Experiences of mental health nurses working in general practice: A Qualitative Study

Abstract

Background: This paper reports on a qualitative study utilising in-depth interviews of sixteen Australian mental health nurses (MHNs) working in general practice. On 1st July 2015, the commonwealth government of Australia established 31 primary health networks (PHN) to increase the efficiency and effectiveness of medical services for people, particularly those at risk of poor health outcomes, and to improve coordination of care.

Aim: This study explores the experiences of Australian MHNs working in general practice.

Design: Data were analysed using thematic analysis. Four themes emerged through the data analysis: 1) autonomy and flexibility, 2) opportunity for more clinically focused work, 3) health promotion and preventative health and 4) excited to work in general practice.

Findings: Study Participants identified many clinical opportunities working in primary practice and noted that the autonomy and flexibility of their role was quite different from other areas they had previously worked. They reported having more time to spend with the patients and being able to engage in health promotion.

Conclusions: In order to make mental health care more accessible it is important to have a well-qualified workforce within primary health care (PHC) settings such as general practice. The participants of this study have identified ways they have been best utilised in the Primary Care workforce. They embrace the autonomy of the role and the ability to engage with consumers by providing clinical interventions that can assess and intervene with people experiencing mental illness.

Keywords: mental health nursing, primary health care, general practice, mental health nursing incentive program
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Impact statement

This study identifies the reasons why mental health nurses choose to work in general practice.

Introduction

Primary Health Care (PHC) is the first level of contact for individuals connecting them to the national health system. Primary health care brings 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 Organisation [WHO], 2007). Most developed nations have made concerted efforts to redesign their health care systems to ensure primary care plays a strategic role in the provision of cost effective and quality health care (Soman & Larson, 2009). It has also been argued that the primary care based system is the only system that has the potential to reach the broader population (WHO, 2007).

Background

In Australia, there has been a growing emphasis on the role of primary health care in the provision of mental health care (Commonwealth of Australia, 2010). On 1st July 2015, the commonwealth government of Australia established 31 primary health networks (PHN) across the country (Booth et al., 2016). The primary care networks were established with the policy objectives to increase the efficiency and effectiveness of medical services for people, particularly those at risk of poor health outcomes, and to improve coordination of care.

Primary health networks work directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for service users. PHNs are provided with flexible funding to enable them to respond to national priorities as determined by Government, and to respond to PHN-specific priorities, identified in their needs assessments, by purchasing and commissioning required services. PHNs are
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required to commission primary mental health care services for people with severe and complex mental illnesses utilising the services of mental health nurses and other health professionals (Meehan & Robertson, 2013).

Nurses play a significant role in every nation’s health care system and any changes made in the way care is delivered would generally involve the nursing profession. Nurses have historically responded well to changes in the healthcare system and are often instrumental for successful change outcomes. Groenewegen (2008) suggested that primary care is a major driver for change in the ways a country offers health care and that nurses are the “grease” in the system that implements major change for patient care. There has been much 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 (Carryer, Halcomb & Davidson, 2015; Salvage, 2009).

As early as 2001, the Australian Government established the Nursing in General Practice Incentive (NIGPI) program, which consisted of three intended outcomes: to improve consumer access and the affordability of primary health care; assistance in the integration of primary care; and proactive contribution to the prevention and management of chronic diseases (Olasoji & Maude, 2010). An evaluation revealed that the program improved the quality of the general practice, had a positive impact on the management of people with chronic diseases and reduced waiting times. The program was found to increase the awareness of practice nurses and their role and raised their profile in the community (Olasoji & Maude, 2010). Berkiwitz (2016) identified that consumer experience and overall satisfaction with a service could be improved with a dedicated health care service that can provide access to a mental health nurse.
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Ashley et al (2017) reported the reasons nurses’ transition from acute care to primary health care setting, noting that nurses rated balancing life and responsibilities, improved work hours, which suited personal lifestyle and the opportunity to improve work satisfaction as the main reasons for choosing to work in the primary health setting. Other reasons noted were, the ability to work autonomously and the desire to pursue a career in PHC. Similarly, Halcomb and Ashley (2016) noted in their study that the most satisfying aspects of working in primary health care for nurses were, helping people, teamwork, autonomy, work/life balance and the variety of work.

