Mental health nursing as a distinct speciality has been in decline in New South Wales, Australia for two decades. Arguably, this decline has worsened both consumer outcomes and the workplace experiences of mental health nurses. This paper reports on a study designed to ascertain the nature of contemporary mental health nursing practice in New South Wales. The study utilised focus group research methodology, with participants recounting the realities of their day-to-day professional practice and perceptions of their professional identity. The findings indicate a contracting, if not moribund, profession, a decrease in the value attached to mental health nursing and a pattern of persistent underfunding by successive governments of mental health services. Analysis of present and historical trends reveal there is a pressing need for a restructure and re-formation of mental health nursing in rural areas.
Realities of Mental Health Nursing Practice in Rural Australia

Abstract

Mental health nursing as a distinct speciality has been in decline in New South Wales, Australia for two decades. Arguably, this decline has worsened both consumer outcomes and the workplace experiences of mental health nurses. This paper reports on a study designed to ascertain the nature of contemporary mental health nursing practice in New South Wales. The study utilised focus group research methodology, with participants recounting the realities of their day-to-day professional practice and perceptions of their professional identity. The findings indicate a contracting, if not moribund, profession, a decrease in the value attached to mental health nursing and a pattern of persistent underfunding by successive governments of mental health services. Analysis of present and historical trends reveal there is a pressing need for a restructure and reformation of mental health nursing in rural areas.

Keywords; community, mental health nursing, rural.

Summary:

This paper links the shortage of mental health nurses in NSW to the closure of the mental health nursing register, a shift to comprehensive/generalist nurse education models, a perceived lack of nurses' professional standing
and natural attrition without suitably qualified replacements. Mental health nurses in this study perceived that they were not valued by other health professionals or by their own managers. Participants in this study reported mental health nursing in rural areas was an unattractive career choice. These findings are important to the understanding of recruitment and retention issues in rural mental health nursing in Australia.

Introduction

In Australia, nursing is facing major challenges in issues of recruitment and retention of nurses (Hegney, Rogers-Clark, Gorman & McCarthy, 2001) and much attention is presently being paid to the ominous situation of general nursing shortages throughout the country. The rural health context has been written about extensively in terms of disadvantage (Gibb, 2000; Gibb, 2001a), with mental health services specifically mentioned (Gibb, 2001b). The challenges faced by mental health services are even greater, yet receive less public attention (Allan, 2001). Limited mental health nursing services are available in rural areas and, where services do exist, there is an acute shortage of adequately trained staff (Hegney, 1996; Clinton & Hazelton, 2000; National Review of Nursing Education, 2002). The realities of practice for mental health nurses differ significantly in rural and metropolitan areas (Drury, Francis & Dulhunty, 2005), and recent trends reveal that decreasing numbers of nurses with appropriate training are willing to relocate to rural areas (Clinton & Hazelton, 2000). In the Australian state of Queensland, research findings point to a high level of reliance on inadequately educated nurses to care for the mental health client. (Aust Nurs J (2005). Further, low value and status are ascribed to
mental health work (Clinton & Hazelton, 2000). These factors have impacted on mental health nursing internationally, and have contributed in the US to a situation in which mental health care is being delivered by non-mental professionals (McCabe and Macnee 2002). From Ireland emerges evidence of a high level of aggression and violence being experienced by rural mental health nurses (Maguire and Ryan 2007).

To address these and other concerns, we begin by contextualising the historical development of mental health nursing as a specialisation within academia, a career and a profession. By examining the impact deinstitutionalisation has had on mental health nursing practices in rural communities, we first identify key individual and environmental concerns which have emerged over the past two decades. Next, in order to investigate the contemporary relevance and existence of key challenges facing mental health nursing, we present an analysis of focus group research collected with rural mental health nursing professionals in specific rural communities in New South Wales.

