mental illness, this has not been clearly defined as evidenced by the findings from this study.

Table 6.3: Percentage of patient's categories reported by MHN.

	N	Mean	Std. Deviation	Median	IQR
Major Depressive disorder	83	30.45	17.38	30.00	20.0
Anxiety Disorder	83	24.36	21.04	20.00	20.0
Bipolar Affective disorder	83	17.64	14.94	18.10	20.0
Personality disorders	83	14.00	17.00	10.00	20.0
Panic disorder	83	12.73	29.05	5.00	10.0
Schizophrenia	84	11.35	15.75	10.00	11.7
Other diagnosis	83	8.92	15.70	0.00	10.0
Schizoaffective disorder	83	4.55	5.11	2.00	10.0

Figure 6: Percentage of patients' categories reported by MHN with 95% confidence intervals.



Main Activities Carried Out by MHNs

MHNs were asked to identify the core duties that they perform in their role under the MHNIP (Question A03). This was in the form of an open-ended question. The responses were then categorised, examined for commonality and assigned a number in rank order for the purpose of analysis via SPSS (Pallant, 2011).

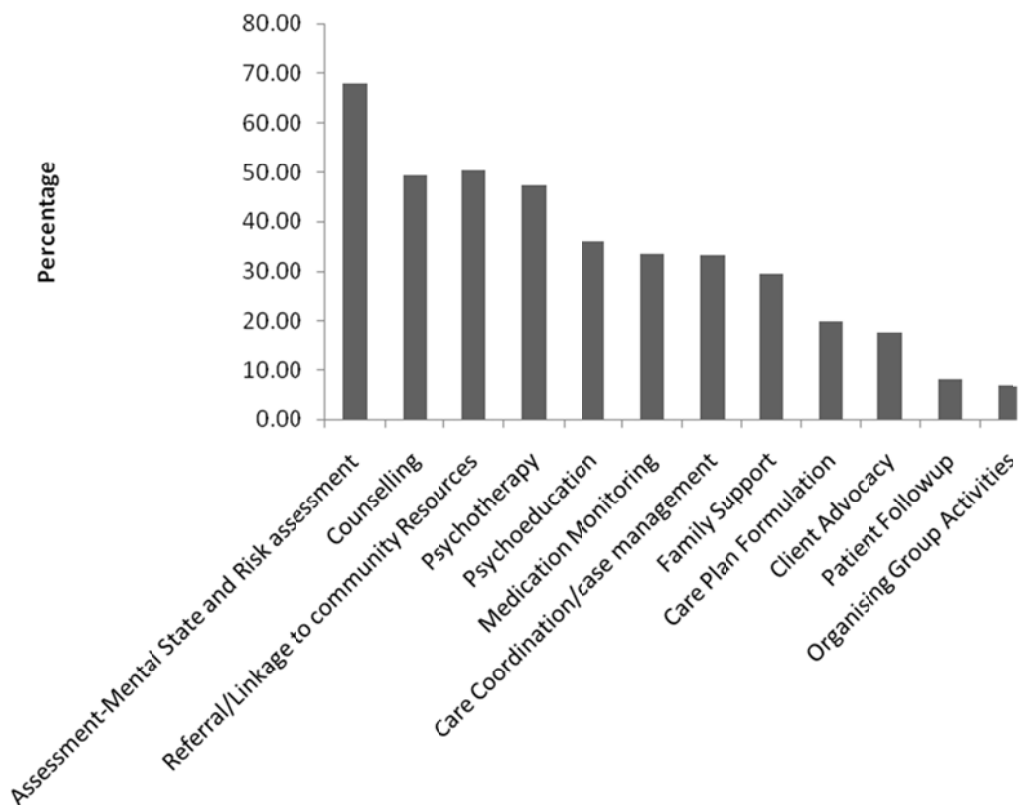
Table 6.4 and Figure 7 shows the main activities/interventions used in the MHNs' role. The top three main activities were 'Assessment – Mental state and risk assessment' (67.99%), 'referral/linkage to community resources' (49.44%) and 'counselling' (49.44%). The next five were 'psychotherapy' (47.29%), 'psycho-education' (36.12%), medication monitoring (33.44%), care coordination/case management' (33.28%) and 'family support' (29.50%). The last three activities were stated by less than 20% of MHNs and they were 'client advocacy', 'patient follow-up' and 'organising group activities'.

One of the roles in which participants reported engaging as part of their work under the MHNIP was psychotherapy.

Table 6.4: Main activities/interventions used in MHN role.

	<i>N</i>	%	95% CI
Assessment-Mental State and Risk assessment	59	67.99	(58.19, 77.79)
Referral/Linkage to community Resources	43	49.44	(38.93, 59.94)
Counselling	43	49.44	(38.93, 59.94)
Psychotherapy	41	47.29	(36.8, 57.78)
Psycho-education	31	36.12	(26.02, 46.21)
Medication Monitoring	29	33.44	(23.53, 43.36)
Care Coordination/case management	28	33.28	(23.38, 43.18)
Family Support	25	29.50	(19.92, 39.08)
Care Plan Formulation	17	19.95	(11.55, 28.35)
Client Advocacy	15	17.66	(9.65, 25.68)
Patient Follow-up	7	8.05	(2.33, 13.76)
Organizing Group Activities	6	6.98	(1.62, 12.33)

^a 95% confidence intervals of percentage.

Figure 7: Main activities/interventions used in MHN role.

Reasons for Working Under the MHNIP-MHN Respondents

The MHNs were asked in open-ended questions why they decided to work under the MHNIP.

The reason for choosing open-ended questions was the fact that there is no available study that has explored the motivating factors behind MHNs decisions to work in general practice.

The responses were then categorised, examined for commonality and assigned a number in rank order for the purpose of analysis via SPSS (Pallant, 2011).

Table 6.5 and Figure 8 show the main reasons that influenced MHNs' decision to work under the MHNIP and the proportion of MHNs who stated these as their main reasons. The top two reasons were 'autonomy' and 'flexibility'. A total of 66.67% and 59.77% of MHNs indicated that autonomy and flexibility were the main reasons and these proportions were significantly higher than the proportion of MHNs who indicated other reasons. In Phase 2 of this study as reported in Chapter 5, most of the MHN participants indicated that their role in general

practice was rewarding as it offered them a degree of autonomy and flexibility in their clinical practice. This view on autonomy and flexibility is consistent with what is reported in the literature with respect to aspects of their work that mental health nurses find satisfying (this will be discussed further in Chapter 7).

The issue of job satisfaction would have implications for future recruitment and retention in the face of a currently ageing nursing workforce. The third to sixth reasons were 'to experience a new practice area', 'unhappy with public system', 'better use of clinical skills and 'to make a difference'. The desire to experience a new practice area and feeling of frustration with secondary mental health care expressed by the participants is consistent with what nurses in similar roles have reported in the literature. Prior to the establishment of the MHNIP, the areas that MHNs could practice in Australia were limited to public mental health services and certain areas of private psychiatric facilities. While MHNs have had contacts with GPs, this has often been limited to an *ad hoc* basis to check patient progress, make referrals or follow-up on specific issues. The opportunity to work alongside GPs within general practice was considered a unique extension of their scope of practice. As MHNs develop expertise in their areas of practice, there is also a need to expand their scope of practice.

The views of participants surveyed echoed those of the participants in the semi-structured described in Chapter 5 when it comes to desire to experience a new practice area. The workload associated with working in the public mental health system results in the MHNs' work being that of containment. Shorter stays in acute settings and clients with more complex needs have resulted in a situation where a great deal of emphasis and nursing work is placed on ensuring safety and risk aversion (Elder, Sharrock, Maude & Olasoji, 2012). The last four reasons were 'to make mental service accessible and affordable', 'provide service to those

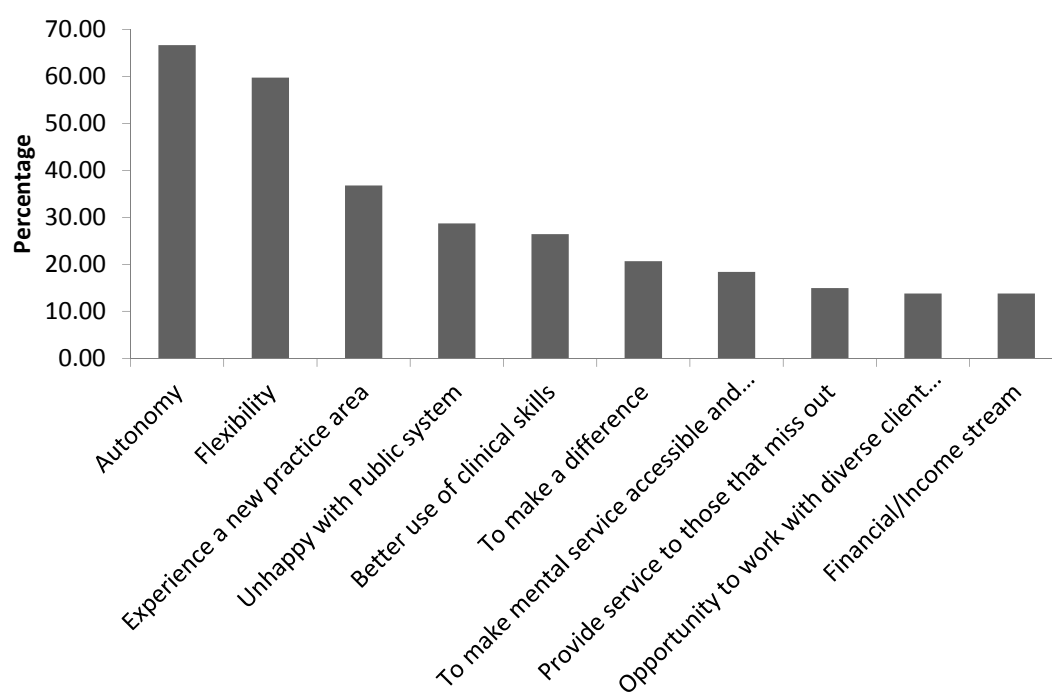
that miss out', 'opportunity to work with diverse client group' and 'financial/income stream".

Less than 20% of MHNs indicated these as the main reasons to work under the MHNIP.

Table 6.5: Main reasons influenced your decision to work as a MHN under the MHNIP.

	<i>N</i>	%	95% CI
Autonomy	58	66.67	(56.76, 76.57)
Flexibility	52	59.77	(49.47, 70.07)
Experience a new practice area	32	36.78	(26.65, 46.91)
Unhappy with Public system	25	28.74	(19.23, 38.24)
Better use of clinical skills	23	26.44	(17.17, 35.7)
To make a difference	18	20.69	(12.18, 29.2)
To make mental service accessible and affordable	16	18.39	(10.25, 26.53)
Provide service to those that miss out	13	14.94	(7.45, 22.43)
Opportunity to work with diverse client group	12	13.79	(6.55, 21.04)
Financial/Income stream	12	13.79	(6.55, 21.04)

^a 95% confidence intervals of percentage

Figure 8: Main reasons influencing the decision to work as a MHN under the MHNIP.

Reasons for Engaging a MHN under the MHNIP–GP Respondents

GP respondents were also asked in open-ended questions why they decided to engage the services of a MHN under the MHNIP. The reason for seeking open-ended question responses was the fact that there is no available Australian study that has explored the reasons that GPs would decide to engage the services of MHNs in general practice. The responses were then categorised, examined for commonality and assigned a number for the purpose of analysis via SPSS (Pallant 2011).

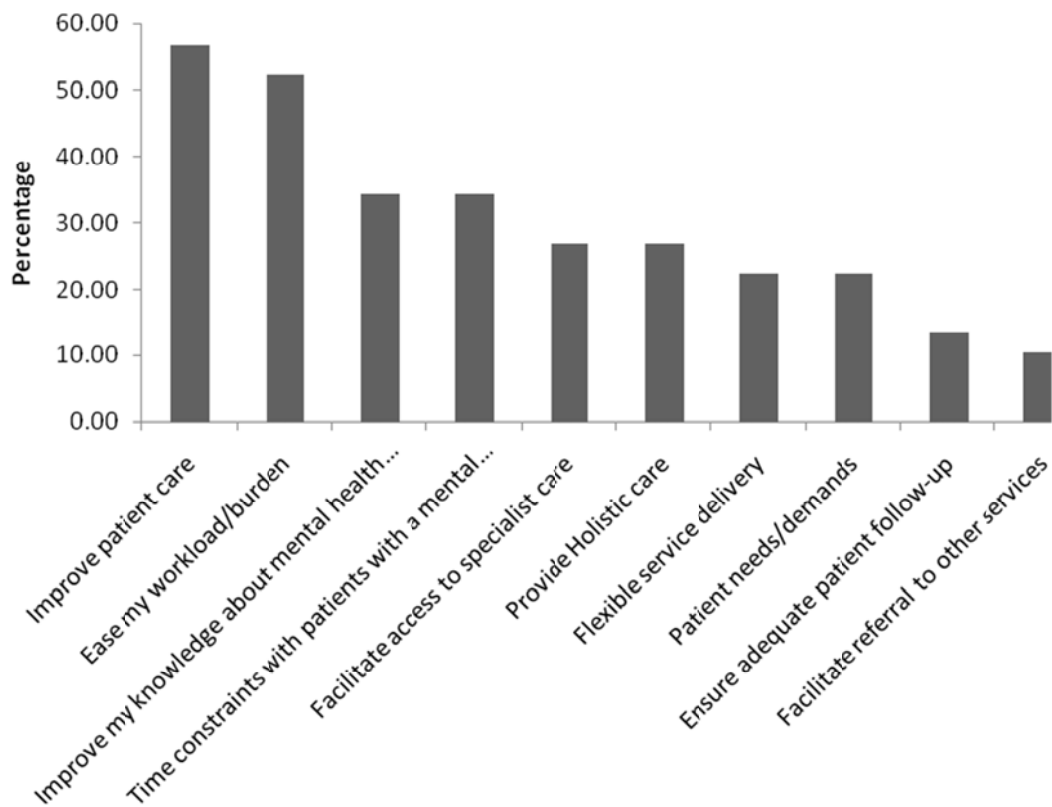
Table 6.6 and Figure 9 show the main reasons that influenced GPs' decision to engage the services of a MHN and the proportion of GPs who stated these as their reason. Just over half (56.72%) of GPs stated that 'improve patient care' was the main reason and this proportion was significantly higher than the proportion of GPs who stated all other reason except 'ease my workload/burden'. The second most-stated reason (52.24% of GPs) was 'ease my workload/burden'. The third to eighth ranked reasons were 'improve my knowledge about

mental healthcare', 'time constraints with patients with a mental illness', 'facilitate holistic care', 'flexible service delivery' and 'patient needs/demands'. The proportion of GPs who stated these as the main reason were from 34.33% to 22.39%. The least stated reasons (less than 20% GPs) were 'ensure adequate patient follow-up' and 'facilitate referral to other services'. GPs were interested in improving the care they provided to their patients with mental illness.

Table 6.6: Main reasons influenced your decision to engage a MHN under MHNIP

	<i>N</i>	%	95% CI
Improve patient care	38	56.72	(44.85, 68.58)
Ease my workload/burden	35	52.24	(40.28, 64.2)
Improve my knowledge about mental health care	23	34.33	(22.96, 45.7)
Time constraints with patients with a mental illness	23	34.33	(22.96, 45.7)
Facilitate access to specialist care	18	26.87	(16.25, 37.48)
Provide Holistic care	18	26.87	(16.25, 37.48)
Flexible service delivery	15	22.39	(12.41, 32.37)
Patient needs/demands	15	22.39	(12.41, 32.37)
Ensure adequate patient follow-up	9	13.43	(5.27, 21.6)
Facilitate referral to other services	7	10.45	(3.12, 17.77)

^a 95% confidence intervals of percentage.

