PERCEPTIONS OF PROFESSIONAL IDENTITY IN MENTAL HEALTH NURSING AND THE IMPLICATIONS FOR RECRUITMENT AND RETENTION

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It has been said that completing a PhD is a lonely journey. In the past I have found this to be the case. However, in the last year or so, a number of people have helped make the final leg of my journey less onerous.

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ABSTRACT

Mental illness and its consequences present an ongoing challenge in terms of the provision of accessible, timely and evidence based interventions by suitably qualified mental health clinicians. Contemporary mental health services have been transformed with the introduction of primary health care and recovery based models of care. However, the numbers of nursing graduates entering mental health have been steadily declining and there is limited retention of experienced mental health nurses within the health care system.

This naturalistic study gathered the views of a group of experienced mental health nurses and a group of student nurses. It used a qualitative exploratory descriptive design to explore participants’ understanding of their role as mental health nurses and the impact of this on their professional identity within the theoretical framework of Role Theory. The study found that changes to the role of the mental health nurse have impacted on professional identity and that this has implications for ongoing recruitment and retention. In particular, the development of generic mental health clinician roles has caused mental health nurses to experience increasing role strain related to role ambiguity and role conflict.

This study has contributed to existing research into the professional identity of mental health nurses in relation to their role in contemporary practice. It has enunciated the complexity of the mental health nurse’s role and explored the impact of changes to mental health service delivery, developments in nurse education and the inherent challenges of an increasingly complex consumer group.

Recommendations related to undergraduate nursing education and support and professional development for mental health nurse clinicians have been made. These will assist in the development of strategies to improve recruitment and retention and promote mental health nursing as a career choice.
DECLARATION

I hereby declare that the work herein, now submitted as a thesis for the degree of Doctor of Philosophy of the Charles Darwin University, is the result of my own investigations, and to the best of my knowledge, all references to ideas and work of other researchers have been specifically acknowledged.

I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, and is not being currently submitted in candidature for any other degree.

Gylo Hercelinkyj
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CHAPTER ONE
INTRODUCTION

1.1 INTRODUCTION

Current statistics in relation to the prevalence of mental illness in the population are alarming. Internationally, the World Health Organisation (WHO) has estimated that next to coronary disease, mental illnesses such as mood disorders will be the second leading health problem by 2020 (WHO, 2001). In 2007, one hundred and twenty one million people globally were diagnosed with depression while another 450 million (1 in 4) people experienced some form of mental illness (Australian Institute of Health and Welfare, 2007). In Australia, it is estimated that mental illness will affect at least 1 in 5 adults and 1 in 10 children in any given year (Department of Health & Ageing, 2005). The growing number of people diagnosed with mental illness indicates a need for targeted strategies to support appropriate interventions and recovery based models of care. Patterson, Curtis and Reid (2008, p.410), state that mental health nurses “play a major role in the care and treatment of people experiencing mental health problems” and are pivotal to the success of any management strategies (WHO, 2007). However, there is growing evidence that the number of mental health nurses will be insufficient to meet the needs of the population into the future.

Chapter One highlights the contextual, educational and policy delivery framework changes that have impacted on the contemporary role of the mental health nurse. It explores how these factors influence mental health and the recruitment and retention of mental health nurses. It also considers student nurses’ understanding of the role of the mental health nurse and the significance of this understanding to the formation of professional identity and career decisions. Listening to mental health nurses’ experiences and their understandings of their role provides important insights that will contribute to ongoing promotion of the discipline and its central place in the development and delivery of mental health services. This chapter will also outline the purpose, aims and significance of the study. An overview of the theoretical framework and its application is provided together with an outline of the underpinning methodology. The key assumptions and limitations of the study will be presented together with a list of definitions of terms used in this thesis. Chapter One will conclude with an overview of the structure of the thesis.
1.2 BACKGROUND TO THE STUDY

1.2.1 Incidence of Mental Illness

Although mental illnesses account for approximately 1% of deaths, they are responsible for an estimated 11% of disease burden worldwide. The World Health Organisation has projected that this will rise to 15% by the year 2020 (WHO, 2001). In Australia, and according to Begg et al. (2007), mental health disorders are the third leading cause of overall disease burden, following cardiovascular disease and cancer. They account for 13% of the total burden of disease and 25% of total years lost due to disability. Burden of disease is defined as the number of years of life, or healthy living lost due to premature death, or disability, respectively (Begg et al. 2007). In Australia, the most common mental illnesses are reported as anxiety, depression and alcohol dependence disorders, with approximately 18% or 2.4 million adults experiencing symptoms of at least one of these disorders within the past 12 months (Andrews, Henderson & Hall, 2001; Australian Bureau of Statistics, 2007). Additionally, more than one-third of these adults will experience two or more conditions at the same time (Andrews et al. 2001). The National Mental Health and Well Being Survey (2008) found similar results for 3.2 million people who had experienced symptoms of a mental illness in the previous 12 month period. Anxiety and depression are expected to remain the third leading mental health cause of disease burden into the future (Begg et al. 2007).

Jablensky et al. (2000) argue that whilst the statistics for serious mental illness are less dramatic, serious mental illness has a significant impact on the development and delivery of mental health services. Furthermore, they account for most of the cost associated with specialist mental health services in the public mental health system across Australia. Between 0.4% and 0.7% of the adult population are affected by psychosis at any given point in time. In any one month, approximately 58,000 adults are in contact with mental health services because of psychotic illness. Of these, approximately 40,000 adults have schizophrenia, with most of the remainder having a severe mood disorder (Jablensky et al. 2000). When other disorders including conditions such as eating disorders, obsessive compulsive disorder and severe personality disorder are added to the group of people affected by severe mental illnesses, it is estimated that 23% of the total Australian adult population are affected by one or more mental disorders in any given year (Andrews et al. 2001).
1.2.2 Funding of Mental Health Services

The available figures provide evidence that mental health disorders affect the lives of a significant proportion of the population and impact substantially on their quality of life, productivity, social and employment opportunities. Despite this, Hickie, Groom, McGorry, Davenport and Luscombe (2005) argue that mental health services have historically been poorly funded. In the previous decade, mental health services have received less than 7% of total budget expenditure while at the same time mental illness has accounted for 27% of all disability costs in Australia.

There has been increasing public outrage regarding the poor access to suitably qualified mental health staff and services as well as the ongoing discrimination that consumers and carers experience. In response to this, a $1.9 billion boost to mental health services from the Commonwealth Government was announced by the Council of Australian Governments (COAG) in April 2006 (COAG, 2006). Reports such as the ‘Not for Service Report’ (Mental Health Council of Australia, 2005), have clearly highlighted the continuing plight of people with serious mental illness. Issues such as homelessness or substandard housing, inadequate access to health care, lack of respect for consumers and carers, as well as the burden carried by carers as primary caregivers all remain significant realities for many people.

Government funding boosts that occurred in 2006, together with changes in policy direction since 1992, have seen mental health services move from a predominantly tertiary, medically oriented, delivery focused system to one with a stronger emphasis on integrating mental health services within a primary health care focus. There is also a greater involvement and participation by consumers and carers in all aspects of mental health care delivery. These changes can be traced through the reforms to mental health services outlined in the First National Mental Health Strategy in 1992. This strategy consisted of the National Mental Health Policy, the National Mental Health Plan, the statement on the rights and responsibilities of mental health consumers and the Australian Health Care Agreement. In 1998, the Second Mental Health Plan was implemented (Department of Health & Ageing, 2010). The objectives of the first two National Mental Health Strategies related to the shift from institutional to community-based care and the delivery of services in mainstream settings. The Third National Mental Health Plan 2003–2008 consolidated the reforms begun under the first two plans. This resulted in the development of a number of priority themes focusing upon
the promotion of mental health and the prevention of mental health problems, increasing the quality and responsiveness of service provision and fostering research, innovation and sustainability (Australian Health Ministers, 2003). The Fourth National Mental Health Plan has extended these ideas and identified five priority areas for action in mental health. These are social inclusion and recovery, accountability for health care service provision, quality improvement and innovation, prevention and early intervention and access to services that are coordinated and continuous (Department of Health and Ageing, 2010).

In 2006, COAG ratified the National Action Plan on Mental Health 2006-2011 (COAG, 2006). This plan focuses on effective promotion of better mental health. Specifically it aims to reduce the prevalence of risk factors, and the severity of mental illness, to improve access to mental health care through medical services and community and non-government organisations (NGO’s), and to increase the rates of participation in training, education, employment and appropriate accommodation.

The following section will provide an overview of some of the salient issues regarding the current education of mental health nurses that have occurred in parallel to the policy and service delivery developments in mental health. All these factors have combined to create significant changes to the way in which student nurses are currently prepared today for practice in mental health.

1.2.3 The Mental Health Strategy and Education

Changes to the education of mental health nurses and legislative changes to registration for nurses working in mental health paralleled the new policy directions outlined in the First National Mental Health Strategy (1992). Nursing education had been conducted in the tertiary sector since the late 1980’s, however direct entry training for mental health nursing continued as the primary training method for mental health nurses until the 1990’s (Mental Health Nurse Education Task Force, 2008). The introduction of comprehensive undergraduate education for nurses in the 1990’s changed the entry level requirements for mental health nurses into practice. New educational models in undergraduate nursing focused on holistic frameworks of care, presenting primary health care as an integrating focus for nursing practice and prioritising the health of people across the lifespan. These changes in education were consistent with the changes in health care policy at the national level as outlined above, with the focus being on normalisation, community based care and integration of services (Neville, 1995).
Charleston and Happell (2004, 2005), Happell (1997, 2002), and Rushworth and Happell (2000) point out that mental health nursing education was integrated into comprehensive curricula, which varied with the amount of theoretical and clinical preparation given to mental health nursing. The argument for this comprehensive educational model centred on the need to prepare nurses to work across a range of settings which included mental health. Mental health nursing practice was regarded as a specialty area in which practitioners were best prepared at the postgraduate level of education. However, according to the Mental Health Nurse Education Task Force [MHNET] (2008), the undergraduate curriculum has become overcrowded with academic and clinical content. MHNET argues that in its current form the curriculum fails to prepare beginning level practitioners to meet the health related needs of consumers in mental health.

The educational changes were also consistent with the changes to registration that abolished separate registers for nurses working in mental health in all states and territories with the exception of South Australia (Happell, 2006). In Victoria, the separate register for mental health nursing was closed to new graduates from approximately 1994, following the introduction of the Nurses Act (Victorian Government, 1993). These changes have significantly impacted on the recruitment and retention of mental health nurses and subsequently upon the care of the mentally ill (Australian Institute of Health and Welfare, 2008). Furthermore, Happell (1997, 1999, 2002) and Rushworth and Happell (2000) have identified that mental health nursing is not viewed as an attractive career choice by students. This can be attributed in part to the stigma that still attaches to mental illness in the public imagination as well as the role and value of nursing in society (Halter, 2002; Overton & Medina, 2008).

The following section will discuss the way in which the role of the mental health nurse has been conceptualised and the difficulty in effectively defining and articulating the role.

1.2.4 The Role of the Mental Health Nurse

Mental health nurses play a central role as clinicians, case managers, clinical nurse specialists and nurse practitioners in mental health care settings. They are increasingly involved in a range of psychosocial interventions and work within recovery based models of care with consumers and carers.
Interventions include the development and implementation of psychosocial therapies for psychological distress, consumer participation in the development, implementation and evaluation of mental health services and the development and coordination of aggression management programs in acute inpatient facilities (Sinclair, Townsend, Keith, Hazelton, & Constable, 2007). Recently, mental health nurses have also renewed their skills in the more traditional area of medication management (Hemingway 2004, 2005; Hemingway et al. 2008). The World Health Organisation (2001) believes that nurses, as part of the multidisciplinary team, are especially relevant in the management of mental illness.

Furthermore, population health approaches have identified that mental health nurses take up the bulk of the work with consumers in both community and inpatient settings (Raphael, 2000). This is verified by the moves towards expanded practice roles for mental health nurses, particularly in the area of community mental health which have occurred in the last decade (Elsom, Happell & Manias, 2005, 2007, 2009).

However, these changes to policy direction, health service delivery and undergraduate nursing education have combined to increase role ambiguity in mental health nursing (Chang & Hancock, 2003; Rungapadiachy, Madill & Gough, 2006). As Waislitz points out:

*The role of the mental health nurse is not sufficiently understood, valued or supported in the wider community. Partly this is because although we’ve made progress in raising awareness of mental health generally, the indispensable role of nurses as carers and, importantly, healers who deal face-to-face with patients… on a 24-7 basis is not grasped outside those who have to deal with their own mental health and their families (Waislitz, 2008, p.5).*

One debate that surrounds the knowledge and skills required for mental health nurses to carry out their role is centred on whether mental health nurses work within a biomedical or an interpersonal framework (Barker et al. 1997; Gournay, 1995; Peplau, 1962). The difficulty in articulating the role of the mental health nurse lies in part with what is referred to as the invisibility of the core skills of mental health nursing, the nurse–consumer relationship rather than the execution of specific technical skills (Bray, 1999; Forchuk, 1994; Hamilton & Manias, 2007; O’Brien, 1999; Peplau, 1962; Welch, 2005). Hamblet (2000) believes that the low visibility of mental health nursing practice makes it difficult to quantify outcomes of interventions as they are less tangible. Hamilton and
Manias (2007) believe that the invisibility of mental health nursing interventions such as focussed observations has negative consequences in the capacity for mental health nurses to describe their role. Recent discussion on the role of the mental health nurse by the Department of Health in South Australia (2006), identified mental health nurses as multiskilled professionals whose holistic approach to care sets them apart from others working in the sector. Mental health nurses act as informed advocates. They are involved with consumers and carers 24 hours a day and have the capacity to apply a range of psychological therapies to their practice (Department of Health South Australia, 2006). Despite this range of skills, Fitzpatrick (2005) has drawn attention to the potential loss of mental health nursing’s distinctive professional identity. The present study proposes that if mental health nurses were enabled to more fully define and describe their professional roles, the situation of identity loss would be significantly improved.

With regard to professional identity and esteem it is important to observe that mental health nursing across Australia has been viewed since the late 1990’s as being in a state of crisis. There are a reduced number of graduates being recruited for specialist training in mental health nursing (Happell, 1997). Although specialist postgraduate education in mental health nursing might be viewed as essential by those in the field, there is no mandatory requirement for nurses working in the sector to obtain this qualification. Clinton (2001) has acknowledged this feature of mental health nursing preparation, stating that only 29.3% of mental health nurses have specialist post registration education. More recently, Happell and Gough (2009) indicate that the numbers of registered nurses undertaking specialist education in mental health nursing continues to be low. In addition, Clinton (2001) has detailed concerns surrounding the departure of mental health nurses in Australia to positions overseas and the high proportion of mental health nurses not employed in the sector. Another issue identified was that postgraduate qualifications in mental health nursing were insufficiently acknowledged, a factor which contributed to concerns about a lack of status and professional recognition.

Prebble (2001) supports the view of Hamblet (2000) that the move to a comprehensive based educational system in nursing “reveals a process of marginalization and ‘invisibilisation’ of psychiatric/mental health nursing…with a consequent reduction of skills and a weakening of the profession” (Prebble, p.136). This rendering invisible of mental health nursing in nursing education and clinical practice increases role ambiguity
which in turn increases the difficulty of articulating the role of the mental health nurse. This study proposes that the difficulty in describing the role of the mental health nurse and articulating this within the current role requirements creates ambiguity and uncertainty for the discipline which impacts on professional identity. This has significant ramifications. The continuing debate surrounding the role of the mental health nurse and the questions about who is best placed to assume these roles has become increasingly controversial. It has also increased the difficulty of promoting mental health practice as a career option to undergraduate and postgraduate nurses.

Public perceptions of mental health nurses and their role are considered in the professional and scholarly literature that has explored the role of the mental health nurse. As Halter (2002) and Humble and Cross (2010) argue, mental health nursing is inextricably linked to psychiatry and public perceptions of mental illness remain largely stigmatised (Adewuya & Oguntade, 2007; Halter, 2002; Overton & Medina 2008). The research literature also demonstrates that consumers value the therapeutic potential of the nurse-client partnership. Key elements are identified as clear communication, empathy, trust and cultural sensitivity. Concerns are also raised with regard to client autonomy, notably that there be an absence of coercion (Gilburt, Rose & Slade, 2008; Langley & Klopper 2005; Williams & Irurita 2004).

Discussions about role and identity have taken various approaches over the last four decades. Traditionally, research relating to the role of the mental health nurse has focused upon mental health nurses own perceptions of the most important elements of their work. For example, studies by authors such as Altschul (1972), Barker, Jackson, & Stevenson (1999); O’Brien (1999); Raingruber (2003); and Tummers, Janssen, Landerween and Houks (2001) have all identified that mental health nurses view the relationship between themselves and consumers as integral to their role.

1.2.5 Recruitment and Retention of Mental Health Nurses

In 2004, the Australian Institute of Health and Welfare [AIHW] (2007) reported that 14,123 nurses identified mental health nursing as their main area of nursing. However, this number represents only 6.0% of all employed clinical nurses. According to the AIHW (2007), the average age of mental health nurses was slightly higher than that of their acute care colleagues, 44.9 to 43.3 years respectively, with a higher proportion of males working in mental health when compared to the national average.
Major cities and inner regional areas had a relatively high number of Full Time Equivalent (FTE) mental health nurses per 100,000 of the population. Rural and remote areas had fewer mental health nurses per 100,000 head of population, with rates decreasing between 1999 and 2003 (AIHW, 2005). Currie (2007), and Greenwood and Cheers (2003) suggest that low remuneration, inadequate accommodation, poorly defined role structure, lack of support and orientation to the role, and loneliness and isolation all contribute to the ongoing problem of recruiting and retaining nurses to rural and remote area practice. In addition, authors such as Happell (2008b), O’Brien-Pallas, Duffield and Hayes (2006) and Robinson, Murrells, and Smith (2005) have identified major issues impacting on nurses’ job satisfaction in both general and acute mental health facilities. These include work life balance, the capacity to contribute to clinical decision making, low morale, poor inter- and intra-professional relationships, workplace safety and poor service provision. The national shortage of mental health nurses persists and (in some cases) continues to worsen across most states and territories in Australia, with the exception of Tasmania which also has a shortage of mental health nurses in regional centres (Department of Employment Education and Workplace Relations, 2009).

1.2.6 The Public View of Mental Health Nurses

The recruitment of nurses to mental health nursing requires a concerted effort to articulate and promote the work of mental health nurses. Roche and Duffield (2007) and Halter (2002) suggest that the decline in the attractiveness of mental health nursing as a career choice is that the public perception of psychiatry and mental health nurses in particular are framed by popular cultural representations such as *One Flew Over the Cuckoo’s Nest* (Forman, 1975), “Shine” (Hicks, 1996), and *Girl Interrupted* (Mangold, 1999). The image of Nurse Ratched as a jailor and tormentor in *One Flew Over the Cuckoo’s Nest* remains indelibly printed in the minds of many members of the public when they think about the role of mental health nurses.

According to several authors (Aber & Hawkins, 1992; Bridges 1990; Brodie et al. 2004; Fiedler, 1998; Gordon, 2001; Gordon and Johnson, 2004; Kalisch, Kalisch & McHugh 1980; Takase, Maude & Manias, 2006), the public does hold perceptions about who nurses are and what they do. This holds true as well – although to a lesser degree – for mental health nurses (Kalisch and Kalisch, 1981; Rungapadiachy et al. 2006). Some researchers have hypothesised that these social perceptions, media representations and
professional attitudes converge and stigmatise mental health nurses through a negative association with mental health (Halter, 2002).

1.2.7 The Impact of Being a Mental Health Nurse

Mental health nurses operate in a complex environment. They are required to create therapeutic encounters while simultaneously navigating the social, political and professional tensions that inevitably influence their experience of practice. However, there are limited opportunities for mental health nurses to talk about their experiences of their practice, how this informs their professional identity and the impact on their work. Mental health nurses are commonly affected by and exposed to issues such as stress, ethical tensions, workplace aggression and burnout. This is recognised in the sector and strategies directed at addressing the problems are implemented. However, mental health nurses are not often involved in the development of these strategies. Unsurprisingly burnout remains a major contributor to shortages of experienced mental health nurses in hospitals and clinics (Edward & Herelinskyj, 2007; Robinson et al. 2005; Taylor & Barling, 2004).

Morrall (1998, 2003) has drawn attention to the inherent ambiguity which characterises the mission and labour of mental health. There is a constant tension between the therapeutic intent of their engagement with consumers and the legislative demands that govern involuntary admission and enforced treatment of the seriously unwell. The literature also suggests a correlation between stress and burnout in nurses to date (Austin, Bergum & Goldberg, 2003; Currid, 2008), while Clarke and Aiken (2008), clearly demonstrate a correlation between adequacy of staffing levels, burnout and intent to leave nursing in acute healthcare areas. According to Happell (2008b), the majority of studies regarding mental health nursing and burnout have been carried out in the United Kingdom rather than in Australia. The factors which have been identified in these studies include high and complex case loads, the nature of working with patients with mental illness, variable staffing levels, lack of professional development opportunities, poor career structure, and lack of support from management.

Working with people who suffer from mental illness is more challenging than ever in the contemporary health care environment. The increasing level of workplace aggression has a significant impact on the morale of nurses in all areas of practice. In mental health nursing, violence and aggression are seen as major contributors to
increased stress levels in nursing staff and have a significant personal and an economic cost (Currid, 2008; Happell, 2008b).

The seminal work of Hochschild (1983) on emotional labour suggests that the organizational and professional expectations of the role of the mental health nurse can create tensions and therefore increase stress levels. For example, mental health nurses are required to respond in a particular way to verbal and physical aggression. This may well be at odds with their instinctive or preferred personal response to such an event. Such points of conflict can impact on mental health nurses’ professional identity. There is tension between professional role expectations, legal requirements that impact on caregiving policies, and personal reactions to the trauma occasioned by verbal and physical violence. This may leave clinicians feeling conflicted or confused regarding their role. This study addresses the important implications of such workforce issues on professional identity and the subsequent impact on staff retention.

In summary, the ongoing changes to the education of mental health nurses, the developments in policy and service delivery and the social views of mental illness have all impacted on the role of the mental health nurse.

1.3 PURPOSE AND AIMS OF THE STUDY

As previously described, this study argues that changes to the role of the mental health nurse have impacted on professional identity in ways which negatively affect the ongoing recruitment and retention of mental health nurses. Within the theoretical framework of Role Theory, the thesis explores how the role of the mental health nurse impacts on their professional identity. The aims of the study are twofold. The first aim is to identify strategies for promoting mental health nursing which will assist recruitment and retention. The second aim is to identify educational strategies in undergraduate nursing courses that have the potential to increase students’ career choice in mental health nursing.

1.4 SIGNIFICANCE OF THE STUDY

It is clear that a significant problem exists in mental health nursing. Currently there is a shortage of experienced mental health nurses and fewer nursing graduates are entering the mental health workforce. At the same time, there is an increasing number of people being diagnosed with mental illness and experiencing all the social, psychological and physical effects. Consumers require access to timely, appropriate care from suitably
qualified staff, and mental health nurses have been identified as being at the forefront of many of the new models of mental health care delivery. The literature has shown that much of the debate surrounding the decline of people working in mental health has centred on the social and cultural constructions of mental health, mental health nursing and workforce issues facing mental health services.

This study will make both a practical and theoretical contribution. A number of studies have considered aspects of the role of the mental health nurse, different factors influencing students’ career choice in nursing, workforce issues and to a smaller extent, skills mix in mental health nursing. However, no study has yet explored how the role of the mental health nurse impacts on professional identity and the implications this has for recruitment and retention in mental health nursing in Australia. In this study, professional identity will be comprehensively explored with regard to mental health nursing in one community of nurses. The results of this study will provide valuable data for policy formation and future healthcare planning. It will offer rich insight into the professional understandings of mental health nurses. In particular it will demonstrate how participants understand the role of the mental health nurse and its effect on professional identity, the knowledge and skills they believe mental health nurses need, and the impact of current educational and workforce issues on recruitment and retention.

This thesis will also make a contribution to existing literature on the subject by exploring professional identity through the framework of Role Theory. The approach will illustrate how participants’ understanding of their role, considered within the framework of Role Theory, can influence their professional identity. While the researcher acknowledges that the findings of this study cannot be generalised, they will contribute to knowledge regarding professional identity in mental health nursing and demonstrate how role theory can facilitate an understanding of the role perceptions of mental health nurses.

The results of this study will make a significant practical contribution by identifying strategies that can contribute to recruitment and retention in the workplace and educational settings. Research literature demonstrates that mental health nursing is not a popular career pathway for undergraduate nursing students (Happell, 1999, 2002, 2008a; Hoekstra, 2009). Gathering detailed information about nursing students’ understanding of the role of the mental health nurse and their view of mental health as a career choice will contribute data enabling practice and policy at the undergraduate nursing level. In
addition, the study will provide important information from mental health nurses regarding the educational preparation of undergraduate nursing students, particularly in mental health nursing. The results will also provide vital information about the reasons which influence mental health nurses to remain, to leave or to return to mental health nursing.

Finally, the findings from this study will provide the basis for the formulation of future research questions that can be explored in other Australian states and territories. Specifically, research that considers the influence of mental health nurses’ professional identity on recruitment and retention not only across different jurisdictions but also different practice areas, such as acute inpatient units and primary mental health teams, will help build a broader picture that will assist mental health nurses to have their role and contribution to contemporary mental health care recognised.

1.5 METHODOLOGY AND THEORETICAL FRAMEWORK

Mental health nurses work in a complex and dynamic environment. Their practice frequently involves circumstances of extreme emotional and psychological turmoil for consumers, carers and themselves. The changes to mental health care delivery have changed the way many mental health nurses are now expected to work (Brookes, Daly, Davidson & Halcomb, 2007). Selecting the naturalistic paradigm in which to explore participants understanding of their role and its impact on their individual and collective professional identities, recognizes the fact that this understanding evolves from their interaction with people and the changing events in their environment (Lincoln & Guba 1985). A qualitative, descriptive research design using in-depth interviews with a purposive sample of eleven mental health nurses and seven student nurses supports the naturalistic paradigm. A qualitative descriptive research design enables the researcher to present the participants’ experiences in their own words and highlights the unique context of each participant’s experience, not only where these experiences converge but also where there is divergence. The detailed rationale for the research design is provided in Chapter Three. As previously mentioned, the intent of this study is not to make generalizations about individual’s unique understandings of their world or to suggest causal interpretations, but rather to provide rich, insightful information that can help illuminate the current situation of mental health nursing in one contemporary, healthcare community.
Role Theory has been selected as the theoretical framework underpinning this study. Brookes et al. (2007) point out that nurses’ perceptions of their role are impacted upon by a number of factors including government policies, professional issues and wider social attitudes. Role Theory predicts "how people in organisations will perform in a given role or the circumstances, under which certain behaviours would be expected (Hardy & Conway, 1988, p. 28). The embedded concepts of role expectations, role stress, role conflict, role ambiguity and role strain will be defined and explored in relation to the participants’ perceptions of their role and professional identity. The application of Role Theory will show how people come to understand their role and what is expected of them. It provides a theoretical framework through which to effectively understand the broad diversity of responses to workplace challenges. In this study, these challenges include conflict between personal role and organisational role expectations, role ambiguity, and the overload of individual achievement capacity. This theoretical framework will guide the study at all stages including sampling, instrumentation development, data collection, data analysis and the interpretation of the study findings.

1.6 RESEARCHER’S PERSPECTIVE

The researcher comes to this study both as a mental health nurse and nurse academic. In my 28-year career I have worked as a mental health nurse and academic at both the undergraduate and postgraduate levels and in professional development in the clinical setting. Over this time I have repeatedly been asked ‘But what do psych nurses actually do?’ This question has also extended outside of the professional context to members of the public asking ‘You’re a psych nurse? That must be so hard. You deserve a medal’.

This has led me to reflect on the following questions, ‘Is it hard to be a psych nurse? How do I explain what I do?’ These questions have remained with me as I have witnessed the increasing stress under which mental health nurses work, the challenge in making mental health ‘come alive’ for nursing students in a positive way and the ongoing difficulty in attracting nurses to work in the field of mental health.

Because I occupy these various roles as well as that of researcher, it was necessary to be transparent regarding my own interest and investment in this study (Kamler, 2001). The aim of a qualitative descriptive research design is to hear about and present the participants’ understanding of their world (Kvale, 1996). In making this assertion, I am cognisant of entering the project not only as the ‘researcher’, but also as a mental health
nurse, and nurse academic who has contributed to the debates and decisions regarding policy direction in nursing education and who presents the first ‘face’ of mental health nursing that many undergraduate students experience. However, as the researcher I do not believe it is possible or desirable to try and distance myself from the research process in a way that denies the fact that I also occupy various positions in this study. In this, as in any study, the researcher must be aware that participants will have their own interpretation of their place within the project. What are essential is an awareness of this and recognition of the need to reflect on, and identify how power may influence the research process as it takes place. As Kamler states, recognizing and claiming the authority of our experience “demands a rigorously reflexive examination of ourselves as researchers and writers” (2001, p. 9). Given the different roles the researcher occupies in this study, specific strategies will need to be employed to minimise the risk of researcher bias, and the potential sense of participant coercion. Using the reflective tool of a researcher’s journal and building careful parameters around the process of recruiting participants will support the process. These will be discussed in detail in Chapter Three.

1.7 LIMITATIONS AND KEY ASSUMPTIONS

Before progressing further it is timely to map out the limitations and key assumptions which demarcate this examination of the role and professional identity of mental health nurses in the context of Role Theory.

The central tenet of Role Theory claims that when people take on roles they have expectations about what that role will involve, what their responsibilities will be and the recognition or rewards which might result from that role. These expectations are based on the personal and professional socialisation they have experienced. Therefore, a mental health nurse will have expectations about what a mental health nurse does, who they work with, what they need to know, and the values and attitudes that define their practice. These factors constitute their professional identity. Specifically, it is the way they describe their role, the value they place on it, how they view themselves and how they believe others view them as a professional group.

However, a person’s professional identity does not develop in isolation from other people, events and institutions. The role of the mental health nurse has gone through significant changes related to legislative developments, new policies and health care delivery frameworks. All of these shifts are challenging mental health nurses to reconceptualise their role and the way they contribute to care delivery. As previously
discussed, changes to the education and registration of nurses has meant that nursing students are educated across a broad spectrum of health disciplines in a much shorter timeframe in undergraduate nursing courses in Australia. Entry to practice in mental health is no longer achieved through direct entry programs, but is undertaken at the postgraduate level. Previous research studies (Clinton & Hazelton, 2000a; Happell, 2002, 2008a; Hoekstra, 2009) have also indicated that fewer graduate nurses are entering the field of mental health and workforce statistics indicates that there is a chronic shortage of mental health nurses across all jurisdictions in Australia.

Based on the literature reviewed, the assumption of this study is that there is an incompatibility between the contemporary role expectations placed on mental health nurses and their personal and professional role expectations, individually and as a professional group. This negatively impacts upon their workplace experiences. It also has implications for mental health nurses sense of professional identity, their understanding of themselves as active and valid members of the mental health workforce. This assumption stems not only from the literature but also from the researcher’s own experience in teaching mental health nursing at the undergraduate and postgraduate levels for over 20 years. Undergraduate nursing students often demonstrate an interest in mental health nursing. However, the thought of interacting with people experiencing mental illness can be frightening to them. Additionally, in the researcher’s experience, students are often uncomfortable about what they perceive as lack of clear direction regarding the role and responsibilities of a mental health nurse.

When mental health nurses perceive that there is conflict or ambiguity between their role expectations and those of the institution or professional organisation, this is reflected in their self-perception. The need to reconcile the disparity in role expectations may mean they accept the new role expectations and internalise the accompanying requirements and values. Alternatively, they may seek to shape or reshape their role to fit with their sense of professional identity, or may even reject the new role requirements. The choice that mental health nurses make will have an indirect but important impact on the recruitment and retention of nurses in mental health.

The researcher’s choice to utilise a sample of student nurses may be perceived as a methodological limitation to this study. As a group of participants with limited experience in mental health, the value of their contribution could be questioned. However, in the context of this study, the information obtained from the student nurse participants will not be viewed as a major data source. It is anticipated that their
perceptions will provide a good indication of how a group of student nurses view mental health nursing as a possible career choice. These insights will provide useful information when developing educational strategies at the undergraduate nursing level and also when planning for recruitment and retention.

1.8 DEFINITIONS

The following definitions are used throughout this thesis to maintain consistency.

**BNurse**: Three-year comprehensive undergraduate degree leading to registration in Victoria in Division One of the Nurses Board of Victoria Register.

**BNurse (Mental Health)**: A graduate of a three-year undergraduate degree in psychiatric nursing. This was offered in Victoria in the early to mid-1990s, but it is no longer available.

**Direct entry hospital based course**: A three-year apprenticeship style course leading to a Certificate in Psychiatric Nursing. It was phased out in Australia with the introduction of comprehensive undergraduate degrees in nursing in the mid-1990s.

**Hospital Based Direct entry (Post Basic Certificate)**: Registered general nurse who completed a 12–18 month hospital-based conversion course to hold registration as a mental health nurse. Separate registration for mental health nurses ceased in Victoria in the mid-1990s. The register only lists those nurses who hold a single qualification as a psychiatric nurse.

**Mental Health Nurse**: A mental health nurse works in mental health nursing which is a specialised field of nursing which focuses on meeting the mental health needs of the consumers, in partnership with family, significant others and the community in any setting. It is a specialised interpersonal process embodying a concept of caring, which is designed to be therapeutic by:

- Supporting consumers to optimise their health status within the reality of their life situation;
- Encouraging consumers to take an active role in decisions about their care; and
- Involving family/significant others and communities in the care and support of consumers.
Registered mental health nurses recognise the need for flexibility, adaptability, responsiveness and sensitivity as they continually shape their practice to the dynamically changing needs of the family, significant others and the community (The Australian and New Zealand College of Mental Health Nurses 1995, p. 3).

**Professional Identity:** Professional identity develops as a complex phenomenon that reflects the internalization of the knowledge, skills and attitudes which are considered to reflect the particular profession. It is also formed through, the interaction of the mental health nurse’s own beliefs and expectations about their role, and the public and professional expectations of other groups regarding the role of the mental health nurse. Professional identity is seen in the mental health nurse’s interactions with others in the context of their role within the particular institution. A mental health nurse’s professional identity will be reflected in how they describe their role, their self-image and perceptions of how they believe others view them (du Toit, 1995; Ohlen & Segesteben, 1998; Takase, Kershaw & Burt, 2002).

**Psychiatric Nurse:** A registered nurse who works with consumers during times of emotional or psychological distress to provide supportive physical, emotional and social conditions that assist to contain, diffuse or limit such distress (Barker 2003).

### 1.9 STRUCTURE OF THE THESIS

This study is a naturalistic inquiry that explores the role of mental health nurses and the impact this has on professional identity. This aims of the research will be achieved using a qualitative descriptive research design.

Chapter One has introduced the reader to the context of contemporary mental health nursing practice through a précis of the funding issues and concurrent policy changes related to health care that are taking place. On an international and national level mental health nurses are recognised as pivotal to the success of these new initiatives. However, workforce issues surrounding education, recruitment and retention indicate that it has become increasingly difficult to attract and retain nurses in mental health. The ways in which these changes have impacted on mental health nurses understanding of their role, and therefore their professional identity, has been identified as the focus of this study.

Chapter Two will offer a critique of the relevant research and scholarly literature within the theoretical framework of Role Theory. The literature related to the development of mental health nursing from a historical perspective sets an important context in which
to view traditional ideas regarding the role of the mental health nurse. This historical overview will be set against contemporary trends in nurse education and the impact that these trends have had on mental health nursing education at undergraduate and postgraduate levels. Following this, there will be a discussion related to the debate regarding the knowledge base and conceptual underpinnings of mental health nursing. A range of relevant research literature related to the description of the role of the mental health nurse and professional identity will also be presented. A discussion of the current workforce issues in mental health related to recruitment, retention and emotional labour in mental health nursing will conclude the chapter.

Chapter Three presents the research design and methodology of the thesis. The selection of the naturalistic paradigm to underpin the study will be presented and will include an exploration of its philosophical underpinnings and relevance to the research topic. A qualitative descriptive research design has been selected and the rationale for its selection is presented. The research methods include sampling procedures, pilot study, instrumentation, data collection, and data analysis. Procedures to enhance rigour and trustworthiness as well as ethical considerations and methodological limitations will be addressed.

Chapter Four presents the data analysis procedure and the major themes and subthemes identified through the data analysis process. Throughout this chapter the findings are linked to the literature. Chapter Five will discuss the major findings and conclusions. It will also address the implications for nursing policy and practice and make recommendations for further research.

1.10 CONCLUSION

In summation, this chapter has outlined the key features of the proposed study. The background to the study, its significance, purpose and aims have been identified together with the researcher’s perspective. The limitations and key assumptions of the study were also mapped out. In Chapter Two, a review of the literature in relation to the study purpose and aims will be presented and critically reviewed and the rationale for the selected theoretical framework will be established.
CHAPTER TWO
REVIEW OF THE LITERATURE
AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

As previously stated in Chapter One this study argues that changes to the role of the mental health nurse have impacted on professional identity in ways which negatively affect the ongoing recruitment and retention of mental health nurses. Within the theoretical framework of Role Theory, the thesis explores how the role of the mental health nurse impacts on their professional identity. The aims of the study are twofold. The first aim is to identify strategies for promoting mental health nursing which will assist recruitment and retention. The second aim is to identify educational strategies in undergraduate nursing courses that have the potential to increase students’ career choice in mental health nursing.

This chapter reviews the current literature informing the thesis. The layers of research foundational to this study may be grouped into four distinct genres and so the chapter is similarly organised into four review sections. Section One reviews the literature related to the history of mental health nursing practice the images of mental health nursing in the public domain, and mental health service delivery in Australia.

Section Two introduces the concept of Role Theory and discusses the rationale for utilising it as the theoretical framework in this study. Role stress, role conflict and role ambiguity are discussed in relation to the role of the mental health nurse. Section Two also reviews the scholarly and research literature related to professional identity in mental health nursing.

Section Three follows with a review of literature relating to emotional work in mental health nursing. Section Four reviews the current debate regarding the academic preparation of nursing students to work in mental health. It also considers the complex issues surrounding the recruitment and retention of mental health nurses. Table 2.1 presents the four sections in Chapter Two.
### Table 2.1: Organisation of Chapter Two

| SECTION ONE | • Mental health nursing in the Australian context  
|             | • The history of mental health nursing in Australia  
|             | • Images of mental health nursing  
|             | • Mental health service delivery in Australia  |
| SECTION TWO | • Theoretical Framework-Role Theory and the role of the mental health nurse  
|             | • Defining role theory  
|             | • Roles in organisations  
|             | • Describing the role of the mental health nurse  
|             | • Conceptual frameworks used to describe the role of the mental health nurse  
|             | • Research related to the role of the mental health nurse  |
| SECTION THREE | • The emotional work of mental health nursing  
|              | • Theoretical perspectives on emotion work  
|              | • Anxiety and stress in mental health nursing  
|              | • Resilience in mental health nursing  |
| SECTION FOUR | • Workforce Issues in Mental Health Nursing  
|              | • Contemporary educational preparation of nurses to work in mental health  
|              | • Career choices, clinical experience and recruitment  
|              | • Retention in mental health nursing  |
2.2 ACCESSING THE RELEVANT LITERATURE

To identify the relevant literature, the researcher began by using computer-assisted searches of several health, education and social science related databases. These included the Cumulative Index of Nursing and Allied Health Review (CINAHL), Educational Resources Information Centre (ERIC), Sociological Abstracts (SOCIOABS), SocINDEX, CROSSSEARCHER, and ProQuest. The relevant literature for this study was located using the key words: nursing, mental health nursing, recruitment, retention, workforce issues, stress, burnout, emotional labour, professional identity and images. Because of the extensive literature related to recruitment, retention, stress and burnout in nursing, the search was limited to the past 15 years. However, this timeframe was extended significantly for the section on images in mental health nursing to allow discussion of any relevant iconic pieces of literary work and films. The researcher also utilized some classic texts that went back to the 1960’s to the 1980’s. Examples such as Peplau (1962), and Reischel (1974), were included as significant contributions to the discussion on the history of mental health nursing, professional identity, and the role of the mental health nurse. Other sources were provided by manually searching for relevant articles or texts, cross referencing the references at the end of each article to identify additional relevant references and scanning the university library catalogue for general texts focusing on professional identity and professional socialization in nursing.

2.3 SECTION ONE: MENTAL HEALTH NURSING IN THE AUSTRALIAN CONTEXT

As stated in the introduction to this chapter, Section One will review the literature related to the historical development of mental health nursing in Australia. Providing a comprehensive overview of the history of mental health nursing in Australia is beyond the scope of this study. However, if the role of the mental health nurse in contemporary health care delivery is to be explored, it is important to have a sense of the historical development of the discipline. Therefore, the aim of this section is to map a range key points and issues which relate to the early development of mental health nursing in Australia. This will be followed by an analysis of popular representations of mental health nurses in mainstream literature and film. Traditional representations of mental health nurses impact upon and are reflective of public understandings of mental health generally and mental health nurses in particular. These images have broad implications for the public standing and professional identity of those working or planning to work
in the field. Finally, Section One will provide an overview of mental health service delivery in Australia. This will set the context in which to explore the role that mental health nurses play in contemporary health care delivery frameworks.

2.3.1 The History of Mental Health Nursing in Australia

Maude (2002) argues that historians have overlooked the contribution that nurses have made to the care of people with mental illnesses in Australia by making only fleeting reference to mental health nursing. This marginalises the mental health nurse’s role in the delivery of health care. The literature that exists primarily relates to the history of psychiatric services with nursing only considered, in a marginal capacity (Nolan1993). These interpretations have not been extensively reviewed or critiqued. Nevertheless, the history of psychiatry, or mental health as it is now referred to, has had a considerable impact on the development of nursing practice in this area. Concomitantly, as this study proposes, mental health nurses’ perceptions of their professional identity have been inextricably linked to the changes and developments to the field of psychiatry. Nolan (1993) traced the development of mental health nursing in the United Kingdom (UK) and believes that if nurses developed their history through researching the available evidence, it would confirm the legitimacy of the service they provide and promote their identity as a professional group. The history of mental health nurses is usually only given consort status, included in relation to the dominant history of another group, such as psychiatrists. This type of contextualisation carries an implicit assumption of the subordinate position of mental health nurses in their own discipline (Colliere, 1986; Nolan, 1993; Reverby, 1987). This study argues that the absence of mental health nurses in the history of psychiatry, and the lack of acknowledgment, is perpetuated in a contemporary sense by the continuing invisibility of nursing’s place within the mental health care team.

As Happell (2007b) points out, the history of mental health nursing differs significantly from that of other branches of nursing, where the influence of iconic figures such as Florence Nightingale and Lucy Osborne on the development of nursing services in the Colonies, is clear (Bessant, 1999). Historically, the care of the mentally ill was a different matter. Prior to the establishment of the first asylums in Australia, the mentally ill were confined to gaols or cared for privately. There was no distinction between those individuals experiencing mental illness and those who were intellectually disabled (Happell, 2007b). Gaols were always custodial rather than treatment oriented with
regard to the mentally ill. Bessant (1999) does not refer to mental health nursing as a discrete nursing entity until 1974, when the first conference of the then Australian Congress of Mental Health Nurses was held. The existence of ‘other’ branches of nursing is implied in the reference to the increasing specialisation in nursing between the 1950’s and 1980’s. It is not specified whether mental health nursing is included in this reference to specialisation.

The advent of the first Australian asylum at Castle Hill, NSW, in 1811 failed to provide a viable alternative to existing options in the lives of the mentally ill. Although the philosophy underpinning care was based on humane treatment, the day to day reality of caring for patients was primarily about containment. This could in part be attributed to the overcrowding at Castle Hill (Curry, 1989), but also as Sands (2009) points out, the prevailing attitude that mental illness was incurable. The work of attendants, who managed and cared for the mentally ill, came under the jurisdiction of the medical profession in Australia at the same time that the first legislation relating to mental health was enacted, through the 1843 Lunacy Act (Curry 1989). Prior to this, the first superintendent had been a layperson, whose approach to the care of mentally ill was grounded in a moral philosophy which focused on using the environment and the patient’s relations with others as the means of managing their behaviour. Curry (1989) has argued that the moral perspective can still be seen in contemporary therapeutic strategies which focus upon using the environment as a means of engaging and treating the patient (Elder, 2009). However, the ideological conflict between proponents of a moral philosophy of care and those who supported medical approaches to treatment “based in neurophysiology and neuropathology” (Curry 1989, p.10), contributed to the establishment of the Select Committee on the Lunatic Asylum, Tarban Creek in 1846. The findings of this committee enabled medical practitioners to assume the responsibility for governance and treatment. This development meant that the lay superintendent was demoted to senior warden. Curry (1989) has argued that this arrangement established the medical and nursing systems for the asylums and was copied everywhere throughout the colonies.

The first facility for the mentally ill in Victoria was only established in 1848 and was proclaimed a ward of the NSW asylum at Tarban Creek. It became locally known as the Merri Creek Lunatic Asylum. Following separation from NSW it became known as the Yarra Bend Lunatic Asylum (Reischel 2001). The first evidence of education for ‘mental nurses’ in Victoria was noted in the Annual Report for 1887 of the Kew asylum in
Victoria, Australia (Reischel, 1974). This was the beginning of a formal training system for staff in asylums. Reischel (2001) observes that lectures were provided by medical staff who also oversaw and controlled the educative process. In 1902, a number of general trained nurses were employed at the Kew asylum and several trained and untrained female nurses were employed in the main male ward (Reischel, 1974). As Reischel (1974) also points out, this was the first attempt at the integration of general and psychiatric staff in Victoria. This was the first recorded occasion that female staff became involved in the care of the mentally ill. Women were specifically referred to as nurses defining them differently to their male colleagues who were known as ‘attendants’ (Reischel, 1974). This demarcation of title suggests that the role of female staff was viewed in opposition to the more custodial approach to care that had previously been the norm. Education continued to be provided to attendants and nurses by medical staff and a three year training program approved by the relevant health authority in Victoria was introduced. However, this qualification was not recognized outside of Victoria, and nurses and attendants were not registered with the Nurses’ Board of Victoria (Reischel, 1974). Recognized education and registration as psychiatric nurses only commenced in Victoria with the passing of the 1958 Victorian Nurses’ Act (Reischel, 1974). The resistance to formal education and registration in Victoria mirrored the experience of mental health nurses in the UK, where there was also resistance to mental health nurses being officially recognised and registered as nurses alongside their general nursing colleagues (Chatterton 2004).

The advent of the antipsychotic drugs in the 1950’s saw radical changes in the care and treatment of people with a mental illness. Pharmaceutical management meant that there was less reliance on physical restraint and increased opportunities for mental health nurses to engage therapeutically. The concept of the psychiatric hospital as a therapeutic community, where nurses took “a personal interest in and formed a healthy relationship” with clients was incorporated into the education and training of mental health nurses (Sainsbury, 1968, p.20). Education programs included psychology, psychiatric nursing, sociology and rehabilitation as well as anatomy and physiology, medical and surgical nursing and pharmacology. These programs moved away from what Sainsbury (1968) viewed as the previous authoritarian approach to the care of the mentally ill.

Modern mental health nursing education commenced in the mid 20th Century (Rieschel, 2001). In relation to nurse education it is worth considering how the role of the mental
health nurse was conceptualised and communicated to students through the educational process. This thesis argues that educational texts have reflected the intended role of the mental health nurse. Through texts the parameters of this role were inculcated to students at the level of the Nurse Training School. However, shifts occurring beyond the bounds of the Nurse Training School – notably changes to mental health service delivery – created role conflict and role ambiguity for students when they entered the clinical setting as practitioners.

Reviewing a selection of text demonstrates how the role of the mental health nurse was conceptualised and communicated to students from the late 1960’s though to 1982. Highlighting three popular texts from the latter half of the 20th century, Alchin and Weatherhead (1976), Maddison, Day and Leabeater, (1968; 1970; 1975) Maddison and Kellehear, (1982) and Sainsbury, (1968), it is possible to see how the role of the mental health nurse was conceptualised in terms of their place within the overall structure of the mental health team, where they practiced, and the language used to describe their work. Reviewing four consecutive editions of one text illustrates how the role of the mental health nurse until 1982 was positioned in the hospital, reflecting the view that there was very little treatment and follow-up of consumers within a community based framework. The term contemporary mental health service replaced psychiatric hospital in 1982. This suggests a concerted effort to shift the ways that students conceptualised mental health care delivery and the role of the mental health nurse (Maddison, Day and Leabeater, 1968; 1970; 1975; Maddison and Kellehear,1982). Sainsbury (1968) makes a clear distinction between mental health nurses, psychiatrists and other staff, with mental health nurses and psychiatrist being considered together. This sets nurses apart from the remainder of the team, locates them firmly within a medical approach to treatment and suggests a dependency in their relationship to medical staff. Alchin and Weatherhead (1976) developed their text on the premise that “psychiatric nurses in training need to know what to do in the specific situations with which they will be confronted on the ward and the community” (Shea, 1976, p.i). The text presents the role of the mental health nurse as one which is grounded in helping clients deal with their reactions to the symptomatology of their illness. There is little or no focus on broader concepts of psychology or psychiatry, which the authors argue is dealt with in other texts. Their text is about “what psychiatric nurses are expected to do” (Alchin & Weatherhead 1976, p.ii).
Parallel to these developments, statements regarding changes to health care delivery generally, and mental health care in particular, were also being reported. Holland (1978, p. 16) stated that “A greater emphasis was emerging on health services outside institutions such as hospitals”. Another interesting point for consideration relates to the distinction that is made between general and mental health nursing. From 1968 until 1982 the authors of nursing texts contrast general nursing and mental health nursing as ‘different’. Mental health nursing was simultaneously positioned as sharing similarities with but being fundamentally different to general nursing. This perceived difference was seen to be one of orientation. The primary focus of mental health nurses was towards the behaviour of clients as a response to the emotional and personality changes resulting from mental illness. In contrast, general nurses were seen to be mostly involved with the physical care of clients. The concept of difference will be addressed later in this chapter.

The preceding discussion has illustrated how nursing in mental health evolved from the custodial framework of the penal system to the control of knowledge and practice by medicine. This thesis will argue that the impact of this history when combined with other factors has been detrimental to the formation of the professional identity of mental health nurses. In particular, mental health has been perceived as different and potentially not quite equal to other branches of nursing. Mental health nurses have battled to be regarded as a valid branch of nursing by peers in general nursing. These perceptions should not be seen in isolation from the history of psychiatry which demonstrates that people with mental illness were feared and reviled (El-Badri & Mellsop, 2007; Kelly, 1997; Overton & Medina, 2008). This association meant that the role of the mental health nurse may have been viewed as dangerous and synonymous with earlier models of incarceration. Mental health nursing is therefore at risk of being stigmatised by its association with psychiatry (Halter, 2002). In this context it is of value to critically examine the ways in which nurses generally and mental health nurses in particular have been represented in the public domain. Of particular relevance here is the way that mental health nurses understand their own professional identity and the conflicted relationship between public, professional and personal representations. This thesis argues that someone’s view about their profession and understanding of themselves as a professional influence their thoughts and actions in professional relationships and impacts on their professional identity.

Professional identity develops as a complex phenomenon that reflects the internalization of the knowledge, skills and attitudes considered to reflect the profession.
It evolves as well through the interaction of the individual nurse’s own beliefs and professional expectations about their role, and the public and professional expectations of other groups regarding the place and purpose of the mental health nurse. Professional identity is seen in the mental health nurse’s interactions with others in the context of their role within the particular institution (du Toit, 1995; Ohlen & Segesteben, 1998; Takase, Kershaw & Burt, 2002). This interaction is reciprocal, meaning that for the mental health nurse’s identity formation to be successful it must be understood and accepted by the other person or group. With this in mind, the next section will consider a range of literature that analyses how mental health nurses have been represented in the public domain and will review specific research related to professional identity in mental health nursing.

In the preceding discussion a brief outline has been provided which shows how mental health nursing developed from a penal system of incarceration that was focused on containment and isolation from the wider community. The education of nursing staff was determined by the medical profession and it would appear from the sources cited that this process continued until the mid 20th Century.

### 2.3.2 Images of Mental Health Nursing

Delacour (1991, p. 414) offers no explanation, but clearly sets mental health nursing apart from other areas of nursing when she states that her analysis of nursing “… does not include the construction of psychiatric nursing”. Given this dismissal of mental health nursing from the canon of nursing types it is important to review the available representations of mental health nurses and consider how these have reflected the public imagination. The cultural and political assumptions attached to these images should not be understated nor their embeddedness in contextually specific understandings of mental illness.

One seminal image from film that stands is that of Nurse Ratched from *One Flew Over the Cuckoo’s Nest* (Forman, 1975). Nurse Ratched is viewed as the archetypal image of a mental health nurse and Martyr (1999) suggests, that the opportunity for mental health nurses to build a credible public image has been inhibited by the film *One Flew Over The Cuckoo’s Nest* (Forman, 1975), which ‘contain[ed] one of the most immortal and yet repellent portrayals of a psychiatric nurse that anyone could hope to see’ (Martyr, 1999, p. 2). Nurse Ratched has been studied in various ways. Gilbert (1976) argues that the character is more symbolic of the power of the institution rather than a real
representation of nursing. Kalisch and Kalisch (1981, 1987), saw the representation of Nurse Ratched operating on two levels. Although she superficially “exhibit[ed] all the virtues associated with the nursing profession,” her non-verbal behaviour and communication “expose her … need to totally control the lives of her patients” through manipulation and guilt (Kalisch & Kalisch, 1987, p.175). Even contemporary films such as *Cosi* (Joffe, 1996) set up the mental health nurse as largely invisible or as a source of comic relief, and in *Girl Interrupted* (Mangold, 1999) the nurse is a nameless ‘observer’ who ‘symbolically’ removes her protective shield, a poncho, when called to action. All these images are typical of representations which reinforce negative attitudes towards mental health nurses. They also reflect the stigma traditionally associated with mental illness.

