

The Mental Health Nurse Incentive Program: desirable knowledge, skills and attitudes from the perspective of nurses

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Aim. To enhance the understanding of the skills and attitudes of mental health nurses working in the Australian Mental Health Nurse Incentive Program.

Background. The Mental Health Nurse Incentive Program places qualified mental health nurses alongside community-based general practitioners, private psychiatric practices and other appropriate organisations to provide clients with mental health conditions with a more integrated treatment plan.

Design. An exploratory, qualitative approach was undertaken, given the paucity of relevant research in this area.

Methods. Exploratory individual interviews were conducted with ten mental health nurses working in this scheme. Data analysis was organised and managed using QSR NVivo qualitative analysis software.

Results. Respondents identified specific skills and attitudes required for practice under the Mental Health Nurse Incentive Program. Eight areas of skill and attitude were identified as essential for mental health nurses working in this field. This study highlights that many of these skills and attitudes are specific to the setting where mental health nurses are working.

Conclusion. Mental health nurses working under this programme have a role to play in the dissemination of knowledge about their practice. More needs to be done by governments and other institutions to ensure that general practitioners and other health professionals understand the role played by mental health nurses in the provision of care.

Relevance to clinical practice. The extent to which the Mental Health Nurse Incentive Program becomes a sustainable strategy to promote quality and accessible mental health care will depend to some degree on the capacity to identify the skills and attitudes necessary for practice. The findings presented in this paper provide a significant contribution to articulating the essential characteristics required for this area of practice.

Key words: attitudes, Mental Health Nurse Incentive Program, mental health nurses, skills

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Introduction

Mental health nurses (MHNs) play an increasingly important role in the provision of care for clients with mental health conditions in Australia (Clinton & Hazelton 2000, Fisher 2005, Elsom *et al.* 2009). The Mental Health Nurse Incentive Program (MHNIP) initiated by the National Action Plan on

Mental Health facilitates a collaborative approach to the provision of mental health care between credentialed mental health nurses, general practitioners (GPs) and psychiatrists (Council of Australian Governments 2006).

The MHNIP was introduced in 2007 in response to an identified need for improved access to mental health care in primary health settings (Australian Government Medicare

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Australia 2009). Through this scheme, funding was made available to general practices, private psychiatrists and other designated organisations to enable them to engage the services of MHNs. The MHNs would implement specific interventions designed to address mental health issues.

The high prevalence of mental health issues in the general community (Henderson *et al.* 2000, Australian Bureau of Statistics 2007) prompted the development of schemes to improve access to mental health care. The MHNIP has the potential to increase the availability of mental health care and treatment to people who are accessing primary care rather than specialist mental health services (Crawford *et al.* 2001, Unützer *et al.* 2002, Fisher 2005, Chew-Graham *et al.* 2007, Wand & White 2007, Ling 2009). One of the main goals of the MHNIP is to reduce hospitalisation rates by bringing mental health care into the primary practice setting (Council of Australian Governments 2006).

Under this programme, GPs refer patients to MHNs for the coordination and provision of clinical care, which may include developing mental health care plans, undertaking cognitive behaviour therapy (CBT) and other psychotherapies, ensuring medication regimes are appropriately prescribed and adequately adhered to and the provision of education. In many cases, clients receive collaborative mental health care from several providers located in the one practice (e.g. psychologists and GP Counsellors). General practitioners have the discretion to refer any clients they believe would benefit from involvement in this programme. There are no restrictions based on criteria such as diagnosis or severity of symptoms. This means that mental health care can be provided to a broad range of people who are not likely to meet the criteria for access to the public mental health system.

The minimum standards for MHNIP practice are mediated by the eligibility requirements for credentialing with the Australian College of Mental Health Nurses (ACMHN) from 1 January 2010. The ACMHN is the peak professional body for mental health nurses in Australia and the only organisation that exclusively represents mental health nurses. The aim of the ACMHN is to: 'promote public confidence and professional recognition of mental health nursing; set standards of practice and encourage professional accountability, autonomy and partnership; participate in National Benchmarking for mental health nursing; provide a forum for collegial support, networking and collaboration; provide and support quality education and ongoing professional development; develop and facilitate research into mental health nursing practice and health care; represent the profession and provide advice to consumer and carer agencies, the government and non-government sector, community groups and the general public; and participate in policy development con-

cerning the profession, health care delivery, promotion of mental health and prevention of mental illness and disability' (Australian College of Mental Health Nurses nd).

