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Exploring practice staffs' perspectives regarding professional roles, confidence, and motivations in delivering mental health care within rural general practice: a qualitative exploration

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Abstract

Background General practice is pivotal in delivering mental health care within communities, yet the attitudes and professional factors influencing this provision remain underexplored. This study seeks to understand the perspective of general practice staff around the professional factors that influence the provision of primary mental health care.

Methods A qualitative study was conducted with semi-structured interviews of 14 general practice staff involved in mental health care. Participants included receptionists ($n=3$), nurses ($n=4$), practice managers ($n=3$), and general practitioners ($n=4$), recruited via purposive sampling. The Theoretical Domains Framework (TDF) guided the interviews, and thematic analysis was used to identify themes and subthemes.

Results Three themes were identified. The first, 'Role identity, skills, and leadership in mental health care,' included subthemes of distinct role recognition with overlap, essential relational and practical skills, and leadership valued among experienced GPs. The second theme, 'Confidence and involvement in mental health care,' covered variability in confidence levels, differing perceptions of involvement, and attitudes towards further involvement. The third theme, 'Drivers for and outcomes of delivering mental health care,' revealed intrinsic motivations and acknowledged both benefits and serious consequences.

Conclusion This study explored general practice staff beliefs about role identity, skills, leadership, confidence, involvement, motivations, and perceptions of benefits in mental health care provision. The findings offer valuable insights into the complexities of mental health care in general practice, with significant implications for practice management and healthcare policy development.

Keywords General practice, Mental health, Confidence, Motivation, Role identity, Skills, Leadership

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Introduction

'Mental disorders', a broad spectrum of conditions ranging from anxiety and depression to psychosis, mania, and eating disorders, are becoming increasingly prevalent worldwide, affecting individuals of all genders and age groups [1]. An astonishing 970 million people worldwide (equivalent to 1 in every 8 individuals) were living with a mental disorder in 2019 [1], with anxiety and depressive disorders ranking among the most common [2]. In Australia alone, over 4.2 million adults between the ages of 16 and 85 (equivalent to 21.5% of the population) experience a mental health (MH) disorder each year [3]. These statistics are concerning, given the profound impact mental illness has on individuals, including reduced life expectancy [4] and poorer physical health [5]. Furthermore, the economic toll associated with these impacts is estimated at $43–70 billion AUD annually [6]. As such, early detection of mental illness is paramount to facilitate prompt intervention, leading to improved outcomes for both individuals and the healthcare system.

In Australia, much like in other Western nations, general practice stands at the forefront of MH care, serving as the primary point of contact for treatment [7]. General practitioners (GPs) and other practice staff, including nurses, play pivotal roles in delivering and supporting MH care within communities, with individuals often turning to these staff to discuss MH concerns more frequently than any other issue [8]. While individuals may have direct access to other MH medical practitioners such as psychologists and psychiatrists, consulting a GP is the common first step, especially for prevalent conditions like anxiety and depression [9]. Moreover, the introduction of Mental Health Care Plans (MHCPs) under Australia's Medicare Benefits Scheme (MBS) has facilitated improved access to MH services through GPs [10]. As a result, GPs carry a large proportion of the MH workload, with up to 71% of the health problems discussed with them relating to psychological issues [7]. Given the central role of general practice in providing and coordinating MH care, it is imperative to comprehend the perspectives and responsibilities of general practice staff in this realm.

While prior research has provided insights into the attitudes of GPs and nurses towards MH care [11–13], as well as their delivery methods [14], gaps persist. Specifically, there is a notable paucity in fully comprehending the array of professional factors that impact the provision of MH care within general practice, including aspects such as confidence, motivations, skills, and leadership. Furthermore, each member of the general practice team brings unique skills and perspectives to client care, including practice managers who influence practice policies and resource allocation, and receptionists who may shape initial perceptions. However, the perceived roles and attitudes of these staff in MH care provision have been understudied. Thus, further work underpinned by theoretical frameworks and involving key informant interviews, which allow in-depth understanding of a phenomenon [15], is required to comprehensively understand the perspectives of different staff roles on the professional factors involved in providing care to individuals in general practice.