Several groups of nurses work in mental health settings in Australia, these include enrolled nurses (trained in the vocational education and training system), registered nurses (university-trained nurses) and specialist mental health nurses (registered nurses with postgraduate advanced education in mental health). According to the Australian Institute of health and Welfare, (AIHW, 2019), in 2017, approximately 7% of employed nurses (22,159 nurses) indicated they were working primary in mental health settings with 94% (20,792 nurses) spending the majority of their time in clinical roles. It was also noted that approximately 85% of these nurses did not have a specialist mental health qualification. Among those that had specialist mental health qualifications, 30% had a post-graduate qualification in mental health while 70% had a nursing qualification solely in mental health (so may have restrictions to practice only in mental health clinical areas) (AIHW, 2019).

Historically, community mental health nurses (CMHNs) in Australia have worked as part of community mental health teams, which are usually part of larger public mental health services where they deliver care to people with severe mental illness within a multidisciplinary team structure. While having MHNs working in primary health is relatively new in Australia, it is not new globally. In the United Kingdom, several models of mental health care delivery in primary health have been trialled. For example, in 2011, the Primary
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Care Liaison Nurse (PCLN) was established in response to an increasing number of people with complex mental and physical health issues requiring care in General Practices. The PCLN is part of the stepped care model of care, which is a MHN-led service (McLeod & Simpson, 2017). A review of the work of MHNs working as PCLN suggested improved integration of services, clinical effectiveness, provision of patient centred care, improved access to care for mental health patients as well as efficiency in care delivery (McLeod & Simpson, 2017).

As part of its reform agenda, the Australian Government established the Mental Health Nurse Incentive Program (MHNIP), which was transformed into the mental health integrated complex care (MHICC) initiative in April 2018. The original 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 the services of credentialed mental health nurses in the provision of coordinated clinical care for people with severe mental disorders (Department of Health & Ageing, 2007). The Nursing and Midwifery Board of Australia (NMBA) does not endorse specialty areas of nursing practice. However, in order to work as a MHN in a primary care setting, the nurse must be approved by the Australian College of Mental Health Nurses (ACMHN) specialist nurse professional credentialing program. It is mandatory for any MHN intending to work under the MHICC to be credentialed by the ACMHN.

Several role examples of MHNs working within primary health care have been reported. Lakeman, Cashin and Hurley (2014) reported on the characteristics and noted that they were very experienced nurses and highly educated. Most of these nurses had specific training in psychotherapy. The interventions provided by MHNs resulted in a significant reduction of the severity of symptoms experienced by people accessing the program (Lakeman & Bradbury, 2014; Lakeman, 2013). Similarly, MHNs make significant contributions to improving access
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to and quality of mental health care provision in PHC settings (Happell, Palmer & Tennent (2010). Clients accessing services by MHNs have also reported benefits from this model of service delivery. Happell and Palmer (2010) noted that the model offers flexible, holistic and affordable care to people experiencing mental illness.

It has been reported that there would be shortfall of 11,500 to 18,500 mental health nurses by the year 2030 (Health Workforce Australia, 2014). Mental health nursing is often considered as a less attractive type of nursing for most pre-registration nurses (Redknap, Twigg, Rock, & Tower, 2015). In general, attracting and retaining nurses by Australian mental health services has been historically problematic (Happell 2009).

Attracting good quality mental health nurses into the primary care setting is crucial to the survival of this government initiative. It is important to understand the reasons motivating MHNs to explore and remain in this area of practice. The aim of this study was to explore the reasons why these nurses chose to work in general practice and the challenges that they faced transitioning into the role within the context of the Australian Government funding. It is important to explore this issue as it has future workforce implications particularly in primary health care settings.

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 could be implemented to promote retention. The Committee’s recommendations included encouraging mental health nurses to work in different clinical settings, allowing them to experience new and different consumers, peers and situations.

This study contributes to nursing knowledge and in particular, mental health nurses perceptions concerning their contribution to primary care. No studies have examined the reasons why Australian MHNs choose to work in General Practice settings or their
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experiences of working in this setting. Thus, this paper fills a gap in the understanding of the experience of MHNs transforming from traditional roles to expanded practice in primary health care.

