



FEATURE ARTICLE

Mental health nurses in primary care: Qualitative outcomes of the Mental Health Nurse Incentive Program

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ABSTRACT: *The Mental Health Nurse Incentive Program (MHNIP) is a government-funded programme, which, since 2007, has enabled mental health nurses to work in primary care settings in Australia in collaboration with general practitioners (GPs) or private psychiatrists. To date, small-scale qualitative studies have explored outcomes of the programme from the point of view of nurses, consumers, and the perceptions of GPs. This study reports on an on-line survey of credentialed mental health nurses perceptions of outcomes of the MHNIP. Two hundred and twenty five nurses who worked in MHNIP provided detailed narrative responses that were examined using thematic content analysis. The most commonly-cited outcomes were reductions in symptoms or improved coping, improved relationships, and enhanced community participation. Other reported outcomes included reduced hospitalization or use of state-funded mental health services, better use of health services, the continuation or establishment of meaningful occupation, improved physical health and medication management, less use of coercive interventions, and greater independence.*

KEY WORDS: *Mental Health Nurse Incentive Program, outcome, primary care, qualitative research.*

INTRODUCTION

The Mental Health Nurse Incentive Program (MHNIP) was established in 2007 by the Australian Government as part of the 2006 National Action Plan on Mental Health. According to the Department of Health and Ageing (2012), incentive payments are made to community-based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals, and Aboriginal and Torres Strait Islander Primary Health Care Services that engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental illnesses. There has been a steady increase in nurses choosing to work within the programme, with 444 organi-

zations registered, 529 nurses engaged in the programme, and 41 535 individual consumers having received a service under the programme in the year prior to April 2012 (Senate Community Affairs Committee 2012).

According to the World Health Organization (1978), primary health care is the first level of contact individuals have with the national health system, bringing health care as close as possible to where people live and work. Different countries have developed different ways to attempt to address people's mental health needs in primary care settings (Gask *et al.* 1997; Gournay 2002; Gray *et al.* 1999; Lee & Knight 2006; McKinlay *et al.* 2011). The role of nurses and specialist allied health professionals in primary care is highly contingent on funding models and broader public policy. In Australia, primary health care has come to be understood as health care undertaken outside of mainstream hospital and community mental health systems. The mainstream mental health system is paid for by state governments and is 'block funded', while primary

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Accepted February 2013.

care is largely paid for by the Australian Government through incentives, fees for service, and subsidies for medications.

Australia has relatively well-developed (state-funded) community mental health teams, which have been varyingly faithful to assertive community treatment principles (Hoult *et al.* 1981) or intensive case management (Issakidis *et al.* 1999) for over 30 years, but these serve only a small proportion of people in need. Various methods of improving the care of people with complex mental health problems in primary care settings have been tried, including consultation and liaison models (van der Feltz-Cornelis *et al.* 2010) and co-location of state and federally-funded specialist services (Ahrens 2006). Co-location of mental health service staff in primary care settings has shown considerable promise in Australia to deliver youth-specific mental health services, but this relies largely on existing government fees for service mechanisms to sustain day-to-day operations (Scott *et al.* 2009). That is, outside of (state-funded) mental health services sharing staff, health professionals need to generate income by billing the government for services through various eligible programmes. The MHNIP provides one of the few means by which nurses can be employed or engaged by primary care organizations outside of secondment from state health services.

The Australian Medical Association (AMA) (2010) has asserted strongly and successfully lobbied to ensure that general practitioners (GPs) 'are the only primary care health professionals who can take responsibility for diagnosing, treating and managing care', while supporting a team-based approach, so long as team based models are 'under the control of the medical practitioner'. It has lobbied for a medical benefit schedule that supports a structure whereby the GP is the leader of a team, and determines how the patient ought to be managed by other members of the primary care team through referral and reporting. The medical benefit scheme is an uncapped fee-for-service funding scheme that enables GPs and other medical doctors in the private sector to obtain funding for the services they provide. Allied health professionals can claim a limited number of Medicare items on referral from a medical doctor, and can only see people for focused psychological therapies for a capped number of sessions.