Figure 9: Main reasons influencing the decision to engage a MHN under MHNIP.

Positive Impact of the Role of the MHN

Question B02 was common to both MHNs and GPs. Both groups of participants were asked in open-ended questions to identify four main impacts the role of the MHN has added to the practice in the care of people with a mental illness.

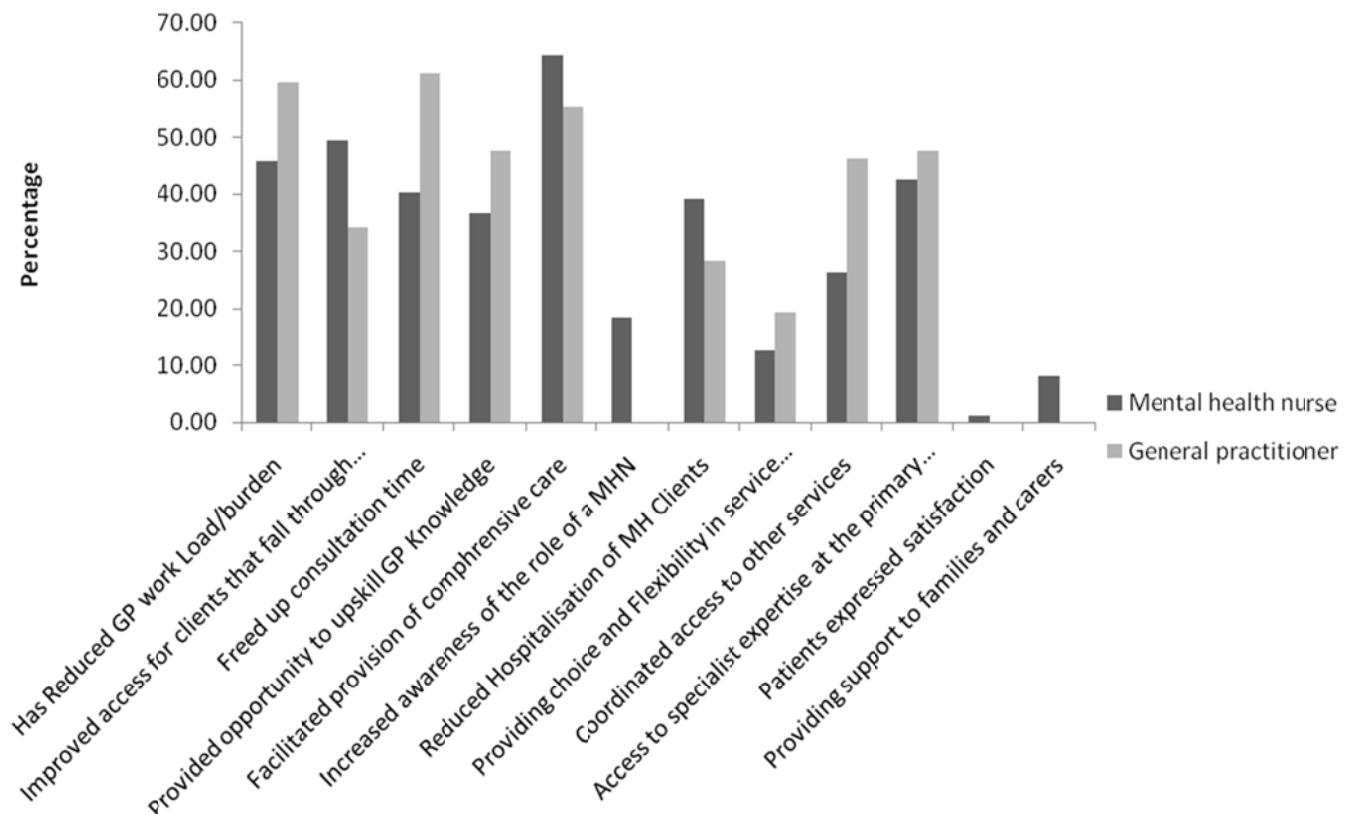
Table 6.7 and Figure 10 show the proportion of MHNs and GPs who stated different positive impacts of the presence of a MHN in general practice. For MHNs, the top three stated positive impacts were ‘facilitated provision of comprehensive care’ (64.37%, n=43), ‘improved access for clients that fall through the gaps’ (49.43%, n=33) and ‘has reduced GP work load/burden’ (45.98%, n=31). For GPs, the top three stated positive impact was ‘freed up consultation time’ (61.19%, n=41), ‘has reduced GP work load/burden’ (59.70%, n=40), and ‘facilitated provision of comprehensive care’ (55.22%, n=37). There was a significant difference in proportion of stating ‘freed up consultation time’ and ‘coordinated access to other services’

between MHNs and GPs, $p = .016$ and, $p = .017$ respectively. A significant higher proportion of GPs stated these two as the main positive impact of having MHNs working in general practice. For all other reasons, the results of GPs' and MHNs' responses were not significantly different ($p > .05$).

Table 6.7: Impact of the role of the MHN by profession.

	Mental health nurse		General practitioner		χ^2
	n	%	n	%	
Has Reduced GP work Load/burden	40	45.98	40	59.70	2.33
Improved access for clients that fall through the gaps	43	49.43	23	34.33	2.93
Freed up consultation time	35	40.23	41	61.19	5.84*
Provided opportunity to up skill GP Knowledge	32	36.78	32	47.76	1.45
Facilitated provision of comprehensive care	56	64.37	37	55.22	0.97
Increased awareness of the role of a MHN	16	18.39	18	26.87	1.12
Reduced hospitalisation of MH Clients	34	39.08	19	28.36	1.48
Providing choice and Flexibility in service delivery	11	12.64	13	19.40	0.85
Coordinated access to other services	23	26.44	31	46.27	5.70*
Access to specialist expertise at the primary care level	37	42.53	32	47.76	0.23
Patients expressed satisfaction	1	1.15	0	0.00	N/A ^a
Providing support to families and carers	7	8.05	0	0.00	N/A ^a

^aAssumption of χ^2 was violated due to small cell size. Fisher's exact test was used instead.

Figure 10: Impact of the role of the MHN.

SECTION 2

This section of the chapter presents results from Likert Scale questions exploring various aspects of the role of MHNs as well as overall care in a primary health care setting of people with a mental illness.

Factors Impacting on the Role of the MHN

MHNs were asked (Items C04–C15) to state on a Likert Scale (1=Strongly Agree to 5=Strongly Disagree) to what extent they agreed on certain statements relating to the impact of certain factors on the enactment of their role in primary care. Items C04, C05, C06, C08 & C11 were selected to form the factor as there was a good level of agreement between the items. The items had a Cronbach's alpha coefficient of 0.752. Under the MHNIP, MHNs have to work alongside GPs and other health professionals while carrying out their role under the MHNIP. GP and other health professional related factors were important to the MHNs when it

comes to the enactment of their role. Most of the participants reported the personality of the GP (79.3%, n=69), the philosophy of the GP (86%, n=75), the model of collaboration (87.3%, n=76), as well as the relationship with other members of the multidisciplinary team (80.4%, n=70) as factors that impact on the enactment of their role.

MHN Ability to Look After People with SMI

MHNs were also asked (Item C04s–C15) to state on a Likert Scale (1=Strongly Agree to 5=Strongly Disagree) to what extent they agreed with certain statements relating to their ability to look after people with a severe mental illness in primary care. Most of the MHN participants (97.7%, n=85) reported that they had sufficient time to look after people with a severe mental illness (Question D20) and they were equally confident of providing such care without assistance (90.8%, n=79). However, as expected, 94% of GPs (n=63) did not believe they had time to provide care to people with a severe mental illness and were equally not confident on taking on such a role without assistance (85.1%, n=57). This view is consistent with what has been previously reported in the literature about the ability of GPs to manage people with a severe mental illness (Zantinge et al., 2005). Both MHNs (91%, n=80) and GPs (94%, n=63) believed the MHNIP is well targeted for people with a severe mental illness (Question D22).

Positive and Negative Aspects of the Role of the MHN

Items G64–G74 related to what aspects of their role MHNs found positive. MHNs were asked to state on a Likert Scale (1=Strongly Agree to 5= Strongly Disagree) to what extent they agreed on certain statements. 51.7% of the participants (n=45) reported they did not have enough time to carry out all their other duties, which is surprising given the fact that the majority of their time was devoted to clinical work. The aspects of the job that the MHNs did not have sufficient time to carry out were not explored in this study. However, in response to Question C15, which asked whether having to follow-up billings and other administrative

matters with Medicare was a barrier to their role, 54% (n=47) reported in the affirmative. 56.3% of the MHN participants (n=49) reported having regular updates about their role under the MHNIP, it is unclear what sources the MHNs utilise to obtain such updates but Medicare Australia usually provides quarterly updates about the MHNIP. There is a role for ACMHN to also provide such updates. Rather surprisingly, even though 63.2% of the MHNs (n=56) did not believe their salary was commensurate to their work (Question G68) or that there was a career structure available under the MHNIP (60.9%, n=54), most of the participants (98.8%, n=87) reported that they enjoyed their work under the MHNIP (Question G74). During interviews with the MHNs in Phase 2 of the study, most reported that they had a drop in their salary/conditions coming into the program. However, the loss in conditions was compensated by the others factors/benefits the role has brought to the nurses, such as autonomy, flexibility and variety of work. The opportunity to utilise their clinical skills (Question G70) was reported by 87.4% of MHNs (n=76). As reported earlier in Chapter 2, the lack of opportunities to adequately utilise their skills has been associated with job dissatisfaction and intentions to leave by nurses.

During interviews with the key stakeholders, there were concerns raised about how the MHNs would access clinical supervision. Although this problem seems to have been overcome by the MHNs, as 87.9% of the participants (n=76) reported having adequate clinical supervision in place (Question G73), this does not necessarily mean they receive such support as part of the funding arrangement available through the MHNIP. During the semi-structured interviews with the MHNs in Phase 2, most reported not having enough time built into the program for them to access clinical supervision. However, in recognition of the value of clinical supervision, most of the participants made their own arrangements to access clinical supervision outside of the program funding arrangement, which often involves paying to obtain such service.

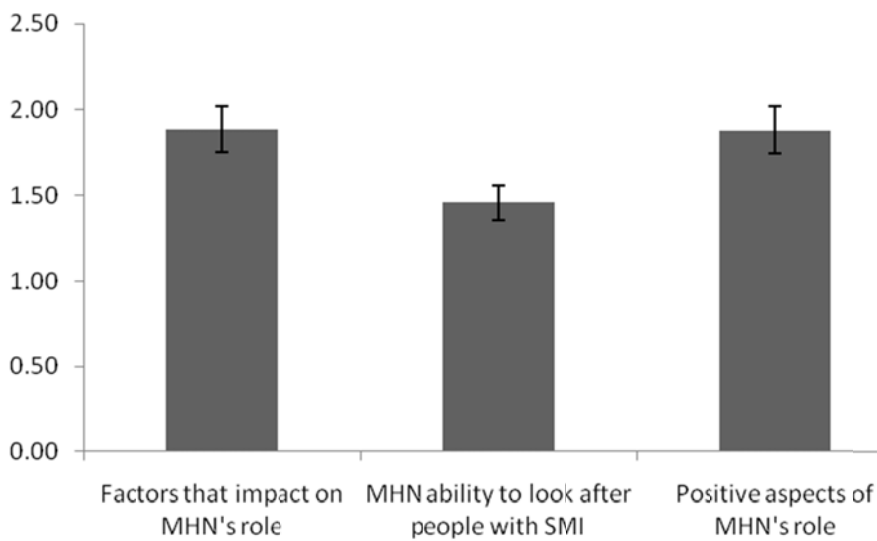
Table 6.8 shows the descriptive statistics of three scales: ‘Factors that impact on MHN’s role’, ‘MHN ability to look after people with SMI’ and ‘Positive aspects of MHN’s role’. Figure 11 shows the mean score and the 95% confidence intervals.

Table 6.8: Factors that impact on MHN's role, MHN ability to look after people with SMI and Job satisfaction.

	Mean	SD	95% CI	Median	IQR
<u>Factors that impact on MHN's role</u>					
C04: The personality of the GP with whom I work with at the practice					
C05: The Philosophy of the GP with whom I practice					
C06: Orientation to the multidisciplinary team at the Practice					
C08: The GP's model of operation (e.g. collaborative or consultative practice)					
C11: Working relationship with other providers within the practice					
	1.89	0.65	(1.75, 2.02)	1.80	.80
<u>MHN ability to look after people with SMI</u>					
D20: I have sufficient time to provide comprehensive care to clients with serious mental illness in my practice e.g. schizophrenia, bipolar					
D21: I can effectively manage clients with severe mental illness without assistance					
D22: The Mental Health Nurse Incentive Program is well targeted towards clients with a serious mental illness					
	1.46	0.47	(1.36, 1.56)	1.50	1.00
<u>Positive and negative aspects of the job</u>					
G64: I have enough time to perform all my work					
G70: I have adequate opportunities to use my skills					
G71: My hours of work are satisfactory to me					
G72: I have an enough variety in my work, i.e. client mix, types of interventions					
G73: I have adequate clinical supervision arrangements in place					
G74: I enjoy the work I am doing under the MHNIP					
	1.88	0.66	(1.74, 2.02)	1.71	.86
(Rating Scale: Strongly Agree=1, Agree=2; Unsure=3; Disagree=4; Strongly Disagree=5)					

NOTE: Relevant Items listed under the 3 Main Factors

Figure 11: Means and 95% confidence intervals of factors that impact on MHN's role, MHN ability to look after people with SMI and positive aspects of the job.



Person Who Should Look After Mental Health Patients

Both GPs and MHNs were asked (Items E30–E42) to indicate on a Likert Scale (1=Strongly Agree to 5=Strongly Disagree) to what extent they agreed to statements relating to the most appropriate health professional that should provide care to people with a severe mental illness in primary care. There was significant difference between MHNs and GPs in the scale ‘Person who should look after mental health clients’ ($t(152) = 4.25, p < .001$), with GPs scoring higher in this scale. Both GPs and MHNs believe that MHNs are the most appropriate professionals to look after people with serious mental illness in a primary health care setting (Question E30), with 95.6% of GPs ($n=64$) and 86.2% of MHNs ($n=76$) agreeing. There was also an agreement in Question E31 that MHNs have the skills needed to provide adequate care for clients with a severe mental illness (63 GPs, 94.5%; 87 MHNs, 98.8%). Equally, 86.5% of GPs ($n=58$) and 94.2% of MHNs ($n=83$) believe that MHNs have the ability to coordinate the care of people with a serious mental illness in the primary health care setting (Question E42).

Treating Mental Health Patients in Primary Health Care

Section C: Both GPs and MHNs were asked (Items D17–D24) to indicate on a Likert Scale (1=Strongly Agree to 5=Strongly Disagree) to what extent they agreed on certain statements relating to the provision of mental health care in the primary health care setting. Three items (D17, D22 & D24) had a Cronbach's alpha coefficient of 0.780, suggesting a good level of agreement between the items. The addition of other items under this factor (treating mental health patients in primary health care) resulted in a lower score. There was significant difference between MHNs and GPs in the scale 'treating mental health patients in primary care' ($t(152) = 3.54, p < .001$) with GPs scoring higher in this scale. When asked whether primary health was a suitable place to look after people with a serious mental illness (Question D17), 95.4% of MHNs ($n=84$) agreed compared to 94% of GPs ($n=63$). Both participants believe that the MHNIP is well targeted towards clients with a serious mental illness (Question D22) with 90.8% of MHNs ($n=80$) and 82.1% of GPs ($n=55$) agreeing respectively. There is also an agreement between MHNs and GPs that it is better to provide care to people with serious mental illness in primary health care setting, with 85% of MHNs ($n=74$) and 95.5% of GPs ($n=64$) agreeing.