Methods

Research design
A descriptive qualitative method was used for the study. Exploratory descriptive qualitative designs are useful in answering questions that explore a particular population. (Sandelowski, 2010). Exploratory descriptive designs are most useful when there is little known about the phenomena of interest. The reasons Australian mental health nurses chose to work in primary health care setting have not been previously reported. Sandelowski is a key advocate of descriptive qualitative research whose initial conceptual ideas "Whatever happened to qualitative description?" being published in 2000 with further revisions ten years later (2010). Sandelowski suggests that descriptive qualitative design is a good fit when the aims of the research is to produce a vivid yet practical description of the phenomena. Thus this work can be atheoretical and provides a narrative of the actual experience (Hunter et al., 2018).

Ethical consideration

The University Human Research Ethics Committee granted permission for the study to be undertaken (Approval number- BSETAPP 40-08).

Participant recruitment and setting

Data Collection
Participants (N = 16) were recruited through a group forum that hosted mental health nurses working within primary care. The researcher attended this forum, made a short presentation
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about the project and sought expressions of interest to participate in the study. The contact
details of the researcher were provided and potential participants who contacted the
researcher were then sent the explanatory statement of the study, a consent form and a date
was set for the interviews. There was a schedule of questions with prompts to assist the
person to focus. The questions were reviewed by two researchers for content and to ensure
they fit the study aims. The interview questions provided the participants with the opportunity
to provide a background about their previous experience working in mental health, and to
address questions about the reasons they decided to work in general practice and the
perceived benefits. All interviews (60 to 75 minutes duration) were audio recorded with the
participant’s permission. Transcripts were returned to participants and no changes were
requested. The audio-recordings from the semi-structured interviews were professionally
transcribed for thematic analysis.

Data Analysis

The transcribed text was confirmed by the first author, by comparing it to the digital audio-
recordings. Two researchers then analysed the transcripts using thematic analysis. There was
an initial familiarization with the data, followed by creation of early codes and then
generating, examining and revising the themes. The researcher achieved familiarisation by
listening to the audio-taped interviews and reading the type-written transcripts.
The thematic analysis was undertaken through multiple iterations of each transcript using
constant comparison to generate provisional themes and name them (Braun & Clarke 2006).

Findings

Sixteen MHNs (11 females and 5 males) were interviewed for the study. The average age of
the participants was 47 years who 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 other
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settings included acute in-patient units (adult & adolescents), community mental health clinics, drug & alcohol services as well as private mental health clinics. The majority of the participants (n=14) were hospital trained, others (n=2) obtained their training through the university sector. However all but two of the participants had a postgraduate qualification 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 original government funding. This participant worked as a GP Liaison MHN employed by a public community mental health service and the role was to coordinate discharge of consumers to GPs who then took over their ongoing care from the community mental health service.

Whilst each participant had unique experiences, they shared commonalities which form the four themes that emerged within this study: autonomy and flexibility, opportunity for more clinically focused work, health promotion and preventative health and excitement of working in general practice. Quotations from the participants are presented to highlight and exemplify the themes. All participants have been de-identified by using a coding system of a unique number allocated to each interview. Only the researchers had access to the original names, consent forms and list of codes.

**Autonomy and Flexibility**

Most of the participants viewed their work in general practice as offering them a degree of autonomy and flexibility, which they did not fully enjoy while working in other mental health settings.

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 wanting more autonomy in my practice (Par 10)
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The participants also noted that due to the nature of their work, they are able to deliver care in a more flexible manner and in response to the needs of the consumer. There was also the scope for them to be more creative in their delivery of mental health nursing care.

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).

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

Others talked about flexibility in care delivery that their role 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 [and] 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 the 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 7).

Opportunity for clinically focused work

The participants reported that their role offered greater opportunity to spend more time in providing clinical services and less time on documentation compared to working in public or community mental health settings. The participants noted that they were able to spend more time with the patients and engage in clinically focused activities.

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
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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 paperwork 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 attention paid to those patients who are involuntary (Par 12)

Engaging health promotion and preventative health
Participants noted that their role offered them the opportunity to be engaged in more preventative health promotion activities, which is less crisis driven compared to working in public mental health systems. The participants noted that they were able to build capacity.