The AMA (2010) does not support 'lesser-trained groups', such as 'independent' nurse practitioners, but it does support general practice nurses and general practices can bill Medicare for some services they provide. The MHNIP is essentially a practice nurse-funding model, rather than a fee-for-service model accessed by

other allied health professionals. In a practice nurse-funding model, payments are paid to eligible organizations or medical doctors, rather than the provider (nurse). The nurse is an extension of the medical doctor, undertaking essential but lesser skilled tasks. Unlike other schemes in which a person might be referred for allied health services, which presumably they can provide autonomously, the nurse as Healthcare Management Advisors (2012, p. 52) asserts under the supervision of a medical practitioner. The MHNIP has some unique features, in that it allows nurses to see people for as long as is necessary, and payment to the eligible organization is for a 3.5-hour session (up to 10 per week, with an average 2 face-to-face consultations per session) at \$A240 (with a 25% loading applied to sessions provided in remote or outer regional areas). In 2011–2012, 114 573 sessions were claimed, and the programme was estimated to have cost \$A35.6 million (Senate Community Affairs Committee 2012).

According to the official documentation from the Department of Health and Ageing (2012), nurses are not envisaged to have any particular or independent psychotherapeutic value and are supposed to work in collaboration with GPs and private psychiatrists to review people's mental state, monitor and manage medication, provide information on physical health care to patients, and arrange access to other health professionals. This is expected to have some benefits. For example, one Medicare Local (Townsville-Mackay Medicare Local 2012) suggested that the support provided could reduce practice and GP workload in the care of people with moderate-to-severe illness and improve patient outcomes, such as reducing admissions to mental health services. A recent qualitative study on the experience of GPs working with MHNIP nurses (Meehan & Robertson 2012a) suggested that GPs support the programme and believe it contributes to better patient outcomes, but have only a cursory understanding of the kinds of interventions that a nurse might provide.

There are limited data on how nurses are actually engaged with eligible organizations, how they collaborate in practice, how they work, what they do, and the actual outcomes of their involvement for consumers. A recent study comparing the Health of the Nation Outcome Scales scores of 403 people referred to the MHNIP in regional Queensland to another programme, Access to Allied Psychological Services, suggests that people referred to the MHNIP are at the severe end of the symptom-severity spectrum compared to those referred to other community programmes (Meehan & Robertson 2012b). Happell *et al.* (2010) interviewed 10 nurses who

had been working within the programme for between 2 and 18 months. Respondents provided some narrative accounts of what might be considered improvements in care coordination, and suggested that rates of hospitalization and length of hospital stay had reduced for those people who had been referred to the programme. Happell and Palmer (2010) also interviewed 14 clients of the MHNIP, and despite initial apprehension associated with past experiences with the public mental health system and uncertainty, these people found the programme to be comfortable, the approach of the nurses flexible and supportive, appreciated the holistic approach to care, and found the programme accessible.

A recent evaluation of the programme (Healthcare Management Advisors 2012) included a survey of medical practitioners ($n = 191$) and nurses ($n = 258$) characterized by closed questions. There was strong agreement from both groups that the MHNIP led to improvements in care, reduced unnecessary hospitalizations, and assisted people to feel well and connected with their communities. Medical practitioners were asked what the benefits of the programme were, and these included increased level of care/continuity of care/follow up, improved access, improved patient outcomes, increased compliance with treatment plans, and keeping people out of hospital. The evaluation also included interviews with 72 non-randomly selected patients at 'case study' sites, and an analysis of a sample of Health of the Nations Outcome Scale (HoNOS) data. These demonstrated a reduction in HoNOS scores between admission and 12 months' follow up, and also a reduction in hospitalization compared to the previous 12 months, as reported by patients. Twenty percent of the patient sample also found employment while receiving care from the nurse. Little detail was provided of the perceptions of nurses regarding outcomes.

This paper reports on the most important outcomes of the MHNIP, as described by nurses themselves. This also serves to illuminate something of what nurses claim that they do.