Role of Mental Health Nurses in Primary Health Care

Section D: Both GPs and MHNs were asked (Items E41–E51) to indicate on a Likert Scale (1=Strongly Agree to 5=Strongly disagree) to what extent they agreed on certain statements relating to the role of MHNs in primary care. Seven items had a Cronbach's alpha coefficient of 0.814 (Items E41, E45, E46, E47, E48, E50, and E51). There was significant difference between MHNs and GPs in the scale 'role of MHN in primary care' ($t(108.12) = 4.53, p < .001$) with GPs scoring higher in this scale; however, there was a strong agreement about what the role of the MHN should encompass in the primary health care setting. This ranges from the ability to build therapeutic relationships with clients, provide education about medications,

and education to clients and their families/carers. Other roles of MHNs include educating other members of the practice about mental health issues, acting as screening agents in order to direct clients to the most appropriate services and providing health promotion activities.

Collaboration between GPs and MHNs

Section G: Both GPs and MHNs were asked (Items F54–F60) to indicate on a Likert Scale (1=Strongly Agree to 5=Strongly Disagree) to what extent they agreed on certain statements relating to the nature of collaborative practice that exists between the two professionals in primary care. For the scale, ‘collaboration between GPs and MHNs’, there was no significant difference between MHNs and GPs, $t(133.16) = 1.03$, $p = .30$. From the analysis of the results, there seems to exist a good level of collaboration between MHNs and GPs. As noted in Chapter 5 of this study during the initial implementation of the MHNIP, some participants reported difficulties when it comes to communication with GPs; however, they also reported this was overcome through proper dialogue and clear definition of roles. Surprisingly, both GPs and MHNs have responded in the affirmative when asked about their level of collaboration.

In response to Question F54 about whether they both work together in making decisions, 82 MHNs (94%) and 65 GPs (97%) agreed with the statement and also 77% of MHNs ($n=68$) and 95% of GPs ($n=64$) believed they took into consideration both medical and nursing perspectives in making decisions about patient care (Question F57).

Both MHNs and GPs believed there was a clear boundary between their roles (Question F55) with 84% of MHNs ($n=73$) and 88% of GPs ($n=59$) agreeing about the statement and they both respected each other’s expertise and skills (Question F58) with 92% of MHNs ($n=81$) and 100% of the GPs ($n=67$) agreeing. Most GPs (91%, $n=61$) agreed that they were fully aware of the MHNs’ scope of practice (Question F59) compared to 64% of MHNs ($n=56$) that

agreed with that view. Overall, there is a good working relationship between GPs and MHNs; given the fact that MHNs have experience working mainly with psychiatrists when it comes to mental health care, this is rather good. It is also positive to note that the skills and expertise of MHNs are respected in primary health care settings by GPs.

Table 6.9 shows the means and standard deviations of the four scales: ‘person who should look after mental health clients’, ‘treating mental health patients in primary care’, ‘role of MHN in primary care and collaboration’ and ‘collaboration between GPs and MHNs by profession’.

Table 6.9: Descriptive statistics of ‘person who should look after mental health clients’, ‘treating mental health patients in primary care’, ‘role of MHN in primary care’ and ‘collaboration between GPs and MHNs by profession’.

	MHNs		GPs		t
	M	SD	M	SD	
<u>Person who should look after mental health clients</u>	1.47	0.50	1.84	0.58	4.25***
E30: MHNs are the most appropriate health professionals to provide care for clients with SMI in PHC settings					
E31: MHNs have the skills needed to provide adequate care for clients with SMI					
E42: MHNs are able to coordinate care of people with serious mental illness in PHC					
<u>Treating mental health patients in primary care</u>	1.52	0.57	1.87	0.61	3.54**
D17: Primary health is a suitable place to look after clients with a serious mental illness					
D22: The Mental Health Nurse Incentive Program is well targeted towards clients with a serious mental illness					
D24: Mental Health service provision is inadequate in primary care					
<u>Role of MHN in primary care</u>	1.35	0.36	1.70	0.54	4.53***
E41: Building therapeutic relationships with clients is an essential element of the MHN's role					
E45: MHNs should be able to provide health education about psychotropic medications					
E46: MHNs have a major role in providing education to clients and their families about mental illness					
E47: MHN have a role in educating other members of the practice about mental health related issues					
E48: MHN should act as a screening agent in order to direct clients to the most appropriate resources available					
E49: MHNs should provide leadership in primary mental health care					
E51: MHN should be initiate mental health promotion activities in PHC					
E52: It is essential that MHNs have family therapy skills when working in primary care					

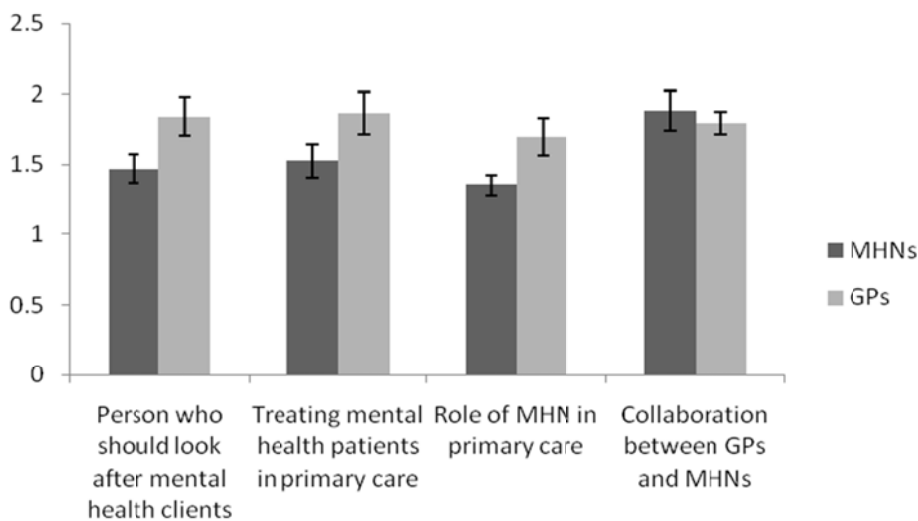
Collaboration between GPs and MHNs

	1.88	0.66	1.80	0.33
F54: The GP and I plan work together to make decisions about the care of patients				
F55: I believe there is a clear boundary between my role and that of the GP				
F56: I would describe our frequency of communication as adequate				
F57: The GP and myself both consider medical and nursing considerations in making decisions about patient care				
F58: The GP and myself both respect each other's expertise and skills in decision making about patient care				
F59: The GP is fully aware of the scope of practice of my role				
F60: Collaborative practice between GPs and MHNs enables good clinical outcomes for the patients				
				1.03

**** $p < .01$; *** $p < .001$** (Rating Scale: Strongly Agree=1, Agree=2; Unsure=3; Disagree=4;

Strongly Disagree=5)

Figure 12: Means and 95% confidence intervals of treating mental health patients in primary care, role of MHN in primary care and collaboration between GPs and MHNs by profession.



Summary of Chapter

This chapter has presented findings from Phase 3 of this study, which involved the administration of questionnaires to mental health nurses and general practitioners about the role of MHNs in primary health care under the MHNIP. The main activities and interventions used by the MHNs were presented. The findings are consistent with some of the findings reported in the literature from non-Australian studies. The findings also corroborate the findings from Phase 2 of this study. In addition, the findings from the chapter provide the views of GPs that were not included in the second phase of the study. These, included the GP's views about the impact of the role of the MHNs as well as reasons that made them engage the service of the MHNs. Importantly, the reasons stated by the key stakeholders in Chapter 4 of this study for the establishment of the MHNIP align with the views of both GP and MHN participants.

The last chapter of this thesis (Chapter 7) provides discussion of the major study findings, considers both the study's strengths and limitations, makes recommendations, suggests implications for clinical practice and further research, and provides a conclusion to the study.

CHAPTER 7

DISCUSSION, RECOMMENDATIONS FOR PRACTICE AND CONCLUSION

The purpose of this study was to explore the role and scope of practice of mental health nurses working in the Australian general practice setting under the Australian Government's initiative entitled the Mental Health Nurse Incentive Program (MHNIP). The MHNIP extended the area of practice of Mental Health Nurses who had traditionally worked in acute public and private in-patient psychiatric wards and within community mental health teams. There has been no study in Australia that has explored what contribution Mental Health Nurses can make to the provision of mental health care at the primary care level. Hence, this study sought to answer the following questions:

1. What were the drivers for the establishment of the MHNIP?
2. What are the reasons behind MHNs' desire to work in primary health care and the reasons why general practitioners engage the services of mental health nurses in their practice?
3. What role do MHNs play in the delivery of mental health care in primary health care settings?
4. What factors impact on the enactment of the role of the MHNs in the delivery of mental health care under the MHNIP?
5. What impacts has the role of MHNs had in primary health care?
6. What is the nature of collaboration between GPs and MHNs engaged under the MHNIP?

A three-phase study was undertaken to address these research questions.

Phase 1 was an initial scoping exercise, involving semi-structured interviews with individuals identified as key stakeholders in the establishment of the MHNIP. The purpose of this phase was to gather information about issues pertinent to the establishment of the MHNIP. At the time of conducting Phase 1 of the study there was no publicly available information regarding how the role MHNs was to be enacted. It was also useful to gather information about the intended outcome for the program from key stakeholders.

Phase 2 of the study involved semi-structured interviews with MHNs from various general practices across Victoria, Australia. The purpose of this phase of the study was to explore the issues surrounding the establishment of the MHNIP including the type of nurses working under the program, why they decided to work and what type of work they were engaged in.

Phase 3 of the study was designed to extend findings from the semi-structured interviews in developing instruments for both MHNs and GPs and capture a much wider population. A total of 88 MHNs and 67 GPs were sampled during the phase. There was a 69% response rate from the MHNs (from a total of 128 surveys sent out) and 50.4% response rate from GPs (from a total of 125 surveys sent out). A response rate of about 48% according to Thorpe et al. (2009) has been associated with GP/physician studies. The GP response rates to surveys have been reported to be more substantial when financial incentives are added (Barclay et al., 2002). This study did not have the funding to offer such incentives, but nonetheless claims a typical (and thus good) response rate.

The findings are examined under the framework of Donabedian's structure-process-outcome model of quality care (Sidani & Irvine, 1999). *Structure* consists of nurse, patient, and organizational variables that influence the processes and outcomes of care delivered. The nurse's experience, knowledge and skills are some of the items that are nurse-related. Patient variables are those reflecting demographic characteristics such as age and gender, illness-

related characteristics such as severity of illness; and physical and psychosocial function at the time of admission to health care. Organizational variables focus on measures of staffing patterns such as staffing mix and workload. Research questions 1 and 2 provide the structure.

Process represents the independent, interdependent and dependent roles that nurses assume for delivering care. Research questions 3, 4 and 6 relate to the process of care. *Outcome* includes nursing-sensitive patient outcomes, defined as patient states, behaviours or perceptions resulting from nursing actions. Outcome examines the impact of care delivery (Research question 5).

This chapter provides a discussion of key findings from the study and these will be presented in relation to each of the research questions posed. These key findings will be discussed with reference to and reflection on existing literature. The chapter considers the strengths as well as limitations of the study. Recommendations are made for practice, training, policy and further research, and general conclusions are made.

Key Findings from the Study

Question 1: What were the drivers for the introduction of the mental health nursing role in primary care?

There are currently attempts in most developed and developing nations of the world to position their primary health sector as a vehicle for the delivery of health care that is affordable and accessible to the entire population. The primary health care setting remains a strategic mode for the delivery of such services. Health systems with a strong primary care focus have been known to be associated with improved equity, better access for patients to an increased number of appropriate services at lower costs, and improved population health (Atun, 2004). The World Health Organization noted in the *World Health Report* that nations

should avoid excessive focus on specialised health services in order to maintain sustainable health services (WHO, 2008).

In Australia, the process of deinstitutionalisation witnessed the closure of large psychiatric institutions and integration of psychiatric services with the mainstream public health system. This process of deinstitutionalisation also initiated the opening of several community-based mental health services to enable people with long term mental illnesses to receive on-going care in the community. However, the funding/resources available for these individuals have not kept pace with the increased number of people seeking or receiving community-based care. Most case managers/care coordinators in community-based mental health services often struggle with high case load size which has been associated with increase in stress and burnout (Edwards et al., 2000). This means the capacity to provide services for more people becomes diminished as the service struggles to adequately cater for all the needs of the clients. This has led to situations whereby people who require treatment often miss out on such treatment and are sometimes labelled as ‘not sick enough’ or ‘not for service’ (Mental Health Council of Australia, MHCA, 2005).

Consumer, carers and the general public have been advocating for the establishment of more accessible and affordable specialist mental health care. There has been a similar move from other countries such as the United Kingdom, New Zealand, United States and Canada, all of which have witnessed the establishment of programs/initiatives whereby specialist mental health care has been made available at primary care settings especially general practices to facilitate greater access to mental health care by the population.

This study sought to understand the reasons behind the establishment of the Australian Government’s MHNIP, an initiative whereby specialist mental health nurses are engaged by general practitioners and other eligible organisations to work in general practices across

Australia. The MHNIP provides an opportunity to change the role of primary health care as ‘gatekeeper’ for specialist mental health services. The researcher interviewed key stakeholders who were involved in the initial establishment of the MHNIP (a program that has led to the expansion of the role of mental health nursing into the primary health care setting). The findings reveal that there was no real evidence-based research that informed the establishment of the program; similar programs from other countries were not carefully looked at or considered to inform the design of the MHNIP. One of the events that ‘jump started’ the need for reform of how mental health care was delivered in Australia was the establishment of a Senate Select Committee on Mental Health in 2005. The committee identified shortcomings in the way mental health care is delivered in Australia in their report, *A national approach to mental health-from crisis to community*. The committee also suggested the establishment of new direct Medicare recurrent funding at the primary health care level to meet the needs and demands of people living with a mental illness. There was an identified gap in service delivery; several people in the community were missing out on much-needed service and the public health sector was struggling to cope with the ever-increasing demand for services. Once again, nurses were called upon as key professional group to provide the needed specialist mental health care at the primary care level.

According to key stakeholders from this current study as well as policy documents reviewed, the primary aim of establishing the MHNIP was to increase accessibility to care for people suffering from a severe mental illness by tapping into the opportunity that settings such as general practice offers. Findings from this study suggests that people who may have lost contact with psychiatric services or may have been considered as ‘not sick enough’ to warrant follow-up by community based mental health services are having access to specialist mental health care by MHNs in general practice. Hence, the desired outcome to improve access to care has, to a large extent, been met.

The finding from this study in terms of the impact of the presence of specialist mental health professional in primary care is consistent with previous studies from the literature that examined similar integration models. The Hamilton-Wentworth HSO Mental Health Program in Canada for example was set up as a result gaps identified in the system when it comes to accessing of mental health services. The program resulted in increased accessibility to mental health services following the addition of mental health counsellors to primary care practices (Kates et al., 1997). Similarly in New Zealand, the Primary Mental Health Initiatives, a program that introduced the delivery of mental health services in general practice by specialist mental health professionals (including MHNs), was found to have improved access to mental health care. Again, access to care was a big driver for the establishment of the initiative. For the New Zealand initiatives, however, a greater percentage of those accessing the services were patients with high-prevalence disorders (Dowell, et al., 2009).