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. So actually being able to help people with prevention of relapse and things so that they are not readmitted into hospital (Par 10)

This view was 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)

Excited to work 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 people 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. There was also a sense of hope that perhaps the role could evolve
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in the future to more independent practice. 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 6)

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 challenges and difficulties, it does present many opportunities and possibilities for the profession. Mental health nurses 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 the public mental health system and was another reason why they decided to work within the primary health care. 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)
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In the public health system, you lurch from crisis to the next literally every day, every minute, it’s one crisis to the next. You know, I managed a psych ward for 10 years and that’s just what you do (Par 9)

Discussion
In Australia, mental health nurses have traditionally worked in acute in-patient, community based mental health teams or private psychiatric hospitals. In 2007, mental health nurses experienced the opportunity for an extension of their scope of practice with the establishment of the mental health nurse incentive program (now known as mental health integrated complex care). The aim of this study was to explore the experiences of Australian mental health nurses working in general practice.

Participants in this study were quite keen to explore the new opportunities that exists in general practice settings. The ability to work autonomously within clinical settings has implications when it comes to ongoing retention and recruitment of mental health nurses in the face of a declining workforce. This has been previously identified as a strategy for retention by the Australian Health Workforce Advisory Committee (AHWAC, 2003).

Participants in this study enjoyed the autonomy and flexibility that working in general practice offered them. They noted that their clinical skills and expertise was not only appreciated, but there was scope for them to fully utilise these skills in practice. McNamara et al., (2008) examined the job satisfaction of mental health consultation-liaison (MHN-CL) in relation to aspects of the role. They noted factors such as autonomy, different clinical settings and use of a range of skills as some of the reasons MHN-CL 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% of (n=48) community health nurse participants rated as highly important the autonomy and flexibility of their role.
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The original government funded program was a welcome development and opportunity for mental health nursing to further position itself as a unique professional group with valuable contribution to the overall wellbeing of the population. Participants in this study noted that their role has given them the opportunity to be able to spend time with consumers thereby establishing quality interactions. The quality of the nurse-patient interaction is a fundamental factor in achieving positive outcomes for service users and there is evidence to suggest that there is a link between the quality of nursing interactions and a person’s overall satisfaction with care received (Berkowiz, 2016). There is therefore a need for MHNs to spend quality time with consumers in order to be able to achieve better health care outcomes that are recovery focussed.

Participants in this study considered the opportunity to engage in preventative health and health promotion activity as an attractive and important aspect of working in general practice. Health promotion is the process that enables people to increase control over, and to improve, their health. It includes all those activities intended to prevent disease, improve health and enhance well-being (Thomas et al., 2016). Health promotion aims to help raise awareness in the individual on how to prevent illness. Another concept identified in the literature is clinical health promotion, which is defined as health education and counselling aimed at behaviour change in people at risk of lifestyle related illnesses, or who have diseases for which lifestyle modification can improve function or outcome (Weare & Nind, 2011).

Mental health promotion in primary care is an important activity that mental health nurses can engage in. Mental health promotion is defined as any action taken to maximise mental health and wellbeing among populations and individuals (Holder, Peterson, Stephens & Crandall, 2019; Reif et al., 2019). Mental health promotion is relevant before, during and after the onset of mental health disorders. Hence individuals who are well, those at risk of experiencing an illness as well as those experiencing an illness will benefit from mental health promotion.
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health promotion activities. The primary purpose of mental health promotion is to protect, support and sustain emotional and social well-being. Mental health promotion also aims to promote mentally healthy lifestyles and living, increase sense of belonging and improve coping skills amongst others (Reif et al., 2019).

