PSYCHIATRIC/MENTAL HEALTH NURSING: POSITIONING UNDERGRADUATE EDUCATION

by

Sandra Matheson

A research paper submitted to the Victoria University of Wellington
in partial fulfilment of the requirements for the degree of
Master of Arts (Applied)
in Nursing

Victoria University of Wellington

2002

ABSTRACT

The effectiveness of undergraduate comprehensive nursing programmes to prepare nurses to practice in the field of mental health is of concern to practitioners, educators and service providers. A crisis in the recruitment and retention of nurses to this field of practice is often linked to the marginalised position of psychiatric/mental health nursing within the comprehensive curriculum. In this paper the critique of the mental health component of comprehensive nursing education and the questions that it raises are explored from historical, structural and ideological perspectives.

In order to locate the past and highlight its significance to where psychiatric/mental health nurses find themselves today some of the history of the asylum system and the development of psychiatric nursing in New Zealand within these structures are presented. Ideological changes to the way mental health was thought about and responded to have had considerable impact on where psychiatric nurses practiced, how they practised and what they were named. This created the need for a different kind of nurse and has led to changes in the education of nurses.

The structural influences on the training and education of nurses are identified through relevant reports and their recommendations and significance in relation to psychiatric/mental health nursing are examined. Issues deriving from the critique of undergraduate psychiatric/mental health nursing education highlight the urgent nature of the crisis and draw out the multiple and competing discourses that inform the education of nurses. In acknowledging that the crisis can be viewed from multiple perspectives the need for responses from multiple levels involving the Nursing Council of New Zealand, the Ministry of Health, the Mental Health Commission and nurses in education and practice are recommended.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

DELIBERATIONS

What is the purpose of this paper? What is the motivation for choosing this topic? How will the topic be approached?

As a nurse teaching psychiatric/mental health nursing in a comprehensive undergraduate programme I have become increasingly aware of a disquieting commentary on the inability of these programmes to prepare nurses with both the skills and the inclination for the practice of psychiatric/mental health nursing. This awareness has made me curious about the questions this commentary raises with a view to understanding and clarifying the current situation. On the surface this might seem straightforward but my reading of the professional literature, relevant reports and research has revealed multiple and competing analytical discourses on the education and practice of psychiatric/mental health nurses. A single authoritative description of the situation is therefore not possible or desirable. However it is possible, using current and less recent literature to see some of the critical issues facing the focus of the discipline and the legitimacy of its many and varied practices.

The critique of undergraduate psychiatric/mental health nursing education raises for me the question, "what is the focus for mental health nursing?" By focus I mean the unique nursing response to a persons mental health difficulties and the nursing knowledge that underpins that response. I have deliberately left the word psychiatric out of this statement because its inclusion can tend to skew the view of the work or role of the nurse. I draw attention to this omission because the divide between psychiatric and mental health nursing is one of the threads weaving through this paper. Why this paradox should exist is the result of ideological, historical and structural influences on the development of mental health care. These influences provide a framework on which to base this paper. The amalgamation of these two seemingly conflicting terms is an uneasy one and highlights the tensions in defining the particular focus for psychiatric/mental health nursing. Clarity over this would be of benefit to nurses like myself who are involved with the education of potential psychiatric/mental health nurses but a consensus may never be reached. I want to acknowledge also that my only claim to the title nurse is through registration as a psychiatric nurse since 1984. I honour this by using the term psychiatric/mental health to refer to the work of the nurse in this paper but with the awareness that this language is problematic.

The lack of an authentic nursing approach to mental health care has, according to Hopton (1997) a mental health nurse and lecturer in Applied Social Studies at The University of Manchester, created a crisis of legitimacy for mental health nursing. He argues that psychiatric/mental health nurses have embraced fashionable theories about mental health from other disciplines like counselling and psychotherapy and have neglected to critically examine much of the psychiatric theory upon which many of their practices are based. Examples of these practices include seclusion; observation; electro-convulsive therapy (ECT); diagnosis/medication and compulsory treatment under Mental Health Legislation. Other nurses writing from this perspective like Barker, Reynolds and Stevenson (1997), Crowe (2000), Hall (1996), Horsfall (1997), and Peplau (1995) also question the medically driven focus of psychiatric nursing. They suggest that the adoption of a largely biomedical orthodoxy to the management of mental health difficulties has restricted the development of authentic nursing practice.

Alternatively Gournay (1996), Gournay and Ritter (1997), Lowery (1992), Trnobranski (1993) and Trygstad (1994) insist that the focus for knowledge development should align more with empirical modes of inquiry. Gournay and Ritter go as far as to describe the poor condition of mental health nursing research, claiming that too many studies are based on qualitative uncontrolled methodologies rather than that gold standard, the randomised controlled trial. Indeed some nurses like Lowery (1992), Flaskeraud and Wuerker (1999) and McBride (1999) maintain that biological psychiatry is now a reality, so psychiatric/mental health nurses need to adapt their practices to fit with neuro-biological and genetic beliefs about mental health difficulties. Does this mean that nurses need to learn neuro-anatomy, biochemistry and genetics and to be familiar with computed tomography (CT) and positron emission tomography (PET) scans so that they can educate people about the causes of their distress? Is this the work of nursing? Does knowing the medical origin or cause of a mental health difficulty really help with managing the realities associated with living it?

There seems to be some truth to the assertion that psychiatric/mental health nursing is more drawn to qualitative methods of developing knowledge. Cutliffe and Goward (2000), two nurse educators, posit that psychiatric/mental health nurses are drawn to the qualitative paradigm to generate knowledge of and for the discipline because there is a

synchronicity between the qualities of qualitative research and the practice of psychiatric/mental health nursing. They have identified three themes to this synchronicity: the purposeful use of self; the creation of an interpersonal relationship, and the ability to accept and embrace ambiguity and uncertainty.

How does a teacher work with the lack of agreement evident from these two conflicting positions? It is so important for nursing educators to get it right, but right for whom? Questions such as "what do students need to know", "how should they know it?" and "how can what is known best be assessed?" are very problematic when there is a variety of different answers to consider and none of them certain.

Nurses and nurse educators are not alone in their concern over mental health care. The rise of a vocal and influential mental health users movement during the early 1990s suggests that levels of dissatisfaction with current provision of mental health services are sufficient to galvanise people into organised and focused action. It would be a mistake to assume that users of mental health services are composed of a homogenous group of people with shared meanings, experiences, ideologies or agendas. However varied the people who use mental health services are, clearly they have some very important insights into what works and what does not in relation to how they are helped to manage their experiences and, at a more fundamental level what they are named. The mental health users' movement like other civil rights movements has grown out of a quest for self-determination and resistance to the way medical psychiatry interprets mental disorder and the implications this has on its treatment and management. As a result the status of medical psychiatry and therefore psychiatric/mental health nursing as experts on mental disorder is under question. Breggin (1993), Busfield (1996), Cooper (1980), Laing (1982) and Szasz (1971) have all provided compelling critiques of bio-medical psychiatry. It is not the intention of this paper to demonise psychiatry - I acknowledge the positive contributions made by mainstream medical psychiatrists - but it is important for nurses to take these critiques seriously.

The considerable curiosity generated by these issues and uncertainties drives the purpose of this paper which is to explore the complex interplay of critique, ideology, history and structural influences shaping and moving the teaching, learning and practice

of psychiatric/mental health nursing. In light of the uncertain and unstable nature of psychiatric/mental health nursing knowledge this paper seeks to explore, wonder and question, and to suggest and offer views that I hope will reveal the associated uncertainties and ambiguities. Vignettes are used to present other voices or views sometimes mine, sometimes others'. The viewpoints taken are descriptive rather than prescriptive; partial, not total, and framed around a series of questions that channel the content and analysis of each part to the paper. Each section therefore is self-contained and the paper may at first give an impression of being fragmented and disordered. The importance of each becomes evident when the threads are drawn into conclusions that position psychiatric/mental health nursing undergraduate education within historical, ideological and structural contexts. The significance of this work lies in pulling together the multiple and competing threads in order to put the teaching and learning of psychiatric/mental health nursing into the context of social change, practice and education. By connecting past events to present realities a foundation is laid for finding a way forward.