Literature review

Significant issues that impact on practicing as a rural mental health nurse include staff shortages (Hegney & McCarthy, 2000; Hegney et.al., 2001; Gibb, 2000), deinstitutionalisation (Allan, 2001; Sands, 2004), generational issues that affect how mental health nurses view their work (Crowther & Kemp, 2009), changes to undergraduate nurse education (Brown, 1988; Allan, 2001), consumer stigma (Allan, 2001; McColl, 2007), the lack of opportunity for promotion and violence and bullying (Allan,
Healthcare professionals working as part of community mental health teams are experiencing increasing levels of stress and burnout as a result of increasing workloads, increasing administration, lack of resources, increases in workload and administration, time management, inappropriate referrals, safety issues, role conflict, role ambiguity and lack of supervision (Edwards et al., 2000). Drury, Francis and Dulhunty (2005) suggest that isolation, autonomy, and high caseloads further impact on the nurses' work experience, and O'Brien and Jackson (2007) highlight as significant problems in nurses adapting to a rural culture.

Some of these experiences can be attributed to changes in the professional accreditation required of mental health nurses and their corresponding location within the hierarchy of health providers. When nurse education was transferred to the tertiary education section in the mid 1980s the comprehensive and generalist nature of the new approach to nurse education was inadequate to prepare students for mental health nursing practice, requiring further specialist preparation to meet workforce demands (Parliament of Australia, 2002; Roche & Duffield, 2007; McKenna, Thom, & O'Brien, 2008). This change in education has been found to have had a negative impact on encouraging students into mental health careers (Piazza et al., 2003). The inclusion of three distinctly different foci of general, psychiatric and developmental disability nursing into a single three year course diminished the strength and role of the mental health nurse (Report on the Inquiry into Nursing, 2002). The effect of changes in mental health nurse education resulted in a diminished interest in mental health nursing as a career (Brown, 1988; Allan, 2001; Mental Health Nurse
Education Taskforce, 2008). For instance, student enrollments specializing in mental health nursing have steadily decreased and fewer males have been entering mental health nursing (Allan, 2001; National Review of Nursing Education, 2002). Roche and Duffield (2007) also confirm a decline in the number of males working in mental health nursing, and further point out a steady decline in male nursing graduate numbers.

Interest in mental health nursing as a career choice by students is influenced by broader, institutionalized conceptualizations of work. In both historical and contemporary Western societies, healthcare careers have largely been characterized by gender stratification, with the predominance of nurses being female and physicians being male (Macionis, 2009). A large representation of women not only contributes to the stereotype of nursing as ‘women’s work’, but further contributes towards the career’s economic devaluation. According to sociologists, “in any field, the greater a job’s, income and prestige, the more likely it is to be held by a man” (Macionis, 2009, p. 283).

In Australia, national statistics also confirm ‘women’s work’ is socioeconomically devalued, over-represented in service-industry sectors and more subject to casualization and higher employee turnover rates (see Australian Bureau of Statistics, 2008; 2009). Nevertheless, some typically masculine professions have experienced an increase in the number of female employees. Today, women hold career positions in many previously masculine occupations, such as law (Chiu & Leicht, 1999), engineering and information technology (Stevens, 2009; Peterson, 2007). Women’s entry into traditionally male occupations is part of a broader
process known as the feminization of the workforce which commenced in the 1960s when men began to enter traditionally ‘female’ occupations such as primary school teaching, nursing and library studies (Blau & Hendricks, 1979 cited in Coventry, 1999). The entry of men into some typically female professions has witnessed a unique phenomenon whereby feminization has been associated with the up-skilling of the labour force where “men have largely retained their pay in the face of feminization” (Bruegel, 2000, pp. 98-99). Nursing is one of these anomalies. Analysis of the feminization of work in Britain found men who worked in feminised professional and semi-professional occupations, particularly in teaching, nursing and social work, (Abbott, 2006) were not subjected to the economic negatives typically associated with feminization because of their higher-than-average qualifications (Bruegel, 2000). Although this does not explain why there are fewer male nurses, and particularly male mental health nurses in Australia than might be desirable, the existing research identifies that men’s lack of entry into nursing may not be due to salary.