To address these gaps, this study utilises the Theoretical Domains Framework (TDF), a theoretically based approach to behaviour change [16], aiming to explore the professional perspectives held by staff, including practice managers, receptionists, nurses, and GPs, toward the provision of MH care in general practice. By qualitatively exploring these factors among various staff groups, the findings of this study may inform strategies to better support general practice staff to provide optimal care delivery to patients living with MH challenges.

Method

Study design and setting

This phenomenological study was a component of a broader project focused on co-designing a lived experience peer support intervention for MH service users in rural primary care settings [17]. As part of this project, individual semi-structured interviews were conducted to elicit staffs' current perspectives on providing MH care within the scope of their roles in general practice. This methodology was deemed appropriate as it facilitates a deeper understanding of the phenomenon being investigated and allows researchers to grasp the world from the participants' viewpoint [18]. Ethics approval was secured from the Human Research Ethics Subcommittee in the College of Medicine and Public Health at Flinders University (HREC no. 6034). The approach used in this study adhered to the guidelines outlined in the Consolidated Criteria for Reporting Qualitative Research (COREQ) [19] (see additional file 1) and the Standards for Reporting Qualitative Research (SRQR) [20].

Study setting

Interviews were conducted across three general practices in Australia. These practices, situated in rural regions of South Australia ($n=2$) and Queensland ($n=1$), were selected as the sites for implementing the intervention. All clinics are located in health workforce Distribution Priority Areas, categorised at MM5 within the Modified Monash Model of geographical remoteness and population size on a scale of MM1 (major city) to MM7 (very remote). The preferred procedure within general practices for scheduling a MH appointment involves clients contacting the clinic beforehand to request a double appointment (typically 30 min) with a GP. At the time of the interviews, the clinics employed between 12 and 29

full-time and part-time staff, including 6–12 GPs, 2–6 administrative staff, 2–7 nurses, and 1 practice manager.

Participants and recruitment

Practice nurses, practice managers, receptionist and GPs employed at the participating study sites were eligible to participate. A combination of snowballing and purposive sampling was utilised for participant recruitment. Initially, the Project Coordinator (BF) contacted the Practice Manager at each site to schedule an interview. Subsequently, Practice Managers invited nurses, GPs, and reception staff who were willing and available for interviews to ensure comprehensive coverage of perspectives from various staffing roles. This approach was chosen to streamline the recruitment process while minimising disruption to staff availability. To mitigate the risk of coercion, the Project Coordinator clearly instructed the Practice Manager to emphasise the voluntary nature of participation to the practice staff. Staff who volunteered to participate were then contacted by the Project Coordinator (BF), provided with study information, and given a consent form. An email was sent to the Practice Managers at each site to coordinate a convenient interview time for these practice staff. To reimburse the clinics for the time taken by staff from their work hours, each practice was granted a payment of $100 per staff member interviewed. This payment was intended to compensate for lost productivity within work hours, as general practices are businesses with operational considerations. While the initial estimate was to interview approximately 3–5 staff from each practice, recruitment continued until data saturation was achieved, meaning no new information could be gathered [21]. This occurred after the thirteenth interview; however, one more interview was conducted to confirm this and to ensure adequate representation for each of the four staff groups interviewed. Informed written consent was obtained from all participants.

Data collection

Interview questions were developed using the TDF to gain insights into the perspectives of staff providing MH support in general practice. The research team generated 1–2 questions for each domain in the TDF (additional file 2). While the interviewer (BF) adopted a conversational style, questions generally followed a sequence similar to the interview guide. Probing, follow-up or new questions were introduced as needed during the interviews. No pilot or repeat interviews were carried out. The interviews took place between June and September 2023, using video-conferencing (Microsoft Teams classic, V1.6) at a mutually convenient time, and were conducted by a PhD qualified female interviewer with a background in psychology and experience with interviewing techniques. Some participants were already acquainted with the interviewer, as she served as the Project Coordinator for the larger project encompassing this study. During the interviews, most participants were situated at their workplace, opting for either communal spaces or private offices. The interviews ranged from 32 to 57 min in duration (average=45, SD=7). Interviews were transcribed verbatim for analysis using Otter.ai and were cross-checked for accuracy. While the option to review their own transcript were not offered, participants were given the chance to review the consolidated findings including themes, codes, and quotes. One participant chose to take advantage of this opportunity and provided feedback.

