A grounded theory study of the provision of mental health nursing by practice nurses

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"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published by another person (except explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning"

Name: Carole Schneebeli

Signature: 

Date: 30th November 2013

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"Masters is a journey not a destination. It is an unfolding journey that we cannot make speed up or slow down. What we can choose to do is engage it as fully as we can. For this journey involves learning and growing, changing, evolving, and maturing in order to get to the end of the journey and begin another"

Adapted from A.J. Mahari

This journey is not a lonely one and I am exceptionally grateful to my thesis supervisor, Associate Professor Antoinette McCallin. Without her encouragement and belief in me as a student, I would not have been able to do this. I have been very fortunate to have had her emotional intelligence, walking with me throughout. A heartfelt thank you.

To the people who held out a helping hand. It certainly lightened the load. My transcribers, Sue and Lisa. My critical reader Janice. My manager Alex Craig who gave me the space to do the much needed thinking. And of course, my family who have experienced my absence in the home. Thank you all.

To the practice nurses who agreed to be in this study. Without your willingness to get involved I would not have been able to share your story as you told it. This thesis is for all of you, and may help to share with a wider audience, what it is in reality to be a practice nurse providing mental health nursing care.

Abstract

In New Zealand changes to health policy have affected health professionals working in primary health care. This group have had to expand their role and involvement in the care of patients with mental health problems. Practice nurses, the largest primary health care nursing group, have developed their role to provide identification, assessment, and monitoring of patients with mental health problems. Little is known though about the knowledge, skill, and capabilities practice nurse have, or the strategies they use to manage patients with mental health problems.

The aim of this study is to explain the processes practice nurses use when they work with patients that have mental illness. The methodology was grounded theory. Data was collected from 17 interviews with practice nurses working in city and rural practices. Data was analysed using Strauss and Corbin's axial coding model. Data was constantly compared during the analytical process. Theoretical sampling was used to develop categories, examine relationships, and dimensions, until data was saturated, and a substantive theory of referring was clarified.

The research has shown that practice nurses have limited knowledge about patients with mental health problems. They manage this situation using the strategy of referring. Referring occurs in conditions of generalist nursing practice, changing values and attitudes, and interchangeable boundaries that include time, funding, and medical dominance constraints. Consequently, practice nurses resort to handing over the responsibility of care for patients to experts in mental health care. It was evident that referring was multidirectional, sometimes circular, and depended on the strength of the

relationship with the referral source. This research is significant, as it has analysed the taken for granted practice of referring, which is a common nursing strategy used when nurses have limited knowledge in an area. It was also evident that if health policy changes were to be enacted in practice, funding streams structures must change to support policy development, and the profession needs substantial involvement in promoting professional development as well. Recommendations for practice include professional development using protected educational time, shared clinical governance, and inclusion of mental health nursing in all areas of the undergraduate curriculum, national implementation of primary liaison roles in all primary health organisations, and general practice, and the development of postgraduate pathways in primary mental health nursing care management.

Glossary

The following terms are defined for the purpose of this study.

Specialist mental health nursing:

This refers to mental health nurses who are skilled in the specialised use of communication, counselling, psychopharmacology, applying speciality knowledge in the provision of clinical assessment, monitoring, therapeutic interventions, treatment, and referral to other health professionals.

Hospital trained nurses:

For the purpose of this thesis hospital trained nurses are nurses who were trained in the hospital context in New Zealand until 1988.

Comprehensive trained nurses:

From 1972 onwards training of Registered nurses changed in New Zealand. A shift from hospital based training to educational institutes saw a move from different types of registrations to a single registration incorporating all areas of nursing practice.

Whānau Ora:

Is an evidence-based framework that aims to strengthen whanau (family) capabilities and wellbeing. The New Zealand government approved the establishment of the Whānau Ora Taskforce in 2009. Imbedded within Whānau Ora philosophy are aspirational goals which focus on social, economic, cultural and collective benefits for Māori (Durie et al, 2009), which meet the needs of urban and rural whanau (family), iwi (tribe) and service providers .

Chapter One

Introduction

Without mental health there can be no true physical health

(World Health Organization, 1954)

Introduction

In 2001 the World Health Organization (WHO) released a report that identified there has been a global neglect of mental health illness in most Western countries. The authors argued that mental health is crucial to the overall well-being of individuals, societies and countries. They proposed that mental health must be incorporated into health policies and strategies to ensure that effective mental health prevention and treatment are needed to be developed. The WHO advocated for greater involvement of primary health care in addressing mental health problems. According to the report, basic mental health care was to be provided at the first point of contact of entry into the health care system (WHO, 2001). This lead to an international movement, towards the development of health policies and strategies, which acknowledges and places a greater emphasis on mental health problem prevention, health promotion, and care in the primary health care sector (WHO, and World Organization of Family Doctors, 2008).

When considered in relation to the international movement, New Zealand's primary health care system has undergone dramatic changes. The launch of the New Zealand health policy in the early 2000's described expectations on how mental health and primary health care services would be delivered (King, 2001; Minster of Health, 2005, 2006). What followed were the development of primary health organisations (PHOs), and the integration of mental health services into the broader health system. PHOs are now expected to take

greater responsibility for the care of people presenting with mild to moderate mental health problems. The numbers of potential patients in this group involves the 17% of the population that at any one time will have a discernible mental problem (Mental Health Commission, 1998). The PHOs are also expected to care for those people who have mental health problems that are transferred from the secondary health services back into the community and into primary health care. This group is known as the 5% of the population with acute or enduring mental health problems (Oakley-Browne, Wells, & Scott, 2006). It is not surprising that the implementation of health policy has impacted the practice nurse (PN) role. Their role has evolved significantly and rapidly (McKinlay, 2006; Richardson & Gage, 2010). Practice Nurses everyday roles now include greater mental health care management.

In this chapter, I outline the background of mental health care in the primary health care context. I set the scene around the evolving roles of PNs, and define the research problem. Following on, the choice of methodology is discussed. The aim and purpose of the research are outlined. Lastly, my researcher position and the significance of this study for nursing are presented.

Background

Supporting mental health and well-being for patients in primary care settings is seen as an important strategy to address increasing mental health treatment needs (World Health Organization (WHO) and World Organization of Family Doctors (WOFD), 2008). Researchers contend that PNs, as the largest primary health nursing group, are in a prime position to support and provide care for people who have enduring mental health problems. This thereby reduces the need for care by general practitioners (GP) and secondary mental health services (Ministry of Health, 2008a; Pearce, Phillips, Hall, Kljakovic, Sibbald, et al.,

2009). Indeed, over the last two decades there has been growing international interest in the role that PNs have in the management of mental health service delivery (Andrews, Issakidis & Carter, 2001; Elsom, Happell, Manias, & Lambert, 2007; Kanton, Von Korff, Lin & Simon, 2001; Prince, 2009).

For example, in New Zealand, as a response to primary health care policies and the development of PHOs, PNs have taken on expanded roles in patient care (Cumming & Gribben, 2007; Finlayson, Sheridan & Cumming, 2008, 2009a.; McKinlay et al., 2011; Ministry of Health, 2009). This has seen PNs expand their roles, to increase the support of patients with mental health problems who often have associated physical conditions, such as diabetes (Mergl et al. 2007; Minister of Health, 2006; Prince & Nelson, 2011). New Zealand researchers suggest that approximately 30% of PNs report that they have delivered mental health care to patients who had attended their general practice (Finlayson, Sheridan, & Cumming, 2008, 2009b.; Prince & Nelson, 2011). However, we do not know what happens when mental health nursing care is provided. Nor do we know what skills and expertise PNs have to fulfil a mental health nursing role. Additionally, there is little known about how PNs manage situations with patients who have mental health problems. Part of the difficulty is that most practices in New Zealand employ PNs who have a generic nursing qualification. These nurses generally do not have specialist mental health nursing experience, skills or knowledge (O'Brien, Hughes, & Kidd, 2006; Prince & Nelson, 2011; Rashid, 2010). This suggests that PNs are not prepared for the expanded role of caring for this group of patients in general practice.

Practice Nurses however, do not have wide ranging specialist mental health nursing experience. For example, the *Primary Health Care and Community Nursing Survey 2001*

(Ministry of Health, 2003), established that within general practice, PNs were predominantly European females around 40 to 50 years of age with an average of 10-14 years of experience working in primary health care. A subsequent survey by the Ministry of Health (2009) indicated that there has been little change, with very few recruits from younger age groups. This suggests that PNs exist as an aging workforce of general trained nurses that likely have limited skills or knowledge about mental health nursing.

Evolving roles of nurses

Nurses in general practice have held traditional roles that have developed alongside their GP colleagues. These roles have evolved within the paradigm of illness and disease states, which support a reductionist position, where human complexity is dismantled into measurable concepts associated with tasks (Savage & Moore, 2004). In this model, the care is focused on body systems or states such as the cardiac, respiratory, and immune systems, plus maternity. Therefore, the role of the PN in general practice is usually task orientated and influenced by objective measures such as vital signs, cardiac measures, respiratory measures, and signs and symptoms, which are assessed against treatable disease or illness states.

Traditional roles of nurses though, have gradually altered. Health care reform in New Zealand has stimulated a plethora of literature in which authors discuss the evolving roles of PNs that have been subject to economic, and demographic pressures (Finlayson, Sheridon, & Cumming 2009a; King, 2001; O'Brien, Hughes, & Kidd, 2006; Parker, Keleher, & Forest, 2011; Ryall, 2007). Role change and development has been influenced further by legislative change. In 2003, the Health Practitioners Competency Assurance Act (HPCAA) of New Zealand was introduced and defined nursing roles in terms of scopes of practice.

The professional body associated with PNs, the New Zealand Nurses Organisation (NZNO), recognised the importance of the HPCAA and health policy, and defined the role of PNs accordingly. The redefined role maintained a focus on health promotion, prevention of disease, and early detection and treatment of illness (McKinlay, 2006; Ministry of Health, 2003). However, there is little literature on how PNs enact these evolving roles, or how the context may affect the accountabilities and responsibilities of the practice nursing position. For example, there is some evidence that development of generic roles has been successful in New Zealand, but requires flexibility on behalf of the individual nurse and their nursing colleagues to make them work (Yarwood, 2008). In contrast, resistance by nursing colleagues and other health-care professionals has limited the evolving role of practice nurses in Australia. The restriction of the Medicare benefit favouring GP care, lack of policy direction, and the power relationship of GPs managing the scope of PNs are examples how this resistance is played out (Halcomb, Davidson, Daly, Yallop, & Tofler, 2005; Jasiak, & Passmore 2009).

Critical to these reactions, is how nurses define their new role and establish boundaries in relation to their practice, and that of other nursing and health care professionals (Clancy & Svensson, 2009; Gray, Hogg, & Kennedy, 2011; Philibin et al., 2010). It has become evident that the changes require the acquisition of knowledge and skills, so that expanded roles can be enacted. But it also seems that role change and role expansion require PNs to be self-aware about what they do, and what they do or do not know, so that they can seek assistance as required. In other words, nurses need to know who to turn to obtain knowledge, and understand the processes required facilitating access to specialist help (van Loon & Kralik, 2007).

Clearly, there are many different perspectives about nursing role development. Some authors have argued, that even with the opportunities for PNs to evolve their role, the on-going theme of medical dominance and nurse disempowerment prevail (Davis, 2005; Woodroffe, 2006). Traditional arrangements, attitudes, and differing philosophies about practice, remain key issues that have impacted on the role of PNs as envisaged in the health strategy. Indeed, it is argued the evolving nursing roles have an attached risk in terms of role confusion, overload, and incompetence, if nurses are not fully prepared (Tulgan, 2007). This may leave PNs struggling to embrace the policy changes and take on new roles. One of the specialist areas set out in health policy, as an expanded PN role relates to mental health care (King 2001, 2002). Neither health policy nor the nursing professional bodies have indicated how PNs might manage patients with mental health problems. There remains little knowledge or guidance on this point.

Terms used in this study

In this section I will clarify the meaning of key terms used in this study.

Primary health care (PHC)

Primary health care is an approach to health that includes health promotion, screening for diseases, assessment, diagnosis, treatment, and rehabilitation. Primary health care services provide first level contact that is universally acceptable by self referral, and has a strong emphasis on working with communities and individuals to improve their health (National Health Committee, 2000; World Health Organization, 1978).

Primary Health Organisations (PHOs)

Primary health organisations are not-for-profit entities, funded on a capitation basis to provide essential services to their enrolled populations. These entities have been set up to

provide services alongside GPs and PNs. First-line and preventative services consist of health promotion programmes that offer a range of health services, including dieticians, psychologists, and pharmacists. Primary health organisations contain both the community and health providers in their governance structure (King, 2001).

Expanded practice roles

Expanded practice roles occur when a nurse assumes responsibility for a health care activity or role, which is currently outside the scope of practice. An expanded practice role may cover areas of practice that previously have not been in the nursing realm, or a role that may have been the responsibility of other health professionals (NCNZ, 2010).

Practice nurse (PN)

Practice Nurses are registered nurses that work within general practice, providing a comprehensive range of first contact primary health care services to an enrolled patient population (Ministry of Health, 2003). In this thesis, primary health care nurses who are employed in general practices are referred to as practice nurses (PNs).

Mental health problems

Mental health problems refer to the mild to moderate mental health problems and chronic and enduring mental health problems addressed in primary health care.

Research problem

This study begins with the assumption that the PN role is potentially problematic, because PNs are not prepared for a more complex new role, which requires specialist mental health nursing skills. The lack of preparation in what is recognised as a specialist area has the potential to challenge PNs' ability to perform their roles. It may also limit their practice, when working with patients who present with mental health problems.

Research question

The central question to be asked of PNs is:

"What is your role in the management of patients who have mental health problems?"

Choice of methodology

I have chosen grounded theory by Corbin and Strauss (2008) as the research methodology. Grounded theory is an emergent design, which supports the systematic generation of theory from data. Findings can be used to provide direction in areas that are little researched or poorly understood, such as the PNs ability to manage patients with mental health problems. In grounded theory meaning is discovered, developed, and provisionally verified through a systematic simultaneous approach to data collection and analysis (Strauss & Corbin, 1990, 1998). According to Strauss and Corbin (1990, 1998) the theoretical basis of grounded theory is derived from symbolic interactionism and pragmatism. This approach suggests that to understand human behaviour, one must examine the nature of the social interaction (Crotty, 1998). The focus is on the practical realities, or everyday practices of PNs, and is well suited to answering the question 'what is going on here?'(Morse, 2001). The methodology not only provides an empirical basis for generating an explanation of behaviour, but has the potential to add insight and

understanding about the context, and consequence of behaviours (Strauss & Corbin, 1990). Therefore, the inductive approach using grounded theory supports an exploration of PNs' strategies, when managing mental health problems, which could provide explanations that, are grounded in every day realities (Giddings & Woods, 2000; Murray & Chamberlain, 1999).

Aim of the study

The aim of this study is to explain the processes PNs use when they work with patients that have mental illness. The aim of the research is to develop a substantive theory of mental health nursing practice in the general practice situation. Within the New Zealand context there is a paucity of literature specifically identifying the everyday experiences of PNs and the strategies they use as they provide mental health nursing care. Much of the existing research is situated in the medical fields of study, in particular the provision of mental health services by GPs (Doughty, 2006; MaGPIe Research Group, 2003, 2005; Rodenberg, et al. 2004). From the limited available literature it is clear that everyday PNs encounter patients with mental health problems (Lee & Knight, 2006; Ministry of Health, 2003). Despite this, debates continue about the nursing role and practice when caring for patients who present with mental health problems (Prince & Nelson, 2011).

Research purpose

The purpose of generating a theory is to provide trustworthy evidence within a framework that will inform PNs, PHOs, and policy makers about one aspect of the PN role. It may also identify the forms of support PNs require to successfully manage the everyday needs of patients with mental health problems. More specifically, research findings may be used to promote further development of a clinical teaching programme.

Researcher position

This masters' research is an extension of my clinical interests and experiences. I currently work as a nurse leader, within a secondary mental health service, in a large urban area in New Zealand. My role focuses on leading the development of mental health nursing. This requires the provision of professional nursing leadership, strategic direction, and the promotion of an integrated interface between mental health services, primary health care, and non-government organisations.

As I reflect on my nursing role over the last 10 years, it is apparent that there have been significant changes in health policy. These have influenced not only the educational requirements of nurses, but also the context in which they work. The launch of New Zealand health policy over a decade ago detailed expectations about mental health and primary health care services delivery (King, 2001; Minister of Health, 2005). In particular, the health strategies integrated mental health care into the broader health care system. As a result, PHOs are now expected to take greater responsibility for the care of people presenting with a range of mental health problems. Drawing on my clinical background, I am cognisant of the specialty knowledge and skills required of clinicians who work in mental health. For that reason, I question if primary health care practitioners have similar skills and experiences to secondary health care practitioners, so that they can manage what is, to my mind, a specialist group of patients. In particular, do they have the range of mental health skills to address not only the mild to moderate, but also patients presenting with enduring mental health problems? As such, this raises more questions about the mental health nursing care on offer, in a situation where PNs are the largest primary health care

nursing group working in the community. Subsequently, this research came out of a desire to understand better what was happening in practice.

Significance for nursing

The theoretical explanations generated by a grounded theory approach can be valuable for describing, interpreting, and explaining social phenomena (Glaser & Strauss, 1967; Strauss & Corbin, 1998). New understandings generated from grounded theory are useful to inform nursing practice, education, policy, and research. This study is important, given the increased number of patients presenting to primary health care. In New Zealand it is recognised that 80% of patients will visit their general practice at least once a year. Of this group 35% of them will have a mental health problem. Yet, up to 50% of these patients will go undiagnosed, or will not be treated for their mental health problems (MaGPIe Research Group, 2003, 2005). A number of patients with mental health problems will be cared for by PNs, therefore it is important that they can recognise and address patient's needs. However, if we do not know what it is that PNs do, it is difficult to prepare PNs to implement policy changes. This research will however identify concepts and relationships central to both the process and context of PNs managing patients' with mental health problems. The explanation of the strategies PNs engage with in this situation, and the identification of its essential features, may contribute information that can be of use in future research. Consequently, the results of this study have potential to enhance understanding about one aspect of practice nursing, and identify educational interventions to improve PN's role in mental health management and health outcomes.

Structure of the thesis

This thesis is divided into six chapters:

In Chapter One the study was introduced. The background was outlined; the evolving roles of nurses discussed; and terminology clarified. The research problem was identified and the research question stated. Then, the choice of methodology was explained, along with the aim and purpose of the research. Finally, the researcher position was presented, and the significance for nursing outlined.

In Chapter Two relevant literature is reviewed. The purpose of the literature review in a grounded theory study is clarified. The political context influencing the research is examined. The prevalence of patients with mental health problems in primary health care and issues related to co-morbidity are analysed, and the professional development needs of PNs working in the area are explored.

Chapter Three outlines the research process, providing rationale for the chosen methodology, explanation of the data collection methods and methods of data analysis. Ethical implications arising from the research question are discussed.

Chapter Four presents the method in action, outlining in detail how the researcher used the methods in this study.

Chapter Five presents the findings of this study in relation to primary concepts developed into categories determined to be important to the study.

Chapter Six is the critical discussion and conclusions taken from this study. This chapter will also outline the limitations of this study, implications for PNs and recommendations for further research.

Appendices follow the chapters.

Chapter summary

This chapter has provided the reader with a brief outline of the health reforms that have signalled the expansion of the role of primary health care nurses, specifically PNs, in managing patients with mental health problems. This has set the scene, identifying that there is little known about the role that PNs have in mental health nursing care. It has been argued that it is important that the PN role in this area is described and explained. This is a necessary step towards ascertaining what it is that PNs actually do, possibly articulating the complexity of the role, and the problems encountered. The appropriate methodology to generate knowledge in the area is grounded theory. The next chapter will explore the literature relevant to PNs role. In doing this as a grounded theory student it is also relevant that literature in this thesis is positioned and explained in regards to how it contributes to this study.

Chapter Two

Literature review: Setting the scene

Introduction

The purpose of the literature review is to provide the reader with an overview of the literature exploring issues that influence the role of practice nurses (PNs). This review will outline the political context in which PNs work, why they need to address mental health as part of their role and responsibility, and discuss how they are achieving this to date. The literature will be revisited in Chapter Six, where it will be used to both support and contest the concepts derived from the theory that is developed.

As such, this chapter begins with a discussion of the role of literature in grounded theory. After examining the search strategy, the political context that underpins the request to support mental health care in the primary health care setting is outlined. Then, the prevalence and types of mental health problems that PNs may encounter in their everyday practice, is outlined. Next, is an exploration of the known demographics and qualifications of PNs. Following this, there is a description of what is known about the mental health nursing activities that PNs engage in when patients present with mental health problems.

Role of literature in grounded theory study

Within this study the literature review is focused on technical literature. This refers to "reports of research studies characteristic of professional and disciplinary writing" (Strauss & Corbin, 1998, p. 35). In the original development of grounded theory, Glaser and Strauss (1967) proposed that a review of literature may interfere with the researchers understanding

of the research problem, which needs to be identified by the participants. Glaser confirms with this stance (Glaser, 1998), and argued that only when the grounded theory is near completion can the literature search in the substantive area be accomplished to be weaved into the theory as more data for constant comparison.

However, thirty years on Corbin and Strauss (2008) recognised that researchers have a background in professional and disciplinary literature. This proves useful in formulating the questions, which may be asked at interview, and when identifying some of the concepts to be investigated. For example, as a health care professional, I am constantly reading health related literature. This is part of my role in developing and implementing evidence based practice. Therefore, the staying removed from current literature is not realistic for me, as I need to keep up-to-date and fully informed about the latest developments in practice. McCallin (2003) conceded that most health care professionals will read and be familiar with evidence based literature. Similarly, Corbin and Strauss (2008) argued that literature can be used as a source for, "making comparisons; enhancing sensitivity; providing questions for initial observations; suggesting areas for theoretical sampling; or even confirm, reverse or challenge the findings" (p. 37).

The literature I located and used in this research was accessed with the intention of supporting the research question, and the initial interview questions. As the study progressed, the literature was also utilised to check out ideas from the emerging data analysis and to maintain sensitivity to the data during the research process. For example, literature has been part of the constant comparative data analysis both to uphold and refute emerging concepts, which support the evolving theory. Therefore, as a researcher-in-

training, I have not ignored literature but rather integrated it with methods, to ensure that rigorous knowledge is generated (McCallin, 2003).

Search strategies and results

The literature searches initially focused on two distinct areas: the prevalence and types of mental health problems in primary health care; and PN's management of mental health problems. There is a large body of work on the prevalence of mental health problems in primary health care. However, it became apparent that there are few studies on how PNs manage mental health care in the area. Most of the research focused on general practitioners (GPs). Therefore, the search was expanded to include the label of primary health care nurse. It must be noted that the term primary health care nurse is problematic, for some literature incorporates all primary health care nurses i.e. school nurses, public health nurses, practice nurses, as one group. In contrast, other literature consigns the term primary health care nurse to refer predominantly to PNs. The search was global and included countries with similar health settings, for example the United Kingdom (UK), Europe, Canada, and the United States (US).

Bibliographical databases ranging from 1999-2013 were searched inclusive of the Combined Index of Nursing and Allied Health Literature (CINAHL), ProQuest, PsyARTRICLES, and Medline. Search terms included: ‘mental health problems’, combinations of key words such as, ‘primary health’, ‘types of mental health issues’, 'prevalence of mental health issues’ and ‘primary health care’, ‘practice nurse’, ‘nurse and general practice’ or ‘nurse and primary health care’, ‘nurse and community and New Zealand’, and ‘role and practice nurse’.

The New Zealand Ministry of Health (MoH) website was useful to find key primary mental health care documents. Google Scholar was also accessed and was quick and useful when there was difficulty locating up to date literature. The literature search was updated in October 2013, prior to the completion of the work, to check recent knowledge that was considered in terms of constant comparison. While it is acknowledged that this review is not exhaustive, literature was at times difficult to locate. The demographic information on New Zealand PNs yielded only two national surveys (Ministry of Health, 2003, 2005). However, the Nursing Council Annual Registration data was useful to access data on the demographics of New Zealand nurses. The most recent published survey of New Zealand nurses was 2010 (Nursing Council of New Zealand, 2010). Most PN research has concentrated on the physical aspects of their work (Prince, 2009, Ministry of Health 2009b.). There is very little specific information about PN interventions in mental health care management. For example, the journal articles on PN activities related to specific disease states, innovation and development of primary health care clinics, or disciplinary debate. Actual responsibilities are not discussed. Also, there has been an increase in literature on shared care models of practice in primary health care (Craven, & Bland, 2002; Sharrock, & Happell, 2001). However, that discussion though, did not relate directly to my topic.

Political context

As has been noted in Chapter One, at the beginning of the new millennium the New Zealand Health Strategy (King, 2000) set out the overall direction for health in Aotearoa / New Zealand. Part of this direction included key health strategies that recognised and acknowledged the importance of providing effective mental health care in primary health care settings (King, 2000, 2001, 2002; Minister of Health, 2005, 2006). Since then, recent health policy in New Zealand has outlined the growing expectation that PHOs take greater

responsibility for the care of people presenting with mental health problems (King, 2001; Minister of Health, 2005, 2006; Ministry of Health, 2008a, 2012, 2013). With growing evidence that many more patients present to their GPs with mental health problems, several authors (Dowell, Garrett, Collings, McBain, McKinlay, & Stanley, 2009) have suggested that it is important for all health professionals working in general practice to be aware of the problems, and be prepared to manage these patients more effectively.