To be credentialed, MHNs were required to meet a set of criteria including to:

- 1 Hold a license to practice as a registered nurse in Australia.
- 2 Hold a recognised specialist/postgraduate mental health nursing qualification or equivalent.
- 3 Have had at least 12 months of experience since completing specialist/postgraduate qualification or have three years of experience as a registered nurse working in mental health.
- 4 Have been practicing within the last three years (Australian College of Mental Health Nurses 2009).

Furthermore, to satisfy the criteria to become credentialed and to maintain the credential, MHNs need to accrue a specified number of points in two domains, Practice Development and Professional Education. These points are earned through engaging in, for example, formal education, professional development activities, contribution to the profession through active membership of key committees and dissemination of knowledge through conference presentations and refereed publications.

In the MHNIP, MHNs play a pivotal role in the delivery of mental health services, and the MHNIP marks a step forward in the recognition of the role specialist trained MHNs should play in delivering high-quality primary mental health care. Competency in this group of MHNs is thus important on two levels. First, MHNs delivering care to medium- and high-needs clients with little supervision must be proficient in their ability to provide professional care without the institutional support provided in other contexts, such as inpatient settings. Second, with MHNs oftentimes forced to defend their status as a specialty subgroup of nurses (Rydon 2005), success in the MHNIP will signal the vital role MHNs can play in this centrepiece programme for the delivery of primary mental health care (Council of Australian Governments 2006).

There is currently very little formally documented research about the nature and outcomes of the MHNIP. An informal study undertaken in 2009 found that nurses involved in this programme, while indicating they realised a high level of job satisfaction through the MHNIP, conceded that there were complications to be resolved, including increasing the broader understandings of the role of mental health nurses under the MHNIP and expectations of clinical oversight of MHNs by GPs untrained in mental health (ACMHN 2008, 2009). These alone suggest a suite of skills will be required beyond the standard MHN practice competencies.

Previous studies have determined the expectations of MHNs on graduation (Patterson *et al.* 2008, Kenny *et al.*

2009) from the perspective of mental health service clients (Rydon 2005, Bee *et al.* 2008) and in various situation-specific roles (for example Kudless & White 2007, Keady 2008, Thompson *et al.* 2008, McConachie & Whitford 2009, Nash 2009, Reid-Searl *et al.* 2009), and the majority of these suggest the skills required for MHNs are somewhat situation specific. There has been some acknowledgement of the need for additional skills in advanced MHN roles (McDonough *et al.* 2003, Elsom *et al.* 2007); however, these skills have not been articulated or explored in detail. In particular, the specific skills required of MHNs working in primary care settings have not been addressed.

Background

Specialised mental health nursing has been defined as:

the level of practice which is achieved by a graduate registered nurse after extended practice in mental health nursing and related professional development or equivalent experience. (Clinton & Hazelton 2000, p. 106)

In Australia, the *Standards for Practice* document published by the Australian College of Mental Health Nurses (ACMHN) provides an industry standard for professional practice by outlining several standards required for competency in the field. These include, for example, the provision of culturally appropriate care, the promotion of wellness and so on (ACMHN 1995). The development of standards is, according to Elder *et al.* (2005), important for reflecting the professionalism of mental health nursing. Nonetheless, mental health nursing remains subject to:

... poorly articulated frameworks of philosophy, practice and theory... [which] contribute to a limited understanding of the practice of mental health nurses and the perpetuation of inappropriate practice. (Rydon 2005, p. 79)

As previous studies have documented, the skills employed by MHNs transcend well beyond basic job-related functionality. A study of users of mental health services in New Zealand found that MHNs should be professional, convey hope, know and respect the client, work alongside the client, privilege human quality and be able to connect with clients (Rydon 2005). Furthermore, they should have good interpersonal and practical skills, a high level of personal and professional knowledge and be able to view the client in context. Other studies have found a range of requirements is needed as diverse as knowledge of specific legal proceedings (Patterson *et al.* 2008), the ability to sympathise with children (Reid-Searl *et al.* 2009) and the provision of dietary advice (Nash 2009). These highly varied requirements

emphasise the importance of articulation of the role of MHNs in the MHNIP.