Although the experience of mental health nursing in Australia may be affected by the broader institutionalized and gendered work conditions characteristic of nursing and healthcare more broadly, the major influence on the practice of rural mental health nursing has been deinstitutionalisation and the implementation of a community-based model of mental health care. Arguably, deinstitutionalisation has had a greater impact on rural communities than metropolitan ones, since to receive in-patient care, rural mental health consumers had to travel considerably greater distances, and experience a greater dislocation from their support networks, than those in
metropolitan areas. In Australia, the most significant mental health reform has been the introduction of the National Mental Health Policy in 1992 which emphasised mainstreaming and integration as the future direction for delivery of mental health services (Sands, 2004). For the most part, mental health services are found in the community, rather than in the traditional psychiatric hospitals. The deinstitutionalization process occurred without the anticipated levels of funding. This impacted upon the ability of mental health services to provide role transition support and education for mental health nurses and to insufficient funding for best practice in community mental health nursing (Roche & Duffield, 2007; Mulvaney, 1994; Rosenman, 1995). Even within the psychiatric hospital system, nurses claimed they were being replaced by lower paid new graduates in the allied health professions (Allan, 2001).

Sanders and Tooth (1996) suggested the inadequacies of mental health care in the community setting have been compounded by the process of deinstitutionalisation because many consumers with persistent and enduring mental health problems now reside permanently in the community rather than in long-stay hospitals. The original intention of transferring funds to the community has not transpired because of the well-recognised problem that considerable resources have remained tied up in institutions (National Mental Health Report, 2007).

Roche and Duffield (2007) mention that deinstitutionalisation has had a significant effect on mental health nursing, claiming that roles and relationships have changed substantially and educational needs of the
mental health workforce in relation to these changes have not been met. Further, there was a major impact on remuneration and conditions of work. Perusal of Nurse’s Awards indicates that relocation from hospital based shift work to community based day work resulted in a loss of earnings of around one third of previous wages. (Nurses (South Australia) Award 2000, 2003, Public Health System Nurses’ and Midwives’ (State) Awards 2000, 2008).

Massey’s research into the effects of early phases of deinstitutionalisation on mental health nurses found that those who had been employed in hospital settings experienced loss, isolation, anger, grief and anxiety, as well as the financial impact of salary changes (Massey, 1992). There has been little progress since. There remains a tension between the roles of the nurses in the hospital setting and those in the community. Put simply, the nurses in the hospital cared for involuntary patients, people with enduring mental illness who were unable to be sufficiently rehabilitated to return to the community, psycho-geriatric patients and voluntary patients admitted for short stay management. Workplace practices put a strong emphasis on controlling the environment, protection, surveillance and biological methods of treatment such as psychotropic medication and electroconvulsive therapy in the Special Care Unit (Allan, 2001).

Allan (2001) identified the major concern for rural mental health nurses was the difficulty in engaging in therapeutic relationships. Nurses felt that they were required to engage in short term or ‘band-aid’ interventions, rather than in the development of sound interpersonal relationships and
therapeutic alliances (Allan, 2001). This inability to do what they were educated for was, they felt, due to the lack of staff and limited funding. However, the reality for Allan (2001) is that, in rural practice, there is little time for mental health nurses to engage in therapeutic activities because of the demands of crisis intervention. The primary health care/preventive focus is lacking for these rural mental health nurses (Allan, 2001).

Previous research has identified a range of enduring issues for rural mental health nurse practice. Ongoing issues include health care financial constraints, recruitment and retention issues, lack of opportunity for mental health nurses to develop therapeutic relationships, stigma of mental health consumers in small rural areas and inequity in promotions (Allan, 2001). In contrast, issues for rural mental health consumers include isolation, stigma, service provision problems and community estrangement (McColl, 2007).