This expectation of primary health care workers to increase their involvement in the care of people with chronic health problems, inclusive of mental health care, is echoed in many of the key strategy documents (Minister of Health, 2005, 2006; Ministry of Health, 2008a, 2012, 2013). The New Zealand Health Strategy supported primary health care expansion, mandating nurses to be more involved with effective delivery of health services in primary health care. Significantly, the New Zealand Health Strategy also signalled a national strategic move to develop and grow a workforce of well-trained nurses working in primary health care (King, 2001).

Increasing prevalence of chronic and complex conditions inclusive of mental health problems, has led to a growing interest in the role primary health care nurses play in patient health care management. In the last 10 years, a growing international and national interest in the general demographic make-up and function of primary health nurses has ensued. This interest has grown out of recognition that primary health care nurses, in particular PNs, will play an important part in the delivery of primary health care (Elsom, Happell, Manias, & Lambert, 2007; Kent, Horsburgh, Lay-Yee, Davis, & Pearson 2005; Parker, Keleher, & Forrest, 2011; Senior, 2008). These authors argue that PNs are in a prime position to detect early warning signs, and to support and provide care for patients with enduring health issues.

The recommendations are in keeping with the New Zealand Health Strategy that aims to reduce the need for care by GPs and secondary health services (Ministry of Health, 2008a.; Richardson & Gage, 2010).

However, questions have been raised as to whether PNs have the capability to expand their role to include the care of patients with chronic health problems inclusive of mental health care in primary health (McCaughan, Thompson, Cullum, Sheldon, & Raynor, 2005; O'Brien, Hughes, & Kidd, 2006). Capability refers to the notion that PNs have the skills, experience, education, and qualification opportunities, to enable them to work autonomously and develop new models of care that integrate culturally based practices and relationships (Carthew, 2011). However, before reviewing PN's capability to address the care of patients who present with mental health problems, it is necessary to explore the types and prevalence of mental health presentations they are likely to encounter.

Prevalence of mental health problems in primary health care

In 2003/04, 13,000 people were interviewed for the Te Rau Hinengaro - New Zealand Mental Health Survey. The outcomes indicated that one in five New Zealanders had experienced a mental health problem in that year. The most common problems were anxiety, mood disorders, and drug and alcohol issues. The researchers reported that over a 12 month period, only 39% of people with a mental health disorder had visited primary health care services (Oakley Browne, Wells, & Scott, 2006). Oakley–Browne et al. (2006) found that there is a high rate of co-morbidity between mental and physical disorders. They also reported that in many instances, the mental health problems were not addressed. This implies that there is a high rate of unmet need for people who present with mental health problems in primary health care. The findings seem to be similar to overseas trends.

For example, in Australia, results from the 2007 National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2007) suggest that of the 16 million Australians aged 16 – 85, almost 45% (7.3 million) of the population, were affected by mental illness at some time in their life. One in five Australians had a mental health disorder in the 12 months prior to completing the survey questionnaire. These results are similar to the New Zealand Mental Health Survey (Oakley Browne, Wells, & Scott, 2006). The results from the two surveys suggest that many people attending primary health care clinics have co-morbidities of mental health and physical health issues, and may not have their mental health needs met. Furthermore, there is no indication as to why this occurs in either study.

Interestingly, other international studies concur. An earlier survey from the US conducted by the National Mental Health Association (2000) estimated that of the 956 million visits were made to physician offices, 4 % were for psychiatric diagnoses. A further survey a few years later, found that only 49% of patients with clinical depression, and 52% of patients with generalised anxiety disorder, were receiving treatment (The National Ambulatory Medical Survey, 2000, 2008). Once again, this suggests that over half of the people presenting to primary health care are not receiving appropriate treatment for their mental health problems. These results raise questions as to whether primary health care practitioners (GPs and PNs) are competent to recognise mental health problems. Furthermore, questions arise as to whether they are capable of implementing interventions and support. It also draws attention to the fact that mental health diagnosis is a specialist area that is being managed by GPs and PNs, who have general health knowledge only. As a result, it is likely that many patients with mental health problems are not diagnosed. This raises questions about how well patients are managed.

In a more recent Canadian study (Marcus, Westra, Vermani, & Katzman, 2011), 277 participants attending primary health care clinics were interviewed. The researchers concluded that many did not report their mental health problems to primary health care practitioners. One explanation for this is that patient disclosure was related to patients' attitudes towards mental health diagnosis, which was predominantly negative. Marcus et al. (2011) concluded that the negative attitudes correlated with underreporting, and therefore, contributed to under-detection of mental illness. On this basis the rates of mental illness in the community may be higher than is recorded. Additionally, it may also explain why there were many patients not being diagnosed with mental health problems/illnesses.

Clearly, establishing the exact number of patients with mental health problems presenting in primary health care, is problematic. Part of the challenge is that there are notable differences internationally in the diagnosing criteria used. This makes identification of the true rates of mental illness difficult to quantify (Patel, Belkin, Chockalingam, Cooper, Saxena et al. 2013; Prince, 2009). Additionally, the patients' fear of stigmatisation is a noted barrier to disclosing mental health problems to primary health care practitioners (Dew, Morgan, Dowell, McLeod, Bushnell, & Collings, 2007). As a result, researchers tend to disagree about the prevalence of the problem. What authors do agree on is that generally there is a large unmet need, and poor detection and identification of mental health problems. Furthermore, there is evidence of attitudinal barriers on the part of the health care professionals towards patients that need mental health care in primary health care.

People with mental health problems presenting to primary health

There is growing evidence of increased prevalence of people with mental health problems in the community. The 2001/2002 World Health Report estimated that 25% of all people are affected by mental health and behavioural disorders at some time during their lives (WHO, 2001, 2002). The WHO report suggested that the burden of mental health disorders in all societies is great. It is estimated for instance, that in 2020, the second most burdensome illness facing most societies will be depression. Depression is noted to have associated issues of anxiety and / or drug and alcohol misuse. Nevertheless, the exact figures on the types of mental illness evident in primary health vary internationally and with age.

For example, an American study by Bittner et al. (2007) reported that in childhood, anxiety disorders (16%), oppositional/conduct disorder (15%), substance abuse (12%), and depression (10%), are predominant. However, co morbidity between anxiety disorders and other mental disorders is already apparent in childhood and adolescence. New Zealand data are similar (Oakley Browne, Wells, & Scott, 2006). The New Zealand data included a combined age range of 0-19, with no delineation between childhood and adolescent mental health problems. One explanation for this may be that it is difficult to get a true rate of specific childhood issues, for the exact figures on types of mental illness in primary health vary internationally and with age (Prince, 2009). Not unexpectedly, statistical interpretations influence results and affect how trends are reported.

However, international studies on the occurrence of adolescent mental health problems, identifies drug and alcohol misuse as the most significant problem (Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Ustun, 2007; Patel, Flisher, Hetrick, &

McGorry, 2007; Rey, Sawyer, Raphael, Patton, & Lynskey, 2002). Patel et al. (2007), in their global review of adolescent health, found that 75% of young people with mental health disorders began having issues between the ages of 12- 24. Yet, very few were diagnosed or treated until later in life. As this was an international review, it is difficult to ascertain the level of contact this age range had with primary health care practices in their countries. Nevertheless, the findings suggest that there is a large unmet need for this particular age group. What most international studies do agree on, is that adolescents tend to present to primary health care with a significant association between the co–morbid problems of mental health issues and drug and alcohol misuse (Johns, 2001; Fleming, Mason, Mazza, Abbott, & Catalano, 2008; Rey & Tenant, 2002; Rey, Sawyer, Raphael, Patton, & Lynskey, 2002). In New Zealand, for instance, the rate of cannabis use in this group is reported at 31% (Pettit, Ng, & Frith, 2003). In contrast, Australian statistics suggest that 41% of youth admit to being regular drug and alcohol users (Rey, Sawyer, Raphael, Patton, & Lynskey, 2002). What New Zealand and Australian researchers report is that younger adults and adolescents may have a higher risk of co-morbidity than the general population. This is especially so with alcohol/substance misuse and depression.

Perhaps not unexpectedly, is the fact that the patterns of mental health presentations for adolescents are also seen in the older age group. Parker, Hetrick, Purcell, and Gillies (2008, 2009), systematically reviewed adults with mental health problems, and identified that depression (20–40%) and anxiety (11–20%) are two of the most problematic presentations. This evidence is similar to the WHO data, which predicts that anxiety and depression will be the second major illness faced by primary health care in 2020 (WHO, 2001). Along the same lines Singleton (2003) designed a longitudinal study in the U.K., and found that the impact of common mental health problems escalated for people who are

poorer, have long-term sickness, and/or are unemployed. This group are more likely to be still affected than the general population.

Overall, the trends seem common to all age groups. *Te Rau Hingengaro*, the New Zealand Mental Health Survey (2006) reported that of the participants surveyed, 7% of adults aged 65 years and older and living in the community, met diagnostic criteria associated with the Diagnostic and Statistical Manual IV (DSMIV) for depression over the previous year. Other international studies conclude that one-fifth of people aged 65 and older experience mental illness, with the most common conditions being dementia and depression (Holsinger, Deveau, Boutani, & Williams, 2007; Hsu, Moyle, Creedy, Venturato, 2005). The WHO (2012) advises that the number of people living with dementia and associated depression worldwide is currently estimated at 35.6 million. It is predicted that this number will double by 2030, and more than triple by 2050. Researchers suggest the lack of awareness and understanding of dementia in most countries, results in stigmatisation. This in turn raises barriers to diagnosis and care, and impacts on caregivers, families, and societies physically, psychologically, and economically. Needless to say, dementia is overwhelming not only for the people who have it, but also for their caregivers and families (Brodaty, Thomson, Thompson, & Fine, 2005).

Co-morbidity and mental health problems

Co morbidity is defined as the presence of more than one illness or disorder in the same person (Cuncic, 2013). However, it should be noted that there is no agreement on the exact meaning of the term. Related constructs, such as multi-morbidity, morbidity burden, and patient complexity, which are not well conceptualized, are used to convey a similar meaning (Valderaz, Starfield, Sibbald, Salbury, & Roland, 2013). Therefore, the meaning of

co-morbidity in this study refers to the literature attributed to the co-existence of mental health problems (including drug and alcohol), and physical health illness, disease states and disorders.

Epidemiological studies in Europe (Belgium, France, Italy, Netherlands, Spain, and Greece) of people with mental health disorders presenting to primary health care, found that patients usually had co existing issues (Alonso et al., 2004; Iacovides & Siamouli, 2008). Often, people presented with one or more issues, and the presentations were complex. The European researchers concluded that people do not use mental health services very much at all. These results though need to be reviewed cautiously, as the aetiology of the presentation is not clear, and it is not known if the mental health problem or the physical health problems came first. What researchers did find out was that GPs tended to treat only the main physical health complaint in the limited time they had for consultation. It seemed that some probable barriers to recognition of underlying, or co-morbid mental health problems, include time limitations, inadequate knowledge of the diagnostic procedure, frequent somatisation of mental health disorders, and possible lack of empathy toward psychiatric patients. Furthermore, the researchers suggested patients may have had a reluctance to consult about their psychiatric condition, for fear of stigmatisation.

These European results are similar to the New Zealand trend. In New Zealand, the *Te Rau Hinengaro* epidemiological study identified that people with mental health problems (including substance use problems) do not necessarily make a mental health visit only. Only 58% of those with serious disorder, 37% of those with moderate disorder, and 19% of those with mild disorders, presented to a health care service saying they had a mental health

concern. Most people presented with some other physical health concern (Oakley Browne, Wells, & Scott, 2006).

Certainly these are interesting factors, worthy of consideration in the case of PNs, who work in similar settings with GPs. What is apparent from the review of prevalence and types and co-morbidity of mental health problems occurring in primary health care is that potential patients seem to be vulnerable to a wide range of other health and social care problems. However, it is difficult to determine the etiological relationships between mental and physical conditions, and alcohol and drug misuse. It is unclear where each fits and which comes first. Equally, there are challenges with accurate reporting and detection of underlying mental health and drug and alcohol problems. Underreporting is linked to the privileging of physical health over mental health issues, and attitudinal barriers of stigma. Consequently, it is evident that PNs are most likely to encounter these patients and we need more knowledge is needed about how they manage this group of patients in primary health care.

Practice nurses' demographic and professional development

Practice Nurses in New Zealand are generally employed by GPs (Ministry of Health, 2003). However, since 2001, a number of different employment models have developed, where a local iwi (Maori tribe of geographical area) provider, rural trust, or PHO employs both nurses and doctors on salaries (Barrett & Barrett, 2004). New Zealand PNs' demographic makeup is similar to other western countries. Most western countries report that PNs are European, predominantly female, with an age range of 40 – 55 years, suggesting an aging workforce (Canadian Institute for Health Information (CIHI), 2005; O'Donnell, Jabareen, & Watt, 2010; Ministry of Health, 2003). The recent New Zealand

Nursing Council Nursing workforce stock-take found that, of the 2511 PNs, only 146 identified as Maori (NCNZ, 2010). Within New Zealand, there is a mandated expectation that cultural fit and competency is part of all health care provision (Health and Disability Code of Rights, 1996; Health Professional Competence Assurance Act, 2003). This is particularly relevant to primary health care service delivery, as it is evident that health inequalities affecting Maori, the Indigenous people of New Zealand, have long been recognised with poorer health experienced by Maori compare to non-Maori (King, 2001). The small proportion of Maori PNs suggests that there is a need for PNs working in primary health to have a high level of cultural competency to meet the legislative requirements. In 2009, government policy of Whanua Ora framework supported the enhancement of access by Maori to primary health care services. This policy outlined the need to provide a quality primary health care workforce, including PNs, that is responsive to and culturally appropriate in regards to Maori health care (Durie et al, 2009; Carthew, 2011). The literature reviewed does not seem to indicate if this has, or is occurring.

Key activities of Practice Nurses

The National Primary Medical Care Survey (NatMedCa) 2001/02 found that the key activities of the PN include nurse-led clinics for disease-state management such as diabetes, health care screening, dressings, antenatal care, contraception, and advice on child care and lifestyle. Of note, 63% of 3,562 nurses surveyed responded that they gave counselling, but the type of counselling was not qualified. No other potential mental health intervention was mentioned (Kent, Horsburgh, Lay-Yee, Davis, & Pearson, 2005). It was noted that 88% of patients will specifically make appointments to see PNs. This suggests that PNs are in a prime position to assess their patients' physical and mental health.

Professional development

The Ministry of Health survey in 2003 reported that of the Practice Nurses in New Zealand (NZ), only 21% of nurses in primary health care had a comprehensive nursing training and 69% had received general hospital nurse training. This suggests that the majority of PNs have general health knowledge and skills about mental health nursing. It can be assumed that they would have very limited knowledge or skills in managing chronic health issues inclusive of mental health problems in primary health care. These figures align with the National Primary Medical Care Survey (Kent, Horsburgh, Lay-Yee, Davies, & Pearson, 2005), which found that the majority of PNs had been qualified in excess of 15 years, with most PNs having had general training backgrounds, that being hospital based training, with minimal mental health education or training. This suggests that the majority of PNs are not prepared in their undergraduate training, to care for mental health problems presenting to primary health care. Much of their knowledge would be reliant on in-service education and/or clinical experience.

Professional development may have been influenced by changing funding systems. In NZ, the inception of the PHOs, sustained the PN's position to work alongside GPs as their employer. As a result, the PN subsidy[1] changed with the introduction of capitation funding. The PN subsidy has become part of a new system of capitation funding. However, this new funding system, previously monitored by the government, is now managed by the PHOs and

[1] In 1970 there was an international drive to maximise primary health care. The NZ government introduced the Practice Nurse Subsidy Scheme (PNSS). The introduction of this scheme was to support general practice to employ more registered nurses. However, later reviews found that the PNSS payment being directly paid to the GPs as PNs employers lead to the PN role being used in varying ways. Often they were used for non- patient contact inclusive of receptionist and administrators (Ministry of Health, 1998). The 1990s saw new guidelines being introduced to challenge primary health care as a market driven business, individualist, medical model, that was fragmented with limited intersectorial collaboration (Carryer, Digman, Horsburgh, Hughes, & Martin, 1999). However, even with the PNSS guidelines in place, Docherty, Sheridan and Kenealy (2008) found that little had changed for PNs, where there continued to be challenges around role ambiguity, poor professional development pathways, and on-going power/authority differentials between GP and PN.

practice employers, of which many remain GPs. With the implementation of the PHC strategy, and subsequent expansion of the PN responsibilities that placed higher expectations on PN duties, questions have been raised as to whether PNs are fairly remunerated as compared to nurses who work in the hospital context (McKinley, 2006).

Professional development has also been influenced by legislative change. The introduction of the HPCAA in New Zealand, has led to the definition of nursing according to scopes of practice. This was a major 'driver' towards professional development and clear identification of the PN role. The position of the PN since then has been clearly linked to the primary health care nurse, all of which were defined by the Expert Advisory Group of Primary Health Care Nursing (2003). Practice Nurses are defined as autonomous practitioners that work collaboratively to promote, improve, and restore health from an individual to population-based approach across the life span. They are usually the first point of contact, providing care to a wide range of cultural groups (Expert Advisory Group of Primary Health Care Nursing, 2003). As a result, the role remains generalist with little specialist care offered.

The changes to the PN role and responsibilities has seen practice nursing evolve professional standards of practice, position descriptions, and a college journal the New Zealand college of primary health care nurses. Included also is the professional development and recognition portfolio programme administered by the College of Practice Nurses that acts as a subdivision of the New Zealand Nurses' Organisation (Fyers, 2010). These changes were possible due to the government funding of $8.1 million over five years, to support primary health care nursing development. This funding was implemented to support the development of new models of care, provide post graduate study scholarships,

which focus on rural nurses, as well as support the expansion of roles as envisaged by health policy (Ashton, 2009).

Despite political support and government assistance, Finlayson, Sheridan, and Cumming, (2009b); and McKinlay et al. (2011) suggested that many PNs were not engaged in expanded practice. It was suggested that their skills were often under-utilised; they had limited graduate and post education, and there were limited numbers of Maori or Pacific Island nurses working in primary health care. McKinlay et al (2011), suggested that structural, attitudinal, and workforce barriers continued to limit the expansion and development of PNs. As such, even with apparent opportunities for PNs to take on expanded practice responsibilities, and access professional development, nationwide variable uptake of these opportunities has occurred.

One reason for this may be that PNs professional development may have been limited due to long-standing professional boundary issues. Themes of on-going medical dominance and PN disempowerment through inequality of power and status have been consistently outlined as a significant barrier to the expansion and professionalism of PNs in New Zealand (Ashton, 2009; Cumming et al., 2005; Finlayson, Sheridan, & Cumming, 2009b; McKinlay, Garrett, McBain, Dowell, Collings, & Stanley, 2011). However, other authors argued that employment structures had had little to do with the PN development (Hoare, Fairhurst-Winstanley, Horsburgh, & McCormick, 2008). Indeed, Hoare et al. suggested that nurse-led clinics, and integrated community and practice nurse teams, are not part of the New Zealand primary health care culture. Therefore, focusing on the employment structures of PNs may have little relevance in addressing the inequalities in health, and achieving the goals of the Primary Health Care Strategy in New Zealand.

Other authors disagree with Hoaer et al.(2008), suggesting that PNs are undervalued and invisible. Although PNs are one of the largest groups of primary health nurses, their skills and competence are often not recognised by their GP colleagues or general public (Cohen, 2007; Sullivan, 2004). They suggest that PNs have been largely left alone with little professional development (Checkland, 2007; Halcomb et al., 2005; O'Donnell, Jabareen, & Watts, 2010; Watts et al., 2004).

What is clear though is that since the implementation of the New Zealand Health Strategy, and the associated Primary Health Care Strategy, there has been a change of government resulting in further scrutiny on the New Zealand Health Strategy outcomes. Several years ago, the Minister of Health, the Honourable Tony Ryall, suggested that the primary health care strategy was failing to deliver a strong and expanded involvement of nurses (Ryall, 2007). This is an issue, as the National Coalition party supports, 'Better, sooner, more convenient primary health', and sees nursing as "vital to the future" (Ryall, 2007, p. 45). For this to occur effectively, Ryall (2007) recognises that education and training for nurses, at all levels, inclusive of post graduate, new graduate, and undergraduate nursing, is required.

To date, researchers in Australia and New Zealand continue to raise concerns around the lack of consistent development of educational opportunities, and career pathways for PNs, in the light of policy directives (Lakeman, 2013; O'Brien, Hughes, & Kidd, 2006; O'Donnell, Jabareen, & Watt, 2010; Parker, Keleher, & Forrest, 2011; Prince & Nelson, 2011; Richardson & Gage, 2010; Workforce Taskforce, 2008). However, in New Zealand it should be acknowledged that PHOs have been established in primary health for nearly 12 years. There have been increased opportunities for PNs to access post graduate education

for over a decade. Furthermore, undergraduate training has changed as well. Therefore, the demographics of PNs, in terms of their education attainment, may be changing.

In addition, Te Ao Maramatanga New Zealand College of Mental Health Nurses began a credentialing process for PNs in 2011. The purpose of the credentialing was to support clarity and consistency about how to competently and confidently provide a primary care response for people who have mental health or substance use problems. Credentialing has only just begun in New Zealand. As such, there is limited information on the uptake by PNs. Therefore, it can be assumed that the impact of this credentialing process is minimal on PN practice development as a whole at this point in time.

In summary, health policy changes have led to PNs expanding the range of responsibilities they have in health management inclusive of mental health. Furthermore, the ability to undertake these expanded responsibilities appears to be problematic due to historical barriers of culture and attitudes, which are perpetuated further in a context where medical hierarchical power supports the continuance of inequality between professional groups such as doctors and nurses.

Provision of mental health care by practice nurses

While professional development for PNs has been slow in New Zealand, it is encouraging to note that more progress has been made internationally. International and national literature suggests that many PNs working in primary health care undertake mental health assessments, and provide interventions to people who present with mental health problems (King, 2002; Owens, Gilmore, & Pirmohamed, 2000). But in New Zealand,

researchers argue that there is a lack of detail and description of what PNs define as mental health care (Finlayson, Sheridan, & Cumming, 2009a; Kent et al., 2005). Therefore, the nature and extent of their involvement warrants further investigation (Prince, 2009; Prince & Nelson, 2011).

Several authors report that most practices in New Zealand employ PNs as practitioners with a generic nursing qualification, without specialist mental health nursing experience, skills, or knowledge (O'Brien, Hughes, & Kidd, 2006; Prince & Nelson, 2011). Dowell et al. (2008) identified PNs as the group that require up-skilling of their knowledge in mental health provision. They argued that PNs hold core primary care values of holistic care, and are in a prime position to detect early changes in the mental health of patients, as they will already know them. However, Finlayson, Sheridan and Cumming (2009) argued that the comprehensive training of the 1980s in New Zealand, has included mental health, and imply this is sufficient to meet the needs of PNs. Conversely, several authors debate this, suggesting that the undergraduate training alone is inadequate to prepare any registered nurse for mental health nursing (Cleary, Horsfall, Baines, & Happell, 2010; Happell, Moxham, & Platania-Phung, 2011). Therefore, concerns remain around the capability of generalist PNs to manage mental health problems in practice. As well, there are questions as to whether PNs have the necessary levels of knowledge and skill to utilise screening tools and other mental health assessments in practice (McKinlay et al. 2011).

Opportunities for practice nurses in the management of mental health problems

Researchers indicate that with adequate training in the use of screening tools, mental health promotion, illness prevention, maintenance, and management, PNs could play an important part in reducing co-morbidities and the enduring mental health problems, which

require secondary service intervention (Andrews, Issakidis, & Carter, 2001; Kanton, Von Korff, Lin, & Simon, 2001; Wynaden, 2010). The role of screening for patient illness is a task that many PNs undertake. Tools can be used to enhance early detection of physical and mental health problems, and promote health across the lifespan (Goodyear-Smith et al., 2004; McMenamin, & Handley, 2005).

Unfortunately, despite international recommendations about screening tests for mental health problems, they are not widely used within New Zealand (Goodyear-Smith, Arroll, & Coupe, 2009). Many of the overt barriers to screening were identified as lack of confidence, training, and time. Interestingly, Dowell et al. (2008), in their evaluation study, found that mental health care was poorly understood in primary health care, beyond the knowledge that anxiety and depressive disorders are prevalent, and that there are complex barriers to problem disclosure. Clearly, there are overt barriers to mental health care, namely time constraints as well as lack of mental health education and training. However, there is little research on PNs experiences of managing patients who experience mental health problems. Further research in this area may provide more clarity and provide direction for PNs that need to keep up-to-date with the strategic direction of mental health care.

Chapter summary

In this chapter I have positioned the use of literature in this grounded theory study in which literature becomes a means to help establish the problem at hand. The political context of the study was outlined. The prevalence of patients with mental health problems and associated co-morbidity issues that affect patient management in primary health care, were analysed. International trends have been noted and illustrate how PNs are the largest group of nurses most likely to encounter patients with mental health problems in the

community. Because PNs are one of the first points of contact for patients, they are considered to be in an ideal position to recognise patients with mental health problems. However, their lack of professional development in the area means that role potential is not yet realised. Although few PNs have been educated to manage this group of patients, they potentially have an important part to play in the screening and assessment of patients with mental health problems. What is clear from this review is that PNs' professional development needs in relation to mental health nursing in primary health care are not addressed. This must change, if PNs are to receive the mental health education and support to provide mental health care as envisaged in health policy. In the next chapter the research methodology and methods are discussed.