### 2.3.3 Mental Health Service Delivery in Australia

As outlined in Chapter One, there have been significant changes to the philosophy, policy direction and funding of mental health services since the 1980’s. Mental health nurses have been identified by a number of authors as being at the front-line in the move towards primary care and population health models of mental health care (Patterson et al. 2008; WHO 2001). Raphael (2000, p.37) believed that “mental health nurses in both community and inpatient settings provide the bulk of the care”. The Victorian Mental Health Act (1986) introduced through legislation the requirement for consumer involvement, community-based care and promotion of individual self-reliance. These changes were considered ground-breaking at their inception. To accord with this legislation, there were innovative developments in the way that mental health service delivery to all age groups was to be conceptualized and delivered (Australian Health Ministers, 2003). The Commonwealth Government also recognised the need for health professionals’ roles to evolve and become more flexible and less boundaried (Australian Health Minister’s Conference, 2004) in line with recognising consumer needs and right to accessible, quality care. These changes saw a fundamental shift from confinement in acute based inpatient facilities, to models of care designed to help people stay at home (Elsom, 2007). These new service models included: The Better Outcomes in Mental Health Care Initiative (Department of Health & Ageing, 2008), cross border agreements, state-wide specialist services, the mainstreaming of acute mental health services into general hospitals and the closure of the old stand alone psychiatric hospitals (Roche & Duffield, 2007). In addition the Mental Health Nurse Incentive Program was established in 2007. This provides funding to general
practitioners, psychiatrists, Aboriginal Health Services and other primary health care providers so that they may employ mental health nurses as part of their service (Chesterson et al. 2009). In the last decade there have also been increasing moves to develop and support Nurse Practitioner models of practice in mental health (Human, Rights, & Equal Opportunity Commission, 1993). These changes have had a profound impact on the role of mental health nurses in relation to the environmental, social and professional models of where, how and with whom they practice.

However, a number of key reports since the 1990’s, commencing with the Burdekin Report (Mental Health Council of Australia, 2005) through to the Not for Service Report (Surgenor, Dunn, & Horn, 2005), have presented clear evidence that consumers and carers continue to have difficulty accessing appropriate services in a timely manner and without experiencing feelings of ongoing stigma and discrimination. The negative responses reported come from mental health professionals (El-Badri & Mellsop, 2007; Kelly, 1997; Overton & Medina, 2008) as well as the broader community (Hayman-White, Sgro, & Happell, 2006). Hayman-White, Sgro and Happell (2007) argue that mental health nurses must contribute to the debate regarding policy development and program delivery. Epstein (2005) asserts that the Burdekin Report provided a unique opportunity for real consumer involvement in their own care and paved the way for collaborative methods of working. Epstein (2005) views the establishment of the National Community Advisory Group in mental health (NCAG), which came from the initial national mental health reform strategy as the only real effort by any government to provide consumers and carers with a voice in mental health care policy. Successive National Mental Health Strategies have increasingly failed consumers and carers. The abolition of the NCAG with the Mental Health Council of Australia (MHCA) marked the end of what Epstein (2005) considers to have been the first real attempt at collaborative partnerships between consumers and mental health professionals. Epstein’s (2005) views are important to the context of this study. Firstly successive government reports (1992, 1994, 1998, 2003, 2005, 2009) have highlighted the need to for new ways of working with consumers at the centre of any care initiatives. This has required mental health nurses to up-skill relocate work environments and move into new models of care. However, Epstein (2005) believes that these initiatives have largely failed and that mental health services continue to be delivered in a medically oriented, paternalistic manner. If this has indeed been the case, then in the context of this study
an important question that must be examined is the impact on mental health nurses’ professional identity as they have tried to find their place in this ‘brave new world’.

New roles such as the Nurse Practitioner which as Elsom (2005) pointed out, was being promoted as the pinnacle of nursing practice, was at that time not clearly defined. The Nurse Practitioner role has been conflicted, fractured by assumptions that to be truly professional, a nurse needs to be more like a doctor and less like a nurse. However, Elsom also indicated that consumer satisfaction tended to be higher with the Nurse Practitioner role than the General Practitioner role. Elsom's subsequent work in 2007 and 2009 has provided further insights into the expansion of the mental health nursing role with the author considering that mental health nurses are an ‘underutilised resource’ (Elsom, 2009, p100). Although this study is not exploring the Nurse Practitioner role or expanded nursing role responsibilities specifically, Elsom’s work is important as it reflects the ongoing redefinition of the mental health nursing role. However, this work does not consider the impact of expanded and nurse practitioners’ role on the professional identity of mental health nurses and how this influences recruitment and retention. This study interrogates the impact of the mental health nurses’ role on their professional identity irrespective of clinical context or a restricted definition of their professional responsibilities.

In the next section the theoretical framework of Role Theory will be discussed. The key assumptions of Role Theory and the rationale for the choice of Role Theory and its application to this study will be provided.

**2.4 SECTION TWO: THEORETICAL FRAMEWORK: ROLE THEORY AND THE ROLE OF THE MENTAL HEALTH NURSE**

When a person is asked ‘what do you do for a living?’ it is common to hear them refer to their position title, for example ‘I am a nurse’, or ‘I am a teacher’. Explaining what a nurse does is usually described in terms of their place of employment, specific tasks or functions, who they work with and perhaps examples of their work. What people are actually describing is their role. If there is confusion, lack of clarity or misunderstanding in these descriptions other people may be left to wonder exactly what it is that the person does.
Role Theory has been utilised in this study as the most appropriate theoretical framework through which to explore how participants’ understanding of the role the mental health nurse impacts on their sense of professional identity. The embedded concepts of role expectations, role conflict, role ambiguity, role overload, role stress and role strain will be defined and explored in relation to the participants’ perceptions of their professional identity. The concepts of Role Theory support the exploration of the participants’ perception of their own professional identity in relation to the significant role changes that have taken place over the preceding two decades. Employing this theoretical framework enables the exploration of professional identity to take place with the people who are carrying out the role of a mental health nurses in their natural context. However, there are limitations to the application of Role Theory. The researcher believes that no single theoretical perspective of Role Theory such as symbolic interactionist, structural, functional or organisational perspectives can account for the complexity of how mental health nurses understand, carry out and experience their role and therefore their professional identity in contemporary health care. For this reason a range of embedded concepts used in Role Theory will be defined and utilised in this study. The works of authors such as Khan, Wolfe, Quinn, Snoek and Rosenthal (1964), Biddle and Thomas (1966), Hardy and Conway (1988) and Katz and Khan (1966) will be utilised to provide a more comprehensive application of the concepts to the research purpose and aims.

2.4.1 Defining Role Theory

According to Conway (1988, p. 63), Role Theory is concerned with and predicts “how people will perform in a given role or the circumstances under which certain behaviours would be expected”. That is, the “patterned and characteristic social behaviours, parts or identities that are assumed by social participants, the scripts and expectations for behaviour that are understood by all and adhered to” (Biddle, 1986, p. 68). Biddle (1986) believes that people behave in ways that are different yet predictable because of their social identity and situation. Here is the first clear connection between role and identity. How an individual views themselves as a professional will be closely linked to what tasks or functions they are expected to carry out, how these expectations align with their understanding of their role and what factors in their workplace impact on this. These factors can be in relation to their working relationships with others or the organisational structures and expectations of employees. These beginning ideas form the basis from
which the participants’ perceptions of the professional identity of the mental health nurse will be explored in this study.

Roles have recognisable patterns of behaviours and expected behaviours assigned to them. Role expectations refer to the position specific demands made of or obligations felt by the person occupying that role (Hardy & Hardy, 1988b). There are also expectations regarding the behaviour of the individual or group that the role occupant interacts with. Furthermore, to make the complex nature of roles even more apparent, each of these individuals will have a set of role expectations they are required to meet. Kahn et al. (1964) refer to the concept of role sets to explain how connections between members of an organisation are attached to each other with varying degrees of responsibility, authority and autonomy in regard to the activities required in their role. Biddle (1986) also frames the idea of expectations in terms of norms. Norms are the expectations of behaviour that individuals and the group as a whole expect from themselves and each other (Hardy & Hardy, 1988a). Hardy and Conway (1988) consider that norms are specific to the position occupied by the individual. This study argues that these norms arise from professional, organisational and personal sources and coheres with Biddle’s (1986) belief in group and individual awareness of expectations. The attitudes, behaviour and knowledge required of an individual or group are embedded in role expectations (Hardy & Hardy, 1988a). This understanding is integral to the key point that expectations, in order to be known, must be communicated in some way. Expectations cannot exist in the absence of some form of relationship. In professional relationships colleagues and peers all have their own role set in relation to the context of the others (Kahn et al. 1964). This concept is seen most clearly in the advent and evolution of the multidisciplinary team within mental health services. Each member of the team is required to understand and meet the normative expectations of their role. In exploring the professional identity of mental health nurses this study explores the impact of working within the multidisciplinary team, how participants experience their role in relation to their responsibilities and the degree of autonomy and authority they believe they have. The manifold ways in which these factors are enacted in the workplace will be a focus of this thesis, as participants reflect on their role as mental health nurses and the link between this and their professional identity.

Norms will also be exerted by others external to the individual or group. That is, through changing government and organisational polices regarding mental health care and education of nurses, public perceptions regarding the rights and responsibilities of
consumers and carers receiving mental health care as well as prevailing attitudes towards mental illness. These ideas and requirements will be enacted through statements of expected activities or tasks. Where the expected activities stipulated match those of the individual or group, there is role congruence. However, where activities are additional to, in conflict with, or only match to varying degrees what the person themselves perceives as their role, there is the potential for role incongruence. These ideas highlight the degree to which a role is complexly formed through organisational requirements and expectations. This formation is also inflected and driven by the socialisation processes that prepare people to undertake the activities associated with the prescribed role and which occur in the context of reciprocal relationships between individuals and groups.

### 2.4.2 Roles in Organisations

Roles are associated with the specific social position an individual occupies and are also the result of normative expectations as described previously. The assignment of work roles prescribes the behaviour that employees are expected to comply with so that organisational goals which may be economic or social, will be achieved (Katz & Kahn, 1966). However, norms can vary among individuals and may reflect both the official demands of the organisation and the pressures of informal groups who may communicate via public perceptions. Because norms arise from a number of external sources, the individual may be subjected to role stress. In this situation, opposing norms must be contended with, competed against, accommodated through modification or accepted at the cost of compromising individual identity. Role ambiguity, role conflict or role overload may result from this (Hardy & Hardy, 1988b).

Role ambiguity occurs when an individual is unable or unwilling to assent completely with the normative prescriptions of a given role (Hardy & Hardy, 1988; Katz & Kahn, 1978). This may take place when there is lack of transparency or clarity regarding role expectations (Kahn et al. 1964). Kahn et al. (1964) indicate that role ambiguity is a type of role conflict. Role ambiguity occurs in the context of poorly communicated, poorly understood or inadequate information. In order to meet role expectations an individual needs to have access to and understanding of what responsibilities and rights they have, the activities and goals that are expected of them and the possible consequences of meeting or not meeting these role expectations. In the context of this study, role ambiguity is understood to occur when there is a perceived lack of clarity regarding
professional behaviours and practices expected as part of the role of the mental health nurse that clearly sets their practice apart from other mental health colleagues.

Role conflict is viewed by Kahn et al. (1964) as either the discrepancy between the role expectations with various roles or when individuals have differing perceptions of how a role should be performed. In other words, conflict occurs when an individual experiences stress from a difference or contradiction in one work role from that of another (Wickham & Parson, 2007). Role conflict can also take place when there are varying expectations by others towards the person occupying a particular role (Kahn et al. 1964). The key feature of this conflict is a breakdown in communication in role expectations between two or more people.

In the context of role theory and mental health nursing it is valuable to review Kahn et al.’s (1964, p.20) concept of role overload as a “complex emergent type” of role conflict. Role overload is said to occur when the expectation exists that an individual or group can assume a broad range of task functions which are congruent in theory (Brookes et al. 2007; Hardy & Conway, 1988; Major, 2003). However, the individual or group experience varying degrees of difficulty in meeting the expectations placed on them and experience role overload as a conflict of priorities. For example, research into workforce issues such as job satisfaction, stress and burnout has identified high case loads as one of the contributing factors (Happell 2008; Nolan, Haque & Doran, 2007).

Role conflict in nursing can occur when there is a dissonance between the professional nursing role and competing organisational roles and demands. Kelly (1998) states that new graduates experience role conflict due to severe job stress and role ambiguity and job stress has also been identified as a key issue in retention of mental health nurses. Role conflict experienced by mental health nurse participants will be explored further in this study. Also of interest is whether student nurse participants experienced role conflict between their expectations of the role of the mental health nurse and their experience in working with mental health nurses during their undergraduate studies. Additionally, the extent to which student nurse participants were aware of the mental health nurses attempting to reconcile divergent role expectations will be of interest.

Role Theory postulates that the organisation confers the assigned work roles to suitable workers who by accepting this role accept the expectations of that role. The assumption of consensus presumes that both the worker and organisation hold shared values and norms about the role (Wickham & Parker, 2007). However, as Katz and Khan (1966,
p.205) point out, 100 per cent agreement is not essential; “organisations can run on less than perfection”. Nevertheless, sharing these common norms ensures consistency in performance among workers and is best seen through such mechanisms as the employment contract, and enterprise bargaining agreements. Kerr (1978) noted that in order for role consensus to occur roles must be predefined, agreed upon and be consistent. However, as described in this study, mental health nurses work in an environment which is dynamic and rapidly evolving. Role displacement and role adjustment are continually occurring as health care organisations attempt to keep pace with external change. These include developments in medical and pharmaceutical technologies, changes to the economic policy and legislative mandates of varying governments and increasingly better informed health care consumers (Hardy & Conway, 1988). How mental health nurse participants perceive their professional identity in relation to changes in their work roles, and how student nurse participants develop a sense of identity within the context of mental health are key questions in this study.

Role stress is said to occur as a negative response to the multiple roles that can be assumed within the same context. Hardy and Hardy (1988) propose that role stress is located within the social structure of an organisation, notably within strategic goals, policies and role expectations. Role stress is ‘primarily external to the individual’ (Hardy & Hardy, 1988, p.159). The external nature of role stress occurs when role expectations are ambiguous, inconsistent, conflicting or difficult to meet. Hardy and Hardy (1988b) propose that there are a number of role stresses that affect clinicians. The types of role stress considered in this study are role conflict, role ambiguity, and role overload. The experience of role stress can, according to Hardy and Hardy (1988b), lead to role strain, which they describe as the individual’s subjective response to role stress and which must be resolved. The aim of any organisation is to employ staff who meet organisational expectations for behaviour, enabling the achievement of organisational goals and resulting in high levels of individual satisfaction among employees. Of particular interest in this study is how individuals cope with or adapt to changes in the role expectations of other groups when these no longer match their own professional role expectations. Role Theory provides the opportunity to consider how new roles are shaped and evolve from the discrepancy between professional and organisational expectations and demands.

Role strain, which is the internal emotional response to role stress (Hardy & Hardy, 1988) will impact on, and lead to a response from the individual affected. The individual may respond in one or more of several ways. They may adapt to the different role
expectations in the process of role acceptance. Alternatively they may negotiate and find a ‘common ground’ by shaping or reshaping their role or making a new role or they may withdraw from their role.

2.4.3 Describing the Role of the Mental Health Nurse

Discussion on the role of the mental health nurse is not new. Sheehan’s (1998) study reported on the role and rewards of asylum attendants at a West Yorkshire, England, asylum from 1852 – 1889. Defining their role as the list of functions an individual performs, Sheehan identifies those specific tasks that were prescribed for attendants. These functions included qualities such as kindness, gentleness and firmness. Attendants were expected to promote the safety, comfort and recovery of patients and every effort was to be made to secure the goodwill of the patient and friendship. Physical care was to be provided through maintaining good hygiene, and good nutrition. There was also a large emphasis on preventing the patient from absconding.

The following table charts the degree to which the role expectations of the nineteenth century mental health nurse identified in Sheehan’s (1998) study are similar to ideas about the current role of the mental health nurse in the contemporary scholarly literature. Some of the immediate comparisons can be seen with concepts such as the therapeutic relationship, therapeutic use of self, therapeutic milieu, professional boundaries and risk assessment. Table 2.2 shows the various role expectations of the mental health nurse in the mid-nineteenth century and in the contemporary literature,

**Table 2.2: Comparison between historical and contemporary roles of the mental health nurse**

<table>
<thead>
<tr>
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<tr>
<td>Kindness, gentleness and firmness</td>
<td>Limit setting and Boundaries</td>
</tr>
<tr>
<td>Securing the goodwill of the patient and friendship</td>
<td>Therapeutic relationship/therapeutic use of self</td>
</tr>
<tr>
<td>Maintaining safety and comfort</td>
<td>Therapeutic milieu</td>
</tr>
<tr>
<td>Prevent patient from absconding</td>
<td>Risk assessment/supervision</td>
</tr>
<tr>
<td>Physical care/nutrition/hygiene</td>
<td>Support activities of daily living</td>
</tr>
</tbody>
</table>
Whilst the language used in the nineteenth and twenty-first centuries differs, the ideas behind the role functions bear a number of similarities. This could suggest that the role of the mental health nurse has remained essentially unchanged and centred around a housekeeping and custodial role.

The counterpoint to this argument however, is that although the historical and contemporary roles may share a similar meaning this is at a superficial level only. The contemporary mental health nurse’s role is broader than the custodial role and takes place in a range of settings external to the institutional settings of the past.

The idea that mental health nursing is somehow ‘different’ has been explored in research literature relating to the specialist nature of mental health nursing. Peplau (1962) asserts this difference in terms of orientation and the mental health nurse’s particular emphasis in clinical practice. The reference to mental health nursing as a specialist area of nursing practice is argued in the context of the requirement for additional postgraduate qualifications and the specific knowledge and skill set required by mental health nurses (Warelow & Edward, 2007, Humble & Cross, 2010). It could be argued that evidence based research and the integration of findings into practice is the way in which the specialty nature of mental health nursing will be identified, disseminated and confirmed. Although this study does not specifically address if and how mental health nursing is a specialty, it will explore the skills and qualities that mental health nurses believe they need in order to be able to carry out their role. While the extent to which their perceptions impact on their professional identity is the main focus of this study, the degree to which their perceptions reflect the literature relating to specialty practice in mental health will also be of interest.

In addition to the arguments put forward claiming mental health nursing as a field of specialist practice, mental health nursing has also been conceptualised as ‘different’ to other branches of nursing. In earlier analysis of nurse educational texts the thesis has noted how mental health nursing is located as a site of professional difference. This is not only in terms of the skills and knowledge required but also in relation to the types of people who choose to be mental health nurses, the client population they work with and the conceptual frameworks which they use.

Humble and Cross (2010), undertook a phenomenological study with seven veteran mental health nurses to explore the reasons why participants chose to remain working as
mental health nurses. All participants had had more than 10 years clinical experience in mental health and worked at the same mental health facility across both inpatient and community settings. Following in-depth interviews the emergent theme identified by the researchers was ‘being different’ (Humble & Cross 2010, p.131). Being different related to the respondents’ attitudes towards consumers, their ability to work closely and collaboratively with consumers and their families and their confidence in their knowledge and skills. Respondents also believed that they based their work on a different philosophical framework to other nurses. This perceived difference in outlook and attitude was a strong feature of their professional identity and enabled them to view and work with consumers in a holistic manner. In exploring their perceptions of their role, mental health nurse participants in the current study will have the opportunity to add further rich data to Humble and Cross’s (2010) work. This is timely, as it appears the presumed differences between mental health and general nursing are a prevailing theme in nurse identity despite seventeen years of comprehensive undergraduate education. For this reason, the views of student nurses will also prove valuable in understanding the issues of difference.

2.4.4 Conceptual Frameworks Used to Describe the Role of the Mental Health Nurse

According to Norman and Ryrie (2009), the identity of the mental health nurse has been shaped by two distinct and at times conflicting traditions. These arguments centre on the ‘artistic interpersonal relations tradition’ (p. 1537) of mental health nursing, in which the therapeutic relationship assumes the central position in relation to how mental health nurses enact their role, and the ‘scientific tradition with the delivery of evidence-based interventions that can be applied with good effect’ (Norman & Ryrie 2009, p.1537). Research literature in this field demonstrates how the role of the mental health nurse has been contested within these two frameworks.

The following sections will present arguments supporting the notion of the interpersonal relations role of the mental health nurse to further extend and clarify the issues in this debate. Peplau (1962), Barker (2001), Barker, Jackson and Stevenson (1999a; 1999b) and Barker, Reynolds and Stevenson (1997) have all argued strongly for the significance of the interpersonal relationship between nurses and patients in mental health. Their work, developed across a period of five decades, places the relationship between the mental health nurse and consumer at the centre of the consumers’
experience of their illness. A close analysis of this argument will be followed by a consideration of the principal ideas underpinning an evidence based approach to the role of the mental health nurse. This study argues that such a variation in ideas about the role of the mental health nurse, when coupled with continuing changes to mental health care delivery and education, has the potential to precipitate role conflict and ambiguity for mental health nurses and students who are seeking to understand the role of mental health nurses. Cross (2009), has argued in a similar vein, asserting that policy directives in relation to health care delivery increase the risk of role diffusion and also affect the relationship between and within professional groups.

2.4.4.1 The Interpersonal Relations Approach to Mental Health Nursing

Viewing mental health nursing as an essential therapeutic and interpersonal process, Peplau (1962) believed that the nurse-consumer relationship was the crux of mental health nursing. Through this relationship, the nurse uses themselves as the therapeutic instrument. That is, the nurse engages with consumers through a variety of psychosocial interventions to facilitate personal growth on the part of the consumer. This concept moved the idea of nursing practice to one of ‘being with’ a consumer rather than ‘doing things’ to them. This implied a much more active and interactive dialogue between nurse and consumer (Barkway 2009). Peplau (1962) also proposed the therapeutic relationship passed through a number of phases that evolved from the initial contact through to discharge. Peplau identified these phases as the orientation, working and resolution (Forchuk, 1993). In order to maximize their work with consumers, Peplau (1962) proposed that nurses assume a variety of roles at different times, in response to the emerging needs of the consumer. It was through the therapeutic relationship and the variety of roles that mental health nurses undertake that Peplau believed clinicians create an environment or milieu to help consumers develop the ability to connect with others in their environment. Gournay (1995) has argued that ideas such as Peplau’s reflect an outdated method of practice. Nevertheless, other researchers have argued that Peplau’s ideas continue to have merit in contemporary practice (Barker & Reynolds 1996, Barker, Reynolds & Stevenson 1997 1999a, 1999b, 2001; Forchuk, 1993, 1994, 2005, 2007).

Forchuk (1994) began working with Peplau’s (1962) ideas and explored the orientation phase of the therapeutic relationship. This author argued that the orientation phase of the therapeutic relationship was a clinically significant phase that must be worked through by nurses and those who suffer from chronic mental illness. The orientation
phase is primarily concerned with both the nurse and client working through preconceptions which may have developed during past experiences of health care. It also involves the development of initial trust and the negotiation of an understanding of each other’s roles (Forchuk, 1994). Based on this definition Forchuk (1994) investigated eight hypotheses related to the orientation phase of the therapeutic relationship. Using a non-probability, purposive sample of 124 new established nurse-client dyads, results indicated that the preconceptions of the nurse or patient about the other person in the dyad would have an impact on the length of the orientation phase and the development of the relationship overall (Forchuk, 1994). When clients experienced more positive interpersonal relationships generally, this was associated with a greater success in establishing the therapeutic relationship. This initial research has been developed into the Transitional Discharge Model (Forchuk, Martin, Chan & Jensen, 2005; Forchuk, Reynolds, Sharkey, Martin & Jensen, 2007) and the use of peer support and bridging staff who maintain contact with consumers until they have established a therapeutic relationship with a community case manager (Forchuk et al. 2007). Forchuk’s work demonstrates the power of the relationship and its impact on consumer outcomes and is built on Peplau’s theory of interpersonal relations. In contrast to the arguments put forward for a much closer alignment with the biomedical approach to care (Gournay 1995, 1996; Nye 2003), Forchuk (1994) and Forchuk et al. (2005; 2007) demonstrate that it is entirely possible to research theories such as Peplau’s (1962) to identify quantifiable outcomes in relation to decreased lengths of stay in hospital, reduced costs of care and improved quality of life measures. The research indicated that consumers and nurses similarly value the interpersonal approach to mental health nursing practice. This supports the recent literature regarding consumers’ beliefs about the role of the mental health nurse. As roles in contemporary mental health care continuously evolve, it is important to understand the weight which participants give to their interpersonal contact with consumers. This also enables an exploration of the continuing relevance of Peplau’s work. For the purposes of this study, participants have been asked to reflect on how they describe their role. The extent to which they describe their role in interpersonal terms will also reflect how concepts such as those described here influence mental health nurses’ perceptions of their professional identity.

A second conceptual framework which best describes the intended role of the mental health nurse is the Tidal Model developed by Phil Barker (1997, 1999a; 1999b; 2001). The key principles of this interdisciplinary model are active collaboration, person-
centred care plans, multidisciplinary work and narrative based interventions. According to Barker, Reynolds and Stevenson (1997) mental health nurses do not attempt to address mental illness in and of itself. Rather their focus is on the individual’s human response to their illness. The Tidal Model is the culmination of a five year study by Barker et al. (1999a, 1999b) titled The Need for Psychiatric Nursing Study which explored the perceived need for mental health nursing. Using focus group interviews and a critical incident technique the authors explored three questions related to what participants expressed as a need for psychiatric nursing. The aim was to define the core activities that distinguished nurses from other mental health professionals, and seek a consensus across the mental health disciplines regarding the need for psychiatric nursing. Through this study the authors aimed to demonstrate the unique contribution of mental health nurses to care delivery. This study identified that the core requirement of mental health nursing, as viewed by the participants, was the need for mental health nurses to have a high level of empathy in order to ‘know’ what consumers needed at any given point of time in their illness. This constituted a continual and reciprocal process of the mental health nurse and consumer getting to know and re-know each other as the relationship evolved and the needs of the consumer changed. Mental health nurses achieved this by moving between three interrelated domains (Barker et al. 1999a), which referred to the degree and depth with which the mental health nurse engaged with consumers. These domains reflected what the authors referred to as a “disposition” of the nurse, that is, the extent to which the mental health nurse is inclined to act in a given context. The degree to which mental health nurses engaged with consumers was influenced by any one or combination of the following four dimensions: time, depth of knowing, power and translation (Barker et al. 1999a). This model recognises that mental illness is a complex phenomenon and the idea of recovery is closely aligned with caring as opposed to curing. This approach conceptualises the individual as living with a mental illness and therefore managing symptoms as part of their life. Health is not seen in terms of merely the absence of symptoms but living a positive life in the presence of symptoms. Recovery is developing an identity that includes illness and wellness (Helm, 2003) and involves metaphorically reducing the ‘dis’ from disease.

This study argues that the interpersonal relations approach to the role of the mental health nurse maps the role of the mental health nurse as a reciprocal and interactive relationship between the nurse and consumer. The relationship between the mental health nurse and consumer moves through a number of phases in which each member,
defines, negotiates andreshapes their role as the condition of the client changes. Role specific expectations are placed upon the mental health nurse, including the ability and willingness to adapt to changing situations or demands. However, it needs to be acknowledged here that this relationship takes place within the context of specific organisational, legislative and professional role expectations. This study is particularly interested in the impact of any role conflict, ambiguity or overload on the mental health nurses’ professional identity.

2.4.4.2 The Biomedical and Evidence Based Approach to the Role of the Mental Health Nurse

A second approach that informs the view of the role of the mental health nurse is the biomedical and evidence based approach. Proponents of this approach argue for a greater emphasis on neurological and biological approaches to understanding the experience of mental illness and working with consumers. Mental illness is viewed as occurring at the neuro-chemical level. Recovery from mental illness is conceptualized in terms of the elimination of symptomatology (Nye, 2003). Gournay (1995; 1996) dismisses psychoanalytic understandings and nursing knowledge such Peplau’s (1962) ideas as outdated relics, presumably because they are not supported by empirical evidence. Gournay argued that community mental health nurses must embrace specific knowledge to meet local context needs, such as information processing theory, neuropsychology and attribution theory through specific training and simultaneously be “sensitive and responsive to the needs of individual users and their carers’ and families”(Gournay 1995, p. 14).

One year later, Gournay (1996) argued that mental health nurses should be using the same core skills regardless of the setting in which they practice. The focus of mental health nurses should be on working with people with serious mental illness and the connections between in-patient and community based care must be strengthened rather than remain siloed. Nursing roles that he considered had been neglected, including consumer's physical health and medication management, needed to be incorporated back into the mental health nurse’s role. Undergraduate education was viewed as being anti-psychiatry and lacking in sufficient knowledge regarding biological aspects of mental illness and medication management.

While Gournay (1996) acknowledges the role of the mental health nurse in providing direct care, he nevertheless suggests that “none of the nurses of the future will want to
attend to basic nursing care tasks for the mentally ill” (p.106). It must be noted here that Gournay’s comments are in reference to the UK model of nurse education which from the mid-950’s until the mid-1980’s offered direct entry programs for mental health nurses. The implementation of Project 2000 saw mental health nursing offered as a branch program with the demise of the direct entry system of education and training (Playle, personal communication 28/02/2010). However, unlike the comprehensive undergraduate programs offered in Australia, nursing students still complete their qualification in one of four branches of nursing, undertaking a one year common foundation and two year branch model. The University that student nurse participants were recruited from for this study states that students have undertaken a program of study that focuses on the understanding and application of holistic theory to practice (Deakin University, 2004). The extent to which students’ perceive the role of the mental health nurse to be holistic, and encompassing a biopsychosocial approach to care will be of interest. Gournay (1996) also argued for a greater emphasis on evidence-based approaches to nurse education and promoted the development of research in psychiatric nursing within the context of multidisciplinary investigations using randomised controlled trials and economic analyses.

Nine years later, Gournay (2005) believed that many of these new roles had in fact emerged, but the increasing emphasis on working with people with serious mental illness meant that attention to those experiencing common mental illnesses had been diminished. Reasons identified included the lack of community mental health nurses and the change in the focus of training to the specific skills seen as relevant to the needs of consumers suffering serious mental illness. The idea that some mental illnesses are ‘more serious’ than others is troubling, as it suggests that one group of consumers is potentially deemed to be less in need of treatment approaches from suitably qualified staff. If the intent is to distinguish the prevalence of these disorders rather than the seriousness of any illness, the fact that these common illnesses, including post-traumatic stress and anxiety disorders are contrasted against serious illnesses such as schizophrenia is contradictory, as the statistics identified in Chapter One illustrated. In addition, the roles that Gournay (2005) claims to be necessary for working with people with serious mental illness are equally important when working with people with common mental disorders. These roles include family interventions, physical healthcare, medication management and psychosocial interventions (Gournay, 2005). This thesis explores participants’ views regarding the knowledge and skills required by mental health nurses.
and the extent to which they distinguish between different groups of consumers as being more or less in need of their expertise. Studies such as those by Usher, Holmes, Lindsay and Luck (2003), Usher and Luck (2004) and White and Winstanley (2009; 2010) demonstrate the growing trend towards research that is focused on identifying gaps in evidence based research and promoting best practice which is “important for providing evidence for practice” (Warelow and Edward 2007a, p. 58). For example, Usher, Holmes, Lindsay and Luck (2003), argue that the administration of PRN (as needed) medications is a problematic legal, professional and clinical issue for nurses, yet little empirical research has been done on ‘prn prescription or administration practices” (Usher, Holmes, Lindsay & Luck 2003, p. 249). A large amount of research is now focused on clinical issues such as medication management and consumer adherence interventions by nurses and the use of psychological interventions with consumers (Jones, Bennett, Gray, Arya, & Lucas, 2006; McCann, Clark & Lu, 2009). However, Montgomery, Rose and Carter’s (2009) view is that research on the relationship between mental health nursing intervention using outcome measurement tools and patient outcomes, does not provide consistently strong evidence to support best practice recommendations for the specific use of particular tools. Interestingly Gournay (2006) appeared to qualify his remarks regarding the biological model. Stating that the biological approach is one approach to the care and treatment of people living with mental illness and cannot be divorced from others, he argues that it has “major importance’ (Gournay 2006, p. 354) in understanding and treating mental illness. He also states “that a humane approach to all patients, regardless of the problem, must be paramount” (Gournay 2006, p.345). His comments support this study’s view that all understanding of mental illness and the applications of interventions must occur through the therapeutic engagement between nurse and client.

The interpersonal and biomedical, evidence based approaches to the role of the mental health nurse seem to be consistently placed in opposition to each other. However, according to Hamblet (2000) and Norman and Ryrie (2009), the complexity of mental health nursing work means that it is not possible to classify mental health nursing in such a distinct way. Because of the diversity of clinical contexts that mental health nurses work in and the role expectations in these areas of practice, this study argues that mental health nurses should be supported to find ways in which to demonstrate and articulate how their professional identity is built from both an interpersonal and evidence based platform. The following section reviews a range of research literature

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related to the role of the mental health nurse, particularly in relation to the importance of the interpersonal relationship between mental health nurses and consumers.

2.5 RESEARCH RELATED TO THE ROLE OF THE MENTAL HEALTH NURSE

An exploratory study by O’Brien (1999) in New Zealand used focus groups to investigate experienced nurses’ perceptions of expertise in relation to their practice. The focus groups comprised two groups of four inpatient acute mental health nurses and five community mental health nurses. The nurse-patient relationship was the central theme in both focus group discussions. The three sub-themes identified were involvement; individualising care; and minimising visibility.

The major finding of O’Brien’s (1999) study was that both groups viewed the nurse-patient relationship as being central to their practice. Relationships were negotiated and renegotiated with the process being both contextual and dynamic which correlate with the concepts identified in the Tidal Model (Barker et al. 1999a; Barker et al. 1999b; Barker et al. 1997). Each of the sub-themes identified above described those practices as integral in the negotiation and maintenance of relationships with clients. Participants described the tension they experienced between being involved with consumers and the legal mandate that required them to participate in procedures such as involuntary admissions. O’Brien (1999) did not address how participants reconciled such tensions. If professional identity and value in one’s work as a nurse involves a sense of nurturing, compassion and caring, it is important to explore how mental health nurses reconcile this tension and any impact this might have on role strain and their professional identity.

The current study will provide an opportunity for participants to reflect on those characteristics they view as important to their role, the circumstances that create role stress and how they manage these situations.

The respondents in O’Brien's (1999) study saw minimising visibility as a process in which they “negotiated … involvement while recognizing and respecting the interpersonal and “…social boundaries which surround mental illness” (O’Brien, 1998, p. 158). A particularly interesting point was the notion that a “clinical professional role was seen as a potential barrier to their relationships with their clients” (O’Brien, p. 158).

It appears from this account that in attempting to humanise their relationships with clients, mental health nurses may potentially place themselves at risk of overstepping the boundaries of their professional relationship. This present study will explore whether or
not mental health nurse research subjects view this as an issue and how this tension is reconciled.

Nolan, Haque and Doran (2007) compared aspects of mental health nurses work in the United States with equivalent United Kingdom mental health care settings. The sample size consisted of 65 mental health nurses in the UK and 43 mental health nurses in the United States. The aims of the study were to identify the most and least satisfying aspects of participants’ work and document their suggestions regarding strategies for improvement. Using a 12 item questionnaire comprising open and closed questions, the results illuminated some crucial factors in the working lives and preferences of the respondents. Three primary concerns were given equal weight in the responses of those surveyed. The first of these was anxiety regarding their role in mental health care delivery with the advent of primary care teams. The second was confusion regarding the use of new role descriptors in teams and the third was disagreement with some care decisions made in the course of team work. Satisfaction from their work came from direct client contact, being able to use their clinical skills and knowing they were ‘doing a good job’ (Nolan et al. 2007 p.381). Additionally, effective team work, teaching and personal growth were identified as positive features of their work. Administrative issues, such as lack of support and resources, overload and poor communication were features of participants’ work that caused dissatisfaction. The ability to prioritise, adapt to changing demands and good communication skills were seen as important skills in their work. Qualities such as the capacity to be empathic, open-minded, caring, value clients, demonstrate teamwork skills, have patience, hope and being committed were all highly valued qualities. The majority of the participants indicated that their work was underpinned by one or more models of care. A wide variety of models were cited. The three major approaches used in both countries were Cognitive Behavioural Therapy, Eclectic Models, which were not specified and Peplau’s Model of interpersonal nursing. It is interesting to note that despite Gournay’s (1995) assertion that Peplau’s ideas are outdated, the concepts appear to remain relevant to the current practice of nurses.

Suggested improvements to service delivery made by respondents in Nolan et al’s. (2007) study, centred primarily on improving access to resources available to provide care, increasing training and professional development activities and improving access to clinical supervision. Reducing case loads and developing more effective communication and working relationships with team colleagues were also acknowledged. The value that respondents placed on professional roles such as direct client contact, effective team
work and teaching strongly indicate the importance of the relationships they established with consumers and colleagues and reflects Nolan et al.’s (2007) findings. It draws attention as well to the difficulty facing mental health nurses when they encounter structural issues in organisations which create role conflict and subsequent role stress related to their work. This thesis will extend existing research in relation to positive and negative aspects of the participants work and the strategies they believe can contribute to recruitment and retention.

Rungapadiachy, Madill and Gough (2004) argued in their study that a clear role definition of mental health nursing practice is crucial for developing proactive and realistic educational opportunities for students. The participants in Rungapadiachy et al.’s (2004) study were all enrolled in a Diploma program leading to registration as a mental health nurse in the UK. Semi-structured interviews were held with 14 mental health student nurses to explore, as part of their transition to registration, how mental health student nurses perceived the role of the mental health nurse.

The respondents described the primary role of the mental health nurse as technocratic in nature (Rungapadiachy, Madill & Gough, 2004). Mental health nurses were seen to have a large role in drug administration and monitoring. According to some respondents the extent to which mental health nurses assumed this role was at the expense of other activities such as communicating with clients. Themes describing the mental health nurse’s role as an administrator and agent of physical interventions such as clinical observations showed that many of these functions were delegated to unlicensed staff. Mental health nurses were described as only taking on these roles when there was a shortage in unqualified staff (Rungapadiachy et al. 2004). Attending to the physical needs of consumers was a function assumed by mental health nurses but it appeared to be selective. Only those deemed unable to meet their own hygiene and nutritional needs were assisted and this role appeared to be confined to inpatient units with high needs residents such as consumers with dementia. There was no indication that mental health nurses were viewed as broadly supporting client’s activities of daily living in a supportive, educative or role modelling capacity.

In Rungapadiachy et al.’s (2004) study, implementing psychological interventions through spending time with consumers and utilising specific therapeutic approaches such as Cognitive Behavioural Therapy (CBT) was also identified as a theme. However, these functions were not perceived as a priority for mental health nurses by participants, and structured programmes such as CBT were restricted to specialised units. The in
teaching role identified by participants, could be divided into informal and formal teaching activities. Mental health nurses were seen to engage more frequently in informal teaching with a range of staff, consumers and carers, but less often in a formal sense through, for example, structured psycho-education sessions. Non-therapeutic activities were described in relation to alleged malpractice such as intimidation, non-involvement of staff, poor interpersonal or clinical skill base and what the respondents viewed as a negative attitude to their work.

This study raises a number of points. Whilst respondents described a range of therapeutic roles, their descriptions suggest that mental health nurses make a distinction between active involvement in certain tasks and the delegation of them. For example, the importance attached to a task such as observation appeared to depend on whether it was viewed as a therapeutic intervention, intended to have a positive outcome, or as policy directive intended to prevent absconding and the attached legal obligations. This contrasts with activities such as medication administration and administrative tasks which were viewed by respondents as being more highly valued elements of the mental health nurse’s role. Students undertaking clinical practice are necessarily exposed as part of their socialisation to the value that clinicians place on various aspects of their role. The extent to which students accept and internalise the values they are exposed to in the clinical environment will impact on their developing sense of professional identity.

The therapeutic and teaching roles seem to be implemented on two levels. Informally it appears that mental health nurses engage in educative activities with a range of people, yet this was not translated into formal endeavours on a consistent basis. Lack of skills would account at least partially for the uneven implementation of psychological therapies across clinical areas and/or mental health nurses’ lack of confidence in implementing them. Spending time with clients was generally a less planned encounter and one that respondents believed was difficult to promote as a valid role, not least because it often occurred in a superficially social context. This made it difficult to identify specific interventions and measure any outcomes.

As mental health nursing students in a British based program, the respondents Rungapadiachy et al.’s (2004) study would have completed significant time in a variety of clinical areas. Although time is certainly not the only factor; students in this type of program have more opportunity to consider and make sense of the range of consumer issues needs and behaviours they encounter in their work with registered staff. This contrasts with the experience of student nurse participants in the present study, who
only had a four week period in the clinical setting. In the course of this brief experience, assisted by clinical supervision, they are expected to develop an understanding of the role of the mental health nurse. If mental health nursing is to be promoted as a career choice, it is evident that students must be able to bring together their knowledge of the intended role of the mental health nurse with meaningful experiences and actual practice.

Additionally, many of the activities identified by respondents in Rungapadiachy et al.’s (2004) study would be viewed as medical or clinical acts (Clarke, 2006). Clarke (2006) has queried the parameters which define nursing, asserting that none of the common tasks usually identified by nurses are clearly definable as part of nursing practice. This includes tasks identified by students in Rungapadiachy et al.’s (2004) study such as physical interventions, psychological interventions and drug administration. The ability to articulate the role that mental health nurses enact in their professional relationships is fundamental to authenticating their professional identity. If this role incorporates functions or tasks that can be claimed by a range of discipline areas it is essential to distinguish the way in which their use by mental health nurses is unique and contributes to positive consumer outcomes. Therefore, mental health nurse and student nurse participants in this study will be asked to consider how they would describe the role of the mental health nurse to others.

Rungapadiachy et al.’s (2004) study draws attention to two significant limitations. The first is that the contextual nature of participants’ views is only implied in the presentation of the findings, but then highlighted as a major feature of the various mental health nurse roles identified. The second is that there is no mention of how participants viewed the range of structural and organisational demands or the priority given to some roles over others. Nevertheless, this is purported to be a major factor in the lack of nurse client contact that participants described.

In 2006, a Discussion Paper commissioned by the South Australian Government, reported on the perceptions of the mental health nurses role from 86 registered mental health nurses. Acknowledging that “the professional role of the mental health nurse appears to be less ambiguous in inpatient settings where roles are more clearly defined” (Department of Health, 2006, p. 1), this report detailed the results of a survey seeking to identify the unique role and contribution of mental health nurses in South Australia. Respondents were asked to identify changes in the role of the mental health nurse in the preceding decade. The primary shifts were described as changes to the model of care.
delivery, professional profile and how mental health nurses work. The report did not
detail what impact these role changes have had on mental health nurses sense of
professional identity. Nevertheless, comments relating to an increased pressure to be
outcome focused, suggest that that changes have challenged their professional identity
as mental health nurses and have increased the amount of ‘administrivia’ they are required
to do. Respondents also believed that the use of a holistic approach to care, acting as
informed advocates, needing high level assessment and crisis skills and their 24 hour
availability in inpatient settings, set them apart from other mental health professionals.

Whilst the report indicated that not involving consumers and other health professionals
in the study was a limitation, the opportunity for mental health nurses to directly record
their thoughts cannot be undervalued. It is important to note that this report was
completed in the only Australian State that maintains a separate register for mental
health nurses. This is relevant and may well mean that respondents have a stronger
sense of identity being viewed as members of both the nursing and mental health
workforce. The present study undertaken by the researcher will build on the insights
gained from the South Australian experience in another Australian State, Victoria.

A further way in which to conceptualise the role of the mental health nurse is provided
by Patterson, Curtis and Reid (2008) in their Australian study on the knowledge, skills
and attitudes expected of a new mental health nurse in the acute inpatient setting.
Registration as a nurse in Australia is based on demonstrating competency in the 10
domains of professional practice (Australian Nursing and Midwifery Council (ANMC),
2006). However, although competencies are deemed to prepare a graduate to perform
their prescribed role to the prescribed standard, there is no clearly defined set of
competencies for mental health nurses. Even the standards of practice developed by the
Australian College of Mental Health Nurses (ACMHN, 1995) represent competencies
expected of a nurse working in mental health for a minimum period of 12 months and
who is considered to be at a specialized level.

Conducting a phenomenological study that explored the competencies expected of new
mental health nurse graduates, Patterson et al. (2008) carried out semi-structured
interviews with eight mental health nurses working in one of three acute inpatient
settings in regional NSW, Australia. Analysis revealed four themes, communication,
safety, self-awareness and treatment. Fourteen competencies were then grouped across
the four themes.
In Patterson et al’s. (2008) study, communication centred on the capacity to develop ethical, professional, collaborative relationships with consumers and carers, and the development of the skills required in interpreting and communicating with people experiencing symptoms of mental illness. The capacity to communicate was closely aligned to the other major themes of safety, self-awareness and treatment.

The theme of safety related to competencies that demonstrated the ability to recognize and manage unsafe behaviour including aggression. It also incorporated the development of professional maturity, and the capacity to work in a legally safe manner. The third theme of self-awareness incorporated the competencies related to graduates developing personal insight and their practice. Self-awareness according to the study respondents involved the capacity of graduates to know their limitations and accept their position as new graduates. This implied accepting that they were at a significant point in their professional development and to not push themselves too hard as they risked burnout and disillusionment. The final theme of treatment related to the competencies expected of graduates in organizing and providing care. The findings from Patterson et al.’s (2008) study suggest that the primary way in which mental health nurses work with consumers and carers is through the context of the relationship. The capacity of the mental health nurse to communicate effectively and flexibly and to adapt to dynamic circumstances is crucial to this process. Although the findings cannot be generalized, they do reflect how nurses carry out their role and what knowledge and skills are considered necessary. In the present study both mental health and student nurse participants’ will be asked what knowledge, skills and qualities they believe mental health nurses have or need to develop.

The next section of this chapter will consider the mental health team as the organisational context in which mental health nurses carry out their professional role.

2.5.1 Research Related to the Role of the Mental Health Nurse as a Member of the Multidisciplinary Team

Renouf and Meadows (2007, p. 228) state “much mental health work is organised as teamwork, and the mental health team is one of the main vehicles of collaborative work.” This statement puts the mental health team at the centre of mental health care delivery. It is directly oppositional to the idea that it is an end product of different occupational groups occupying a shared space and working with the same group of consumers.
Typically, teams are considered relatively stable structures which are task oriented and have a shared purpose and goal (Renouf & Meadows, 2007). Renouf and Meadows (2007) believe that most teams in mental health are either multidisciplinary or trans-disciplinary (see Table 2.3, p.54) in composition and purpose, with mental health nurses making up the bulk of team membership.

Multidisciplinary approaches to health are an integral part of mental health care service delivery. Policy directives regarding primary care increasingly call for teamwork and cooperation in multidisciplinary group practice (Belanger & Rodriguez, 2008). Dennis (2006) believes that interdisciplinary work in its most positive sense provides the opportunity for consumers to receive care influenced by a range of professional understandings which should improve the quality and diversity of care options offered. This would also assume that all team members’ views are heard and respected as equally valid. The history of nursing generally and mental health nursing in particular would suggest that this is not always the case.

Table 2.3 presents a summary of the various types of teams employed within the health care context. Renouf and Meadows (2007) define the multidisciplinary team as comprising “members from a range of disciplines working in parallel, coordinating, cooperating and conferring” (2007, p.228). This is contrasted against the characteristics of the interdisciplinary team which “has all the features of multidisciplinary teams and in addition require a system of collaboration, which brings joint activity and some degree of shared responsibility” (2007, p. 229). Different again, the trans-disciplinary team which “comprise(s) a range of professions, place little emphasis on individual team member’s different disciplinary backgrounds, but use a common set of axioms and integrated methods and concepts “(2007, p.229). Although the literature reviewed refers overwhelmingly to the multidisciplinary team, the definitions provided by Renouf and Meadows (2007) would suggest the use of the term multidisciplinary is somewhat ambiguous. In the context of the argument being advanced by this thesis it is proposed such inconsistencies actively contribute to role ambiguity and role strain. This study will provide mental health nurse participants with an important opportunity to describe the experience and their view of working in a team. These experiences can provide further insights into how participants experience their role within the team context.
**Table 2.3: Different Types of Health Teams** (Adapted from Renouf & Meadows 2007; Stone 2010)

<table>
<thead>
<tr>
<th>Team Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Team (IDT)</td>
<td>Used in the 1970’s when research suggested that lives were saved by better coordination and collaboration in health services</td>
</tr>
<tr>
<td>Multidisciplinary Team (MDT)</td>
<td>Members from a range of disciplines who work in parallel. There is coordination, collaboration and conferring</td>
</tr>
<tr>
<td>Trans-disciplinary Team (TDT)</td>
<td>Teams where there is professional boundary overlap</td>
</tr>
<tr>
<td>Interprofessional Collaborative Team (IPCT)</td>
<td>A range of disciplines collaborating in mutually supportive teams, optimising the skills and knowledge of each individual to the fullest extent</td>
</tr>
<tr>
<td>Multi-professional Team (MPT)</td>
<td>Professional practitioners who work in parallel. There are clear role definitions, specified tasks, hierarchical lines of authority and high levels of professional autonomy</td>
</tr>
</tbody>
</table>

A study by Hamilton, Manias, Maude and Marjoribanks (2004) provided a useful way in which to understand the different perspectives health disciplines bring to their role using the example of the assessment process. The authors used a descriptive case study method to explore health professional’s perspectives on patient assessment in the mental health setting. The participants comprised a nurse, social worker and psychiatrist currently employed in separate inpatient units. In-depth interviews were utilised and two themes of interest to the current study emerged. The first theme of interest relates to the constraints on participants contact with patients. For the nursing respondent their contact with patients was limited by the time available and policy, as opposed to the social worker respondent whose contact was dictated by the request of other clinicians such as nurses. The second theme of relevance to this study related to the distinctive way in which they undertook assessment and theme three identified the place they gave to patient involvement in the assessment process.

Nursing assessment differed to other disciplines’ assessment in its focus on the patient’s behaviour and interactions in the immediate environment of the inpatient unit. There
was less consideration of the broader social or personal context of the consumer. The nursing assessment was often framed in medical terms. The assessment of the social worker respondent indicated a focus on the patient’s usual community context and information was often sourced from other family members who were also included in the social worker’s assessment. A medical diagnosis was central to the social worker’s understanding of the patient prior to meeting with them. For the psychiatrist, diagnosis was integral to any assessment they engaged in. Relevant information about social factors contributed to the diagnostic process. This study is important as it demonstrates that each discipline is to some degree using a medical framework of understanding to collect and describe information, interpret and understand that information from within their disciplinary lens. Each discipline has also mapped the boundaries in their practice through the role they enact in the assessment process. Within the context of this study each discipline appears to give priority to some elements of the assessment over others, notably the degree to which respondents used the social context of clients to inform the assessment. Also of importance, is the degree to which all three disciplines used a medical lens to frame their understanding and description of the assessment and subsequent rationale for the choice of interventions. However, this study was conducted in an inpatient environment. The degree to which these findings would apply to the broader context of the community setting was not addressed in this study. The present study will provide an opportunity to explore how mental health nurse participants view their role and scope of practice from a variety of contexts and in relation to the roles of their disciplinary colleagues. It will use this information to analyse the impact of these perceptions on their professional identity.

A study by Jones (2006) explored how the multidisciplinary team approached the task of care planning for people with a diagnosis of schizophrenia. A participatory action research project was conducted with a range of mental health clinicians in East London. Participants worked either in the acute inpatient unit or community care team of a large National Health Service Trust and came from a range of disciplines including nursing, allied health and medical staff. The care plan was developed and implemented over a 15 month timeframe. Data were collected at three points. This included data collected through participant observation during the care plan development phase, in-depth interviews with participants and an audit of the care pathway post implementation for the purpose of adherence. In total 29 participants took part in the care plan development sessions but only eighteen participants agreed to an in-depth interview.
Interviews were held with ten nurses, two social workers, one mental health purchaser, two occupational therapists, one psychologist and two psychiatrists (Jones 2006).

Findings indicated that there was discomfort in the process of developing the care plan. Participants experienced conflicting perceptions and demonstrated a need to maintain clear role boundaries, rather than accept that various occupational groups may overlap across some roles. Some respondents felt that their role and function would be threatened if they did not maintain distinct role boundaries. Some nurse respondents spoke of increasing ambiguity in their role, a sense of role erosion or diminution and an increasing competiveness with other disciplines regarding who was best placed to undertake certain roles. If a nurse was confident in their role they were more able to discuss this and contribute to the care planning exercise. Participants brought specific disciplinary perceptions and ideas to the process of care planning which reflected their ‘silenced’ educational preparation and sense of discrete professional boundaries. There was active resistance to the shared knowledge, assessment and intervention approaches with some participants being reluctant to contribute evidence based interventions. Nurse respondents in particular felt that their role had been eroded, with an increased responsibility for administrative tasks replacing their participation in therapeutic activities. This resulted in the view that other mental health clinicians particularly allied health professionals had 'taken over' these responsibilities. The study by Jones (2006) highlights the challenge of bringing together a seemingly disparate group of professionals for the purpose of a coordinated approach to care delivery. Educational processes which teach professionals in isolation from each other were destructive of an integrated professional approach. This highlighted the importance of a transitional and educationally supported move towards multidisciplinary professional understandings and a multidisciplinary team approach. The anxiety attached to the maintenance of professional boundaries also draws attention to the inherent challenge in moving from an individual to organisational professional identity. However, there is no indication of what factors nurse respondents felt increased their confidence in their role, or what impact the sense of role erosion had on their professional identity. This present study will provide an opportunity for participants to reflect on the degree to which they feel part of the various multidisciplinary teams they work in. Participants’ experiences across a range of community and inpatient clinical contexts will add further important insights to both Jones (2006) and Belanger and Rodriguez’s (2008) work.
Priest et al. (2008) believe that the recent literature on inter-professional learning promotes the benefits for all health professionals, particularly in relation to improving communication and teamwork. However, although there has been research focused on its implementation and evaluation, few of these studies have been undertaken within mental health. The authors define interprofessional education as collaborative learning from and about other disciplines in order to improve team work and consumer outcomes. Interprofessional education is seen as the means by which more effective, efficient service delivery can occur. The aim of Priest et al.’s (2008) study was to add to the evidence base regarding interprofessional education. It achieved this by introducing and evaluating a model of interprofessional education for two discipline groups in a mental health setting. The specific research questions explored the participants’ experience of an interprofessional learning program related to mental health and what, if any, changes in knowledge and stereotypical attitudes had occurred across the two groups. The two participant groups comprised eleven undergraduate mental health nursing students and ten clinical psychology trainees at an English University. A one year pilot study was followed by a two year project and involved a range of teaching and learning approaches. Participants completed a questionnaire regarding their experience of interprofessional learning at three points during the pilot study and five times over the two year period of the major study.