The early history of mental health care is drawn on to explain how psychiatric institutions came to exist at all and how eventually nursing came to be connected to the care of people with mental health difficulties. Maintaining the historical perspective, views of psychiatric nursing practice from a New Zealand context are then presented and located prior to the transfer of nursing training to tertiary institutions. The next section picks up on changes to the training of nurses and examines the recommendations of significant reports as they relate to psychiatric/mental health nursing. Views of undergraduate psychiatric/mental health nursing education within the comprehensive nursing curriculum follow. In this section the various issues forming the critique of comprehensive nursing curriculum are surfaced. The last section addresses the teaching and learning of psychiatric/mental health nursing and reveals some tensions between the many expectations. To conclude the many origins to the crisis facing psychiatric/mental health nurses and drawn from this exploration are merged and recommendations made. The paper begins however with some thoughts about language. That this should be the starting point may seem strange; however, one of the issues that has arisen for me during the process of researching this paper is the overabundance of terms, labels and language connected with the field of mental health.

The power of language to construct values, attitudes and beliefs needs to be addressed and some explanation of the terms used in this paper given.

SOME THOUGHTS ON LANGUAGE

Why are words important? What has it got to do with nurses?

I have already alluded to a paradox arising out of the term psychiatric/mental health nurse and that, although there are some problems with using the term, I am committed to it because it was my personal link to nursing. The terms psychiatric nursing and mental health nursing do not seem to refer to the same thing. Psychiatric nursing was taught and practised in psychiatric institutions. As they closed and nursing education became comprehensive, ideology changed, language changed and the term mental health emerged. The index for *The New Zealand Nursing Journal* (1988) refers to psychiatric nursing but in the following year it does not appear as a subject heading. Articles related to psychiatric nursing are found under the subject heading mental health. This change in nomenclature came about relatively recently with the focus on the psychosocial aspects of mental health, community care and a more holistic view of people reflecting another way of thinking about mental health.

There are a number of ways to think about and make sense of mental health difficulties and different approaches use different language to talk about what is going on. Based on the different assumptions about the origins and causes of mental health difficulties, the kind of response that would be helpful or useful is determined. Thinking about mental health difficulties as illnesses for example institutes a set of ideas, language and practices focused on medical diagnosis, treatment and cure. Working from this sort of model the person with a mental health difficulty is seen as having a disordered mind arising from a damaged or diseased body. The system of organising mental health difficulties into diagnostic categories has spawned numerous terms to define people's experiences but the process of being labelled or marked in this way reduces people to nothing more than their difficulties. This is one the most damaging and dehumanising forms of language (Perkins & Repper, 2001) and is particularly evident in the language of psychiatry.

The language of psychiatry and by implication psychiatric nursing connotes the medical model of understanding of mental health difficulties. But why should this be an issue? There are groups that argue that an illness construction of mental health difficulties

helps to demystify madness. They argue that seeing mental illness as a disease process with organic or genetic origins helps to reduce stigma and allows treatment to reach more people thus diminishing the fear that madness engenders (National Alliance for the Mentally Ill, 1996). This argument assumes that social attitudes and beliefs about illnesses of the mind and illnesses of the body are constructed in the same way.

On the other hand explaining mental health problems as diseases can make people more fearful. Questions arise, such as "if I have a disease how can I be in control of my behaviour?" "How can I be trusted if a disease process or faulty genes is affecting my thinking, feeling and behaving?" In a study of public attitudes Nieradzik and Cochrane (1985) found that deviant behaviour is more likely to be tolerated if it is not given the label of mental illness. When participants in the study were told certain behaviour was related to mental illness they were more likely to say that they did not want to live in the same vicinity as the person with the behaviour. When the behaviour was explained as a result of traumatic life experiences people were more likely to tolerate and less likely to exclude the person.

Choosing the right words to talk about mental health from a nursing perspective is therefore very important but also problematic. There are many terms to choose from when referring to a person who uses mental health services ranging from "patient", "client", "consumer", "user" and "recipient" - all bringing different connotations. Shifting the language away from the connotations of illness, diagnosis and patient-hood is part of a project to reduce the stigma of mental health difficulties (Mental Health Commission, 1997; Mental Health Commission, 1998). The language of "mad pride" on the other hand resists attempts to minimise difference through the use of inclusive language (see Shaughnessy, 2002) and this is another perspective of which nurses need to be aware.

As the deliberate use of language is one way to reduce stigma clearly nurses have a vital role in a project of this nature. In this paper many different terms are used and some of the language connotes unwelcome meanings. This is particularly evident and unavoidable in the parts with a historical perspective. The language called on in this paper reflects the period under scrutiny so terms like "lunatic", "defective" "deficient"

and "patient" are used where relevant. The relatively modern terms "mental health difficulty", "mental health problem" and "mental illness" are used interchangeably. Also when referring to a researchers work I adopt their terminology. Interestingly the changing role of those officially responsible for the welfare of people with mental health difficulties is evident in the language of the time. This begins in the prison with the gaoler and keeper, and then moves to the asylum with its attendants. The next section picks up this thread.

GAOLER, KEEPER, ATTENDANT – SOME HISTORICAL BACKGROUND

How did asylums develop? What were the most significant influences on their development? What connections can be made between past events and present realities?

To understand how and why psychiatric nursing emerged requires inquiry into why asylums came to be created when they did. Some views on the history of asylums are presented and linked with the New Zealand scene but I acknowledge two difficulties that exist in retelling this history. Firstly, my particular construction of the history can only be partial because I have made choices about what views to present and how to present them. Secondly, there are so many competing accounts, each providing different interpretations of the events and philosophies that were instrumental in the establishment of the asylum system and psychiatry, that it is difficult to know where to begin or end.

Pilgrim and Rogers (1999) refer to two rival accounts of asylum history. There is the "great man version" that is usually written by the successful and powerful and emphasises valiant deeds, altruism and humanitarianism. From this perspective the asylum system is viewed as a necessary part of medical progress and a humane way to manage lunatics and maniacs. The other accounts come from more critical perspectives, who challenge these conventional accounts and offer a range of alternative interpretations and explanations related to the wider-scale containment of social deviancy and issues of social control. There is disagreement within and among these revisionist ideas but Coppock and Hopton (2000) have identified three principles relevant to a critical understanding of the asylum system, psychiatry and mental health services. The first is that the process of recognising and responding to madness is a culture-bound activity. Second, what constitutes madness is uncertain and unstable. The third principle is that mad people, psychiatrists and psychiatric institutions (and psychiatric nursing) must be understood within their sociological contexts

The building of asylums was a social phenomenon that began in Europe at the end of the eighteenth century and extended to the colonial outreaches of Australia and New Zealand. During the early colonisation of New Zealand those who were considered

socially undesirable were sent to the gaol for safe keeping. This included debtors, drunkards, deserters, waifs and strays, prostitutes, vagabonds and lunatics. Mentally disordered behaviour was seen as a problem of law and order, so lunatics were sent to gaol when they upset the peace (Hunter Williams, 1987; Shorter, 1997). Lunatics were also accommodated in general hospitals in the 1850s until overcrowding led the public to demand that they be accommodated in purpose built asylums rather than prisons or hospitals. The Lunatics Ordinance 1846 was the first legislation associated with mental disorder in New Zealand and detailed a criminal code for persons dangerous to the community. In 1867 the idea of a single central asylum was debated in the House of Representatives as an alternative to a regional network. It was suggested that a central asylum might be more economical in serving the needs of the whole country but the idea was abandoned eventually due to reduced accessibility for visitors (Brunton, 1986; Mackie, 1972). Eventually a network of provincial lunatic asylums was established throughout New Zealand and by 1876 there were eight asylums in New Zealand under the control of the Department of Lunacy, these institutions were governed by the Lunatics Act of 1862 (Division of Mental Hygiene, 1948).

The nature and function of the asylum has been analysed from several perspectives by critical historians such as Foucault (1967), Jones (1993), Morall and Hazelton (2000), Scull (1979) and by sociologists like Goffman (1961). The analyses these writers have undertaken interpret the asylum structure as an architectural device, a complicated machine of many parts and a total institution designed to contain, control, treat, discipline and punish. The asylum is an example of a total institution because every aspect of patient living (and to large extent staff practice) is detailed, regulated and restricted. The means by which the institution's smooth functioning is maintained and upheld begins during the admission procedure where a series of personal losses begins the process of extinguishing the person's individuality and self-concept.