Chapter Three

Research methodology and methods

Introduction

Crotty (1998), notes that there is considerable confusion about research methodologies, theoretical perspectives, and epistemologies for both the novice and experienced researchers. To overcome this confusion, he has identified elements to a research process that need to be understood and articulated in any study. The elements include methods, methodology, epistemology, and ontology. These elements are defined in this chapter and their application in the research process is discussed. Outlining these elements ensures that the research process is sound and the outcomes established from this study are convincing (Crotty, 1998; Hunter, Murphy, Grealish, Casey, & Keady, 2011). Making the research process explicit supports rigour and credibility. It constitutes a penetrating analysis of the process, and points out the theoretical assumptions that underpin the study, determining the status of its findings (Crotty, 1998).

In this chapter, methodological assumptions underlying the grounded theory approach, and the rationale for choosing it for this study, are addressed. The sources used to guide the research are Corbin and Strauss (2008), Strauss and Corbin (1990, 1998), and Glaser and Strauss (1967). The practical considerations related to managing the research process are explained. This includes the specific procedures, techniques, and terminology. Finally, the chapter concludes with a discussion about setting up an audit trail, so that the decision making is transparent.

Methodological positioning

According to Creswell (2009), grounded theory is "a qualitative strategy of inquiry in which the researcher derives a general, abstract theory of process, action, or interaction grounded in the views of participants in a study" (p.13). The term grounded theory denotes the identification of theoretical constructs that are derived from qualitative analysis of data (Corbin & Strauss, 2008). This process requires systematic data collection, analysis, and eventual theory to stand in close relationship with one another (Strauss & Corbin, 1998).

Grounded theory is useful when examining complex phenomena, such as PNs management of patients with mental health problems. It is emergent in design, supports the systematic generation of theory from data, where findings can be used to provide direction in areas that are little researched or poorly understood (Creswell, 2007). In other words, grounded theory can help to describe and explain the day-to-day understandings of PNs interacting in primary health care settings. This approach is useful to explain problems and solutions that occur in everyday situations (Glaser, 1998).

The grounded theory approach is inductive, meaning that it moves from the specific to the more general (Corbin & Strauss, 2008). The procedures are based on three elements: concepts, categories, and propositions. However, concepts are the key components of analysis, since the theory is developed from the conceptualisation of data, rather than presenting descriptions of the actual data (Starks & Trinidad, 2007). The preferred result of a grounded theory study is the development of a theoretical explanation, which contributes to a new understanding of the phenomena of interest (Hutchinson & Wilson, 2001). This new understanding can be used to inform practice, education, policy, and research.

However, concerns have been raised around the more explicit approach of Strausserian grounded theory. Cooney (2011) suggests one of the main critiques is that the explicit nature of this version makes data analysis more difficult, rather than the intended simplifying of the approach. The challenge is that data analysis can lead the analyst down pathways that are irrelevant, where the ability to look *at* data is lost to the need to look *for* data (Heath & Cowley 2004; Kendall, 1999). Conversely, Strauss and Corbin (1990, 1998) and Corbin and Strauss (2008), maintain that researchers should trust their instincts and not focus too closely on the analytical procedures. Therefore, as a novice researcher, my attention focuses on the systematic application of the procedures, as well as the procedures themselves. It requires me to be alert to intuitive interpretations of what is going on in the data, to trust in myself and the research process whilst remaining creative, flexible, and true to the data, all in the same instance. While everything is referred to as data (Glaser, 1998), what is important is that data is continually compared until a pattern of behaviour becomes evident.

Rationale for selecting grounded theory

With growing literature on PNs' role and challenges, the situation of how PNs manage when they work with people who present with mental health problems, remains poorly understood. Grounded theory offers an approach that not only generates theory in what it is that PNs do, but grounds that theory in PN's day to day realities (Strauss & Corbin, 1998). Therefore, grounded theory drawn from the data is likely to offer insight, enhance understanding, and provide a meaningful guide to the action of PNs' management of those situations.

Methodology

Methodology is defined as the strategy, process, or design, which lies behind the choice and use of a method (Crotty, 1998). Strauss and Corbin (1998) suggest grounded theory is a methodology that offers a way of thinking about and studying social reality. Essentially, grounded theory as a methodology seeks to explore real life situations that require a high degree of interaction between the researcher, and between the researcher and the individual, groups or situations being examined (Todres & Holloway, 2006).

Grounded theory was developed in the 1960's by sociologists Glaser and Strauss. Grounded theory is a general research method and as such, is not owned by any one school or discipline. However, grounded theory tends to be thought of as a qualitative approach to generating theory, by observing human experience and thus provides explanations of phenomena that are grounded in reality (Giddings & Woods, 2000; Glaser, 1998; Murray & Chamberlain, 1999). Grounded theory emphasises the importance of developing an understanding of human behaviour through a process of discovery and induction, rather than the process of hypothesis testing and deduction, found in traditional quantitative approaches (Streubert – Speziale & Carpenter, 2003). Grounded theorists can include all data sources that might contribute to theory development such as, interviews, observations, diaries, images, and past literature. Nevertheless, interviews tend to be the predominant source of data (Fain, 2004). Using the technique of constant comparative analysis, grounded theorists compare all the data collected with all other data, looking for similarities, differences, and contradictory cases, which might challenge interpretation of the emerging theory. It may also, ultimately, strengthen theory development. Theoretical sampling, combined with data collection and analysis is expected to produce an emergent theory that incorporates the cultural processes and meanings (Ryan, Coughlan, & Cronin, 2007).

Grounded theory has often been critiqued for its inability to clearly outline the theoretical perspectives that underpin the methodology (McCann & Clark, 2003). Bryant (2002) suggests that the methodological indifference apparent in grounded theory has ended with this approach often giving superficial and ambiguous conclusions to the research question. Bryant proposes that negotiating the tension, where researchers who use grounded theory are expected to retain some form of objectivity to the data collected, but a degree of closeness to participants, may be part of the reasons that this approach is misused. Then again, Charmaz (2006) argues that most of the issues are not with the philosophical underpinnings, but rather the misuse of grounded theory. Examples of misuse are demonstrated in table one.

Table 1. Misuse of grounded theory

Recruitment of participants as only being purposeful and lacking the theoretical sampling that is required to develop categories and theories.
Interviews as the only source of data collection, and/or doing data analysis at the completion of data collection, rather than using the constant comparison method and theoretical sampling.
Thinking in a deductive framework rather than inductive-deductive thinking, as the former requires more abstract thinking than the latter.

(Beck, 1993; Hutchinson, 1992; Morse, 2001)

Over time, the amount of information written about the methodology of grounded theory has grown, as varying authors attempt to merge with the current times and changing expectations of the research community (Bryant, 2002; Charmaz, 2002; Clark, 2003). As a novice researcher, this is to my benefit as there is now a greater clarity around the epistemological/ ontological foundations of this approach, which gives me a degree of understanding before entering the field for data collection and analysis.

Epistemology

Epistemology is understood as the philosophy of knowledge, or how we come to know (Trochim, Marcus, Masse, Moser, & Weld, 2008). In any study, it is important that an explanation of the knowledge embedded in the methodology is outlined. According to Corbin and Strauss (2008), the theoretical basis of grounded theory is derived from symbolic interactionism and pragmatism. This suggests that to understand human behaviour, then one must examine the nature of the social interaction (Crotty, 1998). So to understand what it is that PNs do when managing patients with mental health problems requires careful study of the practical realities that influence the social interactions of PNs. Central to the pragmatist interest is the question of what is going on (Morse, 2001). Pragmatist questioning of 'what is going on', provides an empirical basis for generating an explanation of behaviour that has the potential to add insight and understanding to the context and consequence of behaviours (Strauss & Corbin, 1990). Therefore, "action and interaction are crucial to pragmatism and our own conception of the world, and knowledge" (Corbin & Strauss, 2008, p. 5).

At the same time, symbolic interactionism suggests that people socially construct the world they inhabit. In particular, the meaning of objects, events, and behaviours comes from the interpretation people give them, and interpretations vary from one group to another (Corbin & Strauss, 2008). This position suggests that human beings act based on their interpretation of the meaning of events. Therefore, when interviewing PNs on their management of patients with mental health problems, the information gathered and analysed, is a reflection of the reality they have constructed and the meaning they attribute to their part in the interaction. But as a researcher, I am also constructing the stories that have been constructed by PNs, who are trying to make sense out of their experience. Out of these

multiple constructions, knowledge is constructed, which can lead to a body of knowledge about a phenomenon at a point of time (Corbin & Strauss, 2008).

Ontology

Ontology, as part of any methodology refers to assumptions held about the world we exist in (Corbin & Strauss, 2008). Therefore the fundamental question is 'what is the nature of the world in which we wish to study' (p. 5). Ontology is intimately related to epistemology and methodology. Ontology involves the philosophy of reality, whereas epistemology addresses how we come to know that reality, while methodology identifies the particular practices used to attain knowledge about reality (Krauss, 2005). From this standpoint, the world is complex, often ambiguous, evincing change as well as periods of permanence. As such, routine action today may be problematic tomorrow, and answers come from questions that come from answers. Grounded theory determines that the great varieties of human action, interaction, and emotional responses to the events and problems they encounter, are important (Corbin & Strauss, 2008). For human responses create conditions that impact, restrict, limit, and contribute toward restructuring the variety of action/interaction, which can be noted in societies. Applying grounded theory to the PNs' management of patients with mental health problems has potential to illuminate complex social processes, and the contexts in which they occur. Consequently, it is an ideal method to study phenomena in their natural settings (Greenberg, 2005). This will add insight, enhance understanding, and provide a meaningful guide to PN mental health care management (Strauss & Corbin, 1998).

Desired outcome of grounded theory study

The desired outcome for this study is to produce a well-developed theory. The theory should also provide a description and explanation for the phenomenon identifying clear

concepts and hypotheses that can be both verified by future research and operationalised for quantitative studies (Glaser & Strauss, 1967). Morse (2001) suggests that a grounded theory can be either substantive or formal. Substantive theory is developed for a specific area of inquiry, whereas formal theory is for a conceptual area of inquiry. This thesis is aimed at enquiring after a specific form of patient care provided by PNs; therefore, it aligns reasonably to the generation of substantive theory, which is the main goal (Glaser & Strauss, 1967). It allows the researcher to generate knowledge that will have specific outcomes for patient care and nursing practice.

Methodological source

Grounded theory over time has evolved within the eras of post positivism, post modernism, deconstructionism, and constructionism. As each era evolved, more has been written about interpretation and application of grounded theory. Therefore, it is essential that this study specifies the source used to guide the research (Wilson & Hutchinson, 1996; Munhall, 2000). By the same token, trustworthiness is established in the research when the research method is found to adhere to the source specified (Lincoln & Guba, 1985). As stated earlier, this study has applied the Strausierian approach as outlined by Corbin and Strauss (2008). However, the earlier versions of Strauss and Corbin (1990, 1998) and Glaser and Strauss (1967) will also be accessed as an additional source.

More recently, Corbin and Strauss (2008) acknowledge that grounded theory has evolved into many different approaches to building theory, grounded in data. Each edition, aimed to explain the original method more clearly. Although Corbin has retained the methodological vision of Strauss, she also acknowledges that there are some differences in the latest version. Firstly, there is an explicit description of the theoretical foundations of

this approach. Secondly, the book is more open, analytically reflecting changes to make the data analysis less complex, to be able to look *at* data, rather than *finding* data. Lastly, this version acknowledges that not all grounded theory research reaches theory building. Thus, there is an acceptance that there is a use in research for "thick, rich" description of concepts (Corbin & Strauss, 2008, pp. ix). However, it is anticipated that theory construction will be part of the outcome of this study. Theory is described as a set of well-developed concepts and statements of relationship, which offer an explanation about some complex phenomena (i.e. problem, issue, or event) (Strauss & Corbin, 1998). A theory developed in this research will include a description of the objects or events, the context or condition in which the event or action occurs, and the consequences or outcomes of the action (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

Method described

The study begins with a question identifying the problem and the context of the study. The initial question is broad and flexible to allow freedom to explore a topic in some depth. The research question in this study is: "How do you manage working with patients who have mental health problems?" The research question will initially be used for data collection. In grounded theory, data collected in response to the initial research question generates more refined and focused inquiries, as the data collection and analysis unfold. As is required of grounded theory, the data from one interview is analysed and constantly compared with the incoming data. For to have data collection and data analysis as separate entities risks over emphasis on abstraction and threatens the validity of the study (Schreiber & Stern, 2001). On-going data analysis and collection allows sampling and verification of provisional categories and hypotheses based on the emerging concepts (Strauss & Corbin, 1998).

The initial interview question is based on knowledge from my nursing background, and the literature on the topic. However, in grounded theory the initial interview is unstructured and uses general guidelines only, such as: "Can you tell me about the experience/s"; "In light of what you have said, what do you think your role is in regards to the management of mental health care?" Although the questions are framed in a broad manner, it is clear that the focus is on PNs' management of patients with mental health problems.

Sampling

"Sampling in grounded theory is different from that of other conventional methods of sampling, in that it is responsive to the data rather than established at the end" (Corbin & Strauss, 2008, p. 144). Sampling is based on concepts rather than individuals, where the researcher collects information about representative events or incidents (Strauss & Corbin, 1998). The participants were purposely picked as PNs as they were the most likely group to address the phenomena under question – provision of mental health care by PNs. The initial sampling decision was made based on the research question, though this was modified related to the research goals, access and availability to the resources, and the time limitations of a Masters thesis. The initial sampling decision was based on the need to collect information that addresses the main research question. Once data collection and analysis began, the data was coded using open, axial, and selective coding. Concepts emerging from the data guided the questions asked and sampling done. *Theoretical sampling* is concept driven and allows the researcher to discover the concepts that are relevant to the problem and the population (Corbin & Strauss, 2008; Strauss & Corbin, 1998). This will be elaborated on later in the chapter.

As such, the data will come from the initial sampling. However, after the first data had been collected from the initial sample and analysed, theoretical sampling continued as a systematic and cumulative process. This is driven by the emerging concepts and the need to fully develop each conceptual category (Strauss & Corbin, 1998). Corbin and Strauss (2008) suggest that through theoretical sampling, the core category and concepts are elaborated and tend to form the basis for thick, rich description and theory construction. Theoretical sampling continued until all the categories are saturated.

Data collection

In a grounded theory study, data collection usually takes place with face-to-face interviews. Interviews are semi-structured initially, in order to allow the participant flexibility to talk about the topic area. Once concepts have emerged from the early interviews, both sampling and interview structure are based on constantly comparing emerging concepts. As the theoretical concepts emerge, notes of the analysis and theoretical sampling will be made, to provide an audit trail of the decisions made in the development of the theory. Credibility of analysis will be enhanced through keeping memos at each stage that capture the analysis and emerging concepts (Chiovitti & Piran, 2003; Corbin & Strauss, 1990; Strauss & Corbin, 1998).

Data analysis

Data analysis is achieved through coding of interview data, questioning and comparison, and identification of the concepts arising (Corbin & Straus, 2008). The process of constant comparison, examination of data for properties and dimensions arising, is balanced by the development of sensitivity to the meaning of the data (Strauss & Corbin, 1998). During data analysis, all concepts will be checked back against pre-ceding data and

may also be checked against literature, as the theory and concepts and the theory become more abstract. The process will be recorded in detail with memos.

Concepts and categories

During data analysis, concepts, categories, and relationships are identified and validated. "Concepts are defined as words that stand for groups or classes of objects, events and actions that share some major common property/ies, though the property/ies can vary dimensionally" (Corbin & Strauss, 2008, p. 45). Concepts are developed by abstracting raw data, labelling it, and comparing it with new data. Categories are developed by abstracting groups of similar concepts and specifying their properties and dimensions, by constantly comparing and validating them with new data. Each component of the theory is developed in much the same way.

Every concept is challenged with new data, and only items that are repeatedly present in the data make their way into the theory (Greenberg, 2005). The continual process of testing, revision, verification, and finally identifying specificity of the theoretical concepts, contributes to the credibility of the theoretical interpretation and will address any issue of bias. In addition, when clarification or confirmation is needed, the concepts and categories are checked by asking participants if the researcher's interpretations and ideas being identified match their experiences. Corbin and Strauss (2008) support the use of in–vivo coding, where the concepts are names with language or words that the participants used, rather than the analyst.

Coding

Corbin and Strauss define coding as the "derision and development of concepts from data" (2008, p. 65). Coding refers to the procedures used to examine, organise, and interpret data. It is a dynamic process, which becomes increasingly more focused and abstract. Corbin and Strauss (2008) indicate that it is akin to mining, where you "dig beneath the surface to discover the hidden treasure within the data" (p. 66). Coding requires interaction with data through questioning, comparing, and theoretical sampling. This in turn supports the identification of similarities, differences, and meaning in the data, to ensure the analysis moves from specific events and concepts to more general abstract categories and their interactions (Corbin & Strauss, 2008; Strauss & Corbin, 1998). There are three types of coding: open, axial, and selective. However, the three areas of coding are interrelated and do not separate out, as has been so in previous versions of grounded theory. Corbin suggests that open and axial coding go together (Corbin & Strauss, 2008). This is useful to facilitate the researcher distinction, to note differences between codes, so that the interplay is better understood.

Open coding

Open coding starts by listening to the taped interviews, and then reading the transcripts, in parallel to checking the accuracy of the text. Open coding is the process of breaking the data apart, to delineate concepts to stand for blocks of raw data. These blocks of raw data must also be qualified on terms of their properties and dimensions, to account for any variation. Strauss and Corbin (1998) suggest that open coding can be done line-by-line, to generate concepts and categories early in the process. Open coding can also be achieved by looking for the central idea in sentences or paragraphs, or by looking at the entire document to determine what is going on there (Strauss & Corbin, 1998).

In open coding, concepts are uncovered, examined for differences and similarities, and labelled, and grouped according to the identified properties. During this initial data coding, memos are used to record the data analysis. Memos support the researcher to record the analysis, thoughts, interpretations and identify future questions directed by the data collected (Corbin & Strauss, 2008). At the same time, concepts with similar characteristics are grouped into categories. Once a category has been identified, the properties and dimensions are developed. Properties are the characteristics or attributes of the category, and dimensions refers to the range in which the properties vary (Strauss & Corbin, 1998). Categories are further developed into subcategories for additional specification and clarification.

Axial coding

Axial coding is the process of reassembling the categories according to the properties and dimensions of the concepts. In axial coding, the researcher gets closer to the explanatory aspects of the data by relating the categories and subcategories (Strauss & Corbin, 1998). Axial coding requires the researcher to identify the category properties and dimensions, describe the relationship between each category and subcategory, and clarify how they are related. Looking for explanations to uncover relationships and help to develop explanatory schemes is fundamental to the analysis.

The researcher examines the categories according to the associated conditions (structure), the actions/interactions (process) taking place, and consequences. Process refers to the on-going action/ interaction/ emotions taking place, and describes how they evolve in response to situations or problems (Corbin & Strauss, 2008). Process can take a major or a minor role in the theory, and can range from orderly, sequential, purposeful, to uncontrolled

and chaotic. Consequences occur in response to action or lack of it; they can be intended or unintended, and vary in impact and duration (Corbin & Strauss, 2008; Strauss & Corbin, 2008).

Selective coding

Selective coding is the integration and refinement of categories and relationships into a theory (Strauss & Corbin, 1998). Connecting the elements of context, process, and consequences creates an explanatory framework and describes 'what is going on here'. The transition from axial coding to selective coding is flexible, however will result in the accumulation of data collected (Morse, 2001). This process is completed when there is no new data. To achieve integration, a central explanatory and unifying category is indentified (Strauss & Corbin, 1998). Strauss and Corbin call this the central explanatory category (1998). The unifying concept represents the main theme of the research and draws together all other major categories. The identification of the central explanatory category links categories and thus creates an explanatory whole. Corbin and Strauss (2008) suggest that the central category has analytical power, meaning that the category can explain what the research is all about.

The tentative theory is then refined by reviewing it for internal consistency and logical development, by filling in poorly developed areas, or trimming excess categories (Corbin & Strauss, 2008; Strauss & Corbin, 1998). If the story line, memos and diagrams are clear, then consistency and logic should follow (Corbin & Strauss, 2008). The theory constructed from raw data becomes an abstract version of that raw data, and it requires validation. This occurs through the comparison of the scheme against the raw data, or by presenting theory to participants to determine how well it fits their cases. However, Corbin and Strauss caution

that often the theoretical scheme may not always account for variation, and this must be acknowledged within a grounded theory study, for even within categories there is variation with different participants.

Memos

Writing memos is considered an integral part of the analysis in grounded theory. Corbin and Strauss (2008) state that the main features of memos include: references to raw data excerpts, records of the researcher's analytical insights, and the researcher's responses to the data collected. However, as the data collection progresses, memos often capture aspects of the data analysis process inclusive of coding; development of properties and dimensions of concepts or categories; the relationships amongst conditions, actions/interactions and the consequences; or they may be used to support the integration of categories towards the development of the story line.

A technique used to facilitate the identification of the central category and the integration of concepts is the writing of the story line. This entails the use of memos to write a descriptive account of the unfolding story. This works effectively if the researcher returning to the raw data "reads it not for detail but to gather a general sense of the emerging story" (Strauss & Corbin, 1998 p. 148). The questions asked are what is the main issues or problems with what people seem to be grappling with?, what keeps coming up over and over again even when not directly stated.

Strengths and limitations

In grounded theory, it is argued that data collection and simultaneous analysis and interpretation are both strengths and limitations. Both Strauss and Corbin (1998) and Corbin

and Strauss (2008) advise creativity in the development of the categories, and the theory. The authors suggest that can occur through open mindedness, allowing the data to speak for itself, rather than forcing it into categories.

As a novice researcher, this advice is wisely considered, however I am aware of my previous knowledge of the field of enquiry and engagement with the literature that may serve to bias or sensitise me towards emerging concepts. Corbin and Strauss (2008) concede that when formulating the research problems and questions, the researcher can use his or her experience, knowledge, and even the literature if it is needed. As such, the process of grounded theory supports the balance between objectivity and sensitivity to ensure that validity is maintained.

As addressed earlier, one potential limitation is the time required to develop theory. The fully developed theory depends on saturation (density and variation) in all categories. It is anticipated that research findings will give a 'snapshot' of the social behaviours as demonstrated by PNs in the complex environment of primary health. This 'snapshot' will illuminate how PNs manage patients with mental health problems. The theory constructed from the stories, experiences, events, and situations of participants should then resonate with anyone interested in the subject, whether novice or expert (Straus & Corbin, 1998; Glaser & Strauss, 1967; Chenitz & Swanson, 1986; Hutchinson & Wilson, 2001). Grounded theory presents excellent representations of reality and can create new knowledge to inform nursing practice (Morse, 2001).

Rigour

Conceptualising rigour is an essential part of any research. Glaser and Strauss (1967) emphasised two main criteria for judging the adequacy of an emerging grounded theory: that it fits the situation and it works, helping the people involved in the situation to make sense of their experiences and manage the situation better. Corbin and Strauss added that the emergent theory should be understandable, general and allow partial control (2008). Yet, the authors did not specify how to demonstrate quality.

A study by Cooney (2011), explored the challenges of rigour in grounded theory. What this study concluded was that novice researchers need to audit the extent to which they are demonstrating rigour when writing up their studies. This requires the careful application of grounded theory methodology as the the single most important factor in ensuring rigour. However, Cooney (2011) also pointed out that rigour is built into the grounded theory method through the inductive-deductive cycle of theory generation.

Elliott and Lazenbatts' (2005) article on *How to recognise quality research*, argues that it is more important to consider the research methods such as the constant comparative technique or theoretical sampling and question as to whether this was used correctly when evaluating a grounded theory study. Their focus was the process of the study or how the study was carried out. Conversely, Guba and Lincoln (1989), Beck (1993), and Chiovitti and Piran (2003) suggest that interpretative rigour is the way to conceptualise rigour in a study and emphasise the trustworthiness of the interpretations made. Consequently, attention is paid to the analytical process of how researchers draw their conclusions and the extent to which these are grounded in the data (Fossey, Harvey, McDermott, & Davidson, 2002). Cooney (2011) concluded that both process and product must be considered when judging credibility of a grounded theory study. Therefore in this study, rigour will include

both aspects of process and product accountability by adapting a general framework by Beck (1993) of credibility, audibility, and fittingness associated with grounded theory.

Credibility

Credibility refers to the vividness and faithfulness of the description of the study (Beck, 1993; Guba & Lincoln, 1989). This means that the participants, when presented with the emerging theory, will recognise this as their experience. Cooney (2011) suggests that credibility is also evident when others can recognise the experience when they encounter it, or as they read about it in a study. Cooney outlines how to enhance credibility, which will be applied in this study. Firstly, the study will give a sound description of how the methodology is applied. Secondly, the emerging codes will be confirmed with the participants in later interviews, to ensure that interpretations fit with their reality or understanding of the phenomenon. Participant's concepts will be used to develop new questions. Any feedback from participants or experts in the field on the emerging theory will be incorporated.

Audibility

Audibility, known also as the 'audit trail' (Guba & Lincoln, 1985), should be sufficiently detailed, to make it possible for other researchers to repeat the same enquiry, in the same setting should they want too. This necessitates that the researcher presents a clear and concise record of all methodological decisions, sources of data, sampling decisions, and analytical procedures, and their implementation. In grounded theory, memos provide an audit trail that details the researcher's personal beliefs, assumptions, and values. Memos detail how data is collected and any sampling decisions. Importantly, a memo will also outline the approach to analysis and the generation of theory. However, McGhee, Marland,

and Atkinson (2007) caution against over-reflexivity within the process of memoing, which stifles the creativity and may limit theoretical development. Alvesson and Sköldberg (2000) describe it as the 'interpretation of interpretation' another layer of analysis after data have been interpreted. For a grounded theory study to over interpret runs the risk of not being true to the data coming forth. Therefore, memo writing will be guided by Corbin and Strauss's (2008) chapter on memos and diagrams (p.117).