Results from the pilot study demonstrated an increased understanding by each group of the role and work of their partner group from the other discipline and respondents also indicated that they were able to learn with each other. However, the degree to which each professional group learned from each other is debatable. The authors noted that “it was apparent that there was an inherent tribalism and tendency for participants to gravitate towards their own professional group, even though mixed professional groups were created for all learning tasks’ (Priest et al. 2008, p. 480). These findings suggest that even when specific learning strategies are put in place, the challenge of fostering meaningful collaborative and reciprocal learning opportunities between professional groups is difficult to overcome. Different entry requirements, level of preparation and knowledge base may account for this. The participants in this present study have not had the preparation of dedicated interprofessional education. The researcher intends that their documented experience of working within models of health care delivery that demand a team approach will deepen understandings of the way that increasingly generic role expectations influence professional identity.
Webster and Harrison (2004) discussed the development of mental health liaison teams within an Emergency Department setting in Sydney, Australia. Reviewing a range of models used to support emergency department staff the study reviewed the implementation of a mental health liaison team. This model uses a multidisciplinary approach to mental health service delivery, with psychiatrists and mental health nurses forming the core of a team, complemented by social workers and psychologists. Using a case study design, the authors reviewed how effective the use of the multidisciplinary liaison team was in supporting emergency department clinicians. In this study, the mental health liaison team consisted of three nurses, two social workers, two psychologists and two occupational therapists. Each team member operated in a generic community member health worker capacity (Webster & Harrison 2004). While the author’s review concluded that the implementation of the team was successful, more research was needed to confirm the effectiveness of such a team. The authors do argue that in Australian practice mental health liaison teams remain largely medically dominated, with psychiatric registrars taking responsibility for the team. This present study proposes that irrespective of the composition of a multidisciplinary team, clear communication between members regarding their role and responsibilities decreases the potential for role ambiguity, role conflict and potential role stress. This would help promote confidence in clinicians’ view of their role and understanding of their professional identity. It appears that generic models of team care have the potential to lead to greater role ambiguity. This may be because there seems to be a core set of skills viewed as common to and necessary to all clinicians and an accompanying disregard for discipline specific specialised skills (Renouf & Meadows, 2007).

In summation, this section of the chapter has reviewed the underpinning philosophy behind the use of the multidisciplinary approach to mental health care delivery. It has also appraised a range of literature related to the impact of the multidisciplinary team on the role expectations of mental health nurses and other groups, and its effect upon mental health nurses’ sense of professional identity. Role Theory has been integrated in to the literature review to demonstrate how the mental health nurses are increasingly at risk of role ambiguity, conflict and role stress. This is most apparent when role expectations and requirements are in conflict, when communication is ambiguous or when staff feel unable to let go of traditional role boundaries. The next section will consider the impact of consumers’ and other stakeholders view of the role of the mental health nurse on clinicians’ professional identity.
2.5.2 Research on Consumers’ Views on the Role of the Mental Health Nurse

A further way of exploring the role of the mental health nurse is to review the research surrounding consumer’s view of the role of the mental health nurse. Mental health nurses are developing roles within recovery based paradigms and working collaboratively with consumers and carers, so the ways that this group perceive the role and effectiveness of the nurse add important information to any discussion on professional identity.

Johansson and Eklund’s (2003) study demonstrated the importance of the therapeutic relationship in mental health care. Conducting a qualitative study using open-ended, in-depth interviews the researchers focused on patients’ experiences of receiving psychiatric care. Two sample groups were used. Group one comprised seven consumers who had been treated through an outpatient mental health unit in the previous twelve months and group two comprised nine consumers who were being treated in an inpatient unit. The major theme identified was the quality of the helping relationship. The understanding of quality was broken down into a number of sub-themes. These included having sufficient time for the relationship to develop, a shared understanding of the problems encountered by the consumer and the capacity of the clinician to be open in the relationship without relying upon pre-conceived understandings regarding mental illness and its clinical presentation. Other themes were identified as staff being open to trying a range of interventions and staff not holding stigmatized views of the consumer which might prevent the development of a supportive psychosocial climate. This study demonstrated that clients viewed the therapeutic approach to their care as essential. Although the present study does not engage in consumer interviews, it coheres with the findings of the Johansson and Eklund (2003) research, particularly the importance of consumer/staff relationships. Johansson and Eklund (2003) did not focus exclusively on the consumers’ view of their relationship with mental health nurses, but on their overall experience. Nevertheless, this thesis is influenced by the mapping of staff as vehicles for implementing care and the understanding of the collaborative role of the mental health clinician. For these reasons, the present study will continue to add the clinicians’ perspective to Johansson and Eklund’s (2003) by exploring the participants’ views regarding the important elements of their role as mental health nurses in working with consumers.
Gilburt, Rose and Slade (2008) reported on a user-led participatory qualitative research project focusing on 19 service users, 10 males and 9 females from varied ethnic backgrounds. All had experienced inpatient admissions in psychiatric hospitals in London and were interviewed in the community. Participants described the relationships with mental health clinicians as the core of the user’s experience. Themes of coercion, communication, safety, trust and cultural competence contributed to the concept of relationships. Participant’s experiences of hospitalisation were primarily contextualised in relation to the people they met, with five of the eight themes related to relationships.

In Gilburt, Roses and Slade’s (2008) study, respondents highlighted communication as being crucial to their experience of a positive admission through three specific activities which were listening, talking and understanding. Staff needed to be seen to be approachable and engage with participants in order for communication to take place. Listening was highly regarded and described as a characteristic of being human. In addition, listeners who were open, non-judgemental and not patronising were valued by respondents. Trust was viewed as essential to the positive experience of being an inpatient and was linked to feelings of safety and coercion. The respondents’ experiences of coercion were described in terms of being restricted through such interventions as restraint and seclusion, rather than the legal process of involuntary admission.

This experience of the primacy of the relationship as making a difference to an individual’s experience of hospitalisation (Gilburt, Rose & Slade 2008) is an important one. It suggests that the relationship is dynamic and evolving with consumers accepting and valuing varying degrees of direction from staff. There is a tension between the need to feel safe and protected and the autonomy limiting practices that may sometimes be employed to achieve this. Additionally, this study did not consider how the relationship between consumers and staff may have changed because of such episodes or the resolution of any negative issues.

Shanley, Watson and Cole (2001) conducted a telephone survey with representatives of mental health user groups, purchasers and providers of community mental health nursing services in Scotland, using a descriptive study methodology. The aim of the study was to identify participants’ views on what constituted good practice in community mental health nursing. Interviewing 32 service users, providers and purchasers, participants were asked to respond to forced choice questions with
responses ranging on a five point likert scale from very poor to very good plus open-ended questions in which participants were asked about the best and least favourable aspects of the community mental health nursing service.

Overall, the findings showed general satisfaction with community mental health nursing services in Scotland particularly in relation to the need to increase the numbers of nurses working in community mental health and their level of availability. Specific differences in the respondents’ views related to the role of the community mental health nurses. Service users and National Health trust providers believed that the community mental health nurse’s role should be focused on working with people with serious and enduring mental illness. However, general practitioners as purchasers of this service believed that community mental health nurses should have a broader role in working with people living with less serious but more commonly experienced disorders. This disagreement provides a clear illustration of the conflict that can occur when there are conflicting expectations between different groups who all have their own perspective on the role of the mental health nurse. There was also a distinction between how service users, providers and purchasers of mental health services viewed the qualities and skills of community mental health nurses. Users focused on the qualities of the community mental health nurses whereas providers and purchaser focused on the skill base of clinicians. Criticisms of their skill base related to poor time management and poor documentation of their work practices as well as not spending sufficient time with consumers. Community mental health nurses’ flexible approach to care delivery, approachability and capacity to network with other agencies were identified as positive aspects of their role. In this distinction between service users and service purchasers and providers, there is evidence of the debate surrounding the required role of the mental health nurse. Service users appear to be highlighting the interpersonal aspects of their role as supported by authors such as Barker et al. (1999a, 1999b, 2001), Peplau (1962) and Forchuk (1994, 2001 2007). Service providers and purchasers of services would appear to value measurable outcomes more akin to evidence based approaches to care which call for documented evidence of interventions and their outcomes. Shanley et al.’s (2001) study did not include the ways that community mental health nurses viewed their role. These insights would have contributed greater understanding to any role conflict and ambiguity regarding role expectations. The findings of this Scottish study suggest that respondents wanted community mental health nurses to be ‘all things to all people’. This suggests that like the respondent in Crawford et al.’s (2008) study, other health care
providers and consumers view mental health nurses as a ‘jack of all trades’. This broad spectrum vision has the potential to create role strain, placing ambiguous and competing demands on the mental health nurse. Nevertheless, the Crawford study provides useful insights into the ways that key stakeholder groups perceive the efficacy of a specific group of mental health nurses’ work practices. The current study will add to this work, through student nurse participants’ reflections on good and poor practice in mental health nursing. In addition, the views of mental health nurse participants regarding the knowledge, skills and qualities they believe clinicians require will provide a useful counterpoint to the views identified in Shanley et al. (2001). It will be of value to note any similarities and differences expressed between different participant groups.

Section 2.5.2 has illustrated the depth and breadth of available research into the role of the mental health nurse. Beginning with consideration of two, often opposing views of the role of the mental health nurses, the literature illustrates the multifaceted nature of the mental health nurse’s role and the importance of the therapeutic relationship in setting a context for the mental health nurses to effectively work with consumers. This study has proposed that mental health nurses can and should work in a way that involves a range of interventions, but that their use is grounded in the effective therapeutic engagement between nurse and consumer. Existing research has also highlighted the importance that consumers place on the therapeutic relationship with communication, trust and respect being highly valued. The next section will consider how intrapersonal and interpersonal dynamics as well as the organisational contexts in which mental health nurses carry out their professional role impacts on their professional identity.

2.5.3 Research Regarding Professional Identity in Mental Health Nursing

Using a modified hybrid model for concept development incorporating empirical and theoretical analysis, Ohlen and Segestebn (1998), interviewed eight registered nurses in Sweden. Incorporating their views with a theoretical analysis of existing research, the authors described the concept of professional identity as emanating from personal, interpersonal and socio-historical dimensions. From a personal dimension, the respondents described the development of professional identity as stemming from a “sense of being a nurse as opposed to simply working as a nurse” (Ohlen & Segestebn 1998, p. 723). This description was analogous to the idea that the personal identity a
nurse associates with their role is crucial to their overall professional identity. In addition, the personal dimension of professional identity incorporates the capacity to recognize one’s own limitations and personal strengths, and experience a sense of belonging to the larger community of nurses. Secondly, on an interpersonal level, professional identity is described as developing through the socialization process that student nurses undergo when they enter nursing studies and interact with the academic and clinical environments during their studies and following registration. Both the personal and interpersonal dimensions identified by Ohlen and Segestebn (1998) are captured in the definition of professional identity that informs this present study and which was presented earlier in this chapter. The authors argue that where professional socialization results in a positive professional identity, nurses are more able to clearly define their role responsibilities and contribute more productively to consumer outcomes. Respondents in the Ohlen and Segestebn (1998), study referred to a positive professional identity in terms of being able to focus on patient needs, viewing and responding to patients as people in distress, being able to assert and maintain their nursing values and collaborate with others. Ohlen and Segestebn (1998), proposed a range of attributes, antecedents and consequences they argued contribute to the concept of a positive professional identity. These included maturity, assertiveness, self-reflection, personal and professional growth and independent thinking. However, their proposal appears to only account for the personal and interpersonal dimensions of professional identity as described above. There is only a small reference made to the impact of social stereotyping on the development of professional identity. The Ohlen and Segestebn study does not consider the connection between respondents’ perceptions of their role and their professional identity. Furthermore, the concept development of professional identity incorporated ideas that were based only on the literature and not necessarily supported by respondents’ views.

Brown, Crawford and Darongkamas (2000), explored participants perceptions of their work and organisational setting in the context of a recent move from a single discipline to interdisciplinary team framework in the Midlands area of the UK. The total sample comprised 29 mental health clinicians working across three mental health teams. In-depth interviews were carried out with each participant. The discussion highlights the professional barriers that exist between different professional roles and areas of responsibility. Some participants saw it as necessary to extinguish professional boundaries in order for the team to evolve and work harmoniously. This was explained
by the authors as being related to a degree of role blurring. Other participants wanted to preserve their own professional identity within the interdisciplinary environment. Their view was that role blurring was problematic and not in the consumer’s best interests. Role blurring was most evident between mental health nurses and allied health staff such as social workers and psychologists. However, boundaries were also viewed as a way of participants knowing the parameters of their expertise and when to delegate, refer to, or liaise with other colleagues. The authors contend that boundaries, as described by the respondents, are personally held and intuitively applied to their practice. Changes to organisational structures that attempt to implement more generic work practices through “flatter, less demarcated structures”, may in fact only reinforce professional boundaries for some participants (Brown et al. p.434). The Brown study is limited by an absence of any clear definition of role blurring. There is only an implied understanding of what this term might mean in relation to professional identity and professional boundaries. Its impact on role strain is likewise not explored. The authors have also not considered how individuals may reshape or renegotiate their role boundaries within the organisation. The present study will explore the participants’ perception of their role in relation to their work in the multidisciplinary team. This may illuminate issues of role blurring identified by Brown et al. (2000). It will also provide the opportunity to identity how easily student nurse participants identified the role of the mental health nurse in mental health settings using generic multidisciplinary teams.

Recent work by Takase, Kershaw and Burt (2002) and Takase, Maude and Manias (2006), suggests that it is important to clarify the impact of public perceptions of the nurse’s role. They argue that this would enable nurses to change their public image to a more realistic one. The authors believe that as a professional group, nursing has long been troubled with its public image, but that there is insufficient research into the impact of images on nurse’s self esteem. They define self esteem as the personal feeling of worth that nurses attribute to themselves. They also give weight to the notion of self concept, defined as the knowledge and beliefs about roles, values, and behaviors. Takase et al. (2002) argued that in order for nurses to achieve a more realistic public image there must also be an exploration of how the professional group view themselves.

Takase, Kershaw and Burt (2002), undertook a descriptive correlational study, which investigated the relationships between the participants’ perceptions of the public stereotypes about nursing and nurses own self concept, self-esteem, job satisfaction and role performance. The study involved 80 registered nursing students at a Western
Australia university undertaking post registration conversion or postgraduate studies in nursing. Ten percent of the participants identified their clinical specialty as mental health. The results mapped out a number of relationships between participants’ views of the public stereotypes held about nursing and the variables under investigation. Several points of interest emerge from Takase et al.’s (2002) study. Younger participants who held a higher degree and who did not work in direct client care situations reported a more positive self-concept. Professional socialisation was suggested as a protective factor in relation to self-concept. That is, participants who experienced a higher degree of professional socialisation were more likely to have a positive self-concept as opposed to participants who viewed their public image more negatively. Third, there was a negative correlation between the image discrepancy of the public and nurses’ self-esteem as a group. A positive self-concept was related to a more positive collective self-esteem. This feature was possibly based on the groups’ identification with professional understandings and models of practice. Despite the acknowledged limitation of the sample size and compromised generalisability of the findings, the research demonstrated the importance of professional socialisation in the process and maintenance of professional identity formation and maintenance. However, the authors did not explore the relationships between the participant’s perceptions of the public stereotypes about nursing and nurses’ self-concept across discipline specific groups. Instead, results were presented in an aggregated format.

The present study will add to the existing literature on professional identity in two important ways. First, by speaking with student nurses, this study will explore the ideas they have about mental health nursing as discipline novices and how their ideas about the role of mental health nurses have evolved over the course of their clinical experience in the practice area. This will contribute important information regarding the impact of professional socialisation on self concept and professional identity. Second, by also listening to mental health nurse participants’ perceptions of their role, this study will add depth and richness to Takase et al.’s (2002) findings regarding mental health nurses’ perceptions of their professional identity and their experience of public responses to their work.

There have been several recent studies from the UK which have explored professional identity in mental health nursing. Crawford, Brown and Majomi (2008) explored how community mental health nurses perceived their working lives in relation to two questions. The first question asked how nurses perceived their professional status in
terms of the public image compared with their own understanding of their working lives. The second question considered how the gap between professional aspirations and experiences of working life impacted on participants’ feelings about their work and their self-image. Thirty-four community mental health nurses who worked with adults were recruited and interviewed sequentially over a three year period. Thematic analysis identified several themes of interest. The first theme related to the way in which respondents believed that their professional role, mandated through constantly changing policy directives, minimized their sense of contribution to consumer outcomes and led to an uncertain, yet flexible expression of professional identity. Participants continued to up-skill in a range of areas not traditionally associated with mental health nursing such as drama therapy. However, these skills, did not necessarily lead to increased remuneration, professional status or recognition. The second theme of interest concerns the need respondents expressed for recognition of their contributions to consumer care. Interestingly, the extent to which policy directives and organisational expectations of the participants’ role had conflicted or remained congruent with respondents’ sense of professional identity was not considered. Respondents in Crawford et al.’s., (2008) study saw themselves as a “jack of all trades” (Crawford et al. 2008, p. 1059) which related to the degree which their professional identity changed and adapted to both consumer needs, and organisational demands. Respondents saw their professional identity as firmly grounded in a consumer orientation, but believed that they lacked real power to influence care decisions. Crawford et al.’s (2008) work suggests that the changing nature of the mental health nurses’ professional identity is problematic, rather than reflecting the broad range of knowledge and skills required to be able to adapt to a dynamic range of client needs.

Recent work by Hurley, Mears and Ramsay (2008) and Hurley (2009a) has also considered professional identity in mental health nursing. In relation to the current need for mental health clinicians to articulate their effectiveness and contribution to care delivery, Hurley et al. (2008) believe that mental health nursing’s difficulty in articulating a distinct professional identity has left it vulnerable to other occupational groups’ definitions. These definitions invariably meet the other occupational group’s own values and needs. Often this approach seems to result in a list of skills and activities such as that highlighted by Clarke (2006) which are isolated acts. As a professional group the authors believe that mental health nursing has been trying to recast its image to correspond with changes to mental health care generally. This is most readily seen in the
adoptions of generic workforce standards across a range of health disciplines, competency based standards for registration and clinical tools such as care pathways. The current study is an important opportunity to build on the ideas of Hurley et al. (2008) by listening to the views of participants regarding their perceptions of their professional identity in the Australian context.

Hurley et al. (2008) argue that mental health nurse identity is contextual in nature and closely linked to personal identity as described by Oheln and Segestebn (1998). The authors refer to this as the individual’s 'practice identity'. This identity is distinct from 'organisational identity' and is played out at the interface of the highly valued therapeutic relationship” (Hurley et al. 2008, p.54). The difficulty comes in quantifying the features of the therapeutic relationship that contribute to or indeed are responsible for positive consumer outcomes.

Policy directives that mandate flexible, cost effective service delivery with measurable outcomes drive the multidisciplinary team movement. Hurley et al. (2008) contend that as mental health nurses identify more strongly with the multidisciplinary team their behaviour will be more consistent with the values and goals of that group than their own discipline. However Brown et al. (2000) argues that an individual’s underpinning professional values remain dominant and relevant to their professional identity. There is an assumption that mental health nurses must assume either a practice or organisational professional identity. It is proposed here that mental health nurses’ move between Hurley’s description of a practice and organisational identity. This creates the potential for role ambiguity and role conflict for clinicians as they try to ‘find their place’ or reshape their role within new organisational structures while maintaining a sense of their professional identity as a mental health nurse. Their response to such ambiguity or conflict will shape how they carry out their role. How mental health nurse participants in the current study, experience and describe their professional identity within the multidisciplinary team context will contribute further insights into this important issue.

Hurley (2009a) in commenting on Crawford et al.’s (2008) paper raises a number of points in response to the authors’ stance on professional identity. The critique of Crawford et al.’s (2008) study in the preceding paragraph is supported by Hurley’s analysis. Hurley (2009a) points out that the impact of the wide range of policy documents on identity development is not addressed. Certainly in Australia, and as outlined previously, the last three decades have seen profound changes to government policy and funding for mental health. These changes have led to significant changes in
the roles, requirements and expectations of mental health nurses and other mental health professionals. Hurley argues that the development of identity is more complex than that proposed by Crawford et al. (2008). Hurley (2009a) stresses the point that professional identity is not a static phenomenon, but always in a process of ‘becoming’. While human features such as gender may be attributed to the notion of a fixed identity, the development of identity is also influenced by and in turn, impacts on the social and political context in which individuals find themselves placed. Hurley proposes that identity is both “fixed and temporary” (Hurley 2009a, p.291) with fixed characteristics such as gender, influencing and being impacted by changing political and social contexts.

Hurley (2009b) conducted a qualitative study with twenty-three mental health nurses in the UK to explore the unique abilities, behaviours and attitudes that mental health nurses bring to the delivery of psychological therapies. A number of themes were identified. The themes identified by Hurley (2009b) that are of interest to the present study include the mental health nurse as a generic specialist, having a service-user focus, and positioning and utilizing the personal self.

As a “generic specialist” (Hurley 2009b, p 385), respondents believed they were required to respond to a wide variety of consumer needs in the course of their therapeutic work with consumers. This focus on responsiveness to a wider range of consumer needs can be seen to link closely to the second theme of interest which was the consumer focus of mental health nurses. However, apart from a fleeting reference, no discussion concerning the possible tensions between this consumer focus and the organisational demands that mental health nurses work within is offered. The participants in the present study are working in a constantly evolving environment where role expectations and requirements are changing rapidly. The way these changes impact on how mental health nurses enact their roles is crucial to articulating the evolving professional identity of the discipline. In discussing the third theme of interest Hurley (2009b) describes how mental health nurses referred to the integration of the personal self within the context of the therapeutic relationship as a key feature of mental health nurses’ professional identity. Speaking of their work as a journey of self development, the respondents highlight the potential therapeutic value that their work with consumers provides to them. Stein-Parbury (2005) identifies the concept of connected and reciprocal relationships between nurses and clients. This thesis argues that within this understanding of the therapeutic relationship, these participants were describing a
potential therapeutic outcome for themselves. However, the professional literature also speaks of the need for the therapeutic relationship to be boundaried (Usher, Foster, & Luck, 2009). This notion mandates a degree of detachment and objectivity to meet the stated aim of the therapeutic relationship which is concerned with meeting consumer health needs. The tension that can result from these two seemingly disparate positions creates potential role conflict for clinicians, between the professional ideas regarding the role of the mental health nurse and the demands of the organisational culture. How mental health nurses might experience this tension in their role and how it is resolved is of interest in this study.

The final themes of interest from Hurley’s (2009b) work relate to the time mental health nurses spend with consumers and the concept that mental health nurses engage with consumers in an ‘everyday’ or practical way. Time spent with consumers is often touted as a defining characteristic of the nurse’s role generally. The lack of time can therefore be viewed as a constraint on the mental health nurse’s capacity to engage in a meaningful way with consumers. The theme of the ‘everyday way’ in which mental health nurses work with consumers referred to the way in which interventions were grounded in practical, ordinary strategies that were often based on the life experience of mental health nurses. Respondents in Hurley’s (2009b) study did not reject the idea of theories informing their work; rather, they worked with consumers in ways that were realistic and “more closely aligned to the service user’s world” (Hurley, 2009b, p. 387). It is not possible to generalise Hurley’s findings as the study sample was limited. However, the concept of life experience informing care planning and decisions in preference to using a specific theoretical framework raises the question of the value and usefulness of theories in practice. Alternatively, it is suggested here that the professional socialisation nurses undertake enables them to understand and implement strategies that are grounded in a theoretical framework. The issue is that the complexity of their work can be obscured by the superficial ordinariness of the task. The extent to which such a contradiction impacts on clinicians’ sense of professional identity was not addressed in Hurley’s study.

From this review of existing research literature it can be seen that the public image of the mental health nurse has been inextricably linked to ideas of madness, coercion and the abuse of power and stigmatised through its association with mental illness (Halter, 2002). Historically, mental health nurses have been presented as invisible and backgrounded against the dominance of psychiatry (Curry, 1989; Nolan, 1993). These images
are in sharp contrast to the research into professional identity that emerges out of mental health nurses’ personal and professional socialisation and interaction with peers, consumers, multidisciplinary colleagues and the wider community including health institutions (Ohlen & Segestebn, 1988). The literature demonstrates that there is a conflict between nurses’ professional identity and the image that mental health nurses believe the public have of them (Takase et al. 2002). There is also a degree of conflict between the desire to maintain professional boundaries, and the recognition that models of health care delivery do not necessarily support this (Brown et al. 2000; Crawford et al. 2008). Finally, the work of Hurley (2009a, 2009b) proposed that professional identity is fluid and contextual in nature, representing the unique mix of knowledge and skills that mental health nurses have and the situations in which they find themselves. The research literature also illustrates that mental health nurses view themselves as multi-skilled, even to the extent of being “a jack of all trades” (Crawford et al. 2008). The ability to use practical, real life strategies is often given precedence over the application of theories (Hurley, 2009b). The question has been raised as to whether such views actually obscure the knowledge and skill mental health nurses employ in their role. The following section of Chapter Two will explore in greater detail the working environment of mental health nurses and the extent to which environmental factors impact on their role and sense of professional identity.

2.6 SECTION THREE: THE EMOTIONAL WORK OF MENTAL HEALTH NURSING

A number of seminal works have argued that caring is a defining characteristic of the ‘art’ of nursing (Benner and Wrubel 1989, Watson 1990, Swanson 1993). Mayeroff (1971, p.7) expresses caring as the act of helping another person grow, a concept which resonates with the interpersonal relations approach to the role of the mental health nurse. Benner and Wrubel (1989) define caring practices as specific actions that demonstrate caring for and caring about others. This definition implies the expenditure of effort or energy. It is reasonable to expect that this effort and energy could be viewed as the ‘work’ of caring. Yet critiques of caring have argued that taking this position constrains nursing’s efforts to be viewed as a professional occupation because of the association of caring with women’s work (Gray and Smith 2009). If regarded as the domain of women, caring is not seen or valued as work, but expected to flow naturally and effortlessly from the fact of being a woman (James, 1989). Personal emotional as
well as physical investment is unrecognized and unacknowledged. The ideas inherent in the concept of caring are seen through the body of research literature relating to the therapeutic relationship. The concept and act of caring can be associated with the ideas regarding the therapeutic relationship described earlier in the work of Peplau (1962), Forchuk, Reynolds, Sharkey Martin and Jensen, and Barker, Jackson and Stevenson (1999b). The caring practices associated with the therapeutic relationship include appropriate implementation of professional boundaries, therapeutic use of self through having self-awareness, and employing specific skills associated with listening, empathy, reflective practice as well as being genuine and authentic (Forchuk, 1994; Jackson & O'Brien, 2009; Stein-Parbury, 2005; Strickle & Freshwater, 2006). However, if caring practices are considered to be natural, it could be argued that these practices require little skill and effort on the part of the person using them.

2.6.1 Theoretical Perspectives on Emotion Work

In 1983, Hochschild published the findings of a benchmark research project which considered the alienation of workers from their work. Hochschild’s work employed a Marxist framework to argue that workers in service industries are dislocated from their feelings. This dislocation occurs when the service provider suppresses their own emotional responses in interactions with consumers in order to meet consumers’ needs (Hochschild, 1983). Considered in the context of mental health nursing, this suppression of emotions may be seen as part of the ‘professional’ imperative to contain potential anxiety in others. Hochschild (1983) spoke of the management of emotions which was “the labour that requires one to induce or suppress feelings in order to sustain an outward countenance that produces the proper state of mind in others” (Hochschild, 1983, p. 7). By describing the work of caring as emotional labour, Hochschild challenged the apparent effortlessness of caring and recognised instead the ‘impression of effortlessness as part of the work of caring” (Duncan, 2003, p.3). As James (1989, p. 19) states, “emotional labour is hard work”.

This display of ‘appropriate emotions’ is through the processes of surface and deep acting (Hochschild, 1983). Surface acting involves the presentation of feelings that one does not own subjectively, for example, “the art of a raised eyebrow here, an upper lip tightened there. The actor does not really experience the world... but he works at seeming to...”(Hochschild, 1983, p.38). Deep acting is the internal work that a person engages in to summon up the feelings that are called for in a given situation. They are
the feelings experienced either directly or in a ‘as if’ moment (Hochschild, 1983) and they are actively worked on by the individual.

The type, degree and intensity of emotion displayed are governed by ‘feeling rules’ (Hochschild, 1979) which reflect societal norms. Feeling rules govern the expectations, extent and duration of feelings a person should experience and in what context they should experience them. That is, what feeling(s) should be experienced, when is it appropriate to experience them, and how and when they should best be expressed. In short, Hochschild (1983) believed that feelings are contextually bound and this affects the work done by the individual in their effort to manage emotions. Hochschild (1983) acknowledged that emotion work takes place in all facets of life. Within an organisational framework Hochschild postulated that emotional labour is used as a commodity and these feelings rules are set by organisational imperatives. Ashforth and Humphrey (1993) extended Hochschild’s (1979, 1983) work on the relationship between emotional labour and identity. Workers comply with societal norms through what they refer to as “display rules” (Ashforth & Humphrey 1993, p89). Display rules are the behaviours displayed in response to the emotions that ‘ought to be publicly expressed’ (Ashforth & Humphrey 1993, p89) rather than the emotion felt, which is more difficult to pinpoint. In the context of this argument emotional labour is considered to be the “act of displaying the appropriate emotion” (1993, p. 90).

Ashforth and Humphrey (1993, p.94) contribute the idea that in addition to surface and deep acting as behaviours that aim to meet the expected norms or display rules, people can also experience spontaneous and genuine emotion. That is, emotion may be experienced and displayed with relatively little prompting. This emotional experience lacks the degree of deliberate effort that surface and deep acting are said to involve, which are viewed as active processes. However, Ashforth and Humphrey (1993) do not suggest that this type of emotional response is desirable as a model for mental health nurses interacting with consumers. Successfully fulfilling display rules through surface and deep acting is seen to facilitate task accomplishment, can make interactions more predictable, and allows for a certain level of cognitive distance between worker and consumer in order to maintain objectivity and facilitate self-expression. This suggests that spontaneous emotional responses should not have a place in the emotional work of mental health nurses. However, if the mental health nurse’s role expectations and organisational expectations associated with effective service delivery conflict, then the constant uses of surface and deep acting whilst meeting organisational goals may
contribute to a sense of role strain. This dissonance between the emotions expressed and suppressed emotions could lead to role stress and role dissatisfaction. The extent to which participants feel that their role creates circumstance where they experience such dissonance will be of interest in this study.

James (1989) contributes to the literature on emotional labour by highlighting the reciprocal nature of managing emotions. Defining emotional labour as the work or labour involved in dealing with other people’s emotions she makes overt the dialectical nature of emotion work. In particular, she notes that there is a consequence to the emotional work involved in managing oneself for the benefit of others. The possible consequence of emotional labour is seen in the numerous documented examples of stress and burnout in nursing generally.

James (1989) argues that in the health care context, emotional labour is an intrinsic part of daily work. Mental health nurses work in an environment that is rapidly changing, where their role in health care is being defined in new ways, and the nature of their contact with consumers and families is often highly emotionally charged. The degree to which mental health nurse participants experienced emotional labour as part of their role and the impact this had on their professional identity is an important feature of this study. Interviews with student nurse participants’ will provide important insights into emotional labour and its influence on their understanding of the role of the mental health nurse. At stake here is the way that these perceptions affect a possible interest in mental health nursing as a career option.

How these ideas relate to mental health nursing practice can be seen in the following example. Mental health nurses have been educated in a humanistic framework predicated on the therapeutic relationship. This calls for intense one to one engagement with consumers and significant others and requires the multidisciplinary team to achieve positive outcomes and meet organisational key performance indicators. Mental health nurses are attempting to connect with another person’s world of which they may have no experience. To achieve caring practices in the context of behaviour that can be resistive, unpredictable and challenging, mental health nurses must work to manage their own anxieties and present an image of “having it all together” so that they decrease the anxiety of consumers and significant others.

Mann (2004, p. 207) discusses the way in which professional groups who engage in ‘emotion work’ as a core activity must learn to express the appropriate range and
intensity of emotions in their interactions with consumers. These ‘rule displays’ or normative role expectations identified by Ashforth and Humphrey (1993) may be formally prescribed through organisational, occupational and societal norms or informally through the socialization processes that employees go through. Mann appears to suggest that these processes are largely independent of each other, even citing nursing as a discipline which is more tightly bound by the informal parameters of the socialization processes in clinical practice. This argument does not allow scope for the possibility that both formal and informal processes such as educational processes, professional socialization and standards of practice, policy funding and organisational requirements, might all come together to impact on the emotion work associated with the mental health nursing role. A second point arising from Mann’s discussion is the idea that nurses may often learn through processes such as those just listed, the scale of appropriateness for levels of emotional display. In an ideal situation, the mental health nurse’s role expectations would be congruent with organisational role requirements, infrastructure and funding, and this ‘on the job learning’ would be a positive experience. Where role conflict, role ambiguity and stress are apparent in the work of mental health nurses this study proposes that clinicians ‘learn’ other less positive ways of managing the emotion work. This point is particularly relevant for students entering the clinical field and developing an understanding of the role of the mental health nurse.

A study by Mann and Coburn (2005) explored a number of hypotheses in relation to emotional labour in mental health nursing. While acknowledging that nursing in any field is a stressful occupation the authors proposed that because mental health nurses engaged in such “intense interpersonal involvement” (Mann & Coburn 2005, p. 155) this placed them at higher risk of experiencing stress.

Surveying 35 registered nurses in the UK, Mann and Coburn (2005) suggested that emotional labour is a consistent feature of the daily interactions of mental health nurses. The results of the survey concluded that the greater the extent of emotional labour employed during interactions the more stressful the interaction. The results of this study suggested that when nurses are more focused on the ‘surface acting’, associated with emotion work, there is a higher incidence of emotional labour. This potentially increases the risk of role strain being experienced by mental health nurses. The authors state this may occur “because being inauthentic is … incompatible with being good at the job” (Mann & Coburn 2005, p160). The present study will give participants the opportunity to reflect on those aspects of their role that they find positive and challenging or
difficult. The degree to which any challenges or difficulties associated in their work with consumers creates role conflict and role strain will be highlighted. The small response rate of 29% in Mann and Coburn’s study (2005) suggests that further work needs to be done in building a more detailed and reliable picture of the impact of emotion work in mental health nursing. Qualitative data can highlight features regarding the social or work contexts and specific events in which increased emotion work takes place. It can also shed light upon the impact on mental health nurses, in terms of role stress, professional identity, and the strategies participants used to counteract emotion work.

Menzies Lyth (1988, p.46) has argued that the key task of health care facilities is to ‘care for ill people who cannot be cared for in their own homes’. This task primarily rests with the nurses. As a consequence of this responsibility, Menzies Lyth, (1988, p46) argues that nurses bear “the full, immediate and concentrated impact of stresses arising from patient care”. The nature of illness and the physical, emotional and social impact which confronts nurses in mental health daily can produce degrees of anxiety that lead to the experience of stress. It is proposed here that mental health nurses’ work is an intensely challenging and often anxiety producing environment. They need to balance their own emotional responses to traumatic events that consumers may have experienced as well as negotiating the emotions feelings and behaviour of the mentally ill. As Menzies Lyth (1988, p. 51) states, “the closer the relationship between the nurse and client, the more the nurse is likely to experience the impact of anxiety”. When the anxiety and stress related to clinical practice is compounded by organisational demands and role requirements that do not match the mental health nurses own role expectations then the potential for role ambiguity, role conflict and role stress increase. This can result in clinicians detaching themselves from the interpersonal aspects of their role, by focusing on the tasks associated with consumer care rather than the more demanding interpersonal process and deep acting emotion work. It can also lead to defensive strategies such as increased absenteeism or resistance to changes in process or role requirements (Menzies Lyth 1988)

Menzies Lyth (1988) asserts that well defined institutional boundaries contribute to the strengthening of the individual’s own psychological boundaries. In the clinical context it could be argued that institutional boundaries are more clearly defined in acute inpatient settings as opposed to more generic mental health settings. These clearly defined role boundaries would increase the individual’s confidence in their ability and capacity to meet their required role expectations and subsequently lead to a more confident sense
of professional identity. Given the move towards primary health care models of treatment and the dominance of the multidisciplinary team approach, the extent to which professional identity is impacted on by increasing anxiety or ambiguity regarding role boundaries must be explored.

2.6.2 Anxiety and Stress in Mental Health Nursing

The preceding section has discussed the concept of emotional labour in mental health nursing. This in turn can lead to anxiety and stress and these two concepts, embedded within role theory will now be reviewed in light of existing research literature. Evans, Pereira and Parker (2008) point out that numerous sources of occupational stress have been identified through predominantly survey based research. Although there is a vast body of literature related to stress in nursing practice, it is not the intent of this thesis to explore this in depth. Rather the literature reviewed for the purpose of this study relates to recent works that explores anxiety and stress in mental health nursing, and the impact this has on the clinician’s role and professional identity.

Moore and Cooper (1996) propose that the majority of stressors experienced by mental health professionals generally and for the purpose of this study, mental health nurses specifically, are intrinsic to working with people living with mental illness. These stressors stem from specific organisational demands or as a consequence of the particular role an individual occupies. These stressors include workload issues (Evans et al. 2008) such as staffing levels, inadequate skills mix in staff, role overload, role ambiguity, lack of support and inadequate coping strategies (Moore & Cooper, 1996).

According to Brooker (2007) mental health nurses have higher rates of burnout and are less effective at dealing with their own psychological needs. Nurses generally, are also more likely to report high levels of stress than other professional groups (Edward and Hercelinskyj 2007). Roche and Duffield (2007) also believe that the expanding role expectations of mental health nurses and the concomitant role ambiguity between nurses and other mental health professionals is a potential source of anxiety for mental health nurses as they attempt to work with new models of mental health care delivery. Menzies Lyth’s (1988) findings on anxiety are consistent with Roche and Duffield’s (2007) comments although the studies are divided by two decades. In the current study, participants will have the opportunity to reflect on their current and past roles in mental health. At stake are the ways and extent to which changes in their role over the course
of their career have caused role conflict, role ambiguity or anxiety and how this impacts on their professional identity.

Tummers, Janssen, Landeweerd and Houkes (2001) explored the differences in work characteristics of autonomy, social support and workload and reactions of emotional exhaustion and job involvement between general and mental health nurses. Self-report questionnaires were administered to 317 general and 280 mental health nurses in two hospitals in the Netherlands. The response rate reflected 61.8% return by general nurses and 63.6% return rate from mental health nurses. The researchers hypothesized that autonomy, emotional exhaustion and job involvement would be higher and social support would be lower in the mental health nursing group. In relation to the second aim of the study, it was hypothesized that workload and social support would be principally related to emotional exhaustion and that autonomy would be mostly associated with job involvement. Finally, the researchers predicted that there would be no major difference in the pattern of specific relationships in either group. All hypotheses were supported with the following exceptions. There was no significant difference in social support across either group, though job involvement was lower than expected for the mental health nurse group. Mental health nurses showed higher levels of emotional exhaustion, a finding which correlates with the earlier discussion on emotional labour. High workload and limited social support was positively correlated with increased emotional exhaustion. This supports arguments put forward by Evans et al. (2008) and Moore and Cooper (1996) in relation to the importance of the association between workload and stress. Tummers et al (2001) have claimed that the lack of correlation between autonomy and job involvement is likely to be due to internal personal factors as much as to specific characteristics of the job itself. This suggests that the individual is perhaps mismatched in someway or unable to cope with the requirements of the job. Given the constant changes to role expectations and requirements in mental health it is important to ask whether this dissonance is only an individual issue or reflects wider systemic issues which must be addressed at the organisational level.

Arguing that research on stress in mental health nursing is scant, Currid (2008) employed a hermeneutical phenomenological framework to interview eight registered mental health nurses at a major London Mental Health Trust. The aim of the study was to explore the stressors and lived experience held by the participants. Five major themes emerged from Currid’s (2008) work. Participants experienced stressors in relation to
chaotic working conditions, the competing demands of client management and pressures emanating from other staff. The participants described feelings of being unable to meet both their own role expectations and those of management. Heavy workloads created stress particularly in relation to tension between meeting the needs of patients and being proactive against what they perceived as inadequate staffing resources. The working environment prevented participants from being able to use their clinical knowledge and skills in the way they had been trained. Respondents experienced a sense of defeat. These findings illustrate an experience of role conflict and role stress leading to role strain. The sense that there was a constant need to prove their credibility and that mental health nursing was not valued by other disciplines was keenly felt. In line with Currid’s (2008) work the mental health nurse participants in this study work in the public mental health sector with over 72% of participants working in acute care areas. The key difference in this study is that participant’s employment context is not limited to the inpatient unit. Therefore it will be possible to identify how participants perceive their role across a range of employment areas. The degree to which an individual experiences role strain will depend on the extent to which they view the role expectations of the organisation as incompatible with their own capacity to adapt.

Happell (2008b) indicated that nurses generally are at higher risk of violence due to their greater visibility in patient care delivery particularly in mental health. This increased risk of violence has a significant impact on recruitment and retention. Workplace violence is also associated with lower job satisfaction, increased emotional issues for staff, stress and burnout (Callaghan, 2003; Happell, 2008b; Sheward, Hunt, Hage, Macleod, & Ball, 2005).

A study by McKinnon and Cross (2008) examined the prevalence of occupational assault against mental health nurses at a major metropolitan mental health service in Victoria Australia. Using a descriptive survey design, the authors invited 90 nurses from acute inpatients and community based mental health teams to participate. The final sample size was 63 respondents. Arguing that repeated workplace violence has significant repercussions in terms of absenteeism, low morale amongst staff and higher rates of sick leave and insurance claims, the authors examined the prevalence of occupational violence at the nominated mental health service, looking at the age, gender and level of staff experience in relation to occupational assault. The authors also considered staff perceptions regarding organisational and personal abilities in managing occupational violence and the risk factors for specific groups of staff.
Results indicated that the prevalence of occupational violence was high at the mental health service studied, but that a high proportion of these incidents were not reported through formal channels. A number of reasons were identified for the underreporting of occupational violence including peer pressure not to report such events. There was also a perception that violence is associated with the work that mental health nurses do and a degree of role conflict between being positioned as a victim of violence and the mental health nurses’ professional expectations. The respondents in this survey also indicated that they experienced emotionally based injuries which were often perceived to be just as traumatic as physical assault. Staff in inpatient units were more likely to experience occupational violence than community based mental health nurses.

While the extent to which respondents believed they had training in how to manage workplace violence varied, only a small percentage of respondents believed they were adequately prepared to manage aggressive incidents. Satisfaction with the organisational response to workplace violence was generally low, particularly if staff felt they had not been adequately prepared to manage such events. Recommendations included a review of organisational policies regarding areas of risk management; aggression training and incident reporting. All of these aspects were considered to be of high priority. Promoting a culture of zero tolerance to aggression along with models of care that were inclusive of consumers and carers was highlighted as another possibility. An acknowledged limitation of this study was the small response rate and the inclusion of only one organisation. This obviously limits the degree to which results can be generalised. However, the identification of emotional trauma as an example of workplace violence is an important finding that was not anticipated. The current study will provide an opportunity for participants to speak about their work in terms of both the positive and negative aspects of their roles. The extent to which workplace violence whether emotional or physical, creates role conflict will be an important factor explored in this research.

2.6.3 Resilience in Mental Health Nursing

The extensive body of research reviewed throughout this chapter unequivocally concludes that mental health nurses are subject to role strain through the emotional labour associated with their role and the role stress created by conflicting or ambiguous organisational expectations. To counteract this there must be ways in which nurses can be supported to work through such events and develop other strategies for coping in
their work. Conway and McMillan (2007) argue that the need to develop a culture that is supportive and nurturing is essential in improving job satisfaction in nursing generally. Strategies that promote engagement in decision-making, promote ongoing professional development and provide clarity regarding role expectations and requirements is crucial to the future development of the nursing workforce.

The concept of resilience is based on the understanding of supporting person’s inner strengths, developing resilient behaviours and supporting the individual to move towards functional coping (Edward, 2005; Warelow & Edward, 2007a). Resilience is viewed as a means by which nurses through support and education “…transcend[ing] burnout and workplace stress”(Edward & Hercelinskyj 2007, p.240).

McAllister and McKinnon’s (2009) review of the literature on resilience puts forward the argument that Resilience Theory and its application to clinical practice should be incorporated at all levels of nursing education. The authors provide recommendations for assisting students and clinicians to develop an understanding of and ability to utilize resilient behaviours in their professional development. These ideas incorporate identity building work, the opportunity for students and clinicians to experience positive mentoring relationships and role models, and helping students and clinicians to identify their own risk and protective factors such as positive self esteem and supportive relationships, (McAllister & McKinnon 2009). Although resilience is a behaviour that can be learned, developing resilience in the workplace requires specific structural and cultural supports in place to facilitate application into clinicians’ practice. The ideas for building resiliency in the workforce rest largely on institutional structures to promote and support their development and application. However, the authors of the study do not identify how the dynamic nature of workforce and health care change might impact on a clinician’s ability to develop and maintain resilient behaviour and the empirical research into this feature of practice is in its infancy.

Research by Edward (2005) explored the phenomenon of resilience in mental health clinicians working in crisis care. Six participants from a variety of mental health disciplines, including nursing, were interviewed using in-depth focused interviews. As a phenomenological study, the transcripts were analysed using Colaizzi’s (1978) seven-step approach. Results from the study identified a number of themes which were related to self care, having insight, having a sense of self and faith and hope. These themes correlated with earlier literature on resilience in relation to people experiencing crises such as homelessness, mental illness and children of mentally ill parents. Understanding
resilience, according to Edward (2005), can provide opportunities for ongoing professional development and support in addition to being used strategically to support staff retention. Again there appears to be an implicit assumption that if resilience is highlighted then health care organisations will proactively work to build resilience in the workforce. There is no mention of how the lack of resilience might impact on consumer outcomes or whether participants believed their professional knowledge and skills, specifically, their sense of professional identity helped them develop and utilize resilient behaviours.

Scholes (2008) believes that nursing’s professional identity generally is under threat because nurses are not taught to develop and apply resilient behaviours to their work context. As a profession, nursing is burdened with an ageing workforce, technological advances and an historical emphasis on the moral imperative of nursing as a caring profession. The insistent myth of the self-sacrificing, virtuous and caring nurse martyr is produced at the expense of professional development and authentic recognition of the demands of health care work. There is a profound and persistent dissonance between role expectations and organisational role requirements which has led to stress, conflict and confusion about professional identity. This study will examine the ways that participants identify and address issues of role conflict and stress and how they view their professional identity in the context of these understandings.

2.6.3.1 Building Resilience in Mental Health Nursing

Reflective processes and clinical supervision are concepts that have gained currency within mental health practice since the early 2000’s (Driscoll & O'Sullivan, 2007; Edward & Hercelniskyj, 2007). Clinical supervision enables nurses to gain support and engage in ongoing professional learning (Heath & Freshwater, 2000). The supervisory process can be viewed as one way of promoting resilience in mental health nurses and strengthening their sense of professional identity (Scholes, 2008).

While clinical supervision has been identified as one strategy to help nurses build resilience to the emotional and physical demands of their work, White and Winstanley (2009) have suggested that various benefits have been attributed to clinical supervision without the necessary evidence to support them. These benefits include, the development of complex skills, higher levels of job satisfaction, increased staff morale and retention and even positive patient outcomes. White and Winstanley (2009) conducted a randomised controlled trial (RCT) in Queensland, Australia. The study
aimed to establish the level of personal well-being, the quality of care provided by mental health nurses and the outcomes for patients as a result of staff undertaking clinical supervision. Sites that participated in the study were not currently offering clinical supervision onsite to staff. The total sample size was 17 mental health facilities across urban and regional areas of Queensland. Random allocation took place to either one of the ten intervention or seven control groups. Staff inclusion criteria included nurses who had been working at the mental health facility for a minimum period of 12 months and at no less than 0.6 EFT. Patient inclusion criteria included consumers who had been inpatients for more than two weeks and greater than one month if they were on the caseload of a community mental health nurses. Individual mental health nurses were identified through a self nomination process and attended a four day intensive clinical supervision training course. These trainee supervisors would conduct group supervision sessions over the 12 month data collection period of the RCT. The final sample numbers in the intervention group of the RCT were 115 mental health nurses, 82 consumers and 43 unit staff.

Data collection was scheduled to occur at three time points. Baseline quantitative data was collected from all sites prior to the randomisation of sites into intervention and control groups. Unit outcome data was collected on a six-month basis. Patient surveys were conducted at three time points, baseline; six months and twelve months. Semi-structured in-depth interviews were also conducted at the six-month time point with 17 staff that worked at the project sites but were not directly involved with the RCT. The aim of these interviews was to add qualitative data to complement the analysis of the quantitative data. Finally, all supervisors kept a journal in which their reflections on the positive aspects, challenges and impediments to implementing clinical supervision as well as ideas regarding how the process of clinical supervision could be improved were documented on a monthly basis.

The authors of the study believed that it would test a number of the prevailing assumptions regarding clinical supervision. They aimed to generate sanctioned change and lead to changes in the organisational culture that supports the mental health nursing workforce and client base through evidence that establishes "a firmer evidence base for a sustainable, strategically significant contribution to the health of the mental health nursing workforce... and the patients they seek to serve" (White & Winstanley 2009, p.272). In 2010 White and Winstanley reported selected findings from this study. Overall, the quantitative data supported the idea that the provision of clinical
supervision training, participation in the project and becoming clinical supervisors in
their own workplace was beneficial. Qualitative data revealed, however, that the degree
to which supervisors felt supported by their managers and the organisational culture
generally varied considerably and this impacted on their confidence in delivering clinical
supervision. The degree to which middle managers, such as unit managers, who
controlled staffing rosters supported clinical supervision was a significant factor for
supervisors as was the ongoing changes to service provision being introduced (AIHW,
2005). However there was no indication as to what impact clinical supervision had made
to intervention groups’ professional identity.

In relation to a causal relationship between clinical supervision and positive patient
outcomes, a statistically significant difference in the quality of care between the
intervention and control groups over the three time periods could not be demonstrated,
apart from one venue. The authors of the study refer to the limited data that supported
this observation but do not include details of the nature of this data. A number of
recommendations are made by White and Winstanley (2010, p.163) who propose that
this study had added “incremental headway to establishing an evidence base for some of
the claims made about clinical supervision.”

Although this current study does not specifically explore clinical supervision in practice,
participants will be asked to reflect on the challenges of their role and professional
identity. Due to the reciprocal nature of the interview process it is important to
anticipate that participants may employ strategies from their professional practice to
assist them to manage any challenges.

2.7 SECTION FOUR: WORKFORCE ISSUES IN MENTAL
HEALTH NURSING

This section of Chapter Two will review the relevant research literature related to career
choice, recruitment and retention in mental health nursing. As highlighted in Chapter
One, there have been significant changes to the educational preparation of
undergraduate and postgraduate nursing student with regard to working in the area of
mental health. In exploring the role of the mental health nurse, it is therefore necessary
to understand how nursing students view mental health nursing as a career choice. The
literature reviewed in section 2.5 demonstrated that there is an emotional impact on
mental health nurses. How this and other workplace factors impact on their capacity to
carry out their role may well have an impact on retention of existing staff and influence the choices of student nurses.

2.7.1 Contemporary Educational Preparation of Nurses to Work in Mental Health

Prior to the mid-1990's entry to practice as a mental health nurse was via two pathways. These were direct entry programs and as a post-basic qualification endorsed by the relevant State or Territory Nurses Board. As Happell (1997) notes, Victoria was the last Australian State to cease direct pre-registration entry into mental health. This was enforced as a consequence of changes to the Victorian Nurses' Act in 1993.

Since the mid-1990's, all pre-registration nursing education courses have been comprehensive with direct entry education no longer available. Comprehensive courses prepare graduates to work at a ‘beginning level in a variety of health settings, including mental health’ (Mental Health Nurse Education Taskforce, 2008, p. 10). Currently, undergraduate programs offer studies in mental health that incorporate communication skills, foundational mental health studies and humanistic principles of care (Farrell & Bobrowski, 2005; Geldard & Geldard 2001; Reynolds 2003). All education for a specialist field of study takes place at the Post-Graduate Certificate or Diploma level. Universities offering these programs often utilize an employment model of education in which being employed by a mental health facility as part of their course requirements, reduces the need for separate clinical learning opportunities. A number of health facilities in Victoria offer Graduate Nurse Programs in mental health. These programs are often offered in collaboration with Universities and graduate nurses complete approximately 50% of a postgraduate qualification in mental health during their graduate year. Work by Happell and Gough (2009), indicates however, that recruitment into postgraduate courses continues to be haphazard, predominantly by word of mouth and is poorly promoted.

Credentialing has been endorsed by the peak professional organisation for mental health nurses, the Australian College of Mental Health Nurses (ACMHN), as the means to promote continuing professional education and practice development (Chesterson, Hazelton, & O'Brien, 2009). Credentialing is viewed as a key strategy in recognising and validating the skills, qualifications and experience of mental health nurses and strengthens the argument for the need for specialist education in this area (Happell, 2006). At the time of this study, legislation had not mandated specialist postgraduate
qualifications in mental health for nurses, although health care facilities are increasingly stipulating the need for postgraduate qualifications in mental health for the purpose of promotion and financial remuneration.

A prolonged critique of the changes to education for mental health nurses has been evident in relevant research literature since the overhaul was first proposed. The overwhelming view is that the move to comprehensive undergraduate nursing programs has been to the detriment of the mental health nursing profession with a loss in content, lack of depth in academic preparation and inadequate clinical practice hours in undergraduate programs. This has led to a dearth of appropriately knowledgeable and skilled clinicians in the workforce (Clinton & Hazelton, 2000; Roche & Duffield, 2007; Wynaden, Orb, McGowan, & Downie, 2000).

The 2008 Report on Mental Health in Pre-registration Nursing Courses (Mental Health Nurse Education Taskforce, 2008) acknowledged that there were a number of challenges facing nursing education generally at a national level. These included varying State and Territory requirements for course accreditation, inadequate coverage of indigenous, rural and remote health issues, and aged care, safe cross-cultural practice, varying lengths and availability of clinical practice and the availability of adequately prepared academic staff. In relation to mental health content, the lack of adequate mental health content, lack of and inconsistent clinical placements and variable quality in the teaching of and learning approaches used in mental health was also identified. The report pointed out that people living with mental illness continue to be stigmatised and that psychological and social care is prioritised less highly than physical care. The need to include consumers and carers in the development, implementation and evaluation of teaching and learning strategies was also highlighted in the report, with specific mention being made that any person delivering mental health care should have the opportunity to be educated by consumers, their families and their carers.

The MHNET (2008) recommended a number of strategies for ameliorating these inconsistencies. These included mandating a minimum number of core clinical hours, which presumed that all jurisdictions would be required to provide clinical practice experience as opposed to the current situation where in one Territory it is not mandatory. Mental health academic content should be included across all years of an undergraduate program, integrated into relevant units of study as well as provide core foundational studies in mental health. The MHNET (2008) also recommended that mental health content should increase in complexity as students’ progress through their
studies. Finally, content should be holistic in focus, and include concepts such as mental health promotion, early intervention, recovery based interventions, rehabilitation, therapeutic communication, and psychopharmacology.

The literature on recruitment that will be considered will highlight the ongoing difficulties in attracting new graduates. Mental illness continues to be stigmatised and although there are some notable exceptions, the acute medical/surgical care focus of curricula remains high. At the time of writing this thesis, an evaluation on mental health majors’ suites in undergraduate degrees had not yet been published in Victoria. The recommendations from the MHNET (2008) regarding mental health content in undergraduate curricula are broad as might be expected from such a document. Nevertheless, the report does not clearly address the need to include the role of the mental health nurse. It appears that there is an assumption that students will develop an understanding of the role and professional identity of the mental health nurse by a process of osmosis. The content and concepts recommended for inclusion do not appear to be based on one or more underpinning conceptual frameworks, whether that be medical or psychosocial. Doing this would enable academics to develop concepts to be included across a curriculum and build internal coherence between concepts such as psychosocial care, mental illness, recovery, rehabilitation, mental health promotion and primary mental health care and psychopathology.