Goffman (1961) describes a process of mortification of the self occurring in asylums beginning with the loss of an identity kit - that is, the equipment and possessions enabling a person to present his/her usual image to others such as clothing and cosmetics. In addition, there is a violation of information: facts about the person that would ordinarily be concealed are collected, recorded and made readily accessible to

staff. Then the person is expected to undertake imposed routines, activities and roles that may well be alien and unwanted.

A sociological perspective taken by Carpenter (1980) and Pilgrim and Rogers (1999) sees the genesis of the asylum era beginning in the nineteenth century when large numbers of people were bought together in urban settings at a time of profound social change. With large numbers of people condensed into relatively small urban spaces, behaviour that was different or deviant became not only more noticeable but also less tolerable. A new market economy had disrupted traditional means of support and produced a new definition of social deviancy. Accordingly a sorting process took place where the poor but able-bodied (those fit to work) were sent to workhouses which were oriented towards instilling proper work habits, and those that could not work (which included those deemed insane) were sent to asylums. From this sociological perspective the need for institutions like workhouses and asylums is a product of urbanisation, industrialisation and the rise of capitalism, with its demand for wage labour. Carpenter (1980) links the proliferation of asylums during the Victorian era to a widespread obsession and fear of contagion. One positive outcome of this mindset was the establishment of the great systems of sewers and drains to manage contaminating effluvia. Asylums according to Carpenter fulfilled a similar function.

Meanwhile by 1876 in New Zealand there were 783 people in asylums. By 1946 the total number of patients on registers held by the Division of Mental Hygiene was approximately 9,000. In 70 intervening years the patient population had increased 11 fold (Division of Mental Hygiene, 1948). How might this increase be explained? It is not surprising that, in fact, New Zealand's increase follows the pattern of the United Kingdom even though New Zealand was a young colony with all the challenges that accompanied rapid growth. Brunton (1967) discusses the dilemmas facing those involved in the welfare of the mad in the 1860s. His examination of the Nelson Asylum records reveals recurring conflict over the definition of lunacy. Was it a disease or a crime? What was the purpose therefore of an asylum? Should it be a hospital for treatment or a prison for reform?

Notwithstanding the above descriptions of the asylum regime, ideas and attitudes regarding madness were changing towards a more benign and humanitarian approach. No longer thought of as base animals, the mad were now thought to have lost their self-control and were suffering from conditions from that were not their fault. It is suggested by Jones (1993) that a new social conscience and philanthropic impulse galvanised a period of reform and with the emergence of more sophisticated and enlightened views of madness the idea of moral treatment arose.

The aim of moral treatment was to help the patients to control themselves and it was thought necessary to separate the insane from family and friends – in this way the lunatic could be taught and shown self-control by the benevolent and authoritative doctor/father and his representatives, the attendants. The asylum was to be orderly, clean and bland and was to run to strict routines so proper that work habits could be instilled in the patients. Attendants were required to model behaviours that upheld quiet and dignified control with the intention that this would eventually permeate into the patients reality (Brunton, 1986).

The treatments associated with moral treatment were non-medical and included the need for compassionate attendants and pleasant natural environments to encourage the return of self-control (Zilboorg, 1941). It would appear that the success of moral treatment depended a great deal on the personal qualities of those caring for the patients and the relationships they developed with them. There is a hint of Nightingale's nursing theory here and according to Church (1987) she had a very important influence on the development of psychiatric nursing in the USA.

Moral treatment was short lived however and it is suggested by Pilgrim and Rogers (1999) that its underlying humanist principles failed to transfer from the early and small charity hospitals like the York Retreat to the larger state-run asylums. The Industrial Revolution had helped to cement the superiority of science over religion and running

parallel with the establishment of the asylum system was the ascendancy of the medical profession. Scientific discoveries like anti-septics, germ theory, psychotropic substances, genetic theories and X-rays contributed to the growing esteem of the medical profession and gave credibility to its claims of how to think about, diagnose and treat insanity.

So how/where was nursing positioned during the asylum period? This is discussed by Carpenter (1980) who locates an essence of nursing theory in the idea of moral treatment. This treatment was not provided by nurses however, but by mainly male attendants and was only practicable in small institutions. Carpenter cites John Connolly, Superintendant of Hanwell, who advocated a ratio of one attendant to 15 patients for public asylums and who regarded the attendant as the most important feature of an asylum's regime. In public asylums with large patient populations, the attendant was especially important to the system of moral treatment because there were insufficient doctors to supervise every aspect of treatment. Responsibility was delegated to attendants who became intermediaries between the doctor and the patient. Gaining formal control over the hiring, training and discipline of attendants was therefore vital for asylum superintendents to establishing their institutional authority, and this pattern is evident in the New Zealand scene in the early 1900s. The medical version of a proper attendant was systematised in the *Handbook for attendants on the insane*, first published in 1885 and surviving with revisions until the mid-twentieth century. An important aspect of an attendant's role was considered to involve instilling acceptable behaviour through example. In reality, attendants were increasingly left with enormous responsibility to carry out procedures and treatments unsupervised (Nolan, 1993).

As institutions grew in size and numbers of patients, medicine and psychiatry became more firmly established and the philosophy of moral treatment became less realistic. The move to custodial care began with the fall of humanism and the rise of psychiatric materialism (Horsfall, 1997).

Eugenic ideas and Degeneracy Theory heavily influenced the ideologies infusing early psychiatry. These theories linked socially undesirable behaviours with the tainted gene

pool of the lower classes. This general attitude towards psychiatric care in the early 1900s is well illustrated by the following quote from a nursing textbook of the era.

> … what is true with regard to the breeding of animals – that poor stock will produce poor stock is equally if not more certain in the case of man. This is bourne (sic) out by the fact that…practically every asylum report shows that in 50 per cent of the cases defective heredity (which includes insanity, imbecility, alcoholism, epilepsy etc) is present. In other words the stock from which the patients spring is poor… (Hughes, 1909, p.37)

Nursing practice as discussed by Crowe (1997) is always influenced by social and political structures, which determine the nature of the nurse's relationship with the person. This suggests that some of the first psychiatric/mental health nurses were taught ideas that asked them to practice from a position of moral superiority and with a view of the person as being contaminated, corrupt and in need of sanitising and correcting. A view of the person with mental health difficulties as somehow tainted or contaminated was validated by the official language of the day and enacted through the geographical isolation of institutions. The New Zealand government agency responsible for the management of mental illness in 1946 was part of the Department of Health and was called the Division of Mental Hygiene, reflecting the philosophy of sanitation underpinning the provision of services.

An interesting feature of the early asylums built in Karori, Christchurch, and Dunedin is that they were originally managed by lay administrators and the attendants were almost exclusively men (Department of Health, 1972). This point is picked up by Brunton (1986) who has established that all but one of the early asylums worked under a dual system of authority shared between visiting medical officers and lay keepers or superintendants. Apparently this system worked well. The shift from lay management to medical management and state regulation began with The Lunatics Act of 1868 and the creation of an Inspectorate of Asylums in 1880. Medical control of these institutions it was argued would ensure an adequate standard of care and offer treatment in the form of moral management. At this time attendants were employed in asylums rather than nurses who had not as yet established a place in the asylum structure. Papps (1997) discusses the development of a psychiatric nursing identity in New Zealand

through formalised training systems. Papps reported that psychiatric nursing did not receive the same attention from contemporary reformers such as Grace Neill or Dr Duncan MacGregor as did general nursing. Even as an asylum inspector with authority in the management of asylums and the power to dismiss staff, Dr MacGregor had little influence over the employment of staff. Asylum administrators were independent in this aspect of management.

The separate development of psychiatric hospitals within the health system in New Zealand up until the 1970s was a consequence of central control by the Department of Health. As a result mental health services developed in geographical, social, professional and political isolation from other health services. The transfer of responsibility for the administration of psychiatric hospitals to individual hospitals boards in 1972 was considered a milestone at the time (Mackie, 1972). Being scattered and isolated might explain why attendants were not included in or considered for the formalised training systems for nurses that led to registration under the Nurses Registration Act 1901. On the other hand asylum workers may have not wanted to see themselves as nurses. Institutionalised gender discrimination was entrenched at this time. The identity of nursing brought with it connotations of women's work and the majority of attendants were men. Nolan (1993) has begun to explore the role of men in psychiatric nursing, their origins (often as ex-servicemen) and the strong ties between the work and families of male attendants.