Ramritu and Barnard (2001) describe skills and attitudes as essential for successful practice. Using this framework, this study presents the skills and attitudes suggested for MHNs working in the Australian MHNIP. As MHNs working in this programme are required to hold a recognised specialist or postgraduate mental health nursing qualification or equivalent, the knowledge applied by MHNs working in this programme has been documented elsewhere (Happell & Palmer 2009).

This paper focuses on the skills and attitudes required in the context of experiences in the MHNIP, in particular, the educative role these MHNs are currently playing in general practices because of a lack of awareness of mental health nursing and the MHNIP, and also on the importance of having sufficient experience in mental health nursing to be autonomous, confident and self-directed.

Methods

Design

As the MHNIP is a new programme and little data are available on the subject, this study used an exploratory approach to data collection. This is an appropriate approach when comparatively little is known about the subject area at the onset of data collection (Stebbins 2001, Polit & Hungler 2008). Although interviews were semistructured, respondents were encouraged to speak freely and at length of their experiences in the programme. This, it was hoped, would facilitate data collection about topics deemed important by research participants, in addition to topics identified by the research team.

Data collection

Data were collected in 2009 in Queensland, Australia. Participants were recruited on the basis that they were currently working in the MHNIP. Initial contact was made with several MHNs through professional networks, and a snowballing approach was subsequently taken to engage an adequate number of participants (Polit & Hungler 2008). Ethical approval was obtained from the host university.

Potential participants were contacted via email, were provided with an overview of the study and were asked to contact the research team if they wished to participate. They were provided with a plain English explanation of the study and were advised that they were under no obligation to

participate and could withdraw from the study at any stage. Participants were then asked to sign a consent form.

Exploratory interviews were conducted with ten mental health nurses. These nurses had been working under the MHNIP between two months and two years at the time of interview. Interviews ranged from 30–60 minutes. Participants were asked to describe their experiences in the MHNIP and how it had evolved over time. The focus of this paper is on the skills and attitudes perceived by the participants as central to their practice in the MHNIP.

Analysis

With the permission of participants, interviews were audio-taped and each interview was professionally transcribed verbatim. This allowed the entire research team to gain an accurate account of each interview. Transcripts were organised and managed using QSR NVivo qualitative analysis software (QSR International Pty Ltd, Melbourne, Australia 2008).

An inductive approach was taken to organise the data. This focused on eliciting the main themes concerning respondents' experiences and observations of the MHNIP. The research team collaboratively identified emerging themes, and a thematic framework was developed using these themes: the two themes, skills and attitudes, each contained subthemes; these are presented in Table 1.

Results

Participants reported that working in the MHNIP required a range of skills and attitudes, not all of which could be achieved through education alone or proven through credentialing. One person highlighted the dangers of assuming that appropriate qualifications alone ensured work-related competency:

I think one or two people have come out of hospital settings and they don't have the skills and competence needed. They may well be

credentialled, but I don't necessarily think that means that they're competent to work in this field.

While a sound knowledge of mental health nursing was clearly necessary and valued highly, other skills were also important for MHNs in the MHNIP additional to the basic skills and competencies for other MHNs.

Skills

Adopting independent and collaborative approaches

Mental health nurses reported that a range of skills was necessary for working in the MHNIP to respond to the complex, yet differing, needs that clients presented. While many of the skills they described were not unique to this environment, the participants described an increased emphasis on the ability to work independently as one respondent highlighted:

... there are not one hundred people backing you up as you would have in other services ... the transition from inpatient or a community setting into a doctor's surgery or into private practice is difficult for a lot of people, because you are standalone.

The practice environment required MHNs to become independent and confident in delivering treatments, effectively working as independent practitioners. It was also important that MHNs were able to work collaboratively with other service providers such as GPs and psychiatrists as well as community service providers, including government departments, non-government organisations, civil society organisations and other health professionals. It was also described as less bureaucratic than the public mental health system which provided more opportunity to focus on meeting the needs of clients.

Educating others about the role

Most respondents reported that they had initiated their own contracts by approaching GPs or psychiatrists for referrals or for practice space, with only three respondents responding to advertisements for MHNs or accessing employment through professional networks. This often required MHNs 'selling' the programme prior to their commencement. Given the lack of skill and sometimes misconceptions surrounding the role, they considered the ability to promote and advocate for the role as crucial. One participant describes the attitudes towards the role that were encountered during the implementation of the role:

Some potential colleagues had great doubts about having a mental health nurse here and they actually said, 'Are we likely to turn our surgery into a mental health ghetto?'