The Report on the Inquiry into Nursing (2002) highlighted the impact of many of these factors and emphasised the importance of urgent action to remedy mental health nursing shortages. Further, the report suggested the main reason for the decline in the numbers of mental health nurses entering the profession was the cessation of mental health nursing-specific tertiary courses. Our research works to address many of these issues by commencing the long overdue task of asking rural mental health nurses to give voice to their day-to-day experiences as professionals. The details of our research methodology are presented below, along with key findings and future recommendations.
Methods

The present project aimed to establish the realities of practice for mental health nurses working in rural areas in New South Wales. Attempting to define what constitutes a rural area has led to the development of several classification systems. We used the Accessibility Remoteness Index of Australia (ARIA) classification system, under which four of the focus groups were held in areas which are categorised as “Accessible, having some restrictions on accessibility of some goods, services and opportunities for social interaction” and one group was held in an area categorised as “Highly accessible, having relatively unrestricted accessibility” to the same support factors. (ARIA, 2001, p7)

To establish realities of practice, qualitative research methodologies were employed that would enable the contextualization of mental health nurses’ workplace experiences. Subsequently, the data collection and data analysis phases of the research process followed a more interactive and mutually informative nature (Maxwell, 2005). Focus groups were chosen as the interview method not only because of their widespread use in health research, but moreover because of the depth of insight they may provide into participants’ experiences and perceptions (Polgar & Thomas, 2000). Focus groups consist of group interviews comprised of four or more people and are facilitated by a group leader (Polit & Beck, 2008) which provide a richness of data and an understanding of a specific phenomenon (Freeman, 2008). Prior to commencement of the research project ethics approval was sought and granted by the university’s Human Research Ethics Committee and by the ethics committees of each employer.
Consistent with qualitative research methodology, a non-probability sampling frame was applied that included purposive and snowball sampling methods which were informed by the geographical parameters of area sampling (Sarantakos, 2005). This sampling frame enabled us to attract research participants who were employed as mental health nurses throughout one state. Flyers advertising the research project, inviting participation, and advising of ethics approvals and procedures were placed in the staff rooms and health centers of mental health services throughout the rural areas of the state. Inclusion criteria were that the participants were mental health nurses, were employed in rural areas and were willing to take part in the project. Focus groups were held in the seminar rooms in each setting. In total, five focus groups were held from July-September in 2007. Thirty two mental health nurses of varying grades and with differing levels of experience took part. Before each focus group started, participants were informed of the purpose of the research, reminded of their right to withdraw from the project at any time, asked to sign a consent form and requested to complete a demographic questionnaire. Each focus group lasted between 90 minutes and two hours and was led by the first author. Participants were asked to share their experiences of being a contemporary mental health nurse in a rural area. Sessions were recorded and transcribed.

Research questions and data analysis

The guiding research questions were concerned with the types and numbers of clients being cared for, the nature of professional relationships within the care team and the impact of remoteness on practice. Qualitative
data analysis commenced first by listening to the focus group audio files twice to gain a broad understanding of salient concepts and trends emerging from the data. This was followed by a close reading of every transcript, line by line, still with no attempt to develop themes or codes. Next, transcripts were re-read again and preliminary notes were made. These notes were then used to develop broad themes which were illuminated by the continued re-reading of transcripts so that 'analyst-constructed typologies' could be compiled (Marshall & Rossman, 1999). As participant-centered understandings emerged, these were subjected to further transcript re-reading to ensure the data analysis reflected the meanings and perceptions of participants rather than any biases of the researchers. From this process, two salient themes emerged. By taking a grounded approach to data analysis, this works to ensure the arising themes have not been artificially imposed by the data collection process (Monette, Sullivan & DeJong, 2008). Nevertheless, as with all qualitative research, it is important to note the non-representative nature of this research limits its capacity for generalization to any broader population (Rubin & Babbie, 2008).

Results

From the analysis of data, two salient themes were determined. These were termed 1) poor collegial recognition and support and 2) location specific mental health nursing issues. Each of these will now be discussed.