Data analysis and rigor

The transcripts underwent thematic analysis following Braun and Clark's six-step guide [22]. Initially, a deductive approach was employed, where codes originating directly from verbatim statements were mapped to the questions asked. Subsequently, an inductive analysis was conducted, abstracting participant codes into subthemes and themes based on common concepts identified in the data. The combination of deductive and inductive methods provides a systematic and objective approach for making valid inferences and quantifying phenomena [23].

Throughout this process, two authors (MR and BF) independently listened to the recordings, immersed themselves in the transcripts, and coded each interview independently each interview using word processing software (Microsoft Office, Version 2312). One author (MR) cross-checked the generated codes for consistency, creating one master document. Both coders (MR and BF) then independently analysed the data, consistently referring to raw data to substantiate emerging ideas and themes. Labelling of themes and subthemes was discussed among the two coders until consensus was reached. A coding tree is available by request.

To enhance trustworthiness and mitigate threats to validity, strategies outlined by Lincoln and Guba [24] were implemented. Firstly, detailed, and in-depth descriptive data, including rich verbatim quotes from participants, are presented throughout the results to fulfill criteria for transferability and confirmability, respectively. Independent analysis by two authors and frequent discussions among the research team regarding codes, quotes, subthemes, and themes bolstered the credibility and dependability of the analysis and findings. Lastly, an audit trail of the analysis process was maintained.

Results

Fourteen participants were interviewed, consisting of four nurses, four GPs, three reception staff, and three practice managers. To the authors knowledge, no staff approached to participate declined. All practice managers, nurses, and reception staff were female. Among the

GPs interviewed, three out of four were male and 2 were practice owners at their respective clinic. Most (75%) GPs had completed level 1 Mental Health Skills Training (MHST) while one had also completed Level 2 Focussed Psychological Strategies (FSP) training. None of the other staff had undertaken MH specific training. Participant responses formed three themes and various subthemes, which are described below and depicted in Table 1 alongside representative verbatim quotes.

Role identity, skills and leadership in mental health care

Recognising distinct roles with some overlap

Staff from each profession highlighted the distinctive roles they play in providing MH care, while also recognising certain areas where responsibilities intersect. Nonetheless, it was emphasised that each staffing role contributes distinct skills and expertise, adding their own invaluable piece to facilitate, assist in, or provide MH care. Receptionists, being the first point of contact, play a pivotal role in triaging appointments, considering factors

Table 1 Themes, subthemes and example quotes from interviews with 14 practice staff