Table 1 Skills and attitudes for mental health nurses (MHNs) working in the Australian Mental Health Nurse Incentive Program

Theme	Subtheme
Skills	Adopting independent and collaborative approaches
	Educating about the role
	Autonomous and self-directed
	Good listening skills
Attitudes	Assertiveness
	Valuing collaboration with clients
	Promoting holism

Given a key aim of the MHNIP was to facilitate the provision of collaborative care, it became important for MHNs to inform colleagues about the role they played in delivering mental health services, as well as to educate about the role of the MHNIP. As one participant stated:

If we're going to do mental health nursing any favours, then we have to demonstrate that we are competent, that we know what we're doing, that we can work independently and that we are independent practitioners.

Autonomous and self-directed

Most participants had stepped into this role without clear guidelines or expectations from the practice, for example:

I stepped into the job with no role restriction, nothing. Just the Medicare criteria and my boss saying, 'I don't know what you're supposed to do'.

In the absence of clear direction, participants needed to develop the scope and functions of the role. This included establishing the basic processes required to facilitate the MHNIP including referral forms, formal agreements, referral procedures and documentation guidelines. Participants observed that facilitating this process required them to be self-directed, as there was little support from the GPs, who, in many cases, had little knowledge of mental health nursing or the MHNIP. The participants consistently commented about the extent to which they 'drove' their role in the MHNIP.

These hurdles required the MHNs to be highly autonomous in how they approached their practice. They also needed a thorough understanding of how the MHNIP sat in the broader institutional framework of mental health services to be able to establish the programme effectively. One participant described some of the process issues that had to be addressed in the early stages of the role:

When I started there certainly wasn't much about the programme out there and it was just trial and error and to take on a programme that had actually worked for the clients in the local area, so you've got to be able to have the energy to go through that process. Plus you have to go through the process of working out with Medicare how it works... And then the rest of the GPs... it is not for the faint hearted.

Good listening skills

Being a good listener was identified as integral to working with clients in this setting and was identified by participants as one of the most significant points of difference with other mental health service settings. By listening to the goals and needs of clients, MHNs were able to help them find their own solutions rather than the MHN dictating the solutions. The

following quote describes how this approach contrasts to that of the GP:

You are not jumping in with solutions all the time. That is part of the GP role, to fix things all the time, whereas that's not our role. [Clients] need to find their own solutions to their difficulties. We can support them with information, education and advocacy but ultimately the decision is theirs.

Listening rather than acting meant that MHNs may have to support the decisions of clients even when they contradicted their own beliefs or opinions about the most appropriate path to take. As one participant stated:

In talking to clients, sometimes you will think, 'Well, just divorce him' and that's not necessarily the answer. So you need to just sit and wait and hear what the real need of the person is, not what I want to rush in and do, necessarily.

Attitudes

Assertiveness

The need to be assertive both professionally and personally was considered a crucial attitudinal approach to the role. More than half of the respondents who worked in a general practice reported that MHNs were treated differently to other practice staff. For example, administrative staff did not assist mental health patients attending the practice, and in some practices, notes on patients taken by MHNs were kept separate from other client notes. In one case, the MHN was not included in practice social events such as lunches and parties. One participant used the following example:

I relate myself as one of the people of the surgery, the team there. And I am fairly well treated there, although at Christmas time I wasn't invited to their Christmas Dinner... Actually when I think about it now, it took a while to even get the administration on side, because when my patients arrived and said they were there to see me [the administrative staff said], 'oh we don't deal with her clients, you just go and sit down'. It took me while to say 'these are your clients, I am working for your Doctors, you really need to give them the same courtesy, whether they were seeing Doctor Jones or Mister Blogs.

In many cases, MHNs made comments indicating they were somewhat powerless in dealing with practices, and this was exacerbated by the lack of knowledge and awareness of mental health nursing among practice staff. It was, therefore, very necessary for MHNs to be assertive in negotiating needs and requirements in the practice.