Fittingness

Fittingness (also termed transferability) is concerned with demonstrating that the findings have meaning to others in similar situations (Beck, 1993). It is often debated as being difficult to achieve in grounded theory, as abstract theory development tends to pertain to the phenomenon of interest in the context of origin. Chiovitti and Piran (2003) suggest that making the similarities between the study findings, and theoretical constructs in the literature explicit, is helpful in demonstrating potential transferability. To enhance fittingness or transferability, the researcher proposes a background section that allows the reader/s to gain a picture of the study context. Additionally, the sample is clearly detailed to enable the reader/s to determine if the sample is sufficiently diverse to reflect the complexity of the situation or problem (Cooney, 2011).

Empirical grounding

To assess empirical grounding of findings, it is important to be able to determine if the concepts are generated from the data. They must also be systematically related and have many conceptual linkages and categories (Strauss & Corbin, 1990). Categories should be dense and contain multiple concepts that demonstrate the properties and variations within the category. Variation is built into the theory in terms of actions/interactions, the

conditions or circumstances in which the action takes place, and consequences (Corbin and Strauss, 2008). Thus, context, or a set of conditions come together to produce a specific situation and process, that are necessarily linked and should explain the phenomena of interest and stimulate further research (Corbin & Strauss, 2008).

Chapter summary

This chapter presents an overview of grounded theory with a description of the methodology and its origin. A discussion of the rationale for this methodology, and the likely study outcomes was discussed. The Corbin and Strauss (2008) method, process, and the associated terminology was outlined in detail. Throughout, the chapter methodology has been critically reviewed in order to ensure that the process and product of the study is valid and justified. Much of the information necessary to judge the adequacy of the research process and the credibility of the findings will be evident in the next chapter.

Chapter Four

Method applied

Introduction

In this chapter procedural detail, techniques, and examples from this study are provided to show how the method was used. To begin, I explain the ethical aspects influencing study decisions. I outline how I accessed and recruited participants, and describe the settings where the interviews took place. Then, I examine the application of grounded theory in practice, outlining the use of concurrent data collection and constant data comparative analysis, theoretical sampling, and memoing. The rigour of this process is also detailed accordingly.

Ethics

Ethical approval in New Zealand is part of student research process with the aim of reducing any potential or actual harm to participants. Ethics approval was sought through the University Committee, AUTEC. The proposal was reviewed and approved (Appendix 1). As part of this approval, the following documents were also submitted: Participant consent form (Appendix 2), confidentiality agreement for the transcribers (Appendix 3), email for recruitment purposes for professional contacts (Appendix 4), information sheet (Appendix 5), and interview questions (Appendix 6).

Recruitment

Following ethics approval, three professional contacts working in primary health care were contacted by electronic mail (email). An introduction letter (Appendix 5), and the information sheet (Appendix 6) were attached. The professional contact email outlined the

study and the inclusion criteria. The information sheet gave details of the study, explained expectations of the potential participants, and provided information about privacy/confidentiality considerations. The professional contact email was sent to the practice managers and lead nurse, who then forwarded the information via email and team meetings to practice nurses (PNs). Over a month, three PNs at different general practices made contact and confirmed their availability to be in the study. Then one PN forwarded the information to PNs in her general practice. This resulted in a further five PNs agreeing to talk with me. Email addresses were sent to me and I made contact with potential participants. Within three months one PN from another practice joined the study. During a visit out of town, I left information sheets at a general practice and two PNs volunteered to be interviewed. Then another PN forwarded the information sheet onto two colleagues that decided to be in the study. They sent me their contact details via email. The majority of the PNs were acquired through referrals from their colleagues. Two final participants were recommended by another professional contact from a learning institution. The last interview was with an earlier participant, who agreed to be re-interviewed as part of the theoretical sampling and verification of the emerging theory.

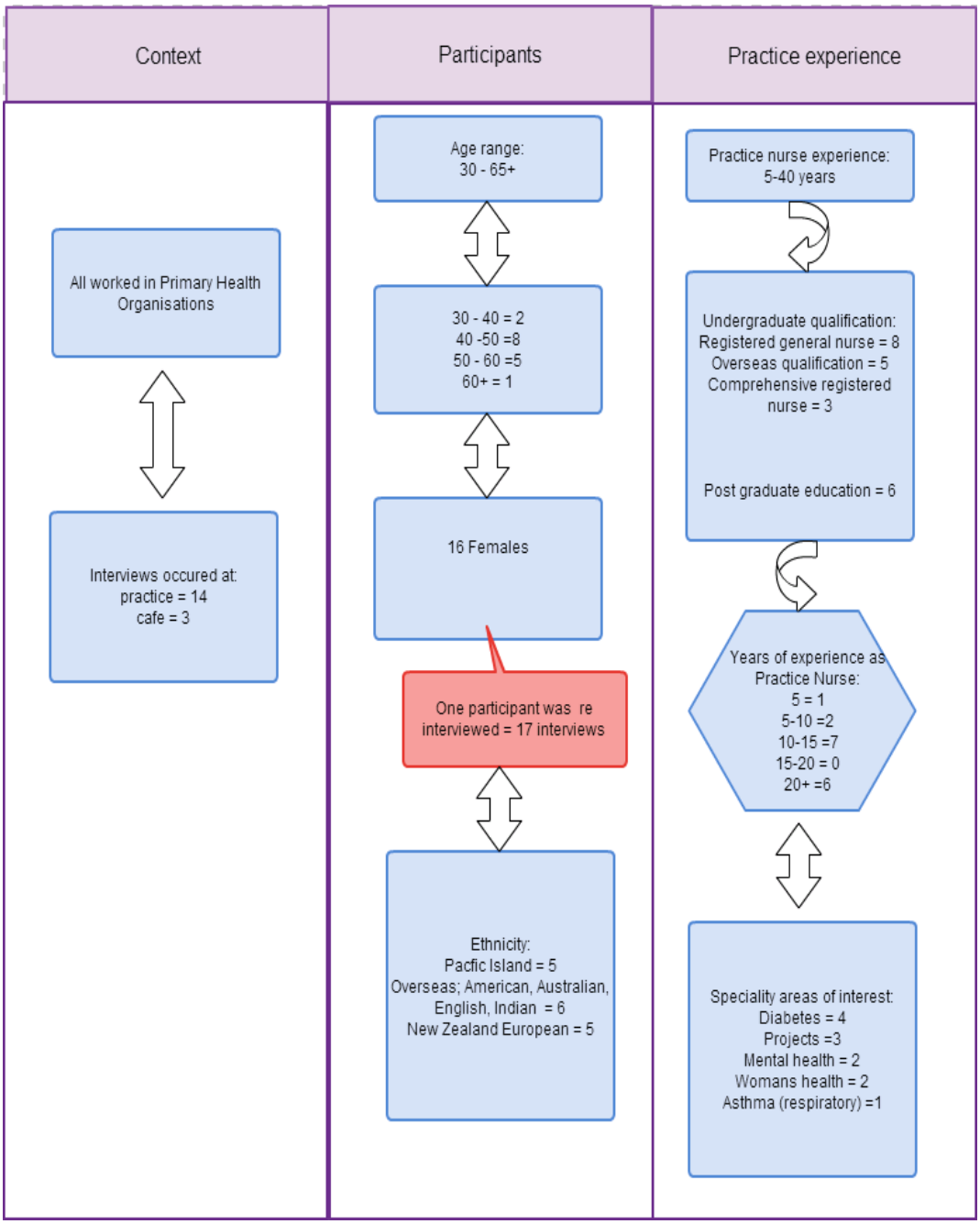
All the PNs who joined the study were emailed the information sheet. This was to ensure they were fully informed. Prior to interviewing, I asked if they had read and understood the information about the study that described risks and benefits. I then offered to provide more detail about the study if they requested it. O'Neill (2002) adds that a better reason for taking informed consent seriously is that it provides assurance that participants are neither deceived nor coerced. This required that I carefully consider my ethical responsibilities to participants, by making sure they fully understood what the study required of them, and where the information would go. Prior to interviewing, I explained the content

of the consent form. It explicitly stated that joining the study was voluntary, participants could refuse to answer any questions asked, and/or withdraw from the study at any time without consequences. In addition, I verbally reviewed the research aims, and offered participants the opportunity to ask questions, or voice any concerns before the audiotape was started. I also offered to share the outcomes of the study with the PNs, to maintain transparency and honesty. When I had ascertained they understood the research, and what their involvement entailed, all participants were given a consent form and asked to sign before they continued with the interview.

Sample

Sampling for the study began with PNs who agreed to be interviewed. Interview sequence was determined by convenience. Practice nurses were drawn from clinical settings within PHOs in New Zealand. The sample group consisted of a total of 16 female participants. All PNs met the inclusion criteria except one. The one that did not was interviewed in order to check out the constant comparison analysis 'flipflop' technique. This is explained later in the chapter. Details about the sample are presented in the following figure 1.

Figure 1. Sample group of practice nurses



The PNs all provided generalist care. However, 11 of the 16 had specialty interests supported by the practice. These interests were in an area of revenue uptake and health target screening for that catchment area[2]. All the PNs worked with booking systems, where patients would schedule a consultation. Some nurses also offered walk-in consultations.

[2] Some of the PHOs have acquired funding associated with project work or programmes. i.e. 'Care does matter': Noncompliance to health interventions. Practice nurses are involved with these projects and/or programmes, which have specific time allocations, associated funding.

Generally, they all worked within a time allocated booking system, which ranged from 15 minutes - 1 hour. The PNs all worked between the hours of 7am – 5pm, Monday to Friday, and some ran after-hours clinics associated to each practice. Six of the PNs were from a specialist population PHO i.e. Cultural PHO. Cultural PHOs were developed to provide services that incorporate cultural care and language components to ensure the services are more appropriate for, and responsive to, patients of that culture. Access to care has been improved through lowering fees, providing local facilities, and giving nurses a greater role in primary care (Ministry of Health, 2010).

The other 10 PNs interviewed, were associated with practices within the general population group. Of the 17 interviews, 12 were in city centres, two took place out of the major city, and three were in a rural setting. Most PNs chose to be interviewed in their workplace. Three participants chose to meet in cafes.

Confidentiality

Confidentiality management is important in order to protect the participant's privacy. This means that the information the participants disclose in a relationship of trust cannot be divulged to others without their permission. Additionally, information obtained should be kept in a secure place (Kaiser, 2009). Completed participant consent forms were submitted to the research supervisor for safekeeping and storage in a safe locked cabinet. The names and contact information of the PNs was accessible only to the researcher, and are kept on a personal database that has password access. This information will be retained for six years, in accordance with the ethics process, before being deleted. Prior to each interview the PN was given an interview number used to label the audiotapes, the interview transcripts, and all other written or computer stored records other than the consents. Participants cultural

specific practices were not discussed during the interviews. Therefore, cultural representations were not detailed intentionally, to protect the anonymity of the PNs. The methodological application of a grounded theory study also contributes to the protection of the participants' identity. For the study is driven by the concept identification. This tends to de-emphasise participant characteristics. This approach minimises the individual's identity and increases anonymity. Furthermore, each interview was audiotaped in its entirety and transcribed verbatim by the researcher and two paid transcriptionists.

Treaty of Waitangi

The Treaty of Waitangi is New Zealand's constitutional document. The Government recognises Maori as both a social group, and as Tangata Whenua, the Indigenous people of New Zealand/ Aotearoa (Ministry of Health, 2001). While the Treaty of Waitangi is primarily about the relationship between Maori and the Crown, it also has application for other cultural groups, if not all New Zealanders who may be participating in research. Within this study the participants came from a range of cultural groups, as demonstrated in figure 1(p.65). Therefore, prior to commencing the interviews, I made sure the participants had the information sheet, understood what was required, and had an opportunity to ask further questions. I also ensured the setting was private, and the conversation was confidential. This met the ethical requirements of informed consent, privacy, confidentiality, and autonomy to withdraw from the study, should they chose. However, during the interview I needed to be culturally aware. Cultural awareness is the process of reflecting on my own cultural identity, reality, and values, as a white middle class woman (Tolich, 2002). This meant, when I encountered the participants, I needed be aware of the impact my cultural identity may have had on the interactions with them when they came from another culture. Therefore, as I encountered the participants I was mindful of my

actions. I engaged in cultural practices of kissing on the check before and after the interview. I also shared food and drink with some of the participants, symbolic of coming together as one.

Data management

Coded interviews, all levels of coded data, and researcher generated memos were stored in a secure database. Data entries were dated, sequential versions of the files saved in the Kingston data storage and, as the analysis progressed, printouts were generated to help document the research process for both the researcher and supervisor.

Methodological procedures: Data collection and analysis

This section will describe the methodological process used to develop the grounded theory. The decision taken to diminish researcher bias and improve the credibility of the study findings is built-in to the detailed description of the analytic process.

Interview

Before beginning the interview, I explained the process and confirmed permission to proceed and to tape record. The interview participants were reassured that the approach would be relaxed, and there were no right or wrong answers. I encouraged them to answer questions freely. All interviews lasted from 15 minutes to one hour. Upon completion, PNs were asked if they were willing to participate in a review of the developing theory. All PNs signalled an interest.

The interviews were guided by the broad research question that was designed initially to generate multiple codes. Codes then became guides that shaped the direction of the data

collection. Strauss and Corbin (1998) suggest defining sensitising questions that tune a researcher into what the data is saying. The first interviews largely dealt with the generalities of mental health management. For example to begin the interview I asked, "I understand that you have had experience in managing mental health nursing care in your practice setting. Can you tell me about the experience/s". As the interviews progressed, although still guided by the research questions, the focus of the interviews became increasingly specific, and were guided by theoretical questioning that aimed to find out more emerging concepts. I would ask, "One thing that has come up is referring. Can you tell me about this?".

One interview was part of the 'flip flop' technique, which turns sampling upside down to gain a different perspective on the phenomenon (Strauss & Corbin, 1990). The PN was intentionally sampled, to check out if knowledge levels altered practice when a nurse had attended a specialist course in mental health care management. This was useful in understanding the concepts of knowledge expectations /limitations, which was later used in the axial coding.

Managing investigator bias

I quickly became aware that my professional involvement in mental health nursing meant that I had lots of assumptions about what happened in practice. To develop my interview technique, I engaged in role play with my supervisor. We carried out a mock interview that was useful to provide feedback on my interview approach. This experience was captured in a memo. "I need to constantly be mindful of my objectivity versus subjectivity. Role play has helped me reflect and gave me an awareness of my subjectivity as displayed in my passion for mental health nursing" (C.Schneebeli, personal

communication, February 14th, 2013). This experience enhanced my confidence in subsequent interviews, and illustrated to me the importance of questions that shape each interview. It heightened my awareness of my interview skills too. Also, it helped me to avoid theoretical preconceptions and engage in theoretical sensitivity i.e. theoretical sensitivity developed as I immersed myself in the data, trying to understand what the participants saw as being significant and important, rather than just listening for my own ideas.

Open sampling

Sampling is open to the persons, places and situations that will provide the greatest opportunity for discovery (Strauss & Corbin, 1998). Therefore, open sampling in this study was the process of systematically going from participant to participant based on PN availability and willingness to be interviewed. The initial interviews lasted just under an hour, and subsequent interviews ranged from one hour to fifteen minutes. Average interview time was forty minutes. Memos were written after each interview, after seeing my supervisor, and after the interviews were coded. The memos included critique of the research technique as it was applied, reflection on emerging data, and interesting ideas, questions, or hypotheses that needed to be pursued. In one memo I explored the definition of *manoeuvring*, as a possible term to describe the emerging theory:

> "One interpretation of manoeuvring implies that there is a strategic approach and movement. It is 'controlled' and there is 'movement' and 'direction'. Certainly practice nurses are in charge of the care and will direct it towards an outcome. Another interpretation refers to gaining something. I am not sure where this would fit, as PNs didn't speak of gaining. Interestingly, there is a darker interpretation to manoeuvring, which implies there is deceit and scheming. I do think this could possibly at a stretch apply to PNs, who have values and attitudes that reflect stigmatisation of patients with mental health problems. Therefore to not be available or to avoid any consultations or even to decline access to the surgery, may be a form of manoeuvring they partake of. However, I am not sure this fits for the majority of PNs interviewed so far; [many]

> displayed compassion in the face of uncertainty. I think I need to ask about this, as I suspect it doesn't reflect what is going on" (C.Schneebeli, personal communication, March 25th, 2013).

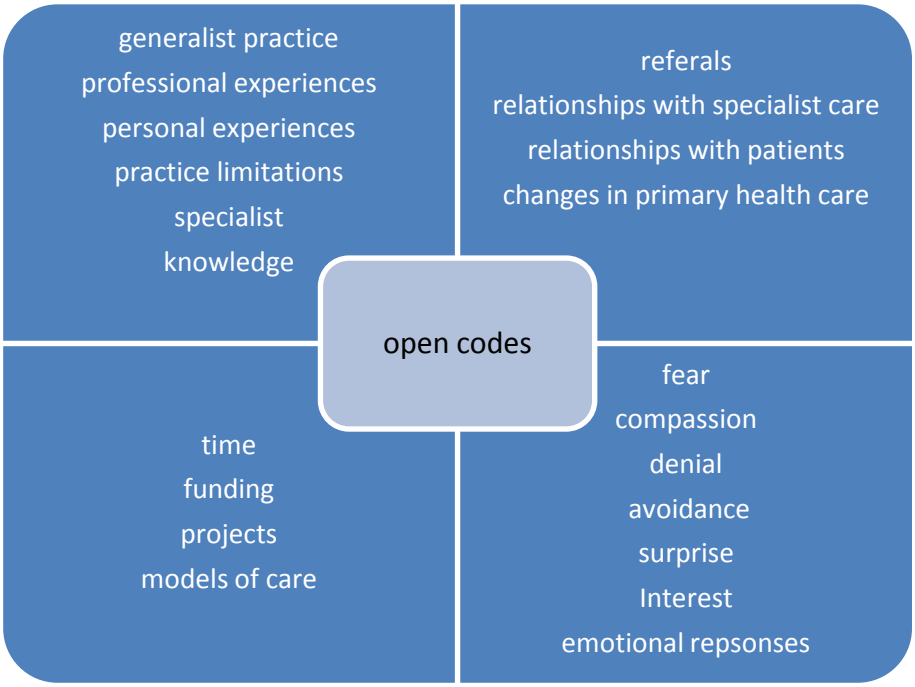
The memos were used to develop sample questions, interview process reminders, and record topics to explore for the next interview. Some memos included tables utilised to manage the data and developing categories and theory.

The final interviews were more practical and structured, as I asked questions that helped with the development of the evolving theory. My questions were often guiding and changed from the earlier approach of "how do you manage mental health presentations" to "how do knowledge limitations of a generalist PN, in a primary health setting [that has] time and funding limitations, influence the frequency, amount, and type of referrals or consultations you make?"

Open coding

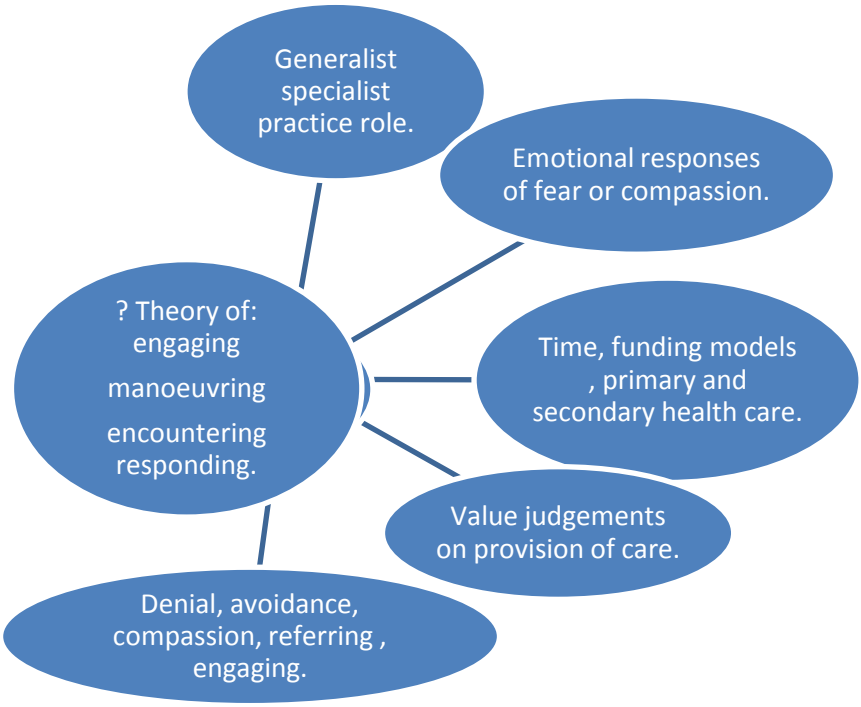
Open coding is a detailed approach to breaking the data apart. This helps to delineate concepts to stand for blocks of raw data (Strauss & Corbin, 1998). Once I had completed the first three interviews, the transcripts were coded for key concepts. Concepts were examined for differences and similarities, and labelled and grouped according to the identified properties. Concepts were compared and some added to the interview questions as I sought clarification of meaning. Figure 2 outlines the key concepts.

Figure 2. Key concepts derived from interviews



With the initial coding, there were over 18 codes. Sometimes though, different terms were used interchangeably. For example, knowledge, clinical experience, and personal experience were combined as ways of knowing. Another example covered the concepts of funding, time, models of care, and secondary health care resources, all of which were categorised as interchangeable boundaries. Constant comparison of concepts resulted in identification of recurring concepts that are outlined in Figure 3.

Figure 3. Main concepts and processes emerging in the theory



Later in the analytical process, hypothesis linking concepts were identified and tested with participants. As a result, analysis was refined.

Theoretical sampling

Once initial concepts were identified in open coding, theoretical sampling continued. This involved the process of gathering more focused information from the participants, to develop particular concepts more fully. In theoretical sampling, data gathering was driven by the concepts derived from the evolving theory and based on the concept of making comparisons (Strauss & Corbin, 1998). Concepts were identified at the first interview, thus theoretical sampling began. The interview guide changed to reflect the direction of the data that led to the questions becoming more specific. For example, prior to interview five, I reviewed the questions to begin with a broad approach around the role of PNs. Then I

moved towards more specific questions as the rapport had built and the conversation was flowing. Table 2 is an example of the reviewed questions.

Table 2. Reviewed questions for Participant five.

"Firstly, can you tell me a little about your role as a PN – have you specialised in any area?"
"I understand that you have had experience in managing mental health care in your practice setting?"
"Can you tell me about the experience/s?"
"What is it like when people present with mental health problems, - how do you feel?'
"What are the problems and issues they have?"
"What happens if someone doesn't meet the time allotment?"

The interview questions, at any point in the analysis, were designed to gather focused information. However, I also needed to be attentive to the incoming data. The interview process was both unstructured and structured, guided by the need to validate and elaborate specific concepts. The incoming data was questioned, compared, and analysed even as it was being collected. For example, I was constantly internally questioning the PN's responses such as: 'Does this fit with what other PNs have said?' 'Is this different and how?', 'Is this a new idea, or just another way of stating what has been confirmed?' This active process often generated interview questions to validate or clarify information (Appendix 6). Memoing was useful to document suggestions for comparisons with existing data. Example of memo post interview 12:

> "This interview was significant as it was part of selective sampling. Along with the other questions I wanted to see if context influenced practice by comparing rural to city PNs. When questioned about managing mental health presentations, it was interesting that the answers were quite similar to most of the PNs. In that they did not have enough time, knowledge and skill to deal with some of the mental health presentations. So what is different? The population group – not really. The interest? – no. The interventions? – no. The PNs in this practice were tied to practice models, attitudes and time

> constraints, very much the same as the city PNs" (C.Schneebeli, personal communication, 28th February, 2013).

After 16 interviews, participants were emailed with a list of key concepts from their interviews. Participants were asked if they would like to add or to clarify concepts. Three responded. I incorporated the feedback, reviewed the transcripts, and again pulled out excerpts to align with the developing analysis. Thus, raw data was prepared for axial coding.

Axial coding

Axial coding is defined as cross cutting or relating the concepts to each other (Corbin & Strauss, 1998). Similar concepts are grouped to form categories. Once the categories were identified, axial codes were clarified. The process of relating categories to axial codes was to conceptualise where each sat, then go back to the data using a line by line approach to describe how each related to one another. Codes were refined by comparing episode against episode for similarities and differences. This in turn added to the general properties and dimensions of that code. The key question that focused the process was, 'are these concepts and links related to the raw data?' Paying attention to each participant's use of language was important, as categories were developed and axial codes identified. This required careful scrutiny of the actual words the participants used, to see if these words, *in-vivo codes,* could be developed as concepts (Corbin & Strauss, 2008).