METHODS

An online survey of the MHNIP was undertaken after approval from the Southern Cross University Human Research Ethics Committee was obtained. To work under the MHNIP, the nurse must be credentialed as a mental health nurse by the Australian College of Mental Health Nurses (ACMHN). The ACMHN sent an email to all credentialed mental health nurses at the time (~1000), requesting they consider completing an online survey if

they currently worked within the MHNIP. The email address was that provided at their last credential or recertification application (Nurses must apply for re-credentialing every three years). The survey was constructed and deployed using Qualtrics Survey Software (Qualtrics Labs Inc. 2009).

The questions were largely open, inviting a descriptive narrative response, and were developed through consultation with a group of nurses working in the MHNIP. The suite of questions asked respondents to describe how they worked within the programme, how they worked with others, what education they had received which informed their role, and what ongoing support or supervision they received. This report focuses on responses to the question: 'Please describe the main outcomes of the MHNIP'. This question generated relatively detailed narrative responses, or in some instances, lists of outcomes. The dataset was comprised of approximately 20 000 words.

The qualitative data were analysed using thematic content analysis, as outlined by Braun and Clarke (2006). The aim was to inductively capture as much of the variation in people's responses under themes. The themes were identified after multiple readings of the entire response set. Each time a new example of an outcome was mentioned, it was placed under a theme, and the response set scanned for other instances of the outcome. As further examples arose, the researcher periodically asked whether the outcome might best be subsumed by other broader themes. Thus, themes, such as improved relationships and community participation, came to represent a range of discretely-mentioned but related outcomes to do with relationships with healthcare providers, family, friends, social networks, and community organizations. Several reviews of the thematic map and dataset took place with a view to ensuring that most data were accounted for. It is possible to discuss dominant themes as those which were explicitly mentioned by the majority of respondents. The final thematic map with more extensive quotations was shared with a group of MHNIP nurses for comment (no revisions were made). Most responses were narrative examples, and these were selectively reported to illustrate themes, but more often the examples traversed multiple themes.

RESPONDENTS

A total of 283 responses were received to the online survey. Only the responses of those people who stated that they had or were presently working under the MHNIP, who had completed all demographic questions and at least one qualitative question, were included in the

descriptive analysis. Thus, 238 responses were included in the analysis, and of these, 225 people answered the question relating to outcomes.

Seventy-two percent of respondents ($n = 171$) were female. The age of the respondents ranged from 27 to 68 years, and only 12% were under the age of 40 years. The average age of respondents at the time of analysis was 50.7 years (standard deviation = 10). Forty-five percent of respondents ($n = 105$) had a postcode in Victoria, 23% from New South Wales ($n = 53$), 21% from Queensland ($n = 49$), and all other mainland states and territories were represented, except for the Northern Territory (Australia). Most (71%) reported some explicit training in psychotherapy. All at least held a post-registration mental health qualification, and 25% reported holding one or more masters degrees (mostly in mental health nursing or psychotherapy).

RESULTS

Reduced symptoms or improved coping

Over half of respondents explicitly cited reduction in symptoms, improved coping, or improvements in mental state as service user outcomes of the MHNIP. Specific symptoms that people cited had resolved or were under control included self-harm, mood regulation problems, symptoms of psychosis (including paranoia, delusions, and hallucinatory experiences), symptoms of post-traumatic stress disorder, obsessive-compulsive symptoms, agoraphobia, social anxiety, and amotivation. Respondents often described how people gained understanding and self-awareness, rather than simply the amelioration of symptoms:

A woman with (a) diagnosis of bipolar has been able to sit with emotions and reflect, no longer reacts in way which leads people to think she may be manic, is reflective of others around her, and has gained full time custody of (her) son who was living with a relative, and no longer meets criteria for mental illness.

Respondents reported that people's reduction in the use of alcohol and illicit drugs was associated with improvements in global well-being, quality of life, housing stability, a reduction in criminal offending, and other pro-social gains:

(A) woman who has heavily used drugs and alcohol since age 8 is now drug and alcohol free. We are working on insight work to minimize potential for going back to drugs.