Primary care presents many opportunities for health promotion, which may not be available in publicly funded community-based services or outpatient clinics. Mental health promotion is a rapidly growing field, with emerging evidence for its effectiveness. Various studies demonstrate that mental health promotion programmes have the potential to lead to a range of positive health and social outcomes (Weare & Nind, 2011)

This has been an exciting period for mental health nurses in Australia. Providing opportunities for Australian mental health nurses to work in general practice settings 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 need for mental health nurses to better position themselves to meet the challenges that lie ahead in the practice of primary health care Working in primary health care provides MHNs with a different career path and greater job opportunities by expanding the scope and autonomy of their clinical practice (Australian College of Mental Health Nurses, 2013). The opportunity to work in a variety of clinical settings especially one that offers 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. Current workforce projections in the nursing workforce in Australia shows that mental health nursing would be the most severely impacted sector of nursing in terms of undersupply by the year 2030 (Health Workforce Australia, 2014).
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Several factors have been attributed to the decline in the number of nurses working in the mental health care, one of which is burnout and job dissatisfaction (Happell, Palmer & Tennent, 2010). The Mental Health Workforce Advisory Committee (MHWAC, 2011) in Australia welcomed the introduction of the original funding program, noting that the establishment of roles with a greater scope of practice supports greater variety in work experience and improves retention of mental health nurses.

In addition to the opportunities that working in general practice provides for MHN, their skills and expertise could be enhanced through the establishment of positions such as Mental Health Nurse Practitioners in the primary care setting which are in operation in countries such as the United States (Durbin, Durbin, Hensel & Deber, 2016). While the Mental Health Nurse Practitioner is not a new concept in Australia, it is surprising though that there are few MHN practitioner positions situated within general practice. There are opportunities as suggested by Barraclough, Longman and Barclay (2016) for nurse practitioner-led mental health service delivery within primary health care settings. The benefits of such mental health nurse-led specialist clinics has also been reported by (Sowerby & Taylor, 2017).

Application to Practice

The existing literature suggests that mental health nurses have long worked across a variety of settings within the health care system. However, the primary health care setting especially within general practice is a growing area of practice for mental health nurses. There are no studies examining the reasons that motivate mental health nurses to choose work in general practice. Previous studies that examined the role of mental health nurses within general practice have reported on the impact of their role and the services that they provide to people living with a mental illness.
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In the face of dwindling resources available in most advanced economies for health care provision, primary health care remains a significant system that could deliver time and accessible care. Mental health nurses have a key role to play in providing much needed mental health care within this setting.

Limitations

This study has limitations due to the small number of participants and the fact they were probably committed to positive outcomes for the new initiative. They were experienced nurses who may hold strong professional opinions, however majority of the participants were hospital trained.

Conclusion

This study examined the views of mental health nurses currently working in general practice and the reasons that made them chose this area of nursing practice. Four themes emerged from the study: autonomy and flexibility, opportunity for more clinically focused work, health promotion and preventative health and excited to work in general practice. Mental health nurses noted that the autonomy and flexibility that the role offered enabled them to engage in more clinical work, less administration and provide better mental health nursing care to their patients. The study has acknowledged ways mental health nurses can be integrated into the Primary Health Care workforce and considers ways they could potentially be recruited.

Acknowledgements

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Disclosure statement

The authors report no conflict of interest. This project did not have external funding.
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Dear Dr. Hickman,

Thank you for accepting our manuscript for publication. We have made the required changes as requested by the reviewer.

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<th>Item #</th>
<th>Reviewer Comments</th>
<th>Response</th>
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<tr>
<td>1</td>
<td>Thanks for the opportunity to review this well written paper. While I can see the previous reviewers point that the authors appear to have taken a very positive/uncritical view of their topic I think this paper has real value. It is just about ready but runs out of steam towards the end. I include a few notes below for the author’s consideration.</td>
<td>Thank you for your comments, they were quite valuable</td>
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<td>2</td>
<td>I enjoyed reading the background section which provides a nice summary of some of the modern policy changes in this area.</td>
<td>Thank you for your comments</td>
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<td>3</td>
<td>Under the subtitle 'Background' on page 2 at line 51 the authors write 'The primary care networks were established to increase efficiency and effectiveness of medical services for people, particularly those at risk of poor health outcomes and to improve coordination of care.'. While this is what the government documents associated with them may have stated at the time of their establishment there were other major political objectives involved here. Anyone who worked in primary mental health during the era of the 'Divisions of General Practice' which were then changed to 'Medicare locals' before being rebadged as Primary Health Networks' knows that these re arrangements are often as much to do with politics and power as they are to do with patients. I would suggest re writing this sentence and others like it with something like the following - &quot;The primary care networks were established with the policy objectives to increase the efficiency.&quot;</td>
<td>Thank you for this valuable insight, the sentence has been revised.</td>
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<td>4</td>
<td>In the final paragraph of your discussion section on page 16 you mention the idea that MHNs in primary care settings could establish positions such as Mental health Nurses Practitioners in the primary care setting like those in place overseas. There are in fact already several mental health nurse practitioners who operate their own practice in a variety of primary care settings throughout Australia. Please see papers below for further info and amend this paragraph as you see fit Currie, J., Chiarella, M., &amp; Buckley, T. (2016). Workforce characteristics of privately practicing nurse practitioners in Australia: Results from a national survey. Journal of the American Association of Nurse Practitioners, 28(10), 546-553. Practice activities of privately-practicing nurse practitioners: Results from an Australian survey</td>
<td>We have included the Barraclough, F., Longman, J., &amp; Barclay, L. (2016) paper which is quite relevant.</td>
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<td>5</td>
<td>Your 'Application to Practice Section' really needs re writing. It doesn't currently state what difference your study makes to practice. Please re write this section so that it really has some punch! This section has been revised</td>
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<td>6</td>
<td>Overall nice work Thank you.</td>
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**Editors Comments**