Another reason the role of MHNs was introduced to general practice through the MHNIP was to ease the workload or burden of care faced by GPs. There is agreement in the literature that GPs are often reluctant to ‘get involved’ with mental health care in general practice due to factors such as the complex nature of certain mental illnesses, which increases the overall workload and consultation time for GPs (Lang, Johnstone & Murray, 1997; Younes et al., 2005). Without adequate financial and specialist mental health professional access, GPs become quite reluctant in providing long-term care to people with a serious mental illness. GPs in this study were asked to state the reasons why they decided to engage the services of a MHN in their practice. A vast majority of the GPs listed easing their workload and freeing up consultation time as one of the major reasons of taking part in the MHNIP. The presence of the MHN facilitates the linkage of patients to other agencies that are vital to the overall recovery.

Studies from the UK, Canada, USA and other developed nations have reported on the perceived barriers that GPs identified when providing care to people with a mental illness in general practice. In these studies GPs noted that inadequate remuneration, increased work load demand, difficulty accessing specialist mental health care and co-morbid substance abuse issues that patients often present with as some of the barriers that they encounter (Fleury, et al., 2012b; Younes et al., 2005). It has also been reported that GP services for people living with a mental illness are more responsive to needs for medication, counselling and information than needs for social interventions and skills training, hence the need for specialist mental health professionals such as mental health nurses (Meadows, Liaw, Burgess, Bobevski & Fossey, 2001).

In terms of the initial work that went into the establishment of the MHNIP, there was not a great deal of consultation that was carried out with key professional groups especially those representing MHNs. According to the key stakeholder representing the MHNs that were interviewed for this study, the government had developed the design of the program and all they had to do was just to ‘tweak’ around the edges of the guidelines. Designing a program that has a huge impact on the way MHNs carry out their role without initial input from the key professional group representing the interest of MHNs and then inviting them to ‘tweak’ around the edges seems rather tokenistic.

Mental health nurses need to be more vocal and political when it comes to matters that would impact on the way they practice their profession. They should be deeply involved in policy development beyond the level of ‘tweaking around the edges’ of already-formulated policies that impact on their practice. This view is corroborated by Hayman-White, Sgro and Happell (2006), who noted the poor representation of mental health nurses in the Productivity Commission’s call for submissions in its health workforce study and the Senate Select

Committee on Mental Health. According to Ballou & Landreneau (2010), the nursing profession in spite of its large number, remains socio-politically weak and internally divisive. This has contributed largely to the nursing profession lack of strong voice when it comes to the health policy debates.

The World Health Organization (2007) noted that as the largest group of health professionals providing care, nurses are important stakeholders and should be involved in health policy development. The role of the MHNs, like the role of their practice nurse counterparts, has been shaped largely by government initiatives (Porritt, 2007). The Chronic Disease Initiative announced in the 2001 Federal Budget defined the role for a practice nurse to provide certain aspect of care on behalf of GPs, especially in the area of asthma and diabetes care (Porritt, 2007). Again the scope of practice of the practice nurses was largely driven by government policy rather than one that is driven by wider consultation or evidence-based practice. It is important that nurses have a greater say in policies that would impact on their clinical practice and the way they deliver care to their patients. Lathrop (2013) suggested nurses have a role to play in educating policy-makers. The author noted policy-makers often pass legislation regarding health care without a complete understanding of the ways in which these policies impact health status.

Question 2: What are the factors that influence mental health nurses to work in primary care and what factors influence general practitioners to engage the services of a mental health nurse?

In Australia, mental health nurses have traditionally worked in acute in-patient, community-based mental health teams and private psychiatric hospitals. Recently, mental health nursing has witnessed an extension of its scope of practice with the establishment of nurse practitioner positions in emergency departments, crisis assessment teams, drug and alcohol services, as

well as primary health care (Middleton, Gardner, Gardner & Della, 2011). Even though nurse practitioners have started to take on roles in primary health care in Australia, mental health nurse practitioner positions are yet to be introduced into the primary health care setting compared with places like the United Kingdom and the United States (Philip, Lucock & Wilson, 2006; Middleton, Gardner, Gardner & Della, 2011). Australian general practice has been an area where there has been limited presence of mental health nursing. Previous Australian trials have seen mental health nurses take up liaison roles through Area Mental Health Services whilst still remaining employees of the public mental health system. One such trial was the North West Melbourne Area Mental Health Service in Victoria that established the Consultation Liaison in Primary Care Psychiatry (CLIPP) service model. Under this model, case managers within the area mental health service identify potential clients who are mostly clinically stable, without recent relapse, and have good insight and some social support. A mental health nurse then acts as a liaison for the transition whilst still being employed by area mental health services (Meadows, 1998). The MHNIP adopted a different model as the MHNs are actually situated within general practice working collaboratively with GPs. In most cases, MHNs are not employed in the public mental health sector.

MHN participants in this study decided to take up this expansion of their scope to practice into primary health care (particularly general practice) for various reasons. The MHNs liked the autonomy and flexibility that working in general practice offers. Their clinical skills and expertise were not only appreciated but there was also scope for them to utilise these skills in practice. McNamara et al. (2008) examined aspects of the role of mental health nurse consultation-liaison that provided job satisfaction. They noted factors such as autonomy, different clinical settings and use of a range of skills as some of the reasons they were satisfied with their job. Most of the MHN participants in this study rated the ability to work

more autonomously and within a flexible framework as very important aspects of overall job satisfaction. This is also consistent with the study by Zurmehly (2007) in which 96% (n=48) of community health nurse participants rated as highly important the autonomy and flexibility of their role. Even though community mental health nurses (CMHNs) reportedly found their job more rewarding than hospital-based mental health nurses (Edwards et al., 2000), there remains within a community mental health team structure a sense of frustration among CMHNs regarding autonomous practice as the medical model continues to dominate. Fagin and Garelick (2004) noted that there have been efforts by nursing to move from dependency to autonomy and mutual interdependency. This is a move away from the subservient role that has been placed upon nursing through such things as institutionalisation and gender stereotypes.

The MHNIP is a welcome development and opportunity for mental health nursing to further position itself as a unique professional group with valuable contributions to the overall wellbeing of the population. Given the gradual 'deskilling' of the role of the MHN over the years (Fisher, 2005), the opportunity to put to use valuable skills and expertise of the MHN is a good thing for mental health patients.

On their part, the majority of the GPs stated the need to improve overall patient care as one of the reasons they decided to engage the services of a MHN. Other reasons identified were the lack of time or skills to provide comprehensive care to their mental health patients. Most GPs believe mental health patients take up a lot of consultation time in general practice. This view is consistent with studies in the literature that have examined the workload of GPs and some of the barriers that they face in providing care to people with a severe mental illness. Most studies identify workload and burden of care as major obstacles confronting GPs (Kendrick, 2007; Bushnell et al., 2005).

Waite et al. (1997) examined the work of clinical case managers within a community mental health team. It was noted by these authors that due to high case loads, the time available for direct client clinical contact was limited, with administration and other activities taking up 54% of the time. MHNs in this study reported that they had enough time within their role to provide care to people with a severe mental illness, and clinical work occupies the majority of their time.

The MHNIP was seen by the participants as offering a new and exciting field of their nursing career. Participants were quite pleased with the prospect of working in general practice. The Australian Health Workforce Advisory Committee (AHWAC, 2003) looked at factors that contribute to the high attrition rate amongst the MHN workforce as well as strategies that can be implemented to promote retention.

The Committee proposed, as part of its recommendations, the possibility of encouraging mental health nurses to work in different clinical settings in order to offer them the opportunity to allow them to experience new and different patients, peers and situations.

Question 3: What role do mental health nurses plays in the delivery of mental health care in general practice?

Although primary health care is a relatively new area of speciality for mental health nurses, there has been a quick assimilation or adaptation into the area as evidenced from the findings of this study. At the establishment of the MHNIP, the MHNs were given a set of guidelines as to what roles they were meant to fulfil. The nurses have not only provided such services but have also been innovative in the way they provide care for people living with a severe mental illness.

One of the major roles in which MHNs are engaged is the coordination of care for people with a serious mental illness. It has been well reported in the literature that people with a severe mental illness often find it hard to navigate the variety of services available to maintain adequate social functioning due to sometimes the nature of their illness. Case management has been identified as a common model for arranging community-based services for people with mental illness living in the community (Bjorkman & Hansson, 2007). Across Australia, case management/care coordination has been implemented in many mental health services in an attempt to overcome deficiencies in community care, particularly those due to fragmented service systems and lack of continuity (Ziguras & Stuart, 2000). The practice of clinical case management, however, has been mainly limited to community-based mental health teams in which mental health nurses, social workers, occupational therapists and psychologists act as case managers. The establishment of the MHNIP means MHNs can now carry out this role within general practice.

Even though there are various viewpoints in the literature as to the efficacy of case management, most authors agree that it improves patient outcomes (Ziguras & Stuart, 2000; Rosen & Teeson, 2010). Bjorkman and Hansson (2007) conducted a study in Sweden investigating changes with regard to symptoms, needs for care, psychosocial functioning, quality of life, and social network for 176 clients with a severe mental illness who were receiving case management services. After a six-year follow-up period, a number of positive clinical changes were noted in the quality of life and overall social network of the people living with mental illnesses, with a concurrent decrease in use of psychiatric services.

Unlike their community-based mental health team counterparts, who often struggle with excessive case loads and sometimes act as a contact person as opposed to a case manager (Muir-Cochrane, 2001), participants in this study reported having adequate time to cater for the needs of their clients. They were able to provide direct clinical services, develop

therapeutic relationships and work to achieve collaborative goals. This is a very significant aspect of the way the MHNIP guideline was established, the MHNs have the ability to cap the number of clients that they have under their care at any given time. It is often the case in community based mental health teams that there is no real cap as to the number of clients the team accept through referrals. This often leads to burnout among CPNs as they lurch from crisis to crisis.

Mental health nurses working in general practice are increasingly embracing principles of health promotion and disease prevention which is synonymous with primary health care. According to Duaso and Cheung (2002), nurses and doctors working in primary care have been identified as key figures to promote health. The primary health care setting provides a good platform for nurses to engage in health promotion and disease prevention. The MHNIP offers MHNs the unique opportunity to engage in health promotional activities aimed at improving the overall mental health wellbeing of the population. MHNs from the present study identified health promotion and teaching as part of their role in primary health care. Not only do they identify with these concepts, they also reported having enough time to incorporate it into their clinical practice.

Clinton and Hazelton (2000b) reported that in the midst of a hospital-based (and to a lesser extent, community-based) custodial role in which MHNs are engaged, other roles are often relegated to the background. The authors noted roles such as health promotion, illness prevention, patient education and wellness counselling have been given lesser attention. A study by Muir-Cochrane (2001) explored the case management practices of a group of community mental health nurses in metropolitan South Australia. Muir-Cochrane noted that while participants expressed commitments to the ideals of the primary health care model of care (including health promotion and ensuring positive client experiences), it was difficult to achieve such goals due to workload issues and the necessity to prioritise needs. This view is

corroborated by Simpson (2005), who noted that the capacity to provide hands-on therapeutic interventions for clients who are being case-managed was significantly hampered by high case loads of CMHNs. This is not the case from findings in this present study, as MHNs in primary care reported the ability to provide hands-on therapeutic interventions due to lower case loads.

Another important role of MHNs that was identified through this current study is the work with carers of their clients. The MHNs noted that as part of their treatment plans, they would routinely include the needs and views of the carers. This comes in the form of emotional support, education and at times, family therapy. This aspect of their role is crucial to the overall improvement of their clients. Carers play a significant role when it comes to looking after people with a serious mental illness. Carers represent a substantial part of the health economy in most countries. Providing such support, however, can be demanding, isolating and exhausting for carers and may result in mental health problems, stress and loneliness (Saunders, 2003; Macleod et al., 2011). The effects of caring have been widely studied and include burden, difficulty in coping and managing, impaired health, and low satisfaction with services (Ruane et al., 2004). So it is significant to see MHNs in primary care as having the ability to provide the needed support for carers of people living with a mental illness.

Another finding from this study as it relates to the role of the MHNs is the category of patients that they provide care for. Findings from Phases 2 and 3 of this study suggest that MHNs are providing care to a variety of patients, which cuts across those with high-prevalence disorders and serious mental illness. The Australian Government needs to look at ways of developing models of care that would support those with high-prevalence disorders, given the evidence in the literature that it is more cost-effective for MHNs to concentrate their efforts in looking after people with a serious mental illness (Kendrick et al., 2006). This would be in line with similar moves in countries like the UK where the National Health

Service (NHS) instructed Primary Care Trusts to employ and train 1,000 new graduate mental health workers to assist in improving access to psychological treatment in the primary care setting. Their target population were people suffering from high-prevalence disorders such as anxiety and depression (Gask, 2007).

Mental health nurses working in primary health care settings are providing the much-needed link between primary and secondary care. The two systems have long been divided and fragmented when it comes to providing care for people with a severe mental illness and more often than not it is the patients that miss out on comprehensive health care.

The roles performed by the MHNs in primary health care (general practice in particular) in Australia in this study are consistent with similar roles reported in the literature. The study by Richards, Rafferty and Gibb (2013) noted assessment, case management, and psychosocial interventions as some of the key roles played by MHNs in a primary care setting. Similarly, Smith (2002) asked CPNs how they viewed their role and assessment was identified as the first most commonly mentioned function. They also stated liaison, developing therapeutic relationships, medication monitoring and carer support as other functions. A study by Johnson, Coleman and Bowler (2001) examined the role of CPNs in Wales and listed medication management and education as essential activities in which CPNs were engaged. The CPNs also rated assessment, care plan formulation, care coordination, arranging reviews of progress and risk assessment as essential activities for CPNs. These roles are consistent with the roles MHNs in this current study engaged under the MHNIP. This highlights the huge potential available in primary health care settings to provide specialist mental health care to people living with a severe mental illness.

Question 4: What factors impact on the enactment of the role of the MHNs in the delivery of mental health care under the MHNIP?

One of the main barriers identified by the MHNs was the lack of allocated time within the current funding model for their role for clinical supervision. This is consistent with findings from the ACMHN (2010), which reported there was no allowance in the funding of the MHNIP for associated costs such as clinical supervision and professional development. The MHNs in this study demonstrated the value they placed in clinical supervision and most have put arrangements in place to obtain clinical supervision outside of the MHNIP funding model. This is not ideal, however, if the MHNs are expected to operate under the current funding arrangement whereby the GPs receive the incentives. There needs to a more formalised recognition of the need for clinical supervision. The values of clinical supervision have been well documented in the literature (Ashmore & Carver, 2000; Alleyne & Jumaa 2007). According to Driscoll (2007), clinical supervision provides a regular protected time for facilitated and in-depth reflection on clinical practice. The individual receiving clinical supervision is able within this setting to achieve, sustain and develop creative high-quality practice within a focused and supportive environment. The issue of clinical supervision was not adequately catered for in the design of the MHNIP and any future changes to the program should take this into consideration.

Another barrier identified by the participants is the current funding structure of the MHNIP. Mental health nursing and nursing generally still operate in a medically dominated environment. The medical profession has a very powerful and highly influential voice when it comes to the formulation of health care policies. Nursing has been facing an uphill task in the primary health care setting to fully exert its authority as an independent professional group. Nursing has not been historically associated with political activity; this has often led to the

decisions and issues relating to the profession being determined by others who are more dominant in the health care system. The current funding model of the MHNIP is another testament to the way the nursing profession is still dominated by the medical profession. Previous initiatives in mental health reform such as Better Access to Mental Health Care enables clinical psychologists to directly bill Medicare Australia or the consumer for services provided (consumers are then able to obtain a partial rebate from Medicare Australia). Under the MHNIP, the GP remains the fund holder.

