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Abstract

This paper explores the effects of mental policy changes and the curtailment of mental health nursing education on the realities of working as a mental health nurse in rural and remote locations in New South Wales, Australia. Using the twin lenses of mental health nursing and the sociology of work and social change, the experiences of mental health nurses are explored and set in the context of the evolution of the mental health nurse into non-specialist mental health worker. At the same time, mental health nurses are challenged to adapt to new practice realities.

Introduction and Literature Review

Mental health nursing is a profession which continues to undergo significant social change in Australia and beyond. Historically termed 'psychiatric nursing', contemporary practice has largely shifted to adopt the label 'mental health nursing' in more recent times (Shah & Burke, 2001). Accompanying linguistic changes are a range of practical changes in both the identity and workplace realities of the profession. Structural shifts, namely the transition from institutionalising to de-institutionalising the mentally ill, have profoundly impacted how the mentally ill are socially viewed and cared for as well as the environments and conditions in which mental health nurses work, in particular transitioning an increasing number of nurses away from traditional employment in large institutions to more community-based settings (Gerrand, 2005; Pickren & Rutherford, 2011).

Shifting structural conditions have notably impacted mental health nurses living and working beyond major metropolises. In rural and remote Australia, de-institutionalisation often entails extensive commuting, resulting in mental health nursing acquiring the characteristics of other mobile workers, such as stress, time pressure and reduced time for other work duties (Ragusa & Crowther, 2014). Indeed, qualitative research into the realities of working as a contemporary mental health nurse in rural and remote Australia revealed a host of mainly negative perceptions about the current state of practice, with disenchantment arising due to the loss of previous, cherished roles and the decline of traditional professional working relationships and opportunities, such as senior clinical positions increasingly being given to allied health staff in preference to nurses

and the ever advancing movement towards tertiary professional qualifications tending to devalue experienced nurses who were perceived as products of an old apprenticeship system of training (Crowther & Ragusa, 2011). Undesirable implications of a clinical practice derived from policy change associated with the de-institutionalisation of mental health care included a drastic reduction in remuneration, the need to work in less structured, and thus less safe environments, an increase in the number of acutely psychotic clients requiring care, challenges presented by dual diagnosis clients, and that client acuity was higher in rural and remote areas than in metropolitan centres in addition to a sense of resignation and cynicism at the repeated failures of various governments to deliver promised reform of public mental health services (Crowther & Ragusa, 2011).

The changing profession of mental health nursing exists alongside a growing demand for mental health services. According to the Australia Institute of Health and Welfare, health expenditure continues to consume a greater proportion of the national budget, with individuals living in rural and remote Australia disadvantaged by the quality and quantity of health services available, including mental health professionals, whilst evidencing heightened need due to greater prevalence of chronic and preventable disease (AIHW, 2010; 2008). Such realities place burden on rural and regional emergency services which provide acute care in the absence of specialist facilities, (AIHW, 2010). Rural Australian emergency service treatment for acute mental illness are consistent with experiences in the United States, relying on administratively overburdened generalist nursing staff assuming responsibility for providing emergency care (Hopkins, Loeb & Fick, 2009). Likewise, Australian Bureau of Statistics data mirrors international trends, including the extensive cost, in both lost productivity as well as health care requirements, endured over time due to mental illness (ABS, 2009; 2008). Hence, concern remains that the training and replacement of new health care professionals is failing to keep pace with the demands not only of Australia's aging population, but also with the strains geography places on rural and remote health care delivery (AIHW, 2010).