The traditional role of mental health nurses was set within the confines of the ‘institution’. The institution provided a clarity and consistency in nursing practice that was medically derived and unchallenged by nurses. The education of mental health nurses also eventually followed a similar pathway to that of their general nursing colleagues. A series of changes to the ways that mentally ill patients were treated in the 1950's brought direct changes to mental health nursing. Broader psychosocial frameworks were adopted to underpin their practice. However, it could be argued that while the mental health nurse’s role became broader in terms of its scope, this role was still firmly located within the institution and retained the more traditional nursing functions. It would appear that mental health nursing has kept adding to its repertoire of skills and maintaining traditional role expectations. This can lead to a conflict between trying to meet new role requirements and maintaining traditional role expectations.

In the next section the research literature relating to student nurses’ experiences in the course of their clinical placements in mental health will be explored. Issues related to their perceptions of mental health, the factors that create a positive experience and view
of mental health as a career choice and the issues in recruiting students to mental health will be reviewed.

### 2.7.2 Career Choice, Clinical Experience and Recruitment

As previously outlined in Chapter One, there has been a consistent problem in recruiting nurses to mental health (AIHW, 2005, 2008). The literature pertaining to student career choice in nursing generally is extensive (Cho, Jung, & Jang, 2010; Marriner Tomey, Schwier, Marticke, & May, 1996; Mooney, Glacken, & O'Brien, 2008; Muldoon & Reilly, 2003). For example, Brodie, Andrews, Andrews, Thomas, Wong and Rixona (2004) demonstrated how students' perceptions of nursing changed over time. The authors conducted a three phase study incorporating mixed method design of 650 current and past students from two universities in the UK. The aim of the study was to investigate the changing perceptions of currently enrolled nursing students and how these changing perceptions influence student attrition. Results indicated that perceptions towards nursing did not always become more negative as students progressed through their studies. There was a positive change in respondents’ perceptions of the depth of knowledge and responsibility in the nurse's role. This contrasted with their earlier perceptions of nursing as a menial occupation. Perceptions became somewhat more negative as students developed an awareness of the lack of respect for nursing as a professional group from consumers and other health professionals. Their perceptions of the value society placed on nursing were affected by their remuneration relative to comparable public and private sector jobs. Furthermore, pay increases in the private sector were also noted to be contrary to the level of knowledge and responsibility required of them. Student attrition was influenced by the treatment and experiences students had during clinical placements and respondents became more aware of the stress associated with nursing as they confronted the reality of clinical practice. Students also became more aware of wider systemic issues such as the lack of funding and resources as they progressed through their course. The degree to which these factors impacted on their developing sense of professional identity as nurses was not considered.

When reviewing the body of research which relates to mental health nursing as a career choice, there is a range of literature over the past decade that has explored the issues in attracting nurses to work in mental health. This section will consider career choice and the experience of students in mental health.
The issues of recruitment and retention in mental health are not unique to Australia. Wells, Ryan and McElwee (2000) explored the perception of psychiatric nursing as a profession in Ireland among school leavers, social care workers and nursing students both in direct entry mental health nursing programs and tertiary based comprehensive programs. Irish school leavers were vague in their understanding of the work of mental health nurses, but it was generally viewed as similar to acute nursing in that it was physically dangerous. Social care workers indicated that psychiatric nurses lacked autonomy and variety in their work. The authors found that emphasising the different groups of clientele that mental health nurses work with was important in increasing the awareness of school leavers in relation to the population groups utilizing psychiatric services. Increasing awareness of the variety of work opportunities available was also seen as necessary to improve recruitment.

Negativity towards mental health nursing was mentioned by all groups in the Wells, Ryan and McElwee (2000) study. The authors reported that negative attitudes by nurses in other areas of practice and media reports on mental health services and the mentally ill had an impact on mental health nursing students’ perception of their role. However, this line of questioning was not developed further. The current study is seeking to explore how factors such as media reports, personal experience and subjective beliefs about what constitutes ‘real’ nursing practice intersect with students’ clinical experience in mental health and perceptions of the role of the mental health nurse. Importantly, it seeks also to analyse the impact of these factors upon the students’ interest in entering mental health nursing.

Students continue to enter nursing programs. The challenge for the higher education sector and the healthcare industry is to promote different discipline specific areas and encourage students to consider their career options. With regard to mental health, educational exposure to theory and practice through a tertiary-based system has been seen by many commentators as a mechanism to assist nursing students in coming to view mental illness and the mentally ill more objectively. However, a three-year longitudinal study of students enrolled in a pre-registration Bachelor of Nursing programs in Australia which examined their intentions towards a career in mental health nursing, found that students continued to hold a negative view of working in mental health at the end of their three-year program (Stevens and Dulhunty 1997). The underlying reasons for this view had shifted from concerns for their personal safety and stereotypical fear of the mentally ill to concerns about the nature of institutions, the type
of work and the experiences gained through their clinical exposure. Stevens and Dulhunty (1997) clearly articulated the different values respondents placed on areas of nursing practice viewed as attractive (areas where medical technology was utilised) and areas not viewed as attractive where medical technology is not a high focus. This demarcation of labour has, Stevens and Dulhunty (1997) believe, grave implications for mental health nursing’s ability to attract graduates into practice. In addition, they found that media presentations surrounding mental illness and students’ subjective views were significant causal factors in negative understandings.

In Australia, Happell (1999) used a survey method design to explore the preferred practice areas for students in the first year of their nursing studies and the reasons underpinning their choice. The results from this study of first year nursing students across nine Victorian Universities indicated that beginning students in nursing favoured working in maternity, paediatric and acute care contexts as opposed to areas such as mental health, gerontology or community health. Specifically, in relation to their dislike of mental health, students generally demonstrated a negative view of mental health nursing and held stereotypical views of people who experience mental illness. The students indicated an inability to cope with this client group, expressed fear related to their assumptions and viewed the working environment as particularly stressful in nature. This contrasted strongly with ideas about areas such as midwifery and paediatrics, which were considered to be rewarding, offered the opportunity to work in an environment with positive outcomes and reinforced those ideas about the naturalness of nursing work as a female pursuit. Clinical areas such as intensive care and operating theatres were viewed positively by respondents as high action areas, providing the opportunity to use a variety of technologies. Through this study, Happell (1999) demonstrated that undergraduate nursing student’s career preferences reflect the prevailing attitudes of the broader society. These views sit firmly within what Happell discusses as the cure versus care binary. Curing is associated with scientific advances, medical prowess and the manipulation of technology. It is these events that are communicated to the public and which students, beginning their studies in nursing, are socialised into believing are more valuable. The imagery associated with cure is used to promote nursing and is also centred on task-oriented functions grounded within medical ideology, for example, taking blood pressures and using ‘high tech’ equipment such as electrocardiogram machines. Caring suggests that a cure is not possible, that the nurse’s role in this context is dependant on and subordinate to the medical, cure, approach.)
The imagery associated with caring is non-specific and often emotive, and based on Scholes (2008) idea of the moral imperative or the “virtue script” (Gordon & Nelson, 2005 p.63), where the nurse is a self sacrificing, virtuous, caring individual.

However, what this study did not explore was students’ actual experience in mental health and how their studies did or did not contribute to their preparation for clinical practice. Neither did it engage with the factors which facilitated their learning in the clinical environment or fostered their understanding of the role of the mental health nurse. Nor was there any information gathered about whether mental health nursing was promoted as a career choice. Studies using a critical incident research design also tend to highlight negative incidents even though the authors acknowledged that positive events occur. The study does not highlight what knowledge and support respondents would have liked included in their studies to help them develop their understanding of the role of the mental health nurse. Despite these limitations, research studies like this provide valuable insights which can assist academics and clinicians to plan more realistic, interactive and supported learning opportunities.

Wynaden, Orb, McGowan, and Downie (2000), questioned whether universities in Australia were adequately preparing graduates to meet the challenges in the current mental health care system. The aim of their study was to explore third year undergraduate nursing students’ readiness to work with consumers suffering mental illness before and after their third year clinical placement and theoretical preparation at a Western Australian University. A convenience sample of first year undergraduate students was invited to participate in this study. A pre- and post-test survey was designed and implemented. A response rate of 100% was obtained on the pre-test questionnaire which was conducted during academic class time and a response of 96% was obtained on the post-test questionnaire. Final results were based on the participants who completed both pre and post-test questionnaires, which gave a final response rate of 96%.

Respondents in Wynaden et al.’s (2000) study indicated that their attitudes towards mental illness and consumers were more positive following academic and clinical studies in mental health, but that they did not feel confident in working in mental health as a beginning practitioner. This was in contrast to their increased confidence related to working in general nursing as a beginning practitioner as well as general nursing being viewed as a “high status area of nursing” (Wynaden et al. 2000, p.142). The authors suggested that the undergraduate curriculum is not comprehensive in nature. A specific
issue identified is that mental health is not integrated across the entire program, but offered as a discrete unit in the first six months of the third year of study. It was also observed that general nursing theory and clinical practice is given much greater emphasis, and dedicated theoretical and clinical time than mental health nursing. A second important point raised by Wynaden et al. (2000) is the confusion regarding the specific knowledge base of mental health nursing and generalised psychosocial aspects of care. The authors believe that this confusion results in a negation of the specialized knowledge and skill base of mental health and theoretical concepts taught by non-mental health nurses. The importance of mental health in their undergraduate studies increased in post-test scoring of the surveyed group but a significant number of respondents did not believe that mental health was given equal weighting or emphasis in the curriculum. The restriction of the sample to one site makes generalisation of results difficult. A number of respondents also added qualitative comments instead of responding to a number of statements. This occurred even though the instrumentation did not include any open-ended questions, suggesting issues in relation to face validity. This thesis will contribute important qualitative data to work by Wynaden et al. (2000) regarding students’ ideas, level of preparedness, experiences and feelings about mental health and the role of the mental health nurse before and after academic and clinical exposure.

Rushworth and Happell (2000) have suggested that the future of mental health nursing may rely upon undergraduate students experiencing clinical placement activities that offer authentic deep learning and that do not reinforce negative attitudes towards mental health nursing. They argue that positive clinical learning experiences are important in increasing students’ interest in mental health nursing. However, statistics recording the numbers of recent graduates of postgraduate mental health nursing programs suggest that experiences are not translating into appropriately qualified registered staff (Clinton, 2001; Happell & Gough, 2009) Therefore, although students may experience positive changes in attitude while immersed in this area of practice, the question remains as to why the discipline appears unable to maintain this interest and attract higher numbers of students into graduate nurse programs in mental health as well as undertake postgraduate studies. The extent to which the timing and presentation of mental health content in undergraduate nursing programs, as well how effectively mental health is promoted in Bachelor of Nursing courses and the degree to which students are assisted to develop an understanding of the role of the mental health nurse
must be explored. The analysis of such questions will assist in developing realistic and relevant learning opportunities for nursing students.

Clinton (2001) conducted a scoping study of mental health nursing in Australia that identified the issues facing the recruitment and retention of mental health nurses in the workforce. The key issues as outlined by Clinton and Hazelton (2000), include an ageing workforce and a loss of significant numbers of mental health nurses overseas or to employment in areas other than nursing. The level of appropriate qualification was also a factor given that postgraduate diplomas are seen as the minimum qualifications for mental health nurses. Overall, the field was identified as suffering from skill shortages with regard to quantity and quality. Happell (1997) also argued that the changes to legislation governing the registration of nurses in Victoria (Nurses Act 1993) brought about the significant changes to the way in which practitioners were prepared to work in mental health. The abolition of separate direct entry educational programs for mental health nursing has meant that “the profession must compete with other areas of nursing in order to sustain its workforce” (Happell, 1997, p. 419). This has occurred in other areas of practice and is not unique to mental health nursing. Nevertheless, it is crucial to understand the factors influencing career choice and recruitment so that appropriate promotional and educational strategies can be implemented.

Surgenor, Dunn and Horn (2005) explored the attitudes of first and third year nursing students to mental illness and mental health nursing in New Zealand. Using a cross-sectional design, the study investigated the associations between attitudes, demographic variables, exposure to mental illness and the career aspirations of 164 nursing students. The findings showed that as a group, nursing students held diverse views and attitudes about mental illness and mental health nursing. The most negative attitudes were held by first year nursing students and those students who had already selected their area of specialisation, for example, paediatrics. Interestingly, positive attitudes towards specialities such as paediatrics decreased over the duration of students’ education, while positive attitudes toward surgical and medical areas of practice increased and psychiatric nursing “held its own” over the time span of the survey (p.106). Those students who planned a career in mental health held positive attitudes about this area of practice. Prior contact, either through work related or personal exposure to mental health also had resulted in more positive attitudes. Negative attitudes towards mental health were higher in first year students, a finding which correlates with Happell’s (1999) work. More positive attitudes in the final year of study is thought to lie in the increasing maturity and
life experience of students and the likelihood that students would have had some contact with mental illness through their studies by this time, as well as exposure to clinical practice in mental health settings. The authors also proposed that the broader non-psychiatric curriculum along with increasing socialisation in nursing promotes a more enlightened attitude towards mental health. There was no discussion of what specific aspects of students’ academic studies in mental health influenced a change in attitudes towards mental health or in what ways clinical experience impacted on the attitudes of students. It appears that any change in attitude is attributed primarily to a serendipitous response to students’ experiences outside of their academic studies. This point is supported when the authors observed that “few of the student nurses intended to pursue psychiatric nursing…those…self selecting psychiatric nursing could be doing so on the basis of prior positive interest and values rather than being attracted to the area as a result of training” (Surgenor et al. 2005, p.106). This suggests that regardless of the learning environment, mental health is only of interest to a pre-defined portion of the population. With evidence of an increasing prevalence of mental illness in the population positive learning experiences would benefit both students themselves and registered. Students must be provided with good role models in the academic and clinical environments so they can develop confidence in their capacity to identify mental health issues and refer and collaborate effectively with other health professionals. This study seeks to discover whether student nurse participants’ clinical experiences provided them with an understanding of the role of the mental health nurse and how this knowledge can be applied to their practice.

Charleston and Happell (2005) support the contention that effective clinical placements are crucial to recruitment in mental health nursing. In their study on the preceptors experience of their role, Charleston and Happell (2005) described how mental health nurses attempted to establish ‘connectedness’ with students (p.56) This involved augmenting the role of the preceptor to provide support and guide students through their limited time in the clinical area. Interviewing nine mental health nurses, the authors describe the central feature of the preceptor relationship, as described by participant mental health nurses, as one which attempted to establish connectedness. This involved working within the system of mental health care delivery to providing support and structured learning to students. It required the preceptor adapting to different learning styles, managing student fears and uncertainty and helping students transfer what they learnt in mental health with other clinical contexts. Importantly it enabled the
reconciliation of difference between mental health nursing and generalist practice. In augmenting the role of preceptor, participants spoke of their desire to have the opportunity to connect with other preceptors and expressed particular concerns with regard to the effective functioning of the program. These included a need for clear protocols about their role and responsibilities, transparent communication with Universities regarding their expectations, organisational support and recognition of the contribution made by staff who assumed the preceptor role. Although this study does not intend to explore how mental health nurses facilitate student learning, the mental health nurse participants will be asked what they believe needs to happen to encourage more graduates into mental health nursing. Student nurse participants will be asked in what way mental health nurses helped them to learn about their role as well as how they would describe this role to others. These insights will add to the work reported in this study on how students are socialised into and learn in the clinical environment.

Recent work by Happell (2009), explored the relationship between the quantity of theoretical preparation in mental health nursing, attitudes towards mental illness, mental health nursing student’s preparedness for clinical experience, and the degree of satisfaction students experienced in their clinical placement. Happell (2009) identified a wide variability of theoretical content ranging between 30 – 160 hours and clinical contact hours varying from 140-160 hours in undergraduate programs in Victoria. The study also drew attention to the dearth of information relating to the impact of academic studies on attitudes towards mental health nursing when compared to clinical studies. Using a quasi-experimental pre- and post-test design, students completing the mental health component of their undergraduate degree were surveyed prior to and immediately following clinical placement. A total of 784 completed questionnaires were received prior to students undertaking clinical placement and 687 completed surveys were returned at the completion of the clinical placement. Additionally, analysis was also undertaken to measure the impact of the University attended, the length of the academic preparation and the impact of theoretical study. The results from this State-wide study of undergraduate nursing students in Victoria demonstrated that academic preparation prior to clinical is an influencing factor in students’ emerging attitudes towards mental health. More positive attitudes towards mental health and mental health nursing tended to be associated with students undertaking larger theoretical components in their program and having longer exposure in the clinical environment. As Happell (2009) highlighted, this study did not explore how factors such as the quality of teaching,
teaching and learning pedagogies and the types of clinical experiences impacted on students’ attitudes. This present study will therefore make an important contribution by highlighting rich contextual data related to student nurse participants’ experiences in mental health and the events and factors that contributed to their developing understanding of the role of the mental health nurse.

Hoekstra, van Meijel and van der Hooft-Leemans (2009) believe there is difficulty in promoting mental health as a career option. A descriptive qualitative study design using semi-structured interviews was conducted with a purposive sample of 120 First-year Bachelor students attending a Dutch school of nursing. The results indicated that students held stereotypical, predominantly negative perceptions about consumers living with mental illness which strongly influenced their ideas about preferred career options. Participants also felt that little was done to promote understanding of mental health nursing by the academy and this contributed to the ongoing negative view that students held about mental health and clients. Hoekstra et al, (2009) suggest that this also contributes to negative perceptions about the professional identity of mental health nurses. This thesis asks student nurse participants to reflect on their ideas about mental illness and mental health nursing, prior to, during and following completion of their studies. Of particular note are the extent to which their ideas and attitudes change and the factors that contribute to or impede their understanding of mental health. These insights will inform the ongoing discussion around teaching and learning strategies in undergraduate education that promote mental health nursing to students in a positive way.

Another way in which to consider the problem of recruitment is what Meyer and Xu (2005) refer to as academic and clinical dissonance. That is, the way in which students encounter, and the degree to which they resolve any tension between academic ideals and the reality of the clinical context. As Meyer and Xu (2005) point out, students enter the clinical area with a learned set of ideals regarding the role of the nurse. Clinical exposure presents a reality that is more dynamic, and ‘grey’ than they have interpreted in their academic studies. The standards of care, clinical pathways, collegial relationships and consumer behaviours do not always match the ideals they brought with them to their studies. Nor do they cohere entirely with the academic role models and theoretical concepts they have been exposed to in their studies. As noted previously, students studying mental health will often have entered their studies with negative images of this area of practice. In their studies they will be exposed to ideas and ideals about the role
of the mental health nurse and their scope of practice. This study will explore how those initial experiences in their academic studies have been challenged and modified by their experience in clinical practice, which as Meyer and Xu (2005) propose, is part of the student’s learning process. It is a contention of this study that studying mental health provides a significant developmental stage in students’ professional socialisation. The degree to which students’ preconceptions are challenged following their academic and clinical experience and the factors that changed their understanding of the role of the mental health nurse are central to the premise of this thesis. Also at stake here is the way these changing understandings impact on their sense of the professional identity of the mental health nurse and the extent to which student nurse participants viewed mental health nursing as a possible career choice.

2.7.3 Retention in Mental Health Nursing

According to Holmes (2006), in Australia as well as internationally there is great difficulty in retaining experienced nurses generally. Of particular relevance to this study, is the retention of mental health nurses. The scoping study by Clinton (2001) report highlighted the difficulties in retaining experienced mental health nurses within the workforce. The solution to the problems of recruitment and retention is usually seen to be the purview of the educational policy makers, managers and legislators who define the scope of practice and prepare nurses to meet industry needs. The following study by Street and Walsh (1998) is of interest in relation to this. Street and Walsh (1998) as part of the of the implementation of the 1992 New Zealand Mental Health Act, analysed the impact of the new role of Duly Authorised Officer (DOA), which was predominantly carried out by community mental health nurses on nursing practice. New Zealand nurses had very little input into the processes surrounding policy development role development or resource requirements for the new Act. The role of DAO was therefore defined and resourced by legal, medical and management groups. The role involved coordination of the assessment and referral process. The authors believe that the net result was to constrain the mental health nurse’s practice to those ‘visible tasks rather than the invisible components of professional nursing knowledge and expertise’ (Street & Walsh 1998, p. 554. This makes, for example, reports such as that from South Australia (Department of Health South Australia, 2006), and this study important as they provide a framework for discussion in relation to policy on recruitment and retention.
The research literature pertaining to retention in nursing generally explores these issues in a number of ways. Two of the most commonly viewed ways is by exploring job satisfaction and stress in nursing (Lu, While & Barriball 2005). As Happell (2008b) points out larger scale research studies have been completed in non-mental health areas. For this reason it is necessary to set some broad parameters regarding the various issues identified in these non-mental health settings. Job satisfaction and the ability to manage the work-life balance are also consistently identified as significant factors in remaining in nursing generally and mental health nursing specifically (Duffield & O’Brien – Pallas 2003; Roche & Duffield 2007).

Lu, While and Barriball (2005) proposed that conventional understandings regarding job satisfaction centre on the subjective feelings that an individual has about or towards their job. However, their primary argument, and a contention supported by this study is that any discussion of job satisfaction must also take role expectations into account. Specifically, the expectation that an individual has of their job and the resulting impact when role expectations do not meet an individual’s expectations must be accounted for.

Reviewing the literature on job satisfaction in nursing from 1982-2004. Lu et al. (2005) concluded that issues related to inter- and intra-professional relationships, such as support and respect, organisational demands, the ‘fit’ between role expectations and role demands, work-life balance, autonomy and decision-making opportunities as well as opportunities for professional development and promotion all contributed to positive or negative satisfaction with work. Effects of job satisfaction were found by the authors to be ambiguous in some cases. Job satisfaction was a significant predictor of absenteeism, intention to leave, nursing turnover and burnout. However, some findings were inconsistent. For example, some studies cited by the authors, indicated a correlation between job satisfaction and intention to leave, others did not and one study showed inconsistency between the sample groups.

The works in this field which were reviewed by Lu et al (2005) have since been augmented by a number of authors. Building on the earlier work, these research papers published since 2004 have explored the reasons underlying the challenges in retaining a suitably qualified mental health nursing workforce.

An early study by Farrell and Dares (1999) examined the level of job satisfaction for 22 mental health nurses in an acute in-patient mental health setting in Tasmania, Australia. This study focused on the job characteristics staff viewed as important in their work, an
assessment of participants’ satisfaction with each of these characteristics and the reasons behind their choice. Data was collected through a mixed method design using a survey questionnaire and follow-up interviews. Results indicated that overall the respondents in Farrell and Dares’ (1999) study were mildly satisfied with their current employment. The three most important job characteristics identified by respondents were having work that was interesting, which provided them with responsibility and independence in relation to their practice, and also having good interpersonal relationships with their colleagues. Follow-up interviews yielded important qualitative information related to their satisfaction with each of the characteristics identified. Generally, respondents believed they had little control over decision-making in relation to client care, few opportunities for staff development and low staff morale. This study is important as it presents the views of mental health nurses’ work “at the coal face”. The present study also provides an opportunity for current mental health practitioners to reflect on those aspects of the work they find satisfying and challenging and the reasons for this. Further, this present study will make a link between those experiences and how they influence the participants’ sense of professional identity.

Robinson, Murrells and Smith (2005) explored aspects of mental health nurses’ working lives that impacted on retention at specific career points in the United Kingdom using a longitudinal quantitative survey approach. A stratified sample of mental health nursing graduates was selected and invited to participate by the researchers who met with groups of potential participants prior to qualification. Of the 1142 estimated mental health nursing student graduates between 1997 and 1998, a sample of 802 was selected and invited to participate. The final sample size agreeing to take part in the study was 678.

Data was collected at four occasions. These were at qualification and subsequently six, twelve and eighteen months post registration. A five point likert scale exploring career experiences was used. This was followed up with exploration of specific aspects of participant’s career experience such as clinical supervision and career development at 6 months post-registration. At qualification, 82% of the final sample population of mental health nurses completed the questionnaire. Of this 80% of respondents completed returned the 6 month questionnaire. Results at the 6 month data collection phase identified issues such as low morale; poor inter- and intra-professional relationships and diminishing service provision as factors contributing to persistently low retention rates in mental health nursing in the UK. Care-giving opportunities and supportive working
relationships were positive influences with regard to retention particularly for new graduates. This coheres with research by O’Brien, Duffield and Hayes (2006). The degree to which these ‘systemic issues’ impacted on participants’ experience of mental health nursing and their sense of professional identity is an important feature of this study.

These findings are supported in the broader canon of research literature on retention in nursing. There is a consensus on the observation that nurses seek to actively contribute to the delivery of health care in ways specific to their professional preparation, knowledge base and expertise. It is also generally acknowledged that nurses seek to be recognized for their particular skill base and to contribute to organisational processes at varying levels of the service (Roche & Duffield, 2007). The capacity to contribute nursing expertise in a supportive environment and 'make a difference' to client care is about the recognition of the value of nursing knowledge. If professional identity is seen primarily in the context of the mental health nurse’s role with clients then lack of recognition may create role strain for nurses. Job satisfaction and the ability to manage the work-life balance are also identified consistently in the literature as being factors that impact on the decision to remain in mental health nursing (Roche & Duffield 2007). In this study, these issues will be considered within the theoretical framework of Role Theory.

Ward and Cowman (2007) used a mixed method study design to investigate the influence of work location and choice of work location on the job satisfaction of psychiatric nurses in Ireland. The specific objectives of the study were to describe the importance of work location and choice of either institutional or community work location on participants’ levels of job satisfaction. The second objective was to identify the extent to which other factors in the nursing environment influenced job satisfaction. Eight hundred survey questionnaires were distributed to registered mental health nurses across five mental health facilities. There was a 43% response rate to the questionnaire which the authors claimed represented a variety of clinical areas. Qualitative data was collected via two focus group interviews using a purposive sample of respondents. There is no indication if the focus group participants had also completed the survey. Findings indicated that community based nurses reported significantly higher levels of job satisfaction than mental health nurses working in inpatient units. Where respondents indicated they had a choice of work location there was a corresponding higher level of job satisfaction also reported.
Reasons for the differences in job satisfaction between inpatient and community settings related to factors such as the staff allocation systems used in inpatient and community settings, the physical ward environment and the isolation of inpatient units from the broader multidisciplinary team focus and activities. In addition, the nature of the routine of inpatient and community areas was viewed differently. Nurses in inpatient units were subject to a rigid routine which they felt they had little capacity to manage or control unlike nurse respondents who worked in community settings.

The results of this study point to a correlation with studies reported previously on the multidisciplinary team (Jones 2006). Interestingly, the authors indicated that low job satisfaction impacted on the quality of patient care, but this point was not explored any further. Further detail from the focus group interviews could have added important contextual data to the experiences of respondents within the multidisciplinary team particularly in the inpatient unit. Because of the sampling process that will be used in the current study it is anticipated that mental health nurse participants may well come from a range of inpatient and community based settings. The degree to which their experiences support Ward and Cowman’s (2007) work is debatable.

2.8 CONCLUSION

Chapter Two has reviewed a range of research literature relevant to the current study in relation to the selected theoretical framework of Role Theory. It has also focused upon the educational preparation and role of the mental health nurse as well as a range of workforce issues that impact on recruitment and retention in mental health.

Section one provided an overview of the history of mental health nursing in Australia and contemporary education in mental health, together with mental health service delivery. The role of the mental health nurse was reviewed and two competing frameworks that inform the debate about the required and preferred role of the mental health nurse were discussed. The relevant research literature suggests that a choice needs to be made regarding the conceptual framework mental health nurses use in their practice. This study has proposed, however, that the role of the mental health nurse should encompass both interpersonal and evidence based theories. Mental health nurses are, as a result of the developments in mental health care policy and delivery models, increasingly moving out of the traditional inpatient, custodial role they have occupied into multidisciplinary, trans-disciplinary and community team settings. Research reflects an ongoing struggle for mental health nurses to let go of traditional ideas about
their professional identity and embrace an organisational professional identity that reflects the broader scope of their working environment. The literature also suggests that although multidisciplinary approaches are extolled as part of the ‘new world order’ of mental health, educational processes do not appear to have made a significant impact in improving understanding and communication amongst mental health clinicians. Research literature related to public and professional identity in mental health nursing was also appraised. There is a discrepancy and resulting tension in many of the images of mental health nurses in the public domain. The image of the mental health nurses is inextricably linked to the image of mental illness and the mentally ill. Scholarly research suggests that attempting to articulate the professional identity of the mental health nurse is difficult and at best nebulous. Authors such as Hurley (2009a, 2009b), suggest that part of the difficulty in articulating a professional identity is that mental health nurses are tied to the belief that they must only have one identity. Hurley (2009b) believes that this is at odds with the myriad of roles that mental health nurses now assume. Research also suggests that mental health nurses must take the lead in defining who they are as a professional group, rather than allowing others to do this for them.

In section two, Role theory was applied as a framework to enable a consideration of the factors that may lead to role stress and conflict and how these impact on the professional identity of mental health nurses. Continued role stress and role strain may lead to a confused professional identity and low self-esteem regarding the value of their contributions to consumer care. Contemporary mental health services are charged with the responsibility of delivering an equitable, accessible, efficient, and cost effective service to consumers. When staff experience role strain related to conflict, overload or ambiguity in their roles, this impacts negatively on the discipline’s efforts to promote itself to potential clinicians and retain staff.

In section three, Role Theory was used to consider the emotional work associated with contemporary mental health nursing practice. Mental health nurses’ work in what is at times an intensely emotive environment. Their professional socialisation, which extols the importance of the therapeutic relationship, the legal requirements associated with their practice and policy and complex care delivery models can create tensions which may be difficult to resolve. The work of Hochschild (1983) was used to set a context in which the role requirements of an organisation together with the role expectations of the mental health nurse can lead to role stress. The impact of role stress and subsequent role strain was discussed in the context of a range of literature which explored anxiety.
and stress in mental health nursing practice. Section four reviewed the research literature related to career choice, recruitment and retention in mental health nursing.

The next chapter will outline the methodology and research design which are used to address the purpose and aims of this study. The rationale for the choice of naturalistic inquiry as a paradigm and a qualitative descriptive methodology to investigate the phenomena of interest is presented. The participant recruitment strategies, sampling approach, data collection and analysis techniques are described as is the justification for the data collection method. The processes used to achieve rigour and trustworthiness and ethical considerations will be discussed in detail. The chapter will conclude by discussing the methodological limitations of the study.
CHAPTER THREE
METHODOLOGY

3.1 INTRODUCTION

As previously described, this study argues that changes to the role of the mental health nurse have impacted on professional identity in ways which negatively affect the ongoing recruitment and retention of mental health nurses. Within the theoretical framework of Role Theory, the thesis explores how the role of the mental health nurse impacts on their professional identity. The aims of the study are twofold. The first aim is to identify strategies for promoting mental health nursing which will assist recruitment and retention. The second aim is to identify educational strategies in undergraduate nursing courses that have the potential to increase students’ career choice in mental health nursing.

This chapter discusses the paradigm, research design and research methods utilised in this study. To address the purpose and aims of the study, naturalistic inquiry as a paradigm and a qualitative descriptive research design were selected to investigate the phenomena of interest. The philosophical assumptions of the naturalistic paradigm are discussed; the choice of qualitative descriptive methods examined, and their relevance to this study are identified. The participant recruitment strategies, sampling approach, data collection and analysis techniques are also presented. The processes used to achieve rigour and trustworthiness are described in detail and relevant ethical considerations are presented. In conclusion, the chapter explains the methodological limitations of the study.

3.2 JUSTIFICATION OF THE RESEARCH METHODOLOGY UNDERPINNING THIS STUDY

Naturalistic inquiry as a paradigm is constructivist in nature. Reality is not viewed as a universal set of ‘truths’ which are context free, but as an experience enmeshed in its social, political or temporal, context (Appleton & King, 1997; Lincoln & Guba, 1985). People seek to describe and make sense of their experience of the world around them (Appleton & King 1997; Lincoln & Guba, 1895). The researcher does not seek to
manipulate or control any variable that contributes to a person’s view of their world, nor is there any attempt to control the outcome of the inquiry (Lincoln & Guba, 1985). According to Patton (2002), naturalistic inquiry as a paradigm is an emergent theory. The aim is to facilitate the participants’ descriptions of their experiences naturally through the research process. The intention is that the day to day reality of the phenomenon under exploration will emerge in all its complexity. This view of the research endeavour acknowledges the dynamic nature of each participant’s experience. Through naturalistic inquiry this study seeks to build a rich body of knowledge about the way that the role of the mental health nurse is perceived and the subsequent impact on professional identity. Generalisations are not the goal of the naturalistic researcher, rather the aim is to “develop working hypotheses and case based knowledge” (Norris & Walker 2005, p. 132). The clinical environment in mental health is diverse and complex. It was necessary to work within a research paradigm which enabled participants to communicate their own perceptions of the role of the mental health nurse and the impact of this on their professional identity. Naturalistic inquiry shares a commitment to a detailed description ‘to tell it like it is’ (Wilkin, 2003). For these reasons it was deemed an appropriate choice for the thesis.

This study utilised a qualitative descriptive research design to study how a group of experienced mental health nurses and a group of students in the third year of an undergraduate nursing course each described the role of the mental health nurse. It employed the same design process to study the impact of these individual and collective understandings on the professional identity of the mental health nurse. As stated in Chapter Two, if understanding is the core business of mental health nursing, then understanding the participants’ perceptions of the role of the mental health nurse, as described by current and future mental health nurses, is crucial to the ongoing development of the discipline (Wilkin, 2003).

The theoretical foundations of this study are located in the precepts of Role Theory which meets the criteria for a naturalistic inquiry. It provides a framework to explore how people understand the roles they occupy in different social contexts. Role Theory explains roles in terms of social structure and individual positioning. The place of an individual in a given social order enables the development of a set of expectations about their own behaviour and the behaviour of others. Integral to this research is the naturalistic paradigm’s focus on the contextualised and situated realities that people
experience and the way in which their experience of the world is shaped through their interactions with others.

The questions that one asks about the world, the way in which answers are sought and the decisions about what constitutes knowledge are characterised by a number of concerns. These concerns include the ontological drive to understand the nature of reality; the epistemological urge to interrogate the relationship between the inquirer and the known or knowable; and the methodological dilemma of how the inquirer should proceed in discovering this knowledge. Also at stake is axiology, or the role and place of values in the research process, the rhetorical structure or language and presentation of the research and the methodology which comprises the process and procedures of research (Lincoln & Guba, 1985). How the researcher explores a question will be dependant on what the research question is, how it is asked and what they are trying to discover. In the context of this study, the researcher was interested in exploring how current and potentially, future mental health nurses understand the role of the mental health nurse; the factors influencing this understanding and the impact of this on the professional identity of the mental health nurse. From her own position as a mental health nurse the researcher acknowledged that her experiences of practice could potentially influence how participants’ views were understood and represented. Therefore it was important to employ a research methodology and method that took this into account and reflective processes which enabled the researcher’s own embedded knowledge to enrich the data and analysis.

A person’s unique experience of the world stems from their individual interaction(s) with that world and the people they interact with. People construct meaning out of social and cultural realities (Jansen & Roe Davis, 1998). Clandinin and Connelly (2000) explicate this notion further when they describe experience as having both a personal and social dimension. People are viewed and understood as individuals, but always in relation to their social context. Meaning is hidden and is brought to the surface through deep reflection, stimulated by a reciprocal researcher-participant dialogue. The research process is therefore a collaborative process in which the researcher was a central part of the inquiry process (Erlandson, Harris, Skipper & Allen, 1993). By natural extension, the data collection process becomes "a valid, authentic, shared construction of the human experience" (Morris 2006, p. 194). Experience only makes sense in relation to how it is shaped by language (Lincoln & Guba, 1985) through the reciprocal dialogue between the researcher and participant. Lincoln and Guba (1985, p.189) state:
Naturalistic inquiry is always carried out...in a natural setting, since context is so heavily implicated in meaning. Such a contextual inquiry demands a human instrument, one fully adaptive to the indeterminate situation that will be encountered (Lincoln & Guba 1985, p. 189).

The roles of the qualitative researcher and interviewer cannot stand apart from the phenomenon they seek to understand (Wright & Flenmons, 2002). Understanding is grounded in the contextualized accounts under investigation (Buller & Butterworth, 2001).

### 3.3 JUSTIFICATION OF THE RESEARCH DESIGN

A qualitative description research design was used in this study. Using Guba’s (1990) explication, qualitative descriptive research is viewed within this study as: 1) constructivist, in that participants’ understanding of the role of the mental health nurse practice is socially and experientially based and that it is local and specific for each participant; 2) that the reciprocal nature of the interview endeavour creates an opportunity for the development of shared creation of that experience; and 3) using a qualitative descriptive research design will highlight the temporal, social, and cultural context in which the participants understandings have developed.

A qualitative descriptive design, as a research design, aims to provide a rich description of a phenomenon from the participants’ viewpoints. The goal of a qualitative descriptive design is to provide a “comprehensive summary of events in the everyday terms of those events” (Sandelowski 2000, p. 334). This is accomplished when the researcher captures all features of a phenomenon; remains close to the data and surface of words and events and, communicates these facts in everyday language (Sandelowski, 2000). Language is therefore used as a way of communicating experience, rather than being an in-depth interpretive process (Sandelowski, 2000). This is not to suggest that some level of interpretation does not take place. Sandelowski (2000) points out that all inquiry requires interpretation at some level in order to understand people’s experiences. However, this understanding does not exist outside of the context that gives those experiences their meaning. The interpretations made in this way are defined as tentative rather than categorical. This maintains the accuracy and authenticity of participants’ descriptions.
A qualitative descriptive research design produces a low inference description of events. Information gathered is minimally theorised or otherwise transformed or spun and is ‘especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers’ (Sandelowski 2000, p. 337). This is in contrast to other qualitative research approaches such as phenomenology, ethnography, and grounded theory.

A qualitative descriptive research enables the researcher to present the experiences and perceptions of participants in their own words without the overlay of the researcher’s interpretations. That is “enquiry is grounded in contextualised accounts of the phenomenon under investigation” (Buller & Butterworth 2001, p. 406).

### 3.4 JUSTIFICATION OF THE DATA COLLECTION METHOD

Individual, semi-structured, in-depth interviews were utilised as the data collection method in this study. A total of eighteen face to face interviews were conducted. Eleven interviews were conducted with Registered Nurses who were employed in mental health services at the time of the study, and seven interviews were conducted with student nurses in the third year of study in an undergraduate nursing program.

Interviews are an inter-active process in which ideas, thoughts, belief emotions and values are brought to the surface and shared (Curasi, 2001; Eide & Kahn, 2008). The most significant events in people's lives only become known to others through interviews (Wiess, 1994). Kvale (1996, p.1) states that the qualitative research interview “attempts to understand the world from the subjects point of view, unfold the meaning of people's experiences”. The interview is thought of as a journey that the researcher and participant go on together (Kvale, 1996). With this approach qualitative researchers are better placed to understand the significant events in people’s lives. In-depth interviews give voice to these experiences (Patton, 2002; Wiess, 1994). By choosing to take this approach to this study the researcher becomes the primary data collection instrument.

The intention of this study is that the participants’ understanding of the role of the mental health nurse will emerge through their descriptions of their experience of practice. Their understanding will be reflected in the accounts of practice which they articulate through the reciprocal dialogue that emerges during the interview. Achieving open/reciprocal dialogue requires the researcher to develop a “productive interpersonal
climate” with each participant (Minichiello, Aroni & Hays, 2008; Minichiello, Aroni, Timewell, & Alexander, 1995). Cohering with Minichiello et al.’s (2008) idea of a productive interpersonal climate, Bogdan and Taylor (1984) believe that establishing points of commonality are important in developing rapport. This ‘breaks down the barriers’ potentially separating researcher and participant, presenting the researcher as someone who gives as well as takes.

Developing rapport also requires that the researcher have the capacity to maintain appropriate boundaries or distance (Eide & Kahn, 2008). Participants need to believe their stories will be treated respectfully and to trust that they will not be subject to any risks related to the disclosure of information.

Trust is crucial to developing rapport (Wright & Flemons, 2002). In a research endeavour involving a number of contacts this is a process that develops gradually. In this study the researcher met only once with each participant. Therefore, the development of trust was a more complex and challenging process than might have been the case over several meetings. As Berger (2003) points out, people share stories in part at least because of their need to express their feelings. This is unlikely to take place if people feel vulnerable and if they anticipate the possibility of negative outcomes. Because the researcher was known to a number of mental health nurse participants through professional and educational connections, the prior knowledge participants had regarding her background facilitated the discussion during the interview. For those mental health nurse participants that the researcher had not known previously, providing this information was a specific strategy to establish rapport and build trust. Furthermore, because the researcher was known to a number of the mental health nurse participants the maintenance of appropriate professional and interview boundaries was deemed crucial to the integrity of the data. This was particularly relevant to the student nurse participant group. Because the researcher had taught the mental health component during their three year undergraduate course, maintaining a distanced approach to the study was essential if potential ethical issues were to be avoided. It was also crucial that the researcher not impose preconceived views or lead the participants in any way but focus on the participants experience (Crotty 1996). Making the researcher’s position transparent while reinforcing her commitment to hearing the participants experience at the beginning of each interview and using a formally semi-structured interview guide further facilitated the development of trust with both participant groups. This will be discussed in more detail later in this chapter.
3.5 JUSTIFICATION OF DATA ANALYSIS TECHNIQUE

According to Taylor and Bogdan (1984) and Bogdan and Biklen (2007) data analysis is an ongoing process in which the goal is to develop concepts and propositions to make sense out of the data sources obtained. Erlandson et al. (1993) emphasize that data collection and analysis are inseparable and occur simultaneously as an interactive process. The dynamic and emergent nature of naturalistic inquiry makes any clear distinction between data collection and data analysis artificial at best and inaccurate at worst. Analysis occurs both at the research site during collection and away from the site. Without this parallel process data has no direction (Minichiello et al. 2008). Pope, Ziebland and Mays (2000) assert that it is impossible to avoid thinking about the data, what it might mean and what relationships exist between what is heard in interactions with participants. Lincoln and Guba (1985, p.333) believe that data analysis is the process “in which constructions that have emerged… are reconstructed into meaningful wholes”. The challenge for the qualitative researcher is to make sense out of large amounts of data (Patton, 2002).

Thematic analysis was used as the analytic strategy in this study where the focus was on identification of themes arising from the data and across individual stories of the participants (Browne, 2004; Miles & Huberman, 1984). Thematic analysis is achieved through the systematic examination and re-examination of the data (Bogdan & Taylor, 1984; Bogdan & Biklen, 2007). This type of analysis is inductive in nature and supports the understanding of the participant’s experiences being grounded in and emerging from the data (Thorne, 2000). According to Hansen (2006), thematic analysis is iterative and involves the process of immersion in the data. Thematic analysis also uses the process of coding (Bogdan & Biklen, 2007).

3.6 RESEARCH METHODS

3.6.1 Setting

In order to obtain a diverse, purposeful sample, mental health nurse participants were recruited from metropolitan and regional areas of Victoria, Australia. The selection criteria aimed to facilitate a broad range of participants who would be able to focus specifically on the practice area of mental health. Therefore, mental health nurse participants came from a variety of clinical settings. These included Community Mental Health Teams, Inpatient Units and Child and Adolescent Units. As the intention of the
study was not to produce generalisable findings from the data but to focus on eliciting a wide range of ideas and experiences from participants, this approach was identified as the most appropriate.

Student nurse participants were recruited from one metropolitan university in Melbourne, Australia. As noted in Chapter One, the student nurse participant group were not considered the major data source in this study. Furthermore, it is acknowledged that a sample from one university can be considered a small sample size. However, this feature is mitigated by the variety of mental health care facilities where students undertook their clinical placement, the voluntary nature of the recruitment process, and the mechanisms used to minimise any potential feelings of coercion.

The researcher was employed as a lecturer at the university from which student participants were recruited. As previously noted this presented particular ethical issues which will be addressed in more detail later in this chapter.

3.6.2 Recruitment Strategy

Following ethics approval from the Deakin University Human Research and Ethics Committee (DUHREC), (Appendix 1) to conduct the study, the purpose of the study was presented to the Victorian State Chapter of the Australian College of Mental Health Nurses and information flyers were provided for members to distribute at their workplace (Appendix 2). Interested persons were able to contact the researcher directly who then forwarded a copy of the Plain Language Statement for their consideration (Appendix 3). Eleven mental health nurses agreed to take part in the study following this recruitment strategy.

At the same time, following ethical approval as stated above, the researcher presented the purpose of the study to third year undergraduate nursing students at the beginning of a lecture at the metropolitan university. Information flyers for student nurses (Appendix 4) and the Plain Language Statement (Appendix 3) were left at the venue for students to collect. Interested persons were able to contact the researcher directly, who then forwarded a copy of the Plain Language Statement for their consideration. The researcher repeated the presentation after one month and seven student nurses in total responded positively to the recruitment strategy and agreed to participate in the study.
3.6.3 Sampling Strategy and Selection Criteria

Erlandson et al. (1993) argue that purposive sampling is central to naturalistic inquiry and this sampling approach guided the recruitment of nurses and student nurses for this study. Purposive sampling enables the researcher to undertake a detailed analysis of information rich cases which will provide insights and an in-depth understanding of the questions central to the inquiry (Patton, 2002).

The use of purposive sampling requires the researcher to have clear criteria for selection that is based on experience and prior knowledge about the population (Lincoln & Guba, 1985). In this study, a purposive sample of experienced mental health nurses and nursing students who had completed their undergraduate academic and clinical studies in mental health was utilised. Lincoln and Guba (1985) identify that one of the criticisms of this type of sampling method is that it is not sufficiently representative of a particular population, thereby making generalisations difficult. However, as previously stated, it was not the intention in this study to obtain a sample that was representative. Rather, the purpose of this study is to give voice to a wide range of experiences and describe the participants’ perceptions of the role of the mental health nurse as experienced by these two groups (Patton, 2002).

The two sample groups and selection criteria for each group were as follows.

3.6.3.1 Group One: Mental Health Nurse Participants

Group One consisted of mental health nurses who all had at least five years experience of working in mental health services. Common to the group were current registration as a Registered Nurse in Victoria and current employment in a clinical setting offering mental health services. It was a feature of the research that all members of this group identified their primary area of practice as mental health nursing at the time of the study. Therefore, the sample for Group One consisted of eleven experienced mental health nurses who met the selection criteria.

In line with Buller and Butterworth’s (2001) selection criteria for expert informants, an experienced nurse was considered to be a registered nurse who had a minimum of five years clinical experience in mental health, who was involved in clinical practice at the time of the study, and who had undertaken recognised basic, post-basic, or postgraduate training. Five years has also been identified by Benner (1984) as the timeframe during
which clinicians generally develop expert practice through their advanced perceptual and recognitional abilities.

### 3.6.3.2 Group Two: Student Nurse Participants

The selection criteria for undergraduate student nurses were that they were enrolled in an undergraduate Bachelor of Nursing program and they had successfully completed their academic and clinical studies in mental health. Because student nurses were recruited from the researcher’s workplace, it was essential to strictly adhere to these specific inclusion criteria in order to minimize any possible feeling of coercion and subsequent bias.

### 3.6.4 Pilot Study

The pilot study was conducted in line with Van Teijlingen and Hundley’s (2001) explanation of a pilot study as the pretesting of a particular research instrument. For the purpose of this study, the first two participants in both the mental health nurse and student nurse groups constituted the pilot study.

The process of the pilot study commenced with the initial review of the relevant research literature to develop an insight into the role of the mental health nurse in contemporary practice and the current issues affecting the mental health nurse workforce in Australia. This enabled the researcher to develop a series of potential interview topics. As the purpose of this study relates to how participants understood the role of the mental health nurse and its impact on professional identity in mental health nursing, the researcher also explored the literature related to images of nursing in the scholarly literature and media. This led to the decision to use a range of visual prompts that were designed to explore mental health nurse and student nurse participants’ perceptions of the role and image of the mental health nurse being presented. The interview schedules and images were submitted to the researcher’s supervisors who provided feedback regarding the phrasing, clarity and integration of the visual prompts into the interview schedule. This process enabled the researcher to amend any questions, develop additional probing questions that could be used if needed, and determine the final composition of the visual prompts to be used. The interview schedules and use of the visual prompts were then reviewed following the first two interviews with the mental health nurse participant group. Feedback from mental health nurse participants 1 and 2 indicated that the visual prompts were confusing, ambiguous and distracted them from reflecting on the questions that had been asked. As the
subsequent review of the interview schedule and visual prompts with the researcher’s supervisors indicated that the visual prompts did not add anything to the conversation between the researcher and participants, they were removed from the interview schedule for both groups. Verbal feedback from the student nurse participants 1 and 2 indicated they understood the questions and found them useful in reflecting on their experience in mental health. Therefore no changes were made to the interview schedule for the student nurse participant group.

### 3.6.5 Instrumentation

The use of an interview schedule ensured that key concepts were raised for consideration and discussion, while allowing the opportunity for the researcher and participant to move the discussion to points of interest that were not previously identified. Interview questions were developed from several sources. As previously noted, questions used in the interviews were developed from research literature related to student learning in the clinical environment, professional identity, public image and representations of nursing, as well as the role and scope of practice in mental health nursing and workforce issues. The researcher also used her extensive experience as an academic in the development of the questions and additional probing questions.

While a semi-structured interview process was used for both participant groups, the interview schedule for the student nurse participants had greater structure and direction than that used with the mental health nurse participants. In view of the student nurse participants’ level of experience in this area of nursing practice and the possible length of time between completion of their mental health studies and the interviews, the researcher believed it was necessary to provide a clear and more structured range of questions to assist them when reflecting on their clinical experience in mental health.

The concept of probing described by Patterson et al. (2008) was used to assist in the development of questions. Probing involved collecting further details related to specific questions in order to clarify participants’ answers or obtain further information. Probing questions are highlighted in italics (refer to Box 3.1 and Box 3.2). Since the mental health nurse participants were able to reflect more easily on their experiences and perceptions given their currency in practice, length of experience and level of education in the clinical area, fewer probing questions were required.

The interview schedules used for the mental health nurse and student nurse participant groups are presented on Box 3.1 and 3.2:
### Box 3.1: Interview Schedule: Mental Health Nurse Participants

**Background information**

1. How long have you been working as a mental health nurse?
2. Can you tell me about the type of work you are currently doing?
3. Why did you become a mental health nurse?
4. What are your perceptions of your role as a mental health nurse? *(Probe) How would you describe your work?*
5. What knowledge/skills/qualities does a mental health nurse need?
6. What are the positive aspects of your work? *(Probe) What could be better?*
7. What recollections can you share of your role as a mental health nurse? *(Probe) As you look back on your career what event/moment stands out for you as a significant experience as a mental health nurse?*
8. How would you describe your work to people who are not mental health nurses? *(Probe) When you tell people, you are a mental health nurse what is their response? (Probe) What is your view of the profession?*
10. What do we need to do to recruit nurses to work in mental health?

### Box 3.2: Interview Schedule: Student Nurse Participants

**Background information**

1. What stage are you currently at in your Bachelor of Nursing studies?
2. When did you complete your studies in mental health?
3. What was your understanding of mental health nursing prior to studying it? *(Probe) What image did you have of the profession? (Probe) Where did you develop these ideas from, e.g., did you know any mental health nurses? How did they describe their work? What work did they do? What was their role? (Probe) What were your thoughts and feelings about mental health nursing prior to clinical*
4. Can you tell me about your clinical experience in mental health nursing?
   (Probe) What were your thoughts/feelings on your first day?

5. What stood out for you about that first day?
   (Probe) What were your impressions? Were you made to feel welcome?
   (Probe) Can you recall an average day in your clinical venue? What did the mental health nurses do?
   (Probe) Can you recall an example of good/poor practice? Can you tell me about it? What did you learn from it in relation to what mental health nurses’ do/shouldn’t/didn’t do?

6. Did mental health nurses facilitate your learning, and if so how?

7. Did your academic studies prepare you effectively for clinical? And if so how? What were the issues you encountered?
   (Probe) Were you encouraged by mental health nurses to consider a career in this area? What did they say/why, etc.

8. Since you finished clinical how would you describe what mental health nurses do?
   (Probe) Have your ideas about mental health nursing changed since completing your studies?
   (Probe) What are your views now of the profession?

9. What skills, knowledge and qualities do you think mental health nurses need to have?

10. In your opinion what would be the challenges in working as a mental health nurse?
    (Probe) What do you think would be the exciting/positive/rewarding things about working as a mental health nurse?

11. How do you describe the work of mental health nurses to others?
    (Probe) Would you consider a career in mental health nursing? Why/why not?
    (Probe) What would have helped you consider a career in mental health nursing during your Bachelor of Nursing program?

3.6.6 Data Collection Procedure

Data collection was conducted between 2005 and 2007. As previously noted, the participants formed two distinct sample groups. Group one comprised of experienced mental health nurses working in a variety of mental health clinical settings at the time of the study in the state of Victoria. Group two consisted of student nurses enrolled in a Bachelor of Nursing program at a university in Victoria, Australia. Eleven interviews
were conducted with the mental health nurse participant group, and seven interviews were conducted with the student nurse participant group. All interviews were conducted with only the researcher and participant present, to ensure privacy and to increase the participants’ comfort during the interview process. Nine mental health nurse interviews were conducted at the participant’s workplace. One mental health nurse interview was held at the participant’s home while one was held in the researcher’s office. All seven student nurse interviews were held at the university with six interviews taking place in a colleague’s office. This was to provide a more neutral environment for the student nurse participants and to help minimize any feelings of discomfort as several of the participants had been previously taught by the researcher. The seventh interview was held in a small meeting room on a regional campus.

Prior to the commencement of each interview, the researcher provided a verbal summary of the purpose of the study and an explanation of the procedure for the interview. Participants were also offered a copy of the Plain Language Statement to review if they wished. The researcher informed participants that information shared during the interview would not be attributed to any particular individual or workplace and pseudonyms would be used in all reports and publications arising from the study. The researcher also informed the participants that they were free to withdraw from the study at any time, without penalty or prejudice. Each participant was then asked if they were willing to proceed with the interview and they were asked to sign an Informed Consent Form (Appendix 5).

Following completion of the informed consent, all participants were given a demographic questionnaire to complete (Appendix 6). The purpose of the questionnaire was to obtain information regarding the location and type of clinical area where the participants were either employed at the time of the study or had undertaken clinical placement as student nurses. The demographic data was used to provide a snapshot of the two sample groups which is presented in Chapter Four. Participants were not asked to identify their age as this was not considered relevant to the purpose or aims of the study. Participants were also given the opportunity to review the interview schedule prior to commencing the interview.

Data were collected via in-depth, semi-structured interviews. Each interview lasted between 60 to 90 minutes, and was audio taped with permission of the participants. The duration of the interviews was longer for the mental health participants. This was to be
expected as their depth of experience enabled them to respond in much greater detail to the questions.