In order to make the MHNIP an attractive and sustainable area of practice for MHNs, there is a need to put measures in place to include career progression in the design of the program. However, findings from the stakeholders interview suggest that the Government was reluctant to make this area of speciality too attractive for MHNs so as not to 'bleed' nurses from the public mental health system. It is therefore unclear what the future holds in terms of redesigning the career prospect and remuneration of MHNs working under the MHNIP. According to Shields and Ward (2001), dissatisfaction with promotion has been shown to have impact on nurse turnover; however, pay has been reported to have less impact on turnover or intentions to leave (Irvine & Evans, 1995). Most of the participants in this study noted that they experienced a drop in their pay moving from the public mental health system into general practice; however, to some extent this has been offset by other factors such as experiencing a new practice setting, autonomy and flexibility of their role and ability to utilise their clinical skills more effectively. At the moment, the salary or remuneration of the MHN is at the discretion of the eligible organisation engaging the nurse, although the Australian College of Mental Health Nurses suggests the nurses be paid at an hourly rate not lower than what a clinical nurse specialist in New South Wales, Australia is been paid. There needs to be a closer look at the current funding arrangement for the MHNIP.

Even though it was an exciting move for most of the participants to work in general practice, there were some challenges that they faced as they made the transition. The MHNs noted the need to understand the business model under which general practice operates. There was also the issue of infrastructure within the general practice. Floyd, Kretschmann, & Young (2005) noted that the needs of nurses who move from acute to community care are often enormous, and these nurses are sometimes ill-prepared to deal with the challenges of functioning independently in the community. Over the years, most mental health nurses have been able to work quite well in community-based services; however, general practice operates as a business model.

In fact, there has been criticism of the undergraduate nursing curriculum for not adequately preparing students to work in mental health, not to mention working as a MHN in primary care setting (Happell, Moxham & Clarke, 2011).

There is a need to extend undergraduate and post-graduate mental health nursing clinical placements into general practice. There is also the need to improve the knowledge of mental health nurses, as part of the overall curriculum, about the way general practice operates.

In terms of the factors that facilitated their role, the MHNs noted the satisfaction of working in general practice, making a difference in the lives of their patients as some of the factors. They also noted the ability to utilise skills that they would have normally used as a factor that contributed to their overall job satisfaction. Farrell and Dares (1999), in an Australian study examined nursing staff satisfaction on a mental health unit noted that lack of autonomy and undervalue by the medical staff were factors that impacted on their overall job satisfaction. Job satisfaction has been linked to absenteeism, burnout and intention to quit (Tzeng 2002).

Question 5: What impacts has the role of mental health nurses in primary care achieved?

The impact of the role of MHNs working under the MHNIP was examined utilising key stakeholders (GPs and MHNs) as key informants, similar to the approach utilised by Coster et al. (2006) described in Chapter 3 of this study.

According to Wilkin (2001), mental health nurses working in primary care have eight primary foci which their role should achieve. These include: raising the profile of and destigmatising mental health, promoting mental healthfulness, educating and training other members of the primary care team in mental health-related matters. Others include: responding to and comprehensively assessing anyone with a questionable or confirmed mental health problem, and acting as a screening and signpost agent who links people into the most appropriate resources. They are also meant to provide short therapeutic interventions for people with transient mental health problems, guiding people to and receiving people from secondary psychiatric services, and also ensuring that people who do not meet secondary services criteria do not fall through the net. Findings from this study suggest MHNs are fulfilling these objectives while enacting their role in the Australian general practice setting.

Findings from this study suggest that the presence of mental health nurses in primary care has resulted in increased capacity for GPs to provide care for people with a severe mental illness as reported by both GP and MHN participants in this study. It has made specialist mental health care more accessible to those living with a severe mental illness. It has also enabled people to access care close to their homes and often with GPs, with whom the clients have developed relationships for a number of years. It has been acknowledged in the literature that integrating mental health care and primary care opens up opportunity for more people to receive treatment for mental health-related disorders (WHO, 2008b). These findings are

consistent with the study by Meehan and Robertson (2013) in which GPs from that study reported the huge benefit of having a MHN present at their practice. The GPs noted their lack of appropriate skill and time to provide care for people with a serious mental illness.

Findings from this study are consistent with other studies in the literature that have examined the impact of attaching specialist mental health workers especially mental health nurses to general practice (Weaver, Patmore, Cunningham & Renton, 1999). Bindman et al. (1997) investigated the impact of having linked mental health workers in the primary care setting using a case-controlled methodology to determine whether this model of care affected hospital bed use. Their study also examined whether a focus on the patients with a severe mental illness could be maintained and also whether the model was cost-effective. Team members from a community mental health team were assigned to the patients with a severe mental illness cared for by the GP. The role of the mental health link workers was to establish a relationship with the GP, coordinate and facilitate referrals, and advise GPs on patients with high-prevalence disorders. Another nearby general practice served as the control group and they received usual support from community mental health teams. The link workers provided care to the patients at their homes or the GP clinic, facilitated referrals as needed and shared information with the GPs. Positive outcomes were reported including a more responsive service and fewer admissions to specialist mental health services. However, there was no evidence to suggest a compensatory cost offset to pay for the increased costs of the new service.

The World Health Organization (2007) suggested that the integration of mental health care and primary care would create the best practice model to deliver mental health care to a larger section of the general population. General practitioners remain the first point of contact for most people seeking mental health care; however, most GPs lack the skill and knowledge base

to accurately detect and manage serious mental illness. It has been noted that many people presenting to primary care with mental illness often do not have their condition detected early by GPs (Roy-Byrne, cited in Happell & Platania-Phung, 2005, p. 42). There has been an argument that this may affect help-seeking behaviours; when people do not receive the adequate treatment they expect, or believe the health professional lacks the necessary expertise to provide such care, they may decide not to seek help (Jorm, Korten & Rodgers, 1997).

Even though GPs are the first point of contact for most people seeking help for mental health problems, most GPs do not possess adequate skills, knowledge and time to provide care to people with severe mental illness. Without specialist assistance in primary care, the patients would often miss out on more comprehensive mental health care. It has been reported in the literature that where nurses are trained in specific aspects of clinical care, they have helped to reduce cost and GP workload whilst increasing patient satisfaction with care (Wilson, Pearson & Hassey, 2002; Fall, Walters & Read, 1997). A significant impact of the role of MHNs reported in this current study is the ability to provide adequate consultation to mental health patients without the pressure of time constraints in the ever busy general practice. The GPs and MHNs in this current study both acknowledged the ability of MHNs to provide care to the patients with mental health problems whilst freeing up GP time and workload. As reported in the literature some GPs deliberately avoid delving into details during consultations with their mental health patients due to usually limited 10 minute time per patient consultation time available (Younes et al. 2005)

The literature suggests primary care to be more accessible and less stigmatising as it manages physical ailments along with mental illness (Rothman & Wagner, 2003). Gask and Croft (2000) also reported that patients with mental illness feel less stigmatised if they see a mental

health professional in a primary health care setting. Findings from this study are consistent with what arises from the literature about the benefits of an attachment model of specialist mental health nurses in primary care.

In Australia, people with severe mental illness access specialist care through community mental health teams that are funded by state and territory governments. The changes that accompanied the process of deinstitutionalisation included a reduction in psychiatric beds across the nation without the accompanying community-based services (Whiteford & Buckingham, 2005). Even though there has been a gradual funding increase over the years of community-based services, the funding has not been able to catch up with the increasing demands of the population. High caseloads have been reported among case managers in community mental health services, which has impacted on the quality of services provided to patients (Henderson et al., 2008). There is often difficulty faced by case managers in finding suitable discharge options for their clients that do not require the high level of support provided in specialist mental health services but still require on-going follow-up. These groups of clients now receive such support through the work of MHNs in primary care settings.

Part of the reforms in the Australian Government's Primary Health Care Strategy is the creation of GP Super Clinics across the nation. Unfortunately, there was no mention of including MHNs in these clinics, which seems to be another missed opportunity for real reform in the primary care sector.

Another important impact of the role of MHNs working general practice from this study is the opportunity for interdisciplinary learning. The MHNs were able to give advice and education to other team members about mental health issues. The GP participants from this study had acknowledged the depth of knowledge the MHNs bring to the team about mental health care.

Lucas et al. (2005) noted that role models and personal contacts with people with clinical experience were the preferred mode of learning of registrars entering general practice when it comes to working with mental health patients. On their part, MHNs also benefit from working with other primary health care professionals as it offers the opportunity to explore a different care setting.

Question 6: What is the nature of collaboration that exists between mental health nurses and general practitioners?

McGregor-Robertson (cited in Fagin & Garelick, 2004, p. 227) in 1902 stated '*A nurse must begin her work with the idea firmly implanted in her mind that she is the only instrument by whom the doctor gets his instructions carried out; she occupies no independent position in the treatment of the sick*'. The role of the nurse has since evolved and become better appreciated; however, some of the elements of those statements still shape the relationship between nurses and doctors in today's health care setting.

One of the questions this study sought to answer was the extent of collaboration and communication that exists between general practitioners and mental health nurses as they both work in general practice to provide care to people with severe mental illness.

The delivery of health care service at any level involves a team approach where there is a continued emphasis on the multidisciplinary approach, with the unique set of skills each team member brings. The importance of collaboration between nurses and doctors in improving overall patient outcomes has been well documented in the literature (Lockhart-Wood, 2000; Clarin, 2007). Collaboration is defined as the process of joint decision-making among independent parties, involving joint ownership of decisions and collective responsibility for outcomes. Each participant has the self-confidence to share knowledge and information on an

equal basis, and mutual respect is given to each opinion. The focus remains on the needs of the patient, and negotiations result in a plan of care (McCaffrey et al., 2010). Lack of communication and collaboration has been cited as a reason for poor patient outcomes. Indeed, psychiatric practice depends a great deal on a good understanding between nurses and doctors (Fagin & Garelick, 2004).

Collaboration – a relationship of interdependence – requires the recognition of complementary roles. Traditionally, physicians generally have not demonstrated collaboration in their work with nurses; on the other hand, nurses have more often sought a collaborative relationship (Lockhart-Wood, 2000). Lindeke and Sieckert (2005) argue that maximising nurse–physician collaboration holds promise for improving patient care and creating satisfying work roles.

Findings from this current study suggest that there is mutual respect and understanding between GPs and MHNs. There were no apparent conflicts when it came to roles; each professional was aware and respected the skills of their counterparts. This relationship has enabled effective collaboration in the delivery of care. The MHNs reported their skills and expertise were well valued by the GPs with whom they worked. Similar findings were reported by Meehan and Robertson (2013).

Implications for practice

Closer working relationships between GPs and MHNs will help provide coordinated care for people with severe mental illness and a wider reach of services. General practitioners play an important role in the delivery of primary health care in Australia. Their ability to work closely with MHNs has the potential to free up GPs' consultation times and invariably, the workload. It also provides comprehensive assessment and care coordination for clients with a mental illness managed in general practice. In this manner, not only will these patients have their

mental health care needs met, but they will also receive comprehensive physical health interventions. This is particularly important especially in view of the evidence in the literature of poor physical health outcomes for people with severe mental illness (Dixon et al., 2000).

The co-location of mental health nurses (MHNs) with GPs has the potential to facilitate a sharing of learning as well a greater awareness of individual roles. It is reported that general practitioners have limited training in mental health care (Kerwick, Jones, Mann & Goldberg, 1997), which in turn limits their ability to manage patients with severe mental illness. There is still a great deal of stigma amongst the general public concerning mental illness. Current destigmatisation campaigns, according to Hickie and Groom (2002), aim to promote mental health as 'health'. Hence, the more people with mental illness who are managed primarily by general practitioners, the more quickly the community attitudes will change towards help-seeking for mental health problems. The presence of a MHN in a local general practice provides the so-called 'non-squeaky wheel' clients the opportunity to obtain specialist mental health services whilst receiving physical health treatments. By providing assessment and care at a local level, people who are never seen by traditional mental health services can be provided with support and care.

Study Strengths

The use of key stakeholders in the scoping exercise phase of the study gave insight into what was in the mind of policy-makers when the program was established. At the commencement of this study, there was no literature around the work that mental health nurses do in primary health care. Thus, it was important to get the views of key stakeholders on the drivers behind the establishment of the program, as this would also influence the evaluation and long-term sustainability of the program. No other study in Australia has included the views of key stakeholders to establish the reasons behind the introduction of the MHNIP. The triangulation

of both data collection and methods allowed for comparison of data results, thereby increasing the validity of the results. No other study on the MHNIP has utilised mixed methods to explore the role of MHNs in primary care. Combining quantitative and qualitative analyses also provided a more comprehensive view of the work of MHNs in Australian primary care under the MHNIP.

Limitations of the study

Prior to this study there has been no study in Australia that has examined the role of mental health nurses in primary health care. The study adopted an exploratory descriptive method to gain insight into how the role of MHNs is being enacted under the MHNIP. A limited total population of nurses and GPs working under the MHNIP was available; therefore the study was limited to an accessible convenience sample for Phases 2 and 3.

Phase 2 interviews were taken from 16 MHNs from only one state in the country. It is possible that the results may have varied if nurses from rural and remote areas as well as other states were interviewed. The qualitative interviews did provide valuable data that enabled the development of a questionnaire used to survey a wider population of 87 nurses across various states in Australia. Nonetheless, generalisation of the findings may not be entirely possible.

There was also some difficulty encountered with the plan to initially obtain qualitative data from the GP population; however, the views of the GPs were captured through a survey.

Triangulation of the sampling method used in the MHN population was not possible for the GPs in this study.

The development of the instrument places limitations on the findings of the study. The validity of the instrument was achieved using face and content validity. Due to the limited

number of participants, a large-scale pilot study could not be carried out in order to preserve potential participants.

While the study provided findings about the impact of the role of MHNs in a primary health care setting, it was through the perspective of care providers. Further study will be required to evaluate the impact of the MHNs' role that would take into account the views of the care recipients.

RECOMMENDATIONS

Recommendations for Mental Health Nursing Clinical Practice

This is an exciting period for mental health nursing in Australia. The extension of their scope of practice into a general practice setting brings them in line with similar moves that their counterparts in countries such as the UK have also experienced. However, with this opportunity also comes a great deal of responsibility. There is a need for mental health nursing as a profession to position itself to meet the challenges that lie ahead as they begin to practice in 'GP Land'. The MHNIP provides MHNs with a new career path and greater job opportunities by expanding the scope and autonomy of their clinical practice (Australian College of Mental Health Nurses, 2007). The opportunity to work in a variety of clinical settings especially those that offer a level of professional autonomy will go a long way in promoting work force development for mental health nursing, which has been experiencing a decline in workforce numbers in recent years. The overall 11.0% increase in the total number of employed nurses in Australia between 1999 and 2004 was not reflected in the proportion working in mental health nursing, which declined by 2.6% over the same period (AIHW, 2007). Several factors have been attributed to the decline in the number of nurses working in the mental health care setting, including burnout and job satisfaction (Happell, Martin & Pinikahana, 2003). The Mental Health Workforce Advisory Committee (MHWAC, 2011) in

Australia recommended the further development of specialist mental health professionals to act as secondary consultants at key points in the health care system, such as in general practice. The committee therefore welcomed the introduction of the MHNIP and also noted that the establishment of roles with a greater scope of practice supports greater variety in work experience and improves retention of mental health nurses. Findings from this present study also support this view.

In spite of the opportunities that working in general practice provides for MHNs, perhaps their skills and expertise could be better utilised through the establishment of positions such as mental health nurse practitioners in the primary care setting which has been in operation in Countries such as the United States (Soderlund, 2006). While the mental health nurse practitioner is not a new concept in Australia, it is surprising though that there are no MHN practitioner positions that have been situated within general practice. The success of mental health nurse-led specialist clinics has been documented in the literature (Burns & Bale, 1997; Lester, 2005; Krothe & Clendon, 2006).