Theme	Subtheme
1) Role identity, skills and leadership in mental health care	1.1 Recognising distinct roles with some overlap *"Like, I wouldn't say [we have] a huge [role in mental health], but we definitely do have on occasion, the patient that calls up and they're not coping and they tell us what their plans are. So then obviously we've got a protocol. So we do a welfare check on them straight away, especially if they can't get an appointment. Do a welfare check and pop some notes in there file just in case anything happens. And of course offer our support as much as we can."* [S13, Receptionist]
	1.2 Identifying essential relational and practical skills *"Just listening to people sometimes I think makes a huge difference, especially if they're in that mindset of they're having a terrible day or life or whatever. Sometimes they just need someone to listen and not talk over them and let them get out of it, I guess, and maybe understand where they're coming from a little bit. Not be dismissive."* [S13, Receptionist] *"I know that a lot of people wouldn't ring or wouldn't come in if they didn't need it. Like there's a reason for it. So I think that the ability to listen, show compassion and empathy to people and just an interest like just in the interest in what they're trying to tell you."* [S14, Receptionist]
	1.3 Seeking and valuing leadership among experienced GPs *"I think [deidentified GP] takes the lead. And because he does have that caring nature about how everybody in the practice is and how his patients are and how they're doing, you can see a lot of people just follow in his footsteps. So we have a really good practice culture at the moment, which is great."* [S01, Practice Manager] *"What we try and instil in the junior GPs is, you know, follow people up, you know, if they cancel cause they don't need it, that's great. But often people appreciate the fact that you give a damn, and you follow them up. But really, it's pretty simple, if you care, you're going to get a good outcome, and they're gonna get more rapport with you, they're going to come back, you gotta find out what's going on…. it's probably the practice partners that tend to educate and provide the guidance on how we do things more than anything."* [S06, GP]
2) Confidence and involvement in mental health care	2.1 Variability in confidence levels *"[Are you confident in providing mental health care?] Not in my setting. I straight up I have zero qualifications in mental health and my qualifications extend to nursing and then: 'How can I help you? Where can I point you in the right direction?' So basically it is just resources, resources and immediate mental healthcare if they need it."* [S04, Nurse]
	2.2 Differing perceptions of involvement *"I tend to do a lot of the chronic disease care, but I think every second or third person that I've seen with that has some sort of anxiety, depression, PTSD, stress, sort of aspect that goes with it. So in terms of like, dedicated mental health might be 5%. But in terms of incidental regular care, checking in on the mental health, probably 80%, realistically, like it's a huge component… I sort of touch on like a whole person approach… the physical and mental are very much sort of symbiotic."* [S06, GP] *"As nurses, though, it [mental health] does come up when we're doing GP management plans… stuff will come out and that's because there's two of you in the room having that conversation. We have tissues in and out quite close. … you're meant to be talking about diabetes, but then mental health stuff comes up… [so] then [you need to] work out how important that is to the person and be flexible around what you need to do vs. what you feel you need to accomplish, as opposed to what you might end up accomplishing."* [S02, Nurse]
	2.3 Understanding attitudes toward further involvement *"It's not exactly in my job description to check on their mental health. But it's just something that happens to me. I think it's probably because I am a mental health sufferer anyway, myself, so I can pick up on it quite quickly."* [S08, Nurse]
3) Drivers for and outcomes of delivering mental health care	3.1 Unveiling primarily intrinsic motivations *"That's the unique thing about GP practices, I think, is that there's already established relationships with every patient that walks through our doors. So there's that genuine desire I have to do whatever we can to help that help that patient in our setting. If it's something that we can't help, well, obviously we refer. But again, it's not like the people that are coming. through are strangers to us. Quite often, you know, they will, they're, they're members of the community."* [P05, Receptionist]
	3.2 Acknowledging benefits and serious consequences *"I just think getting wins is the antidote largely to burnout. Seeing people get better, you go, 'Oh, well, this was worth it'."* [S10, GP] *"If you can't, if you can't provide the care, you know, we're going to have more issues where our patients just end up in emergency or we get calls from the police about, you know, potential coroner's reports and adverse events, which becomes time consuming and distressing in a different way. So if we have them there as I said, anything that we can do to address it without them having to go to hospital and go to emergency, improving the safety netting and support in the community. So that way, you know, they don't end up there."* [S06, GP]

like urgency and patient needs. These staff also spoke about prioritising patient comfort by offering water while waiting and/or listening to their concerns, ensuring individuals feel calm and prepared for their consultations with the GP. Practice managers, while sharing some responsibilities with receptionists, primarily focus on the "*paperwork and keeping everybody's documents up to date*" [S09], while also offering flexibility in appointment scheduling to cater to individual preferences, including handling sensitive information discreetly. Nurses, similar to receptionists, sometimes engage in patient triage and emotional support but often in a more structured manner. For example, they may create a private space for distressed patients and conduct a MH assessment, even coordinating with the ambulance or police if immediate support is necessary. Additionally, one nurse [S04] said she sees herself as the "*middleman*", guiding patients in the "*right*" direction (i.e. towards appropriate care options and providing essential resources). Lastly, GPs self-identified and were viewed by other staff as playing a vital role in MH care, conducting initial assessments, developing comprehensive MHCPs, and facilitating specialist referrals. It was also that they offer counselling and therapy within their level of specialised MH training, monitor patient progress, manage medication, and foster communication with other mental health professionals to ensure integrated and effective care, among many other services.