Following completion of the demographic questionnaire, the researcher thanked each participant for agreeing to take part in the study and acknowledged that while they might also know her as a colleague or lecturer, for the purpose of their interview she was interested only in their thoughts and responses to the questions. The researcher then proceeded to ask a number of background questions to build on the initial demographic data. These initial questions were structured to help build a rapport with the participants. The mental health nurse participants were asked the following introductory questions: “How long have you been working as a mental health nurse?” and “Can you tell me a little about the work you are currently doing?” These questions provided the opportunity for the mental health nurse participants to discuss issues that they were familiar with which helped to further build a rapport. It also allowed the researcher to follow-on with questions that encouraged participants to reflect on the changes to the role over their years in practice. Student nurse participants were asked: “What stage are you currently at in your Bachelor of Nursing studies?” and “When did you complete your studies in mental health?” This was followed with the question: “What was your understanding of mental health nursing prior to studying it?”

These questions encouraged the student nurse participants to reflect on their studies and clinical experience and served as the basis for the ongoing dialogue. From this point, each interview progressed as a conversation during which the researcher focused more extensively on the participants’ perceptions of the role of the mental health nurse.

At the conclusion of each interview participants were asked if they wished to make any further comments. Following this, participants were thanked for their time and informed that they would be sent a copy of their completed transcript for review and any amendments. Data collection was ceased at the conclusion of the eleven mental health nurse interviews and seven student nurse interviews.

Lincoln and Guba (1985) recommend that informational considerations guide the sample size and that sampling continues to a point of redundancy, where no new information is obtained. Guest, Bunce and Johnson (2006, p. 60) state that data saturation has “become the gold standard by which purposive sample sizes are determined in health science research” and they suggest that data saturation can occur after 12 interviews. According to these authors, smaller sample sizes can be sufficient in
providing complete and accurate information within a particular cultural context, as long as participants possess a certain degree of expertise about the domain of inquiry. It is argued that these experiences contribute to the participant’s sense of reality and in Guest et al’s. (2006) view ‘truth’. Following interviews with eleven mental health nurse participants, no new insights were obtained and it was decided to cease data collection. In Group Two interviews ceased following seven student nurse interviews, when no new information was forthcoming.

### 3.7 THE RESEARCHER’S JOURNAL

Reflexivity, as described by Russell and Kelly (2002), is the mediator in the research process and was central to this study. As a co-creator of knowledge, the researcher was required to explore her personal assumptions and goals, clarify her individual beliefs and subjectivities and identify how these influenced her understanding of the dialogue that emerged through the interactions with participants. In this sense it was clear that a constructivist position is inherently value laden (Lincoln & Guba, 1985). The researcher’s own understanding or construction of mental health nursing has been influenced by her experiences as a mental health nurse clinician, and academic. It was essential that a reflexive process was used to clearly differentiate between the researcher’s experiences and values and those of the participants. The same space of reflection enabled the researcher to identify those points where her own experiences impacted both on the interview process and the understanding of the participants’ descriptions (Russell & Kelly, 2002). A reflective journal was used to raise the researcher’s awareness of these issues throughout the study. Observations about the recruitment of participants, the researcher’s personal feelings about the interviews and her response to the interview process and data collected were noted. The importance of these reflections was demonstrated when they enabled refinements to the mental health nurse participant interview schedule following the first two interviews. In addition, procedures related to achieving rigour included member checking, independent reviews of the transcripts and thematic comparison by the researcher’s supervisors.

### 3.8 DATA ANALYSIS

As previously discussed in Chapter Two, the purpose of this study is to explore the role of the mental health nurse and the impact this has on professional identity. This is examined within the theoretical framework of Role Theory. The aims of the study are
twofold. The first aim is to identify strategies for promoting mental health nursing which will assist recruitment and retention. The second aim is to identify educational strategies in undergraduate nursing courses that have the potential to increase students’ career choice in mental health nursing.

In this study of the role and identity of the mental health nurse, data analysis was guided by the thematic analytic steps of Aronson (1994) and Bogdan and Biklen (2007). In addition, strategies outlined by Bogdan and Taylor (1984) and Lincoln and Guba (1985) helped to frame the analysis. First, the process of data analysis commenced following the first interviews. The audio recordings and written file notes made by the researcher following each interview provided the means to begin exploring the data obtained. These reflections resulted in refinements to the interview schedule during the first two mental health nurse participant interviews in the pilot study. Each interview was conducted by the researcher and then transcribed. This approach allowed the researcher to view the preliminary data and highlight any initial ideas as they became evident. Importantly, it also enabled the exploration of other issues that may not have initially been considered central to the research question (Grbich, 2007).

Second, the researcher immersed herself in the data by reading and re-reading each interview transcript a number of times. This strategy meets Lincoln and Guba’s (1985) requirement of data immersion being an inductive rather than deductive activity that requires repeated exposure to and engagement with the data. Immersion in the data enabled the researcher to see how the participants’ perceptions of the role of the mental health nurse were viewed from their perspective. It also allowed the researcher to fully comprehend how insights were grounded in and developed from the data with the emphasis on understanding participants’ experiences through their descriptions (Taylor & Bogdan, 1984). The researcher read each transcript as a whole while listening to the audiotape to gain a sense of the participant’s entire story and to reflect on comments, phrases and any associated vocal qualities that stood out. Patterns and themes that emerged from the data were noted and highlighted in different colours and ideas and thoughts were noted next to particular parts of the text in order to clearly track the researcher’s emerging observations about the data, rather than searching for instances that reflected a previous theoretical position (Lincoln & Guba 1985; Taylor & Bogdan 1984).

Third, key terms or phrases together with the corresponding text that illustrated the key terms and phrases were highlighted and then assigned a code (Bogdan & Biklen, 2007).
At this point the transcripts and codes were sent to the researcher's supervisors for review. The results of the preliminary coding by the researcher and supervisors were then compared and any differences discussed until consensus was reached.

Fourth, sub-themes were derived from the codes. This involved comparing the coded concepts from each transcript against each other to identify those concepts that were shared by participants in some way. The result was that eight sub-themes were identified for the mental health nurse group and three sub-themes for the student nurse participant group.

Fourth, the data was then re-examined with the research purpose and aims in mind. Major theme headings were identified to develop the overall story of the participant’s perceptions of the role of the mental health nurse. In several instances direct quotes from participants were selected as major theme headings and these are italicised. The emergent themes were compared against the theoretical framework and the findings of pre-existing research pertaining to workforce issues such as career choice and retention, government policy and educational development in mental health nursing, and the role of the mental health nurse and professional identity. Linking the participants’ descriptions back to the relevant research literature enabled the researcher to validate the choice of themes (Aronson 1994). This process was used to illuminate the participants’ descriptions of their perceptions and understandings. The major themes and sub-themes for each participant group are described in Boxes 3.3 and 3.4

**Box 3.3: Major Themes and Sub-themes for the Mental Health Nurse Participant Group**

<table>
<thead>
<tr>
<th>Theme 1: The Challenges to Our Role as Mental Health Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-theme 1.1: The System Challenges How We Carry Out Our Role</td>
</tr>
<tr>
<td>Sub-theme 1.2: To Leave or Not to Leave – That is the Challenge</td>
</tr>
<tr>
<td>Sub-theme 1.3: The Challenge in Attracting the Next Generation of Mental Health Nurses</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Theme 2: The Work of Mental Health Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-theme 2.1: Being a Team Player</td>
</tr>
<tr>
<td>Sub-theme 2.2: The Emotional Load of the Mental Health Nurse’s Work</td>
</tr>
<tr>
<td>Sub-theme 2.3: Describing Our Work to Others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3: ‘We Are Unusual. We’re the Kind Of People Who Want To Work With People Who Have Mental Illnesses’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-theme 3.1: Others’ Stereotypes of Mental Health Nurses</td>
</tr>
</tbody>
</table>
Sub-theme 3.2: Mental Health Nurses’ View of Themselves

Box 3.4: Major Themes and Sub-themes for the Student Nurse Participant Group

Major Theme: Perceptions of the Role of the Mental Health Nurse

Sub-theme 1.1: Being a Mental Health Nurse is a Challenge
Sub-theme 1.2: What Mental Health Nurses Need to Know to Carry Out Their Role
Sub-theme 1.3: Preparing For and Learning About the Role of the Mental Health Nurse

3.9 ETHICAL CONSIDERATIONS

As this qualitative study involved the participation of humans, ethical approval was sought through the Deakin University Human Research Ethics Committee and ethical clearance was granted in July 2003. Due to issues in recruitment the researcher submitted an amendment to the original ethics approval for a variation to the recruitment process and an extension of the data collection period. The request was approved to allow the researcher to recruit student nurse participants from their place of work. Ethical approval was also sought to conduct a focus group discussion. However, due to data saturation and candidature linked time constraints, the researcher consulted with her supervisors and made the decision to conduct only individual interviews.

Skene (1991, p. 439) asserts that autonomy is premised on the concept that “competent, informed people are entitled to make their own decisions, even if those decisions are not to their benefit”. The author’s description of autonomy alerts us to the fact that participants must be fully informed in a manner that explains the purpose of the study, the manner in which the study will be carried out, what will be done with the information provided and any associated risks. Along with knowledge of potential risks, participants must be able to access appropriate support services and networks in the event that they become distressed. Evans and Jakupec (1996, p.87) state that participants have the right to consent or not to participate and that this choice is grounded in comprehensive information being made available that explains the “nature, effects, benefits and purposes of the research”. In this study the nature and purpose of the research, the time requirements, the voluntary nature of participation and ability to withdraw at any time, possible risks, conditions governing confidentiality, and maintenance of records and methods and techniques to be used in collecting information were clearly communicated to potential participants through the use of the Plain Language Statement (Appendices 5 & 6).
In this study it was essential that no prospective participants experienced any undue pressure to participate, particularly the student nurse participants. This was achieved through initial presentations of the study at meetings of the peak professional group for mental health nurses, and at a lecture for student nurses. From these presentations the mental health nurses could take copies of the information flyer back to their workplace for distribution to their colleagues. For the student nurse group, information flyers were left on the lectern at the end of the lecture to collect if they were interested. Potential participants then contacted the researcher if they were interested in participating in the study. At this point the researcher gave a verbal summary of the project and forwarded a copy of the Plain Language Statement to them.

In order to minimise any harm that participants might experience from being involved in the research, processes were established to maximise confidentiality. The Plain Language Statement indicated that confidentiality would be maintained by the researcher during all phases of the study. As previously mentioned, pseudonyms would be used for all participants in the thesis and any publications arising from the study.

The privacy of participants and the confidentiality of data were also maintained in the study through the following strategies. Demographic questionnaires did not contain any personally identifying codes or markings and all transcripts were de-identified. The participants were not coerced in any way and it was made clear that they could withdraw at any time without penalty or prejudice. The researcher also maintained confidentiality while keeping a reflective journal throughout the study.

Data was stored in a locked filing cabinet in the office of the researcher. Data on audiocassette, computer hard disk, UBS memory sticks and hard copy will remain in the possession of the researcher and be only accessed by the researcher and her supervisors. Data will be kept for a period of five years in accordance with the National Health and Medical Research Council Guidelines (1997, 2007).

3.10 RIGOUR AND TRUSTWORTHINESS

Lincoln and Guba (1985) identify several factors which are critical to demonstrating rigour in a naturalistic inquiry. First, the inquiry must demonstrate its truth value. Second, a study must provide the basis for its applicability in other contexts. Third, a study must allow for external judgments to be made about the consistency of its procedures; and the neutrality of its findings (Erlandson et al. 1993; Lincoln & Guba,
The term trustworthiness is used when referring to the truth value, applicability, consistency and neutrality of an inquiry. Trustworthiness must be established if a study is to be considered methodologically sound and worthy of attention (Erlandson et al. 1993, Lincoln & Guba, 1985).

Trustworthiness in a study is achieved through strategies that demonstrate credibility; transferability; dependability and confirmability (Erlandson et al., 1993). By achieving trustworthiness the researcher demonstrates the quality of the research process (Knight 2002).

### 3.10.1 Credibility

Credibility was established through several processes and procedures. The procedures used to enhance credibility were researcher reflexivity, member checking and peer debriefing (Cresswell & Miller, 2000; Lincoln & Guba 1985). Being reflexive required the researcher to position herself within the study, which Patton (1999) believes is a primary responsibility of the researcher. In this study the researcher was an experienced mental health nurse and the desire to explore this topic was influenced by that experience. According to Lincoln and Guba (1985) and Patton (1999), the researcher will enter a study with personal expertise in the phenomena of interest and will have invariably considered the literature. The researcher has, as recommended by Patton (2002), located herself in the study particularly with reference to “any personal and professional information that may have affected data collection, analysis, and interpretation” (Patton 2002, p. 566). The researcher’s background as an experienced mental health nurse assisted her in the development of the study. She was well placed to examine the issues of recruitment and retention in the field of mental health nursing and to explore the role and professional identity of the mental health nurse. The experience of the researcher actively contributed to her understanding and description of the participants’ experiences and was consistent with the naturalistic approach (Lincoln & Guba 1985).

Being reflexive was achieved through the process of writing a reflective journal. Maintaining a journal is accepted practice in qualitative research (Lincoln & Guba, 1985). Keeping the journal allowed the researcher to record information and feelings about herself so that, along with factors that impacted on the actual process of the study, insights developed and the decisions that arose from them were recorded (Erlandson et al. 1993). For example, the researcher recorded her thoughts about each
interview prior to and following the interaction. Notes about the general interview atmosphere, any difficulties experienced by the interviewer and impressions of the overall interaction were recorded. Sandelowski (1986) suggests that credibility is enhanced when researchers “describe and interpret their own behaviour and experiences as researchers in relation to the behaviour and experiences of subjects” and become “subjects in their own studies” (1986, p.30).

The second strategy of member checking was also utilised to enhance credibility. A study is credible when the descriptions or interpretations of participant’s experiences are recognised by those participants as being their own (Erlandson et al., 1993; Lincoln & Guba, 1985). Member checking allows participants who have shared their experiences to “test the data, analytic categories, interpretations and conclusions” (Lincoln & Guba 1985, p. 314). In essence, member checking enables participants to confirm the authenticity of their transcripts. During this process errors can be corrected and there is the opportunity for participants to volunteer further information. In this study, member checking was achieved by returning individual transcripts to the participants (Creswell & Miller 2000). They were then invited to read the transcripts and make any additions, deletions or amendments they wished. Participants either made their own additions to the transcript or responded to the request for further information or clarification from the researcher. For example, two participants made amendments to their descriptions of the role of the mental health nurse and these were incorporated into the final transcript.

Lincoln and Guba (1985) refer to the process of peer debriefing, in which the researcher has the opportunity to “explore aspects of the inquiry process that might otherwise remain only implicit within the inquirers mind” (p.308). In this study, this was achieved through the supervisory process. In supervision meetings, the researcher was challenged to confirm her emerging ideas about the data in a supportive environment and to consider other ways of conceptualizing the data from participants.

Finally, the use of in-depth interviews allowed prolonged interactions with participants and provided time and space for them to share their stories. In addition, the use of an interview schedule ensured that key concepts were raised for consideration and discussion, and allowed scope to include topics that were not previously identified.

3.10.2 Transferability

Transferability refers to the extent to which other people can see similarities in the findings that may relate to other settings (Lincoln & Guba, 1985; Sandelowski, 1986).
Utilising a qualitative research design in this study helped to ensure that it could be replicated in a diverse range of settings. The researcher has also ensured that sufficient information regarding the research process has been provided to replicate this study. This has included a description of the research design, recruitment and sampling strategies, data collection procedure, the interview schedule, and the data analysis technique. In addition, the thick description has provided sufficient detail of the phenomena, making it possible for the reader to gain a clear picture of the events being described (Twycross & Shields, 2007) and the context in which these experiences occurred (Morrow, 2005). Using information rich cases makes understanding possible by others as they develop meaningful insights and in-depth understanding (Patton, 2002).

3.10.3 Dependability

Dependability is the criterion used to judge the completeness, accuracy and accessibility of the research process (Lincoln & Guba, 1985; Sandelowski, 1986). Dependability in this study was achieved through the following two major processes.

First, an audit trail was utilised in this study. According to Erlandson et al. (1993), an auditor is required to review the documentation that provides an audit trail of how the research process was conducted and the process of the inquiry. Copies of all records of this study have been kept in print and electronic format, and audiotapes have also been retained.

Second, dependability was achieved by the independent review of the interview transcripts by the researcher’s supervisors. This review process was also carried out on the thematic comparisons. The researcher’s first reading and analysis of the transcripts were sent to her supervisors who read a selection of transcripts and then reviewed the researcher’s thematic analysis against their own. This cycle was completed nine times to ensure consistency.

3.10.4 Confirmability

Lincoln and Guba (1985) describe confirmability as the degree to which the research findings are the product of the focus of the inquiry and not of the biases of the researcher. That is that the researcher has acted in good faith in presenting the data, the analysis, and the findings. Confirmability was achieved in this study through the following processes.
First, the researcher identified her position within this study and the major assumption underpinning her understanding of the topic in Chapter One. This helped to ensure that the reader was clearly informed of the researcher’s background, and the legitimacy of her reason for wanting to conduct the study.

Second, in addition to the researcher, the researcher’s supervisors also participated in the data analysis and helped to enhance the rigour of the study by providing confirmability of the data analysis. For example, although the researcher was the primary source of the thematic analysis, an independent assessment of the emerging themes was made by the researcher’s supervisors. Following agreement on the themes, the researcher also referred to the extant literature to facilitate further exploration of the themes identified. Iterations of the data analysis and conclusions and discussion chapters were also reviewed by the researcher’s supervisors to ensure an accurate and fair presentation of the results through to the findings of this study. This strategy further enhanced the validity of the findings.

3.11 METHODOLOGICAL ISSUES AND LIMITATIONS

The study presented a number of methodological issues and potential limitations. These relate to the sample size, the role of the researcher and data collection method.

As previously stated, the sampling strategy employed in this study was purposive sampling. A randomised sampling approach was not appropriate for the study as the purpose of the study was not to achieve representational sampling of the population or generalize the findings. This is in keeping with what Green (2002) sees as a core feature of naturalistic inquiry. Because context is central to naturalistic inquiry, the understanding that emerged through the findings was a reflection of the myriad of factors impacting on experienced mental health nurse and student participants and was in essence a snapshot of people’s contextualised lives. Therefore it was neither possible nor appropriate to attempt generalisations. Ultimately issues of transferability must rest with the reader’s confidence in the reporting process in this thesis, and the transparency of the decision making processes and choices made by the researcher.

The choice to explore the concept of professional identity with two discrete groups of participants presented a methodological challenge for the researcher. As previously stated, it was necessary for the researcher to clearly define her own position in the research process and state her level of investment in the topic area. Given the
researcher's insider status as a mental health nurse and the reciprocal nature of the interview process, this was an essential strategy to minimise the risk of researcher bias. It was also to safeguard against the possibility that the researcher's experiences might take precedence over the experiences described by the interview subject. Because the researcher was also an academic employed at the University where student nurses were recruited, an additional specific measure had to be taken to ensure that no students experienced feelings of coercion to participate. This was achieved by inviting participation only from students who had completed both their academic and clinical studies in mental health. The structure of the course meant that the researcher would have no further (teaching) communication with them following completion of their mental health studies. Therefore, the student nurse participants were able to be assured that their decision to participate would have no influence on their course progression.

An inherent problem with any research design using interviews to collect data is that participants are placed in a subordinate role, with the interviewer in a position of power. It is a recognised possibility that this subordination may have been intensified in this study as the researcher was an academic at the university where the student nurses were studying. As a result of this imbalance in power, participants may have related to the researcher in a different way. Nevertheless, all efforts were made by the researcher to build a relationship of trust through developing a good rapport with each participant at the time of interview.

### 3.12 CONCLUSION

Chapter Three commenced with a justification of the research methodology underpinning this study. Utilising a naturalistic paradigm and qualitative descriptive design enabled the researcher to explore the participants’ understanding of the role of the mental health nurse. The qualitative descriptive research design meant that the researcher could provide a rich description of participants' understanding of the role of the mental health nurse, using their own words without the possible distorting effect of inaccurate interpretations. This was followed by a justification for the research design, the data collection procedure, and the data analysis technique.

A description of the sampling process and selection criteria, instrumentation, pilot study, data collection procedure, and the researcher’s journal were presented. A discussion of the ethical issues relevant to this study and the procedures for establishing rigour and trustworthiness were also identified. This chapter concluded with a
consideration of the methodological issues and limitations pertinent to this study. The next chapter is based on the analysis of the mental health nurse and student nurse participants’ interviews. The analysis of these interviews will be presented in relation to the theoretical framework of Role Theory and the relevant scholarly literature reviewed in Chapter Two.
CHAPTER FOUR
RESULTS

4.1 INTRODUCTION

Chapter Three discussed the research methodology and research design used in this study. Chapter Four will present the four major and eleven sub-themes that have emerged from the mental health and student nurse respondent groups. Supportive comments from respondents are used to illustrate each theme and sub-theme. The analysis also incorporates the researcher’s understanding of the views expressed by respondents in this inquiry. As Patton (1999, p. 1198) asserts, “keeping findings in context is a cardinal principle of qualitative analysis”.

This chapter presents the findings of how mental health nurse (MHN) and student nurse (SN) respondents described their understanding of the role of the mental health nurse and the impact this has on their professional identity. Although two groups of respondents participated in this study, it must be acknowledged that the student nurse respondents simply did not have the depth of experience to reflect on aspects of mental health nursing practice as did the mental health nurse respondents. The major purpose of the student nurse participant group in the context of the data overall lay in their contribution of insights relevant to their level of understanding and expertise. Therefore, the views and descriptions of the student nurse respondents complement those provided by the mental health respondents. The views of both respondent groups will be presented separately and compared where appropriate. Such an approach allows the voice of both groups to be heard and highlights the commonalities as well as any differences in the perceptions of experienced mental health nurse and student nurse respondents.

The purpose of this study was to explore the role of the mental health nurse and the impact of this role on professional identity. Group one comprised 11 mental health nurses employed in a range of public mental health services in Victoria, Australia. There were 10 female respondents and one male respondent. They had from 7 – 31 years experience as mental health nurses. Group two comprised seven students enrolled in a Bachelor of Nursing program at a major metropolitan University in Victoria, Australia.
These respondents had completed their undergraduate studies in mental health and were in the third year of their course.

In summary, following data analysis which was guided by the thematic analysis procedure of Aronson (1994) and Bogdan and Biklen (2007), the themes and sub-themes that emerged for each of the participant groups are as follows.

**Mental Health Nurse Respondents**

**Theme 1: The Challenges to Our Role as Mental Health Nurses**

Sub-theme 1.1: The System Challenges How We Carry Out Our Role

Sub-theme 1.2: To Leave or Not to Leave – That is the Challenge

Sub-theme 1.3: The Challenge in Attracting the Next Generation of Mental Health Nurses

**Theme 2: The Work of Mental Health Nurses**

Sub-theme 2.1: Being a Team Player

Sub-theme 2.2: The Emotional Load of the Mental Health Nurse’s Work

Sub-theme 2.3: Describing Our Work to Others

**Theme 3: ‘We Are Unusual. We’re the Kind Of People Who Want To Work With People Who Have Mental Illnesses’**

Sub-theme 3.1: Others’ Stereotypes of Mental Health Nurses

Sub-theme 3.2: Mental Health Nurses’ View of Themselves

### 4.2 OVERVIEW OF MENTAL HEALTH NURSE RESPONDENTS’ THEMES AND SUB-THEMES

Figure 4.1 illustrates the three major themes and eight sub-themes that emerged from the mental health nurse respondent group. Theme One explores mental health nurse respondents’ perceptions of those features of practice which they believed posed a challenge to their role as a mental health nurse. Their descriptions relate to the features of the health care and educational systems that affect their role expectations and sense of identity as a mental health nurse. The issues they identified also gave them cause for concern about the about the future of mental health nursing in relation to recruitment and retention.
Theme Two examines the perceptions of the respondents in relation to what they understood as the role of the mental health nurse. Although the mental health nurse respondents at times struggled to describe their role; student nurse respondents were able to articulate their views on the role of the mental health nurse with greater clarity. The mental health nurse respondents described the role of the mental health nurse in terms of the work they undertook with consumers. In their descriptions of the role of mental health nurses both groups emphasised the interpersonal aspect of the work that mental health nurses undertake with clients. These views correlate with the interpersonal relations perspective of the role of the mental health nurse described by Forchuk (1994) Barker et al. (1999a, 1999b, 2001) and Peplau (1962) in Chapter Two. There was also recognition of the broader focus of mental health nurses’ work, the involvement of families, and how working in multidisciplinary teams has impacted on the respondents’ view of their role and professional identity. Finally, there is recognition that mental health nursing comes at a personal and emotional cost. Respondents in both groups referred to the emotional impact of working in mental health and the strategies they used to deal with the emotional challenges of their work. Perceptions related to role overload, role conflict and role stress were identified in this sub-theme.

Theme Three describes respondents’ view of how mental health nursing is viewed differently to other branches of nursing. In the first instance, respondents reflected on the way they believed others inside and outside of nursing viewed them as being different. Secondly, mental health nurse respondents described how they believed their work made a difference not only to the lives of their clients and families but to other nursing colleagues and themselves. The third feature of this theme relates to respondents’ perceptions of the different knowledge and attitudes that mental health nurses developed and brought to their role.

Figure 4.1 represents the mental health nurse respondents’ perceptions of their professional identity through the three major themes and eight sub-themes elicited from the data analysis process.
The themes identified in this study were not discrete categories, nor were all the sub-themes equally represented in the descriptions of the two respondent groups. Rather, as befits a study framed within the naturalistic paradigm, the themes reflect the contextual nature of, and the interrelationships in, the participants’ descriptions of their experiences. For example, the mental health nurse respondents described how they believed changes in mental health service delivery and mental health educational preparation make it increasingly challenging for them to engage in a more broad or extended scope of practice. Respondents needed to complete ongoing post-basic training in other discipline areas in order to acquire the knowledge and skills in order to do their work. Constantly having to keep up to date and learn new skills in order to meet changing role expectations respondents are faced with increasing role strain as they attempt to realign their professional identity with the new role requirements.

Table 4.1 provides a summary of the demographic data collected from mental health nurse respondents. This information includes their employment area, years of work experience as a mental health nurse and educational preparation in mental health nursing.
Table 4.1: Mental Health Nurse Respondents

<table>
<thead>
<tr>
<th>MHN Identification Code</th>
<th>Employment area</th>
<th>Years working</th>
<th>Educational Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHN1</td>
<td>Women’s mental health</td>
<td>8</td>
<td>BNurse degree</td>
</tr>
<tr>
<td>MHN2</td>
<td>Veterans mental health</td>
<td>27</td>
<td>Hospital Based direct entry</td>
</tr>
<tr>
<td>MHN3</td>
<td>Aged mental health (Regional)</td>
<td>31</td>
<td>Hospital Based Direct entry</td>
</tr>
<tr>
<td>MHN4</td>
<td>CMH (Metropolitan)</td>
<td>13</td>
<td>BNurse (Mental Health)</td>
</tr>
<tr>
<td>MHN5</td>
<td>NUM (Metropolitan Inpatient unit)</td>
<td>12</td>
<td>BNurse degree</td>
</tr>
<tr>
<td>MHN6</td>
<td>Education &amp; Research</td>
<td>26</td>
<td>Hospital Based Direct entry</td>
</tr>
<tr>
<td>MHN7</td>
<td>CMH (Metropolitan)</td>
<td>27</td>
<td>Hospital Based Direct entry</td>
</tr>
<tr>
<td>MHN8</td>
<td>MHN Academic</td>
<td>22</td>
<td>Hospital Based Direct entry</td>
</tr>
<tr>
<td>MHN9</td>
<td>Clinical Education</td>
<td>7</td>
<td>BNurse degree</td>
</tr>
<tr>
<td>MHN10</td>
<td>PCLN</td>
<td>19</td>
<td>Hospital Based Direct entry</td>
</tr>
<tr>
<td>MHN11</td>
<td>CAMHS (Metropolitan)</td>
<td>13</td>
<td>BNurse degree (Mental Health)</td>
</tr>
</tbody>
</table>

Legend:

Adult MHS: Adult Mental Health Service
Aged MHS: Aged Mental Health Service
BNurse: Bachelor of Nursing
CAMHS: Child and Adolescent Mental Health Services
CAT: Crisis and Assessment Team
CMH: Community Mental Health
MHN: Mental Health Nurse
NUM: Nurse Unit Manager
PCLN: Psychiatric Consultation Liaison Nurse
4.3 GROUP ONE: MENTAL HEALTH NURSE RESPONDENTS

4.3.1 Theme 1: The Challenges to Our Role as Mental Health Nurses

Theme One consists of three sub-themes that reflect the experience of respondents in relation to working in the mental health system. These sub-themes relate to the way in which mental health care is delivered through the system and also to the educational preparation of mental health nurses. The significant changes to mental health policy, funding and service delivery together with radical changes to the education and registration of mental health nurses across Australia were discussed in Chapters One and Two. All respondents referred to these changes and their perceptions of how the role of mental health nurses had been affected and how the role had evolved since the mid-1990’s. All mental health nurse respondents spoke about the system of health and education, with eight mental health nurse respondents using the term ‘system’ specifically. For example, MHN4 and MHN5 expressed concern regarding their capacity to carry out their role because their contribution was not considered important and also constrained what they were able to achieve as part of their role.

It would be nice if we felt more valued by the system (MHN4).

Nursing is a fantastic opportunity but I see it being stifled because of the system and the limitations (MHN10).

There was also the sense that the system spent time on trivial issues because of its poor structure.

You spend your time on these niggly little things because the system doesn’t work very well (MHN5).

Several respondents believed that the initiatives related to recruitment and retention had little chance of success unless there were changes to the health and educational systems.

We aren’t going to be successful at either (recruitment or retention) unless we fix the system. Nothing will happen. Nothing will substantially change (MHN8).

The three sub-themes identified in theme one also demonstrate how the challenges of working in the mental health system as it was configured had a cascading effect on their capacity to practice as mental health nurses. The dominance of biological approaches to practice, increasingly restricted respondents’ capacity to utilise broader psychosocial
approaches in their work. These restrictions led to their perception that building a future workforce and retaining current staff was a major challenge for the profession because their distinctiveness as a professional group was being eroded. This challenge needed to be responded to, but there was a lack of confidence in the capacity of current leaders in mental health nursing to do this.

However, not all challenge was viewed negatively. A number of respondents spoke about challenge as a positive aspect of their work. Challenge in this sense was contextualised in the dynamic nature of respondents’ work and individual personal and professional growth they experienced.

*I feel challenged by it. The job excites me, still does the more I find out (MHN6).*

*You were challenged, constantly challenged. You were challenged as an individual not just as a professional but as a person in your development (MHN8).*

The challenge described above also demonstrated the importance respondents attached to ongoing professional development. Mental health nurse respondents expressed the view that they had a professional responsibility to continually develop their knowledge and clinical skill base. This responsibility for ongoing professional development was also expressed in terms of demonstrating their value as part of the mental health team and not being left behind professionally (Clinton & Hazelton 2000a; Clinton 2000).

*Since I left Uni I had for a long time pursued ongoing education and I've gone to night school. What it means to me is that I've haven't slackened off and I haven't become dead wood. I've just kept up with things, trying to be motivated with my professional development (MHN4).*

Colleagues who did not engage in ongoing development were viewed in a poor light and were seen as reinforcing negative professional stereotypes regarding mental health nurses.

*I was looking around me thinking 'you're an old nurse, you're an old nurse'. They weren't very open to doing further study; they weren't open to being flexible in rotating through different clinical areas. I thought no I am not going to get stuck here; this is semi-retirement stuff (MHN11).*

*I know that there are people who are senior and been around for donkeys years who were just digging their heels in and saying no I'm not going to go and do any courses. I get frustrated by that sort of mentality (MHN6).*
Mental health nurse respondents all spoke about the challenge of recruiting and retaining nurses to mental health. The current educational system was viewed as inadequate in preparing students to take on the role of a mental health nurse. Gaps in knowledge and skills needed to be filled at the post graduate level. The consequence of this was a ‘dumbing down’ of scholarly activity in mental health nursing.

*We’ve got post graduate courses trying to fill gaps for deficits. We don’t truly have post graduate education at the degree it should be because it’s just still filling gaps. So we’re teaching really basic stuff in post graduate courses that are supposed to be more advanced practice (MHN8).*

For many respondents the key to retaining staff lies not so much in financial remuneration but in the opportunity to contribute to policy and clinical decision making, to be recognised and respected as a professional within the multidisciplinary context, and for systemic issues such as high case-loads and the emotional stress associated with their work to be addressed. Work by Currid (2008) and Roche and Duffield (2007), discussed in Chapter Two highlights factors like workloads, emotional stress and contributing to clinical care decisions as important factors in job satisfaction. Where respondents felt their role expectations aligned with those of the organisation they experienced greater role satisfaction. Where a discrepancy existed between the respondents’ and organisations’ role expectations, respondents made choices regarding how to work through issues.

**Sub-theme 1.1: The System Challenges How We Carry Out Our Role**

Respondents’ perceptions of their role were impacted by the health care system in two ways. The first challenge to their role related to the major changes in contemporary service delivery models. At the time of this study a number of the respondents had over 20 years of practice experience. They had experienced the significant changes to the philosophy and subsequent policy direction and funding in mental health services that commenced in the 1980’s. As described in Chapters One and Two, these changes commenced in Victoria with the Mental Health Act (1986) which introduced the concepts of consumer involvement, community-based care and promotion of individual self-reliance. In accordance with legislative changes, there were revolutionary developments in the way that mental health service delivery to all age groups was to be conceptualized and delivered (Council of Australian Governments, 2006; Department
of Health & Ageing, 2005; Holmes, 2006; National Mental Health Strategy, 2004). As MHN3 reflected:

When I left it was all big institutions. The emphasis was coming onto community work. It was more an ideal than a reality. We had community nurses but you were given little paper bags of medication, you were a medication dispensing service and we weren’t really treating people in the community. When I came back it was all turned on its head, there was a new mental health, everyone is working in the community, they’ve done away with all the institutions (MHN3).

MHN3’s experience was that the optimism he had viewed on his return to mental health had not translated into long-term positive changes. MHN3 reflected on this more deeply:

My initial response was this is bloody marvellous. Then you find out that not everybody is happy with the changes (MHN3).

MHN6 also expressed her view that the reforms to mental health had not been an easy straightforward process for consumers as well as clinicians.

There’s a lot of issues in terms of the health reforms that’s been a big cross to bear for the staff, and for the patients, they’ve had to move with it as well (MHN6).

As discussed in Chapter Two, various reports since the 1990’s commencing with the Burdekin report (Human, Rights, & Equal Opportunity Commission, 1993) through to the Not for Service Report (Mental Health Council of Australia, 2005) have presented clear evidence that consumers and carers have continued to experience difficulty accessing appropriate services, in a timely manner. In addition, interactions with mental health professional have continued to reflect ongoing stigma and discrimination (Surgenor, Dunn, & Horn, 2005) as well as the broader community (El-Badri & Mellsop, 2007; Kelly, 1997; Overton & Medina, 2008). Epstein (2005) argues that consumer participation in mental health care was the most significant development that resulted from the Burdekin Report but that since the late 1990’s the ability of consumers to contribute significantly to mental health care policy and program development has been increasingly diluted. It is important to remember that the changes to mental health service delivery have not only impacted on clinicians but also on consumers and carers. MHN6 described the way in which changes to service delivery had in her view removed choice and disempowered consumers.
This one particular client had been floridly psychotic and quite uncontrolled and because of the system at the time he had a good continuum of care, he had regular faces, there was consistency, the medications were okay and he was well for many years. The changes came in, and we started using non-government organisations. The staff didn’t have the clinical expertise. They were not able to interact with him in what I would call a therapeutically effective way. They were punitive on a lot of occasions and this guy relapsed in a huge way (MHN6).

MHN5 described her frustration in what she viewed as a tension between the legislative mandates and the economic priorities of health services. In the following comment, MHN5 expresses a degree of role conflict between what she believes should be the priority of health care organisations – supporting the care of consumers – rather than focusing on cost outcomes.

The point should be putting more resources into treatment teams in the community so that hospital becomes your last resort. The Mental Health Act says it’s supposed to be the least restrictive environment and I get frustrated. You have people in here, we hardly treat them, just jab them full of medication because there’s someone sicker that’s got to come in. It doesn’t take into account the twenty year old person with a first presentation psychosis who we now send home, whose parents may not be ready because we don’t want to cost the hospital money. It’s become about KPIs and money, less about people (MHN5).

From an organisational perspective the health system is designed to maintain a consistent throughput of client in order to achieve required targets and receive appropriate funding. The structure of mental health care delivery in Victoria is currently designed for short stay inpatient episodes with consumers being referred to and managed through outpatient, community and/or continuing care programs on discharge or as an alternative to admission through a case management system. Mental health professionals are expected to involve consumers and carers in identifying outcome based measures to establish, and by implication reward, effective mental health care. In Victoria these priorities have been identified in the Victorian Mental Health Reform Strategy 2009-2019 (Victorian Government, February, 2009) and continue to build on previous National and State policies (Council of Australian Governments, 2006; National Mental Health Strategy, 2004). Yet MHN5’s experience suggests that the infrastructure to support consumers and carers does not match the legislative and policy changes in mental health care. This continues to place unrealistic demands on what acute inpatient services can offer. There is a dissonance between MHN5’s professional
and organisational role expectations which could understandably lead to role stress and conflict.

When asked in what ways the changes in mental health care service delivery had affected their role, mental health nurse respondents were very clear that they welcomed the changes to delivery of mental health care. However, they expressed concern about what they identified as the increasing medicalisation of mental health care. This change in focus had resulted in a more pressured and restricted work environment and the loss of a broader psychosocial focus on care.

_Health reforms like closing the asylums needed to happen at one level but it's really changed the way we do our work and the focus of our work, because of the nature of the way things are we are whizzing people through. So that psycho-dynamic type of work which is really quite satisfying work is lost and it's become more of a medical model. I think those changes haven't been so good (MHN6)._ 

Mental health nurse respondents would have to address these changes. It can be seen that there was a level of role stress towards changes which respondents believed had resulted in a decrease in the standard of care. While role re-shaping or withdrawal were two possible responses to the role strain described, no participant indicated that they had made this choice.

MHN8 also reflected on the move to increasing medicalisation that she believed occurred at the expense of a psychosocial approach to working with consumers. This has resulted in a deskilling of the mental health nursing workforce.

_Mental health nurses are all working with less skills and knowledge, less role models, more focus on the medical model that is the predominant paradigm in the world of psychiatry and there's been a huge shift from anything that's psychotherapeutic (MHN8)._ 

As discussed previously in Chapter Two, Curry (1989), has pointed out how the medicalisation of mental health nursing in Australia took place together with the introduction of the first legislation pertaining to mental health; the 1843 Lunacy Act. Prior to this, the first superintendent of the Tarban Creek Asylum in Sydney was a layperson not a medical officer. By the late 1840’s the asylum movement came under the control of the medical profession. The previous incumbent was replaced as superintendent by a medical graduate from Edinburgh and was relegated to the position of senior warden with largely domestic and nursing duties in relation to patients. This arrangement established the medical and nursing systems for the asylums and was
copied everywhere through the colonies. As argued in Chapter Two, Curry’s (1989) work is important as medicine has continued to control access to the information and work practice available to mental health nurses. The increased medicalisation of service delivery has had an impact on the way in which respondents believed they were able to work. MHN10 believed that emotional care was viewed as a lower priority.

*We need the resources to attend to emotional care. Mental health is just so second class citizen (MHN10).*

MHN5 felt constrained by the bureaucratic demands and imperatives of the contemporary mental health system.

*The way this system is structured doesn’t actually allow us to work to the best of our abilities and we’re hampered by the way the system is set up. I found that particularly in the community working in case management. It’s very generic and it becomes quite task orientated. You’ve got to get this accommodation and get these finances sorted out; you’ve got to do this bit of paper work. What about the treatment of patients? (MHN5)*

From an organisational standpoint the systems in place are designed to meet the organisational objectives. Normative expectations include completion of documentation in the ‘total package’ of services offered. This conflicted with MHN5’s sense of what constituted treatment and how her role was actually defined.

MHN2 believed that the dominance of the medical paradigm in contemporary practice was a worrying development:

*Psychiatric nursing has become very medicalised and there are biological models being enforced. For me as a psychiatric nurse that’s a concern (MHN2).*

When asked in what way this development concerned her, MHN2 indicated:

*I’m not so sure that we do our work holistically now. There are biological models being enforced and for me as a psychiatric nurse that’s worrying. In acute psychiatry clients do need to be put into seclusion they do need to be restrained, but that’s not all of what they need and it’s not all of what psychiatric nurses can offer (MHN2).*

A degree of role conflict can be seen from this description. As mentioned in Chapter Two, the educational and clinical socialisation processes of mental health nurses are constantly caught in the middle of the care or cure debate. Authors such as Peplau (1962), Forchuk (1994, 2001) and Barker (2001), situate mental health nursing practice within an interpersonal relations framework, where interventions are grounded in and
enacted through the therapeutic connection with consumers and families. Authors such as Gournay (1995) believe that mental health nursing practice must be empirically grounded in an evidence based framework. At a superficial level such a debate suggests that mental health nursing practice must be one or the other approach. As stated in Chapter Two, this study had proposed in line with Hamblett (2000) and Norman and Ryrie (2009) that mental health nursing is a combination of interpersonal and evidence-based approaches, rather than mutually exclusive.

When speaking about the changes to service delivery models and the impact on their role, the interview subjects were concerned about compromising their commitment to patient care. If professional identity is viewed as an outcome of the professional socialisation process, then these mental health nurses were expressing a role conflict between their beliefs about their role and the imposed mandates of newly developed models of care.

Sub-theme 1.2: To Leave or Not to leave – That is the Challenge

In line with international trends, Holmes (2006) highlights that Australia has great difficulty in retaining experienced nurses generally and mental health nurses in particular.

The issue of retaining suitably qualified nurses is well documented (Happell, 2008b; Lu et al. 2005; Robinson et al. 2005). Issues such as those indentified in Sub-theme 1.2 are linked to the retention of nurses generally and mental health nurses in particular (Happell, 2008b). These ideas were reflected in a number of views expressed by respondents who described the need to support ongoing professional development and the maintenance of a supportive work environment, as crucial ongoing job satisfaction.

*Mental health nurses need to be respected as professionals and have their ideas validated.*

*They need to be recognised as professional (MHN4).*

MHN7 also expressed the view that professional recognition was crucial to retaining mental health nurses in the workforce.

*It gets back to this, if you're valued and you have the sense of being valued you will make your contribution. It doesn't matter how upsetting, how stark, how fantastic, how wonderful things are if you're valued then recognition will also come with the fact that your*
background and whatever discipline you’re in and that includes nursing has prepared you well for this area (MHN7).

MHN10 viewed active participation in decision making about practice as essential to retaining clinicians.

Time needs to be spent empowering staff to be involved in the decision-making processes at all levels. If staff are satisfied then they stay (MHN10).

These comments on retention in nursing support the research literature which identifies that nurses seek to make contributions to the delivery of health care. Furthermore, they want their input to be recognized as professionally grounded and actively contributing to these processes at varying levels of the service (Roche & Duffield, 2007). The concept of the multidisciplinary team supports contributions from all team members. Job satisfaction and the ability to manage work-life balance are also consistently identified in research literature as significant deciders with regard to remaining in nursing generally and mental health nursing specifically (Duffield & O’Brien-Pallas, 2003; Happell, 2008b; Roche & Duffield, 2007). The respondents’ professional identity was connected to their perceived capacity to contribute and be regarded as equal members of the team. When this does not occur, role strain through role conflict can occur. The mental health nurse will respond to role strain in one of three ways. Role acceptance as described in Chapter Two is one such choice.

MHN8 believed that the persistent problem of retaining mental health nurses in practice was not going to be resolved easily. The views expressed by MHN8 confirm a number of the issues highlighted by Nolan et al. (2007). In particular, lack of support or education and professional development, recognition of the validity of using a range of models of care and improved infrastructure and staffing are all factors which impact on mental health nurses satisfaction in their role.

Until there are improvements in the system, and I’m talking about case loads, about resources in terms of education, and training, resources around different models of care, genuine consumer care and participation in all aspects of service provision, until we get adequate resources both human and financial to improve the system we are always going to struggle (MHN8).

One response to such challenges may be for mental health nurses to withdraw from their role. The most extreme example of this is to leave practice. Respondents were
asked if they had ever considered leaving mental health nursing. Ten of the eleven mental health nurse respondents indicated they had thought about leaving.

"I regularly think about leaving. This is a tiring job and you just need a mental break from it. This isn’t just work that we do eight hours a day; this is work that sometimes we take home. This is the work that impacts on our family life or us as people, as individuals and our own growth (MHN4)."

However, only four of the ten mental health nurse respondents had actually left mental health nursing at some point during their career.

"I’ve got fond memories of working in teams that were so collegial and supportive and nurturing and I went and worked with a team located in a general hospital and they were predominantly general nurses working in psychiatry and it didn’t have the same vibe. They were a nasty bunch. They were into blaming a lot and I thought if this is where it’s going, I don’t want any part of it. I’ve never worked in a team like that before and I’ve worked with really entrenched staff. I just wanted to run and get out of there (MHN6)."

If the graduates of comprehensive undergraduate nursing courses have been prepared to work in mental health settings then it would be reasonable to expect that MHN6’s experience of teamwork should have remained a positive one. MHN6’s description suggests this was not the case. This account demonstrates the importance of MHNET’s (2008) recommendations that all nurses working in mental health from comprehensive courses should be educated in teamwork as well as broad based psychosocial, principles of care, mental health and mental illness.

MHN7 reflected on her decision to leave mental health. Following a period of formal study MHN7 returned to clinical practice. In her effort to enact her new role expectations based on her studies, MHN7 experienced role conflict in relation to her relationship with other colleagues who appeared resistant to her ideas. This created a sense of alienation from her colleagues. The tensions she believed she was creating because of her desire to implement change and the resistance from colleagues resulted in MHN7 feeling frustrated at not being able to effect any change in her clinical practice.

"I left because I was tired of it. I couldn’t give anything to it. I’d been through a period of formal learning and when I went back I was around people that were not where I was, and if anything at that time I actually caused havoc rather than did myself any favours so
I left. I hid away in a general hospital for a while, and just pottered around and I would say that that probably saved me to wind down and to get real again (MHN7).

‘Getting real’ enabled MHN7 to gain perspective between what new ideas about her role and her understanding of what she believed her colleagues viewed as important. MHN7 worked in theatre for period of five years, but maintained contact with mental health nursing practice in a roundabout way. This involved the odd casual shift on the ward and interestingly, it was during this time that she was active in the peak professional body of mental health nurses. She eventually returned because:

A friend rang me up and said what the hell do you think you’re doing and I went up to X University for a period of time. I really enjoyed the lecturing side of things (MHN7).

A return to mental health practice through lecturing may have been a way for MHN7 to contribute her ideas about the role of mental health nurse to students. As identified earlier, MHN7 believed she had a responsibility to teach undergraduate students on placement in order to fill in the gaps in their mental health education. MHN7’s eventual return to clinical practice was in her words ‘through the back door’. This return was also facilitated by her colleagues. There is a sense that MHN7 was being ‘welcomed back into the fold’.

I came through the back door and I knew I had to make a fist of it and at the end of three weeks and I said try and make a case for me to stay because I would like to stay and the clinic coordinator said that shouldn’t be too difficult. She came back and she said I’ve found some money and then she followed the procedures, like it had to go up and it was an internal advertisement. She had the advertisement, she put it up on the wall and she said now read it and I read it and she said good and she took it off and said now apply. (MHN7).

MHN3’s reasons for seeking work outside of mental health nursing echoes issues identified throughout the research literature.

There were certain things about the culture of the place that I was looking to get away from I think. The shift work I found onerous, I thought this isn’t how I want to spend my working life. Psychiatry gets a bit ...weary; you get tired of aggression and the crankiness (MHN3).
When asked why they continued to practice in mental health, respondents gave a number of reasons. When asked why she continued to work in mental health, MHN4 answered:

_There are people that just make me feel so humble. One kid that came in the other day; I started to cry because I could see how devastating this illness was on his life and how it had changed who he was as a person. If nothing else I’m going to try and see if I can make his life okay to live with this. That’s what keeps me going._ (MHN4).

Even with the ambiguity she experiences in her role, it is the opportunity to make a difference in the life of another person that resonates with MHN4. This notion of difference will be explored in more detail later in this chapter. However, the sense of connection with others and desire to build relationships that help someone to grow and develop is a strong motivating factor for MHN4. This emotional exposure also increases her vulnerability to role strain. MHN4’s professional identity appears to be a mix of fragility and determination to ‘do good’ so that another person can have a more positive outlook.

MHN8’s professional and personal identity have become so entwined that regardless of where she is located professionally or personally she views the world through this combined perspective.

_A psych nurse is who I am. It’s more than a job, it’s who I am so it’s part of my psyche. Regardless of where I go or what other career path I might go down that’s me so I can’t not be me. I have actually grown into being a psych nurse. I didn’t start my career as a psych nurse but now a psych nurse is part of my psyche._ (MHN8).

MHN9’s firm belief that consumers will improve their health and their quality of life, and her linked belief that she can contribute to their growth enables her to work through any issues. She can ‘put up’ with the negative aspects of her work because the end result is worth it. In essence, MHN9 has hope for the clients’ capacity to have a better future.

_I’ve had patients say you know why do you stay here, why do you put up with that. I say it’s because I know that that person is going to get well. You know I know I’m going to see that person get back to their lives._ (MHN9).
Sub-theme 1.3: The Challenge in Attracting the Next Generation of Mental Health Nurses

All mental health nurse respondents spoke of the need to attract new graduates into mental health nursing. As described in Chapter Two, there has been a consistent problem in recruiting nurses to mental health, as is the case with all areas of nursing (Australian Institute of Health and Welfare, 2005, 2008). The research has also demonstrated that positive clinical placements are likely to increase students’ interest in mental health nursing as a potential career choice with factors such as opportunities for active learning and support identified as being important (Charleston & Happell, 2005; Happell, 2008a; Henderson, Happell, & Martin, 2007; Wynaden et al. 2000). Mental health nurse respondents described the following three broad areas in relation to this issue.

The literature demonstrated that a key factor in promoting mental health as a possible career choice for students is the quality of the students’ clinical experience (Cleary & Happell, 2005; B Happell, 1999; Stevens & Dulhunty, 1997; Wynaden et al. 2000). Mental health nurse respondents described the need for positive clinical placements as crucial to the recruitment of new graduates.

If we can show them where the potential areas psych nurses can work within the opportunities that can be available and defining what we do with clients. That it’s not all about documentation, it’s not all about medicating. It’s the relational aspect of it (MHN2).

In this quote MHN2 described two important points. First, students need to see the broader context of where mental health nursing takes place. With a greater emphasis on primary care in mental health, opportunities for placements outside the inpatient and generic community based settings need to be investigated.

The second point to note here is that MHN2 stated that it was important to demonstrate the broader scope of practice. When viewed in its totality mental health nursing is more than tasks (Clarke 2006). Mental health nursing involves human engagement which MHN2 considered central to her role and her professional identity.

MHN11 indicated

It is more about engaging them in their practice. Addressing their fears and concerns and sometimes it is through media and sometimes it is through personal experience. I suppose I
am unpacking what their issues are and trying to repack it in a manageable way,
hopefully making them more amenable to suggestion and new information (MHN11).

This comment reflects how crucial it is for staff to be actively involved in identifying
and working through any factors that can inhibit a student’s opportunity to have a
positive clinical learning experience (Charleston & Happell, 2005).

MHN10 spoke about the need to make learning about mental health meaningful. She
emphasised the need to actively engage students in the clinical process and to encourage
them to view consumers and mental health nursing practice in its broadest scope.

Make mental health come alive not just to be DSM IV regurgitated but made to come
alive so it actually makes sense in human terms. That it’s not just seen as labelling a
person (MHN10).

All mental health nurse respondents expressed the view that universities have a
responsibility towards promoting mental health nursing as a career choice for students.
This was based on an overwhelming sense that graduates from comprehensive
programs were ill-equipped to work in mental health, because of a lack of appropriate
education and that universities generally failed to promote mental health as a career
choice.

I think the university system really needs to be taken to task around how they promote
nursing so that it starts there at a good level so that we get new people coming in
(MHN4).

Mental health nurse respondents saw this inexperience and lack of preparation when
new graduates entered the workforce. MHN8’s comment reflects the general view held
by the majority of the respondents.

We’ve got comprehensive graduates coming out with very limited skills and knowledge
about the area and then post graduate courses trying to fill gaps for those deficits
(MHN8).

As previously discussed, direct entry preparation of mental health nurses ceased in the
mid-1990’s. According to Cleary and Happell (2005) this impacted significantly on the
capacity to recruit sufficient numbers of suitably qualified nurses (Happell, 1997).
However, Happell and Gough (2009) have asserted that a return to the days of direct
entry training is unlikely to occur in the prevailing economic and educational climate. As
argued in Chapter Two, the MHNET (2008) Report into mental health education in
undergraduate courses indicates that a lack of adequate mental health content and lack of a clear definition regarding what constitutes mental health content in undergraduate courses is common and varies considerably amongst States and Territories. Along with increasing pressure on the availability of relevant clinical placements, mental health education in Bachelor of Nursing programs is in urgent need of attention and needs to be given greater emphasis. Several respondents raised an interesting point with regard to when students should be introduced to mental health content.

MHN2 stated:

*I think it’s very, very difficult for students. Mental health needs to be done even earlier within the unis. What kind of messages get sent to students if uni lecturers are finding it difficult to actually identify, what psychiatry is about. How are they going to then be able to relay that to the students?* (MHN2).

The choice to delay the introduction of mental health education until the latter part of undergraduate programs, means that students do not have the opportunity to integrate concepts into their practice or to explore the issues related to working with people who are mentally ill. MHN2 is also concerned that nurse academics are uncertain about what mental health nursing practice is and/or should be. MHN8 believes that core content and understanding about working effectively with clients is being ignored in contemporary undergraduate nursing courses.

*I seriously believe that there’s not enough in the first twelve to eighteen months of comprehensive training and you can’t deal with patients, without these skills. If I had the capacity to do it I would have a good eighteen months of a purely patient centred approach that would be heavily psychosocial with some psychiatric stuff in there but all about the person and all about them as a person before they even began to think about looking after others.* (MHN8).

MHN7 believed she has a responsibility to teach students:

*My old Charge Nurse said to me if you learn nothing else, learn the four Ds of mental disorders deterioration, disorganization, disintegration, and disability. I use that to cement what I call mental health literacy, that’s what I give the student nurses; I want to give them a solid foundation.* (MHN7).