Table 3: Process of axial coding - the story unfolds

Axial codes	1st process	2nd process	3rd process
Phenomenon	Knowledge expectations	Knowledge limitations	Knowledge limitations
Causal conditions	Generalist specialist nurses	Generalist specialist nurses	Generalist nursing practice
Context conditions	Boundaries of time, funding, primary /secondary care	Interchangeable boundaries of time, funding and relationships	Shifting values and attitudes – lead to emotional responses – fear, surprise, compassion
Intervening conditions	Knowledge and experience	Emotional responses of fear, surprise, compassion	Interchangeable boundaries; time, funding, medical governance dominance
Action/strategy	Manage by engaging/ encountering/ manoeuvring by making a value judgment / or positioning themselves	Referring	Referring
Consequences	Variations of avoidance – denial-engagement-responding – referring	Information seeking	Information

The axial coding supported my process of systematically developing links between the subcategories, categories, and concepts. I was able to look for relationships amongst concepts, move concepts around, re-label them, and integrate them, according to the developing theory. More importantly, it enabled me to stay true to the data and the participants' description of what was happening in practice. Memos recorded the process of axial coding and refining the theoretical development. Constant comparative analysis continued throughout. Subtle differences were noted with some concepts changing, i.e. the phenomenon of knowledge expectations did not capture accurate meaning. Rather PNs spoke at great length of the limited knowledge they had about mental health problems, despite undergraduate education in the area, and professional and personal experiences.

When the differences in the data were uncertain, i.e. charging or not charging for a mental health consultation, where did this fit? Was the behaviour an emotional response, or was it context specific? Theoretical sampling was used to test my interpretations with the

participants. For example: “I noticed that some of the other PNs had difficulty charging for a consultation if the person was distressed or upset. Is this what happens for you?”, “What can you tell me about it?” The responses from the PNs validated the interpretation by sometimes adding new dimensions to the data. Other times, extra data increased the depth of interpretation, as demonstrated in Table 2. Print outs of my questions with the coding of enquiry were very helpful when constantly comparing and theoretically sampling. The fundamental questions were what, how, when, and why did this occur.

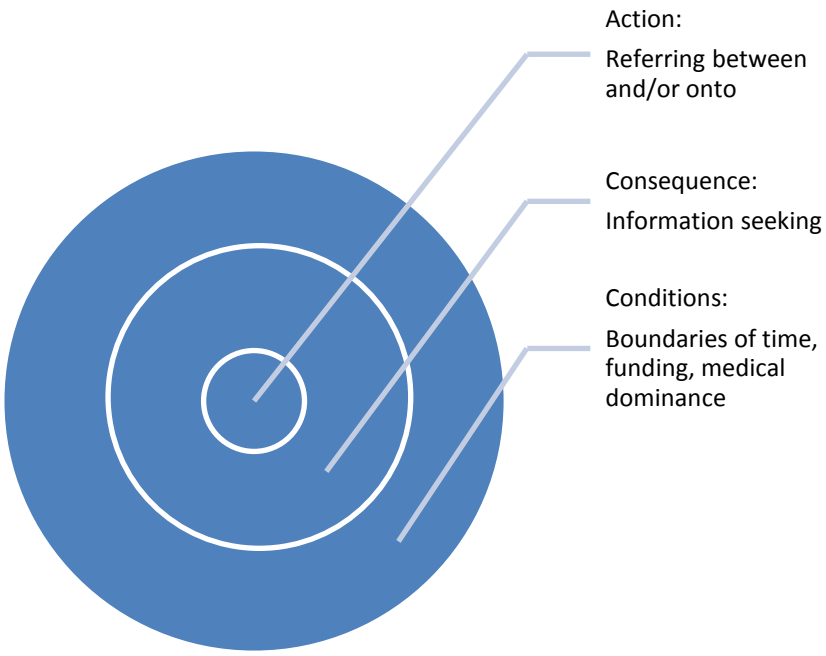
Once theoretical concepts were well developed and I was able to explain ‘what was going on,’ a tentative conceptual framework of the referral process was prepared. By the end of fourteen interviews the central category of ‘referring’ was identified. It was present but needed more development to ensure theoretical saturation. At this stage I had an opportunity to present the developing theory at a Masters/Doctoral Research Presentation Day in July 2013. Feedback from this session was useful and provided an opportunity to reflect on theoretical development. In addition, literature was used during analysis to extend knowledge and sensitise me as the researcher. It also helped me to identify relevant concepts to compare with, and extended my thinking about key concepts. For example, literature was used to explore the precise meaning of the term ‘knowledge’ in nursing, to help make comparisons and distinctions between it, and the more common term, information seeking. Literature such as Carper’s (1978) “Ways of knowing” that combines personal, professional, ethical experience, and formal education, stimulated my thinking about the forms of knowledge that may have been acquired by PNs. Similarly, Chinn and Kramer's (2004) work, which expanded on Carper’s model, helped me to identify the differences and similarities in concepts.

Theoretical saturation

Data from interviews fourteen to sixteen yielded no new concepts, suggesting data saturation had occurred. Interviews were used primarily for clarification and differentiation. Data from interviews ten through to twelve focused on refining the theoretical categories and relationships as demonstrated in Table 2 (p. 74). At interview fourteen the data collected was compared to raw data, coded data, and abstracted concepts from all previous interviews; no new information, concepts, properties, dimensions, or relationships, were identified. This was extensively time consuming, however it established that theoretical saturation was supported.

According to Strauss and Corbin (1998), researchers should locate phenomenon within the full range of macro and micro conditions in which it is embedded, and trace the relationships of subsequent interactions through to their consequences. Therefore, a conditional/consequential matrix was devised to explore the interrelationships between themes. This is seen in Figure 4.

Figure 4: Conditional/consequential matrix



During interviews fifteen and sixteen, the questions focused on relationships among concepts. The questions included: "How do you access information to support you when managing mental health presentations?", "Tell me about your experiences working with mental health presentations?", "How did you respond?", and "How do you decide to refer on?" The data collected was used to review, substantiate, and validate the theoretical components.

Selective coding

Refinement and validation of the proposed theory continued beyond the final interview. Supervisor feedback provided opportunities to review, compare, and look for gaps or inconsistencies. As demonstrated by Table 4, the focus of axial coding was to create a model that detailed the specific conditions that gave rise to a phenomenon's occurrence.

Selection of the core category was based on an adaptation of the six criteria outlined by Strauss and Corbin, (1998).

Table 4: Criteria for choosing a central category.

Theory of referring	
1. Is it central?	Yes it covers all categories.
2. Appears frequently in data	Referring reoccurred in all the interviews.
3. Logical and no forcing of the data	Flows logically all the way through the story line.
4. Abstract enough to be a more general theory	Other health care professionals in general nursing, and a range of clinical settings related to this theory.
5. Depth and explanatory power	As the concepts were moved around, the categories integrated and a good fit occurred. This made it easier to hear and tell the story of referring. It made sense to PNs and others when asked about it.
6. Variation explained	Referring happened in context of varying conditions such as relationships, funding models, and expertise. It was not unidirectional but referring could be: between, onto, back too.

Once I had established the core category, it was timely to review all the central explanatory categories as set out in axial coding. However, there remained one key inconsistency, that being the consequence of information seeking. This label just did not seem to fit with what the PNs were saying. I did one final detailed review of all the interviews, and discussed the concern with my supervisor and colleagues. The informal discussions and interview not only helped facilitate the integration of the categories of interrelated concepts into an explanatory process, but clarified what the consequence of referring was, as described by PNs. A memo reflects my relabeling of the central explanatory category of consequence:

> "A discussion with a colleague revealed that in health we all refer because we want to hand over the responsibility to the right service. That was it! I went back to the data and looked at all the interviews.

> Yes, PNs spoke of referring but they also added that it could be a good thing or a bad thing. The difference between good and bad was the strength of relationship they had with the service or person they referred too. Why? Because when referring you are handing over responsibility. If the service or person you are handing over this responsibility to is trustworthy (i.e. primary liaison nurse or GP whom you know), you feel the patient is going to the right service or person. As such it is a relief, hence good. But, if you hand over to a service that is overburdened (i.e. crisis teams), or a person whom you don't know (i.e. psychologist services off site), there is a worry that they may-not be able to deliver the care required. PNs are concerned for the patient – that makes it bad. Therefore, when referring, *handing over* is the consequence and may have both good and bad outcomes" (C.Schneebeli, personal communication, 20th September, 2013).

Validation of study findings

Once the central theoretical scheme was established, the theory was refined by reviewing the scheme for internal consistencies. I looked for any gaps in logic or poorly defined categories. When the study was considered complete, two of the earlier participants were asked to review the findings as presented in the axial coding. One participant agreed to have another interview. I listened to her comments and input, checking responses against the data and axial coding. The final version of the theory is demonstrated in Figure 5.

Figure 5: Simplified version of the theory of referring (2013)

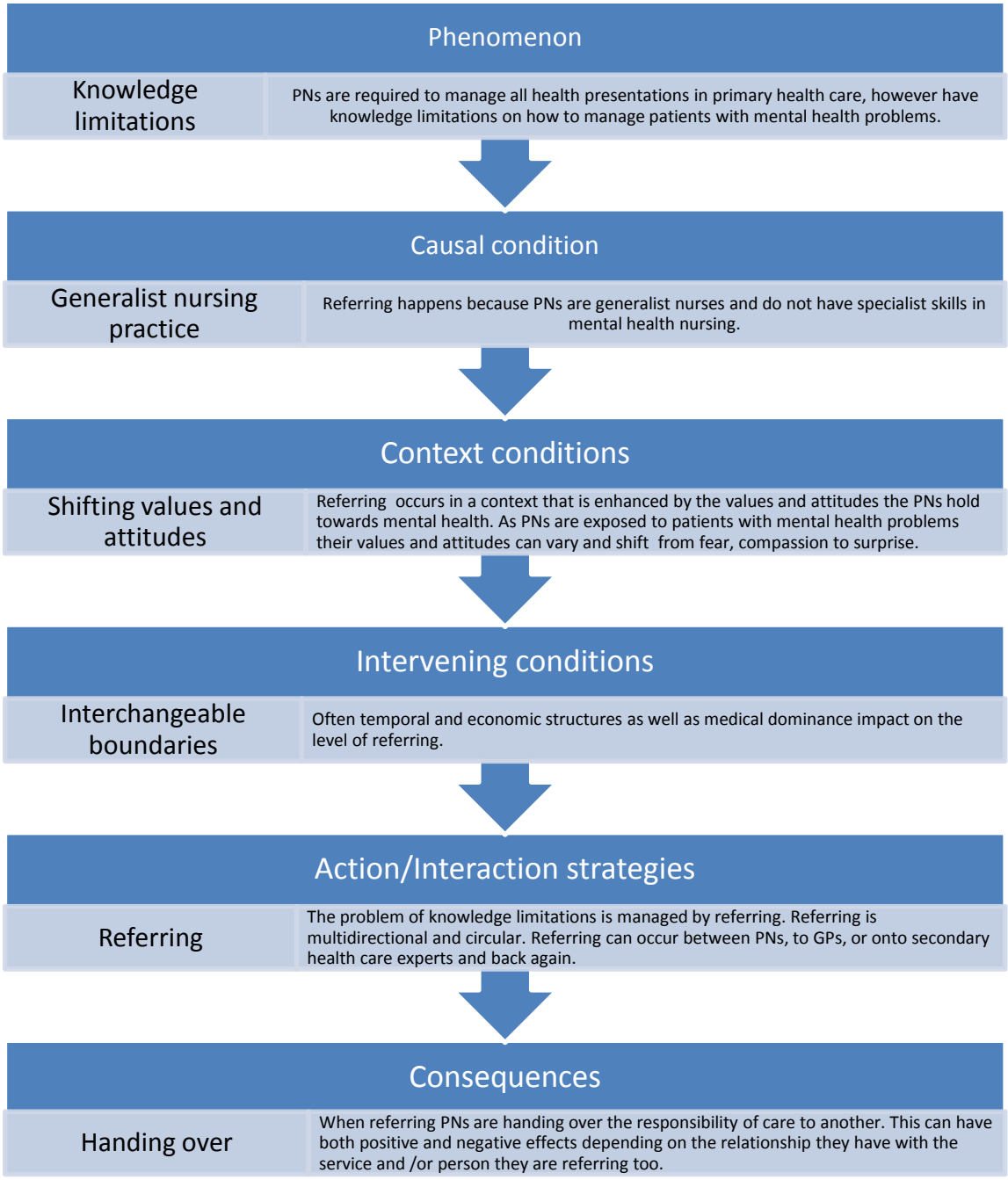


Figure 5 represents the substantive theory of referring that was developed through a robust analytical process outlined in the sections above.

Establishing rigour

One of the major considerations in any piece of research is the rigour and integrity of the research process. Grounded theory is sometimes criticised for a lack of rigour (Ryan,

Coughlan &Cronin, 2007). Criteria suggested for enhancing and demonstrating the rigour of a Straussian grounded theory study include: cross-checking emerging concepts against participants' meanings, asking experts if the theory 'fit' their experiences, and recording detailed memos outlining all analytical and sampling decisions (Cooney, 2011). However, rigour is also built into the grounded theory method through the inductive-deductive cycle of theory generation. Cooney (2011) suggests that care in applying the grounded theory methodology correctly is the single most important factor in ensuring rigour.

As a novice researcher the use of Lincoln and Gubas' (1995) criteria of credibility, transferability, dependability and confirmability are well suited to demonstrating how rigour is managed. I will also discuss the challenges I encountered during the research process, as I learned how to use a new research method.

Credibility

Lincoln and Guba (1985) suggest that credibility relates to how well the researcher's representation of the data fits with the participants' views. Strategies to build credibility include: checking the accuracy of the transcripts; prolonged engagement; and member checks. I checked the accuracy of the transcripts against the tape recorded interview, comparing the transcribed information to make sure the data were recorded verbatim. I asked PNs for feedback on the emerging theory, as the interviews progressed. This helped me to explore if the findings represented their experience in an accurate and complete manner. This is demonstrated in the interview questions (Appendix 6.). The interview questions were a guide and reflected the more targeted questions, as interviewing progressed. My decisions on naming categories were also reviewed in reference to theoretical sampling. Categories had to have achieved adequate saturation to be considered as theoretical. Monthly sessions with my supervisor assisted me to identify codes and

categories in the data. Similarly, the use of role play supported my preparation towards targeting key questions for the future interviews.

Dependability

According to Lincoln and Guba (1985), dependability and credibility cannot exist without the other. Dependability is achieved when research decisions can be traced back to the data. The decisions should be documented to be logical and reliable. The main source of documentation was memoing. Memos were a point of reference to trace thinking and make decisions about the direction of upcoming interviews.

Transferability

Transferability refers to the extent to which the researcher's working hypothesis can be applied to another context (Licoln & Guba, 1985). Transferability refers to the potential usefulness of the findings in explaining the underlying process identified in the substantive theory. Findings need to have application for a similar group of individuals. Theoretical sampling is needed to obtain a diverse and full understanding of the process and increase the likelihood for transferability. Theoretical sampling was fully engaged with from PN four onto PN seventeen. Constant comparisons across the data also ensured that the results were theoretically sound, and may be transferable. The use of the 'flipflop' technique to compare difference and similarities between PNs who had no ongoing formal training in mental health nursing to a PN who had, was useful in understanding the axial explanatory categories of conditions. These conditions are similar in other areas of health.

Confirmability

Lincoln and Guba (1985) suggest that *confirmability* establishes that the data and the interpretations from the data are actually derived from the data and not biased views of the

researcher. Methods used in this study to support confirmability were theoretical memos, reflective memos, and regular supervision sessions.

Challenges

Grounded theory has been critiqued for its use of theoretical sampling in that it does not meet the requirements of statistical generalisability. However, as suggested by Strauss and Corbin (1998), grounded theory is more concerned with analytic generalisability not statistical generalisabilty. Therefore, saturation is found in the patterns that are identified from the data. It is not measured according to the number of subjects that participate in a study. In this study, I purposefully sampled sixteen participants, whereas I originally proposed the number would be ten to fifteen. Therefore, the sample was well outside of the expected number for a masters grounded theory study. However, larger numbers of participants were not required for statistical purposes but to be able to gather meaningful data on a topic that was challenging to discuss. I found that many PNs did not have an interest or a keen knowledge on mental health. The data in the initial interviews was slow in coming forth. As a result of limited data emerging, study of this topic needed more numbers than had been anticipated. As a result, a substantive theory of *referring* emerged, and can therefore be tested in other groups of nurses by asking questions that would either confirm or disconfirm this interpretation.

Glaser and Strauss (1967) maintain that in a grounded theory study, the substantive theory and its application should be judged according to its fit. Fit, in this study was achieved through constant comparison of emerging concepts. This did take some practice, for at the beginning my enthusiasm and biases in the field lead me to misinterpret, and at times force concepts into categories. Yet, practice in the constant comparative technique,

combined with an increasing numbers of interviews, role play, and supervisory feedback, enhanced my confidence and skills. Gradually, I learned to constantly compare the data to establish whether it accurately described the phenomenon at hand. The use of a storyline approach also helped to verify the central category and integration of the concepts. When a concept did not fit with a category it was not forced, but rather I went back to the PNs and their data as evidenced in the interview guideline (Appendix 6).

Chapter summary

In this chapter I have presented a comprehensive description of the research process, the procedures, and specific methodological techniques used to develop the grounded theory in this study. Each step of the method, as explained in Chapter Four was detailed here. This process of theorising is a long and complex activity. It required each theoretical concept to be examined, constantly compared, tested, verified, validated, until there were no more questions about the results. The process also required the concepts to be examined from multiple perspectives, not just that of the researcher. Therefore, scrutiny came from my supervisor and the PNs. Each had knowledge and experience in the various components of this research, from methodology, to knowledge and skills that were relevant to the phenomenon at hand. The complexity of the process also required representative examples of how the findings were constructed from raw data. The rigour of this study was described, and the challenges encountered were discussed. The chapter was written to demonstrate a logic of the method, capturing it as it happened in real time, as the research has been constructed as the data is collected. In the next chapter the research findings are presented.

Chapter Five

Research Findings

Introduction

The purpose of this study was to explore how practice nurses (PNs) manage patients with mental health problems. The goal of this study was to develop a substantive theory explaining this phenomenon. As stated in Chapter Four, the central explanatory category is *referring.* Simply stated, PNs experience knowledge limitations when faced with patients who have mental health problems. This leads to referring. Referring occurs, because practice nursing is influenced by conditions of generalist nursing practice, shifting values and attitudes, and interchangeable boundaries related to time, funding, and medical dominance. The consequence of referring is that PNs manage the situation, as best they can, by handing over the responsibility to others, who have specialist knowledge of mental health. Figure 6 presents a diagrammatic overview of the theory of referring.

Figure 6: Overview of theory of referring

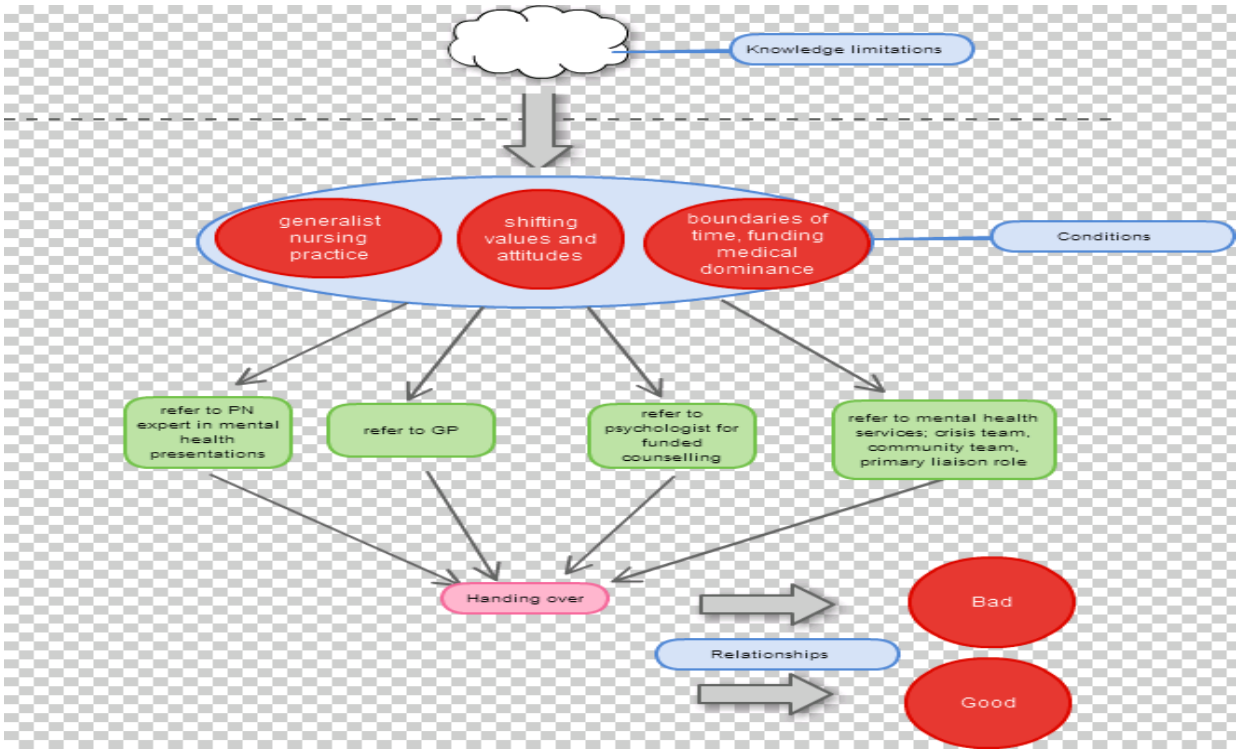


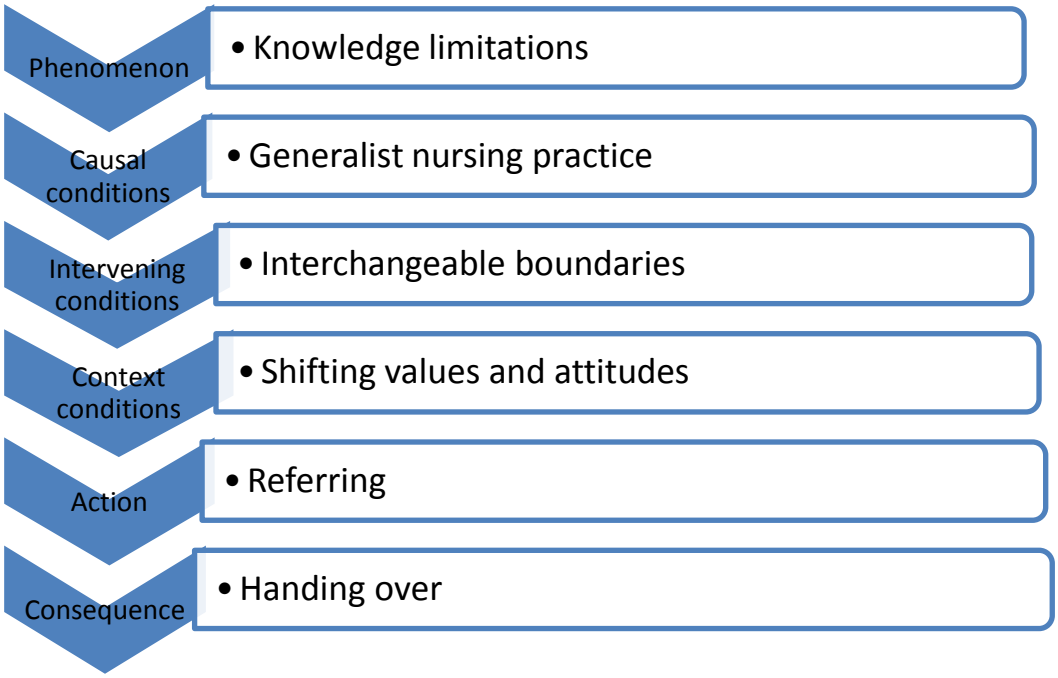
Figure 6, outlines the elements of the story that is the grounded theory. This is the key aspect in formulating the grounded theory. The 'story' assists readers to locate the most salient aspects of data and turns them into several general, descriptive sentences. The story is told at a conceptual level relating subsidiary categories to the central explanatory category (Brown, Stevens, Troiano, & Schneider, 2002; Corbin & Strauss, 2008).

Therefore, the description of the story in this study is: Practice nurses are required to manage all health presentations in primary health care. However, they have knowledge limitations on how to manage patients with mental health problems. Practice nurses manage this problem by referring. Referring happens for, as generalist nurses, they do not have the specialty skills of mental health nursing. Referring is a strategy that is varied, depending on

access to knowledge, information, and resources. Referring is influenced by the shifting values and attitudes PNs hold towards patients who have mental illness. Practice nurses have developed their values and attitudes through undergraduate education and life experiences. It is expressed in emotional responses of fear, compassion, and surprise. The level of referring is determined by pressures of limited funding and time, and pressure to conform to boundaries of medical dominance. This occurs on many levels including referring from one nurse to another, referring onto a GP, or onto mental health experts. As such, PNs hand over the responsibility of care to another professional. This can result in both positive and negative effects for the patient and PN, depending on the relationship the nurse has with the service or the mental health expert they refer to.

This chapter began by outlining the theory of *referring.* In the next section, I will detail the categories and sub-categories that constitute this dimension of the theory. I will explain the process of referring, which the PNs engage in, as they set about managing their knowledge limitations of mental health problems. I will describe the relationships between the central category and other categories generated that leads to the elaboration of the grounded theory of *referring*. The central category will be presented according to the flow of the story.

Figure 7. Central categories associated to the 'story' line.



Phenomenon: Knowledge limitations

The concept that holds the 'bits' together in this study is knowledge limitations. Knowledge limitations refers to the limited knowledge associated with formal education, and life experiences, both of which influence how PNs manage patients with mental health problems. Initially, all PNs identified undergraduate education as the main contributor to their mental health knowledge:

> I have minimal knowledge. The only knowledge I have of mental health is when I was doing undergraduate (Interview 2[3]).