Identifying essential relational and practical skills

All staff emphasised the crucial skills required for assisting with and/or providing MH care. They emphasised the significance of relational abilities, which included expressing empathy, active listening, maintaining non-judgmental attitudes, and demonstrating patience. These skills were deemed essential for building trust and rapport with patients, thereby encouraging them to share their MH concerns openly. Moreover, a genuine desire to help and care for patients was highlighted by several staff members. However, one nurse [S08] perceived that the ability to "*see when someone is putting on a front*" and being attuned to the individual sitting across from you are "*innate skills*" that cannot necessarily be taught. Her perception was you either possess them, or you don't. Furthermore, practical skills were cited as indispensable, such as effective communication, risk management, and a comprehensive understanding of the local environment including available resources, waitlists, and how the system operates. These relational and practical skills were seen as necessary across all professions to varying degrees.

Seeking and valuing leadership among experienced GPs

The staff from the three practices highlighted the presence of a cohesive team of doctors within their clinics, led by experienced GPs who prioritise compassion, teaching, and community engagement. Among the four GPs interviewed, three were acknowledged as leaders in MH care within their respective clinics. They viewed it as their responsibility not only to provide high standard care to patients but also to promote holistic care throughout the practice and the community. Beyond the interviewed GPs, most staff from one of the clinics consistently identified an experienced doctor as a leader in MH care, who established a caring and compassionate culture within the practice and community. While acknowledging the quality of MH care provided by all GPs, some interviewees noted the absence of a single go-to person, attributing it to the proficiency of all doctors in this area. However, it was also recognised that certain doctors excel in specific tasks, which primarily appeared to be due to their relational skills, insight and compassion.

Confidence and engagement in mental health care

Variability in confidence levels

In providing MH care, confidence levels varied among staff members based on their role, experience and qualifications. GPs expressed the highest level of confidence, however, while they exhibited confidence in managing MH in general, they acknowledged their limitations in complex psychiatric and social conditions, emphasising the importance of collaboration with community MH teams, psychologists and psychiatrists when necessary. Further, one GP emphasised that recognising one's scope of practice was crucial and was something that "*some GPs struggle to be taught*" [S10]. When nurses, receptionists, and practice managers were asked about their confidence in MH care provision, most initially responded with little to no confidence, with the exception of one nurse [S02] who expressed confidence from having done "*a fair bit of reading*" to upskill. However, further exploration revealed that while these staff expressed hesitancy initially, it was revealed that most were confident in 'knowing who to pass/refer onto' when they had reached their limit of comfort or expertise. For example, receptionists might transfer a MH call to a GP if the situation were urgent, while nurses cited that if MH concerns arose in an appointment, then a short appointment might be made with the GP to check in with the client and gauge the urgency of their concerns. These staff also appeared relatively confident in providing immediate resources which had been provided by GPs in their clinic if needed and drawing on their relational skills to de-escalate situations or create safe environments for clients.

Differing perceptions of involvement

In general, there was a consensus that working within primary care involved at least some exposure to and assistance with MH care. However, staff shared varying degrees of involvement from a professional perspective in providing MH care within their role. For example, two staff members, including one nurse and one practice manager, emphasised a minimal focus on MH, noting that it constitutes a small percentage of their overall responsibilities and workload. Alternatively, other staff, including GPs and nurses, adopted a more comprehensive approach, often incorporating MH into chronic disease management discussions, recognising the symbiotic nature of physical and MH. As a result, it was estimated that these staff, particularly GPs, consider MH in a high proportion of cases (up to 80%) through incidental regular care. However, in terms of dedicated workload, this varied from an estimated 5–30% of their workload.