To explore how best we might envision future practice, it is first necessary to consider the policy framework from which contemporary mental health nursing in Australia has developed. Mental health nursing in Australia has, in the recent past, been framed by two key policy frameworks. The first of these is the National Mental Health Strategy which, from 1992-2011, attempted a far reaching review of mental health services. Four distinct but linked National Mental Health Plans attempted to operationalise key elements of the national strategy. The first of these plans was in effect from 1992-1998 and had as central foci the up-skilling and restructuring of the mental health workforce, a merging of mental health services with other sectors of the health care system and a shift of inpatient beds from psychiatric hospitals to generalist health care facilities (Commonwealth Department of Health, Housing and Community Services, 1992). The Second National Mental Health Plan (1998-2003) focused on expanding the scope of mental health care. This was largely achieved by moving aspects of treatment away from mental health nurses and towards the ambit of private psychiatrists and general medical practitioners (Australian Health Ministers, 1998). By the time the Third National Mental Health Plan (2003-2008) came into being, it was acknowledged that one readily apparent, and perhaps unforeseen, consequence of the national strategy as it had so far unfolded was the potentiation of a shortage of specialist mental health nurses (Australian Health Ministers, 2003). This concern was echoed and amplified in the Fourth Mental Health Plan (2009-2014) when it was recognised that mental health service providers, who are mainly nurses, needed to continue to change the philosophical paradigm of their practice and focus on client recovery (Australian Health Ministers, 2009).

One of the most obvious consequences of this series of policy changes has been to accelerate the pace of de-institutionalisation of people suffering from mental illness or mental health disorder and the transfer of the treatment and care of those people from large mental hospitals to settings in generalist hospitals and community settings. This change has been a significant result of the National Mental Health Strategy implementation at the beginning of the

decade. For example, following its commencement, only 55% of acute psychiatric beds in Australia were located in generalist hospitals, yet by the end of that decade, 83% of those beds were located in generalist hospitals. (Department of Health and Ageing, 2010). Mental health nurses had perforce to change their place of work, the professional setting of their work and their way of working if they wished to continue in their profession.

The second key policy framework encompassed the decision by nurses' registration authorities to discontinue separate mental health nurse undergraduate education and to subsume mental health into generalist nursing degrees (Commonwealth of Australia, 2002). This process accelerated the decline of mental health nursing as a distinct specialisation within the profession and led to a workplace situation in which specialist treatment and care is provided by psychiatrists, psychologists and social workers, and in which nursing care is often provided by nurses as Non-Specialist Health Workers (NSHW), that is professional health workers without specialised training in mental health and substance-use disorders. (van Ginneken, Tharyan, Lewin, et al, 2013). Thus, mental health nursing, as a distinct speciality, has progressively declined in importance and in workforce number over the last two decades. This decline presents significant challenges to nurses working in the mental health sector in contemporary Australia.

Increased demand for mental health care, coupled with heightened disenchantment with mental health nursing as a profession requires national attention. Although limited past research describes specific features and attributes of the job mental health nurses in a rural or remote area found enjoyable, and which justified and validated career choice and continuation decisions, the perceived deficit in educational attainment of mental health nurses by managers and the allied health professionals with which they work demand further consideration. In contemporary Australian workplace environments, the inability of the two professional groups with whom the mental health nurses most frequently work, general medical practitioners and generalist nurses, to provide adequate care for the mentally ill, is exacerbated by the perceived unrealistic and ineffective

support mental health nurses received from managers they believed lacked knowledge of and expertise in mental health nursing and its culture and ways of operating (Ragusa & Crowther 2012).

Learning how to collaboratively and effectively work in multidisciplinary teams presents a key challenge to mental health nurses working in rural and remote areas wishing to advance their professional practice. Collaborative and interdependent cross-professional groups of health care workers have been variously described as *multidisciplinary, transdisciplinary and interdisciplinary* (Jacobs, Crichton & Visotina, 1989; Brown, Crawford and Darongkamas, 2000; Rees, Huby, McDade and McKechnie, 2004; Bailey, 2012.) A multidisciplinary team is one that is led by a medical practitioner, a transdisciplinary team is led by a nurse or allied health worker, and the leadership of an interdisciplinary team rotates around team members according to client need and team member expertise at any specific time. Whichever of these models is followed by an area mental health team, the generic term for these teams has in practice and in general use become 'multidisciplinary team'. Multidisciplinary integrated community mental health teams (CMHT) are a major provider of mental health care, and are a key component of Australian health policies for integrated service delivery. They provide continuity of care by integrating the range of professional skills and expertise drawn from medicine, psychology, social work, nursing, and occupational therapy into multidisciplinary teams. However, cross disciplinary collaboration and integration of CMHT workers into one team can present a significant challenge (Belling et al., 2011).