Yet, as the interviews progressed they spoke of practical ways of knowing, that was sourced from personal and workplace experiences:

> I have gained [over my life], maybe have a little bit of knowledge of how to manage these people [patients with mental health problems] (Interview 6).

[3] Within this study interview quotes from transcripts have been, for simplicity, numerically labeled 1 - 17. The use of 'interviews' rather than 'participants', reflect the nature of grounded theory, where the data drives the theory development, not the individual participants.

The concept of knowledge extended beyond formal education, but moves along a continuum of practice knowledge, acquired over time. Yet, even with some practical knowledge, PNs continued to assert they had limited knowledge when managing this special group of patients in primary health care:

> I mean I do feel that I often recognise that somebody is depressed and there is a need for help. But, then again I think that [mental health] knowledge [of what to do] isn't there (Interview 10).

Practice nurses attributed mental health care, as a specialty area that needed more than practice knowledge:

> I feel that it's not a speciality area that I am particularly good at, and I feel that in my [undergraduate] training, I did do a block of mental health experience, but... yeah, sometimes it's a bit of a grey area (Interview 14).

Formal education

There were notable differences between the general and comprehensively trained nurses' undergraduate education in mental health:

> We have taken new graduates on for the last three years and they probably do a lot more mental health that we ever did as an older nurse (Interview 1).

However, mental health knowledge acquisition differences were more than just the amount of content acquired, but related to the context, or era in which the nurses were educated. General nurses trained in the era of institutional care, in large hospital settings. The knowledge and experiences the general nurses acquired in their undergraduate training, also contributed to their values and attitudes:

> I don't recall anyone who loved it. That [training in psychiatric hospitals] was not a good introduction to mental health for us and someone so young... half the staff seemed crazy as well (Interview 1).

This theme was evident with all the general trained nurses in this study. Knowledge acquisition was more than formal education; it also included the emotional responses associated with experiences acquired in their leaning:

> Now we are talking 60's here. I had to live in a huge mental institution for months, and... it was horrible. So little happened, it was baffling, and terrifying in some instances. We did insulin shock [treatment] and ECT constantly. I mean it was real 'cuckoo nest' stuff (Interview 3).

> [When I trained the] Mental health hospital was there. That's all gone now. I just came home and cried every night. I said, "I can't take it". I was just so sad to see these people [mental health patients]. Now I [just] couldn't cope with them. I thought I'm going to go mental with these people. That put me off mental health nursing all together. Because I was not equipped to deal with them, and I got sucked [in] every time I'd go near the... [psychiatric patient], and I did everything wrong (Interview 7).

In contrast, comprehensive nurses trained in the era of deinstitutionalisation, where people with mental health disorders or problems are reintegrated into the community:

> [Clinical experience in mental health was between] the hospital and the community, so it was quite intense. We learnt a lot about medications, a lot about schizo[phrenia]. Six months of intense streaming in mental health is one of the core papers. I quite liked it. I enjoyed it, in actual fact. When I finished nursing I thought that mental health was quite interesting (Interview 3).

> Tech [Technical institute of learning] - I worked in [a mental health hospital] in the [ward]. It was awesome. [I] loved it. I actually wanted to do mental health [nursing] (Interview 8).

When comparing the two different training backgrounds, comprehensive trained nurses had more positive experiences of mental health nursing than general trained nurses.

Even with more positive experiences noted by comprehensively trained nurses, the mental health knowledge acquired in undergraduate education was deemed difficult to transfer into the primary health care context:

> [When they come from the community] and they don't have a case worker [we don't know] what is their level of care is, because if they don't have case workers and they are fully independent and we don't understand. As far as we know, someone with mental health issue should present with a case worker (Interview 2).

As such, for both general trained nurses and comprehensively trained nurses the undergraduate training experiences of both institutional and community care did not easily transfer to the primary health care setting.

The other education forum was the continuing medical education (CME) programme. This forum offered PNs opportunities to learn about various specialty topics. Interestingly, all the PNs established that there were limited sessions specifically addressing mental health problems and their management in these forums:

> I mean we get heaps of stuff for wound management and diabetes. But to have simple things like how to recognise post natal depression [that is not offered] (Interview 12).

> Well the CME that we used to go to didn't do a lot of mental health care (Interview 13).

Though, there were some who had taken up the opportunities to gain further post graduate education in mental health care:

> So I did another bachelors in psychology [degree] (Interview 2).

> I'm O and G trained and then this year [I attended training on mental health]... to gain mental health [experience] (Interview 9).

This education resulted in the PHO and associated general practices supporting the participants to be the experts or specialists in the care of patients with mental health problems. However, of the 16 participants only two had looked to gain further formal education towards mental health. Most of the PNs looked to gain further formal education in medical conditions i.e. diabetes, woman's health, asthma and respiratory disorders.

Life experiences

Practical knowledge, as earlier discussed, was also sourced from personal and professional experiences. When asked about personal or professional experiences as

contributing to the way they manage patients with mental health problems, PNs described this as life experiences:

> ... dealing with triage and stuff like that. I think that [management of mental health problems]... we use life experience (Interview 1).

With limited knowledge on specialty mental health care, many PNs relied on life experiences as guidance when managing patients with mental health problems:

I mean experience will teach you... you can put towards mental health care (Interview 7).

Life experiences also incorporated role modelling as a way of acquiring mental health knowledge and skills:

> But um when this young man came with the OT [occupational therapist key worker]... it was good because I could also learn [what to do] from what she was asking him (Interview 8).

However, it was evident in later the interviews that challenges arose, where PNs were not able to easily transfer their undergraduate mental health training, into the primary health care context:

> Well if you look at the average practice nurse, age wise, 45-65 right... hospital trained... So, some of us are also comprehensive trained... So, we had some sort of level of mental health training, but I don't remember anything that I think is now useful in my role here [in primary health care] (Interview 16).

With little mental health education offered in PHOs or general practices, many PNs when exposed to patients with mental health issues would manage mental health problems through trial and error learning experiences rather than any formal education:

> I think that I learned from being [exposed to patients with mental health problems] (Interview 2).

In summary, PNs are generalist nurses. This means that they are expected to have a broad knowledge, to be able to manage any health problem/s, and/ or conditions presenting in primary health care. However, mental health presentations were unanimously considered as a specialist area by PNs, hence the knowledge limitations. Practice nurses responded by

drawing on practical ways of knowing from their undergraduate education, ongoing education, and life experiences. Each aspect was interrelated and overlapping. Nevertheless, the knowledge acquired in undergraduate education was deemed difficult to transfer into the primary health care context. As a result, PNs undergraduate and life experiences continued to shape their attitudes and skills, to deal the best they could with these patients. The context of primary health care and emotional responses towards mental health nursing are integrated in the concept of knowledge limitations. These areas are addressed later in this chapter, for they influence the level of referring. The next section addresses the causal condition of generalist nursing practice, which has influenced and driven the level of knowledge, interest, and skills that PNs have in mental health care.

Causal condition: Generalist nursing practice

The concept generalist nursing practice refers to PNs, who are generalist nurses required to respond to a broad range of health issues they encounter in primary health care. The role of the PN is defined by the Expert Advisory Group on Primary Health Care Nursing (2003), outlining that they are the first point of contact for care and disease management over the life span. They work in collaboration with other PNs and general practitioners, attending to a wide range of health issues, and managing acute and chronic health problems. All the PNs discussed their generalist nursing practice responsibilities of triage and acute care management:

> My role as a PN is [to] basically look after everyone who comes in the door (Interview 2).

> ... you never know what's going to come in the door... we always have to be ready to deal with that too... (Interview 10).

The generalist role requires PNs to engage in diverse activities, which they called specialist interest. The specialist interest practice undertaken included: nurse-led clinics for disease state management such as diabetes, health care screening, antenatal care, contraception, and advice on child care and lifestyle.

Specialty interest

Practice nurses as generalist nurses engage in on-going skill development. This tends to involve a professional certificate, rather than a specialist qualification or education related to a field of specialty, such as paediatrics or mental health. The term specialty interest referred to an area of knowledge and skills that PNs developed:

> I'm a smear taker. [I] just got my certificate and [I have become] a vaccinator (Interview 4).

> My specialty area is women's health... I am a smear taker and I refer patients for breast screening... we do the family planning... we explain to [patients] what this is for... and [that] they have choices (Interview 5).

> I'm a PN and a diabetes nurse, so I look after our diabetes enrolled population [of] about 700 (Interview 6).

> I went and did a paper [course] ... on diabetes, which I found wonderful, as it required all the nurses to start doing diabetes patients because of the numbers…(Interview 8).

It was noticeable that nearly all the interest areas of specialty practice were related to capitation funding associated with targeted health presentations, or prevention strategies such as diabetes, immunisation, and woman's health. This could suggest that the interest in specialty areas was largely influenced by revenue associated with presentations that the practice supported, driven by national health targets:

> ... more recently I have taken on more of a role with diabetic patients... the population is exploding and we need to have more interest in people who have diabetes… (Interview 10).

Despite nurses' interest in well recognised funded specialties, some nurses developed specialty practice in mental health nursing:

> ... one of my special interests... is mental health. I have others, but I look at the recalls, and one of the really important things that I do is phone people. That brief phone intervention... Sometimes it is the only human voice that they hear. To have someone who cares, even if it is a 2-3 minute phone call seems so incredibly valuable... I do have an interest, and a passion for helping people [patients with mental health problems] (Interview 16).

Yet, with minimal specific mental health funding, very few PNs undertook mental health as a specialty interest. Those that followed mental health care had to prioritise other generalist practice demands, over the specialty area of mental health care:

> Recently our phoning [follow up phone calls to patients with mental health problems] has gone by the board…it is hard sometimes in general practice. It's always juggling [practice demands of walk-in or appointments with specialty interest of mental health care follow up] (Interview 16).

In the context of knowledge limitations, PNs would initially attempt to manage the patient with a mental health presentation by seeking advice. Often, advice, information, and support, was accessed from wide-ranging sources. Some sought consultation and support from secondary health experts, or services, or from friends, with mixed responses:

> We have to send a lot of requests to hospital to send us information about that part of their [mental] health (Interview 2).

> We can't have shared notes…(Interview 14).

> I have rung them [community mental health service] before, and they weren't very helpful when I needed them (Interview 10).

> I've got a very nice mental health nurse friend. If I'm in trouble I ring her. 'What should I do? How do I go about [it]. What do you think I should do? Am I on the right track?' and if she says yes I'm on the right track, then I keep going forward myself (Interview 7).

> The nurses get overwhelmed at times [with patients with mental health problems]. So, that's why they are always happy to see me [expert in mental health presentation management], because they think that I'm not going to add to their load, but I'm going to take it away, and I'm always supportive (Interview 9).

However, seeking advice was often not a sufficient strategy, for PNs to manage patients' on-going mental health problems. Invariably, most PNs would refer on.

In summary, PNs are generalist nurses, who respond to a range of health concerns and presentations, including patients with mental health problems. They need a broad level of knowledge, skill, and experience to do this effectively. Practice nurses continue to develop their knowledge and skills in general nursing, but also develop specialty interest in practice areas, mostly aligned to capitation funding. When questioned about their ability to respond to patients with mental health problems, PNs as generalists, spoke of knowledge limitations. When faced with this particular group of patients, responses varied between seeking advice and support, that was all too often negated by contextual influences on practice. The next section addresses the context which influenced the problem of knowledge limitations and the strategies PNs used to manage this.

Context: Shifting values and attitudes

The concept of shifting values and attitudes is the set of conditions under which referring takes place in. Values are defined as beliefs of a person or social group in which they have an emotional investment (either for or against something) (Pluperfect, 2009). Attitudes involve the position of feeling or affection, thinking, or acting that shows one's belief and/or opinion (Altmann, 2008). Practice nurses have developed values and attitudes about mental health care, in the context of their undergraduate and life experiences. When

patients presented with mental health problems, PNs expressed their values and attitudes through emotional responses of fear, compassion, and surprise.

Values

The PNs spoke openly of the values and the associated attitudes they held about people who have mental health problems. Most PNs based their values on their experiences of working with people with mental illness, who were defined as strangers, or different:

> Yeah, [we get] some strange ones yeah... yeah, they come up with some bizarre things and you sort of wonder what the underlying problem is (Interview 8).

However, some based their values on personal experiences, of witnessing resilience:

> [I have] friends and family members who have had mental health issues. I have seen them come through. I have seen them come through as strong people (Interview 16).

In most cases there was the integration of both professional and personal experiences, which contributed to the shifting values system that PNs held. The general values PNs held were expressed in emotional responses. Each of the emotional responses of fear, compassion, and surprise are outlined below.

Emotional response of fear

Fear of harm and violence, be it verbal abuse, inappropriate behaviour, or physical assault, was a predominant belief held. The assumption that patients with known mental health problems are dangerous resulted in the amplification of the usual safety protocols associated with practice expectations, such as going on home visits, or waiting room responses:

> One of the nursing staff would go round to the home. Probably for safety we would take one of our GPs with us if they are available (Interview 1).

> We are careful about not letting them [patients with mental health problems] wait. We are ready to give, so that they can go away (Interview 5).

One general practice set up protocols requiring all patients with a known mental health disorder to be seen with their key worker:

> Every time I see someone who has mental health problems, I make sure that they come in with their case worker... not just for me but for everyone. I make sure they [PNs] are safe (Interview 2).

Some practices encouraged combined home visits to cope with the fear for safety:

> So, I'm very scared to go there on my own. I arrange for a combined visit with the support worker. [It] is really hard, to get the time that suits us all (Interview 6).

Fear was not only accounted for in terms of personal safety, but was also aligned to professional safety. Many PNs expressed concerns about their limited knowledge of mental health care management. This was an issue, as it posed a risk around professional accountability as a registered nurse:

> I think I am more scared, because I don't know how to look or care for someone that has already been labelled with a mental health problem. You know, I am more comfortable with this one [referring to patient with general health issue and no mental health problems] who is able to mentally fend for them self (Interview 2).

However, some of the professional fear was accounted for in the perception that patients with mental health problems may not be competent to care for themselves. For when PNs implement care they hand on responsibility to the patient to follow the prescribed regime or treatment advice. Therefore, fear also stemmed from concerns about professional accountability. Part of the problem was that, if the implemented treatment outcomes do not go well, the patient self harms, or harms others, then PNs, as health professionals, risk being held accountable:

> If I make a bad call…I'm the last person that they would have spoken too. As a medical professional, I always think that I need to fully document [what goes on] (Interview 10).

Similarly, tensions are held around fear of physical safety and professional accountability. For PNs need to professionally respond to patients with mental health problems even when they do not have the knowledge, skills, or resources to do so.

Emotional response of surprise

A belief expressed by PNs was that of 'non recovery' of patients who had recognised mental health problems. The discourse of mental illness as a disease state was frequently reflected in comments, that mental health was a lifelong enduring illness, which was incurable. Practice Nurses spoke of this belief:

> You know by the time you get into serious mental health., I would say your chances of recovery are nil (Interview 3).

Yet, many PNs had experienced a challenge to their beliefs about non recovery of patients with mental health problems. This was expressed as surprise:

> "Do you work?!" There was this patient who just talked about his work... He loves talking about his work and he said to me, "oh I couldn't make it on time... I had to catch two buses from [the city] to here". I said, "what are you doing in [the city]? He said, I have to go there, I have to go to my job... (Interview 2).

> Patients come once a fortnight... some of them, I see the changes from the [antipsychotic medication] drugs and how effective [they are]. One of my patients, is already working, and that really impacts on their life. They come [up] to the normal standard of [being] just like you and me. That makes me proud, to be part of their care, even though I'm not a mental health nurse (Interview 5).

The emotional response of 'surprise' signalled the reconciliation of earlier beliefs and attitudes that mental illness was an ongoing disease state where recovery was rare. New beliefs were emerging, under new models of care that were based on community integration and inclusion. Changing attitudes resulted from an increased exposure of patients with mental illness in general practice.

Emotional responses of compassion

Frequently, there was compassion expressed towards patients with mental health problems, even though PNs were not confident in how to manage these behaviours. Compassion was demonstrated in the empathy the PNs had towards the adverse challenges some of the patients encountered:

> I worry that they have support, that there is someone with them... [I let them] know that I am there. If they want to talk some more [I am there], and if they feel comfortable (Interview 4).

There were instances where some PNs demonstrated compassion by going beyond their role requirements:

> So he sits out there [past practice closing time] and I asked him, "Who are you waiting for?"... He said, "I'm waiting for the bus" [So we] took him home in our [her and a PN colleague] car. She [PN colleague] followed me so we dropped him off, and it was fine (Interview 8).

In another instance, a PN concerned for the physical health of a patient with mental health problems, spent many hours coordinating a search to ensure he had the care required:

> So I said, "how about calling the police, I'm pretty sure they know where he is". So I called the police. [This took many phone-calls and coordination with the secondary mental health community team]. And they brought the patient in… [She did this due to concern]... which was very fortunate (Interview 17).

In summary, decision making on how to manage patients with mental health problems occurred in a context that was influenced by both personal and professional values and beliefs. This was demonstrated in emotional responses of fear, surprise, empathy, and compassion, which varied with greater exposure to these patients. Practice nurse increased exposure to mental health presentations, associated to health policy and increased primary mental health care, had led to PNs engaging with their attitudes and beliefs, when determining the course of action in their practice. The next section addresses the consequences of the interplay of knowledge limitations, and values in the context of the

temporal, economic, and historical boundaries, which commonly influence practice in primary health care.

Intervening conditions: Interchangeable boundaries

Temporal, economic, and historical boundaries are conditions that 'bear down' on the phenomenon of knowledge limitations. They also impact on the values and emotional responses PNs experience, when managing patients with mental health problems. For frequently the boundaries of time limitations, funding structures, as well as pressures to conform to medical dominance, impact on the level and frequency of referring.

Time as a commodity

The concept of time as a commodity refers to time as a marketable resource in primary health care. The time allotted of 15-30 minute consultations is a business model adopted from the Independent Practice Association (IPA) of General Practitioners (Thorlby, Smith, Mays, Barnett, 2012). This business model places emphasis on minimum time allotments, to enable a greater number of consultations over a day, which in turn increases the practice revenue. The flexibility to respond to health issues caused an inherent tension that impacted on the pressure to complete consultations in a prescribed time:

> Time is the greatest issue and I'm so pressed with my time! (Interview 7)

> When someone books for half an hour, it will end up one hour, and then when 3 people end up having three hours, then that's really [challenging]... Then people tend to wait, and it's a long time (Interview 6).

> Yes its quite hard, for even if it's not a triage thing, the nurse or sometimes the doctor are with them, and they have this huge blow-up problem, or problems and we are just so busy. Sometimes, you've got the time, but not always (Interview 13).

Time management became further problematic when PNs had to manage patients with chronic conditions, or co-morbid issues:

> Because it's not just their mental health problem, it's often associated with so many other things, [like] diabetes and asthma, hypertension. So it's very difficult (Interview 6).

> People with depression, and anxiety problems, I think we really struggle with. Because they require so much time (Interview 10).

Time as a resource, is carefully monitored in the practice context where there is little room for flexibility. The impact on the practice should a patient's consultation not fit with the allotted time, has an on-going effect on colleagues and other patients in the waiting room:

> You don't know sometimes [what they need], what a patient is coming in for. [It's] not until they are in the room and you have a full waiting room, and other commitments. Then all of a sudden they begin to open up and pour out the issues, and this can take up a lot of our time (Interview 14).

Time management was an internalised feature for PNs. Many expressed feelings of guilt, and beliefs of non-productivity, when they did not adhere to the time limits. They spoke of concerns that they were letting the nursing team down by not being effective in their time management, as well as not doing their share of work:

> Sometimes, you just have to have the time. But it's not always easy, as it makes it hard on all the other staff and patients waiting (Interview 13).
>
> Also your colleagues often wonder what the heck you are doing in there [if they were over the allotted time] (Interview 14).

However, there were a few who were part of funding schemes, which accommodated flexibility of time. These nurses did not experience the same sort of pressure to adhere to time and were aware of the benefits of longer consultations:

> That was a hard thing back in the clinic [when time limitations were in effect] …What I am doing at the moment... [allows for] 45 minute [consultation time].Yeah! I am allowed too. I can actually book on my template how long I spend with my patients, which works out well. They are paying me to do this, however long it takes (Interview 4).

> I reckon I have got the best job in the clinic!...[longer consultations is less stressful] (Interview 8).

Time was associated with funding models, where particular presentations have allocated monetary value. Problems arose when PNs were faced with consultations such as patients with mental health problems, which did not align to any specific funding stream and did not fit into the allotted time of 15 – 30 minutes. Consequently, the pressure for time, lead PNs to becoming concerned when patients un-expectantly extended beyond the usual time slot. Time management was compromised when patients had complex conditions that requires extra time and repeated consultations, if interventions were to be successful:

> They just come in. There is no time - only 15 minutes. [Then they] come back [with the] same thing (Interview 6).

Additionally, subject conditions such as emotional distress did not fit with the objective time allotments. If patients presented as emotionally distressed, extra time was required, although this was not associated with any funding streams:

> I do feel that there is time pressure on us, because generally, if someone leaves here after half an hour of emotional outlet, then we feel we can't really charge for the time they spent with us because we may have only offered reassurance (Interview 14).

> If someone is distraught, we are not going to turn them away. I don't think so. For me it was hard to justify to charge this patient (Interview 15).

In summary, time as a commodity is problematic when patients present with mental health problems. These presentations are often complex have associated co-morbidities that required time, outside the allotted 15-30 minutes. Additionally, there is no specific funding stream associated with mental health, or the subjective condition of emotional distress. As a result, time pressures are felt in respect to the business model of the booking system. When the allotted times are breached, there is an associated impact on the others patients waiting to be seen. As such, revenue intake is important to the general practices, and thus time becomes a resource that must be monitored and managed.

Funding boundaries

Funding boundaries refer to the capitation funding based on enrolled populations, where funding is calculated according to, numbers, age, and gender of the enrolled population (Ministry of Health, 2013). Funding models in general practices have a significant influence on PNs work. Co-payments and funding schemes were actively sought after as a means of bringing in greater revenue. Key activities that supported revenue uptake included screening and assessments, such as cardio vascular and diabetes checks. As already noted, funding models were linked to time as a resource. To get the greatest amount of funding required an increased number of consults associated with specific funding models, which required time management:

> It is true that funding actually drives us, and the way, or how we practice. [An example is] CVD [cardio vascular disease], which is a high risk in New Zealand. There is a lot of funding in diabetes. That's what we focus on. Otherwise our bosses will actually say to us, "look you guys are not doing anything", which is true (Interview 17).

The Primary health care lifestyle options programme was the only government funded formula for mental health issues. Counselling in this programme was limited to 4-6 counselling sessions. To access these counselling sessions, PNs must refer the patient to a registered counsellor whom the PHO had contracted. PNs would also utilise other funding formulas such as care plus for chronic presentations. Also they would merge a mental health consultation with an associated funded consultation such as cardiac assessment:

> We have got Care Plus funding to spend more time with [patients with mental health problems]... to make sure they are managing their own health (Interview 10).

> You can with Care Plus... yeah that's another way of handling it [aligning a mental health consultation with a funding formula] (Interview 13).

The funded counselling session was most often utilised by PNs to manage mental health problems. However, this funding was limited. One PN talked about her frustrations when the quota had been used up in the practice. This resulted in a waiting phase for the next financial period to get more:

> So, once that funding has finished for that particular quarterly, or term or semester... then we basically have to wait till more funding comes through. Which is a pain (Interview 1).

The funding has been reduced in the same PHO to four sessions. As such, funding limitations affected the quality of patient care:

> But when it went down to four sessions... it just doesn't work for the sessions. It's not enough. It's just probably ok. But by four sessions they get to know the patient, they get to know you, and it's really only those last three sessions out of six, that you actually are able to help them (Interview 1).

Funding limitations associated with the counselling scheme, varied between PHOs, with some practices still offering six free counselling sessions:

> It's 3, with the additional option of 3. So at the minute here, I think it is still 6 (Interview 10).

Practice nurses were aware of the limited and varied funding associated with schemes. This required them to be creative when meeting the needs of the patients, all the while managing resources, practice demands, and revenue requirements. One common practice was to add a funded assessment into a mental health consultation. They would often 'piggyback' the consultation onto other funding streams:

> Sometimes my mental health aspect 'piggy backs' something else, like the alcohol assessment counseling, and then we go a little further with drinking, and it really has been covered by the $69 for the alcohol counseling (Interview 3).

> I'll throw in a quick CVD assessment, so that I can account for my time [dealing with a mental health problem]…(Interview 14).

Managing mental health care in the absence of specific funding was in many instances challenging resulting in creative ways of addressing patient needs. However, the other interchangeable boundary influencing funding concerned time. Time management was an implicit factor that imposed boundaries on possibilities for practice options. The other boundary associated with both time and funding limitations is that of historical employment structures.

Employment structures: Medical dominance boundaries

For many PNs the traditional work environment of GP employers/ leads is still evident. The development of PHOs had made little real difference to overall nursing practice and PN role expansion into other areas such as mental health, in this study. For

some the boundaries of the traditional nursing role in primary health care, where the nurse is responsive to the GP governance, remained:

> I feel that we work under the doctors, and the doctors have to be part and parcel of [decision making]... I mean it sounds like I don't want any autonomy... It's not that. But I believe that we are meant to be a team. I started as a PN, and it is the doctors who have that ultimate [say]…(Interview 11).