Understanding attitudes toward further involvement

Despite differences in perceived involvement in MH care, most staff acknowledged the increasing demand for MH support within general practice. However, staff somewhat expressed varying levels of desire to engage in further MH provision and/or assistance. While some staff expressed openness to further education in MH and being more involved, others expressed some hesitancy to take on additional responsibilities or a heavier workload due to their own mental wellbeing, limitations in their roles, or lack of formal training. For example, one GP [S10] spoke about "*compassion fatigue*" being real and the burnout that would be associated with GPs *"going soul-destroying deep*" with every client, while a receptionist [S13] described feeling restricted within her role as clients "*tend to look down on us a bit*," which she associated with her lack of formal education. Alternatively, one nurse [S08] explained that she "*wouldn't want to get overly involved [in MH care]"* as she battles everyday with her "*own demons coming to work*"; thus, she appreciates the fact that she can identify the issue and then have someone else "*take the reins*." Interestingly, this nurse mentioned performing MH-related duties beyond her current scope of practice, but the idea of additional roles or a heavier workload was concerning given its potential impact on her MH.

Drivers for and outcomes of delivering mental health care

Unveiling primarily intrinsic motivations

Various intrinsic and extrinsic drivers were identified for providing and assisting in MH care. Primarily, a genuine desire to assist clients and contribute positively to the community emerged as a prevalent theme among staff members. This motivation appeared to stem from their compassion, with some staff drawing from their own MH experiences to empathise with others in need. Others were driven by the compassion of knowing the clients in their community, seeing an opportunity to make a positive impact on their lives. Further, several staff highlighted MH care provision as part of their and the practice's duty of care, given their role as a one-stop shop without an emergency department in the community. In fact, one receptionist [S14] stated: "*If I can't help, then I would feel that I have probably just failed that person,"* demonstrating a strong sense of responsibility and commitment to assisting others. Lastly, one experienced GP recognised the financial incentives provided by Medicare for offering MH care as a motivating factor, given that it attracts remuneration for the practice and staff. However, perhaps more crucially, this GP highlighted the significance of guiding and motivating less experienced GPs to pursue accreditation for offering MHCPs. He explained that this accreditation not only enhances their understanding of MH care but also results in higher reimbursement rates from the MBS, meaning the doctors get paid "*a little better*", which in turn may prevent "*low job satisfaction*" [P03].

Acknowledging benefits and serious consequences

Staff identified the multifaceted importance of MH care within general practice, recognising it as a pillar for individual and family well-being, community vitality, and economic impacts. Many staff acknowledged its crucial role at an individual level, with one receptionist [S12] noting that people "*cannot function without it [good mental health]*," while a GP [S09] emphasised that, like physical health, MH issues can cause similar "*harm or distress to the person*". Consequently, staff emphasised that providing this support can deter clients from resorting to emergency departments or facing tragic consequences. Furthermore, they recognised that effective support enhances the clinic's reputation, as satisfied clients share their positive experiences, fostering a culture of seeking help in the community and bolstering the clinic's reputation. Additionally, a GP [S01] highlighted that witnessing clients' improvement serves as an "*antidote to burnout*", indicating the benefits for healthcare professionals. Conversely, neglecting MH care was viewed as leading to severe consequences, such as worsening health, increased crime rates, overflow effects among family members, reduced productivity, and higher costs.

Discussion

This study delved into the professional perspectives of various staff members within rural general practice, ranging from practice managers and receptionists to nurses and GPs, all concerning the delivery of MH care. Each professional group, regardless of their role, were found to contribute uniquely to the delivery of MH care in rural

contexts, where resources may be limited and access to specialised mental health services can be challenging. This highlights the importance of recognising and leveraging the diverse skill sets and roles of various staff within the team.