The MHWAC (2011) recommended that MHNIP be expanded to give MHNs limited prescribing rights in the future, order pathology and perform other investigations. The advisory committee also suggested the role of the MHN be expanded to conduct physical health screenings, management of chronic disease prevention and smoking cessation interventions, and healthy lifestyle management. However, as reported in this study, some of these interventions are already being carried out by the MHNs. It is however heartening that the committee recognises the valuable skills and potential of MHNs in primary health care settings.

In terms of how general practice operates, there are still lessons that MHNs could learn. Some of the participants in this study had expressed some surprise on how the sector operates,

especially in terms of the consultation rates and business model. Exposure to the operations of general practice through clinical placements would better prepare mental health nurses to work within general practice.

Recommendations for Training and Education

Due to the changing role of mental health nursing in response to changes in the way health care is delivered, there is a need for MHNs to constantly update their practice in order to be contemporary. This may entail the development of new skills and acquisition of more knowledge. There are currently no national competency standards for mental health nurses working in primary health care in Australia. There is a need to adequately prepare pre-registration and post-graduate nursing students to work in the general practice setting. One of the ways of doing this is to open up more clinical placement opportunities in general practice for aspiring mental health nurses. The current undergraduate curriculum of most tertiary institutions in Australia does not have adequate mental health content, not to mention primary mental health nursing content (Happell, Moxham & Clarke, 2011).

The MHN participants in this study reflected on the value of undertaking different forms of psychotherapy as part of their role in general practice; this includes cognitive behavioural therapy and brief solution-focused therapy, amongst others. If mental health nursing is going to take on a greater role in the delivery of mental health care at the primary care level, there is also a need to prepare aspiring mental health nurses adequately in this area. Perhaps there may be a need to look at how other countries, which have shifted a large percentage of their mental health nursing workforce into primary health care, train their nurses working in this area.

Trainings such as the Thorn Initiatives (Gournay, 2006) which sought to enhance the skills of MHNs in providing care to people with severe mental illness such as schizophrenia could be implemented in Australia to further up skill the MHNs working in primary care.

There is a need for the Commonwealth Government to work closely with tertiary institutions to develop a curriculum for mental health nurse training that would meet the needs of the consumers for whom services are being provided, and also match up with the expanding scope of mental health nursing practice.

The Australian Health Workforce Advisory Committee (2003) had suggested a need to support the varied roles and functions that a mental health nurses performs across a variety of treatment settings. It further suggested the need to encourage job rotations of MHNs to different settings to allow nurses to experience new and different patients, peers and clinical situations.

Recommendations for Policy

While the introduction of mental health nurses into general practice and attempts to integrate primary and secondary care is a laudable one, there needs to be a more solid policy framework to support the move beyond the level of an incentive program. The National Primary Health Care Strategy, which is currently in its infancy in Australia, needs to address the needs of people with severe mental illness who can benefit from primary health care.

There needs to be a greater degree of collaboration between the secondary and primary health care sectors in the management of people with severe mental illness. Primary health care, if properly harnessed, offers a good opportunity to provide comprehensive and more accessible mental health care. In Australia, the fragmentation of mental health services needs to be carefully addressed. Currently, we have a system whereby the Commonwealth Government is responsible for Primary Health Care programs whilst the State and Territories are responsible for secondary mental health services; often, both sides 'don't talk to each other'. This was highlighted by the key stakeholders interviewed in this study, who have been involved in policy development.

Nurses play a key role in bridging the gap in service delivery when it comes to providing care for people with severe mental illness. There is a need for the Australian government to fully harness the potential available through the MHN workforce.

Mental health nurses currently can claim a rebate from Medicare for activities such as non-directive pregnancy counselling (Medicare Australia, 2012). However, it seems odd that MHNs are not able to be primary care providers when they engage in their core business, which is caring for people with severe mental illness. Studies have revealed, for example, that nurse practitioners in primary care can provide care that leads to increased patient satisfaction and similar health outcomes compared with care from a doctor in certain common disorders (Horrocks, Anderson & Salisbury, 2004; Clarin, 2007).

As reported in Chapter 2 of this study, there have been successful trials of nurse-led clinics providing care to people with serious mental illness such as the Integrated Health Care (IHC) program operated through the University of Illinois, USA. This program is run by mental health nurse specialists and faculty members with the aim to provide integrated physical and mental health care at the primary care level (McDevitt et al., 2005).

Recommendations for Future Research

This study offers preliminary data about the work of MHNs in Australian general practice. It examined the role of MHNs from the perspective of the nurses themselves, GPs that they work with, as well as key stakeholders who were involved in the establishment of the initiative that carved out their role. Even though the findings have offered valuable insights into the role and scope of practice of the MHNs, the activities they carry out and the impact of their role, it did not examine the perspective of the recipients of care – namely, clients with serious mental illness. The views of carers would also be valuable in future research; for

example, does the presence of a MHN in general practice influence the help seeking behaviours of carers and the patients?

When the study was carried out, the accessible population of MHNs and GPs was targeted during recruitment for the study. The MHNIP has been growing since, and a much wider study would further strengthen some of the findings. The perspective of GPs that chose not to engage the services of a MHN was not considered in this study. However, the reasons why some GPs chose not to engage a MHN despite the stated benefits would be valuable.

The difficulties of carrying out primary care research have been well documented in the literature (Mason et al., 2007; MacPherson & Bisset, 1995; Kaner, Haighton & McAvoy, 1998). GPs have reported being overwhelmed with requests to collaborate in research; often, research can fall low on the GP's list of priorities (Silagy & Carson, 1989). In undertaking this current study, the researcher – similar to other researchers – encountered difficulties recruiting GP participants.

The focus of this present study was MHNs working in general practice. The MHNIP also extends to MHNs working with private psychiatrists. While the majority of the MHNs under the program work in general practice, the views of nurses working with private psychiatrists would add to the body of knowledge.

There needs to be a more organised national approach to foster research at the primary health care level, as this would help produce evidence-based policy development. There is a need for organisations such as the Primary Health Care Research and Information Service (PHC RIS), which is funded by the Australian Government Department of Health and Ageing to engage GPs in more research activities that would lead to improved patient outcomes.

It should also be noted that there have been recent changes to the funding of the MHNIP. Future studies could examine the impact of the freezing of the MHNIP funding on the delivery of care by both GPs and MHNs.

Thesis conclusion

The advent of MHNs into the Australian primary health care system, especially general practice, through the MHNIP is a welcome development and it is in line with similar trends in countries such as the UK, Canada, USA and New Zealand (O'Brien, Hughes, & Kidd, 2006). The program sets the stage for expanding the scope of practice of mental health nurses and thus opening up new career pathways. It also recognises the valuable role that mental health nurses play in the delivery of mental health care in both the tertiary and primary health system.

The design of the MHNIP however has some flaws. There is a need for clearer and more detailed government policy around mental health care in primary health, and more specifically a better-defined role for mental health nurses. Better remuneration is needed to attract qualified mental health nurses to primary care and a proper career structure needs to be in place for MHNs working in primary care. Findings from the study suggest most MHNs reported a drop in their overall remuneration since entering into the MHNIP. There is also the need to include in the post-graduate training courses for mental health nurses units that covers primary health care issues. The evaluation of the MHNIP by the government is currently being undertaken; any evaluation carried out should take into consideration some of the issues raised.

This author strongly advocates that MHNs be given more recognition of their skills and training. It is unacceptable that other professional groups such as psychologists, social workers and occupational therapists are viewed from a policy point of view as independent

practitioners while MHNs are not. Surely as a profession, MHNs have come a long way from the days where a nurse '*occupies no independent position in the treatment of the sick person*' (Fagin & Garelick, 2004, p227). MHNs in this study have demonstrated that they are able to practice effectively at the primary care level and provide much-needed services to people with severe mental illness.

Sadly, the Australian Government, during the 2012–13 Federal Budget announced a freeze on the MHNIP pending the outcome of evaluation of the program. Hopefully, this would not be a case of '*one step forward, two steps backward*' not just for mental health nursing in Australia but also for mental health consumers and their carers who are desperate for more accessible and affordable mental health care.

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Appendix A: International conference presentations and journal article published by researcher arising from the study

Conferences

- **Horatio European Psychiatric Nursing Congress 2013, Istanbul, Turkey, Oct, 2013**

Title: *The Advent of Mental Health Nurses in Australian Primary Health Care*

- **25th International Conference of the American Psychiatric Nurses Association, Pittsburgh, USA. Nov 2012.**

Title: *Mental Health Nurses and General Practitioners in primary care Destigmatising mental illness: An Australian initiative*

- **36th International Conference of the Australian College of Mental Health Nurses, Hobart Tasmania, 2010.**

Title: *The advent of Mental Health Nurses in Australian General Practice*

- **2009 Primary Health Care Research Conference (The Primary Health Care Research & Information Service (PHC RIS)), Melbourne, Australia. 2009**

Title: *Mental Health Nurses in GP Land: A new and adventurous approach in Primary Health Care*

- **34th Annual International Conference of the Australian College of Mental Health Nurses, Sydney, 2009.**

Title: *Mental Health Nurses working in General Practice.*

Journal Article

Olasoji, M & Maude, P (2010). The Advent of Mental Health Nurses in Australian General Practice. *Contemporary Nurse*, 36(2), 106-117

Book Chapter

Elder, R., Sharrock, J., Maude, P., & Olasoji, M (2012). *Settings for Mental Healthcare*. In Elder, R., Evans., K., & Nizette., D (Eds), *Psychiatric and Mental Health Nursing* (3rd Ed) (pp 429-452), Sydney: Mosby Elsevier

Appendix B: Ethics Approval for study



3rd October 2008

Michael Olasoji

Dear Michael

BSETAPP 40 – 08 OLASOJI The role of mental health nurses in Australian primary health care

Thank you for submitting your amended application for review.

I am pleased to inform you that the committee has approved your application for a period of 3 Years to October 2011 and your research may now proceed.

The committee would like to remind you that:

All data should be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed up on a regular basis and can provide Disaster Recover processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving, data transport where necessary and for some works in progress;

The authoritative copy of all current data should reside on appropriate network systems; and the Principal Investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.

Annual reports are due during December for all research projects that have been approved by the Human Research Ethics Sub-Committee.

The necessary form can be found at: <http://www.rmit.edu.au/browse;ID=sp7y1u3kp66w>

Yours faithfully,

Associate Professor Barbara Polus

Chair, Science Engineering & Technology Portfolio

Human Research Ethics Sub-Committee 'B'

Cc HRE-SC Member: Zhen Zheng School of Health Science

Supervisor: Phillip Maude School of Health Science

Appendix C: Letter of Invite to key stakeholders



Dear

Research Project: The Advent of Mental health nurses in Australian Primary Health Care

This letter is to seek your assistance in a research project currently undertaken at RMIT Division of Nursing & Midwifery. This project is being carried out as part of the fulfilment for the award of Doctor of Philosophy in Nursing for the student Researcher Michael Olasoji. The principal supervisor of the project is Assoc. Prof Phillip Maude. This research has been approved by the RMIT Human Research Ethics Committee. You have been approached to participate in this study because of your involvement as a stakeholder in the establishment of the Mental Health Nurse Incentive Program (MHNIP).

The purpose of this study is to explore the role and scope of practice of Australian Mental Health Nurses working in Primary health care settings within the context of Australian Government Mental Health Nurse Incentive Program (MHNIP). The MHNIP was set up in October 2007 by the Australian Government as part of the Council of Australian Governments (COAG) health reform; however there has been no formal evaluation of the program.

The primary research questions are;

- What were the drivers for the establishment of the MHNIP?
 - What are the reasons behind MHNs desire to work in Primary Health Care and also reasons why General Practitioners engage the services of mental health nurses in their practice?
 - What role do MHNs play in the delivery of mental health care in primary health care settings?
 - What are the barriers and facilitators to the delivery of mental health care in primary care by MHNs under the MHNIP?
 - What positive impacts has the role of MHNs had in primary health care?
-

- What is the nature of collaboration between GPs and MHNs engaged under the MHNIP and the facilitators and barriers to collaborative working relationships?

This mixed method study will utilise three phases to collect data. Phase1 involves interviews with key stakeholders, Phase 2 involves interviews with mental health nurses and general Practitioners and Phase 3 involves survey of mental health nurses and General Practitioners. You are being invited to take part in phase 1 of the project which includes a scoping exercise of key stakeholders in the establishment of the MHNIP.

If you agree to participate, please sign the enclosed consent form and further information including a schedule of interview questions will be forwarded to you. Please do not hesitate to contact the researchers if you require further information. Thank You.

Michael Olasoji

Student Researcher

A/Prof Phil Maude

Principal Supervisor

Appendix D: Letter of Invitation to Mental Health Nurses to participate in Phase 2 of study



School of Health Sciences

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Project Title: The Advent of Mental Health Nurses in

Australian Primary Health Care

Dear

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in straightforward language, or 'plain English'. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

This project is being carried out as part of the fulfilment for the award of Doctor of Philosophy in Nursing for the student Researcher Michael Olasoji. The principal supervisor of the project is Assoc. Prof Phillip Maude. This research has been approved by the RMIT Human Research Ethics Committee (**Approval No: BSETAPP 40-08**).

Why have you been approached?

You have been approached to participate in this study because you are currently engaged as a mental health nurse under the Government's Mental Health Nurse Incentive Program.

What is the project about? What are the questions being addressed?

The purpose of this study is to explore the role and scope of practice of Australian Mental Health Nurses working in Primary health care settings within the context of Australian Government Mental Health Nurse Incentive Program. The Mental Health Nurse Incentive Program was set up in October 2007 by the Australian Government as part of the Council of Australian Governments (COAG) health reform; however there has been no evaluation of the program and it was set up without any evidence based research around the role of mental health nurses in primary health care.

The primary research questions are;

- What were the drivers for the establishment of the MHNIP?
- What are the reasons behind MHNs desire to work in Primary Health Care and also reasons why General Practitioners engage the services of mental health nurses in their practice?
- What role do MHNs play in the delivery of mental health care in primary health care settings?
- What are the factors that impact on the enactment of the role of MHNs in the delivery of mental health care the MHNIP?
- What impacts has the role of MHNs had in primary health care?
- What is the nature of collaboration between GPs and MHNs engaged under the MHNIP and the facilitators and barriers to collaborative working relationships?

This project will be carried out in three Phases. **Phase 1** is a scoping exercise that involves key stakeholders involved in the establishment of the MHNIP. **Phase 2**, which you are now invited to participate, involves semi-structured interviews with mental health nurses working under the MHNIP and **Phase 3** of the project involves survey of mental health nurses and general practitioners across Australia.

If I agree to participate, what will I be required to do?

- You will be invited to participate in an interview which would last between 45-60 minutes; the interview explores your experience working under the MHNIP.
-

What are the risks or disadvantages associated with participation?

- There are no known risks associated with your participation in this project outside normal day-to-day risks.

What are the benefits associated with participation?

- As you may be aware the Federal Health Minister recently kicked off a nationwide debate on the current role that nurses play in Australian primary health care and the possibilities of expanding these roles. The mental health nurse incentive program which you are currently working under has not yet been evaluated and there is no evidence based research in Australia about the role of mental health nurses in the nation's primary health care. This research will give you the opportunity to highlight the role that you play in primary care and also help inform the development of future policies.

What will happen to the information I provide?