Poor collegial recognition and support
Respondents stated they felt undervalued in comparison with and by non-mental health colleagues. There was a general perception that mental health nursing had declined as a professional discipline. Professional decline was cited as coinciding with the closure of the New South Wales mental health nursing register in the early 1990’s which terminated recognition of the discipline as a specialty area, and subsumed mental health nurses under the umbrella title of ‘Registered Nurse’. Respondents felt that the demise of their profession was a nearly terminal one and that a major national initiative was needed to recraft and redefine their profession. The impact of a lack of respect for the knowledge base of mental health nurses and a willing ignorance on the part of nurse and hospital managers as to the issues of mental health nursing practice, was marked and widespread throughout the responses. The statement, “You walk in (to the hospital) and you know you’ve got a battle on your hands for the validity of your profession” (2007, Focus Group 5) conveys the general lack of respect experienced by many. Likewise, as another participant noted, “People still have the idea that you aren’t a real nurse if you work in mental health” (2007, Focus Group 2).

Respondents shared that the closure of the mental health nursing register and the consequent shift to a ‘comprehensive’ or ‘generalist’ model of nurse education had a significantly adverse affect on their work and their professional standing. The mental health nurse workforce is generally older than the whole clinical nurse workforce (Piazza et al., 2003). Respondents indicated that this had already led to a loss of staff, as older
retiring colleagues were either not replaced or were replaced with nurses without a specific mental health qualification.

Recruitment problems were compounded by inadequate practices of successive governments and management teams. The cumulative effect of these was further impacted by the allied health subsuming mental health nursing roles. Once professional responsibilities were surrendered, it was believed to be impossible to regain them, and the emerging ‘slimmed down’ sphere of nursing responsibility was deemed less attractive to potential nursing recruits.

Perceptions of a lack of respect and support also included the judiciary. Assaulted and attacked nurses who attempted to press charges against a consumer or carer were dismissed with cursory disinterest; nurses who choose to work in mental health must accept a situation in which their personal safety is at risk. Policies of ‘zero tolerance’ of any aggression towards health staff were seen as political window dressing that merely bred contempt in the minds of consumers and carers. There were similar concerns about the behaviour of psychiatrists towards mental health nurses who were accused of bullying and intimidating nursing staff. Some participants noted that psychiatrists acted as if they ‘owned’ the patient and could therefore control the entire hospitalization, including what was written in the medical record about events they had not witnessed. For example, “…one of the psychiatrists said to me how dare you write that in the files” (2007, Focus Group 2) and,
“It all depends on the psychiatrist, on how they want things written, their in-thing and what you are expected to do.” (2007, Focus Group 2).

Many mental health nurses stated that since the closure of large mental hospitals their role had markedly expanded in some areas of practice and was eroded in others. Thus, participants spoke of having on the one hand to decide whether or not a client in crisis should be admitted, and on the other having to have each of their decisions validated by a social worker who was not in a supervisory role. The rise of the allied health professional had been particularly significant in this respect, and the incessant and persistent erosion of nursing responsibilities and nursing roles was resented. For example, participants noted, “you’re finding it more and more that Allied Health are taking on our client's loads, and it's very worrying for nurses” (2007, Focus Group 1) and “It was fully run by nurses, there weren’t any allied health whatsoever and that for me is the biggest change.” (2007, Focus Group 3).

Staff voiced anger at their apparent abandonment by allied health professionals as valued colleagues and by their own nurse managers, adding that mental nurses do all the ‘grunt work’ that allied health staff ‘run away’ from. For instance, nurses often had to make decisions as to whether or not to admit a potentially suicidal person, without collegial or managers’ support if the decision went awry. A participant in the first focus group noted,
“It’s ridiculous – look what happens when one of our clients commits suicide, the first thing they ask is ‘Is the file up to date? Is there a care plan? ‘Not are you OK?’” (2007).