The idea of offering an educational program that introduces students to the principles of person centred care as a foundational framework sits in stark contrast to many
contemporary undergraduate nursing curricula. Bench-marking across several universities reveals that in most instances mental health nursing is offered as a discrete unit of study and is generally introduced in the second year of undergraduate programs (for example, Charles Darwin University, 2007; Deakin University 2004). These are generally discrete units and mental health is not overtly identified anywhere else in either curriculum documents or general course information. In the early 2000’s several Victorian Universities introduced mental health as a major sequence of study. However, because of the extent to which many undergraduate nursing courses are ‘theory crammed’ (MHNET 2008), this option can only be offered as an elective pathway for students. Basic knowledge in broader psychosocial principles also appears to be inconsistently offered through Bachelor of Nursing programs.

The mental health nurse respondents clearly identified those aspects of education that are missing from students’ educational preparation:

I wonder with current education whether they are getting a solid grounding in psychiatric nursing. Particularly interpersonal communication and how to use themselves in a therapeutic way and the creation of a therapeutic environment. Concepts like psychological holding of people and managing the extreme emotions that people have. I also worry that because the system is so focused on psychosis and self harm that they are becoming really narrow in what they view as the role of the psychiatric nurse as. That we only deal with schizophrenia and so called serious mental health or high prevalence disorders (MHN10).

The MHNET (2008) Report details nine principles and four benchmarking criteria for mental content in undergraduate nursing curricula that highlight several of the points made by MHN10. These include course content that should reflect a holistic and lifespan approach to mental health, ensuring that students learn about and value the psychological and social care of consumers equally to physical care, and course content which addresses a range of mental health issues.

Respondents were outspoken in their view that in order for students to choose mental health nursing as a career, they first need to understand something of what mental health nurses actually do. Respondents spoke of the need to ‘tell their stories’.

We don’t get up there and tell our stories enough (MHN10).

The inability to share stories of the work of mental health nursing was thought by MHN2 as increasing the likelihood that students would not consider mental health
nursing. Augmenting the views expressed in the MHNET (2008) Report which advocated for the inclusion of content that promotes positive images of mental health, and a positive professional identity of mental health nurses, MHN2 stated that:

*The likelihood is students are going to go to general unless they have some kind of preconceived notion of wanting to be in psychiatry. There’s a bias towards general nursing and I’m not so sure if we in psychiatry can do very much about that, how we portray ourselves I think we can do something about (MHN2).*

MHN10 believes that promoting the good work that mental health nurses perform is crucial to encouraging students to consider this field of practice.

*Articulating what we do and doing it in a way that actually promotes mental health nursing (MHN10).*

MHN1 had received positive feedback regarding her presentations on mental health nursing to undergraduate nursing students at university. She believed that this activity needed to be encouraged.

*Do lectures, actually go out. We got fabulous feedback from the lecture we from the students (and) from the lecturer. He actually said he got lots of feedback from the students afterwards (MHN1).*

MHN4 expressed the opinion that it is essential to communicate with young people before they start university. Changing perceptions about mental illness and promoting mental health nursing as a viable career choice provided an exciting opportunity.

*Get out to the high schools and start there. Start de-stigmatizing it, start encouraging people with a career in psych nursing (MHN4).*

Many of these ideas reflect a desire to challenge the misconceptions and myths surrounding mental illness, and support the recommendation by MHNET (2008). This strategy would allow mental health nurses to promote a more realistic view of mental illness and importantly the role of mental health nurses as part of the mental health team.

MHN6 believed that not promoting mental health nursing would lead to mental health nursing eventually being irrelevant in service delivery.

*I don’t think we’re very good at you know getting out there and promoting ourselves you know and I think that we have to do that otherwise we’re just going to fizz away like the*
retardation nurses. We’re just going to fizzle out. I have almost a sense of urgency about it (MHN6).

Respondents were asked what stories they would like to be able to share about their role with the broader community as well as students at school and university to promote mental health nursing.

I’d like to see more of a focus on the counselling aspect of our job, I think, that would attract a lot of people who don’t realise that’s what we do (MHN1).

I always describe it with enthusiasm especially. I’ll reflect and talk about the communication. How good it is to see people get well (MHN9).

In this comment MHN 9 reinforces that mental health is about positive outcomes. This type of imagery is important to challenge the overwhelming negative view of mental illness held by the community (Hazelton, 1997).

I’d like there to be a stronger picture of our professionalism and our clinical specialization and the scope of understanding of the knowledge and experience we have (MHN3).

MHN11 also believed that it is crucial to emphasise the positive impact that mental health nurses have and in this way to begin to de-stigmatise mental health nursing (Halter, 2002).

It’s about our sensitive caring side, actually dealing with people, in the most vulnerable state and respecting them irrespective of their state and not taking advantage of them in any kind of a sense but actually supporting them so they can learn the skills and strategies to help get back on track and become more independent and more responsible in their own self care (MHN11).

These ideas contradict the argument put forward that mental health nurses cannot and/or do not talk about their work (Hurley, Mears, & Ramsay, 2008). The respondents in this study were very clear about the types of stories they wanted told. They shared stories that highlighted the relational aspect of their role, their skill in psychotherapeutic strategies, the humanness of the people they work with and their awareness of the vulnerability of this consumer group. Importantly they wanted to hear and tell stories about the positive contribution mental health nurses can make to consumer outcomes. This suggests that these mental health nurses have a clear understanding of their role and therefore their professional identity. However, some respondents did acknowledge that it would be a challenge to demonstrate exactly what mental health nurses ‘did’.
When you think about it how could we portray what we do? How could we portray that in a movie? I don’t know how we could. You know if you take a glimpse of just a little part of what we do so you’d see us in the medication room handing medication out or if you see us in the office we’re answering a phone or we open the door and we talk to the patient. But none of those things really tell you what we do (MHN9).

Although respondents clearly expressed the view that more needed to be known about their work, their own understanding of mental health prior to commencing their training was scant in many cases.

Never seen any psych. I never knew anyone at that point who had a mental illness (MHN1).

I didn’t understand what psychiatry was or know what it was going to mean to be in psychiatry (MHN2).

I didn’t know anything about psych nursing (MHN9).

The reasons for the decision to enter mental health nursing varied among the mental health nurse respondents. Certainly it did not always reflect the commonly expressed views in the research literature that the choice related to seeking a career that involved caring and helping others (Cho, Jung, & Jang, 2010; Mooney, Glacken, & O’Brien, 2008).

I had no burning desire to be a nurse, it was just I didn’t like what I was doing, this sounded different and I thought well why not, I’ll give it a go and that was it. I sort of fell into it really by accident rather than any design (MHN3).

For these respondents the connection to their work came later.

When asked why he stayed MHN3 indicated:

I enjoyed the work and, it’s hard to find the word. I found a certain sense of satisfaction (MHN3).

MHN4 illustrates how she ‘stumbled across’ mental health nursing.

I was in year twelve and had no idea what I wanted to do with my life so my parents said they’re having an open day and nursing is on and we think you’d be good at it. We went and had a look at the general nursing and it just wasn’t grabbing me. We were walking out and quite by accident stepped into the psych nursing department. They started to talk to me and I got linked in and I said I think this is it, now I’ve got a goal. (MHN4).
MHN8 commenced mental health nursing as a means to an end. Her original goal had been to enter general nursing.

*I left school in year 10 so when I looked into nursing I didn’t have what I needed to do, to be an RN so somebody said do Div 2 first. By that stage I’d outsmarted myself and I still couldn’t do Div 1 because I still didn’t have fifth form but I also wasn’t old enough to go in as a mature age student. Somebody said to me go and do psych nursing. If you do that you can just do the general course which doesn’t take you as long so I thought oh okay* (MHN8).

However, MHN8’s experience of mental health made her rethink her career plans.

*As soon as I started working in psych I loved it. Because I’d worked as a Div 2 and it was all about task, task, task and I wanted to stop and talk to people. In the general hospitals I couldn’t (do that) It was the fact that it was about the person. I loved that whole idea of being able to talk to people and for that to be one of recognised main roles of what you did* (MHN8).

MHN7 reluctantly began nursing in order to have steady employment;

*I started in mental health on the recommendation of a case manager, I was unemployed and he said to me you’ve got all these qualifications how come you’re out of a job? Why don’t you try this (mental health)? The matron said I suppose you’re looking for a job. When would you like to start? That was on the Tuesday and she said well what about Thursday morning. So that’s how I started in psych* (MHN7).

MHN6 spoke about wanting a significant role in health that built on her interest in science. She viewed general nursing as limited in its capacity to offer her this opportunity

*I saw general nursing as very much the hand maiden role. Do as you’re told, run around empty pans, be busy. I thought that even though they’re important things to do I really didn’t see that it was a significant role. The way I was looking at it, anyone could do that. I guess I saw it as a glorified cleaner and for me that wasn’t what I wanted* (MHN6).

Respondents’ experiences and understanding of mental health do not appear to be all that different to that of undergraduate nursing students in current Bachelor of Nursing Programs. Respondents knew little about the field, it did not appear to be actively promoted and even those respondents who had some an awareness of this area of
practice only appeared to have a superficial understanding of mental health. Other respondents viewed mental health nursing as a means to achieve some stability and direction or as a stepping stone towards another longer term goal.

4.3.2 Theme 2: The Work of Mental Health Nurses

If mental health nursing is to assert its position as a specialty, it is imperative that nurses be able to articulate how they work with consumers and carers, what their role is, how they view their work and what their work means to them. Answering these questions provides an insight into the mental health nurse’s professional identity.

In theme two, three sub-themes emerged. The first sub-theme reflects the work of mental health nurses as part of the multidisciplinary team. As discussed in Chapter Two, the multidisciplinary team has evolved as the dominant model through which mental health services are delivered. This is can be seen in the case of community based settings, which operate along more generic models of care delivery. For example, some primary mental health and community mental health settings now employ a range of clinicians as case managers or mental health clinicians, rather than under discipline specific titles. However, other community facilities continue to use the title mental health nurse or even psychiatric nurse. Clinicians in inpatient units continue to be classified as mental health nurses regardless of the title used. Nevertheless, all clinical contexts are premised on the delivery of care through a team approach.

The second subtheme reflects respondent’s experiences of the emotional impact of their work. This subtheme considers the issues related to emotional labour in nursing and its impact on the mental health respondents’ perceptions of stress. It also takes into account the impact of emotional labour on their capacity to fulfil their role and how this affected their professional identity. This subtheme adds to the existing body of research on emotional labour in mental health nursing.

The final sub-theme reflects the mental health nurse respondents’ perceptions of how they would describe their role to others. In sub-theme 1.3, respondents discussed the need to promote mental health nursing. Telling stories of practice, speaking in public forums about their work and mental health were viewed as essential strategies that needed to be implemented. This sub theme will highlight the way in which the respondents struggled to capture the essence of their role.
Sub-theme 2.1: Being a Team Player

Mental health nurse respondents described their thoughts about the increasing focus on care managed through a multidisciplinary team. These perspectives provide some important insights into the role ambiguity experienced by the respondents.

*I actually think that the nursing role has been eroded quite dramatically in the community to this generic title. Now that’s great for multidisciplinary teamwork and making sure that we’re all part of a team. The negative to that is that nurses are starting to lose what it is that makes them separate in their professional identity separate to the rest of them* (MHN4).

Using Hurley et al.’s (2008) description of organisational and practice identities, MHN4 comment reflects a sense that the organisational identity she has assumed in her role takes precedence over her practice identity as a mental health nurse. There is also a sense that losing her practice identity is inevitable when working in a multidisciplinary team.

MHN11 expressed the view that it was not always easy reaching a consensus when working as part of a team.

*Discrepancies within the team about clinical management of clients can always be a bit tricky* (MHN11).

Multidisciplinary approaches to health care have been an evolving model for mental health care delivery. Proponents argue that a team approach to care delivery, involving a range of professional groups, improves communication between health professionals and leads to an improvement in the quality and diversity of care possible (Dennis, 2006; Priest et al., 2008).

It is argued that this type of approach to client care promotes best practice (Priest et al., 2008). Current policy direction in Victoria supports this though a push to develop “a sustainable, flexible and dynamic …workforce” (Victorian Government, 2009 Summary). Despite these arguments for a multidisciplinary focus, MHN4’s comments above reflect mental health nurses’ perception of the concomitant erosion in their specific professional role as a mental health nurse. MHN6 linked this erosion to the increased outsourcing of psychosocial rehabilitation services to non-government agencies and allied health professionals. In both instances, these reflections come from practitioners who have worked extensively in community mental health settings. The
research literature also indicates that it is within community settings that the boundaries between various disciplines are less clearly defined. For example, Brown, et al. (2000) explored how three multidisciplinary community teams worked. Although some team members welcomed a certain degree of role blurring, others sought to maintain their own professional identity within the multidisciplinary environment. The push towards a generic model of professional practice appeared to increase the desire by some team members to maintain a separate professional identity. MHN11 reflected that:

I find I personally work easiest with other psychiatric nurses where we share a common body of knowledge, we don’t need to stop and explain all of our decision making process to others (MHN11).

Descriptions such as this reflect what Jones (2006) and Priest et al. (2008) view as maintaining rigid role boundaries. It may even be considered as an example of the inability of professional groups such as nurses to let go of traditional ideas about the role and scope of practice in different health care groups. It also highlights the degree to which educational processes have not supported the understanding of team approaches and have not encouraged nurses to develop the ability to work as part of a multidisciplinary team. Views such as MHN11’s reinforce historical traditions which are incongruent with contemporary health service needs. However, this perspective must be contextualised in relation to the clinical area this participant worked in. As a registered nurse within a specialist mental health unit MHN11’s comment also reflects a strong sense of professional connection with other nursing colleagues and a shared professional identity. This sense of solidarity was also expressed by MHN1:

We’re a family. Particularly the nursing staff because the other staff around us haven’t stayed, they aren’t as stable, I mean the doctors change anyway but the consultants stay the same (MHN1).

For those respondents working in primary mental health, community based mental health programs and as Nurse Unit Managers there was as greater sense of isolation from their colleagues.

The role that I’m in, I don’t have another nurse around and I want to be identified as a psychiatric nurse so I seek out that connection because I still want to be part of that (MHN2).

MHN5 who worked as a Unit Manager stated:
When you’re a nurse unit manager you’re in the middle of senior management and your staff. I feel supported from my staff, not all of them but I also have an incredible amount of support from my manager also my peers within the service (MHN5).

Nevertheless, it would be inaccurate to suggest that respondents were passive recipients of changes to service delivery. How then did they ‘work their way’ around the ‘system’?

I was one of the first people to come out here over ten years ago and I helped to establish a program however it was conducted without the knowledge of the organization and eventually somebody squealed. I had the line manager say you’re to stop this immediately because you’re operating outside organizational objectives and I said so what are they and she wasn’t able to tell me what they were. I said well shift your goal posts because what we’ve got here actually works. So later on this other program was set up but it was so restrictive I just carried on very quietly, my colleagues did as well (MHN7).

In responding to the role ambiguity encountered in this event, MHN7 also refers to how she worked ‘around’ and even ‘in spite’ of the system. In the absence of any specific role expectations, MHN7 created a new role for herself and functioned within these self designed parameters. Her capacity to negotiate this role was dependent on support from others within her immediate work environment and the support from external stakeholders such as general practitioners. Being ‘squealed’ on appears to represent a sense of betrayal by colleagues within the organisation.

MHN10 found that she adapted to the demands of the ‘system’ by choosing her battles.

I was so angry at the system and couldn’t work out a way not to be angry and I think to stop incessantly trying to fight the system, being angry with the system but, just try to make changes where I can and not to be too ambitious with what I do (MHN10).

MHN7 also reflected on the way her expectations of what she could achieve had changed over time.

I don’t want to be moving the world, I might have had that idea twenty-five years ago because I probably had less boundaries around me at the time but everybody wants to move the world at twenty five (MHN7).

However, it would also be erroneous to conclude that all respondents viewed working as part of the multidisciplinary team as a negative experience. MHN2 described her disappointment in what she perceived as the loss of the multidisciplinary focus.
Our team has expanded over the years and there’s a movement towards more psychologists being in the team so it’s feeling less multidisciplinary. It would be more stimulating for me to have different disciplines around and it has been, that’s what I’ve really enjoyed about this kind of work is that it’s stimulating (MHN2).

MHN4 also observed that working in a team has had a positive outcome on mental health practice.

*Working in a multidisciplinary team with people who are just as interested in psychiatry as you are. Working with people who always go oh I didn’t know that, I think that’s great* (MHN4).

Working in multidisciplinary teams was seen paradoxically by these respondents as having the benefit of collegiality, increasing their scope of practice and learning from others. The increasing genericism described by respondents reflects what Brown et al. (2000) and others, notably Cross (2009), have identified as a source of conflict in multidisciplinary teamwork. Multidisciplinary teamwork challenges traditional, socially valued role definitions and expectations (Brown et al., 2000). The lack of role boundaries which typifies the generic structures of the multidisciplinary team can lead to role stresses. In particular it can result in role ambiguity and role conflict when professionals are torn between their sense of being part of the multidisciplinary team and their identification with their own discipline groups. That is, there is role strain between the expected organisational identity and their practice identity (Hurley et al. 2008). The benefits of the multidisciplinary approach are extolled in the policy and reform initiatives of governments. Although respondents certainly identified these benefits, the experiences they described made it clear that professional role boundaries have become increasingly blurred. This appears to be the case in all areas outside of acute care contexts whether adult or specialist areas such as child and adolescent mental health units. This increasing role ambiguity threatens the ongoing professional identity of mental health nurses as distinctive members of the mental health team. The systemic changes to mental health care delivery have led to increasing role ambiguity for mental health nurses working in primary mental health and community based programs. The concept of mental health nursing as a specialist area of practice is therefore becoming increasingly difficult to articulate.
However, it is important to note that respondents took a number of actions to maintain their profile within the multidisciplinary team. Credentialing was viewed by MHN4 as a process that helped her re-establish those boundaries.

* I just recently became a credentialed nurse. Becoming credentialed is saying hold on there’s a profile here in nursing as well. I’ve got a piece of paper on my wall that reminds people that I’m a nurse and that I do have skills beyond giving an injection and I think I needed to do that as well because it just gets so eroded here. I mean we have so many skills but so many other disciplines think that’s theirs or that they own it (MHN4).

Being clear about what she regarded as her specific knowledge and skills through the process of credentialing helped MHN4 feel validated as a professional within the multidisciplinary team. This sense of validation of her role as a mental health nurse appears important to MHN4’s sense of professional identity. As identified in Chapter Two, Menzies Lyth (1988) argued that clear institutional boundaries contribute to the strengthening of an individual’s own psychological boundaries. In the clinical context it could be argued that institutional boundaries are more clearly defined in traditional areas such as acute inpatient settings as opposed to more generic mental health settings. MHN4’s description above illustrates this increased sense of certainty about her role as a mental health nurse while at the same time acknowledging the tension in relation to what other professionals in the multidisciplinary team perceived as their role.

MHN2 also illustrates this tension when she stated:

* This role, it’s not clearly defined, and some people say well are you still being a nurse when you do what you’re doing and I have given that some thought. I still see myself as nurse; I can’t really claim to be any other discipline. I am a psychiatric nurse. I could say I’m a nurse therapist, I could say I’m a psychiatric nurse counsellor but there’s always got to be that nurse there so within myself I feel an identity there but looking at the team that I work in, it may get lost (MHN2).

Again MHN2 is highlighting the sense that working as part of a team involves the inevitable loss of one’s professional identity. MHN2 also experienced the challenge of having to justify her right to be on the team. This was identified by Currid in his 2008 work on stress in mental health nursing. Professional self-development is a complex process through which nurses acquire the knowledge, skills and attitudes reflective of the characteristics of nurses in general, that is, a professional identity. Developing a professional identity involves the internalisation of the principles and practices of
nursing into the learner’s professional self-concept. Working as part of a multidisciplinary team with few or even no other mental health nurse colleagues isolates the clinician from the opportunity to maintain a connection with their professional base on a day to day basis. The view that someone has of their own profession and their understanding of themself as a professional person necessarily influences their thoughts and actions in professional relationships. Experiences such as those of MHN4 and MHN2 highlight the significance of having other mechanisms to maintain a sense of professional identity. Happell (2007b) has proposed that a process such as credentialing is crucial to maintaining a distinct professional identity.

Sub-theme 2.2: The Emotional Load of the Mental Health Nurse’s Work

As previously discussed, nursing is an occupation where practitioners work with people when they are experiencing varying degrees of vulnerability in relation to their health. Caring is viewed by many authors as the fundamental concern of nursing (Benner & Wrubel 1989, Watson 1990, Swanson 1993).

By describing the work of caring as emotional labour, Duncan (2003) argued that Hochschild (1983) challenged the apparent “effortlessness of caring and recognised instead the impression of effortlessness as part of the work of caring” (Duncan, 2003, p.3). Therefore the decision to care for or emotionally engage with a client is one that exposes the nurse to the potential for personal costs or benefits as well as professional ones.

The mental health nurse respondents described the impact their work has on them. They spoke about the impact of their work in terms of the stress they experienced personally and the impact on their colleagues. They also described their frustration at the perceived lack of concern by some colleagues in relation to personal safety. Regardless of the clinical area or role undertaken by respondents, the experience of the emotional impact of work was evident. There is, it appears, both a personal reward and a personal cost associated with caring for clients.

The idea of working with people in extreme circumstances was described by MHN10.

\textit{Being with people at these extreme ends of human experience (MHN10).}

All respondents were able to relate stories of practice that illustrates this idea of the ‘extreme end of human experience’. For example:
The other end of the scale and the things that made me question what on earth I think I’m doing is I had a client who suicided by cutting his throat with an angle grinder. He was a person who I’d case managed over a significant period of time (MHN3).

The time that MHN3 spent building trust and establishing a productive relationship with this client were all lost by the client’s sudden and violent death. If, as MHN4 and MHN9 indicated earlier, one of the reasons they remain in mental health nursing is because of the opportunity to make a difference in people’s lives, then the sudden death of a client can be particularly traumatic. MHN3, who was a senior clinician with over 30 year’s experience, recalled the impact of this event.

I thought ‘oh shit’. There are times like this when you think I wish I just had a job (MHN3).

MHN3’s role is more than ‘just a job’. A job seems to be something that can be done with less effort and investment of time and doesn’t have the level of emotional impact that situations such as those above have. A job is contained and manageable.

The issues related to stress in mental health nursing have been well documented in the literature and reviewed in Chapter Two. Brooker (2007) believes that mental health nurses have higher rates of burnout and are less effective at dealing with their own psychological needs. Nurses generally, are also more likely to report high levels of stress than other professional groups (Edward & Hercelinskyj, 2007).

Respondents’ perceptions of stress were also linked to working in different clinical contexts. As case managers in community mental health teams MHN3 and MHN4 reflected on the role overload they experienced in managing between twenty to thirty clients each, who all presented with complex health needs. This created significant role stress.

I think the case management is the hard work. It’s emotionally burdensome work (MHN3).

Many days I sit there and I can’t do this anymore. I can’t work with this kind of level of stress. I feel really fragile around sometimes working with this population (MHN4).

As a nurse unit manager in an acute inpatient unit, MHN5 reflected.

Every day I always think I’d like to go and do something that’s less stressful (MHN5)
MHN5 described what she sees as the impact on staff who worked directly in the acute inpatient unit.

This unit has had quite a number of incidents and assaults and people have actually been quite traumatized. Sometimes I walk in and it’s like walking into the PTSD ward (MHN5).

Currid (2008) found that the acute inpatient environment creates a number of distinct stressors for staff. These are related to the complexity of the client group and increased level of aggression and violence. Happell (2008b) also identified that the majority of studies related to stress and burnout in mental health nursing identified excessive workloads, poor staffing levels, the inadequate skill mix of staff, levels of perceived autonomy, access to and control over resources, and relationships with medical staff as issues contributing to stress and burnout. Tummers, Janssen, Landerweed and Houks (2001) agreed that factors such as heavy workloads, lack of autonomy and poor social support were all important precursors to ill health, stress reactions and job satisfaction.

MHN5 defines several features of what she refers to as the ‘culture of the place’ that impact emotionally and professionally on nurses’ role expectations and job satisfaction. The ability to balance work life issues and demands, the aggression that nurses encounter in practice and the resultant burnout all potentially arise from ongoing feelings of role strain. MHN5’s experience reflects the literature related to workforce issues and retention (Currid, 2008; Happell, 2008b).

It’s probably a bit of culture and I don’t know that we take that into account enough. How they actually emotionally manage all that stuff that’s going on and they just take it and take it and take it and work with the system and then they go no I don’t want to do this anymore (MHN5).

In this statement MHN5 identifies the need to help staff build resilience as part of their practice. Building resilience can increase confidence in one’s ability as a mental health nurse and therefore promote a more positive professional identity. Her statements highlights the importance of supporting staff proactively before leaving practice becomes the only viable choice clinicians have.

An important factor identified by a several respondents was the increased stress of their work related to the increasing complexity of the client group.
The population’s changing. It’s not the old chronics that bumble along. It’s the more hardcore drug affected, first presentation stuff that’s kind of scary (MHN4).

Because the growing need for mental health is huge, with addictions, drug use, increasing family breakdown. Financial pressures impacts on someone’s health as well and it is just growing (MHN11).

As discussed in Chapter One, the incidence of mental illness is rising rapidly on a national and international scale. The comments by MHN4 and MHN11 reflect both the broader range of mental health issues affecting people, but also the changing presentation in serious mental illness with substance misuse and first episode psychosis. The increasing complexity of the client population is problematic for MHN4.

MHN4 is concerned that her training and experience has not adequately prepared her to work with the changing health needs of the community. Feeling unprepared to meet the changing role expectations which are driven by the changing health profile of clients may well contribute to feelings of increased role strain for mental health nurses. This raises questions about the efficacy of current ongoing professional development. It also draws attention to the degree to which higher education nursing studies are assisting mental health nurses to extend their understanding and skill base in accordance with changing health needs.

MHN11’s expressed the view that the mental health nurse’s lack of experience and skills means that clients are not being treated fully.

There are not enough nurses to go around. I actually see the most unwell patients being managed on the wards by often new limited experienced staff, often leaving the patients with unmet needs (MHN11).

However, MHN8 did not believe that consumer acuity levels had necessarily increased. Rather the environment in which consumers were cared for had altered and was less therapeutic.

For me the dilemma of contemporary practice is that acuity is higher. Apart from dual diagnosis with substances and mental illness I would have to question that because I don’t
MHN8 does not equate acuity with complexity. Her view is that there have always been acutely ill clients. Rather, the issue for mental health nurses is that client health needs have become more complex. As pointed out in Chapter One, illnesses such as alcohol dependence disorders are some of the most commonly reported mental illnesses in Australia. Approximately 18% or 2.4 million adults have experienced symptoms of at least one of these disorders within the past 12 months in Australia. Additionally, more than one-third of these adults will experience two or more conditions at the same time (Andrews, Henderson, & Hall, 2001; Hickie, Groom, McGorry, Davenport & Luscombe, 2005). With statistics such as these it is essential that both undergraduate and postgraduate preparation as well as the ongoing professional development needs of mental health nurses be addressed to support their contribution to positive client outcomes. MHN8’s earlier reflection on the inadequacy of current postgraduate programs to adequately support ongoing professional development and scholarly activity in mental health nursing is important.

The literature related to workplace issues identifies occupational violence as a reality of contemporary health care. Happell (2008b) indicated that nurses generally are at a higher risk of violence due to their greater visibility in patient care delivery. It was also noted that mental health is an area of particular need and that exposure to violence has a significant impact on recruitment and retention. A number of respondents’ identified that they had been the recipient of both verbal and physical workplace aggression. Workplace violence is also associated with lower job satisfaction, increased absenteeism, stress and burnout (Callaghan, 2003; Happell, 2008b; Sheward, Hunt, Hage, Macleod, & Ball, 2005).

MHN5 saw that physical aggression was reflective of wider systemic issues in health care delivery. MHN5 felt that her capacity as a unit manager to support her staff to carry out their roles is compromised by the fear of being hurt and the subsequent changes to staff and consumer interaction.

The effect of continually being abused or assaulted on an ongoing basis actually makes your behaviour change and then therefore how you deal with situations and patients and if you feel very scared of patients and scared to approach them because you might get your head bashed in (MHN5).
However, in other cases the incidence and impact of violence was minimized. Comments such as ‘the odd spit’, or ‘it wasn’t that bad, suggest as research by McKinnon and Cross (2008) identified, that respondents saw violence as part of the job.

*I’ve been thumped once but it wasn’t that bad (MHN1).*

*Always getting assaulted is never much fun, whether it be verbal or physical, the odd spit, kick and hit. One time I got bitten that wasn’t much fun! (MHN11).*

*Most of us have actually been physically assaulted and so are much more protective of that. I don’t think I’ve ever come across a nurse who hasn’t been physically assaulted (MHN4).*

The data gathered through the interview process demonstrated that the context of specific issues impacted on respondents in ways that reflected the literature related to stress and burnout. Several respondents also described issues in their experience of working within current mental health care service delivery which contributed to frustration related to their role expectations and role stress:

*What I see is actually not primary mental health. If anything we spend a lot of time gate keeping rather than supporting the client and I find that quite frustrating because that’s I’m not going there to gate keep, I’m going to support a GP who’s asked for an assessment who respects the fact that we have this expertise. What we’ve done is simply taken out the institutionalization of mental health in the old psychiatric hospitals and transplanted it to the community and I can’t say that that’s very job enriching at all (MHN7).*

*The reduction in practitioner health care drives me to despair. And dedicated funding to psychiatry within [acute] health services that recognises need and distributes it across the country (MHN10).*

How then did respondents deal with or work through stressful incidents such as workplace violence, traumatic events such as client suicide and system issues related to delivery of health care?

For some respondents the experience of workplace stress led to very specific choices regarding where they practiced.

MHN1 actively sought not to work in acute adult mental health.
One of the reasons I give for not liking the acute environment is that I find the constant need to be so vigilant about your own physical safety impedes my ability to sit down and interact properly (MHN1).

MHN10 also chose their practice area based on their experience of stress. Choosing to work in a mental health role within the general acute sector, appears to be have been MHN11’s compromise between her desire to be a mental health nurse and her capacity to deal with the stresses involved in the public mental health system.

I am working in a part of the system that I can actually cope with. (MHN10).

Other respondents spoke about the need to work through stressful incidents and how this was not necessarily something they were able to do early on in their career. According to MHN9:

In the early years it was really hard to go home every night and leave that all behind it’s a real burden” (MHN9).

In describing her inability to ‘leave all that behind’ this participant highlighted an important perspective on her work. Working as a mental health nurse is a stressful occupation and it is not always easy for clinicians to maintain a professional and emotional work-life balance.

MHN3’s comments suggest that he was left to ‘work out ‘how best to handle the role stress associated with this. The ability to deal with stress was a combination of learnt skill and intuition.

You can develop skills but there’s something that’s intrinsically within you as a person about how you do and don’t sort of manage those stresses. That’s an issue, that’s hard to communicate to people. I can’t tell my friends. I can (try to) tell them and some of my friends have a degree of empathy but I don’t know that I’ve ever really successfully communicated to anyone else some of the emotional burdensome nature of that sort of stuff (MHN3).

As Duncan (2003) highlights, when the normative role expectations are that emotion work in nursing is natural, there is an emotional cost to clinicians. The mental health nurse respondents’ comments above reflect the hard work involved in caring for people living with mental illness, the challenge in maintaining boundaries between their professional and personal lives and the need to address it.
MHN9 goes onto describe how several years later she utilised clinical supervision to address work issues but that this wasn’t always the case.

*I have clinical supervision now, in the early years I didn’t. I’d talk to family and I guess that was my clinical supervision (MHN9).*

The use of clinical supervision was identified by a number of respondents as the way in which they addressed work issues. Several participants spoke of the value this process gave to their practice, particularly with regard to maintaining a boundary between work and home.

*Clinical supervision can be helpful. You can’t go home and say ‘by the way’ or spill the beans on everything that has happened at work (MHN11).*

Other respondents highlighted the idea of overall support as being crucial to their wellbeing. This support occurred through peer support as well as the formal process of clinical supervision.

*I don’t really feel supported from my staff, but I have an incredible amount of support from my peers within the service people who are in team leader or unit manager level across the psych service, we will meet regularly for peer supervision and just a debrief (MHN5).*

*I began to notice that there were a few of us in the sole nurse roles; we developed a clinical supervision support group (MHN2).*

Reflective processes and clinical supervision are concepts that have gained currency within mental health practice since the early 2000’s (Driscoll & O'Sullivan, 2007; Edward & Hercelinskyj, 2007). Clinical supervision enables nurses to gain support and engage in ongoing professional learning (Heath & Freshwater, 2000). The supervisory process can be seen as one way of promoting resilience in mental health nurses and strengthening their sense of professional identity (Scholes, 2008). In the context of this study, respondents clearly identified the importance of being able to locate ongoing peer and organisational support so that they could maintain effective work-life boundaries.

**Sub-theme 2.3: Describing Our Work to Others**

A number of authors have written about the role of the mental health nurse. Chapter Two provided several examples of the long-standing debate between those who argue that mental health nursing should be biomedically focused and those who believe that the interpersonal relationship should be used as the core feature of nursing practice.
Professional identity has been defined within the context of the mental health nurses role. This role is enacted through the clinicians’ interaction with other people and the institutional requirements they work under. A major feature of this study involved the researcher asking respondents to describe their work. Listening to their accounts of how they perceived their role elicited important insights about their sense of professional identity.

In the first instance respondents described their work which highlighted strongly the relational nature of their engagement with clients. They did not discount the broader responsibility of care but this did not appear to be their primary focus. Rather, this work took place through the therapeutic encounter. The mental health nurse respondents who also worked with non-mental health personnel described their role as helping their colleagues to understand the psychological and emotional needs of consumers, and increase their knowledge base and confidence in mental health. In presenting this sub-theme it will be evident that respondents’ clinical focus was centred in the psychological and psychosocial aspects of care. Aspects of physical care were frequently mentioned but classed as “basic stuff”. This distinction is important as all mental health nurse respondents also viewed their practice as holistic; a feature which they felt set them apart from other mental health professionals and other nurses.

The mental health nurse respondents described their role in varying ways but a number of their ideas reflect the importance of the human connection between themselves and consumers.

*My work I describe as walking a journey with people (MHN8).*

Walking a journey is a powerful metaphor. The experience of mental illness is a frightening one, and being prepared to share that journey, suggests that the client is not alone. MHN8 elaborated on this by describing her approach to working with consumers:

*I’ve always tried to be present without being directive. My work is about helping somebody get from where they currently are to a position where they can function the best that they can and walk with them along the way (MHN8).*

Being present and being non directive echoes the views made by respondents in O’Brien’s (1999) study which highlighted the theme of minimising visibility. Not being directive suggests the idea of the mental health nurse as a ‘silent partner’. MHN8’s goal
is also about helping the client to reach their potential which is not the same as being cured. This highlights the recovery based framework of care that MHN8 appears to use to frame her work with consumers.

MHN2 described her views on what mental health nurses could offer:

*One of the biggest things psychiatric nurses can offer is that the being with the client. Just being with the person who's crying or person who's in distress or person who, just sitting with them, being with them, doesn't look like it's doing very much but it's quite a lot* (MHN2).

MHN2’s description of ‘being with’ focuses the mental health nurses connection with consumers in an emotionally supportive sense. Her comment also highlights the contradiction between what she understands as a complex role and the superficial simplicity of the ‘act’ of being with someone. This capacity to ‘be with’ someone is described further by MHN9 when she states:

*Recognizing if a person is a bit up tight. Making them feel a bit more comfortable. Making them a cup of tea* (MHN9).

‘Being with’ as described by MHN9 focuses on her connection with assessment and emotional support of consumers through everyday activities. These ‘practical activities’ reflect Hurley’s (2009b) theme of the ‘everyday way’ in which mental health nurses work with consumers. Sharing life experiences and engaging in activities which ‘normalise’ the situation were valued highly by a number of respondents.

In describing their role a number of respondents used the term *privilege*. The context in which this word was used highlights several facets of the respondents’ role. MHN8 describes her sense of privilege in relation to be allowed or given permission to connect closely with another person.

*We’re in a unique privileged position of not only being very intimate with somebody’s psyche because I think that encompasses everything but we’re also very intimate and have to be a role with their physical body* (MHN8).

MHN10’s experience highlights what respondents in Nolan et al’s. 2007 study described as the positive impact of knowing they were “doing a good job” Nolan et al. 2007 p.381

*That’s where I get my reward, just the privilege of being with people at these extreme ends of human experience which hospitalisation often is* (MHN10).
MHN11 described a key issue in contemporary mental health care which relates to the notion of the power inherent in the nurse-patient relationship. The legislation under which mental health nurses work is seen by Morrall (1998) to create a tension with the therapeutic role. Legislation mandates the ethical principle of treatment in the least restrictive environment, yet it also stipulates provision for the involuntary detention of clients. This disparity between the therapeutic role and what Morrall (1998) describes as the social control function of the mental health nurse may contribute to a heightened sense of role conflict and role ambiguity for mental health nurses as they attempt to resolve the potential tension between their professional expectations or practice identity and their organisational identity (Hurley et al. 2008).

\textit{You are dealing with the very vulnerable people so you are in a privileged position} (MHN11).

MHN11 recognised the degree of potential control she has in her working relationship with clients. Her comment recognises that consumer’s vulnerability leaves them at risk of exploitation. However, she viewed her role as helping people to regain autonomy and control of their own lives.

\textit{Dealing with people, in the most vulnerable state and respecting them irrespective of their state and not taking advantage of them in any kind of a sense but actually supporting them so they can learn the skills and strategies to help get back on track and become more independent and more responsible in their own self care} (MHN11).

MHN8 also reflected on the intimacy of her work with clients. Her comment suggests that being permitted to work with someone closely is a privilege, not to be taken lightly.

\textit{I’m a psych nurse; I’m looking after people’s souls which positions you in a place of privilege, in someone’s space. It’s about looking after what is at the centre of people} (MHN8).

Reflecting what Gordon and Nelson (2006) described as the “virtue script” of nursing, the comments made above also indicate a sense of professional identity that continues to be bound by the values of a virtuous and caring identity. Historically nursing sprang from the religious orders and was viewed as an honourable vocation for respectable young ladies. The concept of service to others, through virtue and hard work were supposed to imbue young ladies with a special place in the minds and hearts of their communities. The comments made by the respondents however, suggest that the idea of
service to others features as an important part of their sense of professional identity, and resonate with what Scholes (2008) identified as the moral imperative of nursing.

The respondents also perceived their capacity to have a degree of control or autonomy over their work environment as a privilege. MHN2 believed that a core feature that defined her role was the capacity to control how she organized and managed her work. MHN2 believed that her particular workplace provided that opportunity:

*I'm in a reasonably privileged position of being able to manage my own time and be fairly autonomous (MHN2).*

As the sole mental health nurse in a team delivering specialist services to defence force veterans, MHN2 said:

*The work that I currently do is not in a traditional psych nursing role (MHN2).*

By labelling her work as ‘not traditional’, MHN2 appears to be suggesting that there are different mental health nursing roles and that her role includes functions not usually associated with mental health nursing practice. These functions could be viewed as advanced or extended practice roles (Elsom et al. 2007, 2008) but can only be so defined in comparison to those functions usually regarded as traditional. These traditional functions may include some of the clinical and medical acts described previously by Clarke (2006) such as medication administration, observations and giving injections. MHN2’s comment also supports Hurley’s (2009a, 2009b) argument that there are many mental health nursing roles rather than just one. The multiplicity of roles available should be seen as reflective of a well skilled and diverse group of professionals, rather than an indication that the role of the mental health nurses is poorly defined.

When describing the sense of privilege which their work gives to them a number of mental health nurse respondents located it specifically within the therapeutic relationship itself. It is the ability to establish this connection that leads to understanding and the capacity to work with another person.

*I was in this privileged position to get into the mind of somebody because of my relationship with her (MHN4).*

*I currently have a client who’s touring with his caravan. This is the bloke who could barely go to do his shopping because of his social phobia and anxiety and here he is travelling around the country. I just know what it’s meant to this guy to not be a prisoner of his anxiety and he’s not doing that because of anything particularly dynamic at a*
It just took us four years to work out that he should never have been taken off XXX in the first place, that he's better off on his XXX than he was on anything else and just having some continuity of case management, and someone who he could connect with and who could listen to him. It's not rocket science (MHN3).

Both of these descriptions illustrate the importance of time in establishing a productive therapeutic relationship with consumers. Recognising that part of their role involved having sufficient time to get to know a consumer as a person was important. This enabled respondents to build an in-depth therapeutic relationship with consumers and was a strong source of their professional identity.

All respondents were asked how they would describe the role of the mental health nurse to others, but a number of respondents were unclear about how they would do this.

> There are so many things that a psychiatric nurse does in the role and might not do in every role that they have because there are things that I don't do now that I did do in other roles and things I do now that I didn't do in those roles. How you capture all of that? (MHN2).

MHN2's comment reflects her ambiguity regarding the role of the mental health nurse. The role as far as she describes it and has experienced it, has been designed to meet the needs or objectives of the organization rather than being comprised of a core set of activities skills, knowledge or values that are recognizable as mental health nursing.

MHN3 also identified the difficulty he had in describing his due to its diversity. His comment alludes to a degree of ambiguity in his perception of the mental health nurse’s role. In moving away from traditional models of service delivery it is not possible, according to MHN3, to confine the role of the contemporary mental health nurse to a defined list of actions and behaviours.

> That's a really hard question to ask because it's so diverse now and so specialized (MHN3).

It appears that the diversity that MHN2 and MHN3 are referring to has led to role ambiguity. However, as Hurley (2009a) Hurley et al. (2008) these descriptions also highlight the diversity in roles available to mental health nurses. Although the descriptors and the practice environments may vary they are all roles which require an in-depth knowledge of health and illness and skills that can be adapted to a range of contexts.
MHN2 went on to say:

*I can’t really tell them what a psychiatric nurse does generally; I can tell them what I do and they understand that. They can see what a builder does and what someone is doing in business but I think unless they actually have a relative or someone close to them who has been depressed or needs some kind of help that’s when the real understanding comes* (MHN2).

Professional identity is said to develop out of the professional and educational socialisation process that nurses engage in (Hardy & Hardy, 1988; Meyer & Xu, 2005). Accepting this would imply that all areas of nursing can only be understood through direct or indirect experience with nurses through healthcare. Wells et al.’s. (2000) and Hoekstra et al.'s. (2009) work suggests that while professional identity does indeed develop through the professional socialisation of students, they will also have acquired an understanding of mental health and mental illness based on personal experiences, the images they have been exposed to and the stories they have read or been told about. This feature will be explored under Theme Two of the student nurse respondents. However what MHN2 and MHN3’s comments do highlight is the need to provide clinical experience that is varied, well structured and effectively supported. This need has also been substantively argued in the work of Happell (1999, 2009).

MHN3 concurred with MHN2’s view:

*It’s always been the challenge to describe what you do to people that don’t know because unless people have had some sort of contact with mental illness or with the service provision for mental illness it’s very hard for them to relate because they’re coming from their pre conceptions* (MHN3).

MHN3 explained this further in terms of the different reactions he experienced when he saw the movie *One Flew Over the Cuckoo’s Nest* (Forman 1975). The reactions he had conflicted with the reactions from members of the general public and demonstrated what MHN3 regarded as a disparity between lay and professional views of mental health. This created a sense of isolation from the broader community.

*The cinema is packed and there are people laughing at scenes in the film that made me really angry. I was getting really cranky with all these ill informed people but the irony was I was the sole person in the theatre that burst out laughing uproariously at things that they all found offensive. They didn’t relate to it but I’d go “oh yeah like every day I*
“know it”, and then think “oh I’m the Lone Ranger”. It reinforced the gap for me (MHN3).

Several mental health nurse respondents indicated a degree of reticence about telling people what they did. They spoke about wanting to avoiding long winded explanations, or stereotypical responses about mental illness and nursing and even in some instances the expectation that they would respond to personal issues raised with them in a social context. On one level this reticence to speak about their work may appear to contradict their earlier views about the need to promote their work publicly. However their choice may be more to do with maintaining boundaries between work and personal life rather than a reluctance to speak out about their role. This tension could create a degree of role conflict or role ambiguity in relation to respondents’ broader role in promoting the profession and mental illness generally. As MHN4 explained:

*I try not to get into that conversation because I think it’s kind of a long one* (MHN4).

MHN11 also felt the need to maintain a degree of separation between her professional and personal self.

*S sometimes I say I am a nurse because I have found in the past if I say I am a psych nurse straight up they then think you can read their minds and do all the wonderful things and they are either very intrigued and ask a lot of intrusive questions You find that people tell you stuff that you wouldn’t normally be told or exposed to and its like ‘hang on now I am not at work give me a break’* (MHN11).

When asked what knowledge, skills and qualities they believed mental health nurses needed, respondents expressed ideas that focused heavily on the relationship with the person and their family and were less about the tasks or clinical acts associated with nursing.

*We provide comfort and support. If you can talk to that patient who is so upright, offer them a cup of tea, provide explanation [and] education during admission* (MHN9).

In this quote, MHN9 illustrates how a warm drink, emotional containment and support during periods of anxiety such as admission together with clear and transparent communication with clients and families was central to her role as a mental health nurse. A seemingly ordinary act is underpinned by an understanding that comfort is both an emotional and psychological intervention grounded in an understanding of anxiety and how it manifests. Yet MHN9 has not fore-grounded the knowledge and skill needed to
achieve her goal of ‘providing comfort’. The act of ‘providing comfort’ through a cup of tea or explanation belies the knowledge she must have regarding the psycho-pathology of mental illness, the signs and symptoms of anxiety, and how to manage it, what level of explanation or education to provide, and the interpersonal skills required to establish trust and a reciprocal dialogue. Hurley (2009b p.387) identified the mental health nurse as having ‘an everyday attitude’. This comprised a world view that was practically oriented, grounded in the present and based on common sense. MHN7 exemplified Hurley’s (2009b) idea when she stated:

So what makes a mental health nurse? Well it is common sense. Common sense in terms of safety, common sense in terms of how you speak, how you behave, what you do for yourself, how you get through life. These are all the kinds of things that happen to patients [the] capacity to keep an open mind, alright. To know what your own limitations are. To be respectful of who you are firstly, how you behave with others, how you would like to be perceived by others just as very normal, to me the very normal social kinds of things (MHN7).

While all respondents referred to the skills a mental health nurse needs, only three specifically outlined the skills that they perceived to be ‘basic’ to mental health nursing. These skills were certainly not seen as menial or trivialised. Nevertheless, there is danger in thinking of such skills as ‘basic’ because it negates the level of professional knowledge required to complete these tasks in the context of their work with clients. Both MHN7 and MHN9 believed that assessment was fundamental to their role.

Assessments, that’s basic to who we are as nurses. It’s basic stuff (MHN7).

MHN9 explained this further as she described her view that assessment was not merely focused on just the mental status of the person, but also their response to the physical and interpersonal environment.

You need good assessment skills. It’s a matter of being observant, of the environment and of the patients, what’s happening. And a can do attitude (MHN9).

MHN10 identified a range of tasks that could be equated with Clarke’s (2006) view that many of the skills that mental health nurses undertake are medical or clinical acts that are not by definition confined to nursing practice. On a superficial level, it appears that MHN10 almost has a checklist approach to how she describes these tasks. However, activities such a medication administration, discharge planning, individual work with clients and clinical supervision are underpinned by an extensive knowledge base and
ability to implement and evaluate them appropriately. These aspects of the mental health
nurse role are not necessarily visible to those outside the profession. Therefore, their
professional identity can be ambiguous and difficult to articulate.

You have your core and your basic foundations. Physical obs, bloods, medication
administration, clinical discussion, handover, MSE’s, risk assessments, individual work
with patients, liaison with families & carers, groups, organising patient leave from the
ward and organising their meds, discharge planning, supervising students, documentation
– nursing notes, seclusion obs and Mental Health Act requirements (MHN11).

Other mental health nurses expressed other ideas about the necessary skills required by
mental health nurses.

I think the service needs to get into this millennium in terms of its management skills. We
still have the hangover from the old days where, if you were a half decent nurse you’d get to
be a deputy charge nurse and if you were a half decent deputy charge nurse you became a
charge nurse and they put you in charge of management which we had no skills for. I’d
probably get shot for saying this but I still think there’s a part of that culture that instead
of us having excellence in management we have nurses in management and it’s not
necessarily the same thing (MHN3).

MHN7’s reflection illustrates a concept common for a number of respondents. They
described their role as working with clients, being proactive and promoting and building
on consumer’s strengths. Also, importantly in MHN7’s view was the need to spend time
with consumers. Spending time was the way in which she established the rapport and
trust necessary to identify issues with consumers and then develop strategies based on
the consumer’s needs. The key for MHN7 was identifying strategies that the consumer
already used or had used in the past and building on these ideas. This promoted self
esteem and trust (Johansson & Eklund 2003).

I like to spend time with people and find out what practical self help things they already
have in place and getting them to recognise what their strengths are. Going from a strength
space (MHN7).

The ideas of time, depth of knowing, power and translation can be seen in the
descriptions of the respondents. There is a focus on specific tasks and a basic need to
attend to an interpersonal connection with consumers and families.
MHN4 described the knowledge, skills and qualities she needed in her role as more than ‘basic’.

*We do more than just give injections. We know how to do mental states thoroughly, we know how to assess risk thoroughly, we know how to do group work, we just forget it but we do know how to do it. We work with patients or consumers to get things happening. I actually think we’re great time managers and organizers. We handle crisis really well too because we know how to prioritise really well (MHN4).*

MHN4’s comment regarding group is particularly poignant. The role ambiguity she has experienced due to what she sees as the erosion of the mental health nurse’s identity has meant that skills such as this have been lost. The process of credentialing described in sub-theme 1.2 on page 155, illustrated how she has regained a part of professional identity related to her practice.

Other respondents described the ability of mental health nurses to work within the dynamics of relationship with consumers as an advanced skill.

*I think you’ve got to be able to plan ahead in terms of just even conversations you have with people and the consequences of the things you say and their impact on others. I see it as multi layered because everyone has their own internal world and when we speak there’s an interface with that, so there’s a lot of stuff going on that you really don’t see in terms of the dynamics that happen in setting up therapeutic relationships. There’s a lot of stuff that goes on that you don’t see and I think they’re advanced skills [we’re] required to work with. (MHN6).*

MHN4 and MHN6’s comments support the findings from Nolan et al (2007) regarding what skills respondents viewed as important. MHN8’s comments reflect some of the qualities that were identified in Nolan et al’s. (2007) study, particularly in relation to being open-minded and empathic.

MHN9 spoke about the quality of openness to others as an important value.

*It’s an openness [the ability] to meet people on a level ground. A good psychiatric nurse [must] be able to communicate and to listen (MHN9)*

*The ability to almost embrace difference. I don’t think we would be able to do our job or cope at our job or love and be passionate about our job if we weren’t able to tolerate and I would say even more is embrace difference because we have to be able to offer*
individualised kind of sensitive care to people. We confront it all the time with extremes (MHN8).

MHN 8 identified the notion that difference is central to her understanding of her role as a mental health nurse. This difference is viewed from the perspective of extremes. Even if difference challenges them as mental health nurses this is not necessarily a negative feature of their work. Instead, they embrace the challenge of working through difference together with consumers. The notion of difference will be considered in Theme Three.

4.3.3 Theme 3: ‘We are Unusual. We’re the Kind of People Who Want to Work With People Who Have Mental Illnesses’

As described previously, having a limited understanding of what mental health nursing involved proved no deterrent to some of the respondents’ choice to enter mental health nursing. The third theme of difference emerged from the participants’ reflections on other people’s response to their decision to become a mental health nurse and current reactions they received from people about their role. As with Humble and Cross’s (2010) work, difference also emerged as a theme in relation to participants perceptions of what being a mental health nurse meant to them. Mental health nurse respondents saw themselves as being different to other nurses and mental health professionals in terms of their knowledge, attitudes towards their work and the value of their work. Finally, some respondents also felt that being a mental health nurse was a therapeutic endeavour in itself and one which encourage personal as well as professional growth.

Sub-theme 3.2, mental health nurse’s view of themselves, presents a view of difference. Specifically, it draws upon respondents powerful sense that their work has ‘made a difference’ to consumers and carers. The capacity to ‘make a difference’ was essential to their role and described through a range of qualities that were important. The theme of difference was also identified through respondents’ view of the fundamental difference between mental health and acute care nursing practice.

Sub-theme 3.1: Others’ Stereotypes of Mental Health Nurses

Sub-theme 3.1, other’s stereotypes of mental health nurses, presents the idea of difference from several perspectives. In the first instance difference was seen through the way in which respondents choice of mental health nursing positioned them as being
‘different to’ others. This was reflected in their recollections of others responses, including, family, friends and other nursing colleagues, to their choice of mental health. These responses highlighted many of the prevailing attitudes towards mental health in general, as well as surprise that nurses actually worked in mental health service delivery even today. The extent to which these views have changed over time was also mentioned. What is significant is the way in which a number of the respondents’ views about their role could be seen to perpetuate various stereotypes about mental health. Respondents’ thoughts about how they are understood and perceived by the public are a significant feature of this sub-theme. The perceptions of the respondents suggest that they are viewed in an ‘all or nothing’ manner.

Chapter Two presented a review and critique of the media images and reports that reinforce the idea that mental health care is a low skill activity, involving unequal power relations between staff and clients and a risk to personal safety (Holmes 2006).

Gordon and Johnson (2004) contend that following a promising start in the 1950’s with a number of films that showed nurses in a positive light, representations of nurses in film could be characterized into three groups- “the Good, the Bad and the Crazy” (¶ 5). Latter day representations have broadened to include “the vanishing nurse” (¶ 20, 26). It would appear that views of mental health nurses continue to be produced that bear little resemblance to contemporary practice and in Halter’s (2002) view, mental health nursing may well be stigmatised by its very association with mental illness. This view is also explored by Fealey (2004) who argues that the various ways in which the nurse has been publicly portrayed reflects the value of nursing in society. The experience described by mental health nurse respondents certainly concurs with this.

Films such as Cosi (Joffe, 1996) set up the mental health nurse as largely invisible or a source of comic relief. Misery (Reiner, 1990) gives us a frightening rendition of the ‘crazy nurse’ and in Girl Interrupted (Mangold, 1999) the nurse is a nameless ‘observer’ who symbolically removes her protective shield (a poncho) when called to action. This observation could also be thought of as taking on a surveillance role. Films such as High Anxiety (Brooks, 1977) set up the mental health nurse as the pathological personality in the extreme to parody all the pathological mental health nurses “who have stalked the corridors of the movie world’s mental institutions” (Kalisch & Kalisch 1981, p. 125). All images are framed within a social and political context that is up to 60 years old. These movies construct the mental health nurse as ‘different’. Images of mental health nursing
are embedded within the discourse of ‘madness’ and our difference is highlighted in a negative sense.

When reflecting on family and friend’s responses to their choice of career in mental health nursing, a several respondents had reactions that resonated with a number of these stereotypes.

I didn’t get a single person who was supportive, except my boyfriend who is now my husband, parents were horrified, that wasn’t what you were supposed to do. What if you get hurt physically hurt? (MHN1).

My mum had an extreme reaction. She said psychiatric nurses don’t do nursing, they’re not nurses, I don’t know what her experience had been or what her understanding was but I think she said she was fearful for me because psychiatry has a stigma, madness and insanity and everything. Why would I want to do that, it’s not a good career to go into (MHN2).