Overall, participants across the four groups expressed a high level of awareness and compassionate attitudes toward MH care. One possible explanation for this is the effective leadership demonstrated within the three clinics where the staff were interviewed. The organisational culture, largely influenced by experienced GPs, some of whom were also practice owners, appeared to play a role in shaping these positive attitudes. In rural areas, where community ties are often stronger, effective leadership can be even more critical in establishing a supportive atmosphere for both staff and patients. Indeed, previous research has highlighted the pivotal role of leaders in setting behavioural norms and creating a sense of psychological safety among primary care staff [25]. Further, behaviour change theories recognise the role of the social environment in influencing behaviour [26]. Consequently, these leaders serve as valuable sources of knowledge for staff members, including directing and encouraging less experienced GPs to pursue accreditation for offering MHCPs, and contribute to fostering a culture inherently supportive of MH care through leading by example and establishing a caring and compassionate culture. These finding emphasis the critical impact of effective leadership and organisational culture in shaping attitudes and practices surrounding MH care within general practice settings, particularly in rural regions.

Motivations and beliefs about consequences also appeared to shape staffs' positive attitudes toward MH care provision. Staff were primarily driven by an intrinsic desire to assist clients and make a positive impact on their community, a motivation likely enhanced by their residence in rural regions where a strong sense of community generally exists. Some drew from personal MH experiences to empathise and support clients, while others were driven by compassion for their community, seeing it as an opportunity for positive change. Extrinsic motivators such as role expectations and beliefs about consequences for not providing MH care also contributed. Despite this motivation, many expressed hesitancies to take on additional MH responsibilities or a heavier workload, with some citing concerns about their own MH. Previous research indicates that many healthcare staff find MH work tiring and emotionally draining [27], with only a minority of GPs defined as 'Interested, Engaged & Resilient' in MH care provision [28]. This is compounded by unpaid time for MH care [28] and marginally lower reimbursement for MH consultations compared to standard ones [29]. Moreover, GPs actively manage their MH loads to mitigate burnout [28], and lower personal involvement in MH care is indeed associated with lower rates of burnout in doctors and nurses [27]. In summary, our findings, along with those of others, highlight the complex interplay between motivating drivers, fair reimbursement considerations, and the importance of supporting healthcare providers in managing their MH while delivering quality care.

While staff generally displayed a strong motivation to deliver MH care, their confidence levels varied. GPs exhibited the highest confidence levels; however, they also acknowledged limitations, particularly in managing complex clients, a sentiment echoed in prior research [30]. It has been reported that GPs with MH training tend to hold more positive attitudes toward depression and its treatment [31], which may help explain the compassionate views held by GPs in our study given most had completed some level of MH training. In contrast, nurses, receptionists, and practice managers, who lacked specific MH training, expressed lower confidence but expressed confidence in their supportive roles like preparing clients for consultations with GPs, triaging needs, providing resources, and de-escalating situations. This confidence appeared to stem from their strong relational skills and drawing on resources selected by GPs at their practice. In our study, relational skills such as expressing empathy, active listening, and maintaining non-judgmental attitudes, along with practical skills like effective communication, were deemed essential in the context of assisting and providing MH care. This highlights the need for MH care to extend beyond clinical expertise to include trauma-informed interpersonal communication [32] and a holistic understanding of client's needs; which prior research has also reported elsewhere [33, 34]. Given the rise in MH issues (2) and the pivotal role of general practice in providing care, ongoing education and professional development in MH care for all practice staff are essential.