In Australia, preparation of health professionals for clinical practice continues to occur in single-discipline programs, in which interactions with other disciplines take place in an *ad hoc*, time-limited way during clinical placements. This can lead to a lack of confidence and trust, and to defensive practices amongst novice practitioners. As a consequence, any advances, insights and solutions identified in one discipline are not usually shared with other disciplines and thus effective interventions are not instituted early or systemically. Ultimately, apathy or inertia in mental health care can be perpetuated (McAllister et al., 2011). Thus, to improve the day-to-day working

environment and conditions of mental health nursing, in light of national policy and local realities, requires improving the disparity between nursing and allied healthcare professionals (Ragusa & Crowther, 2014). Before embarking upon the previously recommended strategies of academic accreditation and further education, we argue in light of current research that a healing process must first commence, accepting mental health nurses' pain, disillusion and loss of previous roles, validating their cynicism and acknowledging their grudging acceptance of the *status quo* in contemporary mental health practice so future growth and change may occur.

Research Methods

The methodology informing the qualitative sampling, recruitment, and focus group design is more fully described in Crowther & Ragusa (2011) and Ragusa & Crowther (2014; 2012). Design and implementation of the research project adhered to requisite human research and ethics guidelines and human research ethics clearance was approved by the affiliated university. In brief, we used a grounded theory approach to guide the data collection and analysis processes (Bryman, 2012; Corbin and Strauss, 2008). Participants had to have work experience and currently be employed as a mental health nurse in a rural or remote area and agree to voluntarily participate in the research without remuneration. Focus groups were chosen to enable participants to discuss issues and maximize participation by sharing different perspectives and allowing discussion of these (Freeman, 2006; Rubin & Babbie, 2011). We followed Neuman (2011) and Polit and Beck (2008) by keeping group size between four and twelve, and although we intended for the focus groups to take up to ninety minutes, each discussion exceeded two hours. A strength of the methodology employed was its capacity to generate rich, location-specific insights about fundamental issues that may prevent optimization of mental health services delivery to clients in rural and remote communities.

Analysis of the focus group data was performed by means of a multiple-reading approach. This is consistent with a grounded theoretical approach to data analysis (Bryman, 2012). The independent and multiple reading of transcripts were supplemented by listening to the audio files from the focus groups in order to hear inflection and emphasis during the discussions. This guided the creation of a scheme of thematic coding which was progressively refined to reflect participants' perceptions and reduce researcher bias to a minimum (Marshall & Rossman, 1999).

Findings

The 32 participants in the five focus groups proved a rich source of data, providing impressions, feelings and thoughts about the nature of contemporary mental health nursing as personally experienced through their professional practice as members of community mental health teams in rural and remote areas of New South Wales. Findings were indicative of senses of loss and regret for the way mental health nursing used to be and no longer is, and a concomitant nostalgia for working in large mental hospitals, and of doubt that existing knowledge and skill levels were adequate enough to enable effective practice in the contemporary mental health nursing environment.

The comments by focus group participants listed in the box below are indicative of those perspectives.

*There was a range of therapies that were applied. In those days there was a little bit more liberal thinking, we tend now to be a bit more structured in a fixed way that's set by (government) departmental guidelines.*FG1

*Erosion of nursing and skills, really it was so evident in the 70's. It was fully run by nursing staff, there weren't any Allied Health, we ran the groups...all of it was actually run by nurses and for me that is the biggest change.*FG1

Wasn't it good when you had a psychiatrist and all your medical staff and your senior nursing staff all in attendance to have a case review. FG1

It is almost an abandonment of nursing. Why? Why are we doing that? FG1

It's the changing face of community mental health nursing, having to take on more responsibility. FG5

We're multi-skilled, we've got more skills, more training in psychotherapies, CBT and general drug and alcohol intervention. FG5

You know there's an attitude in nursing as a whole you get your qualifications and go and work as a nurse and that's it. Whereas if you look at other professions they work toward PhDs and doctorates, they have that drive as part of their professions. FG1

I think sometimes the nursing duties are dependent on where you work. FG5

Mental health nursing is quite undervalued, the concept of mental health nursing and what a mental health nurse does is very undervalued. FG5