Nursing does not appear to be strongly connected with caring for the mentally disordered in either an ideological or practical sense at this early stage although by 1890 some asylums had appointed trained matrons, and a form of on-the-job training for attendants had begun (Department of Health, 1972). How did nursing eventually come to be associated with asylums? This question is considered next in an exploration of the views of psychiatric nursing.

VIEWS OF PSYCHIATRIC NURSING IN NEW ZEALAND

**Who were the nurses? What were they doing? What did they learn?
How did they make sense of their work?**

The separate development of mental health services meant that formal training for nurses in the psychiatric field did not begin until 1905 (Bazley, 1973). The first hospital Final Examination for what was known as Mental Deficiency Nurses was prescribed and conducted by the Division of Mental Hygiene in 1907. Although this qualification conferred the status of trained nurse it did not provide for registration under the Nurses Registration Act 1901 in the same way as nurses trained in general hospitals (Papps, 1997).

In 1925 the conditions in public asylums had been the subject of a comprehensive inspection and as a result the Minister of Health Sir Maui Pomare instigated the reorganisation of mental hospitals. Following Britain's pattern, this consisted of simply building more hospitals. Accordingly mental hospitals proliferated in size and number. In Nelson for example between 1925 and 1939, 13 villas, a bakehouse and nurses' home were constructed. A bowling pavilion in 1948 and hairdressing salon in 1949 followed (Maloquin, 1970).

VIGNETTE

(Letter to Inspector-General, Mental Hospitals Department, Wellington 1925)

...the washing for over 400 persons including staff and 70 defective boys 54 of whom are "wet and dirty" has to be done by some 20 female patients under the direction of two nurses: and these unfortunate women have to work under the worst conditions possible standing over the wash tubs on a soaking wet floor for hours on end. (Gray 1925)

Public psychiatric hospitals were not approved as training schools for nurses until 1939. The three-year hospital programme for registration as a psychiatric nurse was the responsibility of the Department of Health. In 1947 the regulation of psychiatric nursing became the responsibility of the Nurses and Midwives Board, a statutory body concerned with nursing registration (New Zealand Nurses Association, 1984). During these changes to the training and regulation of psychiatric nursing, asylums and psychiatric hospitals were becoming well established.

The structure and organisation of a large psychiatric hospital was different to that of a general hospital. Whereas the general hospital is geographically located for easy access the psychiatric hospital was deliberately built away from towns and cities. This geographical isolation made it difficult to attract and keep staff. An article published in *The New Zealand Nursing Journal* (1948) courtesy of the United Kingdom High Commissioner glorifies the lives and work of psychiatric nurses describing beautiful buildings set in lovely country surroundings. The author attempts to communicate an impression of civilised society and therapeutic optimism with the aim of attracting people (women) to the field. The full and varied social life is described in alluring terms thus;

> She has a pretty bedroom of her own and the use of staff lounges and recreation rooms, swimming bath and library, and – in the modern hospitals – of shampooing rooms, laundry and sewing room. It is an added incentive to competitive endeavour, to share training, nursing duties and off-duty times with colleagues of the opposite sex – and how useful they are for hospital dances and theatricals! (Marshall, 1948, p.216)

Marshall (1948) acknowledges the brilliant male nurses to be found in the psychiatric field who received identical training to their female colleagues but of course received higher salaries. In this article the growing status of psychiatric nursing is linked to the complexity of modern psychiatric treatments. Therefore the modern psychiatric nurse needed to learn;

> the most modern methods of treatment of such cases, including insulin coma treatment (frequently employed for schizophrenia); malaria inoculation treatment (for general paralysis of the insane, a form of treatment which demands the highest nursing skill); continuous narcosis; shock therapy; drug treatment, and so on. In the surgical wards she learns to nurse cases who have undergone most delicate brain operations including the now perfected prefrontal lobotomy. (Marshall 1948, p.217)

The pursuit of rational scientific knowledge about mental illness was and is the aim of modern psychiatry. It was then thought mental disease could be eliminated through

systematic organisation and through treatment in purpose-built institutions designed to segregate "embodied irrationality" from everyday life (Pilgrim & Rogers 1999, p.161). Psychiatric nursing emerged under the patronage of psychiatry (Wilson & Kneisl, 1992) and the damaging effects of this influence on the development of authentic nursing practice has been critically examined by Barker, Reynolds and Stevenson (1997), Hopton (1997), Hall (1996), Horsfall (1997), Nolan (1993) and Sines (1994). The founding of psychiatric institutions and the evolution of psychiatry through the collective control of large numbers of patients are contentious issues. Institutions for the mentally disordered by nature operated along custodial lines and they were frequently over-crowded and understaffed. Speaking of her experiences as a nurse in a typical large psychiatric hospital in New Zealand during the war years Ames (1970) reveals that;

> Conditions were not good either for patients or staff in those days. Patients were people apart, a different species, mad or bad, and nursing was involved in keeping the patients alive and secure. Whatever one felt as a nurse, however frustrated one became, strict limits were imposed by an authoritarian regime and the attitude of the community which, at all costs must be protected from our patients. (p.23)

Holland (1975) relates her experiences in late 1953 at Sunnyside Hospital where;

> Nurses duties were confined to custodial care and rigid control of patients and where locked doors, heavy sedation, mechanical restraint, and unmodified electroconvulsive therapy were used. At no time would a nurse question the authoritarian system. He/she was there to carry out the instructions given by the doctor to the matron or head male nurse and from them to the ward charge on down to the nursing staff in the wards. The whole system appeared to function through fear. (p.24)

How could psychiatric nurses achieve public honour and dignity under these circumstances? Marshall (1948) refers to a "revolution" in the public's attitude towards diseases of the mind and the nursing treatment of them. What was happening to soften

the public attitude towards mental disorder? Nolan (1993) explains the changing public perception of mental disorder as the result of two world wars. Men returning from war as heroes but suffering from shell-shock could hardly be locked away as lunatics in asylums when they displayed characteristics of mental disorder. For one thing there were far too many of them. It is estimated that 100,000 servicemen suffered the effects of shell-shock in Britain. Talking treatments such as psychotherapy, group therapy and psychoanalysis developed rapidly during this period. According to Coppock and Hopton (2000) it is generally acknowledged that the influence of shell-shock and the growth of psychological treatment methods promoted a transformation in mental health theory and practice. When men of "good stock" returned home mad from the war it was necessary to rethink the causes of mental illness. Although these psychological theories opened up possibilities for the treatment of mental illness outside the asylum, very little changed for people inside asylums. Treatment continued to be primarily physical (mainly chemical) and the environment was overcrowded, authoritarian and understaffed.

There were however some significant forces beginning to shape the practice of psychiatric/mental health nursing during the 1950s. The development of psychological therapies like talking and counselling within a voluntary relationship offered nurse theorists like Hildegard Peplau a new paradigm to help explain the point of psychiatric nursing. Now that people with mental health difficulties

> **VIGNETTE**
> **(Echoes of ward orientation 1980)**
>
> ...Never forget that every time you unlock a door you must always re-lock it. Always.

were thought of as human, new approaches to care emerged. Peplau's (1952) theory of interpersonal relations in nursing is based on the body of knowledge used primarily in psychoanalysis and psychotherapy. It is one of the first explanations of psychiatric nursing which recognises that the work of the nurse occurs during the interactions with people (patients). Psychodynamic nursing is being able to help others identify felt difficulties, and to apply principles of human relations to the problems that arise at all levels of experience (Peplau, 1952). Nursing with this in mind meant making the nurse patient relationship central and seeing the patient as a person rather than a set of symptoms or behaviours with a label.

Increasingly from the 1950s onwards a growing body of critical work emerged that reflected a profound disenchantment with institutional care in all its forms (Pilgrim & Rogers, 1999). Russell Barton's *Institutional neurosis* (1959) and Goffman's *Asylums* (1961) pointing out the dehumanising and severe iatrogenic effects of long-term institutionalisation, are two examples of influential works. Barton in particular identified rigid and authoritarian attitudes of psychiatric nurses as one of the most significant factors contributing to the demoralisation and loss of motivation experienced by long-stay patients. Humanistic approaches raised issues about psychiatric hospitals reform and what to do with the thousands of now aging and dependent people that lived in them. Peplau's theory offered nurses another way to be with patients other than as a custodian. Simultaneously the development of major tranquillising drugs during the 1950s facilitated the management of people with mental disorders and along with treatments like insulin coma, ECT and psychosurgery helped foster a belief that a technological solution to the problem of mental illness was imminent.