Respondents stated that people acquired, rediscovered, or built on 'life skills' to resolve crises or cope with their

circumstances. Such skills included parenting, budgeting, assertiveness, conflict resolution, communication, anxiety management, mindfulness, goal setting, and prioritizing.

Improved relationships and community participation

Over half of all respondents explicitly mentioned improved quality in relationships in people's private lives, or increased identification with and participation in community life. Respondents described how improvements in relationships and extensions of social networks were acquired over time often associated with the acquisition of skills through coaching or focused therapies:

A lady (was) very isolated due to her major anxiety. She would only leave her house for groceries, and did not have any friends or social contact. Over a period of 18 months working with her, she had gained insight about her anxiety and started to form friendships and venture out of her house more. She is noteworthy, given her SEVERE suicide attempts, often resulting in surgery. She was attempt free and more content in life.

Parenting skills were often cited as a skill set that people developed either working directly with the nurse or through referral or linkage to other agencies. Improved relationships within families were often mentioned as a positive outcome for people. Respondents reported that people's social networks had been strengthened and that people engaged with their local communities in various ways, such as volunteering, participation in clubs, or community events:

Supporting a man with a psychotic illness who had seen and connected with no one, including any health professionals, for 14 years to build new social links and to understand the possible triggers and meaning of his delusions, which led to his isolation. Hearing his joy when he was invited by peers in his exercise group to join (an organization), and realizing that he had not relapsed in the process.

Employment and study

Eighty-one respondents (36%) explicitly cited examples of people returning to, continuing, or commencing employment or study:

Clients who were chronically unemployed and required inpatient psychiatric treatment several times each year have remained out of hospital and have been able to participate in part-time work or group activities..

Some respondents suggested that changing jobs or pursuing a new course of study were milestones in people's recovery.

Improved physical health

Improved physical health was often cited as an outcome of care. Nurses stated that because of their understanding of physical health, illness, and medical treatment, they were able to monitor and attend to people's physical health problems or collaborate closely with others in managing health problems. In particular, people mentioned managing chronic conditions, such as diabetes and cardiovascular disease, and providing education and coaching to address health concerns or assessing for early warning signs. Increasing exercise, weight reduction or control, and addressing common health problems were mentioned:

One reclusive lady with schizophrenia . . . lost 25 kilos and decreased her diabetes medication after taking her to see the public dietician and diabetic clinic, helping her to monitor her BSL (blood sugar levels), taking her to Heartmoves sessions and for regular walks. She now travels independently to visit her daughters interstate, walks daily, has friends, and is enjoying her life.

Medication-related outcomes

Some respondents discussed stabilization of medication regimes and people's adherence to a prescribed regime. Reductions in medication dosage or cessation of medication were cited by 10 respondents. One nurse noted that 'Many people's problems appeared to have been compounded by medication and abrupt withdrawal'. Respondents reported assisting people to reduce the dosage or number of medications they were prescribed as their problems were addressed through a range of alternative strategies:

Clients report stabilization of condition through regular support, the addition of services, counselling over a longer period of time to address complex issues, re-engagement with community, resilience building of clients, and educating them to manage illness more effectively.

Reduced use of hospitalization and public mental health services

Many respondents reported that hospitalization or use of public mental health services was reduced or avoided. One person stated that of the 50 consumers they had seen, none had any further contact with the public mental health system, and pointed out what a cost saving this was. Many also reported that the length of hospital stays was reduced, if they did occur, because people were confident that the MHNIP nurse could provide effective follow up:

I have a . . . client who has had over 30 hospital admissions and six in a row when I started working with her in

2008. She has had only one overnight admission in over 4 years.

Some people suggested that accessing mental health care in a primary care setting is more acceptable to consumers, and therefore, they seek assistance earlier:

We provide access to high-quality care in a non-confrontational one-stop-shop-type arrangement. It is far less confronting to have one's mental health needs serviced in a GP setting, as opposed to public mental health. We see large volumes of patients, and prevent progression to acute arms of public mental health.