Other respondents whilst not describing such extreme reactions did not recollect overwhelming support for their decision.

Why. True it was, why. I wouldn’t say that they were supportive (MHN7).

MHN10’s decision to leave the intensive care environment to work in mental health was received poorly:

The reaction to me leaving ICU was me thinking this is fantastic. They saw it as a retrograde step in the hierarchy of what (was) respected and thought well of. And I think that’s partly because of technology and you think you’re clever because you can run these machines and that’s bullshit. I think what is harder and I’m still learning is how to work with people (MHN10).

In terms of the public understanding of mental health nursing as a discrete discipline within mental health services, many respondents did not feel that mental health nurses were visible.

I think the public have an image of nurses. When it comes to mental health, I think by and large the community knows about the “bad mental health” and what that is, the way the media portrays mental health and the way the media portrays behaviour of the crisis teams. A lot of people don’t know that nurses are even involved and are quite surprised to hear that there’s actually specific branch called a mental health nurse. So I think the population sees a nurse is a nurse, is a nurse, (MHN7).
I don’t think we have much of an image if at all, because I don’t think people know who we are or what we do so I don’t think there is a common image (MHN8).

The idea of the ‘visibility’ of mental health nurse is also reflected in the educational material available to mental health nursing students. For example, Maddison, Day and Leabeater (1968; 1971) specifically make reference to the ‘difference’ between general and mental health nursing. This ‘difference’ is set up through the focus of their role.

This difference is identified as far broader and more holistic than in general nursing, the relative importance of the nurse client relationship and the different conceptual and practice orientation. The degree of visibility of the skills and role of the mental health nurse is implied in statements such as “it is relatively difficult to make predictions about outcomes…success may come about slowly, in almost imperceptible stages…” (Maddsion et al., 1971, p. 23).

In terms of other people’s understanding of or view about mental health and the role of the mental health nurse, respondents described how they spent a great deal of time ‘teaching’ other health professionals as well as the general public about mental health:

I have to spend a lot of time with nursing homes and other health sort of care facilities and general hospitals gaining personally credibility. “Oh you’re from psych” (they say) and you have this feeling that they don’t know what they’re going to get from you. So you go through this process of gaining their trust and gaining your credibility (MHN3).

Not only does MHN3 have to establish trust and credibility with consumers and their families, he also has to establish credibility and trust with external agencies. There is a sense that part of his role involves proving his trustworthiness to others.

I was talking about something at home a while ago and something to do with the patient and there’s quite a few people there and she [my sister-in-law], said I didn’t know you actually speak to them and I don’t know what you do. I was horrified my God I’ve been doing this for nine years and you’ve got no idea what I do, like you’ve got no idea what a psych nurse does and why would she really? (MHN1).

This comment from MHN1 illustrates the degree to which the role of the mental health nurse can be unknown to the broader public, even those who are family members. This maintains the invisibility of mental health nurses’ role and identity. It also reinforces the importance of promoting the role of the mental health nurse by clinicians themselves.
Sub-theme 3.2: Mental Health Nurses’ View of Themselves

This sub-theme represents several significant ideas that respondents identified in their discussions. The first key word that mental health nurse respondents used to describe how they viewed themselves as a professional group, and their work was ‘different’. Mental health respondents perceived themselves to be different not only to other branches of nursing but also to other mental health clinicians. This difference was in terms of their choice of mental health nursing as a career, the knowledge, qualities and skills required, and the very activities they carried out as part of their role. Furthermore, mental health nurse respondents believed that what they did made a difference not only to consumers and carers but also to other colleagues and to themselves.

They second key term that emerged in this sub-theme was ‘loss’. There was sense of loss of unity and strength as a professional group as well as loss of effective leadership to promote mental health nursing within and outside of the health arena. For several mental health nurse respondents this has significant implications for the future of mental health nursing. Nevertheless, respondents believed that there was hope for the future, if steps were taken to promote future leadership.

All Mental Health Nurse respondents were proud of being involved in mental health nursing and positive about their contribution. There was a confidence in the way they viewed their knowledge and attitudes to their work:

“I’m proud to be a psych nurse. I think that we are a specialty, we are unusual (MHN4).”

“We’re the kind of people who want to work with people who have mental illnesses if you ask me to work with somebody who had mental retardation, I can’t do that. If you asked me to work in aged care, I can’t do that but I can do this (MHN4).”

“I feel very comfortable in the role. I feel very experienced and really comfortable with my experience and I think that helps. And I’m quite proud of being as psych nurse, I’m proud of it (MHN6).”

“I’m proud to be a psych nurse but just recently somebody was indicating that they didn’t want anybody to know that they were a psych nurse and I said I’m proud to be a psych nurse we do good work, we should be proud (MHN9).”

Respondents viewed their work and priorities as being different to that of their colleagues in acute care nursing. This distinction was described in relation to what they viewed as the dynamism and lack of prescriptiveness.
It’s a job that there’s no script. There’s definitely right and wrong but there’s no script and I think that you need to be able to do a lot of things beyond other health roles (MHN6).

I tried general nursing and found it to be too boring. They [general nursing] had a set way of doing things all the time and there was no way of looking at things differently and I like to look at everything from every side then I make a decision or an assessment (MHN11).

The idea was also expressed that the acute care setting was unable to accommodate the psychosocial needs of consumers in the same way that mental health could.

The things that I tried to suggest in the general setting I knew were in the best interests of the patient, were either dismissed or not heard or got lost in the business of everything or the avoidance of staff because they were fearful, they were intimidated (MHN8).

They said that I needed to refresh my general skills. Back to the medical ward and within the first week I knew I was a psych nurse. I missed the team work. And I missed communicating and that was really difficult. It was just very task orientated. That cured me of thinking I was a general nurse (MHN9).

This comment reflects the ideas put forward in the texts of Maddison et al. (1968; 1970; 1975) that mental health nurses attend to the whole person because the nature of their illnesses impact on the individual’s thoughts, feelings and behaviours; in essence their total personality. General nurses are positioned as being primarily concerned with the immediate physical issues. This capacity to view the whole person and work from a broad range of perspectives was viewed as a real distinction between mental health and general nurses. As MHN6 stated:

It’s a conceptual difference. I think psych nurses are able to conceptualize individuals in their world, appreciate their lived experience and …[the]… lived experience of other people around them and still focus on task as nurses are supposed to do, but also focusing on the dynamics in and around where that person sits in the world. I see it as a very advanced clinical skill and one I’m proud to be aligned with people that can do that (MHN6).

Two respondents also described what they viewed as their distinctiveness from other mental health professionals.

The other disciplines come from a different perspective and it’s not a derogatory comment but they also don’t spend 24/7. They don’t ask people to strip, they don’t generally pin
them down if they have to restrain them, they don’t give them injections, they don’t clean them up if they’ve messed themselves so we’re in a unique privileged position of not only being very intimate with somebody’s psyche because I think that encompasses everything but we’re also very intimate and have to be to have a role with their physical body (MHN8).

MHN4 had also alluded to the difference between herself and other mental health clinicians in terms of their training and skills:

*There’s lots of time you just shake your head and go you absolute idiot. You’ve just put yourself at risk. I sit there and think you haven’t been trained, you have learnt it but you’re not trained* (MHN4).

MHN4 raises an important distinction. Learning ‘on the job’ and having specific knowledge about the process of risk assessment are two very different points. While the extent to which other disciplines are trained in specific clinical activities is not within the remit of this study, MHN4’s observation raises the point of what added role stress might be encountered by mental health nurses who feel themselves at risk if working with less knowledgeable colleagues. This question must be asked in relation to other disciplines but also in relation to new graduates from comprehensive programs, who are perceived to be lacking in the necessary knowledge and skills.

When asked what image they had of their profession respondents stated

*I think now psych nursing is so specialized and diverse that it’s really hard to have a stereotypical sort of image or idea of a psych nurse* (MHN3).

On the other hand, MHN2 struggled to articulate her image of the profession.

*That’s a very hard question because I think everybody will put their own kind of slant and interpretation on an image and it would be really hard to be clear* (MHN2).

*People always ask what I do and I say I’m a psychiatric nurse and you still get your people that discriminate and the whole stigma around it but I think it’s changing and people don’t tend to hold those views as much any more and I think if you talk to someone who has had a relative or friend, or knows someone that’s had a mental illness their perception of what you do is very, very different to someone that hasn’t and I think understanding says a lot. If you understand or have some experience with it your perception is going to be very different* (MHN5).
But there was also a sense that mental health nursing had to some extent ‘lost its way’. MHN7 described this perception of mental health nursing losing its place as a discrete entity with mental health care. Not being able to see a clearly defined role as a distinct member of the mental health care team can lead to a sense of being invisible. This invisibility led to a perception that mental health nurses no longer have the professional ‘clout’ they once had and that they will eventually be subsumed within a common definition of nurse.

I hate to have to say this, I used to feel we were very strong and I don’t think we are now. I think in time the mental health nurse as such is probably not going to be there in the way that we know it today. I think they will still be there but they will be all part of your generic notion of nurse (MHN7).

MHN5 appeared to be in conflict over what she regards as the stagnation of mental health nursing and her leadership role with the staff she managed.

I have to be careful because sometimes I get a bit cynical, sometimes I have an image of the profession that we haven’t gone anywhere, I feel like sometimes what’s happening on this acute inpatient unit is what was happening the last time I was a unit manager and that nurses are still saying the same things that I’ve heard a hundred times (MHN5).

MHN8 believed the increasing focus on the medical model made it inevitable that some professional groups would emerge stronger than other.

[It’s ]… very hard to stop the machine of the biomedical model. Very hard to fight and demand against all the changes that happened. It was like a whirlwind and somebody was going to come out on top and drive the direction and it was clearly going to be the people or the group with the most influence and that was the medical practitioners (MHN8).

The need for mental health nurses to be visible and make significant contributions to client care was seen as a both an individual and collective professional responsibility. MHN8 stated that:

If we have a problem with psychiatry and the biomedical model and psychiatry being medically driven then we should do something about that (MHN8).

MHN10 believed that effective leadership in mental health nursing was missing. This resulted in organisational demands taking precedence over clinical care decisions.

I don’t think we have got decent leadership… I’m really disappointed. But then when I say that I feel very guilty. I haven’t put my money where my mouth is, but it’s not what I
want to do. But I think we have got some real problems including our nursing leadership, especially in the hospitals [which have] got so budget orientated and management orientated that we have not got good clinical leadership (MHN10).

MHN3 echoed these comments when he stated:

I think some of the focus on the senior management, the senior leadership, the clinical direction of our service at a state wide level needs work (MHN3).

The idea of leadership was reflected on more broadly by MHN4 who said:

There's not a unity with the profession between nurses. We always used to be together, stay together, that sort of stuff. Where as we’re not so unified now and that’s really evident. Sometimes you can go to meetings and one nurse might say I never knew you were a nurse or where are you from and this person has worked around there for a while as well. So we don’t know who our colleagues are. We don’t network very well (MHN4).

Some mental health nurse respondents referred to the loss they felt that mental health nurses had experienced in terms of their skill base.

That a skill [group therapy] that we have lost. Not that anybody has taken it away from us, we have lost it, we are not savvy enough to try and kick up our heels and get it back. The other is people of my age are not around anymore and the next group that’s coming through don’t have the kind of skills (MHN7).

This experience contrasted with that of MHN2 who stated that:

The kind of groups I’m primarily involved in is communication skills and, relaxation skills training. We work with partners) [We do] an outing group where we, help them to transfer their skills at the learning in the groups in[to] the community and community situations. Sometimes I have been involved with group therapy type groups and education groups around discussion of family issues (MHN2).

In several instances respondents made comments that can be seen to almost perpetuate some of these stereotypes.

Psych nurses see psych nurses as different I think (MHN6).

I think we are less stereotypical than we used to be. Used to have the strange ones, we still do some times but we always were a strange crew, psych nurses (MHN3).

MHN1 recalled various members of her study group:
They were the bizarrrest [sic] mix of people. There was a girl, who’d been out having kids and come back and she’d never worked in psych she’d worked in rehab as a nurse. She stayed for the whole year but she never worked in psych after that. I’m surprised she actually stayed for the whole year, she was a strange lady. (MHN1).

As discussed in Chapter Two, popular images of mental health nurses have tended to be lodged in ideas around deviance and control. Kalisch and Kalisch (1987) present the character of Nurse Ratched, and Miss Davies as contradictions. Visually they display all the positive stereotypes associated with nursing through their dress and superficial behaviour. Beneath this exterior their controlling and exploitative attitudes and actions emerge. The use of words such a bizarre, strange and being suggests that mental health nurses have at some level internalised a negative and partially mythologised view of their professional identity.

4.4 GROUP TWO: STUDENT NURSE RESPONDENTS

The descriptions provided by student nurse respondents of their experiences of mental health nursing reflected a knowledge transition. They journeyed from varying degrees of familiarity with mental health services to a greater understanding of the role of mental health nurses, the constraints on their practice and the impact of mental illness on consumers and their families. The analysis presented for group two is less extensive than that presented for the mental health nurse respondents. Nevertheless, given the limited length of their placement in mental health, it is important to note that the student nurse respondents’ reflections and observation in many instances complemented those of the mental health nurse respondents. This is significant as it adds further depth and richness to the data.

4.5 OVERVIEW OF STUDENT NURSE RESPONDENTS’ MAJOR THEME AND SUB-THEMES

Major Theme: Perceptions of the Role of the Mental Health Nurse

Sub-theme 1.1: Being a Mental Health Nurse is a Challenge

Sub-theme 1.2: What Mental Health Nurses Need to Know to Carry Out Their Role

Sub-theme 1.3: Preparing For and Learning About the Role of the Mental Health Nurse

There is one major theme derived from the student nurse respondent group. This theme concerns the student nurse respondents’ perceptions of the role of the mental health
nurse. This theme and the three sub-themes complement the views expressed by mental health nurse respondents across several themes and sub-themes from that group. In the first instance, sub-theme 1.1 describes how the student nurse respondents’ viewed the role of the mental health nurse as a challenging one. Respondents’ believed that the limited resources available to clinical areas made it challenging for mental health nurses to carry out their role effectively. This was reflected in the limited availability of activities for clients and the lack of structured programs. Student nurse respondents also highlighted the impact that the resourcing of mental health services had on mental health nurses’ work and consumer outcomes. One respondent used the phrase of the ‘revolving door’ to refer to the repeated cycle of admission she saw a number of clients experiencing. Student nurse respondents also described the emotional challenge which they believed mental health nurses faced in carrying out their role. As stated above, the student nurse respondent’s views frequently echoed the experiences described by mental health nurse respondents.

Sub-theme 1.2 explored student nurse respondents’ reflections on the knowledge, skills and qualities they believed mental health nurses required to carry out their role. While the respondents only had four weeks clinical experience in a mental health setting, they had some very clear ideas about the role of the mental health nurse and the knowledge and skills needed for this role. In many instances, their reflections mirror those ideas expressed by the mental health nurse respondents.

Sub-theme 1.3 explored how their academic studies prepared them for placement in mental health and the factors that enhanced or restricted their learning in the clinical environment. How they learnt about and described the role of the mental health nurse and their thoughts about mental health as a career pathway forms part of this sub-theme.

Figure 4.2: Major Theme and Sub-themes for the Student Nurse Respondents
Table 4.2 provides a summary of the demographic data collected from student nurse respondents. This information includes the specific clinical areas where they undertook clinical placement, their academic preparation and length of clinical experience.

### Table 4.2: Student Nurse Respondents

<table>
<thead>
<tr>
<th>SN Identification Code</th>
<th>Clinical experience venue</th>
<th>Academic Preparation</th>
<th>Clinical Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN1</td>
<td>4weeks Acute Adult MHS</td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>SN2</td>
<td>4weeks Acute Adult MHS</td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>SN3</td>
<td>2 weeks Aged MHS 2 weeks Aged CMH</td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>SN4</td>
<td>4 weeks CAT</td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>SN5</td>
<td>2 weeks CMH 2 weeks PCMH</td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>SN6</td>
<td></td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>SN7</td>
<td>4 weeks CAT (Specialist)</td>
<td>9 weeks</td>
<td>4 weeks</td>
</tr>
</tbody>
</table>

**Legend:**

- Adult MHS: Adult mental health service
- Aged MHS: Aged Mental Health Service
- CAT: Crisis and Assessment Team
- CMH: Community mental health
- PCMH: Primary Community Mental Health
- SN: Student nurse

### 4.6 STUDENT NURSE RESPONDENTS

#### 4.6.1 Major Theme: Perceptions of the Role of the Mental Health Nurse

Student nurse respondents identified several issues in line with that of the mental health nurse respondents. These issues related to the lack of resources to deliver care, the ‘revolving door’ syndrome and the lack of opportunity for staff to work more broadly with family members.
Student nurse respondents also saw that the nature of the work mental health nurses engaged in increased the risk to mental health nurses’ emotional wellbeing. Their comments reflected the stress student nurse respondents saw mental health nurses working under. Ideas such as emotional safety, maintaining appropriate boundaries, not being manipulated and overworked mental health nurses were represented here. These challenges were primarily linked to features of the client group that mental health nurses work with, specific behavioural presentations and the complexities associated with working with people with a chronic illness. The need to maintain emotional safety was highlighted by a number of student nurse respondents both as a challenge and (as will be explored later), necessary skill for mental health nurses to have.

**Sub-theme 1.1: Being a Mental Health Nurse is a Challenge**

The delivery of mental health care was commented on by several students. Their comments reflected their belief that mental health nurses did the best with limited resources.

> It’s just a shame that they can’t provide more resources for the family to help them.
> Sometimes they’re stretched so far that they can’t do anything (SN6).

This comment suggests that SN6 felt that mental health nurses had to make a choice about where they directed resources. Whether these were physical or human resources was not articulated. Nevertheless, the point remains that there was a perception of staff having to concede some element of care considered crucial for clients and their families. This reality is at odds with the contemporary ethos of consumer and carer rights to accessible, appropriate health care from well resourced services. This dissonance creates the potential for ethical dilemmas and a sense of moral distress (Peter et al. 2004). As discussed in Chapter Two by Meyer and Xu (2005), students entering health care must often reconcile the discrepancies between the principles and ideals of nursing practice and a clinical environment that often challenges these ideas. The real world or contextual reality of health care and the ideals of mental health nursing practice are at odds. Mental health nurses are viewed as not being able to practice fully and of ‘having to make do with second best’. Students are therefore exposed to the possibility of role stress as they struggle to make sense of conflicting role demands.

As discussed in Chapter One, historically funding to mental health has been low (Hickie et al. 2005). In the course of their placements, the student nurses generally perceived
issues related to a lack of resources. SN1 described the impact of a lack of resources on the capacity of mental health nurses to work effectively with people.

*The patients don’t have much to do. There’s a lot of time to think which is good but I think they need to be able to be doing something productive. They say that people who are depressed often need to start baking cakes so that they’re doing something towards a goal. Like it can be a combination of talking and activity. I don’t like the system we have* (SN1).

SN1’s comment reflects the views expressed by mental health nurse respondents. Time for reflection is useful, but there appears to be a lack of any broader psychosocial interventions in place within the inpatient context SN1 is referring to. Certainly in terms of the concepts developed by Peplau (1962) and Barker (2001) the role of the mental health nurse would not only encompass the clinically oriented skills of medication administration and management but also supportive counselling skills, structured activity programs and living skills education. Unsurprisingly, research has demonstrated that consumers describe higher degrees of satisfaction with health care that is inclusive and provides stability and structure as well as providing a supportive psychosocial ambience (Johansson & Eklund, 2003).

Student nurse respondents pointed out that case overload in the community setting, together with the chronic nature of mental illness, created what could be seen as a degree of role stress for mental health nurses because of role overload. The role overload seen in the increasing volume of consumers rotating through mental health services, was viewed by SN5 as having an impact on the way in which mental health nurses were able to practice. As SN5 described:

*Because of the volume of clients some of them were really mechanistic, sometimes too task focused. It could have ended up more beneficial for the client if they’d extended themselves a bit more* (SN5).

As an outsider, SN5 experienced a contradiction between her expectations of the role of mental health nurses and the actual professional behaviours they observed. The volume of clients was seen to have particular negative effects, resulting in important cues not being identified and mental health nurses not individualizing their approach to clients. SN5’s reflection also resonates with those of MHNs 3, 4 and 5 who spoke about the immense caseloads that they carried in a community setting and the impact on their practice.
Several student nurse respondents’ reflections on the chronic nature of mental illness created what could be described as a ‘revolving door’, SN4 described what they believed was the challenge of the clinical care.

*I think seeing a lot of people relapse would be challenging. To keep trying to help them with that thought in the back of your head. Thinking again and again and again (SN4).*

Other student nurse respondents also described the same experience.

*I think it gets frustrating that they do their best but then these people always seem to come back. They say you’re all better now go and then they haven’t got the support anymore so they drop the bundle and stop taking the medication. The support is there when it reaches the crisis but there seems to be a gap between that and the ongoing support (SN6).*

This idea was also identified by SN7:

*The chronic nature of the people that you’re dealing with. I can see it would be frustrating to see these people coming in and out (SN7).*

Mental health nurses 3 and 5 also referred to the chronic nature of mental illness. Their focus, however, was more on the impact on consumers and families and the importance of maintaining an ongoing rapport with people, rather than the burden of working with consumers. The emotional burden came through the sheer role overload of having to manage large caseloads of consumers.

SN1 commented on how the environment does not contribute to optimal care of clients. The experience of placement was one of an environment that was not able to accommodate the varying intensity and complexity of consumer needs.

*I wonder [why] they put everybody with a mental illness which is very broad spectrum into a psychiatric ward where there’s people who have bipolar and people who have schizophrenia and some of the [presentations] are very contrasting. People with bipolar if they’re quite high will be agitating [sic] and people with schizophrenia might be frightened of that so they kind of counteract each other and that’s not healthy if they’re putting people with schizophrenia in a low, stimulus environment they’ve still got these high stimulus people with them (SN1).*

This observation highlights the contradictory nature of SN1’s experience and O’Brien’s (1999) study which highlighted the importance of individualising care. The concept of the milieu as an active part of the treatment process dates back to the last century where the role of attendants involved creating a safe, harmonious and homely environment.
where inmates felt accepted, not exploited, they were physically healthy and had role models of appropriate behaviour (Sheehan, 1998). However, these roles potentially conflict with other mandates described by Sheehan such as the requirements for constant observation, the need to prevent absconding and significant disciplinary sanctions if rules were contravened. These ideas are manifest today through ideas such as the therapeutic relationship, risk assessment, specialising of clients and contracts. These aspects of the mental health nurse’s role are undertaken within the policy drives of outcome based care mandated through legislative and health policy changes. These changes impact on the continuing evolution of the role of the mental health nurse in clinical practice. This impact can create ongoing role stress between the individual mental health nurse and organisational role expectations.

SN2 commented on the lack of resources available to support families and carers of people living with mental illness. There appeared to be the culture of blame towards families and significant others by the mental health staff including nurses.

*All the blame was placed on them it was why they didn’t they do anything, sooner nothing was done about it, nothing is done now, there was no resources or anything made available* (SN2).

SN2’s experience reflects the literature in relation to stigma in mental health. Importantly, in the context of this study it also illustrates the potential role conflict and clinical dissonance that students may experience. The literature shows that stigma in mental health continues to be an issue for consumers. Stigma associated with mental illness impacts on people’s quality of life, employment opportunities and access to services such as housing (El-Badri & Mellsop 2007, Overton and Medina 2008). It has been identified that mental health professionals such as nurses can perpetuate and reinforce this stigma (Overton & Medina 2008). Where students encounter stigmatised attitudes and behaviours from mental health nurses, they must attempt to reconcile the tension between the humanistic principles of care they are taught and the reality of human responses to the wider political and social factors impacting on the care delivery.

Student nurse respondents also believed that the emotional work involved in mental health nursing was a challenge to the role of the mental health nurse. These reflections reinforced a number of the comments made by mental health nurse respondents in their observations about the emotional challenges faced by mental health nurses.

*I think they’re overworked* (SN6).
It's a lot of work emotionally (SN1).

As with mental health nurse respondents, a number of student nurse respondents spoke of the need to find a balance:

Not being too soft Being able to identify when I'm being manipulated or when people are doing things that aren't for their own good and being able to tell them that without being too soft or being too offensive. Finding that balance (SN7).

Caring, as a foundational nursing concept, is introduced to students at the very beginning of their nursing studies. In many undergraduate courses particularly within mental health studies, caring is contextualised within the idea of the nurse-patient relationship. Nurses and clients enter this relationship with seemingly clear roles and responsibilities. The ultimate goal is touted as meeting the health related needs of the client. When clients respond in a way that challenges the students’ understanding of these roles, they are required to rethink what the role of the nurse actually encompasses. There is also the tension between this idea of caring which presumes humanistic principles such as empathy and unconditional positive regard and deserving of treatment (Geldard & Geldard, 2001; Reynolds, 2003) and the view that behaviours such as manipulation are a deliberate attempt to thwart therapeutic interventions which are not deserving of treatment (Farrell & Bobrowski, 2005).

The idea of balance was also expressed in the need to maintain boundaries between work and home by SN2 and SN1. Their comments reflect their growing self awareness of the impact of mental illness on people and their sense that mental health nurses need to have a way of protecting themselves emotionally.

Not being able to switch off because you know there are people out there with lives that are completely different to what you're used to or how you've been brought up or the realization that everything else is out there and your world is just not in a nice little neat box (SN2).

Getting too attached or getting over it because everyone is so down it would be very hard to keep a positive outlook (SN1).

Educational programs leading to eligibility for professional registration address the issue of professional practice such as professional boundaries and standards of practice. Students enter the clinical arena with an understanding of what the role of the nurse ‘is’. This entry knowledge is framed within concepts of the professional nurse who is also
authentic and human (Stein-Parbury, 2005). The reality of clinical practice often reveals the disparity between role expectation and role delivery. This, together with their burgeoning understanding of the systemic issues affecting delivery of health care can lead to concerns about their own capacity to ‘be professional ‘ and maintain clearly defined role boundaries (Brodie et al., 2004). As with the MHN respondents this can lead to anxiety and role stress with possible consequences of burnout or even working outside professional codes of practice.

Sub theme 1.2: What Mental Health Nurses Need to Know to Carry Out Their Role

Chapter Two discussed how mental health nursing has been a less popular career choice than other branches of nursing (Happell, 1999, 2002; Hoekstra, et al. 2009; Stevens & Dulhunty, 1997). Issues related to fear, the stigma of mental illness, increasing career options for young people and the lack of supportive, high quality clinical placements, have all been attributed to the difficulty in attracting new graduates to mental health.

The notion of recruitment to mental health was addressed through questions that asked student nurse respondents to describe how well their academic studies prepared them for clinical, how they were made to feel part of the team, what factors enhanced their learning in the clinical setting, how their ideas of mental health and mental health nursing had evolved since their studies in mental health and if and how mental health nurses encouraged them to consider mental health nursing as a career choice.

Complementing the ideas expressed by mental health nurse respondents, student nurse respondents also viewed the work of mental health nurses as being primarily about the relationship between the nurse and client. The caring aspect of this relationship was described by one participant. Interestingly this statement shares a number of features in common with statements made by mental health nurse respondents.

*It's more about caring, (for) the soul you're caring for the person from the inside out (SN 1).*

The work of mental health nurses was seen by student respondents to be very much focused on the person and building a ‘connection’ with them.

Only two student nurse respondents made reference to physical aspects of care. These comments related to the lack of emphasis on physical care as opposed to a broader emphasis on the total health and wellbeing of consumers. The links between mental and
physical health and wellbeing, quality of life issues related to medication adherence and social issues such as homelessness and stigma are increasingly recognized as essential to holistic care. That student nurse respondents did not identify this physical aspect of the mental health nurse’s role is noted here as a point of concern.

*Mostly it seems to be talking therapy. Because there’s not many physical things that they do like I guess playing basketball, I loved that they did that, took them outside because otherwise they’d just be inside the whole time (SN1).*

When asked to reflect on their experience in mental health and how they had learnt about the role of the mental health nurse, student nurse respondents were asked to recall episodes of positive or negative care they had witnessed. All respondents were able to recall instances of positive care by mental health nurses.

*I could have been ticking the psychotherapeutic interaction boxes as she went through and it wasn’t clinical, it was organic, it just flowed. I think that was because she had a good strong structure of what her goals were for the interviews with clients. The client wasn’t aware of this ‘agenda’ she was working through. He thought they were having a great chat. I think the ability to have a framework there and do the work but make it so human and natural was just a wonderful thing to observe (SN5).*

The unit SN5 is referring to provided students with an introduction to interpersonal communication knowledge and skills in working with people living with mental illness. The theory and learning activities encourage students to develop their ‘own style’ of relating to clients experiencing emotional distress within a variety of theoretical frameworks and may be applied to various situations, for example undertaking a mental status examination or responding to a distressed family member. SN5’s description reflects her ability to see theory she had learnt being applied in practice in a positive way. This was a significant event for her. SN5’s description also illustrates how a process that on the surface appears ‘natural’ through the registered nurses manner actually belies the complexity of the clinical assessment task they are undertaking.

The next two comments are exemplary of several key concepts that are found in the literature related to mental health nursing practice. The work by Barker et al (1999) and Hurley (2009b) is reflected in the comments made, particularly in relation to use of time, and the apparent ordinariness and everyday quality of their interactions. Terms such as being welcoming and not pushy and ‘always having time’ reflect ideas around how
nurses engage in a way that promotes the use of time, and reflects their knowledge and understanding of clients.

This one nurse was always really nice to everybody even when they were being really annoying (SN1).

There wasn’t one (nurse) that would ignore a patient even though the same person would come to the door ten or twenty or thirty times. They always had time to spend with them even if they were really busy (SN2).

SN2 adds the dimension of time to their description of nurse’s work. Time allows nurses to come to know consumers in a deeper and more connected sense. Consumers respond to this depth of relationship with staff.

I think because all the patients that were there had been there before, they all knew all the staff so everyone knew everybody . . . they just all seemed to be very open with whoever the nurse was that they were working with (SN2).

Other respondents’ identified features of the working relationships with other colleagues. These comments reflect that the student nurse participants saw the role of the mental health nurse as being closely aligned to the multidisciplinary team.

The fact that there’s a stable core group of people that are all working towards the same goal that was really good (SN1).

SN6’s reflection is important on two levels. She identifies that in her experience she saw the multidisciplinary team functioning well. However, it appears that the leader was still considered to be the medical officer. The degree to which this was prescribed in the role descriptions of the team members or represents traditional views of the doctor as the leader of health team needs to be considered further. SN6’s description also raises the question of the extent to which she could clearly differentiate between various team members’ specific role and scope of practice or whether there was little clear distinction between members.

They worked really well together. In hand over there was a registrar and there was a psychiatrist and it took me a couple of days to actually realise he was a psychiatrist because it felt like just one of the team so that was a really good thing and he was really open to them making suggestions about medication and things like that because they had so much hands on experience (SN6).

SN3 reflected on their experience from a unique perspective.
I remember there was this English nurse who was fantastic. She asked me what I did on the weekend because you know a lot of nurses had the weekend off and she was like oh I went to a b-b-q on the weekend with family and that was good. It wasn’t like she was saying their address but she was interacting in the conversation and wasn’t just putting up 100% professional front. They don’t have to talk about their personal life but if they interact it builds a trusting relationship up (SN3).

The interaction between SN3 and the registered nurse took place when SN3 was admitted to an inpatient mental health facility. SN3’s perception of the role of the mental health reveals the value he placed on being able to connect to another individual on a human level while he was receiving care. There is an increasing amount of research literature which engages with consumers’ perceptions of the role of the mental health nurse and what constitutes good care (Jackson & Stevenson, 2000).

Student nurse respondents expressed opinions about what constituted good mental health nursing practice. Their comments reflect recognition of personal qualities, behavioural attitudes towards others and the capacity to have some control of their work.

*They were very compassionate (SN6).*

*They seem to really care about the patients and really believe in what they were doing* (SN4).

A number of student nurse respondents also spoke about the capacity of mental health nurses to be proactive and effective problem solvers. These comments serve to reinforce the views expressed by MHN6 and MHN 8 in relation to key skills.

*They were just really good at coming up with ideas to keep them (clients) out of hospital* (SN6).

*There were a couple of really good mental health nurses that took initiative (SN1).*

The idea of listening to and interacting with consumers was considered an indicator of good mental health nursing practice.

*(Mental health nurses)...really talked to people. There are some people that just say how are you today, how are you going but it’s about listening (SN1).*
They need to have the ability to, not problem solve for the patient but with the patient so to be able to work with a patient and help patients to realise themselves solutions to problems and stuff, well not even solutions but ways of dealing with problems (SN4).

Student nurse respondents also reflected on the things they believed they had learnt about mental health during their studies (SN4).

*Their role is a lot bigger than what I thought. How much work is involved* (SN4).

*The nurses don’t just sit there everyday having conversations because they’ve got nothing better to do, they’re actually working out whatever it is their goal is* (SN2).

*If you want to be a mental health nurse you have to have a giving attitude* (SN1).

*Mental health nursing is a great career for the right people* (SN5).

These comments suggest that even with academic preparation, the reality of the role of the mental health nurses remained elusive for these respondents. In reflecting on the view of mental health nurse respondents’ desire to ‘tell their stories’, it would appear that there needs to be further discussion around how the role of mental health nurses can be articulated in a meaningful and realistic way. Attempts have been made through media representations such as the documentary series ‘Nurses’ (ABC 2000) and the recent introduction of the Ambassadors program through the Australian College of Mental Health Nurses (Australian College of Mental Health Nurses, 2009).

When the respondents were asked what they had learnt about the role of the mental health nurse, a number of the comments reflected not just a developing insight into the role of the mental health nurse but also a growing awareness of the challenge faced by consumers and carers.

For SN6 the importance of the role of the mental health nurse related to their impact on client outcomes.

*Knowing that you’re actually making a difference. On the first day it didn’t look like anybody was doing anything for them because most of the people that I, most of the patients that I was there with were very out of it and very unstable but the fact that you can improve, like when they left they might not be completely well but they definitely much more well than when they first came in.* (SN6)
SN1’s comment seems to suggest that even though there was an effort to remain distanced from consumers, maintaining emotional safety and boundaries is a complex and challenging component of the mental health nurses role.

*Once you’re in there it’s very hard not to feel for these people (SN1)*

Student nurse respondents had a clear sense of what mental health nurses needed to ‘know’ and be able to ‘do’ in order to ‘do their work’.

Student nurse respondents described what they believed to the knowledge and skills that mental health nurses need. Their ideas show a striking congruence with those of the mental health nurse respondents.

*Knowledge of the drugs, the illnesses all the different ways in which this one illness can go. The illness with one person is completely different with the same illness with another person. Medications, interactions with whatever it is with that person whether it’s other drugs (SN2).*

*They need to have a good knowledge of medication and the potential side effects (SN6).*

*They have to have a knowledge base of mental health stuff (SN4).*

Several student nurse respondents also referred to the need for good communication skills:

*You need to have good communication skills, not with just the patients but also with the families because they need to include the family in whatever they’re doing because they can provide a lot of support (SN6).*

Some student nurse respondents also recognized the need for mental health nurses to be aware of themselves.

*Being able to be aware of your own emotions when you’re interacting with people, being aware of how they make you feel and is that because of your own preconceptions (SN7).*

The issue of self awareness is an important one and reflects a number of comments made by mental health nurse respondents in relation to the importance of understanding one’s own strengths and limitations. Mental health nurse respondents also commented on how their work enabled not only professional growth but also personal development. This feature of their practice was enacted in their relationships with family and friends. Being a mental health nurse made them view the world and people in it differently.
Sub-theme 1.3: Preparing For and Learning About the Role of the Mental Health Nurse

In asking students to reflect on their experience of mental health nursing the researcher asked a number of questions that gave respondents the opportunity to describe the process of their journey. This approach was based on research identified in the literature review undertaken in Chapter Two. This demonstrated that students are more likely to develop positive attitudes towards and consider mental health as a career choice if they experience clinical learning in a structured and supportive environment. It is particularly important that students are encouraged to actively engage in the learning process by clinicians who demonstrate interest in their progress and academic preparation (B Happell, 2008a, 2009; Roche & Duffield, 2007).

When asked to consider how well their academic studies had prepared them for clinical placements, student nurse respondents commented positively.

*The lectures were really good. I really liked in my tutorial the actors came in, that was so helpful because they were really quite like the patients (SN1).*

*I would say [my studies prepared me] very well actually. All the drugs, the arts labs everything sort of built you up to a certain point knowledge wise (SN2).*

*To just see the interactions because when you read about it in books it’s hard to imagine interacting with them and in the labs they were just normal people. Just talking to them and work(ing) out some strategies to cope with people who were in acute stages (SN6).*

*They were definitely effective. I really enjoyed the psych units and I thought have(ing) actors come in (is) just a great way to prepare you. I don’t think you can really ever be totally prepared going into your first clinical experience in mental health but I think it really gave me an idea of how it’s not textbook stuff, it’s very dynamic and it changes so much from one person to the other (SN7).*

The use of simulation learning has been shown to assist students in making the transition of theoretical knowledge to practical situations (Edward, HerceLinskyj, Munro, & Warelow, 2007). The majority of student nurse respondents acknowledged the more traditional teaching and learning approaches of lectures and tutorials as useful. However, one student nurse respondent viewed the focus of their academic studies almost as a revelation:
What really surprised and thrilled me was the psychotherapeutic interaction subjects that I did was so holistic and all about the person. Not only the client as a person but about us nurses as people and that thrilled me (SN5).

Comments such as those by SN5 reflect Happell’s (2009) argument that students who complete larger theoretical components of mental health in their studies are more likely to view mental health more positively. The university that all of the student nurse respondents attended offered two core units in mental health nursing and psychotherapeutic processes in mental health nursing. This comprised one semester’s full time study. These units of study encompassed both biomedical and interpersonal aspects of mental health and nursing practice which were integrated through several connecting case studies. These case studies explored a range of mental illnesses including psychotic mood and eating disorders. Psychopathology, nursing assessment and management of these disorders, quality of life and carer issues as well as psychopharmacology were addressed. Actors were employed as part of a teaching and learning strategy to actively immerse students in the learning process. Students were required to engage either with actors in role plays at various points of the case study character’s experience of their illness or with the relevant family member or significant other. This type of learning can be seen as a modified type of situated learning where the students are learning the role of the mental health nurse in a simulated clinical environment.

In their discussions student nurse respondents indicated either their lack of knowledge about mental health and mental health nursing prior to their academic and clinical studies or alternatively how their personal experience with mental health services had contributed to their ideas about mental health.

All respondents indicated that they had very little or no professionally based knowledge of what studies in mental health would entail.

I didn’t really have an understanding at all. Like I didn’t know what the nurse was there for really other than to give medications. And I guess talking to patients, like this other stuff that you see in movies, mental health nursing is completely different (SN4).

A number of the comments made by student nurse respondents reflect stereotypical views about mental illness generally and what Halter (2002) referred to as the stigma by association that mental health nurses experience. The literature considered in Chapter
Two illustrates this within the context of mental health generally and specifically in relation to nursing (Wells et al. 2000).

*It sounded a lot like the nurses were as ill as the patients (SN1).*

*Even before I had that experience you know I had heard that mental health nurses were a bit eccentric (SN3).*

The literature on recruitment into mental health nursing in Chapter Two has demonstrated that students rank mental health nursing low as a preferred career choice and that supportive, positive clinical learning experiences can contribute to a change in perception and increase interest in mental health nursing (Happell 2008; Muldoon & Riley, 2003; Stevens & Delhunty 1997; Wells 2000; Rushworth & Happell 2000).

All respondents were asked if they were encouraged and asked to consider mental health nursing as a career option.

*My preceptor nurse said because I’m a little bit older than a lot of the other students I had a lot more of a go so he really encouraged me in my appraisal (SN7).*

*They said I had the attitude to be a mental health nurse and the mindset. They saw me as very welcoming and friendly. I was so happy that they said that. I'd love to do mental health nursing now and just the fact that they're behind me (SN1).*

At one level the respondent’s descriptions demonstrate the powerful impact that encouragement from experienced nurses can have student choices. This can even be sufficient to change previously held views about working in a particular area. At another level however the comments above reflect the personal qualities of the students that appeared to stand out to the registered nurses. As described, they could be associated with Gordon and Nelson’s (2005) concept of the virtue script. There is little in their comments to suggest that mental health nurses need anything other than a friendly disposition and ‘can do’ attitude.

SN6 reflected:

*They weren’t very pushy. But they were all saying would you [be a mental health nurse] and at that stage I started to think (SN6).*

Nevertheless, these comments do reflect the importance of the relationship between the registered nurse and student in facilitating transition into and positive views about
mental health nursing. As Charleston and Happell (2005) identified in their work, mental health nurses attempt to accomplish connectedness in the preceptor relationship.

For those students who had had personal experience of mental health services as a consumer or carer there was a need to reconcile the tension between two potentially different experiences. As SN 2 indicated:

*I've had family involvement so I had preconceived ideas coming into it. I knew bits and pieces but it was clouded a lot by what other people had said. They (staff) were very negative from what I had dealt with all the blame was placed on them (the family). It was why they didn't do anything, sooner nothing was done about it. There were no resources or anything made available to us* (SN2).

This tension was not easily reconciled as SN2 went on to explain:

*I knew in myself that I would struggle with it. I would struggle with the concept of where I was* (SN2).

Despite actually finding her experience a positive one, the tensions were not resolved as one might expect. Instead a feeling of confusion was engendered.

*The whole time I was thinking I've seen what this is, what I'd said about the profession and now I was there and enjoying it and I shouldn't have been, if that makes sense* (SN2).

SN2’s experience suggests a degree of ambivalence towards mental health generally and the role of the mental health nurse. Having had firm ideas about mental health nursing, which were not positive, and then finding that she enjoyed her placement appears to have created a sense of uncertainty and conflict.

The research literature clearly identifies the clinical environment as a major learning environment for student nurses (Smedley & Morey, 2009). Chapter Two highlighted the degree to which a supportive clinical learning environment promoted more positive views towards mental health nursing practice (Charleston & Happell, 2005; Happell, 1999, 2002). The experiences of student nurse respondents during their clinical practice reflect the findings from the literature regarding the importance of clinical exposure to students’ perceptions of mental health. All student nurse respondents reflected on their clinical experience, both the positive and negative aspects of this and how it contributed to their understanding of the role of the mental health nurse. Feeling welcomed by the mental health nurses, being given time to settle into the clinical environment, being
encouraged in their interactions with consumers but supported as required and being involved in clinical activities were all identified as strategies that assisted their learning.

Feeling welcome rather than being seen as a burden to staff was viewed positively by student nurse respondents.

"The staff were really friendly. They joked a lot and said it’s okay if you don’t know what you’re doing just yet, it’s your first day and they were very together as a group of people (SN1).

(I was made to feel) very, very welcome. Everyone was really nice and willing to answer questions, willing to give information even without being asked a question (SN7)."

Student nurse respondents described a number of ways in which their learning was encouraged by the staff.

"They didn’t expect me to be perfect (SN1)."

The student role is a complex one. Students are designated as supernumerary, and enter the field for a limited amount of time. Yet they are expected within a short timeframe to demonstrate the requisite degree of competency against practice standards for Registered Nurses (Australian, Nursing, Midwifery, & Council, 2006).

"They let you sit in on one on one interviews that they (nurse) did and said if you had any questions just ask them and if you weren’t sure about anything and kept telling us to ask the patient how, rather than going through them because they will tell you, most of them. Pretty much just giving you the chance (SN2)."

One student nurse respondent experienced two distinct clinical learning environments. The degree to which they felt welcomed and acknowledged, affected their learning and how they sought out learning opportunities.

"The (mental health) clinic wasn’t a negative experience by any means but it was personally challenging. I had to really find it in me to make the best of that experience. [Then] at the Primary Mental Health Team I had to be proactive and seek out learning opportunities but the difference between the two placements was at the second one they were such, just amazing human beings and had really mature insights or wise or lovely practitioners you know all the sort of people I’d be happy to make role models of (sic) (SN5)."
Charleston and Happell's (2005) study on preceptorship acknowledged the connection between students and preceptor as crucial to a positive clinical experience in mental health. Being encouraging, integrating students into their practice and demonstrating good practice were considered active ways in which mental health nurses encourage learning.

4.7 CONCLUSION

In this chapter the four major themes and eleven sub-themes from both respondent groups have been presented and discussed.

The results illustrate that mental health nurses experience their role as challenging. Continuing changes to mental health care delivery can make it difficult for mental health nurses to feel that their contributions are valued or recognised within the multidisciplinary team. In the first instance, respondents believe that the professional identity of the mental health nurse has been eroded through their isolation from other mental health nurses in the clinical field, and role expectations and requirements are often in conflict with their own role expectations. Mental health nurses worry about the increasing emphasis on biological models of care that preclude them from using a broader based range of psychosocial interventions as part of their role. Mental health nurse respondents described their role in terms of the therapeutic engagement they establish with consumers and families. Being practical, having hope that consumers will improve and experience a better quality of life, spending time with people and being able to view the consumer holistically were all viewed as elements crucial to their role.

Respondents also spoke of the specific knowledge and skills they believed mental health nurses require. These included communication skills and the ability to recognise and address the various interpersonal challenges that can occur in relationships, assessment skills, teamwork skills, an understanding of pharmacology, use of psychological models of treatment such as CBT, the ability to manage risk and self awareness of their own limitations and strengths as clinicians. The mental health nurses were confident with their knowledge and skill base, but frustrated at what they saw as other health professionals’ lack of regard for this.

Mental health nurses viewed their work as stressful and spoke about the burden of working in mental health, the need to maintain boundaries between work and home, their reasons for leaving clinical practice and eventually returning. All respondents spoke
of the need for ongoing support for clinicians while clinical supervision emerged as an
significant support strategy. The need to maintain professional contact with other
mental health nurses was also regarded as important.

Mental health nurses worry about the future and how to recruit new graduates. The
need to promote mental health nursing by supplying students with innovative clinical
placements and being proactive in the early inclusion of mental health education in
undergraduate nursing courses were identified as vital. Finally, mental health nurses saw
themselves as different from other nurses and believed that their role makes a difference
to consumers and carers.

The descriptions and experiences of the student nurse respondents complemented those
of the mental health nurse respondents. The student nurse respondents spoke about the
challenge mental health nurses face in their work and the stress associated with carrying
out their role. The capacity to maintain boundaries as a protective factor in their work
was also raised by the student nurse respondents. Communication, self awareness,
knowledge of psychopathology and medications were all identified as essential
knowledge. The student nurse respondents also highlighted how their undergraduate
studies had prepared them for the reality of clinical placement and described the factors
that had facilitated or hindered their learning during clinical placement. Spending time
with consumers, doing practical things, and compassion were all mentioned as part of
the mental health nurse’s role.

The next chapter will present the major findings and conclusions of this study. The
implications for policy and practice will be discussed together with recommendations
for further research into this field of study.
CHAPTER FIVE
DISCUSSION AND CONCLUSIONS

5.1 INTRODUCTION

In the preceding chapter the perceptions and experiences of the mental health nurse and student nurse respondents were presented and contextualised within the relevant research literature using a thematic analytic framework. In this chapter the major findings and conclusions are presented and discussed as they relate to the purpose of this study which was to explore how the role of the mental health nurse impacts on their professional identity.

In many instances the findings from this study support the results of previous studies discussed in Chapter Two. This is significant as it demonstrates the continuing issues that mental health nurses face in articulating their role within the health care system. The impact of these issues on the discipline has implications for the professional identity of the mental health nurses, not least in terms of presenting mental health nursing as a viable career choice. As previously mentioned, professional identity in this study was viewed through the organising framework of Role Theory. The dynamic interplay between mental health professionals, combined with organisational demands and changing role requirements in the clinical area, provided the context for exploring respondents’ views of their role as mental health nurses, the factors impacting on their capacity to carry out their role and its influence on their sense of professional identity.

The convergence or lack thereof, between the respondents’ own role expectations and organisational role requirements results in varying degrees of role ambiguity and conflict, which contribute to role strain. In this study, the impact of role ambiguity on the respondents professional identity led them to question the strength and unity of the profession in the current clinical environment. While they also demonstrated how they shaped, accepted, and at times withdrew from the role expectations of the organisation, their frustrations did not dissipate. The impact of these experiences on recruitment and retention must be highlighted and addressed by the profession. As previously stated, the views of the student nurse respondents were obtained to add another dimension to the rich descriptions provided by the mental health nurse respondents.
Following the presentation of the major conclusions, the implications for policy and practice will be identified and discussed and recommendations for further research will be made. It is important to note that the findings and conclusions of this study are not discrete as they all relate to the issue of professional identity but for the purpose of clarity, they are presented and discussed separately in this chapter.

5.2 DISCUSSION OF MAJOR FINDINGS

5.2.1 Finding One: The Role of the Mental Health Nurse

The first major finding from this study which concerns the role of the mental health nurse in contemporary mental health services warrants a comprehensive discussion. Respondents viewed their role as challenging in relation to several factors which affected their capacity to meet the expectations of their role as a mental health nurse. In the first instance, the mental health nurse respondents believe they have a specific contribution to make to patient care but this role is framed within a broader role which cuts across the roles of other members of the health care team. Therefore, the respondents’ role becomes more diffuse and fluid as their work context becomes more generic. The results indicate that mental health nurses seek to maximise their potential contribution to health care decisions within their paradigmatic framework. However, the frameworks which are used by mental health nurse respondents to carry out their role are at odds with the role expectations of organisations and new models of care being implemented. These findings add to the findings of Hamilton et al’s. (2004) study, which also illustrated how policy requirements constrain the ways in which mental health nurses engage with consumers and carers and plan care.

Contemporary mental health nursing roles are not carried out in isolation from other health professional roles. The multidisciplinary focus of mental health care delivery requires that mental health nurses work alongside colleagues who deliver health care from varying disciplinary perspectives. Care is therefore delivered from broader, potentially multiple, foci through generic staffing structures, such as those exemplified in Jones (2006) and Webster and Harrison’s (2004) studies. The multidisciplinary team’s focus of care is embedded within concepts of recovery, resilience and empowerment through collaboration with consumers and carers. The mental health nurse respondents in this study believed strongly in the need to work with consumers, carers and other health team members. However, both mental health nurse and student nurse respondents described their sense of frustration with the way in which mental health
nursing roles lack clarity and distinctiveness within a multidisciplinary team approach. They also perceived the structural features of organisations as being at odds with a person-centred philosophy of care. The focus on meeting key fiscal outcomes, the lack of any real progress in establishing community based services, and the dominance of models of care appears to be inconsistent with the principles of recovery and empowerment. The increasing complexity of mental health issues experienced by the client population, poor educational preparation of nurses to work in mental health, and the poor skills level of staff from other disciplines were also identified as factors which tend to make it even more challenging for mental health nurses to carry out their role.

This study found that the factors described above created a set of role expectations that in many ways were at odds with the professional socialisation that mental health nurses have undergone. Mental health nurses build their professional identity through the process of interacting with their peers, consumers, carers and allied health colleagues, and this identity continues to be refined and modified in their ongoing engagement with others as they carry out their role. This however, is not a complete picture of how the respondents’ professional identity was shaped in this study. Organisations have specific policy requirements and outcomes which they are required to achieve. Roles are developed within these parameters and employees are selected who are judged to be best able to contribute to successful organisational outcomes. Where the role expectations of the mental health nurse are congruent with the role requirements of the organisation, there is role clarity regarding their professional responsibilities and rights and therefore a clearer professional identity. When role requirements constantly change in relation to government policy or organisational demands there is an increased risk of either role ambiguity or role conflict, with a subsequent experience of role stress and ultimately role strain. This can lead to uncertainty about their professional identity for mental health nurses as these new role expectations do not match their own personal and professional view of their role. Despite this, respondents remained optimistic about their work and gained a great deal of satisfaction from their direct contact with consumers. The satisfaction experienced by mental health nurse respondents supports the recent work by Humble and Cross (2010) previously discussed in Chapter Two, who described the satisfaction that experienced clinicians in their study gained from their work with consumers and carers.

However, the mental health nurses experienced greater difficulty in describing their role outside of the acute care setting. As discussed in Chapter Two, Menzies Lyth (1988)
argued that well defined institutional boundaries contribute to the strengthening of the individual’s own psychological boundaries. These clearly defined role boundaries increase the individual’s confidence in their ability and capacity to meet their required role expectations. This in turn leads to a more confident sense of professional identity.

While acute inpatient units will always exist to provide care and treatment to those consumers requiring that level of service, contemporary mental health care is firmly grounded within a primary health and community based framework (Victorian Government, 2009). As mental health nurse respondents moved outside of the well defined boundaries and role expectations of the acute inpatient settings, their perceptions of their role became more ambiguous.

While there was no suggestion from the respondents that there should be a return to previous models of custodial care, what was evident was the confusion and role ambiguity related to the role expectations of community-based work and the respondents’ own understanding of their role as mental health nurses.

Chapter One highlighted the significant changes to policy direction and the philosophy regarding the central remit of contemporary mental health services since the mid-1990’s. However, the reality has continued to be a fragmented service that is not uniformly accessible to all (Epstein, 2005; Mental Health Council of Australia, 2005). It places high expectations and pressure on carers to assume responsibility for care, it is inadequately funded (Hickie, et al. 2005), and service delivery remains acute or sub-acute care focused, plagued by increasing skill shortages in all disciplines including nursing. The respondents in this study tried to fulfil their role as mental health nurses in the face of increased case loads, lack of appropriate funding to mental health, and the loss of what they described as a truly holistic focus in consumer care. This has been a result of the increasing shift to a biologically oriented framework in care delivery at the expense of broader psychosocial interventions. According to the respondents, the shifting demands of organisations in terms of role expectations and expected outcomes create role overload and role stress for them regardless of the clinical context. This finding supports the work of Roche and Duffield (2007) who identified the increasing role ambiguity and potential stress related to the changing role expectations and lack of professional differentiation of mental health nurses with the implementation of new and increasingly generic models of mental health care delivery. The respondents’ experience also reflects Crawford et al.’s. (2008) findings that constantly changing policy directives minimize their sense of contribution to consumer outcomes and lead to a professional
identity that fluctuates in relation to the degree of role ambiguity or stress being experienced.

In this study, the multidisciplinary team was viewed as a double-edged sword by the respondents. Such teams were seen as a positive move towards more inclusive treatment options for consumers and carers. Furthermore, the multidisciplinary team provides opportunities for broader practice and the development of new skills in some areas of practice. Several respondents also viewed working with other discipline groups as intellectually stimulating. Despite this, respondents felt that their expertise as mental health nurses within such a team was either not visible or constrained within the image of medication managers and administrators. The sense of invisibility described by the respondents in this study reflects the views of Prebble’s (2001) and Hamilton et al.’s. (2007) regarding the invisibilisation of mental health nursing.