These contrasting and potentially conflicting developments foreshadow the current debates within psychiatric/mental health nursing as to the proper focus of the development of nursing knowledge. On the one hand the pull of scientific progress, truth and evidence; on the other a concern for interpreting, understanding and managing existential human experience in all its chaos, uncertainty and ambiguity through the use of interpersonal skills.

The idea of the therapeutic community movement developed in Britain during the 1950s. Coppock and Hopton (2000) discuss the development of the therapeutic community as a uniquely liberalising movement within British psychiatry rising out of the Second World War. Working in military hospitals psychiatrists such as Tom Main and Maxwell Jones developed new approaches to mental health care based on the principle of discussing the problems of daily living in groups. The philosophy behind the therapeutic community is at the opposite end of the spectrum from that of custodial institutional care, so implementing new more democratic and enlightened practices within regimes that had operated along strict lines of authority, ritual and routine for many years would have been problematic. Nonetheless the development of major tranquillisers, together with the awareness of interpersonal relationships and group

dynamics, made it possible for nurses to manage the problems associated with mental health difficulties in other non-traditional ways.

One of the first references to the therapeutic community or milieu therapy in New Zealand psychiatric hospitals I could find is by Feringa (1970) who was a ward sister at the Fergusson Clinic at Sunnyside Hospital. In this article Feringa discusses the implementation of a programme based on psychotherapeutic principles in 1968. It yields some remarkable insights into the work of the psychiatric nurse and the changes in approaches to care like group therapy that this model prompted can be gained. In describing some of the routine practices of the time Feringa reveals a glimpse of the institution at work.

> In the admission ward, new patients arrived and were examined by the doctor, who prescribed medication and wrote a preliminary statement which included the provisional diagnosis. The patients would take part in activities, such as occupational therapy. As they improved they were transferred to the convalescent ward. From there they might go to work in other parts of the hospital, or remain in the ward to do various duties. All this was considered a part of their treatment... I realise now, how little we really knew about these patients. We might have known their "diagnosis" but did we know them as people... (Feringa, 1970, p.10)

The implementation of a new programme based on the principles of group psychotherapy represents on one level radical and progressive change and willingness on the part of interested and committed staff to put more enlightened approaches into practice. In reality it was difficult if not impossible to counteract years of tradition and the authoritarian and paternalistic nature of the institution. The following passage highlights these tensions,

> ...physical work was replaced by mental work in the form of group psychotherapy. All patients and staff were to attend. A doctor would take the role of therapist and one staff member would observe and write notes

on all the material that was discussed in "group" by the patients (Feringa, 1970, p.10)

Feringa (1970) admits that originally the team was unsure what group therapy was or why it was a better treatment. The staff learnt that "the important factor in group therapy is that patients are encouraged to take responsibility for each other by discussing problems together, learning to solve them if this is possible, or else accepting them and learning to live with them" (p.10). The emphasis of the new programme was to establish a largely self-governing group of patients with minimal supervision from the team. The idea of a self-governing group of patients existing in a psychiatric institution is an interesting concept. Although these changes were implemented with the best of intentions it has been suggested that the theories and practices of psychotherapy, when introduced into a largely custodial regime, can have the effect of making a system that routinely violates civil liberties seem more humane and benign than it really is (see Szasz, 1994).

Concurrent with the development of the therapeutic community and social psychiatry and the modern treatment it involved were: the changing role of the psychiatric nurse; the development of the multi-disciplinary team, and increasing professionalism in both medicine and nursing. For nurses the move to professionalism was dramatic and, as discussed by Truman (1984), occurred in several ways: nursing duties were narrowed and extended, there were developments in the education offered, and nursing was seen as having a place in management which was not subservient to the doctor.

The mid 1950s had seen the introduction of social workers and occupational therapists into psychiatric hospitals and these staff not only played a large part in the development of the therapeutic community concept (Van Lier, 1976) but they also had an impact on the role of the nurse. Therapy for patients in the form of industrial and occupational activities and prescribed by a doctor replaced the concept of work, and introduced the ideas of rehabilitation and deinstitutionalisation. The *New Zealand Nursing Journal*, March 1971 refers to industrial and occupational therapy as one of the latest trends in the rehabilitation of psychiatric patients.

The changing role of the nurse is also noted in the New Zealand Public Service Association (1974) *Report on Nursing Education*. It identified two problems in relation to the role of the psychiatric nurse in the multi-disciplinary team. There was concern about being left with the traditional aspects of care. Trainees had been recruited and trained to be instrumental in curing the ill and therefore expected to do so. They became dissatisfied with work that was more to do with caring than curing. This suggests that nurses wanted more involvement in therapy. The introduction of other therapists was thought to create confusion about who the central figure in patient care was and the nature of the treatment.

The deinstitutionalisation of hospital patients led to the development of community psychiatric nursing services. The first of these – the Psychiatric Home Visiting Nursing Service – was established in 1966 at Oakley hospital (Van Lier, 1976). The role of the psychiatric home visitor was "to maintain patients in the home with over-sight of medication, as well as giving psychological and social support. Education of the patients' families or friends was a further important task" (Van Lier, 1976, p.23). The shift to community care has been identified by Sanggaran (1993) as one of the main factors influencing the role of the psychiatric nurse. Psychiatric/mental health nurses were very aware of the move to community care although some doubted the motives underlying the policy. Carrington hospital had started reducing patient numbers during the 1960s and by 1976 there were around 1800 outpatients needing domiciliary nursing services. Psychiatric nurses had begun to move the focus of their practice from the institution to the community.

The move to community care represents not only a shift in the psychiatric discourse but a general paradigm shift with regard to health care. Ideas about where it was delivered were changing – the community was seen as key. Focusing on primary health care meant health services would need a different kind of nurse. The way all nurses were trained therefore needed a rethink.

CHANGES TO NURSE TRAINING DURING THE 1970s

What were the significant issues? Why were changes being sought? How do they relate to psychiatric nursing?

When the New Zealand Government approached the World Health Organisation in 1970 to undertake a major review of nursing education there were 126 basic nursing programmes being run at 62 different hospitals. It was generally considered that this system of training nurses was no longer suited to the needs of the health service or nursing students (Department of Health, 1988). Dr Helen Carpenter, Director, School of Nursing from the University of Toronto was appointed to make a report and the following terms of reference were agreed upon:

(1) To study pertinent information with regard to the system of education for nurses at all levels, and to consider this system in relation to the system of education for the other members of the health team.

(2) To study pertinent information and to secure the opinion of authorities concerning –
   (a) social change in New Zealand and the influence of this on recruitment, education and employment with the health services;
   (b) trends and developments in the health field;
   (c) trends and developments in education

(3) To make recommendations to Government with regard to the system of nursing education in the light of the findings. (Carpenter, 1971 p.8-9)

VIGNETTE
(Echoes of training)
In the third year of my training I was rostered for six weeks of night shift, to an old, rambling Gothic villa alone with 45 women patients. It was a scary thought being so responsible for so many on your own. It's just the way it was.

Dr Carpenter was explicit in her responses; in her view reform was urgently needed in order to maintain the standard of New Zealand health services (Carpenter, 1971). She recommended that existing training programmes for nurses be phased out and replaced by nursing education colleges. The three-year programme in psychiatric and psychopaedic nursing would be *phased out* while the general training programme would be *revised* to include additional theoretical content and clinical experiences in psychiatric nursing. There is an

interesting message implicit in these statements – where psychiatric and psychopaedic programmes of training were to be *phased out*, the general programme would be *revised* to accommodate other branches of nursing. How could psychiatric/mental health nurses ensure they were accorded equal status when it came to the carve up of a revised curriculum?

Dr Carpenter conducted surveys and interviews and identified that:

(a) There is too little preparation for the heavy responsibilities a student must carry early in training.

(b) The heavy workload for students makes them neglect human relationships with patients.

(c) Following rigid rules in wards has no training value and constitutes a poor learning situation for students.

(d) Tuition in nursing schools does not have sufficient depth or breadth of knowledge.

(e) Lectures given by tutors, doctors and other special lectures are poorly related to practical clinical situations.

(f) Students who are given heavy responsibilities in wards felt "treated like children" outside work hours and in particular in nurses' homes.

(g) There is a high turnover of tutorial staff due to their isolation from other teachers and conflicts with other nursing personnel (p.17-19).