1. Thank you for resubmitting your paper to Contemporary Nurse. I am delighted to inform you that your paper has now been accepted by the Contemporary Nurse, subject to revision along the lines suggested below, and the reviewer comments at the end of this letter. The reviewer(s)/Editor would like to see some revisions made to your manuscript before publication. Therefore, I invite you to respond to the reviewer(s)' comments and revise your manuscript. When you revise your manuscript please highlight the changes you make in the manuscript by using the track changes mode in MS Word or by using bold or coloured text. We have formatted the document as requested, thank you.

2. I would be grateful if you could now provide a final paper following (Journal) guidelines, with a Title page containing authors affiliation and e-mail address (page 1), followed by Abstract and Key Words (page 2), and full text, all in the same document. Only tables and figures are to be included as a separate document. We have formatted the document as requested, thank you.
### Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

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<td><strong>Domain 1: Research team and reflexivity</strong></td>
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<td><strong>Personal Characteristics</strong></td>
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<td>1. Interviewer/facilitator</td>
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<td>2. Credentials</td>
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<td>MO PhD RN, PM PhD RN, WC PhD RN</td>
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</tr>
<tr>
<td>3. Occupation</td>
<td>What was their occupation at the time of the study?</td>
<td>Mental health nurse</td>
<td></td>
</tr>
<tr>
<td>4. Gender</td>
<td>Was the researcher male or female?</td>
<td>MO Male, PM Male, WC Female</td>
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</tr>
<tr>
<td>5. Experience and training</td>
<td>What experience or training did the researcher have?</td>
<td>Research methodology</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship with participants</strong></td>
<td></td>
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</tr>
<tr>
<td>6. Relationship established</td>
<td>Was a relationship established prior to study commencement?</td>
<td>N/A</td>
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</tr>
<tr>
<td>7. Participant knowledge of the interviewer</td>
<td>What did the participants know about the researcher? e.g. personal goals, reasons for doing the research</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>8. Interviewer characteristics</td>
<td>What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic</td>
<td>Method (Pages 8-9)</td>
<td></td>
</tr>
<tr>
<td><strong>Domain 2: study design</strong></td>
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<tr>
<td><strong>Theoretical framework</strong></td>
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<tr>
<td>9. Methodological orientation and Theory</td>
<td>What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</td>
<td>Methods(Pages 8-9) Qualitative Descriptive design with thematic analysis</td>
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<tr>
<td><strong>Participant selection</strong></td>
<td></td>
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<tr>
<td>10. Sampling</td>
<td>How were participants selected? e.g. purposive, convenience, consecutive, snowball</td>
<td>Methods(Pages 8-9) Purposive from a group of nurses working in Primary Health Care under the Mental Health Incentive Program</td>
<td></td>
</tr>
<tr>
<td>11. Method of approach</td>
<td>How were participants approached? e.g. face-to-face, telephone, mail, email</td>
<td>Methods(Pages 8-9) A presentation at a group forum with invitations handed out to participants to consider to be part of this study</td>
<td></td>
</tr>
<tr>
<td>12. Sample size</td>
<td>How many participants were in the study?</td>
<td>Findings (Pages 9-14)</td>
<td></td>
</tr>
<tr>
<td>13. Non-participation</td>
<td>How many people refused to participate or dropped out? Reasons?</td>
<td>Method</td>
<td></td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td></td>
<td></td>
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<tr>
<td>14. Setting of data collection</td>
<td>Where was the data collected? e.g. home,</td>
<td>Method- Workplace and via</td>
<td></td>
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<tr>
<td></td>
<td>clinic, workplace</td>
<td>telephone</td>
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</tr>
<tr>
<td>15. Presence of non-participants</td>
<td>Was anyone else present besides the participants and researchers?</td>
<td>Findings(Pages 9-14)</td>
<td></td>
</tr>
<tr>
<td>16. Description of sample</td>
<td>What are the important characteristics of the sample? e.g. demographic data, date</td>
<td>Findings(Pages 9-14) All experienced mental health nurses working in a new specialty practice area with GP clinics</td>
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**Data collection**