Sit there and look at someone and make sure they don't escape basically. FG5

The pain and professional discomfort contained in these statements needs to be acknowledged and accepted by health service managers and bureaucrats, by fellow mental health care professionals, and of course by the nurses themselves, and we freely acknowledge this. At the same time however, we contend that it is very possible to view the changes to the nature of mental health nursing practice in rural and remote areas not as an attack on tradition and practice, but rather as unlooked for and unintended consequences of the move towards a mental health system that is by intention not based on long term institutional care but rather on short hospitalisation, community care and recovery. The collateral damage to affectionately remembered ways of being as a mental health nurse is unfortunate, but the core skills and values of mental health nursing are intact, and can as effectively contribute to the work of multidisciplinary mental health teams in rural and remote areas as they did to earlier models of care. To do so will involve mental health nurses following some of the treatment strategies that they use with clients, reframing their thoughts and experiences so that the behaviours that result are orientated towards future practice.

The mental health nurses who took part in our research very obviously hold nursing dear, the reflections and insights they hold and share loudly speak to that. Many of the highly developed skills of self-reflection and awareness, and the practice of working with others in collaborative practice that these nurses show in their narrative are exactly those in which their clients stand in need of. These mental health nurses are not in need of up-skilling or re-skilling in order to work in multidisciplinary mental health teams, they are already there.

We contend that consumers of mental health services continue to need nurses who know about and are adept in using strategies such as therapeutic use of self*,* nurses who are skilled at forming therapeutic alliances, nurses who practice self reflection, and nurses who engage in reflective practice, and that those nurses are able, if they wish, to continue to contribute their specialised knowledge to the work of community mental health teams.

The demographic data collected during the research indicates that a significant proportion (72%) of the mental health nurses who took part in our research are 45 or more years of age, and thus will be products of the apprenticeship system of training rather than the university system of education, which is now some two decades old in Australia. A notable feature of the discussions during the focus groups was that there was a higher level of acceptance of the realities and the importance of contemporary mental health practice in rural and remote areas in university educated nurses than there was in their older colleagues. This reinforces the findings of earlier research into generational attitudes to mental health nursing practice, (Crowther and Kemp, 2009) and also perhaps indicates that the gloom that can appear to envelop these colleagues may not be unduly impacting on their professional practice as mental health nurses. Indeed it can be argued that the variety of locations in which the nurses work in the de-institutionalised reality of their practice can facilitate mental health nursing rather that inhibit or constrain it. Working with the consumers of mental health care in their own home in their own local community, and in a range of community mental health settings allows a flexibility of practice and the application of a greater diversity of nursing interventions than was perhaps possible, or necessary in the now defunct and frequently geographically distant in-patient institutions.

The evolution of mental health in rural and remote areas of New South Wales has, in the eyes of the mental health nurses who took part in our research, led directly and irrefutably to a change in the nature of the role of the mental health nurse and an erosion of professional self image and worth. Nurses seem to be bewildered and unsure as to what their roles should be within the multidisciplinary team, as the statements by participants in the focus groups indicate. Wake (2013) has suggested that one of the trepidations that nurses experience is that their roles are being eroded by and given to members of other occupational groups. This, it is suggested, is erroneous and misplaced, because there is a societal and communal need for the work that nurses do to be

undertaken, and thus whoever carries out *nursing* becomes a nurse, regardless of the nature of their title, their training and their position in the hierarchies of health care organisations. This generalisation holds true for the mental health nurses who took part in our research, in that many of those nurses feel that nursing is not the way it was and that other people have encroached on their turf. However those same mental health nurses continue to effectively care for mental health consumers and their significant others, and do so despite some grumblings. We found no evidence of planned career changes, of ideas of giving up mental health nursing, or needing to radically alter the nature of their profession and its practice. We found rather that these mental health nurses are firmly grounded in the changed reality of their professional practice that has resulted from two decades of administrative and organisational change. A somewhat grudging acceptance of change can imply a reluctance to move beyond traditional power and career structures, but our findings challenge mental health nurses to continue their individual and collective development as key players in Australian mental health service provision.

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