A clear limitation of our study is the potential lack of transferability due to the specific participants and setting. Despite using maximum variation purposive sampling and interviewing across three clinics, some perspectives may be missing. Additionally, since the study is part of a larger project to enhance MH delivery, the staff involved may already have a heightened awareness and advocacy for MH, potentially skewing their perspectives positively. Furthermore, all participants are from rural clinics, suggesting our findings might be more relevant to staff in rural general practices. It should be noted that while the TDF includes a domain titled 'Environmental context and resources,' we have not reported any findings related to this domain in the current study. This is because this domain alone generated a substantial amount of data, and our findings on the contextual factors influencing the delivery of MH support are reported separately [35]. This

- Recognise and utilise the unique contributions of various staff members (e.g., practice managers, receptionists, nurses, and GPs) in delivering MH care.
- Encourage leadership from experienced GPs and practice owners to foster positive organisational culture and compassionate attitudes among staff.
- Use experienced GPs as role models to mentor and guide less experienced GPs in pursuing accreditation for offering MHCPs.
- Implement continuous professional development opportunities to improve MH knowledge and skills across all staff members (i.e. GPs, nurses, receptionists, and practice managers), including the development of relational and trauma-informed communication skills (e.g., empathy, active listening).
- Advocate for fair financial compensation for MH care services, addressing current disparities between MH consultations and standard consultations.
- Implement strategies to support the mental health and well-being of staff, especially those delivering MH care, to reduce the risk of emotional burnout.

Box 1 Practical recommendations to enhance mental health care provision in general practice

is not a limitation of the current study, but it is important for readers to be aware that factors beyond the professional ones discussed here are also significant when considering MH delivery in general practice. A strength of the present study is that we have addressed several practical recommendations to enhance mental health care provision in general practice, particularly in rural locations (Box 1).

Conclusion

This study examined perceptions of role identity, skills, leadership, confidence, involvement, motivations, and beliefs about consequences in delivering MH care in general practice, specifically within rural regions of Australia. Each profession played a unique role, with experienced GPs' leadership fostering positive and compassionate attitudes toward mental health care. Both intrinsic and extrinsic motivations and beliefs about consequences drove staff to provide compassionate care. However, many staff hesitated to engage further in mental health care due to workload and concerns for their own mental well-being. GPs had the highest confidence levels, while other staff, despite lower confidence, showed competence in supportive roles, highlighting the importance of relational and practical skills. These findings offer valuable insights for practice management and healthcare policy development.

Abbreviations

GPs	General practitioners
MH	Mental health
MHCP	Mental Health Care Plan
SD	standard deviation
TDF	Theoretical Domain Framework

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12875-024-02648-2.

Supplementary Material 1

Supplementary Material 2

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Author contributions

MR: Conceptualization, Methodology, Investigation, Formal analysis, Data Curation, Writing- Original draft preparation, Funding Acquisition; BF: Conceptualization, Investigation, Formal analysis, Data Curation, Writing- Original draft preparation; TSJ: Conceptualization, Methodology, Funding Acquisition; Writing- Reviewing and Editing; CP: Funding Acquisition; Writing- Reviewing and Editing; SM: Funding Acquisition; Writing- Reviewing and Editing; PW: Funding Acquisition; Writing- Reviewing and Editing; SL: Conceptualization, Methodology, Funding Acquisition; Writing- Reviewing and Editing. All authors read and approved the final manuscript.

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Data availability

Anonymised data will be shared on reasonable request from the authors.

Declarations

Ethical approval

Ethical approval for this study was granted from the Human Research Ethics Subcommittee in the College of Medicine and Public Health at Flinders University (HREC no. 6034). . Verbal informed consent was obtained from all participants prior to commencing interviews.

Consent for publication

Not applicable.

Competing interests
Co-author Sam Manger (SM), a staff member at one of the clinics in this study, was also a participant. Literature supports the transformation of participants into "co-researchers", particularly when using experience-based co-design processes. He is an author due to his contributions to facilitating the study and writing the article. To minimise potential bias: (1) a second GP at SM's clinic was interviewed to detect divergent data, (2) SM did not collect data outside his own interview, and (3) he was not involved in coding or analysis of the data. SM reviewed the blinded results section, suggesting only minor changes to in-text wording. Including him as an author is ethical due to his significant contributions, despite potential conflict of interest. Co-author Paul Worley (PW) is a staff member at another participating practice but was not involved in data collection, coding, or analysis. All participant details were blinded before PW contributed to writing this manuscript.

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