Based on these findings Dr Carpenter recommended the Minister of Education appoint a committee to study a proposal for the development of colleges of sciences to prepare nurses for the health services. This committee was to recommend to the government the most suitable educational setting for these colleges (Carpenter, 1971).

The *Carpenter Report* was a controversial publication because it disrupted the dominant view of the nurse and highlighted the relationships of power between the various

stakeholders (Papps, 1997). However the Department of Health (1971) annual report notes that while there may be disagreement over some of the changes recommended, "there is substantial agreement by all interested groups that major changes must be made in the system of education" (p.79).

To take a more critical view it seems likely, initially anyway, that the shift from hospital based training to tertiary education settings radically altered or shifted relationships of power. When two powerful discourses, education on the one hand and the ultra-powerful medicine on the other, are both representing and shaping experiences of human health and illness there are bound to be tensions and conflict. The 1987 workshops held between nurse educators and service providers to discuss problems arising from mismatched expectations and misunderstandings of each others' roles, goals and needs highlight the existence of this power struggle (see *The New Zealand Nursing Journal* December, 1984).

It is fair to assume that in the transition from service based training to educational preparation of nurses, service providers experienced many losses. Not only did hospitals lose control over defining what the required skills should be and how they were learnt, practised and transmitted in a particular (medical) culture, they also lost a ready supply of cheap and obedient labour.

In July 1971 the Minister of Education appointed a committee to consider Recommendation 1.6 of the *Carpenter Report* and to report to Government on:

(i) the possibility of development of Colleges of Health and Sciences for the preparation of nurses;

(ii) the possible utilisation of existing tertiary institutions for education in preparation for health services;

(iii) the financial implications of any proposed change in the transfer of responsibility from the Department of Health to the

Department of Education for training in preparation for health services. (Department of Education, 1972 p.2)

The body that came to be known as the '1.6 Committee' was composed of what might be seen as key stakeholders in the areas of health and education. From another perspective however one might ask why there was such influential representation from areas that traditionally had nothing to do with nursing or nurse education. A gender imbalance is also evident in the 10 men to six women committee. The 16 members were; three from the Department of Health, three from the Department of Education, one each from the University Vice Chancellors' Committee, the Otago University Medical School and the Medical Association of New Zealand. The Technical Institutes Association and the New Zealand Nurses Association both had two representatives, and student nurses had one, as did the National Council of Women. There was no representation for psychiatric/mental health nursing. This is notable because psychiatric nursing services had developed separately from and independently of other branches of nursing. Their contributions had the potential to raise the visibility and importance of psychiatric nursing in light of an integrated curriculum. A further omission is representation from the Nursing Council of New Zealand. This oversight had implications for the first pilot programmes that surfaced later. The 1.6 Committee met on nine occasions between October 1971 and August 1972 to consider the wide range of issues and concerns related to the establishment of a new system of nursing education.

One of the issues given careful scrutiny by the 1.6 Committee was the location of nursing education and a consensus was not reached over this. Two members produced minority reports stating their opposition to the location of nursing education in polytechnics and these were appended to the final report that was published in September 1972. One member was the representative of the Medical Association of New Zealand – Mr G Wynne-Jones who thought that technical institutes were unsuitable places for the training of nurses because they were at best a continuation of secondary school. He advocated for nursing colleges. The other was the representative of the Hospital Boards' Association of New Zealand – Mr A G Wicks. Wicks felt that a two-year course was sufficient. His arguments were based on the advantages of the traditional system of training and the cost a new system would incur.

The 1.6 Committee debated the strengths and weaknesses for universities, teachers colleges, separately administered colleges of nursing and technical institutes as potential sites for the education of nurses. It was eventually decided that technical institutes would be most suitable because a number of health disciplines were already established there. This meant that the facilities for teaching physical and biological sciences were already in place. The environment would allow staff and students to interact with allied health professionals and formal tutor-training programmes were available. As technical institutes were accustomed to meeting the vocational needs of a wide variety of occupational groups nursing education could be incorporated without difficulty (Department of Education, 1972).

What agendas were driving the debate over the site for nursing education? The committee notes that, "with one or two exceptions the existing technical institutes are close enough to the clinical environment (hospital) to meet the requirements of our proposed new scheme" (p.19). Clearly nursing was very much identified with the general hospital since psychiatric hospitals are not found in town centres.

Addressing the idea of a university setting for nurse education the committee stated that, "there appeared to be no good reason for the setting up of nursing programmes in the universities for the majority of nurses". This exemplifies a general perception of nurses as doers not thinkers. Nursing could not be envisioned as a university-educated subject. Papps (1997) argues the over-education of nurses is a recurring theme in the writing about nursing education.

The 1.6 Committee specifically acknowledged the ability of technical institutes to offer remedial programmes for students who have deficiencies. Interestingly and subsequently the Ministerial Taskforce on Nursing (1998) has noted that a particular pressure for nursing educators is the nature of the polytechnic education where policies and processes designed to facilitate student success encourage repeated attempts to successfully complete a course.

The 1.6 Committee made 23 recommendations to the Minister of Education and of particular relevance to psychiatric/mental health nursing was the recommendation to transfer nursing education from the Department of Health to the Department of Education. The 1.6 Committee seemed to have little understanding or awareness that the training of psychiatric nurses and general nurses were quite separate. Another recommendation that is interesting, because of the use of language, is the move to prepare approximately 150 trainees for registration as general nurses. It is relevant to the themes of this paper to note the use of the term "general nursing" by the committee to describe the graduates of the first pilot programmes. This further suggests that the committee's deliberations had not recognised or identified other branches of nursing fully enough to be aware of the significance of their choice of language or the hegemony it helped reinforce. Yet the notion of comprehensive preparation was discussed at length by the committee as they deliberated over the nature, content, length and organisation of a "satisfactory programme" of nursing education so the term was familiar to them. The Department of Education (1972, p.4) stated that the "preparation for registered nurses should be comprehensive in nature, incorporating the basic content of general, psychiatric and psychopaedic nursing education programmes…". Perhaps issues of registration, registers and other statutory matters had not been considered fully due to the lack of Nursing Council representation?

These programmes then became the responsibility of the Technical Division of the Department of Education. The 1.6 Committee recommended that the programme of study hours be raised from 2700 to 3000 with 50% to be theory and 50% to be clinical practice and this remains the status quo. However, these 3000 hours were to be "fitted into" two-and-a-half years. Nurse trainees were to have student status in new programmes and the number of students admitted each year to the "general" course of nursing education was to be based on quotas set by the Department of Health.

The 1.6 Committee took the view that it was no longer appropriate to train nurses for the promotion of mental health and the care of the mentally ill in programmes separate from those aiming to prepare nurses in other aspects of health care and maintenance. They recognised that the traditional separation of mental health services from other health services was disappearing and nursing services were becoming more involved in

health promotion, illness prevention and community care, and so a different kind of nurse was needed. For psychiatric/mental health nurses this was particularly significant. With the process of deinstitutionalisation under-way the identity and practice of psychiatric/mental health nursing was already changing. On the other hand the committee was very clear that nurses were required to undertake more delegated medical tasks and more sophisticated technical procedures. This seems to contradict the idea of community care. It is interesting to reflect, some thirty years later on the assumptions behind the eventual recommendations and how a committee with two nurses out of a membership of 16, could be in the position of making such far reaching decisions about the focus of nursing practice.

The language of the report *Nursing education in New Zealand* by the PSAis revealing because it reinforces the image of general nursing as a paradigm for all nursing and implies general nursing having greater status. Another impression that can be gained is the haste with which the recommendations were to be implemented. Christenson (1976), a nurse educator responsible for developing the pilot programme at Wellington Polytechnic in 1973, describes working with a colleague "feverishly night and day to produce a curriculum before the students arrived" (p.24). The only guidelines received were that it "was to be a three year course with a minimum of three thousand hours of instruction, half of which should be clinical experience". The question of how the psychiatric/mental health component was developed or who was consulted in these original pilot programmes remains to be explored.

The Director-General of Health, Dr D P Kennedy is cited in *The New Zealand Nursing Journal* (June, 1971) and echoes the "a nurse is a general nurse" discourse,. In reassuring tones he states that, "The most that is envisaged in the immediate future are a couple of demonstration programmes – one for the community nurse and one for the general nurse – and then from there a phased development. The current nursing education system will be with us for many years to come" (p.10).