Improved access or better use of services

Respondents discussed facilitating access or referring people to services, such as consultant psychiatrists or dentists. Often they spoke about people being actively engaged with services or enjoying a continuity of care with service providers that they had not previously experienced. Some people suggested that the 'one-stop-shop' approach to care provision (being closely aligned to a range of services) was a positive outcome in itself, as is maintaining a relationship with services over a period of time. Nurses spoke of people engaging for long periods of time, with few cancellations or non-attendances. A couple of respondents spoke of the services people received, being culturally appropriate or safe. Continued engagement with services for as long as was necessary was discussed as an important outcome in itself in people who had histories of poor experiences or difficulties engaging with mental health services.

An outcome for the mental health provision system, as well as primary care, is the nurse being available to address mental health, medical, social, economic, and existential issues that others, such as GPs, might be hard pressed to address comprehensively on their own. Nurses spoke of psychiatrists and GPs being often able to reduce the frequency or duration of their contacts with people, and thus being available to others who might need their assistance:

Our GPs say that there are at least six clients of this practice whom would be dead of suicide were it not for my programme. . . . Our records clearly indicate significantly reduced hospitalizations. . . . Our GPs have greatly reduced workloads with these very difficult clients.

Respondents spoke of being able to facilitate timely access to consultation with consultants or the GP if it was needed, thus playing both a triage and facilitative function. The flexibility to respond quickly, and to communicate with a broad range of agencies and people if needed, contributed to good outcomes, but responsiveness was also a service-level outcome.

Managing risk and reducing coercive interactions

Respondents described reduced need to invoke child protection measures, an absence or reduction of recidivism or criminal offending, and reducing or preventing the need for enforced assessment, treatment, or police involvement in the person's life. Some people had lost or risked losing custody of their children, and their reconciliation with their children or improved interfamilial relationships were reported as favourable outcomes.

Respondents reported that people with lengthy histories of criminal offending reduced contact with the criminal justice system or appeared to make commitments to a more healthy or pro-social lifestyle. When hospitalization was required, admission was facilitated in a less traumatic manner:

One young, male, highly-paranoid client was able to take himself to hospital and seek admission . . . having only ever been brought to hospital by police after a violent encounter.

Respondents spoke about respecting the consumer's autonomy, and strong emotions or aberrant behaviour being able to be contained in the context of a web of relationships. Respondents described working with people otherwise considered at risk, and addressing the fundamental issues underlying risk:

A man I took on in 2008 had repeated admissions and police intervention using capsicum spray etc. . . . I have now discharged him; he is working as a bus driver.

Some people stated that outcomes of care included preventing exacerbation of symptoms, increased disability, suicide, or other adverse events:

(The) most significant outcomes that have been achieved so far are: decreased aggression in young boys . . . school retention for young people who were at risk of dropping out of school, and working with the local schools . . . decrease in suicidal ideation, intent, and risk-taking behaviours.

Independent living

Respondents reported people becoming more self-sufficient, self-directive, self-regulating, and independent:

(One of my clients who has bipolar). . . (When) I started to follow up her on MHNIP, her mood was not stabilized, and she couldn't even attend to self-care at the beginning of the programme . . . she slowly started to take an active recovery role, and gained self-management skills. . . . (She) also started to accept support. . . . After 3–4 years, she started to work . . . part time, then completed a TAFE

(technical and further education) teaching course. . . . I rarely see her, as she is living life and requiring minimal support.

The clarification and realization of the consumer's goals were cited as important outcomes, and were idiosyncratic. However, people typically sought to extend the network or improve the quality of relationships, enjoy stable and suitable accommodation and employment, and derive meaning and satisfaction from their lives. Ten percent of respondents mentioned outcomes associated with housing and finance, such as obtaining and maintaining safe, secure, and appropriate accommodation, or having sufficient resources to live independently and realize their goals:

One woman . . . purchased her own washing machine and she is using it . . . for her this was a miracle, as we worked together to get the loan and do the shopping getting quotes, arranging delivery . . . this took quite some time; however, for her . . . a miracle.