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<tr>
<td>17. Interview guide</td>
<td>Were questions, prompts, guides provided by the authors? Was it pilot tested?</td>
<td>Method(Pages 8-9) There was a schedule of questions with prompts to assist the person to focus. Questions were viewed by supervisor and senior clinicians.</td>
</tr>
<tr>
<td>18. Repeat interviews</td>
<td>Were repeat interviews carried out? If yes, how many?</td>
<td>N/A</td>
</tr>
<tr>
<td>19. Audio/visual recording</td>
<td>Did the research use audio or visual recording to collect the data?</td>
<td>Method(Pages 8-9) All interviews were audio recorded with the participants permission</td>
</tr>
<tr>
<td>20. Field notes</td>
<td>Were field notes made during and/or after the interview or focus group?</td>
<td>Method(Pages 8-9) Field notes were made in a diary after each interview</td>
</tr>
<tr>
<td>21. Duration</td>
<td>What was the duration of the interviews or focus group?</td>
<td>Method(Pages 8-9) One hour interviews that sometimes went over time by 15 minutes</td>
</tr>
<tr>
<td>22. Data saturation</td>
<td>Was data saturation discussed?</td>
<td>Method (Pages 8-9) Yes in the ethics application and as part of the supervision of the thesis.</td>
</tr>
<tr>
<td>23. Transcripts returned</td>
<td>Were transcripts returned to participants for comment and/or correction?</td>
<td>Yes but none were returned with changes</td>
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**Domain 3: analysis and findings**

**Data analysis**

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<tr>
<td>24. Number of data coders</td>
<td>How many data coders coded the data?</td>
<td>Method-Data Analysis- Two MO and PM</td>
</tr>
<tr>
<td>25. Description of the coding tree</td>
<td>Did authors provide a description of the coding tree?</td>
<td>N/A- No. Simple thematic analysis was used.</td>
</tr>
<tr>
<td>26. Derivation of themes</td>
<td>Were themes identified in advance or derived from the data?</td>
<td>Method-Data Analysis. Derived from the data</td>
</tr>
<tr>
<td>27. Software</td>
<td>What software, if applicable, was used to manage the data?</td>
<td>N/A</td>
</tr>
<tr>
<td>28. Participant checking</td>
<td>Did participants provide feedback on the findings?</td>
<td>Strengths and limitations</td>
</tr>
<tr>
<td>29. Quotations presented</td>
<td>Were participant quotations presented to</td>
<td>Findings(Pages 9-14)</td>
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<tr>
<td><strong>30. Data and findings consistent</strong></td>
<td>Was there consistency between the data presented and the findings?</td>
<td>Findings and Discussion- Yes and the interview transcripts were read and the findings audited back by the supervisor PM</td>
</tr>
<tr>
<td><strong>31. Clarity of major themes</strong></td>
<td>Were major themes clearly presented in the findings?</td>
<td>Findings- Yes four themes arose</td>
</tr>
<tr>
<td><strong>32. Clarity of minor themes</strong></td>
<td>Is there a description of diverse cases or discussion of minor themes?</td>
<td>No</td>
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