The Health Department's Nursing Division welcomed the recommendations contained in the *Carpenter Report,* particularly the one for an interim curriculum guide. This allowed registered psychiatric and psychopaedic nurses to qualify for registration as

general nurses. *The New Zealand Nursing Journal* (June, 1971, p.23) cites Bohm saying "This will give these nurses better opportunity than in the past to extend their education and advance their promotion in all fields of nursing". This statement raises the same issues implied in *The Carpenter Report* and Department of Education (1972). Would psychiatric nurses only be credible if they completed a general nurse training? Again, the notion of general provides a powerful construct for nursing identity.

At a meeting of Hospital Matrons in 1972 Margaret Bazley, the then Principal Nursing Officer at Sunnyside Hospital, discussed the implications of the *Carpenter Report* in relation to psychopaedic and psychiatric nursing (Bazley, 1972). Sunnyside hospital was a large psychiatric institution with a training school so the *Carpenter Report* was clearly relevant to Bazley. Her insights into recommendation 1.9.2 concerning the "Interim curriculum guide for psychiatric and psychopaedic nurses" present an interesting perspective. This was the most important recommendation in relation to registered psychiatric and psychopaedic nurses and it was of great concern to Bazley that nearly a year had passed since the publication of the *Carpenter Report* and nothing had been done to implement the recommendation. According to Bazley psychiatric nurses recognised that their training was incomplete but to undertake general training meant spending five years in basic nurse training. Furthermore it was only in 1970 that funding had became available to allow people, other than single females, access to the general training. Specific mention is made of this issue because there was some bitterness among the older male staff in particular who had wanted to complete the general training but had been denied the opportunity. The introduction of an interim programme to allow as many psychiatric and psychopaedic nurses as possible to gain the general qualification would in Bazley's opinion dispel resentment and reduce anxiety over the impending changes. The first integrated nursing programmes were actioned very quickly after the 1.6 Committee but the interim curriculum guide was not a priority.

The recommendation for the establishment of Colleges of Health Sciences for the education of nurses was very controversial. Acknowledging this controversy Bazley (1972, p.5) maintained that nurses could not recognise the "gross inadequacies in the present preparation of nurses" or see nursing as occurring anywhere other than in a

hospital. Nurse education according to Bazley should be centered on "people, their environment, and prevention of illness". She acknowledged that psychiatric nurses were being made increasingly aware that hospital nursing would constitute only a small part of the work of the psychiatric nurse of the future and in order to manage this change in function the preparation of nurses must be moved into the community. Recognising that nurses were now expected to function on an equal footing with social workers, occupational therapists, dieticians, psychologists and psychiatrists in a multi-discipline team. Bazley felt that the narrowly defined hospital training would not in fact enable nurses to be regarded equally with these other disciplines.

An interesting comment made by Bazley (1972) reflects some of the social attitudes of the day. It appears that there was much feeling among psychiatric nurses about the traditional type of nursing hierarchy and dedication to duty associated with general hospitals. This feeling along with the reluctance "of the male to be subordinate to any female – and certainly not to a 20-year old staff nurse in a general hospital system" (p.4), meant that psychiatric nurses would not support the setting up of a comprehensive-type programme at a general hospital.

The Public Service Association (PSA) has represented psychiatric/mental health nurses in industrial matters since 1913 and the shift from hospital training to tertiary education settings heralded the first of many significant changes to the context of psychiatric/mental health nursing education in about 60 years. In 1973 the PSA established a sub-committee to report on nursing education. Their report attempts to address some of the issues important to the practice of psychiatric and psychopaedic nursing. Critical of the two-year, two-term training scheme recommended by the 1.6 Committee it noted that,

> …a comprehensive programme of the length proposed by the Nursing
> Education Committee would have insufficient time to explore in depth
> the many important differences between mental and physical ill health. It
> could lead trainees to facile conclusions about the treatment and care of
> mental and physical illnesses particularly touching custodial and
> institutional care and the rehabilitation of patients into the community
> (New Zealand Public Service Association, 1974, p. 16)

What the PSA is acknowledging here is the particular and special knowledge of psychiatric nursing as practised in psychiatric institutions. The PSA sub-committee (1974) agreed with the minority report of Mr Wynn-Jones opposing the use of technical institutes for nursing education and advocated for nursing colleges similar to teachers' training colleges. They proposed a 3-year basic programme with the first year to cover general theoretical and clinical content followed by an exam. At this stage the student would specialise in either psychiatric or general nursing for a year and then complete and internship for a year.

The PSA sub-committee also identified changes to the role of the psychiatric nurse as occupational therapists, social workers, welfare officers, recreation officers and chaplains established their disciplines in Mental Health Services. Although the policy for the delivery of health care services was directing a change to a primary health focus, three hospital boards (Auckland, Palmerston North and the West Coast) perceived difficulties with comprehensive courses and continued to take students for their hospital based programmes. In 1984 all but one hospital board had closed their general obstetric programmes while four psychiatric hospitals still ran programmes (Cherrington, 1984). In 1987 *The New Zealand Nursing Journal* (August, p.6) reported that the chief nurse of the Auckland Hospital Board had recommended the termination of its three-year training programme. Although I have not located any official record of this I am aware anecdotally that the West Coast Hospital Board was the last to close its school of psychiatric nursing.

The introduction of a generic and integrated comprehensive nursing curriculum into the tertiary education setting in New Zealand as a result of *The Carpenter Report* (1973) recognised that hospital based training programmes were narrowly focused, restrictive and maintained the subservient position of nurses in relation to other health professionals. People who wanted to learn nursing were denied true student status and the skills of critical awareness and reflective thinking which are considered vital in facilitating the changing role of the nurse are typically absent in a training model. A tertiary-based education was assumed to redress these deficiencies in a number of ways: by reducing the influence of the medical model and providing a broader knowledge

base; through conferring the status of student on learners of nursing; by emphasising the links between knowledge (theory) and practice and improving responsiveness to ongoing changes in the role and scope of nursing (Perry and Moss, 1989; Russell, 1988).

Nursing programmes in technical institutes proliferated from 1973 onwards even though the programmes set-up as pilot schemes do not appear to have been formally reviewed. Technical institutes took over in an incremental way and nursing programmes brought in a lot of money. However access to placements in mental health institutions or psychiatric hospitals was difficult due the numbers of students and the reduction in bed numbers associated with deinstitutionalisation. The delivery of mental health services was changing and so what constituted clinical practice also needed to change. Nursing education has had to respond to structural changes in the location and practice of psychiatric/mental health nursing and ideological changes in the way that mental health is understood.

VIEWS OF UNDERGRADUATE MENTAL HEALTH NURSING EDUCATION

What are nurses saying about mental health nursing education? What are students saying about mental health nursing education? How is psychiatric/mental health nursing positioned within education?

The literature addressing the topic of undergraduate mental health nursing education raises a number of issues. The submerging of psychiatric/mental health nursing content in undergraduate curricula is a recurring theme and an area of long-standing concern. It has been linked rightly or wrongly with insufficient numbers of comprehensive nursing students choosing to practice as psychiatric/mental health nurses when they graduate. Sixteen years ago a frequently expressed opinion that psychiatric services were being shunned by comprehensive nurse graduates was investigated by Keene (1986). In this article on comprehensive nurse training and its impact on nursing Keene cites a PSA submission to the *Review of the preparation and initial employment of nurses.* The submission refers to the transfer of nursing training to technical institutes as "an unqualified disaster" for psychiatric nursing services because of students' inadequate preparation. Keene further notes an interesting but disturbing strategy, that is, the practice of bonding nurses. It is suggested that the majority of comprehensive nurses who started work in psychiatric hospitals were bonded and directed there, not necessarily by choice. The 1.6 Committee suggested bonding as a type of bursary or service agreement obliging the student to work where they were directed. This could have been to offset anxiety over staffing levels as students had provided much of the care in hospitals.