Education for nurses has traditionally been ‘siloed’ within higher education as opposed to interprofessional learning with a range of other disciplines such as psychology or medicine. The literature on interprofessional education stresses the need to break down these silos and promote interprofessional education and collaboration (Priest et al, 2008; Renouf & Meadows 2007) but at the time of this study the three year Bachelor of Nursing program undertaken by the student nurse respondents did not consist of any discrete studies in interprofessional communication or teamwork. Two hours of content pertaining specifically to teamwork was presented in the first year of their studies with approximately six hours in the third year. Furthermore, these studies took place in discrete nursing only units that focused on issues in professional nursing practice. If nursing students are not provided with the opportunity to learn about teamwork within an interprofessional framework, then it would appear that the ‘art’ of effective teamwork continues to be essentially ‘learnt on the job’ as part of their professional socialisation. The more generic the multidisciplinary team was in terms of the role requirements and expectations of clinicians, the greater the descriptions of role conflict and role ambiguity. The mental health nurse respondents, who worked in clinical contexts that included large numbers of nurses, did not express as much ambivalence about the multidisciplinary team or their role within it.

Conversely, respondents working in multidisciplinary teams or practice areas where there were no other mental health nurses, or where contact with other mental health nurses was limited or intermittent, spoke about the need to remain connected with their colleagues in order to remain connected to their identity. This finding concurs with the
insights from Priest et al. (2008) who found that while understanding between professional groups can increase through education in relation to their role the need to maintain professional boundaries remains strong. Jones’s (2006) study also highlighted the challenges in establishing an organisational professional identity over a discipline based identity. As one mental health nurse in this study explained, regardless of where and with whom she worked, she viewed herself as a nurse. This reflects Ohlen and Segesteben’s, (1998) personal dimension of professional identity: that is, the subjectively held feeling of being a mental health nurse. The lack of interpersonal engagement with other mental health nurses also contributed to the respondents’ need to maintain a connection with their colleagues.

As previously described by Renouf and Meadows (2007) in Chapter Two, a multidisciplinary team is in fact only one way of working collaboratively across disciplines. The descriptions of the mental health nurse respondents suggested that their experiences have been more closely aligned with a transdisciplinary rather than a multidisciplinary approach. This, according to the definitions provided in Chapter Two, would carry a greater risk of role conflict and ambiguity. This point should not be underestimated because the confusion in how different terms are understood and employed in practice is an important one. Interprofessional learning and collaboration is conceptualised as a distinctly different process to that of multidisciplinary teams (Renouf & Meadows 2007), or even interdisciplinary or transdisciplinary teams (Stone 2010). Despite this, the review of the relevant literature and mental health policy documents suggests that the term “multidisciplinary team” has been interpreted in a variety of ways across a diverse range of health care settings. Therefore, it is crucial that there is consistency in the use and understanding of terms across service delivery areas. It is also essential that the role expectations match the service delivery model being utilised and that they are congruent with the expected outcome measures. The respondents’ experiences within the multidisciplinary team highlights what Ohlen and Segesteben, (1998) refer to as the interpersonal dimension of professional identity. Professional identity develops through the interactions between the mental health nurse and others in the course of carrying out their role. The role is negotiated, clarified, renegotiated and even contested as mental health nurses move into new and increasingly generic models of health care delivery.

In addition, the respondents experienced role conflict and role stress related to structural issues in the workplace such as high caseloads and conflict between role
expectations regarding the responsibility of the mental health team and the need to meet organisational performance outcomes. Some respondents experienced role ambiguity relating to what they believed was primary mental health care and the way in which they were being expected to implement primary health within their organisation. Role ambiguity was also experienced through frustration at what they perceived to be the different priorities of organisations regarding mental health versus physical health, and the contradiction between policy and allocation of resources to mental health care. Respondents spoke about not being able to work to the best of their ability, because they were constrained by administrative tasks which had eroded their sense of professional identity. Hurley et al. (2008) distinguished between the practice identity of mental health nurses and their organisational identity. The mental health nurses’ practice identity was seen in their daily work with consumers and carers. The organisational identity, driven by potentially very different requirements, may be at odds with the mental health nurses’ practice identity. The respondents in this study illustrated this discrepancy on a number of occasions. Comments related to stress driven by the conflicting demands of caring for consumers and meeting fiscal outcomes of organisations. Other observations detailed the lack of resources to work extensively with carers, the high administrative workload and decreased opportunity to provide leadership and support to staff, as well as the feeling that skill base was being eroded. These concerns as well as the sense that mental health nurses were losing unity as a professional group all contributed to increasing role stress and role strain and impacted on the respondents’ professional identity.

This finding supports Currid’s (2008) work previously reviewed in Chapter Two. In this current study, mental health nurse respondents described their concerns about administrative work being valued more highly than their clinical expertise. There was also role strain associated in working with other disciplines, particularly when respondents believed they did not fully understand or had not received appropriate training and education in issues related to mental illness. This resulted in an almost cavalier attitude to their work at times, particularly in relation to assessing for and managing risks such as aggression and suicide. Drawing on the work of Brown et al. (2000), this study suggests that when role blurring occurs, because of a realignment of professional knowledge and skills, staff may be left feeling increasingly vulnerable in their capacity to maintain their own, and by extension, other colleagues, consumers and carers’ safety.
This degree of role strain was dealt with by the respondents in terms of the choice of work area, and the need for them to realign their expectations about their role in relation to the organisational demands. That is, respondents had to essentially ‘choose their fights’. These findings also support the argument presented earlier by such authors as Roche and Duffield (2007) who identified a range of issues constraining the role of mental health nurses. Models of care are an area particularly contested in mental health. As Roche and Duffield (2007) point out, staff from a variety of disciplines working in mental health can have similar skills and expertise, and this can create the potential for role conflict and *clashes of culture*. This clash can be exacerbated because disciplines are often trained in disparate and at times, conflicting models of care. This can result in communication barriers and increased interprofessional rivalry and ultimately distract from a patient focus (Jones 2006). As previously discussed in Chapter Two, Priest et al.’s (2008) study demonstrated that even with interprofessional education there is a risk that different disciplines will retain stereotyped images of each other.

The second facet of challenge was related to the emotional and physical factors respondents experienced in working with people with emotional and psychological distress associated with mental illness. These experiences were considered in relation to Hochschild’s (1979, 1983) concept of emotional labour presented in Chapter Two. Mental health nurse respondents in this study spoke about their need to maintain boundaries between their professional and private lives but this was often difficult to achieve. Regardless of the clinical practice area, respondents described their work as emotionally burdensome and stressful and for many respondents this led to persistent thoughts of leaving their practice. Furthermore, the respondents spoke of not being able to leave their work behind, that is, to successfully maintain a work-life balance where they did not worry about work in their private time. Given the highly charged emotional encounters and events described by the respondents, the risk of emotional trauma is very real. One mental health nurse’s analogy of the inpatient unit being akin to a trauma unit provides an evocative image. The need for support and opportunities to debrief were emphasised as being essential but were often not available in the early years of their work as registered nurses. This study supports the view by Robinson et al. (2005) regarding the need for, and value attached to, clinical supervision and support in the early transition of graduates. In addition, the capacity to maintain appropriate boundaries between work and home and ‘*not take work home*’ must be supported by organisations through appropriate debriefing and clinical supervision strategies.
McKinnon and Cross (2008) identified a number of factors influencing the underreporting of aggressive acts. Comments from the respondents in this current study would suggest that they viewed aggression as inevitable, something to be identified and managed but minimised in terms of its impact. The other response was to choose workplaces where the perception of risk was lower. A number of mental health nurse respondents also spoke about the stress associated with the increasing complexity and unpredictability of the client group. For example, in McKinnon and Cross’s (2008) study a large number of respondents had experienced incidents of occupational violence, and in this current study the respondents who had experienced occupational assault also tended to minimise the event. According to McKinnon and Cross (2008), this may be related to the notion that violence was perceived as being part of the role.

For the student nurse respondents the emotional burden of mental health nursing was one reason they would not consider mental health nursing as a career. There was a sense that mental health nurses had to be strong and the right sort of person. These findings support previous studies (Hoekstra, van Meijel & van der Hooft-Leemans, 2009; Stevens & Dulhunty, 1997; Wells, McElwee, & Ryan, 2000) which found that student nurses viewed mental health nursing as a difficult and stressful job.

In this study the student nurse respondents described the mental health nurse as someone who was patient, self-assured and self-reflective. The capacity to be self-assured and self-reflective was also described by the mental health nurse respondents who recalled the difficulty they had in accessing opportunities for support and debriefing particularly early in their career. The graduate in mental health nursing is valued but vulnerable while making the transition to practice as a mental health nurse. Issues such as lack of support and role ambiguity can lead to increased stress and challenges during the transition from student to registered nurse (Rungapadiachy, Madill & Gough, 2006). In addition, failing to retain senior clinicians because of high levels of stress makes the challenge of supporting and mentoring new graduates an issue that requires urgent attention.

In this study, ten of the eleven mental health nurse respondents had either considered leaving or actually left practice for a period of time. The dilemma for these respondents was related to the conflict they experienced between wanting less stress but being concerned for the consumer’s welfare. Respondents felt that if they left practice they would be abandoning the consumers. The mental health nurse respondents wondered who would care for the consumers if they were no longer there and that working with
consumers and families experiencing mental illness was a privilege. This conflict created a tension between the respondents’ desire to ‘do good’ and the need to protect themselves.

This element of the mental health nurses’ role was also identified by some student nurse respondents who were at times surprised by the extent to which mental health nurses cared about consumers and their outcomes. This element of the respondents’ experience highlights the way in which students need to work through what can be entrenched and stigmatised views regarding mental health and mental health clinicians. Comments from student nurse respondents relating to the supposed eccentricity of mental health nurses, and the view that mental health nurses were as ill as the consumers, reflect the stigma in mental health which has been well documented in the literature (El-Badri & Mellsop, 2007; Haque, Dyke, & Khan, 2002; Overton & Medina, 2008). As discussed in Chapter Two, the student nurse respondents’ ideas about mental health and mental health nursing in particular have been grounded in a lay understanding of mental illness. These views support the ideas of Halter (2002) who believes that the view of mental health nursing is intimately connected to stigmatised understandings about mental illness. As discussed in Chapter Two, Happell’s (2008a 2009) work demonstrated that immersion in theoretical and clinical studies related to mental health in undergraduate nursing education has been shown to positively influence perceptions regarding mental health.

5.2.2 Finding Two: The Professional Identity of Mental Health Nurses

The second major finding from this study is that the professional identity of mental health nurses remains ambiguous and poorly communicated. It seems that regardless of the context of practice, the capacity to identify and communicate the role of the mental health nurse has always been indistinct because the practice of mental health nurses is complex and not easy to ‘see’. Mental health nurses work in a variety of clinical contexts outside of the traditional acute and sub-acute care settings. Indeed, the research literature shows that mental health nurses are increasingly working outside of these traditional clinical areas. As the mental health nurse respondents reflected, the more generic the model of care delivery the greater the ambiguity in their role. This is because there are a core set of skills seen as common and necessary for all clinicians and concomitantly, little regard for, or recognition of, specialised skills (Renouf & Meadows,
The experience of respondents also reflects Crawford et al’s. (2008) work which has previously shown that the professional identity of mental health nurses fluctuates as role ambiguity increases. This role ambiguity results from being unable to clearly articulate the role of the mental health nurse and therefore a professional identity (Rungapadiachy et al 2006). However, this study supports Hurley’s (2009b) view that the professional identity of mental health nurses should be viewed as a collection of knowledge, skills and abilities rather than a singular ‘best’ definition. Given that mental health nurses are working in increasingly diverse roles and clinical contexts, it is necessary to move away from thinking that a single definition fits all. Accepting that there is diversity in the professional identity of mental health nurses increases the opportunities for mental health nurses to engage with consumers according to their needs.

As discussed in Chapter Two, professional identity is seen in the mental health nurse’s interactions with others in the context of their role (du Toit, 1995; Ohlen & Segesteben, 1998; Takase, Kershaw & Burt, 2002) and reflects how they describe their role, their self-image and perceptions of how they believe others view them. In this study, professional identity was expressed by the respondents in terms of their role and was contextualised in the primacy of the therapeutic relationship. Phrases such as ‘walking a journey’, ‘being with’ and ‘interacting in the conversation’ all firmly embedded the respondents’ view of their role within the consumer relationship. These descriptions of practice centre on interpersonal and psychosocial concepts which demonstrate the complexity, intensity and difficulty of objectifying the dynamic nature of their engagement with consumers.

Professional identity was explored in greater depth by asking the respondents to identify the knowledge, skills and qualities that were needed by mental health nurses. All respondents spoke of what they believe to be the core and advanced knowledge, attitudes and skills that mental health nurses need in today’s contemporary health care system. There was a range of skills that the majority of respondents referred to as basic stuff, including effective communication, vital signs, mental status assessments and drug administration. When asked to identify the unique qualities, knowledge and skills that mental health nurses need, the respondents spoke about the capacity to work with people who experience extreme emotions, the ability to identify and work with various individual dynamics in relationships, the capacity to utilise a range of psychological therapies, and the importance of using a variety of conceptual models to base their care
The mental health nurse respondents also spoke about the need for mental health nurses to be able to *embrace and work with difference*. Difference in this context refers to people whose illness has led to emotional response and behaviours that were often judged by others to be strange and to be avoided. It also referred to their capacity to enjoy their work and find satisfaction in it. Student nurse respondents highlighted the mental health nurse’s capacity to work with all members of a family in an inclusive manner, to be proactive and care about both the consumer and their family.

The respondents spoke not only about working with difference but about mental health nursing as a site of difference. The notion of difference was conceptualised in several ways. In the first instance, mental health nurse respondents believed that they were different to other nurses. For example, and according to both mental health nurse and student nurse respondents, mental health nursing is less prescriptive and task oriented, the work is more dynamic, and the nurses are treated respectfully and do not appear to be regarded as *handmaidens* by other health team members. Furthermore, mental health nurses think differently and base their care on different conceptual frameworks.

Second, respondents believed they had a different attitude than most other people towards working with people with mental illness. That is, they spoke of their desire to make a difference in the lives of consumers and carers and they viewed this as their *core business*. The respondents were proud of this ability to work with people who still faced stigmatised reactions from the general public and from other health professionals (Adewuya & Oguntade, 2007; Overton & Medina, 2008). Third, the respondents were proud of their ability to work with consumers and families living with mental illness. They were proud of their knowledge base and their capacity to *make things happen* and they were both humbled and privileged to be able to work with people living with mental illness. These experiences resonate strongly with the work of Humble and Cross (2010) who identified the concept of difference in their interviews with veteran mental health nurses. As was also found in the Humble and Cross (2010) research, the concept of difference had not made respondents in this study feel less worthy as mental health nurses. Instead, their perception of difference was integral to their sense of professional identity.

As discussed in Chapter Two, Clarke (2006) argued that the basic tasks such as taking vital signs could be categorised as medical or clinical tasks, and therefore not purely the domain of nursing. The advanced skills move beyond the *basic stuff* identified above and require mental health nurses to be able to think conceptually in a critically reflective
manner, to adjust their work to meet the consumers’ needs and to use an interpersonal process to carry out their role. It is suggested that these attributes are at odds with many of the organisational role requirements and the stigmatised views of mental health nursing, and may often be ‘invisible’ to other health professionals and student nurses (Hamilton & Manias, 2007; O’Brien 1999, Prebble, 2001). The work of O’Brien (1999), Barker (1999) and Peplau (1962) all describe the role of the mental health nurse as being grounded in the interpersonal context. The challenge for mental health nurses is to render visible the specific psychosocial and other nursing interventions they utilise. If professional identity develops through the complex interactions between the mental health nurse and others in the context of their role, then the activities mental health nurses engage in with consumers and carers need to be acknowledged as a significant part of their role.

For example, student nurse respondents described the capacity of mental health nurses to move between different models of practice to suit the needs of consumers and families. The description by one student nurse highlighted how the mental health nurse worked with both the client and her parents. This included observing, using different communication skills, adjusting her language to meet the specific individual’s needs, the range of strategies and interventions she suggested as well as the level of support she provided. This account demonstrates the dynamic way in which this mental health nurse carried out her role. In this instance a mental health nurse was able to use different models of practice that ranged from a more directive role to a supportive one, correlating with the findings from Nolan et al. (2007), regarding how mental health nurses use of a range of theoretical frameworks to underpin their practice. This example also illustrates the way in which mental health nurses work with both consumers and families and it emphasises the holistic frame of reference that they bring to their work. Other respondents noted the importance of the little things. For example, a cup of tea is a supportive, comforting activity. Sitting with a patient implies an active engagement as opposed to sitting next to, which is a behaviour that suggests a degree of separateness between people.

As discussed in Chapter Two in relation to the work of Haque et al. (2002), mental health nurses need to clearly demonstrate the efficacy of their work and the positive contribution it makes to consumer outcomes. The issue should not be about which type of interventions mental health nurses employ, whether they are psychosocial, psychological or biological, but rather, how the interventions contribute to consumer
outcomes. Mental health nurses need to document their work and connect this work to nursing knowledge. That is, as Buller & Butterworth (2001) argue, mental health nurses must have a methodology that allows them to uncover and express their role and effectiveness in terms of nursing. If it is accepted that professional identity emerges through the mental health nurse’s role it then follows that they must highlight those specific practices and roles that contribute to positive consumer outcomes. In this way, mental health nurses will be able to identify, build upon and articulate a positive professional identity.

This study supports the view of Hurley et al. (2009), that mental health nursing’s failure to articulate its own professional identity leaves the discipline vulnerable to definitions imposed by other health professionals. These external role definitions may well conflict with the views of mental health nurses regarding their role and could result in the very ‘list’ of skills and activities highlighted by Clarke (2006). These task based skills are largely isolated acts which do little to draw attention to the complex role of the mental health nurse. In this study, one mental health nurse respondent was passionate in her belief that mental health nurses must research and document the impact of their work in order to demonstrate the efficacy of their work with consumers and carers. If this is not done, mental health nursing will *fizzle out*. All respondents spoke of the importance of working with consumers and their carers. Furthermore, as the research literature reviewed in Chapter Two demonstrated, consumers have consistently viewed the quality of the relationship they had with mental health nurses as being crucial to a positive experience of health care.

Authors such as Bridges (1990) have highlighted a number of stereotypes about nursing generally and mental health nursing in particular (Kalisch & Kalisch 1981). Many of these images have described an idealised and often inaccurate picture of the reality of nursing although they are generally positive. Mental health nursing is in the unusual position of being intimately connected to a part of the human experience that is simultaneously feared and intriguing. Policy makers, educators and clinicians are therefore faced with a unique conundrum. This relates to describing the work of mental health nurses in a way that illuminates the complexity of their role in a positive manner. The choice of a mental health nursing career by respondents was often made in response to what it was not, rather than an informed view of what mental health nurses actually do. For example, the decision to work as a mental health nurse was more often than not based on very little factual information to help inform their decision. Mental
health nurse respondents spoke about *falling into* mental health nursing because it offered a change from their present circumstances. Word of mouth and serendipitous encounters with other mental health nurses also accounted for entry into the discipline. The mental health nurse respondents had little recollection of mental health nursing being actively promoted to them as a career choice. Given that the length of experience for the study respondents ranged from seven to thirty years, this finding is significant. Mental health nurse respondents spoke as if the difficulty in explaining the professional identity of mental health nurses was a recent phenomenon. The respondents’ views suggest that the professional identity of mental health nurses is a fusion of myth, fiction and fact which is at times self-perpetuated and which suggests a lack of professional differentiation from other mental health disciplines. But also importantly, it would appear from their experiences that the difficulty in describing the professional identity of mental health nurses is not recent. Rather, it has become more obvious with the changes in mental health care delivery models over time.

### 5.2.3 Finding Three: The Future of Mental Health Nursing

The third major finding of this study relates to the respondents disquiet regarding the future of the discipline. The mental health nurse respondents were concerned for the future of mental health nursing both in terms of recruitment and retention. There is insufficient advertising of mental health nursing to potential clinicians and several respondents believed that it is too late to wait until nursing students are mid-way through their studies to introduce mental health nursing as a career choice. According to the mental health nurse respondents there needs to be active engagement with the broader community through high school visits and community forums regarding mental health generally and mental health nursing in particular. The lack of promotion helps to maintain the invisibility of the role of mental health nursing and has severe implications for attracting potential mental health nurse clinicians.

The mental health nurse respondents all agreed that once at university, students need an earlier and more comprehensive introduction to mental health studies and preparation for clinical practice plus more adequate supervision during clinical placements due to the nature of the work. The student nurse respondents believed that traditional methods of learning were valuable but only up to a point. This study found that students learn more, and are less fearful of mental health when their learning occurs in a safe
environment to the ‘life like’ situations, or as described by one mental health nurse, when their learning ‘came alive’ through simulated learning activities.

In terms of developing a professional identity as a mental health nurse, the importance of positive, nurturing clinical exposure has been reported in the literature (Charleston & Happell, 2004; 2005; Happell, 2002, 2008b). In this study, the student nurse respondents identified a number of key strategies that encouraged them to feel part of the team, learn safely and ‘test their wings’. Regardless of the clinical context, the relationships that nursing students developed with their preceptors had a significant bearing on their thoughts about mental health generally and their interest in pursuing mental health nursing as a career.

The mental health nurse respondents appeared surprised when asked to identify the stories they would want told about their work. Nevertheless, they all agreed that mental health nurses do not speak out enough about what they do, or the positive impact of their work on consumer outcomes. They expressed views about the aspects of their role that need to be communicated more broadly. These consistently relate to the interpersonal and counselling aspects of the role, and their capacity to work holistically across a range of biopsychosocial needs of consumers and their families that incorporate a biological, psychosocial and strengths based approach. These views support the concept of the mental health nurse as a generic specialist, who is capable of “responding to the full range of service-user needs…necessitating preparedness and capability to intervene across psychological, social and physiological domains” (Hurley 2009b, p.385).

According to Haque et al. (2002) and Nolan et al. (2007), mental health nurses do use models to guide their work, and the utilisation of the models centres on their applicability to various clinical contexts. Which models mental health nurse choose to work with, how consistently they are used in practice, and their impact on client outcomes needs to be further investigated in order to shed light on the choices that mental health nurses make in terms of interventions and how they work with colleagues and importantly, consumers.

In this study, mental health nurses were concerned for the future of the discipline as a discrete identity in mental health care delivery. The respondents believed that changes to registration in Victoria and the move to comprehensive nurse education have not been good for mental health nursing. Because nursing education at the undergraduate level is too narrow in its conceptualisation of mental health nursing practice, graduates entering the workforce are ill prepared to meet the required role expectations. The mental health
education provided to undergraduates is too medically and biologically oriented, and the role of the mental health nurse is viewed only in terms of risk assessment, containment and medication administration and management. The outcome of this limited view regarding what constitutes mental health and mental illness is that students miss out on a whole raft of important learning principles related to mental health care. Therefore, postgraduate studies in mental health are being used to prepare clinicians to work in mental health nursing, in order to meet industry needs. As a result, there is little emphasis on mental health nurses undertaking higher degree research studies.

Although the mental health nurse respondents may have felt respected by other team members, they also experienced frustration regarding the degree of professional recognition and the respect they were accorded by their colleagues as part of the multidisciplinary team. There were few decision making opportunities in relation to patient care and little recognition of the mental health nurses’ contribution to patient care. The respondents felt that it was important to have their nursing expertise acknowledged and valued, and the experience of being devalued was acknowledged as a source of dissatisfaction. They consistently felt that mental health nurses needed to show or prove that they were serious about their work and were clinically current and competent. This presented them with the opportunity to hold their own amongst the other health professionals. The mental health nurse respondents described a sense of ambivalence towards those colleagues who did not pursue further education or professional development. Professional loyalty and the need to show solidarity with other nurses was in conflict with a collective frustration at being limited or held back because other members of the group chose not to upskill. Happell (2007a) has discussed the need to distinguish between mental health nurses and nurses who work in mental health. The lack of mandatory qualifications at the state or territory level for mental health nurses continues to convey the perception that mental health nursing does not require specific knowledge and skills. This is despite the fact that workplaces in the public health care sector are increasingly stipulating postgraduate qualifications as a criterion for employment and promotion. Credentialing is viewed as a mechanism that can circumvent this perception and recognise those nurses who seek to be actively identified with the profession. As of 2008, the number of credentialed mental health nurses in Australia was 267 from a possible 13,472 (Mental Health Workforce Advisory Committee, 2008). The figures published on the ACMHN’s website list the number over 700 (ACMHN, 2010). This accounts for approximately five percent of the total
mental health workforce based on the 2008 data. If credentialing is indeed a mechanism to strengthen the professional identity of mental health nurses then it must continue to be actively promoted to the workforce by the ACMHN and mental health nurse leaders. How credentialing promotes professional identity and the benefits of credentialing for organisations employing mental health nurses through the Mental Health Nurse Incentive Program (Australian College of Mental Health Nurses (ACMHN), 2009) needs to be explored within the mental health and wider nursing communities.

The preceding discussion demonstrates the contribution this study makes to the existing knowledge on how the role of the mental health nurse impacts on the professional identity of the discipline. In the first instance, this study provided a unique opportunity for a group of experienced mental health nurses to express their perceptions regarding their role in their own words, as opposed to having their ideas interpreted and represented for them. This is the strength of the naturalistic paradigm. The experiences, thoughts and feelings of the participants stand on their own merit rather than being lost in the ‘second hand account’ of the researcher. Using role theory provided the opportunity to highlight important connections between how a group of experienced mental health nurses described their role and the impact on their professional identity.

In addition, this study has demonstrated how the role of the mental health nurse and its impacts on the professional identity of mental health nurses is multifaceted. The professional identity of mental health nurses arises from the interplay of historical, social, personal, structural, organisational and educational factors. Using Role Theory has enabled the researcher to illustrate how respondents’ perceptions of their professional identity and unity as a professional group is impacted on not only events and decisions made by other professional groups but also their own personal as well as professional values. Using Role Theory has enabled the researcher to describe the ambiguity and role strain experienced by respondents as they attempt to enact their role within contemporary role expectations which often conflict with their sense of professional identity which is grounded in the interpersonal connection they have with consumers, families and students.

An important contribution of this study is the understanding that has emerged in the way in which the respondents view themselves as nurses. While there is clear sense of difference in they way they practice from other nurses, there are also important commonalities. In terms of their knowledge skills and professional values, Role Theory has been used effectively to describe these professional attributes. It is these
professional attributes that mental health nurses bring to the multidisciplinary context that must be clearly communicated, researched and promoted.

Role Theory has also highlighted how student nurses are able to conceptualise the role of the mental health nurse in a sophisticated manner. The descriptions offered by the student nurse respondents complemented those of the mental health nurse respondents. Mental health nurses have distinct contribution in promoting mental health nursing and educating student nurses, and must be involved in developing, implementing and evaluating learning opportunities.

5.3 MAJOR CONCLUSIONS

- The role of the mental health nurse is complex and not readily observed by other people. The research based literature on mental health nursing practice across a range of clinical contexts must continue to demonstrate how mental health nurses contribute to or lead interventions that have positive health outcomes for consumers. Demonstrating how mental health nurses contribute to consumer outcomes will strengthen the professional identity of the specialty. The descriptions of the respondents in this study highlight a depth and breadth of knowledge and skills that respondents bring to their practice.

- In contemporary society there continues to be a contradictory view of mental health nursing. In some instances this view is a negative one and is held by the public, other nurses and to some extent, mental health nurses themselves. This view is associated in many instances with the historical stigma attached to mental illness. In contrast however, mental health nurses are proud of their work, believing that it makes a difference to consumers and carers. They see themselves as different, but they perceive this difference as a positive attribute.

- Mental health nurses view themselves as nurses and seek to be connected professionally with their nursing colleagues in other disciplines. Contemporary practice has created a barrier to this professional engagement.

- Mental health nurses need to reclaim the nursing focus of their professional identity. Envisioning paradigms of care which elucidate nursing activity as the core element of their work is crucial to them maintaining a viable presence in mental health care delivery. Mental health nurses are best placed to employ models of care that are holistic, focussed on strengths-based and recovery models of practice.
• Student nurses need to be educated from the commencement of undergraduate nursing courses regarding psychosocial, person-centred care and they need to be provided with clinical placements in a diverse range of mental health care clinical settings. Mental health as a core nursing responsibility should be embedded at all levels of undergraduate nursing education and particular emphasis should be on the continued provision of adequate clinical support for students. Concepts such as the use of psychosocial vital signs (Spade, 2008) must be embedded into nursing curricula and inculcated as a core nursing activity alongside side such activities as physical vital signs.

• Mental health nurses must be involved in the design, delivery and evaluation of academic and clinical learning experiences for students. They are best placed to collaborate with both educational institutions and consumers to develop such learning opportunities.

• In this study, the student nurse respondents viewed the mental health nurse as a “safety net”, someone who was goal-directed, worked collaboratively with other mental health professionals, consumers and families and helped people feel less isolated. When the physical properties of a safety net are considered it can be seen that while it is made of flexible material, and secured to some stable structure, it can be applied at any level of need and provide the degree of support necessary. A safety net also works in conjunction with other structures and systems as it provides this support and stability. It enables the individual to be as independent as they can or need to be while providing a supportive and protective environment. The findings of this study suggest that mental health nurses also work like a safety net. They are grounded to the structures of knowledge and skills through which they provide a supportive and protective environment for the consumer. The degree of support given is based on the identified needs of the individual consumer. Mental health nurses work with carers and other health colleagues both to collaboratively identify the need profile, and as an ongoing part of the supportive process.

5.4 IMPLICATIONS FOR POLICY AND PRACTICE

5.4.1 Introduction

In this section the implications of policy and practice that have arisen from this study will be discussed. The implications will address the two stated aims of this study. The
first was to identify strategies for promoting mental health nursing which will assist recruitment and retention. The second was to identify educational strategies in undergraduate nursing courses that have the potential to increase students’ career choice in mental health nursing.

5.4.2 Implications for Policy

There is a danger that nursing shortages and inadequate mental health preparation of nurses in the higher education sector could lead to an increase in the risk of adverse events. Research in this area has been conducted in the acute care sector both internationally and in Australia over recent years and the findings show that increased educational qualifications are linked with a decrease in adverse events (Aiken, Clarke, Cheung, Sloane, & Siber, 2003).

There must be a concerted move to avoid this possibility by the Royal College of Nursing Australia (RCNA) and the Australian College of Mental Health Nurses (ACMHN) respectively. As the peak leadership bodies in nursing and in mental health nursing these organisations must engage in discussions focused upon increased levels of funding for mental health services. Furthermore, recent reports such as a Mentally Healthy Australia and Victoria’s Mental Health Matters Report must be responded to by the RCNA and the ACMHN to demonstrate how a skilled mental health nursing workforce can contribute and lead the various strategic directions (National Advisory Council on Mental health, 2009; State Government of Victoria Department of Human Services, 2009). Funding must incorporate consideration of issues such as more realistic case loads for mental health nurses in multidisciplinary teams. The Mental Health Councils Statement (Mental Health Council, Media Release, 28 January, 2010) said that while the need for additional mental health beds is not in question, this resource should be directed toward community based facilities rather than increasing the number of acute or sub-acute beds. This call to increase the number of community-based beds across a number of jurisdictions provides mental health nurses with an ideal opportunity. As a professional body, mental health nurses could actively contribute to the development and implementation of programs that are holistic and use a strengths-based, recovery paradigm. In this study, the respondents’ comments resonate with the immediate debates regarding allocation of resources and infrastructure to mental health. The recent announcement of health reforms by the Federal Government, including the centralisation of community mental health services at a national level is seen by many as
the first real opportunity to resource this area of mental health (Mental Health Council, Media Release, April 4, 2010).

In order to influence the continuing role developments in mental health nursing and to promote a more positive professional identity, the ACMHN must continue to ensure its voice is heard in the wider arena of health care reform, and that this reflects the views of its members. Steps should be made to collaborate with the RCNA on mental health specific issues. Using the links already established would demonstrate professional unity and exemplify the importance of nurses working together and respecting each others’ expertise. As previously identified in Chapter One, mental health nurses represent the largest proportion of workers in mental health. They must therefore seize opportunities to be actively involved in the debates surrounding policy direction in mental health care. Furthermore, they must be encouraged to render their role in these services visible and audible. This could be partly enabled at an organisational level, by continuing to build on membership numbers in the college. For example, this could occur by electing a college representative to report on college matters through staff meetings and seeking the views of clinicians on matters relevant to their clinical practice and mental health policy generally. The findings could then be forwarded to the State Chapter meetings and to the National office. In addition, the ACMHN could offer reduced subscription rates for the College journal and newsletter to clinical venues. If nurses are going to participate in policy debates they need to have access to the relevant information.

Active steps must be taken to promote a more positive professional identity of mental health nursing. This crucial challenge must be taken up by the mental health nurses themselves. If recruitment and retention are to be seriously addressed then it is essential that mental health nurses, through the ACMHN and via the Victorian Government Nurse Policy Branch and equivalent bodies in other States and Territories, are proactively involved. This ground-up approach to marketing and promotion will also help to control the images that circulate in the public domain. Instead of reflecting archaic fears and stereotypes the available images of the profession need to highlight the knowledge, skills and enthusiasm that mental health nurses bring to their work. Initiatives by ACMHN such as the Mental Health Nurse Ambassador’s Program, which presents mental health nurses talking about their work to secondary school students and nursing students, both face-to-face and through the ACMHN’s website, highlights what clinicians see as the distinctive features of their role. The opportunity also exists for academics to work with the ACMHN and integrate this program into undergraduate
Bachelor of Nursing programs, through involvement in skill development as well as tutorials and guest lectures. Governments should revisit previous campaigns regarding recruitment of mental health nurses and evaluate their effectiveness, and mental health nurses must be involved in this process. Mental health nurse leaders in clinical practice and in management should be encouraging and supporting senior clinicians and clinical educators to promote mental health nursing within secondary schools. Such strategies could be implemented as part of a healthy community’s campaign that could be spearheaded by mental health nurses in collaboration with school nurses. The National Advisory Council on Mental Health’s Report (2009) and the directions outlined in the Victorian Governments Mental Health Reform Strategy Implementation Plan 2009-2011 (State Government of Victoria Department of Human Services, 2010b) clearly identify the importance of investing in communities through education and a socially inclusive approach to mental health, community participation and workforce innovations. The ACMHN must consult with and listen to the profession so they can submit proposals which illustrate how mental health nurses actively contribute to goals such as having more flexible psychosocial mental health services, and improving the coordination of services for people with multiple mental health, physical or social morbidities.

The education of undergraduate nurses must include specific reference to mental health literacy, and psychosocial person-centred care. Mental health literacy, as an underpinning concept of mental health, will provide students with the necessary understanding and knowledge regarding mental illness and its treatment and prevention, a concept which is fundamental to all nursing practice (Jorm et al, 2006).

Mental health nursing must be highlighted as both a distinct area of nursing practice and also a responsibility for all nurses regardless of the clinical context. Academic preparation should incorporate simulated and modified situated learning environments to assist in students’ understanding of the role of the mental health nurse. This can be achieved through teaching and learning strategies including virtual online environments such as virtual primary health or acute inpatient environment, the use of actors in simulated scenarios (Edward et al. 2007) and the use of avatars. These strategies will significantly help to dispel negative images of mental health and as a result, will promote a more informed and positive view of this specialty. The final report of the Mental Health Nursing Education Taskforce (MHNET, 2008) highlighted the difficulties of providing sufficient mental health theoretical and clinical content in contemporary
Bachelor of Nursing programs. For the student nurse respondents in this study, the mental health content consisted of eight weeks of theoretical and four weeks of clinical exposure in the entire three year program. Furthermore, there was little application of mental health or psychosocial content in all other areas of study. With little exposure to mental health nursing at the undergraduate level, students are not able to see the relevance of mental health nursing applied through a range of practice areas and may easily develop a restricted view of the role of the mental health nurse.

Additionally, although the inclusion of more advanced mental health content in undergraduate nursing programs is a praiseworthy strategy it is often only offered as an elective pathway. The theme of mental health needs to be embedded across the three year Bachelor of Nursing courses and not seen as only a discrete or elective component of the course. This study supports the view presented by Happell (cited in Dragon 2010) that core communication and interpersonal skills training should be integrated throughout undergraduate nursing curricula. However, in addition, psychosocial principles should form part of the first year of study. These should be embedded in units of study that introduce person-centred care, resilience, social capital and mental health literacy in year one and they can then be applied throughout the program of study.

In addition, undergraduate nursing curricula must also ensure that the concept of multidisciplinary work is clearly embedded within programs so that graduates are better prepared to take their place as part of a multidisciplinary team. There must be specific opportunities for students to explore, practice and evaluate the experience and outcomes associated with working in multidisciplinary teams. This should occur both in the academic setting through teaching and learning strategies such as those identified previously, as well as the clinical setting. This is one area where effective partnership between academia and clinical agencies is essential. If the relationship between the mental health nurse and the student nurse is the key factor to enhancing learning in mental health then new ways must be considered to promote and recognise preceptoring as a key role of the mental health nurse. Recognition of preceptoring as a criterion for credentialing is one way to ensure a higher profile of this role. Exploring adjunct appointments for clinicians with universities can also enhance the profile and professional identity of mental health nurses. New teaching and learning strategies that promote authentic simulated learning opportunities also need to be trialled and evaluated. Concepts such as simulation laboratories, arts laboratories and virtual reality
and multi-media programs can offer opportunities for learning, and critical reflection in relation to multidisciplinary teams. Consumers must also be involved in the development, implementation and evaluation of learning opportunities for students at both the undergraduate or postgraduate levels. An innovative model of utilising mental health consumers employed as lecturers has been successfully trialled in Victoria and this model could be adapted to suit higher education contexts (Happell & Roper, 2003).

Providing concrete opportunities for students to develop an understanding of mental illness is essential to challenge many of the deeply ingrained views that people have of mental illness. Nursing students should be empowered as lay ambassadors for mental health and nursing curricula must ensure that it inculcates the idea that being politically aware and active is a nursing responsibility. Nursing students could contribute to the ACMHN Ambassador Program by speaking out about how their understanding of the role of the mental health nurse has evolved during their studies. Mental health nurses are well placed to work with students through the Ambassador’s Program of the ACMHN, but also more broadly in learning activities during studies in mental health and while on clinical placement. The opportunity for mental health nurse academics to take up adjunct appointments in the clinical setting must also be explored and trialled. Mental health nurse academics can work with clinicians, providing professional development opportunities and contributing to the development of clinical learning programs for nursing students. They can also work with staff to develop an ongoing learning culture informed by research. As academics they are strongly placed to help students integrate their theoretical knowledge with clinical practice. How students perceive the role of the mental health nurse, the extent to which they view their time in mental health as positive, and its influence on their decision regarding mental health nursing as a career choice will be influenced by their undergraduate preparation.

Opportunities to access the perspectives of clients who live with serious mental illness such as psychosis or bipolar illness “helps students to see the person behind the diagnosis…people with the same hopes, wishes and dreams as the rest of us” (Happell cited May 2010, p.17). This can be achieved by developing educational resources including human resources such as mental health consumers and carers who can contribute to the student’s learning. Such strategies will promote nursing students’ understanding of the role of the mental health nurse through the unique and crucial perspective of the consumer.
5.5 IMPLICATIONS FOR PRACTICE AND EDUCATION

If there is to be a serious attempt to recruit and retain a viable workforce as outlined in the Victorian Government’s Mental Health Reform Strategy (State Government of Victoria Department of Human Services February, 2009) and the Victorian Government’s Mental Health Reform Implementation Plan 2009-2011 (State Government of Victoria Department of Human Services, 2010b), steps must be taken to promote and strengthen the professional identity of mental health nurses. Nurses suffering from stress tend to leave practice. This perpetuates the problem associated with low numbers of suitably qualified staff and the negative impact of what they relate to others about their work. Governments at all levels must invest in their workforce, if innovative programs are to have any chance of succeeding. This investment is not simply equated with remuneration. There should be a person-centred approach to supporting mental health nurses in their work and it is essential to build on clinical supervision and debriefing opportunities. Actively supporting reflective practices that enable clinicians to work through problematic issues, learn from them and integrate these new ways of learning into practice is fundamental to building resilience. Processes which value clinicians’ expertise and encourage their active participation in care decisions also promote resilience. When mental health nurses are clear about their role and feel supported by each other and the organisation, their capacity to work through stressful or distressing events will be enhanced.

From an educational point of view, it is imperative that clinical placements in undergraduate nursing courses be offered across a range of context areas in which mental health nurses work. As Happell (cited in May, 2010) stated, greater effort needs to be made in securing a range of clinical placement areas in mental health facilities other than just acute adult services. Older people’s mental health facilities, community mental health centres, community rehabilitation centres and Non Government Organisations are some examples of other clinical areas that need to be investigated. In making this assertion, the researcher is cognisant of the increasing competitiveness and difficulty in obtaining clinical placements for nursing students across Australia. Schools of Nursing in the higher education sector will have to develop new and innovative partnerships with other health disciplines and clinical agencies in order to secure and support clinical placements for nursing students.
Figure 5.1 diagrammatically illustrates the preceding discussion and shows how the expectations of the mental health nurse role are influenced by and impacted on by a number of factors. These factors include legislation and health care policy, the knowledge base regarding mental health nursing, the experience of team work within a multidisciplinary context and their work with consumers. Also taken into consideration are public perceptions of the mental health nurse role as well as mental health nurses’ own professional values and clinical experience. As previously discussed, if their role expectations are incongruent with the organisational role requirements, then role conflict, role ambiguity or role overload can result, leading to role strain. The mental health nurse will respond to role strain either by accepting the organisational role expectations, withdrawing from the expected role expectations, or shaping the role to accommodate both sets of role expectations. As a result, professional identity may become ambiguous, uncertain and reactive. Strategies for enhancing the professional identity of mental health nurses include documenting the effectiveness of their role through evidenced-based inquiry, expanding their role to reclaim nursing as part of their core business, building resilience as a professional group, promoting mental health nursing through stories of practice, and teaching mental health as core knowledge to nursing students to promote and strengthen professional identity in mental health nursing.
Figure 5.1: Promoting and Strengthening Professional Identity in Mental Health Nursing

Factors That Impact on the Role of the Mental Health Nurse
- Undergraduate and Postgraduate Education
- Legislation, Policy Directives and Models of Care Delivery
- Public and Professional Perceptions of Mental Health
- Changes to the Role of the Mental Health Nurse Role

Role Requirements Ambiguous & Conflicting

Professional Identity Ambiguous Reactive/Uncertain

Role Requirements of the Organisation

Role Expectations of the Mental Health Nurse

Role Expectations of the Mental Health Nurse

Role Requirements Clear & Congruent

Professional Identity Dynamic/Clear/Proactive

Strategies to Promote the Role of the Mental Health Nurse
- Evidence Based Inquiry
- Telling Stories About the Role of the Mental Health Nurse
- Being Involved in Decision Making
- Teaching the Value of Mental Health Nursing
- Working With Consumers and Carers
- Building Resilience
5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

This study provides opportunities for further research and curricula development in mental health nursing practice. Firstly, the professional identity of mental health nurses needs to be further explored. Secondly, this study has offered a number of insights into how a group of mental health nurses and student nurses have understood the role of the mental health nurse and further research will continue to develop this field of study. Thirdly, any further research in this area needs to thoroughly investigate the role of the mental health nurse across a variety of clinical contexts. At the time of this study, most related research has so far been conducted in community mental health settings. Areas such as rural and remote continuing care which may be community-based residential or rehabilitation settings, inpatient settings, and the private sector have not been explored in any great depth. Therefore, a research study, utilising a narrative research design, could be conducted into the working lives of mental health nurses across a range of clinical practice areas, including rural and remote areas. A narrative research design would help to ensure that the voice of mental health nurses is fully captured. It is also important to expand this study to other States and Territories in order to build a greater understanding of the factors impacting on the professional identity of mental health nurses. Additionally, this type of narrative research could be expanded to include consumers and carers and engage with the ways that mental health nurses impact on, and contribute to their experience of care.

Fourthly, research could also be conducted into specific nursing models of care to show how they contribute to positive patient outcomes. A study that explores mental health nursing interventions and their relationship to positive consumer outcomes across a range of clinical areas would be beneficial. Specifically, studies on nurse sensitive indicators in the acute care setting could be replicated in the mental health context.

It is imperative for mental health nurses to demonstrate how they contribute to positive consumer outcomes in all clinical contexts. Mental health nurses have lagged behind other specialties of nursing in exploring and documenting their contribution to positive consumer outcomes. They need now to demonstrate the extent and nature of their contribution. Otherwise they will continue to feel marginalized, experiencing role ambiguity and stress as their role continues to be defined by other professional and bureaucratic groups. As Doran et al. (2006) argue, nurses provide the most care in all sectors of the health care system. Therefore information about the impact of their
interventions on consumer outcomes is needed. There is an urgent need for mental health nurses to systematically explore their practice and contribute data about the impact of their care on consumer outcomes. This data will support the argument that they make an essential independent contribution to positive client outcomes, as well as being a central part of the health care team.

5.7 CONCLUSION

In this chapter the major findings and conclusions of this study have been presented and discussed in the context of Role Theory and the relevant scholarly literature. The implications of the findings in relation to policy and practice have also been discussed. The chapter concluded with recommendations for further research into this field of study.

This study was inspired by the researcher's long-term commitment to mental health nursing education and practice and her desire to help promote mental health nursing as a career choice.

The preceding chapters have demonstrated that mental health nurses believe their work makes a significant difference to consumers and carers. However, mental health nurses are frustrated by the dissonance between their professional role and the many factors that impact on it. In an already emotionally charged environment where mental health nurses encounter stress related to the nature of their work with the mentally ill, this dissonance destabilises their professional identity. This thesis has identified strategies that can assist in the recruitment and retention of mental health nurses and in the promotion of mental health nursing as a career choice to undergraduate nursing students. It is incumbent on the mental health nursing profession to embrace the opportunities provided by these challenging times. There is much at stake as mental health nurses work towards building a positive professional identity that will take them into the next decade.
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APPENDIX ONE:
ETHICS APPROVAL

Research Services
Office of the Deputy Vice-Chancellor (Research) (Melbourne Campus)

MEMORANDUM

TO: Ms Gylo Hercelinskyj
   Social & Cultural Studies in Ed
   Melbourne

FROM: Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 21 September 2006

SUBJECT: PROJECT: EC 85-2003 (Please quote this project number in future communication.)

BECOMING A 'PSYCH NURSE': RECRUITMENT, RETENTION AND PROFESSIONAL IDENTITY IN THE FIELD OF MENTAL HEALTH NURSING

Interim approval for modifications to this project, received 19 July 2006, was ratified by Deakin University HREC on 18 September 2006.

APPROVAL HAS BEEN GIVEN FOR MS GYLO HERCELINSKYJ, UNDER THE SUPERVISION OF PROF BARBARA KAMLER, SCHOOL OF SOCIAL AND CULTURAL STUDIES IN EDUCATION, TO CONTINUE THIS PROJECT AS MODIFIED TO 30 JUNE 2007.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Secretary immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HREC's.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Vicki Xafis
Secretary, DU-HREC
(03) 9251 7123
APPENDIX TWO:
INFORMATION FLYER
FOR MENTAL HEALTH NURSE PARTICIPANTS

RESEARCH ON ATTITUDES
TOWARDS MENTAL HEALTH NURSING

MY NAME IS JULIE HERCELINSKYJ AND I AM SEEKING PARTICIPANTS WHO CURRENTLY WORK IN MENTAL HEALTH EITHER AS NEW GRADUATES OR EXPERIENCED MENTAL HEALTH NURSES TO PARTICIPATE IN A RESEARCH PROJECT THAT I AM UNDERTAKING AS PART OF MY DOCTORAL STUDIES.

THIS PROJECT WILL EXPLORE YOUR ATTITUDES TOWARDS YOUR WORK AS MENTAL HEALTH NURSES THROUGH GROUP DISCUSSION AND INTERVIEWS AND CONSIDER SOME OF THE FOLLOWING QUESTIONS.

WHAT ATTRACTED YOU TOWARDS MENTAL HEALTH NURSING?
HOW WOULD YOU DESCRIBE YOUR WORK?
WHAT ARE YOUR THOUGHTS ABOUT THE PUBLIC PERCEPTION OF MENTAL HEALTH NURSES AND THE WORK THEY DO?
HOW REALISTIC DO YOU THINK THESE VIEWS ARE?

IF YOU ARE INTERESTED IN PARTICIPATING OR WOULD LIKE MORE INFORMATION, PLEASE CONTACT ME ON THE FOLLOWING PHONE NUMBER OR BY EMAIL.

PHONE: 9244 6623
EMAIL: jh@deakin.edu.au

THANK YOU

JULIE HERCELINSKYJ
My name is Gylo (Julie) Herclinskyj and I am enrolled in a doctoral program at Deakin University. My supervisors are Associate Professor Barbara Kamler and Dr. Julie McLeod. My project is called: Becoming a ‘psych nurse’: recruitment, retention and professional identity in the field of mental health nursing. I would like to invite you to participate in this project.

The problems in recruiting mental health nurses have been well documented in recent times. There have been a number of government and industrial initiatives that have sought to attract nurses to this area of practice. My project will investigate factors influencing rates of recruitment and retention; in particular I will explore the factors shaping the professional identity of mental health nurses. Two groups of people will be involved.

i) Undergraduate nursing students who have completed theoretical and clinical experience in a mental health nursing

ii) Experienced mental health nurses who gained their qualifications either through a direct entry program or as a post-basic qualification.

This project will involve interviews with participants in each of the groups listed above. This discussion will last for approximately one to one and a half hours. You will be asked to reflect on how your experiences of and attitudes towards mental health nursing have been shaped. A selection of film excerpts will also be used to stimulate discussion and allow you to reflect on how representative you believe these images are of your role and professional identity. I will ask a range of questions to facilitate this discussion. Examples of questions that may be asked include: What sort of picture do the images you’ve just seen paint of mental health nurses? What attracted you to mental health nursing? ; How have your ideas about mental health nursing been influenced by your clinical experience? ; Why do you stay in mental health nursing? Are you interested in pursuing a career in mental health nursing following graduation? Have you ever thought about leaving mental health nursing? Each interview will be audio taped and transcribed verbatim for analysis. You will receive a copy of the interview to review and make any alterations you wish.

You will also be asked to complete a short form detailing aspects of your current employment or student status. Questions include the type of mental health facility you are employed at, the location of your workplace, the type of mental health service area you work in, areas of mental health practice you worked in during your clinical experience and if you would be willing to meet to discuss the transcript of our discussion if required.
These questions are important as they will enable me to provide an overview of the areas of mental health nursing experience and practice represented in the project. The information provided on this form will not be divulged to any other person or organisation.

When I transcribe the in-depth interviews, I will use pseudonyms for all participants and any information regarding institutions worked at. These interviews will be stored in a locked cupboard at Deakin University for a period of seven years, after which time they will be destroyed. Participation in this project is entirely voluntary. You are free to withdraw at any time during the study in which event your participation in the project will immediately cease and any information obtained from you will not be used and will be destroyed immediately or returned to you upon request.

Findings from this project will be presented at nursing conferences and published as journal articles. In these publications any reference to individuals will use pseudonyms, which will be different to those used in the focus group interviews. Copies of publications will be available you on request.

If you have any further questions about this project, please contact me on the address below. Otherwise please return the consent form for the focus group discussion and I will contact you to organise a convenient interview time.

Thankyou

Gylo (Julie) Hercelinsky
Faculty of Education
Deakin University
221 Burwood Highway,
Burwood 3125
Ph. 92446623
Fax 92446159
Email: jh@deakin.edu.au

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University, 221 Burwood Highway, BURWOOD
APPENDIX FOUR:
INFORMATION FLYER FOR
STUDENT NURSE PARTICIPANTS

RESEARCH ON ATTITUDES
TOWARDS MENTAL HEALTH NURSING

MY NAME IS JULIE HERCELINSKYJ AND I AM SEEKING PARTICIPANTS WHO HAVE COMPLETED THEIR THEORETICAL AND CLINICAL STUDIES IN MENTAL HEALTH NURSING TO PARTICIPATE IN A RESEARCH PROJECT THAT I AM UNDERTAKING AS PART OF MY DOCTORAL STUDIES.

THIS PROJECT WILL EXPLORE YOUR ATTITUDES TOWARDS MENTAL HEALTH NURSING THROUGH GROUP DISCUSSION AND INTERVIEWS AND CONSIDER SOME OF THE FOLLOWING QUESTIONS.

IN YOUR OPINION WHAT DO MENTAL HEALTH NURSES DO?
WHAT WERE YOUR THOUGHTS AND IDEAS ABOUT MENTAL HEALTH NURSING PRIOR TO CLINICAL EXPERIENCE?
HOW HAVE THOSE IDEAS CHANGED?

IF YOU ARE INTERESTED IN PARTICIPATING OR WOULD LIKE MORE INFORMATION, PLEASE CONTACT ME ON THE FOLLOWING PHONE NUMBER OR BY EMAIL.

PHONE: 9244 6623
EMAIL: jh@deakin.edu.au

THANK YOU
JULIE HERCELINSKYJ
APPENDIX FIVE:
CONSENT FORM FOR MENTAL HEALTH NURSE AND
STUDENT NURSE PARTICIPANTS

DEAKIN UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE
CONSENT FORM: INDIVIDUAL INTERVIEW

I, ___________________________________________________ of

hereby consent to be a subject of a human research study to be undertaken
by Gylo (Julie) Hercelinskyj and I understand that the purpose of the research is

(to be completed by researcher)

To reflect on the ideas raised from previous focus group discussion and explore through
an in-depth interview significant moments that have shaped my sense of professional
identity.

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the
research study, have been explained to me.

2. That I voluntarily and freely give my consent to my participation in such research study.

3. I understand that aggregated results will be used for research purposes and may be
reported in scientific and academic journals.

4. Individual results will not be released to any person except at my request and on
my authorisation.

5. That I am free to withdraw my consent at any time during the study, in which event
my participation in the research study will immediately cease and any information
obtained from me will not be used.
APPENDIX SIX:
PARTICIPANT DEMOGRAPHIC AND INFORMATION SHEET

Information sheet

Could you please take a few moments to complete this information sheet?
This information will be used for the purposes of:

- Identifying the range of clinical areas you are working in.
- Identifying the geographical location of your workplace/university.
- Indicating your interest in participating in the second interview.
- Representing a variety of views and opinions in the project

Please note this information is voluntary.

Name:

Gender: □ Male  □ Female

Location of Workplace/University: □ Rural  □ Regional  □ Metropolitan

Type of workplace:

□ Acute Adult MHS
□ AcuteAged MHS
□ Aged Residential
□ CAMHS
□ CAT
□ PGATT/APATT
□ PMHT (Primary Mental Health Team)
□ CCU
□ CRF
□ MST
□ CMHC
☐ Other (please specify) ______________________________

**Areas worked in during clinical experience**
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Would you be interested in being invited to a second interview?  ☐ Yes ☐ No

If yes how would you prefer to be contacted?

☐ Email __________________

☐ Phone __________________

☐ Mail ____________________

Thank you

Julie Hercelinskyj