Confidentiality is very important at RMIT University. The researchers will record and transcribe your interview, but no names will appear on these materials. The tape and the hard copy of the transcript will be kept in a locked filing cabinet in a locked office, which can only be accessed by the researchers. A soft copy of the transcript will be kept on a password-protected computer, in the same locked office. When the interviews are written up, care will be taken to make sure that you cannot be identified on the basis of your responses. Your unique story may negate anonymity; however we will take every precaution to disguise your identity.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission. The research data will be kept securely at RMIT for a period of 5 years before being destroyed. The results of this project will be presented in the PhD theses as well as Journal articles, local and international conferences.

What are my rights as a participant?

Please be aware of your rights regarding this project which include:

- The right to withdraw your participation at any time up until data analysis, without prejudice.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.

Whom should I contact if I have any questions?

- Should you have any question about the project please contact the student researcher on the contact details above.

What other issues should I be aware of before deciding whether to participate?

- There are no other issues we can suggest for you to consider before consenting to participate in this project.

If you require further information about the research project please contact the researcher Michael Olasoji (School of Nursing & Midwifery, m.olasoji@student.rmit.edu.au). If you have any concerns about the conduct of the evaluation, please contact the Executive Officer, Human Research Ethics, RMIT University, phone: 03 99252251).

Yours sincerely

Michael Olasoji (B Nurs Hons, PGDip MHN)

(Mental Health Nurse, PhD candidate)

- Mr Michael Olasoji (Nursing PhD student)
m.olasoji@student.rmit.edu.au
 - Prof Phillip Maude (Principal Supervisor)
-

Appendix E: Letter of Invitation to General Practitioners to participate in Phase 3 of study



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Project Title: The Advent of Mental Health Nurses in

Australian Primary Health Care

Dear Dr -----,

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in straightforward language, or 'plain English'. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

This project is being carried out as part of the fulfilment for the award of Doctor of Philosophy in Nursing for the student Researcher Michael Olasoji. The principal supervisor of the project is Prof Phillip Maude. This research has been approved by the RMIT Human Research Ethics Committee (**Approval No: BSETAPP 40-08**).

Why have you been approached?

You have been approached to participate in this study because you are currently working or has worked with a mental health nurse under the Government's Mental Health Nurse Incentive Program. Your local division of General Practice was approached to send this letter to you and the Researchers do not have access to your details until you consent to participate in the project.

What is the project about? What are the questions being addressed?

The purpose of this study is to explore the role and scope of practice of Australian Mental Health Nurses working in Primary health care settings within the context of Australian Government Mental Health Nurse Incentive Program. The Mental Health Nurse Incentive Program was set up in October 2007 by the Australian Government as part of the Council of Australian Governments (COAG) health reform; however there has been no evaluation of the program and it was set up without any evidence based research around the role of mental health nurses in primary health care.

This project will be carried out in three Phases. Phase 1 is a scoping exercise that involves key stakeholders involved in the establishment of the MHNIP. Phase 2, involves semi-structured interviews with mental health nurses working under the MHNIP and Phase 3 of the project which you are now been invited involves survey of mental health nurses and general practitioners working under the MHNIP across Australia.

If I agree to participate, what will I be required to do?

- You will be invited to complete a questionnaire which explores the Mental Health Nurse Incentive Program. The questions will be centred on your perception of the current role mental health nurse working under the mental health nurse incentive program as well as the implementation of the program. You can either complete a paper based or online questionnaire.

What are the risks or disadvantages associated with participation?

- There are no known risks associated with your participation in this project outside normal day-to-day risks.

What are the benefits associated with participation?

- As you may be aware the Federal Health Minister recently kicked off a nationwide debate on the current role that nurses play in Australian primary health care and the possibilities
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of expanding these roles. The mental health nurse incentive program has not yet been evaluated and there is no evidence based research in Australia about the role of mental health nurses in the nation's primary health care. This research will give the opportunity to highlight the benefits, obstacles of the MHNIP and also help inform the development of future policies.

What will happen to the information I provide?

The research data will be kept securely at RMIT for a period of 5 years before being destroyed. The results of this project will be presented in the PhD theses as well as Journal articles, local and international conferences.

What are my rights as a participant?

Please be aware of your rights regarding this project which include:

- The right to withdraw your participation at any time up until data analysis, without prejudice.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.

Whom should I contact if I have any questions?

- Should you have any question about the project please contact the student researcher on the contact details above.

What other issues should I be aware of before deciding whether to participate?

- There are no other issues we can suggest for you to consider before consenting to participate in this project.

If you require further information about the research project please contact the researcher Michael Olasoji (School of Nursing & Midwifery, m.olasoji@student.rmit.edu.au). If you have any concerns about the conduct of the evaluation, please contact the Executive Officer, Human Research Ethics, RMIT University, phone: 03 99252251).

Yours sincerely

Michael Olosoji (B Nurs Hons, PGDip MHN)

(Mental Health Nurse, PhD candidate)

Investigators:

- Mr Michael Olosoji (Nursing PhD student)
 - Prof Phillip Maude (Project Supervisor)
-

Appendix F: Letter of Invitation to Mental Health Nurses to participate in Phase 3 of study



School of Health Sciences

Nursing and Midwifery

Bundoora Campus West

Building 201

Plenty Road

Bundoora VIC 3083

PO Box 71

Bundoora VIC 3083

Australia

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Fax.+613 90762889

• www.rmit.edu.au

Project Title: The Advent of Mental Health Nurses in Australian Primary Health Care

Dear

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in straightforward language, or ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

This project is being carried out as part of the fulfilment for the award of Doctor of Philosophy in Nursing for the student Researcher Michael Olasoji. The principal supervisor of the project is Assoc. Prof Phillip Maude. This research has been approved by the RMIT Human Research Ethics Committee (**Approval No: BSETAPP 40-08**).

Why have you been approached?

You have been approached to participate in this study because you are currently engaged as a mental health nurse under the Government's Mental Health Nurse Incentive Program.

What is the project about? What are the questions being addressed?

The purpose of this study is to explore the role and scope of practice of Australian Mental Health Nurses working in Primary health care settings within the context of Australian Government Mental Health Nurse Incentive Program. The Mental Health Nurse Incentive Program was set up in October 2007 by the Australian Government as part of the Council of Australian Governments (COAG) health reform; however there has been no evaluation of the program and it was set up without any evidence based research around the role of mental health nurses in primary health care.

The primary research questions are;

- What were the drivers for the establishment of the MHNIP?
- What are the reasons behind MHNs desire to work in Primary Health Care and also reasons why General Practitioners engage the services of mental health nurses in their practice?
- What role do MHNs play in the delivery of mental health care in primary health care settings?
- What are the factors that impact on the enactment of the role of MHNs in the delivery of mental health care the MHNIP?
- What impacts has the role of MHNs had in primary health care?
- What is the nature of collaboration between GPs and MHNs engaged under the MHNIP and the facilitators and barriers to collaborative working relationships?

This project will be carried out in three Phases. **Phase 1** is a scoping exercise that involves key stakeholders involved in the establishment of the MHNIP. **Phase 2**, involves semi-structured interviews with mental health nurses working under the MHNIP and **Phase 3** of the project which you are now been invited involves survey of mental health nurses and general practitioners working under the MHNIP across Australia.

If I agree to participate, what will I be required to do?

- You will be invited to complete a questionnaire/survey that explores your experience working under the MHNIP. You can either complete a paper based or online survey.
-

What are the risks or disadvantages associated with participation?

- There are no known risks associated with your participation in this project outside normal day-to-day risks.

What are the benefits associated with participation?

- As you may be aware the Federal Health Minister recently kicked off a nationwide debate on the current role that nurses play in Australian primary health care and the possibilities of expanding these roles. The mental health nurse incentive program which you are currently working under has not yet been evaluated and there is no evidence based research in Australia about the role of mental health nurses in the nation's primary health care. This research will give you the opportunity to highlight the role that you play in primary care and also help inform the development of future policies.

What will happen to the information I provide?

Confidentiality is very important at RMIT University. The researchers will record and transcribe your interview, but no names will appear on these materials. The tape and the hard copy of the transcript will be kept in a locked filing cabinet in a locked office, which can only be accessed by the researchers. A soft copy of the transcript will be kept on a password-protected computer, in the same locked office. When the interviews are written up, care will be taken to make sure that you cannot be identified on the basis of your responses. Your unique story may negate anonymity; however we will take every precaution to disguise your identity.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission. The research data will be kept securely at RMIT for a period of 5 years before being destroyed. The results of this project will be presented in the PhD theses as well as Journal articles, local and international conferences.

What are my rights as a participant?

Please be aware of your rights regarding this project which include:

- The right to withdraw your participation at any time up until data analysis, without prejudice.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.

Whom should I contact if I have any questions?

- Should you have any question about the project please contact the student researcher on the contact details above.

What other issues should I be aware of before deciding whether to participate?

- There are no other issues we can suggest for you to consider before consenting to participate in this project.

If you require further information about the research project please contact the researcher Michael Olosoji (School of Nursing & Midwifery, m.olasoji@student.rmit.edu.au). If you have any concerns about the conduct of the evaluation, please contact the Executive Officer, Human Research Ethics, RMIT University, phone: 03 99252251).

Yours sincerely

Michael Olosoji (B Nurs Hons, PGDip MHN)

(Mental Health Nurse, PhD candidate)

Appendix G: Consent Form

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Portfolio Science Engineering and Technology

School of Health Sciences

Name of participant: _____

Project Title: The Advent of mental health nurses in Australian primary health care

Name(s) of investigators: (1) A/Prof Phillip Maude Phone: _____

(2) Mr Michael Olasoji Phone: _____

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I acknowledge that:
 - (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
 - (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
 - (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
 - (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
 - (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to _____ (researcher to specify). Any information which will identify me will not be used.

Participant's Consent

Participant: _____

Date: _____

(Signature)

Witness:

Date:

(Signature)

Where participant is under 18 years of age:

I consent to the participation of _____ in the above project.

Signature:

(1)

(2)

Date:

(Signatures of parents or guardians)

Witness:

Date:

(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251.

Details of the complaints procedure are available from the above address.

Appendix H: Schedule of Interview Stakeholder Interviews

Schedule of Interview with XXX by Michael Olosoji PhD Candidate RMIT University

- Thank you for taking time to take part in this interview.
- ***The purpose of this study is to explore the role and scope of practice of Australian Mental health Nurses working in Primary health care settings within the context of the Australian Government Mental Health Nurse Incentive Program.***
- Can you briefly describe your role/involvement in the setting up of the Mental Health Nurse Incentive Program (MHNIP)?
- What were the main drivers/reasons for the setting up of the MHNIP? Why was the program set up?
- The MHNIP seems to be a relatively new mode of service delivery in Australia, was the conceptualisation of the program influenced by similar programs from overseas? If so, what can you tell me about these programs (i.e. which country, how long ago) and are there any available documents about the evaluation of such program or any published work?
- Were there any submissions made by special interest groups such as the Australian College of Mental health Nurses, Royal Australian College of General Practice, Royal Australian and New Zealand College of Psychiatrists, consumer/carer groups?. If so, what were the main themes and are these documents accessible? Where can I get them?
- What sort of consultations took place with these groups? (i.e. how long, any committees, what were the terms of reference), Who were the key representatives that were involved?
- This program seems to fit nicely with the overall Australian Government Mental Health strategy and in particular the proposed primary health care strategy, what is the long term plan for the MHNIP?
- In terms of outcomes, can you briefly itemise some of the key benefits the Government hopes to achieve through this program in the delivery of mental health care? What is the process of evaluation of the program? Any timelines, targets etc.
- Can you tell me about any initial feedback (if any) that is emerging about the current operation of the program? Any centres of excellence? any draw backs?.
- In terms of the mental health nurses, how was the scope of practice determined? Were there any concerns about extending this scope of practice?
- What future role do you envisage for mental health nurses in the provision of care for people with a mental illness at the primary care level?
- What are your views about collaborative practice between mental health nurses and GPs/private psychiatrist under the MHNIP? What opportunities exist, any concerns?
- Finally, do you have any other information about the MHNIP that might be useful and has not already been mentioned?

Others

1. Do you have any suggestions of Government reports/documents, grey literatures that are relevant to the MHNIP or this project?
 2. Have you had any involvement in the Better outcomes/Better Access programs?
-

3. Is there anyone else you can recommend that I contact who can offer relevant information about the MHNIP?
 4. Do you have suggestions about the evaluation of health policy in Australia, i.e. any recommended framework?
 5. If you give permission to record this interview will you want to review the transcripts once completed?
-

Appendix I: Schedule of Interview Mental Health Nurses Interviews

INTERVIEW SCHEDULE FOR NURSES

My name is Michael Olasoji and I am currently conducting research into the ‘Advent of Mental health nurses in Australian Mental Health care system under the Mental Health Nurse Incentive Program. This research is part of the fulfilment for my Doctorate of Nursing Degree at RMIT University.

The reason you have been selected is that you are currently working as a mental health nurse under the MHNIP. Your answers will be treated as confidential and with your permission I would like to record and take notes of this interview.

I will like to begin by asking you some background information about yourself

- How long have you been working as a mental health nurse?
- Have you worked in Primary health care prior to your current role?
- What is your highest educational qualification?
- What is your age range? 18-25/25-34/35-44/45-54/55-64/65+?

What was the main reason that made you decide to work under the MHNIP?

Are you aware of the role and function of the mental health nurse as stipulated under the MHNIP guidelines?

Can you please describe your current role under the MHNIP at your organisation?

Can you describe your current scope of practice under the MHNIP at your organisation?

Are you currently performing any other role that is not contained under the program guidelines?

How would you describe the working relationship that exists between you and the GPs you are working with under the MHNIP?

Can you please describe the category of clients you are currently providing clinical services for?

Do you think your role under the MHNIP has had any positive impact on your clients? If so, in what areas has it had impact?

Do you think your role under the MHNIP has had any negative impact on your clients? If so, in what areas has it had impact?

Do you think your role under the MHNIP has had any positive or negative impact on your practice as a mental health nurse? If so, in what areas has it had impact?

Appendix J: Survey of Mental Health Nurses for Phase 3

MENTAL HEALTH NURSES QUESTIONNAIRE

Study: THE ADVENT OF MENTAL HEALTH NURSES IN AUSTRALIAN PRIMARY HEALTH CARE- EVALUATION OF THE MENTAL HEALTH NURSE INCENTIVE PROGRAM

Section A: Demographics

1) Your age range (Please tick)

- 25 year-under
- 26-35 years
- 36-45 years
- 46-51 years
- 51 years-over

2) What is your gender? Male /Female (please circle one)

3) What is the postcode(s) of your practice?

4) How long have you been practising as a Mental Health Nurse?
_____years

5) How would you best describe your highest level of qualification? (Please tick)
Bachelors

Post Graduate Diploma/Certificate

Masters

Doctorate

Hospital Based Training

Other: _____

6) How long have you been working under the MHNIP?
_____years

- 7) Which of the following best describes the setting where you are currently working?
- Solo Private Practice
 - Group Practice
 - Community Health Practice
 - Division of General Practice
- Others (please specify) _____

Section A1: What percentage of your time in a week do you spend on the following activities?

Activity	%
Clinical	_____
Non-clinical	_____
Clerical/Administrative	_____
Travel (i.e. to see clients)	_____

Section A2: Please provide an estimate of the diagnosis of the clients you are currently seeing or have seen in the past 12 months

Schizophrenia	_____ %
Schizoaffective disorder	_____ %
Bipolar Disorder	_____ %
Depressive disorder	_____ %
Anxiety disorders	_____ %
Personality disorders	_____ %
Others (pls specify)	_____ %
_____	_____ %

Section A3: Please list 4 core activities you perform for patients under the MHNIP

- a. _____
- b. _____
- c. _____
- d. _____

Section A4: What were 3 main reasons that influenced your decision to work under the MHNIP?