The need to be assertive with clients was also identified. During the initial meeting with clients, it was often necessary for MHNs to explain what their role was and why clients

needed treatment. It was also important to be assertive in establishing boundaries with clients, in particular because MHNs worked 'in a personal way' with clients, in their homes, with their families and so on. Some participants suggested it was important to ensure that clients did not encroach on their 'offtime', did not become dependent on MHNs and were aware that they would eventually be discharged from MHN care.

Valuing collaboration with clients

In working with clients, respondents reported that the ability to establish rapport with people was of vital importance, and this was often conveyed in terms of 'working alongside' clients, rather than delivering services 'to' clients. One respondent used the example of a colleague who exercised with her clients, rather than simply imploring that the client exercise more often. This was fostered to some extent by the MHNIP, which allows MHNs to undertake consultations in a flexible way, for example, in places that are comfortable for the client. The participants provided many examples where they engaged in a way that was most suitable for the client. For example, one respondent highlighted that it was important to 'ring, email and text clients if that's the way I know I can get them to engage'. Others met with clients at their workplace, in a coffee shop or at times of the day appropriate for the client, for example:

I do home visits, I do coffee visits in a coffee shop depending on [the clients] needs... It's really good for rapport building and getting to know her and understand her at all levels.

One participant described this as 'experiencing what the client experiences'.

Promoting holism

The participants recognised the complex and multifaceted needs of their clients. Although mental health care was the primary focus of the MHNIP role, they emphasised the importance of providing holistic care, rather than treating the mental health condition in isolation. As one respondent highlighted:

You're not just looking at somebody who's got an illness or who's got schizophrenia and how that affects that person and working with them to improve their quality of life. I mean, you've got the role of the advocate, where you are working and talking on their behalf. You've got that monitoring of their mental health, the medication, the compliance, but you've also got the other side of using what skills you need. I will use whatever I need to, to work with patients.

This was said to be important because respondents were 'working with whatever the client needs'. There was also

value in this approach for MHNs, who were able to apply a range of skills to the treatment of clients and, in doing so, found 'every day is different in this job'.

Discussion

The MHNIP was introduced as a strategy to improve access to mental health care (Australian Government Medicare Australia 2009). However, the extent to which the MHNIP is able to realise this potential requires the MHNs occupying these positions to have the appropriate skills and attitudes to provide the necessary care and treatment. The findings from this study, therefore, make an important contribution by highlighting the broad range of skills and attitudes these pioneering MHNs employ in working in the MHNIP. At a formal level, MHNs need to meet the criteria for credentialing by the ACMHN (from 1 January 2010). This assumes a combination of specialist education, clinical expertise and demonstrable commitment to ongoing professional development.

The participants identified four main skills: adopting independent and collaborative approaches; educating about the role; autonomous and self-directed; and good listening skills; and three attitudes: assertiveness; valuing collaborating with clients; and promoting holism. The extent to which these skills are specific to MHNIP practice will now be considered.

The capacity to practice independently and autonomously yet in collaboration with other health professionals is described as characteristic of community mental health nursing (Elsom *et al.* 2007, White & Kudless 2008). Particular reference is made to the primary care environment where mental health nurses are able to contribute to the provision of a wide range of services for physical and mental health (Sharma *et al.* 2001, Bartels *et al.* 2004, Craven & Bland 2006). Arguably, nurses in MHNIP practice were often the only mental health practitioner on site. Reference to autonomous practice in mental health nursing currently tends to focus on practice in remote locations (Gibb 2003, Burley & Greene 2007) or mental health consultation liaison (Sharrock *et al.* 2008).

The listening skills identified by participants are arguably important in all areas of mental health nursing practice (Jones 1999, Adam *et al.* 2003, Horsfall 2003, McCann & Clark 2005). However, the participants argue that the relatively unstructured context of their practice setting increases the importance of listening and assisting clients to identify their own solutions. General practice settings were identified as the ideal environment to truly listen to clients. Moreover, the clients accessing primary mental health care and support via

the MHNIP are more likely to be living independently, and the goal of interventions would be to maintain that independence. This is best achieved by working collaboratively (non-pater-nalistically) and listening carefully to what the client wants.

The ability to promote and educate other professionals about the role of MHNs in primary practice was also identified as an important skill because of the apparent ignorance and stereotypical views about what MHNs can actually do. Also, because the MHNIP is a relatively new initiative in health, many primary health practitioners have little or no understanding of the programme. MHNs find they need to explain the MHNIP to enable better collaboration and increase the number of referrals received while also advocating for the profession of mental health nursing.