Further, most nurses felt that there were insufficient resources provided by government and by management to enable them to adequately care for their clients. There was a marked consensus that Commonwealth and State governments had shirked their responsibilities in mental care provision for decades and that there was a need for urgent targeted funding for education and replacement of mental health nurses.

Location specific mental health nursing issues

The second major theme to emerge centered around comparisons of urban and rural locations. The majority of nursing staff had worked in the mental health sector in metropolitan areas and found differences in the workplace issues that confronted them when relocating to work in rural areas. There was a perception of greater pressure in the performance of their work in rural areas than in metropolitan areas. A widely shared view was that rural area clients were more unwell, admission data indicated that there were more dual diagnosis clients than they had encountered in practice in metropolitan areas and that all clients were kept too long in the community without therapeutic intervention. Impacting upon and compounding this scenario of high acuity was the lower level of provision of mental health support services (psychology, drug and alcohol teams, adolescent services, for example) when compared to those offered in metropolitan centres. Participating mental health nurses indicated that
their perceptions of high acuity and low support were shared by members of other mental health disciplines. For example, visiting psychiatrists voiced there were marked differences in acuity when compared to the state capital, Sydney.

“We have a lot more social problems, complex diagnoses, mixed diagnoses, dual diagnoses and limited services, and also…a lot of personality issues” (2007, Focus Group 5).

Participants indicated that the wider range of mental health services offered in metropolitan centres enabled mental health teams to undertake earlier detection of mental health problems than was possible in rural areas. In contrast, the relative paucity of services in rural areas meant consumers had mental health issues that had gone unrecognized and were thus less well when admitted to inpatient care. Nurses experienced a sense of professional isolation, which restricted opportunities for professional support and clinical supervision, and of involvement in the activities of professional nursing associations and bodies.

Discussion

This research has identified several key pressing problems with mental health nursing practice in rural areas of New South Wales. The number of mental health nurses in practice is steadily declining and any replacements lack mental health nursing specialist education. Findings revealed a range of factors responsible for the acute shortage of adequately trained staff, as also reported by Hegney (1996), Clinton and Hazelton (2000) and the National Review of Nursing Education (2002). Reasons cited for the
shortage of mental health nurses in NSW included the closure of the mental health nursing register, a shift to comprehensive/generalist nurse education models, perceived lack of nurses’ professional standing and natural attrition via retirement without suitably qualified replacements. The perceptions of those established mental health nurses, and their more recently qualified colleagues who took part in this study, were that neither group felt valued by other health professionals or by their own managers. Akin to the workplace stresses acknowledged by Edwards et al (2000), the acuity of client presentation, the levels of bullying and assault of nurses and the demands being placed on mental health nurses were felt by participants to be significant to their practice as nurses. Congruent with prior findings that changes in mental health nurse education have diminished career interest in mental health nursing (Brown, 1988; Allan, 2001; Mental Health Nurse Education Taskforce, 2008) and reduced student enrollments (Allan, 2001; National Review of Nursing Education, 2002), participants in this study reported mental health nursing in non-metropolitan areas was an unattractive career choice. At the same time, participants shared their belief that mental health consumers continue to need, and have a right as citizens to expect, nursing care that is at least to the same evidence-based and best practice standards as that received by consumers of other health care services. They all felt that if mental health nursing fails to re-establish itself as a vital part of contemporary professional health care in Australia, consumer outcomes would continue to worsen. The implications from this for rural mental health nursing practice are significant. The work-life of rural mental health nurses who took part in this project is onerous and unrewarding, and the level of education and on-going staff development
that they receive is inadequate. There is a pressing need for publicly funded mental health services to work in partnership with universities to ensure a significant increase both in the mental health specific content of undergraduate nursing degrees and in the support of nurses to complete post-graduate courses in relevant areas of practice. Consideration should be given to the concept of moving beyond narrow professional role boundaries by means of the introduction of generic mental health workers, as a way of meeting consumer needs in rural areas.

References


Industrial Relations Commission of South Australia (2000, 2003) *Nurses (South Australia Award)*