- a. _____
- b. _____
- c. _____

Section B: In your opinion what are 4 positive impacts your role has added to where you are practising?

Section C: What factors in your practice setting facilitate or create barriers in your ability to fulfil your role under the MHNIP?

C04	The personality of the GP with whom I practice	SD	D	U	A	SA
C05	The philosophy of the GP with whom I practice	SD	D	U	A	SA
C06	Orientation of the health care team to me	SD	D	U	A	SA
C07	Availability/accessibility of infrastructures	SD	D	U	A	SA
C08	The model of operation (e.g. collaborative or consultative practice)	SD	D	U	A	SA

C09	The way my role has been defined within the organisation	SD	D	U	A	SA
C10	My educational preparation	SD	D	U	A	SA
C11	Working relationship with other providers within the practice	SD	D	U	A	SA
C12	Resistance from the patients	SD	D	U	A	SA
C13	Resistance from external agencies	SD	D	U	A	SA
C14	Lack of peer support (i.e. working in isolation)	SD	D	U	A	SA
C15	Having to follow-up with Medicare regarding billing and other administrative matters	SD	D	U	A	SA

Section D: Primary Mental Health Care

This section relates to mental health services in primary care.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

D17	Primary health is a suitable place to look after clients with a severe mental illness (SMI)	SD	D	U	A	SA
D18	Patients with severe mental illness take up too much of practice time in GP Practices	SD	D	U	A	SA
D19	I have sufficient time to provide care to clients with high prevalence disorders e.g. anxiety, depression	SD	D	U	A	SA
D20	I have sufficient time to provide comprehensive care to clients with a severe mental illness in my practice. e.g. schizophrenia, bipolar disorder	SD	D	U	A	SA
D21	I can effectively manage clients with a severe mental illness without assistance	SD	D	U	A	SA

D22	The Mental Health Nurse incentive Program is well targeted towards clients with a severe mental illness	SD	D	U	A	SA
D23	There is enough Government incentive to assist General Practice to provide care to clients with a severer mental illness	SD	D	U	A	SA
D24	Mental health service provision is inadequate in primary care	SD	D	U	A	SA
D25	Accessing specialist mental health services is difficult in primary health care settings	SD	D	U	A	SA
D26	GP training has an adequate mental health component	SD	D	U	A	SA
D27	Access to specialist mental health services makes it difficult to manage patients with a SMI in primary care	SD	D	U	A	SA

Section E: Mental Health Nurses-Role and Impact

This section relates to role and impact of mental health nurses (MHN) in primary health care.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

E29	MHNs are the most appropriate health professionals to provide care for clients with high prevalence disorders (such as anxiety, depression, panic disorders) in primary health settings	SD	D	U	A	SA
E30	MHNs are the most appropriate health professionals to provide care for clients with severe mental disorders (such as schizophrenia, Bipolar) in primary health settings	SD	D	U	A	SA
E31	MHNs have the skills needed to provide adequate care for clients with severe mental illness	SD	D	U	A	SA

E32	Mental health nurses are a useful addition to General Practice	SD	D	U	A	SA
E33	Employing a MHN in GP Practice is not a good utilisation of resources (e.g. Government funding)	SD	D	U	A	SA
E34	MHN working in primary care will help reduce the stigma associated with mental illness amongst the wider population	SD	D	U	A	SA
E35	My presence within the practice has enhanced the knowledge of the GP in caring for people with a mental illness.	SD	D	U	A	SA
E36	My presence within the practice has helped improve links with specialist mental health services	SD	D	U	A	SA
E37	My presence within the practice has reduced referral rates to specialist services such as Area Mental Health Services	SD	D	U	A	SA
E38	My presence within the practice has helped meet previously unmet needs i.e. seeing more patients with a mental illness	SD	D	U	A	SA
E39	The addition of a MHN has helped improve patient satisfaction with care received	SD	D	U	A	SA
E40	The addition of a MHN has increased treatment options available to my patients	SD	D	U	A	SA

Section E: Mental Health Nurses- Scope of Practice

This section relates to scope of practice of mental health nurses in primary health care.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

E41	Building therapeutic relationships with clients is an essential element of the MHN's role	SD	D	U	A	SA
-----	---	-----------	----------	----------	----------	-----------

E42	Mental health nurses (MHNs) are able to coordinate care of people with severe mental illness (SMI) in Primary Health Care	SD	D	U	A	SA
E43	MHN should be primarily responsible for the care plan of clients with SMI in Primary Health Care	SD	D	U	A	SA
E44	MHN should focus primarily on people with a severe mental illness	SD	D	U	A	SA
E45	MHN should be able to provide health education about psychotropic medications	SD	D	U	A	SA
E46	MHN have a major role in providing education to clients and their families about mental illness	SD	D	U	A	SA
E47	MHN have a role in educating other members of the practice about mental health related issues	SD	D	U	A	SA
E48	MHN should act as a screening agent in order to direct clients people to the most appropriate resources available	SD	D	U	A	SA
E49	MHN should provide people with transient mental health problems with short term therapeutic interventions	SD	D	U	A	SA
E50	MHNs should provide leadership in primary mental health care	SD	D	U	A	SA
E51	MHN should be initiate mental health promotion activities in PHC	SD	D	U	A	SA
E52	It is essential that MHNs have family therapy skills when working in primary care	SD	D	U	A	SA
E53	In the future, I can see MHN having prescribing rights in Primary Health Care	SD	D	U	A	SA

Section G: GP-MHN Relationship

This section examines your working relationship with GPs.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

F54	The GP and I plan work together to make decisions about the care of patients	SD	D	U	A	SA
F55	I believe there is a clear boundary between my role and that of the GP	SD	D	U	A	SA
F56	I would describe our frequency of communication as adequate	SD	D	U	A	SA
F57	The GP and myself both consider medical and nursing considerations in making decisions about patient care	SD	D	U	A	SA
F58	The GP and myself both respect each other's expertise and skills in decision making about patient care	SD	D	U	A	SA
F59	The GP is fully aware of the scope of practice of my role	SD	D	U	A	SA
F60	Collaborative practice between GPs and MHNs enables good clinical outcomes for the patients	SD	D	U	A	SA

Section G: ABOUT YOUR ROLE

This section further explores your role.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

G61	Other colleagues (such as practice Nurses) have a clear view of what my role is within the practice	SD	D	U	A	SA
G62	I have a clear view of what my role is within the practice	SD	D	U	A	SA
G63	I am confident my role will undergo changes in the future	SD	D	U	A	SA

G64	I do not have enough time to perform all my work	SD	D	U	A	SA
G65	I have access to regular updates about my role	SD	D	U	A	SA
G66	I often feel isolated working in General Practice	SD	D	U	A	SA
G67	I have a very good working environment i.e. furniture, equipment.	SD	D	U	A	SA
G68	My salary is commensurate to the work I do	SD	D	U	A	SA
G69	There is a clear career structure available to me under the MHNIP					
G70	I have adequate opportunities to use my skills	SD	D	U	A	SA
G71	My hours of work are satisfactory to me	SD	D	U	A	SA
G72	I have an enough variety in my work, i.e. client mix, types of interventions	SD	D	U	A	SA
G73	I have adequate clinical supervision arrangements in place	SD	D	U	A	SA
G74	I enjoy the work I am doing under the MHNIP	SD	D	U	A	SA

(IBM, Business Consulting Services, 2003; Strain, Hutnik, Gregory & Bowers, 2006)

Thank you very much for your participation.

Appendix K: Survey of General Practitioners for Phase 3

GENERAL PRACTITIONER QUESTIONNAIRE

Study: THE ROLE OF MENTAL HEALTH NURSES IN AUSTRALIAN PRIMARY HEALTH CARE- EVALUATION OF THE MENTAL HEALTH NURSE INCENTIVE PROGRAM

Section A: DEMOGRAPHICS

Your age range (Please tick)

- 25 year-under
- 25-35 years
- 36-45 years
- 46-51 years
- 51 years-over

What is your gender? Male /Female (please circle one)

Do you have any specific interest in Mental Health? *Yes* / *No*

Have you previously had any Mental health training if yes please specify? *Yes* *No*

Which of the following best describes your practice situation?

Solo Practitioner

Principal Doctor employing other doctors

Co-principal of group practice

What is the postcode of your practice? _____

Section B: Mental Health Nurse Incentive Program (MHNIP)

1. Have you worked with a mental health nurse under the MNHIP? *Yes* *No*

- Yes, please proceed to question 2.
- No, kindly provide a brief summary of why you have not engaged the services of a mental health nurse. Please do not answer the remaining set of questions in this section. Please complete section C **only**

2. How long have you been working with a Nurse under the MHNIP? _____ years

3. What were the three main reasons that made you engage the services of a mental health nurse?

4. What positive impact has the presence of a mental health nurse added to your practice?

Section C: Primary Mental Health Care

This section relates to mental health services in primary care.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

1	Primary health is a suitable place to look after clients with a severe mental illness (SMI)	SD	D	U	A	SA
2	Patients with severe mental illness take up too much practice time in GP Practices	SD	D	U	A	SA
3	I have sufficient time to provide care to clients with high prevalence disorders e.g. anxiety, depression	SD	D	U	A	SA
4	I have sufficient time to provide comprehensive care to clients with a severe mental illness in my practice. E.g. schizophrenia, bipolar disorder.	SD	D	U	A	SA
5	I can effectively manage clients with a severe mental illness such as schizophrenia, Bipolar disorder without extra assistance	SD	D	U	A	SA
6	The Mental Health Nurse incentive Program is well targeted towards clients with a severe mental illness	SD	D	U	A	SA
7	There is enough Government incentive to assist General Practice to provide care to clients with a severe mental illness	SD	D	U	A	SA
8	Accessing specialist mental health services is difficult in primary health care settings	SD	D	U	A	SA
9	GP training has an adequate mental health component	SD	D	U	A	SA
10	Access to specialist mental health services makes it difficult to manage patients with a severe mental illness in primary care	SD	D	U	A	SA

Section D: Mental Health Nurses (MHN) - Role & Impact

This section relates to role and impact of mental health nurses (MHN) in primary health care.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

1	MHN are the most appropriate health professionals to provide care for clients with high prevalence disorders (such as anxiety, depression, panic disorders) in primary health settings	SD	D	U	A	SA
2	MHN are the most appropriate health professionals to provide care for clients with severe mental disorders (such as Schizophrenia, Bipolar disorder) in primary health settings	SD	D	U	A	SA
3	MHNs have the skills needed to provide adequate care for clients with severe mental illness	SD	D	U	A	SA
4	Mental health nurses are a useful addition to General Practice	SD	D	U	A	SA
5	Employing a MHN in GP Practice is not a good utilisation of resources (e.g government funding)	SD	D	U	A	SA
6	MHN working in primary care will help reduce the stigma associated with mental illness amongst the wider population	SD	D	U	A	SA
7	Having a MHN in my practice has helped improved my knowledge of caring for people with a mental illness.	SD	D	U	A	SA
8	The presence of a MHN will help improve links with specialist mental health services	SD	D	U	A	SA
9	The presence of a MHN in my practice has reduced referral rates to specialist services such as Area Mental Health Services	SD	D	U	A	SA

10	The presence of a MHN has helped meet previously unmet needs i.e. seeing more patients with a mental illness	SD	D	U	A	SA
11	The addition of a MHN has helped improve patient satisfaction with care received	SD	D	U	A	SA
12	The addition of a MHN has increased treatment options available to my patients	SD	D	U	A	SA
13	Building therapeutic relationships with clients is an essential element of the MHN's role	SD	D	U	A	SA

Section E: Mental Health Nurses- Scope of Practice

This section relates to scope of practice of mental health nurses in primary health care.

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

1	Mental health nurses are able to coordinate care of people with Severe Mental Illness (SMI) in Primary Health Care	SD	D	U	A	SA
2	MHN should be primarily responsible for the care plan of clients with SMI in primary care	SD	D	U	A	SA
3	MHN should focus primarily on people with a Severe Mental Illness	SD	D	U	A	SA
4	MHN should be able to provide health education about psychotropic medications	SD	D	U	A	SA
5	MHN have a major role in providing education to clients and their families about mental illness	SD	D	U	A	SA

6	MHN have a role in educating other members of the practice about mental health related issues	SD	D	U	A	SA
7	MHN should act as a screening agent in order to direct clients to the most appropriate resources available	SD	D	U	A	SA
8	MHN should provide people with transient mental health problems with short term therapeutic interventions	SD	D	U	A	SA
9	MHNs should provide leadership in primary mental health care	SD	D	U	A	SA
10	MHN should be initiate mental health promotion activities in PHC	SD	D	U	A	SA
11	It is essential that MHNs have family therapy skills when working in primary care	SD	D	U	A	SA
12	In the future, I can see MHN having prescribing rights in Primary Health Care	SD	D	U	A	SA

Section F: GP-MHN Relationship

This section examines your working relationship with Mental Health Nurses (MHN)

Please indicate the degree to which you agree with the following statements.

SD= Strongly disagree D= Disagree U= Unsure A= Agree SA= Strongly Agree

1	The MHN and develop a plan together to make decisions about the care of patients	SD	D	U	A	SA
2	I believe there is a clear boundary about our individual clinical roles	SD	D	U	A	SA
3	I would describe our frequency of communication as adequate	SD	D	U	A	SA

4	We both consider medical and nursing considerations in making decisions about patient care	SD	D	U	A	SA
5	We both respect each other's expertise and skills in decision making about patient care	SD	D	U	A	SA
6	I am fully aware of the scope of practice of the MHN	SD	D	U	A	SA
7	Collaborative practice between GPs and MHNs enables good clinical outcomes for the patients	SD	D	U	A	SA

(IBM, Business Consulting Services, 2003; Strain, Hutnik, Gregory & Bowers, 2006)

Thank you very much for your participation.

Appendix L: Sample correspondence from survey pilot group

RMIT University Mail - Re: MICHAEL OLASOJI would like your help testing a stan... Page 1 of 1



Michael Olanrewaju Olasoji <s3212172@student.rmit.edu.au>

Re: MICHAEL OLASOJI would like your help testing a standard survey

1 message

Michael Olasoji <s3212172@student.rmit.edu.au>
To: " " <@alfred.org.au>

24 November 2011 13:23

Thanks . . . I am grateful and would make those changes.
Michael

Sent from my iPhone
Michael Olasoji

On 24/11/2011, at 12:49 PM, " " <@alfred.org.au> wrote:

> Hi Michael,
> I think that this is a great survey with some thought provoking
> questions relating to practice and clientele. I would just make a
> couple of typing changes to the questions.
> Just putting Capital letters in (Q. 27 & 28) and either sticking to MHNs
> or Mental Health Nurses that's all. Otherwise it looks really great.
> Easy to follow, not repetitive and questions aimed at practice. Makes
>
>
>
>
> -----Original Message-----
> From: MICHAEL OLASOJI [mailto:m.olasoji@student.rmit.edu.au]
> Sent: Thursday, 24 November 2011 12:26
> To:
> Subject: MICHAEL OLASOJI would like your help testing a standard survey
>
> Please test this standard survey and email me back any comments or
> problems. Thanks!
>
> Click on the following link to test this survey:
> <http://students.squizmo.com/testsurvey/survey?id=711419&src=ea92d7d55d6ac65d9daa8938cf4d7bea>
>
>
> Powered by SurveyGizmo - <http://www.surveygizmo.com> This message was
> sent to you at the request of S3212172@student.rmit.edu.au for the sole
> purpose of testing a survey. You have not been added to a mailing list.
>
>
> --
> This email was Anti Virus checked by KeyTrust UnityASV