The identified skills are not unique to practice under the MHNIP. This may reflect the view that skills represent the application of knowledge across different contexts (Kudless & White 2007, Keady 2008, Thompson *et al.* 2008, McConachie & Whitford 2009, Nash 2009, Reid-Searl *et al.* 2009). The specific context of the MHNIP requires MHNs to adapt their skill base to an environment that is fundamentally different to public mental health services.

In terms of attitudes, being assertive was identified as crucial to the role. It was established that MHNs needed to be assertive in negotiating their initial contracts with GPs. Once MHNs began work under the MHNIP, they then found they needed to assert the importance of respectful care for clients, particularly when administrative staff marginalised clients as 'not ours'. Assertion skills were also necessary to ensure that the doctors who referred the clients continued to provide thoughtful and courteous care. Ultimately, MHNs also needed to assertively promote an understanding of their role to clients and their families.

Nurses are generally found to be non-assertive (Cartan & Hargie 2004), and the reasons for this are often complex. However, assertiveness is a valued behaviour because of its contribution to leadership, quality patient care and increased job satisfaction. In an Australian study involving women community mental health nurses, Rose and Glass (2006) found that the ability to speak out contributes to the emotional well-being of mental health nurses, ultimately leading to satisfying professional practice. This is also apparent for MHNs working under the MHNIP as they assert their role to locate themselves in the primary health care arena. Curiously, references to GPs as their 'boss' suggest that at least some of the MHN participants here view themselves in subordinate positions to the medical staff with whom they are expected to work collaboratively.

The participants described collaboration with clients as central to their practice. Active collaboration with consumers

is considered a core value of all mental health nursing practice (Pegg & Moxham 2000, Crowe *et al.* 2001, Jubb-Shanley & Shanley 2007), although there is evidence to suggest that this goal is not always realised (Lammers & Happell 2003, 2004, Goodwin & Happell 2006, 2007a,b, 2008, Happell 2008, Fisher & Happell 2009). A particular feature of the participants' practice was the need to adapt engagement strategies to suit the client's needs rather than expecting the client to conform to the structure of service delivery, more commonly expected in specialist mental health services.

Promoting holism was viewed as an essential attitude for MHNIP practice. The importance of providing holistic care for mental health nursing has also been identified in the literature (Graham 2001, Zahourek 2008, Agmon & Zahourek 2009). Promoting holism is therefore not an attitude unique to nurses practicing under the MHNIP, but according to the participants, the opportunity to convert this into practice appears greater.

The findings from the current study articulate the skills and attitudes that the participants as pioneer MHNs working under the MHNIP consider being central to practice in this setting. While the skills and attitudes themselves are not unique, the context of MHNIP practice requires a flexible approach to MHN practice. This knowledge is likely to assist in the establishment of more clearly articulated understandings of mental health nursing and of the role of the MHNIP in the provision of high-quality mental health care in Australia. In particular, future research should explore the specific application of these skills and attitudes in this context and the extent to which this results in improved outcomes for the consumers of this service. This research will enhance our understanding of the roles and functions associated with the MHNIP.

Limitations

This research was undertaken as part of a small, exploratory study in Queensland, Australia. While the skills and attitudes required for MHNs may be relevant across mental health nursing more broadly, care should be taken in generalising these findings in larger populations.

Conclusion

Mental health nurses employed under the MHNIP have identified specific skills and attitudes as crucial to their practice. The participants expressed the view that the skills and attitudes of MHNs needed to be more flexible to reflect the specific context of their work. This poses a challenge for mental health nursing. The success of the programme

depends in part on the ability of general practices to engage and retain MHNs. A clear direction for further research is to determine how the skills and attitudes essential to the MHNIP can be effectively communicated.

Relevance to clinical practice

The Mental Health Nurse Incentive Program was introduced to increase access to mental health services. The success or otherwise of this strategy is largely dependent on the extent to which mental health nurses are able to meet the mental health needs of clients accessing medical care from general practitioners and psychiatrists. The findings of this research suggest that nurses working under the MHNIP have specific skills and attitudes essential to providing the care and treatment required in this setting. This contribution to knowledge provides the foundation for further research to articulate the role of mental health nurses under the MHNIP.

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Contributions

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Conflict of interest

None.

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