The traditional attitudes held by some PNs led to an acceptance of their traditional hierarchical employment structures. For many practice nurses in this study the reality is that they practice according to traditional roles that support GP dominance. Even when PNs were aware of the expanding practices and educational opportunities, many felt that the opportunities were largely dependent on the GP and their personal views much depended on workloads and the practice capacity to release PNs from delegated tasks:

> The practices you are working in are all little empires. Some PNs will be actively discouraged from further education, and developing a speciality depending on where you work, and the relationship you have [with your GPs] (Interview 12).

Despite this, PNs expanded the boundaries of nursing practice to include not just GP governance but other political boundaries reflected in the retention of aspects of the neoliberal approach in primary health care. The introduction of the PHOs as a vehicle to stand alongside the independent practices, owned by GPs, was heralded as an opportunity for greater access to the wider population that included mental health patients. The new PHOs were formed by provider groups that included GPs and sought to have higher levels of community governance. Yet, what has ensued is that many of the independent practices have merged with the PHOs taking with them some of the market driven philosophies of revenue making associated to the free market and GP clinical governance.

In summary, the historical boundaries of medical dominance associated with time and funding limitations, are factors that lead to decision making about how PNs manage patients with mental health problems. Most often the decision is to refer.

Strategy: Referring

The concept of referring relates to the strategy that PNs engage with when faced with patients that present with mental health problems. Referring becomes important to manage this group of patients, as the care they require does not fit with allotted times, funding expectations, and the nurses themselves do not have the specialty mental health knowledge on how to respond. A referral can be described as a process in which health workers at a one level of the health system, having insufficient resources (skills) to manage a clinical condition, seeks the assistance of a better or differently resourced service at the same or higher level to assist in, or take over the management of the patients case:

> That is one very positive thing that we do. With little knowledge of mental health, we know how to refer (Interview 5).

Referring is a strategy that encompassed many variants. Some would refer onto their PN peers, to the GP, funded counselling, and some would refer to secondary health services. However, the reasons for referring were varied and could not be pinned down to a single determinant. Often the process of referring sat in the context of conditions addressed above, of time and funding limitations, or with shifting values and attitudes associated with knowledge limitations. Referring as a process was not unidirectional, but rather multidirectional. Sometimes it was a circular process, moving between PN peers, to GP, onto the secondary health experts, and back again.

Referring between practice nurses

Practice nurses seemed to approach referring in a progressive manner. Mostly, this depended on the easiness of access to a resource. Hence, if a colleague had some mental health nursing skills, this would generally be the first option:

> They do their best [other PNs managing patients with mental health problems]... when I'm not there. But when I am, I get a bit of dumping [they refer to her as an expert in mental health presentations] like this morning... (Interview 3).

> It would definitely happen with my colleagues [referring to another PN expert in mental health presentations]. I've seen it quite often, they will go [calling her name to refer on to her] (Interview 12).

At other times, the PNs referred to the lead nurse. Most practices in this study had lead PNs, who were senior nurses that had oversight and coordination roles within the practice. Referral to lead nurses occurred, particularly if the PN was not confident, or scared of the patient. Lead nurses were generally the next line of authority:

> She [fellow PN] was scared and she dropped everything and came [to me], and I was the only senior person at the time. So I dealt with it... Because I was in the senior role, it was easier to manage (Interview 2).

> They call me [the lead practice nurse]. I see them [patients with mental health problems] (Interview 14).

Referring to the GP

It was also clear in the study that many of the PNs would look to the next most likely expert or lead person in the practice. This was the GP:

> I mean, I leave the bottom line decision up to the doctor (Interview 3).

> If I am not able to help, I will refer them to the doctor (Interview 4).

> If I believed someone needed a referral [the person I would go to would be] the doctor (Interview 11).

> I always go to the doctor to refer and get support... I don't feel that I am ever left floundering on my own (Interview 16).

For some PNs, the reasons for referral to GPs were related to their influence in the wider health services. It was implied that medical referrals had greater influence than nursing:

> I mean [nurses] can't refer to secondary health services as easily as a GP can (Interview 14).

Hence, instead of directly referring to secondary health experts that may decline, they started with GPs, even though the prime intention was to have the patient referred on to secondary health care services.

Referring to mental health experts

Referring patients to mental health experts generally included counselling services, and secondary mental health service such as the crisis team and the community mental health team. Referring to mental health experts was often associated with knowledge limitations. PNs referred because of their own emotional responses of fear or concern:

> Rather, I would give it to the person who is knowledgeable[referring to secondary health services] who is more into the area of telling the patient [what mental health care they need] (Interview 5).

Many of the PNs were aware of the funded counselling scheme and utilised this resource for patients:

> So it is a matter of referring her to a CBT counsellor (Interview 1).

> Sometimes, we refer patients for counselling... (Interview 2).

> We have a lady who is a counsellor who they can refer onto (Interview 12).

However, as earlier noted, when the funding allotted for the practice ran out, referral to this source was not an option for a period of time.

When there were emotional responses of fear or compassion many of the PNs would refer the patient to the secondary mental health service:

> We can ring CADS [drug and alcohol service] if we need too - for alcohol and drug [issues]. If we were really concerned (Interview 1*).*

Conversely, some of the PNs also spoke of their ability to refer directly to the mental health community team if they had a sound relationship with this group. In particular some practices referred patients to the primary liaison nurse. This role has been set up in secondary health care, to support greater interface between primary and secondary mental health care:

> It has and she is a good key person [primary liaison nurse] because you know she would always get back to you, and if she can't help you she would give you someone else who can - which is good (Interview 1).

> It is easy because you just send them [to the primary liaison nurse]. First discuss with them if they are alright and then just send the referral through (Interview 4).

> [These patients are] referred through to... mental health services next door to the DHB [we make] sure that if they have been a previous client [that the DHB] can open up that avenue, or not, and accept the client (Interview 14).

However, sometimes referring was redirected back to the PN:

> We have noticed is a lot of patients from secondary care are coming out to primary and a lot of the patients from secondary care are coming to primary health care for respiridol injections (Interview 2).

In summary, referring is recognised as an important part of continuity of care. For PNs, referring is a strategy that helped them to manage patients with mental health problems. This is important due to their little knowledge or skills in the area. Subsequently, PNs experienced fear, uncertainty and low confidence when dealing with patient with mental health problems. Interestingly, referring was multidirectional occurring back and forth, along a continuum of PNs, GPs, and secondary health experts. The process of referring tends to follow the lines of easy access to resources, accessing those with the most knowledge, or those who could best take on responsibility of the patients. The next section looks at the consequence of referring on, and the factors that influence this.

Consequences: Handing over

The consequence of referring is the handing over of responsibility of care to another expert or higher authority. Handing over can be defined as a process of transferring professional responsibility and accountability for some, if not all aspects of care, for a patient, to another person or professional group. This may be on a temporary or permanent basis (Johnson & Arora, 2009). Handing over can be a form of relief when PNs encounter the dilemma of how to best manage these patients:

> The crisis team are really good... if we were really concerned (Interview 1).

> It's easy [a relief to hand it over] because you just... send them... just send the referral through (Interview 4).

However, handing over for PNs has both positive and negative effects. Yet the ability to hand over was determined by the strength of the relationships the PNs had with the referral source. If the relationship was strong PNs were relieved when handing over. Practice nurses that had sound relationships with the mental health services or experts they handed over to, tended to be more positive about the experience. Positivity was encountered if there was an established trust that the mental health service or expert would meet the patient's mental health needs:

> We work hand in hand... talk it over with [the secondary health care team]. Some of the nurses there know they can help (Interview 4).

> I mean we are lucky as we do have next door [the community mental health service]… that access [helps us get support] (Interview 12).

> But... [the primary liaison nurse] is probably my first point of call, as she always gets back to me... so that's good. It works out well (Interview 1).

Certainly, if the relationship was sound, the level of trust increased and the multi-directional referring occurred. In those situations PNs were more ready to take on the care of patients with mental health problems, if they had strong relationships with secondary health care services or experts that would support them:

> I think we are very grateful [to have a good relationship with secondary mental health care] And that strengthens our fear of attending to patients with mental health problems. And to be honest. I think our mental health clients have increased (Interview 17).

Conversely, there were times when PNs did not have a sound relationship with the secondary health care service or person they were handing over too. This resulted in a sense of distrust, and an expressed lack of confidence in the quality of care the patient would receive:

> [If] PNs don't have that relationship with [secondary health services], or with a mental health group, it is quite hard, [be]cause they don't know where they stand. All they do is refer on, or get the GP to refer on, and pass on the buck (Interview 17).

> I have had a fair amount of experience with the mental health system here...They don't offer counselling and coaching, which would be convenient... I hate to despair about it, but there are just not enough doctors and nurses [in secondary mental health care]. And a lot of the mental health care is strictly keeping people safe and medicated (Interview 3).

> I rang this person at home because I was really worried about them, and she said the crisis team is coming here tomorrow... It didn't feel right for me. You know, you often feel that the crisis team is not funded, over worked, and not able to respond, as we would like (Interview 10).

> What I found was if I did the flat out referrals with certain [mental health patients] was they never showed up... (Interview 6).

Lack of confidence in the quality of care that mental health services could provide, was reflected by PNs in their concerns for the length of time it took for secondary services to follow up on a patient, and the risk of non-adherence or non-attendance of the patient to the referral source. This resulted in a flawed handing over process, for often the responsibility was still with the PNs or primary health care as the last health care service involved.

Similarly, inadequate handing over was evident for many PNs, when referring to the subsidised counseling sessions. Often, the context of counselling as an offsite resource was problematic for the patients, which resulted in non engagement and non adherence of the patients. Often the patients didn't always choose to be referred on to mental health counselling, due to the stigma associated to mental health. Additionally, inconvenience of travelling to another service due to time, petrol money, or a lack of willingness to change health providers was a barrier to counselling that PNs recognised:

> Sometimes, when we refer patients for counseling… you know a lot of mental health issues they have they prefer [to be at the practice with staff they know]... [once referred] after a couple of days they change their minds [they don't attend the counseling session]... (Interview 2).

> Well it was great for our patients, because they could come here [to see the health psychologist in residence]. And, no one would know where they were coming, because they could be going to the dentist... No one would actually know they were coming to see a psychologist. Now we have to refer off site. We have about five psychologists we can send them too... but our patients love or prefer to come here, than go to [other sites]... this is where they actually live [and can afford to get too] (Interview 1).

Referral to funded counselling, although acknowledged as a beneficial resource, was problematic due to the rates of non-adherence. This raised concerns for PNs, around the ineffective handing over of care. It meant some of their patients did not get the mental health care they required.

In summary, handing over professional responsibility had both positive and negative effects, negated by the strength of the relationship the PNs had with the referral source. If the professional relationship was strong, then there was a trust that the patient would get the mental health care required. If the relationship was poor, then the trust in the quality of the care and who was fully responsible for the care was problematic for PNs.

Chapter summary

This chapter opened with a brief explanation of the theory of *referring.* Next, the core categories and the sub-categories related to referring, were analysed. The explanatory concepts included: knowledge limitations, generalist nursing practice, shifting values and attitudes, and interchangeable boundaries. The consequences of referring, *handing over,* was also presented. The research results have established that *referring* links all the other

categories together. It is the key to managing the phenomenon of knowledge limitations. Referring will be analysed further in the next chapter

Chapter Six

Discussion

Introduction

This study began with an exploration of the practice nurse (PN) role when managing patients with mental health problems. It was established in the initial literature review (Chapters One and Two) that the PN role has evolved in response to health policy. This raised expectations that PNs would extend their role to include a greater level of mental health nursing care (King, 2001, 2002; Minister of Health, 2005, 2006). It was also shown that how PNs managed patients with mental health problems was poorly understood (Finlayson, Sheridan, & Cumming, 2009; Kent et al., 2005). Therefore, the aim of this study was to explain the processes PNs used when managing patients with mental health problems. The research question was: "What is your role in the management of patients who have mental health problems?" As has been shown in Chapter Five, it was clear that PNs had limited knowledge about how to assess and care for patients with mental health problems. They managed these phenomena using a process of referring. Referring enabled them to hand over the responsibility of care to mental health experts. Referring was a multidirectional, sometimes circular process, in that referring occurred between PN colleagues, GPs, and secondary health experts. The ease of handing over depended on the strength of relationship the PNs had with the referral source i.e. crisis teams, community mental health teams.

In this final chapter of the thesis the key points of the theory of referring are highlighted for the reader. This is an important stage of theorising, as it illustrates that theorising is an interpretive process, which involves constructing an explanatory scheme

from data to produce a systematic integration of concepts and their inter-relationships (Strauss & Corbin, 1998). Existing knowledge about various aspects of referring will be explored. An analysis of the micro conditions affecting referring follows. Then, the wider macro processes impacting referring are examined. Implications of the findings are discussed. Lastly, the strengths and limitations of the research are reviewed, and concluding points and recommendations considered.

Referring: Existing knowledge

Referral is most often used as a noun. Referral has been defined as the process of directing or redirecting a medical case or a patient to an appropriate specialist or agency that provides definitive treatment (Meridian-Webster, 2013). Within primary health care, referral tended to be seen as the link between primary and specialty care (Forrest, Majeed, Weiner, Carroll, & Bindman, 2002). However, the process of referring identified in this study, concerned the action PNs took, as they managed patients with mental health problems. Indeed, referring was a necessary part of their work, as it allowed them to hand over responsibility of care to a mental health expert or specialist mental health agency.

Knowledge about nursing referral dates back to the 1970s and goes through to the early 1990s. The topic of PNs and referral was not addressed at all during that period. Knowledge focused on secondary health nursing referral practices. It was apparent that nearly all the writing on the topic concentrated on nursing care outcomes and the cost of referral, rather than the action or process of referring (Comb, 1976; Mitchell, et al. 1993). There was some sense of focus on process. For example, a more recent study (Cullen, 2006) explored PN's involvement in 'gate keeping'. Cullen (2006) proposed that many PNs 'gate

keep' patients requesting same-day appointments. Gate-keeping was clearly aligned with the PN's ability to decline or defer appointments. There was no reference to the action of referring though. Broadening the knowledge search to include 'handing over' identified a more formal process that occurred in secondary health care practice. For example, the key findings in these handover studies were time management, standards of information conveyed, and the efficiency of the process (Kasinathan, Ang, & Lee, 2012; Matic, Davidson, & Salamonson, 2011; Stagger, Benham-Hutchins, Goncalves, & Langford-Heermann, 2013).

Most of the knowledge about referral focused on referral between primary health care physicians and secondary health care specialists. Akbari et al. (2008) systematically reviewed referral between primary and secondary health care services, and found that primary care physicians acted as 'gatekeepers', as they were responsible for identifying patients requiring secondary care. In that instance, referral supported organisational structures, moving care between generalists and specialists. Referral was also used to obtain advice on diagnosis or management of a patient; request a specialised procedure when investigation or therapeutic options were exhausted; and was useful for seeking a second opinion (Akbari et al. 2008).

Although referrals were used frequently, the process caused significant frustration among physicians (Akbari et al. 2008; Bodenheimer, 2008; Gandhi et al., 2000). Researchers have shown that there was considerable evidence that referral systems were sub – optimal and problematic. Indeed, knowledge about referral in primary and secondary health care emphasised ineffectiveness issues and the ongoing challenges for clinicians and patients. Bodenheimer (2008) suggested that the referral system was a prominent part of

patient care, and was a perilous journey when poorly achieved. Key issues with referral systems in primary and secondary health care included unexplained variations in referral rates, inappropriate referrals, and evidence of poor communication and hand over of responsibility of care (Chen, Fryer, & Norris 2005; Forrest, Nutting, et al. 2002; Mehrota, Forrest, & Lin, 2006; Starfield, Forrest, Nutting, & von Schrader, 2002).

Mehrotra, Forrest, and Lin (2011) examined the complexity of the referral process between specialist and primary health care. The authors divided the referral process into referral decision making, care coordination, and access to specialty care. They concluded that speciality referrals were limited in terms of referral rates, singular factor investigation, and coordination. Firstly, the variation in referral rates was problematic, because it did not differentiate between over-referral or under-referral. Nor did it account for referral decision making. Mehrotra et al. found, in accordance with other studies, that even when referral guidelines were in place, there was little evidence that the number of referrals reduced, or that the appropriateness of referrals improved (Akbari et al. 2008; Shaw, Smith, Middleton, & Woodward, 2005; Morrison et al., 2001). Secondly, Mehrotra et al. (2011) reported that most researchers examined only one aspect of the referral process. The focus on a single factor, single context, excluded the complexities of the referral process and limited knowledge development. As a result, the generalisation of findings was limited. Thirdly, care coordination between primary and secondary services encompassed more than just patient factors. Both primary and secondary care services operated separately. Integration was minimal, apart from the patient that acted as the go-between. In summary, research provided evidence that knowledge about the referral process was limited. Further research is required to explore the range of factors that influence the referral process (Akbari et al., 2008; Faulkner, 2003; Forrest et al., 2002).

Findings from the current study have moved knowledge development beyond the structural aspect of referral, towards explaining how *referring* is utilised as a strategy to manage knowledge limitations. The theory of *referring* addresses the complexity of issues contributing to knowledge limitations and identifies the broader contextual issues, which are interrelated and influence referring.

For example, it was evident in the theory of referring that PNs' management of patients with mental health problems was mitigated by more than the state of their knowledge. Conditions affecting referring possibly accounted for variations in referring. Conditions such as generalist nursing practice, shifting values and attitudes, time, funding models, and the historical context of care, were major factors influencing when to refer and who to. Existing knowledge included recognition of these factors, but if they were addressed separately, understanding was limited. The theory of referring, as illustrated in Chapter Five, has shown that there was a wider perspective, that conditions were interrelated, and influence referring. Additionally, the strategy of *referring* was closely intertwined with the consequence of referring, handing over. Indeed, Mehrotra et al. (2011) report on the frustrations associated with handing over to primary specialists. In contrast, it was clear in the theory of referring that handover success was largely due to the strength of relationship the PN had with the referral source.

The next section critically analyses the prevailing conditions that affected referring.

Micro conditions

The conditions in which the phenomenon of knowledge limitations occurred are the sets of events that create the issue, explaining why and how PNs respond to this problem. The micro social conditions focus on the individual nurses and their interactions (Strauss & Corbin, 1998).

Generalist nursing practice

The first micro condition to influence referring was generalist nursing practice. This was defined as the knowledge and skills practice nurses drew on to address patients presenting with a broad range of health issues. Despite this, managing patients with mental health problems was still problematic. The PNs recognised that their knowledge was limited when managing that particular group. As a result, PNs used a multifaceted base of knowledge that included evidence from science (research and evaluation), experience, and personally derived understanding (Moule & Goodman, 2009; Zander, 2007). This illustrated that the nursing knowledge underpinning generalist practice was complex, dynamic, and evolving (Hall, 2005). In some ways it was similar to Carper's (1978) four fundamental patterns of knowing that included; empirics, aesthetics, personal knowledge, and ethics. Carper (1978) observed that these patterns of knowing were necessary, interrelated, interdependent, and overlapped. Complex inter-relationships were indeed necessary to create the whole of knowing. Chinn and Kramer (1999) expanded on Carper's work, and concluded that knowing was "an ontologic, dynamic changing process" that could be communicated and accurately verified (Chinn & Kramer, p, 1 cited in Zander, 2007). Gunilla, Drew, Dahlberg, and Lutzen (2002) extended the analysis, proposing that implicit knowledge inclusive of intuition, was part of personal knowledge, and was developed

through experience. Knowledge was then role modelled and displayed in practice to other nurses, thus becoming a major form of knowledge acquisition.

These researchers have shown that knowledge is multifaceted and role modelling is significant. Similarly, in the theory of referring, it was evident that PNs used a range of knowledge sources. Nonetheless, when they had to manage patients with mental health problems, their undergraduate mental health knowledge did not transfer easily into the primary health care context. Practice nurses knowledge was inadequate, as they had not had access to role models in mental health nursing or worked much with visiting mental health experts. Contact with the experts was variable and inconsistent. Consequently, PNs resorted to managing patients with mental health problems predominantly using personal knowledge acquired from trial and error learning. Some reported to using intranet based information or resources in the practice. Personal knowledge was useful when managing an initial situation, but it was not a successful long-term management strategy. Therefore, PNs referred on.

Shifting values and attitudes

Another micro condition that influenced referring was shifting values and attitudes. Practice nurses spoke openly of their values and beliefs about people with mental health problems. Interestingly, shifting values and attitudes were conveyed as emotional responses. Responses seemed to have stemmed from undergraduate practice, professional practice, personal beliefs, and experiences. This is similar to a report from Chin and Balon (2006) who noted that GPs and PNs had attitudes towards people with mental health problems that were similar to those of the general public. Likewise, international and national researchers have shown that the general public is influenced by media portrayal of

mental health, believing people who have mental health issues are dangerous, out of control, and disruptive (Coverdale, Nairn & Claasen, 2002; Cutliffe, & Hannigan, 2001). Certainly, PNs talked about their fears and expectations that patients with mental health issues were likely troublesome (Thornicroft, 2007). Indeed, in some instances, practice protocols for safe consultations with patients with known mental health problems, endorsed this view. It seemed that the perceived fears associated with the instability of these patients were strong. Fear also affected professional responsibility, although fear in this instance was associated with a lack of knowledge about what to do. Ross and Goldner (2009) however, have presented a different view, arguing that fear may not be based on stereotypes, but stem from a nurse's realistic apprehension about managing challenging patients with minimal resources. This was endorsed by PNs that spoke of their concerns about not having the knowledge to say or do the right thing, when people were distressed or had an ongoing problem. Other researchers have concurred with this view, stating that nurses often lacked the skills to confidently or competently manage patients with mental health problems, due to a knowledge gap that perpetuates fear (Reed & Fitzgerald, 2005; Ross & Goldner, 2009). As discussed above, the causal condition of knowledge limitations interplayed with PN's fears on how to deal with these patients in general practice.

However, it was also clear in the theory of referring that values and attitudes were not stagnant entities. With time and greater exposure to patients with mental health problems, PNs' values and attitudes were challenged. This is in keeping with Overton and Medina's (2008) work, which proposed that direct contact may mitigate beliefs and attitudes thereby supporting acceptance. Alexander and Link (2003) found that even a minimal amount of contact with a marginalised group influenced beliefs, attitudes, and behaviours. This was seen in the theory of referring with discussions about surprise, whereby PNs reconciled

earlier notions of non-recovery with evidence of mental health recovery that was promoted through community integration. Nonetheless, the increased number of patients with mental health problems in primary health care also emphasised the challenges these patients had with their day to day living associated to a limited income. Practice nurses responded to this situation with compassion. According to Torjuul, Elstad, and Sørlie (2007), compassion involved being close to patients and seeing their situation as more than a medical scenario or routine procedure. It was evident in the theory of referring that PNs engaged in compassionate behaviours, which extended well beyond their usual role and the business model of service delivery. Demonstrations of compassion involved transporting a patient home, searching relentlessly for a patient with co-morbid mental health problems and diabetes, as well as offering support phone calls. Compassion ultimately impelled and empowered PNs to not only acknowledge that there was an issue, but also to produce an active response (Schantz, 2007). Such a response was consistent with Beckett, Gilbertson, and Greenwood's (2007) work. These authors have argued that therapeutic relationships leading to compassion are foundational to all nursing specialties. Thus all nurses, regardless of the patient's presentation, are expected to engage in compassionate, supportive relationships with their patients.

Interchangeable boundaries

Another intervening micro condition influencing referring was the changing boundaries that affected nursing practice. The interchangeable boundaries discussed in the research were time, funding, and medical constraints. In particular, the boundaries of practice were increasingly blurred when managing patients with mental health problems because of historical, political, and socio cultural issues affecting GP or PHO employers, capitation funding, and small fee for service, where time was a commodity. Boundaries of

practice have changed because primary health care reforms have driven a move from a neoliberal free market where users pay, to a co-funded fee for service based on population deciles model of health service delivery (Barnett & Barnett, 2004). This step in health reforms aimed to promote the 'third way'. This term refers to the meeting in the middle of the democratic stance and the neoliberal free market. This model of service delivery enhances equal community access to health services. This is different to the full neoliberal market, where individuals are responsible to access and fund their own health care, which is known to increase inequality of access (Cheyne, O'Brien, & Belgrave, 2005; Strathdel, 2005). The PHOs were set up to support this 'third way'. What followed was the formation of PHOs that merged with independent practices, taking with them strong market driven revenue making philosophies typical of the free market. As such, PNs were caught up in a political context where medical governance dominated, where nurses were directed by the GP. This meant that PNs were, and indeed are pressured to adhere to the more dominant neoliberal business model of care. Nursing practice therefore, was influenced by increased consultations, key targeted health checks associated with funding, and management of time as a commodity associated with funding streams. Thus, time and funding were barriers to providing mental health care, because patients usually had problems that exceeded the funded time allotments, which were not easily aligned with prescribed funding schemes. So, the PNs referred the patient elsewhere by handing over to the experts. Handing over emphasised the importance of relationships.