DISCUSSION

Over half of those nurses who worked under the MHNIP responded to this survey and shared their perceptions of outcomes associated with the programme. The most common outcomes reported were a reduction in symptoms or improved coping, improved relationships, and greater participation in the community. Other reported outcomes included reduced hospitalization or use of state-funded mental health services, better use of health services, the continuation or establishment of meaningful occupation, improved physical health and medication management, less use of coercive interventions, and greater independence.

The findings represent the perceptions of nurses regarding good outcomes, and these perceptions might not necessarily be shared by others or valued as highly, although the findings are broadly consistent with recent surveys of GPs (Meehan & Robertson 2012a), other medical practitioners (Health Management Advisors 2012), and service users (Happell & Palmer 2010). The methodology did not allow for exploration of what practices the perceived outcomes might be attributed to. The survey did not solicit reports of poor outcomes, which would need to be considered in any comprehensive evaluation of a programme. It ought to also be noted that the survey was conducted at a time when the number of hours nurses were able to claim under the programme was frozen or reduced, people on contract were being 'let go', and the future of the MHNIP was uncertain. This might have

introduced a bias into the reporting of outcomes (although there was no clear evidence of this having occurred).

A further problem with considering outcomes of the MHNIP is the way the programme is specified and marketed. Nurses (at least in the formal programme specifications) are not viewed as having psychotherapeutic skills in their own right, but rather, are seen to help medical doctors and provide linkage or broker access to other services. It might be argued that good outcomes can be attributed to medical treatment, as the clinical governance of consumers in the programme rests with medical doctors. It might also be argued that good outcomes are a result of case management or better collaboration between those involved in the individuals' care. Clearly, the nurses in this study did believe that their work made a positive difference to service users, and the kinds of outcomes cited strongly suggest a psychotherapeutic impact beyond that which one might expect from ensuring compliance to a treatment plan.

Some outcomes reported might best be conceptualized as system-related outcomes. For example, reducing the workload of medical doctors or reducing the use of public mental health services. Others might be considered process related. For example, the provision of early intervention or maintaining a relationship with a health service provider might lead to good consumer outcomes, and in the context of a history of poor engagement with services, this might be considered a positive outcome. However, it might also be considered an indicator of a good service or a positive service outcome. Clearly, both are important, and any future or ongoing evaluation of the MHNIP ought to consider both system performance indicators and consumer-defined outcomes.

Many of the outcomes reported are consistent with broad notions of mental health recovery. For example, the recognition of improved relationships, greater independence, community connection, and realization of the personal goals of consumers are consistent with recovery practices, such as promoting citizenship and supporting personally-defined recovery (Le Boutillier *et al.* 2011). There might be elements of the programme that particularly enable personal-recovery processes, such as connectedness, hope, optimism, identity, meaning in life, and empowerment (Leamy *et al.* 2011). For example, the programme is non-coercive, it affords flexibility in how the nurse works with the person, allows sufficient time to establish a therapeutic alliance, and is undertaken in a non-stigmatizing community setting. The positive outcomes reported ought to inspire a hopeful attitude in the nurse and confidence in their capacity to help the person.

Consistent with the limited amount of research to date, the findings from this survey suggest that the MHNIP does appear to be assisting service users to realize important outcomes, including but not limited to, full clinical recovery (or reducing symptoms and their impacts), as well as personal recovery (defined by the individual). It does appear to help consumers maintain their autonomy, learn, develop, or mobilize methods of coping, and enhance their social networks. Mental health nurses report that they help people with highly-complex needs realize their social and occupational goals, which few other programmes in the Australian context appear to do. The MHNIP might contribute to system-level outcomes, including a reduction or more efficient use of public mental health services.

ACKNOWLEDGEMENTS

This project was commissioned by the Australian College of Mental Health Nurses and supported by a grant of \$A2000.

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