Handing over

Mahlmeister (2009) has argued that the need for effective and strong professional relationships is not simply to engender work satisfaction among staff, but also to foster

patient care. The development of trust between health professionals depends on role boundaries, and is linked with professional responsibility for controlling patient information, managing risk within systems, and ensuring professional accountability (Giddens, 1991). The process of referring emphasised professional accountability issues, and once again, drew attention to the fact that PN knowledge about managing patients with mental health problems was limited. Hence, handing over the responsibility of care to an expert health professional was a positive part of referring, as it was reassuring. Handing over was much easier when the health professionals involved trusted and respected each other and were willing to share responsibility for care. Once a strong relationship was established, handing back a patient to a PN's care was much easier, even though knowledge limitations had not changed at all. Practice nurses valued greatly their connections with mental health experts. The primary liaison and psychology connections were especially valuable. These health professionals helped PNs to access information and knowledge on what to do, and provided a sense of trust that, should there be challenges, they had someone to go to for support. In these instances knowledge about mental health nursing was less important than the back-up support from a trustworthy health professional.

In summary, the phenomenon of knowledge limitations and referring were clearly situated in micro conditions of generalist nursing practice, shifting values and attitudes, and interchangeable boundaries, all of which affected handing over. Micro conditions did not occur in isolation though. They were also influenced by macro conditions of health reforms, practice nursing as a profession, and mental health stigma. All the conditions overlapped and influenced knowledge limitations and referring.

Macro conditions

Health reforms

A significant macro condition that affected referring was the global movement to strengthen primary health care. This developed from a general concern that despite increasing medical knowledge, technology, and expertise, incidences of disease and ill health had not improved in the general population. In particular, the indigenous population's health was reported to be largely ignored, if not neglected (Dew & Kirkman, 2002; MacDonald, 2004). The Alma Ata Declaration (WHO, 1978) promoted a new direction for health recommending universal health care accessible for all. The Ottawa Charter (WHO, 1986) and the Jakarta Declaration (WHO, 1997) followed. These declarations stressed the need to address health inequalities by improving access to affordable health care and community development. The outcome of the forum signalled to the international community the need to reorient health care systems to focus on integrated first level services, known as primary care, which were to be supported by hospital systems (Stewart & Haswell, 2007).

The changes in New Zealand health policy reflected the principles of both the Alma Ata and Ottawa Charter, by supporting the World Health Organizations' reorientation of health services towards stronger primary health care (King, 2000). The *Primary Health Care Strategy* (PHCS) (King, 2001*)* set the direction for primary health care, including mental health care. *Te Tahuhu – improving mental health 2005- 2015: The second New Zealand mental health and addiction* plan (Minister of Health, 2005), supported the emphasis on primary health care as a place where individual mental health needs were to be addressed. As a result, mental health policy broadened, as it moved from people who were severely affected by mental illness and addictions, to include all New Zealanders. As

previously noted in Chapter Two, the reforms raised expectations that the primary health care workforce, predominantly nurses, would play an important part in the implementation of the health reforms.

Yet, regardless of the international and national commitment to redirect health policy and strategies in the community, many countries, including New Zealand, struggled to implement the changes. MacDonald (2004) argued that part of the problem was the medical dominance associated with individualist care and self-responsibility. Smith (2009) critically analysed primary health care implementation, and concurred. The problem was the medical service delivery model of continued co-payments for patients was complicated by partial contracting between the government and general practice. This has continued to be a barrier to the development of different models of service delivery in PHOs. Practice nurses however, had to manage these wider conditions even though patients with mental health problems did not fit into the fee for service co-payment models. As discussed in micro conditions, PNs tried to work creatively providing care, despite constraints of time and funding schemes. However, ultimately the need to conform to practice demands resulted in PNs referring on. This indicated that current service delivery models did not fairly meet the needs of patients with mental health problems. Thus this group had limited access to primary health care. This was and continues to be a significant issue. Access to consistent primary health care is a key part of improving health outcomes, particularly for those who are traditionally underserved, such as patients with mental health problems (McMurray, 2003). Therefore, it is reasonable that the role of the PN requires support and empowerment to extend beyond the traditional medical model of service delivery, to a model that is consistent with policy direction and also better meets the needs of the people they care for.

Nursing professionalism

Another significant macro condition affecting referring was the development of nursing professionalism. The Primary Health Care Strategy (2001) was the most significant policy change that has influenced the role of PNs (McKinlay, 2006). Following its release, the Ministry of Health contracted the Expert Advisory Group on Primary Health Care Nursing, seeking advice on future directions for PNs that were a significant part of the primary health care nursing workforce. Although the scope and the role of the PN had been identified, the advisory group did not explicitly promote or explain what was involved with generalist nursing practice. However, in 2005 the New Zealand Nursing Organisation (NZNO), one of the main professional bodies for nurses, defined the PN role as a generalist role that was situated in the primary health care setting. The NZNO supported the premise that teamwork was a key and unique part of the PN's role, as they work collaboratively with GPs. Other authors disagreed. Several researchers have argued that in many cases the doctor-nurse relationship was not collaborative, but retained a significant interdependent and sometimes dependent relationship (Ashton, 2006; Savage and Moore, 2004; Xyrichis & Ream, 2007). This caused a professional power imbalance around clinical governance and decision making in primary health care. Too often GPs retained clinical and managerial leadership in the practice setting. Ashton (2009) for instance suggested that the themes of on-going medical dominance and PN disempowerment through inequality of power and status have been a consistent barrier to the expansion and professionalisation of the PN role in New Zealand. Indeed, Savage and Moore (2004) claimed that ambiguity and uncertainty pervaded accountability and role boundaries, even though these were envisioned differently in the health strategies. Typically, many PNs were locked into a traditional role that fitted in with GP dominance and oversight. Practice nurses had to negotiate both their work load and that of the GPs. As a result, the PN role developed to include availability and flexibility that

were constructed as a commodity to support medical staff (Philips, 2007; Richardson, & Gage, 2010). Availability and flexibility were useful, as they went beyond the boundaries of physical time or space to encompass an emotional and personal availability to respond to patients who presented with emotional distress, or required reassurance and support. Nonetheless, availability has been shown to be invisible and has been hard to quantify in terms of economic accountability (Hall, 2005). The tension of managing the emotional needs of patients within a context where there were revenue requirements was challenging for participants in this study.

An additional key macro condition influencing referring was the introduction of the Health Practitioner Competency Assurance Act (2003) that impacted how health professionals practice in New Zealand. This Act resulted in the Nursing Council of New Zealand (NZNC) defining a clearer career pathway for PNs. Consequently, increasing numbers of PNs have engaged in education, enrolled in short courses and postgraduate programmes (Pullon, 2008). These educational opportunities were not always linked to a certified educational framework. A coherent educational pathway was not clear. There was also pressure for many PNs to study in their own time, due to practice demands and inabilities to leave the practice for a day (McKinley, 2006). Opportunities to choose career pathways were often negated by revenue opportunities for the practice and PHO. As a result, PNs were supported to undertake courses that enhanced the revenue intake of the practice, such as vaccinators, diabetes, cardiovascular assessments and screening, as well as woman's health (Finlayson, Sheridon, & Cumming, 2009a, 2009b.). Mental health care was not well addressed in short courses. Practice nurses were not encouraged to gain further education in this area, as it was not associated with a prescribed funding scheme. The lack of funding for education was critical, as anxiety and depression are a leading cause of

disability, and primary health care is the place where these patients with these problems seek help (WHO, 2002).

Stigma and discrimination

A further macro condition that had an effect on referring related to the stigma and discrimination towards people with mental health problems in society. In 1996 the Mason Inquiry found that stigma and discrimination were barriers to recovery from mental illness. A public awareness campaign to encourage New Zealanders to re-think their attitudes and responses to people with mental illness was recommended (Mason, 1996). This campaign has seen well recognised public icons share their experiences of mental illness and recovery, in attempts to develop stronger community inclusion of people with mental health problems. This has coincided with health strategies that have expanded mental health into all areas of health care (King, 2001; Minister of Health , 2005;2006).

However, within the health sector negative attitudes attributed to mental health issues prevail, and are perpetuated by the separation of mental health and physical health (Ross & Goldner, 2009). Patient care is fragmented, divided into physical and psychiatric arenas, which has resulted in poor uptake of mental health care in primary health care. As such, mental health care was seen as a specialist area for secondary health experts. Yet, the presence of mental health remained invisible in the community, due to the lack of awareness and education. Furthermore, health professionals in primary health care struggled to recognise what they were looking at, as they did not understand the underlying mental health problem (MaGPIe research group, 2005). In contrast, physical health was deemed 'real', something that could be seen and treated. When faced with a patient who presented with multiple issues, including a mental health problem, PNs had difficulty with the mental health

component, as it was not an area they understood. Therefore, they ended up referring. These responses are not new. For instance, O'Brien, Moir and Thom, (2009) reported that part of the problem of marginalising mental health patients in primary health care was associated with health providers. They argued that the emerging discourse of 'primary mental health' has seen mental health relegated as a separate part of primary health care, with connotations that it was less important and not a priority. The authors suggested there was a sense that mental health was regarded as an optional area of care, rather than an integral aspect of primary health care. It is apparent that until the stigma and underlying beliefs are addressed in health policy, the fragmentation and marginalising of mental health will continue, even in the light of health policy advocating for integration.

Implications and recommendations

In considering the findings of this study, it is clear that the micro to macro conditions in which referring occurs need to change, if PNs are to manage patients with mental health problems in primary health care. The research findings have shown that even though policy may advocate a particular direction, this will not be realised without full support from the professions and the PHOs where practice and patient management take place. It is quite clear that provision of mental health care in primary health care will only occur if funding schemes are developed to manage patients with mental health problems. To date there is no specific funding stream for this group of patients, even though there are research statistics (See Chapter Two) indicating that this is a growing area of need.

Funding changes have the potential to change nursing practice in primary health care. There is no doubt that PNs are best placed to care for patients that have chronic and enduring health issues inclusive of mental health. If funding was altered to that mental

health care was a legitimate funding stream, this would reduce the number of people seeking support from secondary health services, and possibly reduce the economic burden in an area, which has been expensive to fund. For this to proceed, PNs cannot be locked into constraints of time and funded schemes, as occurs presently. Practice nurses need to have a legitimate time allowance for the management of complex, unpredictable patients that require an increased time allocation than is available in the existing systems.

Development of a realistic, prescribed time allowance for PNs to manage this group of patients is essential. In fact, the Primary Health Care Strategy stipulated that the key to strategic success would be effective coordination enhancing the development and integration between primary and secondary care, inclusive of mental health and the disability sector (Ministry of Health, 2009). Although there have been innovations and roles set up to follow this through, the changes have been poorly evaluated and are not consistently applied across the country. As was mentioned earlier in the chapter, PNs need support from mental health experts, that provide role modelling in managing patients with mental health problems. At the moment, the primary liaison roles and primary clinic psychologist are located in secondary health services. These roles could be better situated in the primary health care context.

Implications for nursing education

Undergraduate pathways need to reconsider how mental health nursing is addressed in the curriculum. The national drive towards greater primary health care, inclusive of mental health care, must be reflected in undergraduate nursing education. Much of the national undergraduate curriculum, as audited by the Nursing Council, identifies mental health nursing as a specialty area (2010). Mental health nursing needs to be integrated right across

the curriculum. Undergraduates need to be competent and have the skills for early recognition on mental health problems, assessment, and prevention of mild to moderate mental health problems, which may co-exist with physical health presentations. It is critical that mental health nursing be developed throughout the entire curriculum, and not just exist as an isolated speciality area.

Another area for development concerns postgraduate education that is recognised as an important influence on the professional self- esteem and identity of PNs in general practice. Postgraduate education is transformational in that it acts as a catalyst to develop clinical competence leading to an increased sense of being valued as a health professional (Carryer, 2011). Professional identity, inter-professional respect, and trust in nurse-doctor inter-professional relationships are based on demonstrated professional competence by nurses (Pullon, 2008). If registered nurses have improved access to postgraduate education, it may assist them to better define their roles, to be more confident autonomous practitioners which are capable of addressing patients with mental health problems. While this was envisioned in the Primary Care Health Strategy (2001), on-going professional development requires that PNs have more protected time to leave clinical practice and up-skill to a post graduate level. Opportunities for higher education may improve the levels of respect attributed to PNs, however remuneration must also be included. Literature reviewed indicates that significant pay inequity exists between practice nurses and their District Health Board (secondary health care) counterparts (Clendon, 2010; Finlayson, et al., 2009).

Implications for policy makers

There is growing international and national recognition that PNs are key to the successful implementation of the Primary Health Care Strategy. But, if PNs are to follow

through policy in practice, the professional and systemic structural barriers impacting on PNs' ability to work effectively and equally within a general practice team, must be changed. Clinical leadership is well recognised as an essential component of team work. The lack of leadership is an identified barrier to the expansion of the nurse's role (Finlayson et al, 2009). Similarly, shared governance is crucial if PNs are to assume clinical leadership roles. Clinical leadership is important if nurses are to be active contributors to decision making about patient care and service delivery models. Inclusion in decision making has the potential to increase PNs' visibility and voice as a professional group. These issues need attention if financial constraints are not to undermine policy direction, and if patients are to receive the relational care that is so important for many.

Evaluation of policy implementation is needed as well. There is growing research on the role that PNs have in primary health care, and how they influence the outcomes of care. This is significant, as research is a useful tool to inform PHOs and practices of the contributions the nursing profession can make to patient outcomes. It is therefore imperative to know if PNs have contributed to nurse led initiatives, or if they have contributed to performance indicators such as cardio vascular assessments. Currently, most of the research focuses on GPs. With more specific research on PNs' contributions to patients' outcomes it may be possible to explore other service delivery options as suggested in the Primary Health Care Strategy. Equally, there is a need for more research on the mental health educational needs of PNs, to find out how the education sector could better support improved provision of mental health care in the primary health care sector.

Strengths and limitations

The legitimacy of the theory is supported by its fit with existing literature (Nayar, 2009). As discussed, there is little literature on *referring* as a process or action, rather most

of the literature was on referral between primary health GPs and secondary health specialists. This was also minimal. *Referring* as indicated in this study is a strategy that PNs engaged with when they have knowledge limitations. However, *referring* is poorly understood, even when this approach is a common, everyday, taken for granted, action. The concepts integrated with *referring* were *knowledge limitations* and the consequence of *handing over*. There was an abundance of literature on both topics. Yet, this theory of *referring* is unique because existing knowledge did not attempt to integrate concepts into some sort of coherent whole. It was evident that handing over was a common process that nurses engage with.

A limitation noted in this study was the ability once the theory was fully developed to get more than one participant to re interview. However, the development of the theory was achieved with support of the later participants interviewed. They were influential in shaping the outcome. Other forums were integral to verifying the developing theory. A presentation to researchers and academics in 2013 brought positive feedback from this group, providing strong support that suggested the findings were dependable. Also feedback from my supervisor played a part in verifying the theory as it developed.

This study has contributed to the understanding of how PNs refer when faced with knowledge limitations. Referring was a common practice, but poorly understood or developed in research. It was also clear that the topic of referring was linked to an area of health that was not particularly popular with PNs. It is possible that findings may be transferrable to other specialist areas such as cardiac care or diabetes. If the research was extended into those areas it is possible that data may be readily available. The findings may

be limited, as data was gathered over a short space of time. A study with more time that that indicated in a Master's thesis, may confirm the theory of *referring* in the context of time. Additionally, it took a long period of time to attain the 17 interviews. It can be partially attributed to the topic of mental health, as one that is not well known or popular in health care. However, predominantly it was often difficult for PNs to be released from the clinical floor to be interviewed. Therefore whilst there has been ability to gain a theory from data provided, the findings need to be used cautiously as it may not be apply to all PNs.

The ability to apply this theory to others areas of nursing would be a true test of its transferability. Future studies may indeed apply this theory to areas where nurses work as generalists as they do in emergency departments. However, it may also apply to those nurses who work in specialist areas. For the complexity of health presentations means that often patients present with more than one issue. Knowledge limitations may occur in any situation where a nurse is unfamiliar with a health condition. Therefore referring may apply to all nurses not just generalist nurses.

Conclusions

The implementation of health policy reforms are visionary, and set forth an idealistic stance on where health care should be. The vision, of a greater level of mental health care in primary health care context, cannot be enacted if the professions identified as key to its success, do not take up the cause. Additionally, the cause cannot occur if there are no visible funding streams that align to the presentations, which health care professionals are most likely to see, and address in day to day practice.

Primary health care policy gives us direction on what needs to happen. However it is the professional groups and their employers that enable the changes to happen. The professional bodies of primary health care and the PHOs have a responsibility to support PNs in the enhancement of their role in the provision of mental health nursing care. It should be noted that there have been positive changes in supporting the primary health care nursing workforce towards greater access to education opportunities. However, there has been little offered in the way of mental health nursing education that is meaningful and transferable to primary health care setting. It is timely for the PHOs, and the education providers to work together to support a more robust training for PNs that includes skills in assessment, early recognition and health promotion in mental health nursing. Yet education alone is not the answer. Practice nurses need support from secondary health experts who can offer role modeling and act as a resource in times of doubt, around what to do. Therefore, implementation of primary liaison roles, as a standard role, located nationally within all PHOs, and general practices, will be a significant step towards enhanced mental health nursing care in these settings. Additionally, PHOs and IPA as employers, in the current service delivery business model, must look to align visible funding schemes with mental health presentations. This funding needs to be associated to a different service delivery model. This service delivery model will need to be flexible, to the realities of the extended time it takes to deal with presentations that require a relational approach, such as distress and mental health problems.

For, there is no health without mental health.

We end as we began.

A tautology.

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Appendix One: Ethics approval

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To:	Antoinette McCallin
From:	Rosemary Godbold, Executive Secretary, AUTEC
Date:	20 August 2012
Subject:	Ethics Application Number **12/167 The practice nurse role in mental health service delivery: A grounded theory study.**

Dear Antoinette

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 23 July 2012 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement by AUTEC at its meeting on 10 September 2012.

Your ethics application is approved for a period of three years until 20 August 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 20 August 2015;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 20 August 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken

within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Carole Schneebeli carole.schneebeli@waitematadhb.govt.nz

Appendix Two: Consent Form

Project title: The practice nurse role in mental health service delivery: A grounded theory study

Project Supervisor: ***Associate Professor Antoinette McCallin***
Researcher: ***Carole Schneebeli***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 4th September 2012
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interview and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of the interview, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature:
……
Participant's name:
……
…
Participant's Contact Details (if appropriate):
……..
……..
……..
Date:
Approved by the Auckland University of Technology Ethics Committee on ***type the date on which the final approval was granted*** ***AUTEC Reference number*** ***type the AUTEC reference number***
Note: The Participant should retain a copy of this form

Appendix Three: Confidentiality agreement for the transcribers

Confidentiality agreement

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.
Project title: *The practice nurse role in mental health service delivery: A grounded theory study*
Project Supervisor: ***Associate Professor Antoinette McCallin***
Researcher: ***Carole Schneebeli***

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:.....……
Transcriber's name:
.....……
Transcriber's Contact Details (if appropriate):
……..
……..
……..
……..
Date:

Approved by the Auckland University of Technology Ethics Committee on AUTEC Reference number Ethics Application Number **12/167 The practice nurse role in mental health service delivery: A grounded theory study.**
Note: The Transcriber should retain a copy of this form.

Appendix Four: Email for recruitment purposes for professional contacts

Contacting Potential Participants

Dear…….

Request for Professional Support:

I am doing a Masters research project at AUT University. The topic is:

The practice nurse role in mental health service delivery: A grounded theory study

I need help to contact Practice Nurses who might be willing to have an interview to discuss how they manage patients who have mental health issues.

If you have the names of Registered Nurses who have more than five years of experience working as a Practice Nurse and might be willing to be part of this study, I would be grateful if you would forward the participant information sheet to them. If they decide they wish to be part of the study, they can then email or ring me directly to discuss this further.

If you are unsure or wish to discuss this further please feel free to contact me.

Kind regards

Carole Schneebeli

Masters student

Email: carole.schneebeli@waitematadhb.govt.nz

Work Ph. 09 – 8228716

Mob. 0212427386

Appendix Five: Information sheet

Information Sheet Produced:

Project Title

The practice nurse role in mental health service delivery: A grounded theory study

An Invitation

My name is Carole Schneebeli. I work at Waitemata District health board as a clinical nurse advisor in mental health. I am currently a Master of Nursing student. This research project is part of my Masters of Philosophy.

You are invited to take part in a research project that will look at how practice nurses manage patients who have mental health issues. Participation in this study is voluntary and you may withdraw at any time prior to the completion of the data analysis.

What is the purpose of this research?

There is little known about practice nurse knowledge, skill or capability in managing patients with mental health problems. This study wants to find out what is happening when practice nurses deliver mental health care to patients in general practice.

This will help describe and explain how practice nurses manage patients who have mental health issues.

How was I identified and why am I being invited to participate in this research?

You were recommended by someone in your organisation because you are a registered nurse who has had experience managing patients with mental health issues. I understand that you have worked as a practice nurse for more than five years, are not part of a primary health care new graduate programme and have not been involved in the Te Ao Māramatanga New Zealand College of Mental Health Nurses/PHO, practice nurse, mental health nursing care skills training programme.

I also understand that you have had this information passed onto you by a nurse leader or another practice nurse

What will happen in this research?

If you choose to take part you will be asked to participate in an interview with me that will take no more than 1hour. In the interview I will ask open ended questions about your experiences of managing mental health problems in your role as a practice nurse. The interview will be held in a private setting of your choice. The interview will be audio taped.

At the conclusion of the interview I will offer you an opportunity to review and amend the interview transcripts. Later in the study as the theory emerges I will offer you another opportunity to review the theory to consider if this fits with your understanding of the research topic.

What are the discomforts and risks?

There are no anticipated discomforts or risks in this study. However should there be any instance of discomfort for you related to sharing of data around less positive experiences then you will be offered three free counselling sessions by AUT

Participation is voluntary and the interview is confidential. Within the interview you can decline to answer any questions should you choose too.

What are the benefits?

There are no immediate benefits to you for taking part in this study. You will be contributing to my completion of my Masters in Philosophy. Additionally the information could help to promote the development of a clinical teaching programme for practice nurses.

What are the costs of participating in this research?

The cost to you taking part in this research is your time, which will be an hour for an interview.

A petrol voucher will be offered to you if you are required to travel to the interview.

What opportunity do I have to consider this invitation?

From the time you receive this invitation you will have two weeks to consider participating in this study.

How do I agree to participate in this research?

You will need to complete a consent form prior to taking part in this study. Should you have any further questions regarding this study you can contact me via telephone, mobile or email listed below. Once this is completed, the researcher will contact you.

Will I receive feedback on the results of this research?

You can choose to receive a summary of the findings of this research. When the findings are available you can choose to have them sent to you at an address you provide. Otherwise you can obtain a copy from the researcher. Details of these options are in the consent form. I will in approximately 8-12 months after your interview, I will send you an invitation to receive a copy of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Antoinette McCallin. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, rosemary.godbold@aut.ac.nz , 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:
Carole Schneebeli

Private bag 93-503

North Shore 0704

Work Ph: 09- 8228716

Mobile: 021 2427386

Email:carole.schneebeli@waitematadhb.govt.nz

Project Supervisor Contact Details:
Associate Professor Antoinette McCallin
Phone: 921 9999 Ext. 7884
amccalli@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on type the date final ethics approval was granted, AUTEC Reference number type the reference number.

Appendix Six: Interview questions/ Guide

Questions	Prompters
Lead in: "I understand that you have had experience in managing mental health care in your practice setting?"	
"Can you tell me about the experience/s"	"What was it like for you?" "How did you experience this?"
"In light of what you have said, what do you think your role is in regards to the management of mental health care?"	"Are there complex and challenging aspects to the role?" "Are there positive aspects to the role?"

Initial questions

2. Adjusted for the second interview:
"What is it like for you when people present with mental health problems?"

- Manage them
- Deal with them
- Work with them

"What are the problems and what are the strategies?"

Previous interview identified

- Changes – how have contextual changes (PHO's) funding systems impacted on managing mental health issues
- Knowledge and experience – has this impacted on your ability to manage mental health issues presenting
- Interest – how does this impact on the management of mental health problems/ issues presenting
- Resources/ access and referral strategies to cope with mental health problems/issues presenting
- Fear – does this impact on strategies to manage mental health issue/problems
- Home visit – do you do this for other health conditions

Additional:
"What does a PN do?", "What is their role?", "What does it mean to be a generalist and what other areas do they refer?" (I.e. diabetes)

3. Experience and dimensions – undergraduate - comp./ general/ life experience/ family
"How does this impact on managing mental health presentations?"

4. Same questions for participant 4
5. New set of questions for participant 5

"Firstly can you tell me a little about your role as a PN – have you specialised in any area?"
"I understand that you have had experience in managing mental health care in your practice setting….?"
"Can you tell me about the experience/s"

"What is it like when people present with mental health problems, - how do you feel?"

"What are the problems and issues they have?"

"What happens if someone doesn't meet the time allotment?"

6. Additional questions participant 6

"Fear is a term used often is this an emotional response to mental health presentations you experience? Why?"

"Experience personal and professional – has this influenced your interest in engagement?"

"Context of change…"

7. Questions remained the same till interview 9 as a comparison – they had completed the mental health training.

"What is the difference with your role compared to other PNs?"
"Theory of engagement what do you think?"

8. Interview 13 new questions – continue to interview 17
Look to theory of referring – need to ask about:

- Specialty and background

"One thing that has come up is referring – nurses talked about importance of referring – what does that mean to you"

Let this come forth:

- (access to) information
- learning
- professional knowledge – how do I handle that sort of person
- experiences – life/professional – sensitive or responsiveness
- on-going education
- safety issues
- emotional response
- how do they decide to refer on to…
- confidence – literature on new grad's

There are conditions – why where and how and what happens
Interactions and emotions
Consequences of interactions of emotions - Strauss and Corbin, 1998