The link between the introduction of a generic curriculum, comprehensive nurse registration and the diminution of psychiatric/mental health nursing content in nursing curriculum is also raised by Prebble, (2001) who comments that:

> Although the introduction of comprehensive education expanded the preparation for psychiatric/mental health nursing by broadening its focus to include important social, cultural, bio-medical and educational knowledge, something was lost in the transition. The psychiatric/mental health culture with its unique body of knowledge is not adequately represented. (p. 136)

In a similar vein Clinton and Hazelton (2000, p.3) identify that, "the introduction of generic undergraduate programmes leading to Bachelor of Nursing degrees has had the effect of diluting the mental health content of nursing curricula". The idea of integrated comprehensive nurse education has been challenged by Henderson, (1990) who forewarned the implications of programmes that provided nurses with only superficial skills relevant to psychosocial nursing approaches and little if any instruction related specifically to the care of psychiatric clients. This point is elaborated by Prebble (2000, p.136) who referring to an increasingly voiced opinion in New Zealand, states that, "psychiatric/mental health nursing has been minimalised and marginalised within comprehensive programmes. As a result, nurses are not receiving the necessary grounding in the foundational skills and knowledge of mental health nursing". Prebble considers psychiatric/mental health nursing to be a distinct branch of nursing and warns that nurses will disappear from the mental health system and be replaced by other allied health professionals if this branch of nursing is relegated to the status of a sub-specialty.

What is the distinct nature of psychiatric/mental health nursing and what informs this branch of nursing? Is there a place for nurses in the delivery of mental health services? The development of generic competencies for the mental health workforce would seem to suggest that entry to professional practice in the field does not need to be through registration as a nurse. A model of core competencies, advanced core competencies and specialist skills has been developed to improve the effectiveness of the mental health workforce and to promote a recovery model. They are part of a co-ordinated strategy designed by The National Mental Health Workforce Development Co-ordinating Committee (1999). What special skills do nurses bring that are distinct to these competencies?

The 1996 report of the *National working party on mental health workforce development* (Ministry of Health, 1996) highlights a significant shortage of experienced nurses working in mental health. According to the MOH figures, in May of 1995 there were 209 vacancies in mental health for registered nurses in New Zealand. It was noted that while comprehensive nursing programmes provided a good general theoretical base on which to base specialist skills they were not producing graduates with the requisite skills in psychiatric nursing. In this report the level of the mental health component in

the comprehensive programme is seen as analogous to fewer numbers of registered nurses choosing mental health services as an area of practice after they graduate, although it is unclear how that information was gained. Recruitment is further reduced by the reluctance of employers to employ new graduates who do not have enough specialist skills.

In 1980 the total active registered psychiatric/mental health nurse workforce was 14% of the total active nursing workforce (Department of Health, 1982) and by 1984 it reached about 20% (Division of Nursing, 1985). But by 1994 the total active registered and enrolled nurse psychiatric/mental health workforce was 8% of the total active nursing workforce (National Mental Health Workforce Development Co-ordinating Committee, 1999).

Was the introduction of an integrated comprehensive nursing curriculum based on flawed assumptions? Would a graduate from a comprehensive educational system be just as capable or as interested in caring for someone with a mental illness as graduate who had spent three years in constant contact with people experiencing various degrees of mental distress? A study carried out by Wynaden, Orb, McGowan and Downie (2000) in Australia surveyed a convenience sample of third-year undergraduates to determine their perceived level of preparedness to work with people with mental illnesses. The results are based on 56 students who completed both the pre- and post-test questionnaire with a response rate of 90.3%. The findings raise important issues for nurse educators. Students indicated that their undergraduate curriculum was not comprehensive in nature and perceived that mental health nursing concepts were isolated and separate to other theoretical areas. Students felt prepared for general nursing but not for mental health nursing. The researchers have concluded, through student responses to statements concerning preparedness and emphasis on mental health nursing, that psychosocial aspects of care are confused with mental health nursing skills. It is not until the clinical component of the third year that students are able to differentiate the two concepts and skills. Although the researchers recognise the difficulty in generalising the result of this study, the finding that there is a need to define and clarify the concepts psychosocial care and mental health nursing care has significant implications for the content of comprehensive nursing curriculum. The researchers

found that though students' perceived that they were not attracted to the mental health care setting, exposure to mental health nursing concepts and positive clinical practice experience helped them develop more positive attitudes towards people with mental illnesses. This helped them to recognise the possibilities that practising mental health nursing offered.

This finding is also supported by a quasi-experimental study carried out by Rushworth and Happell (2000) that examined the relationship between exposure to the theory and practice of psychiatric/mental health nursing and the desirability of psychiatric nursing as a career choice. They found that students exposed to the theory and practice of psychiatric nursing increased their ranking of this area from seventh - to the third - most popular preference. A similar group of students who had not experienced knowledge and practice of psychiatric nursing maintained their ranking of this area at number eight.

Chan and Cheng (2001) also compared nursing students' attitudes towards mental health problems, before and after a course called 'Mental Health Nursing'. In this quantitative study carried out in Hong Kong, students who were surveyed showed less authoritative and restrictive attitudes and more positive and tolerant views of people with mental health problems after taking the course. This study further supports the view that knowledge and contact promotes a more positive attitude to mental illness in student nurses. Learning about psychiatric/mental health nursing is therefore an important step in the recruitment process.

Prebble and McDonald (1997) in a qualitative descriptive study, explored the experiences of four new comprehensive nurse graduates as they adapted to their roles as registered nurses in an acute psychiatric service setting. Interviews were conducted with the participants, focusing on their current work experiences and how the philosophical beliefs and values derived from their educational preparation fitted with the reality of the practice setting. All participants described a struggle to mould their personal values and beliefs about nursing around the reality of the acute mental health setting and major themes of conflict and contradiction are experienced in this struggle. All participants commented on a general lack of formal support, information and orientation and their great need for them. During their transition as new graduates, they

had to learn to rely on themselves and experienced a corresponding growth in confidence.

How effective has tertiary-based nursing education been in producing mental health/psychiatric nurses? Happell (1996) examined the extent to which tertiary-based psychiatric nursing education had been effective in producing a different type of psychiatric nurse. The results of this qualitative study identified significant distinguishing characteristics between tertiary graduates and hospital graduates. Positive characteristics considered typical of a tertiary graduate included a flexible approach to care, enthusiasm, a broader theoretical basis for practice, greater interest and willingness to work in community settings and a stronger professional orientation than their hospital graduate counterparts. The negative aspects of new tertiary graduates related to a perceived lack of clinical skills and unfamiliarity with the workplace conditions and routines. Tertiary graduates were more likely to be seen as lacking in competence and confidence due to this lack of familiarity though this was considered a short-term problem. This study identified lack of exposure to workplace conditions and routines as the most significant criticism of tertiary graduates, as some new graduates experienced difficulty adjusting to rosters and shift work.

Farrell and Carr (1996) looked at the number of undergraduate theory and practice hours nurses undertake caring for people with mental illness. Information on mental health curricula was sought from all university schools of nursing in Australia. The findings of this study suggest that undergraduate courses offered variable opportunities for students to develop confidence and competence in nursing people experiencing mental illness. One school had as little as 30 hours theory and no practice, while another school had 128 hours of theory and 200 of practice. Only nine of the 24 courses on offer had a compulsory mental illness focus and the opportunity for quality practice experience was shown to be limited.

Does the position of mental health nursing within integrated programmes simply reflect a social norm of stigma and discrimination? In addressing concern at the amount of content, the quality of the teaching and the popularity of a mental health nursing option, Miller (2001 p.2) writes of the:

frustration that accompany attempts to increase the profile of mental health nursing in undergraduate curricula. Despite some individual gains, mental health nursing remains a small component of the curricula. The publication of research findings has seemingly done little to change the status quo, which clearly favours medical-surgical nursing.

In order to include more mental health content these teachers advocate "curriculum delivery by stealth", a mildly subversive problem-solving strategy useful when legitimate attempts to increase curriculum hours specifically for mental health have failed. This involves manoeuvring mental health concepts into school agendas and teaching content at every possible opportunity.

Service providers also express concerns at the readiness of new graduates to practice in psychiatric/mental health settings. A crisis in recruitment and retention has been linked to a perceived failure of educators to actually provide graduates with either the skills or the inclination for mental health nursing. Quality and quantity of nursing staff in mental health settings remains one of the great challenges for our communities but it is hardly a new crisis. How can nursing education ensure sufficient numbers of quality graduates, ie, with both the skills and inclination, for mental health nursing?

In 1994 Capital Coast Health surveyed team leaders and unit managers in order to understand why psychiatric/mental health work is an unpopular field for practice. Results showed that 70% reported that new graduate nurses had insufficient skills in the areas of mental status assessment, interviewing, psychopharmacology, defended hearings, ECT, seclusion and the Mental Health Act. Quality evaluation also showed that Specific Incident Reports (SIRs) involved too many new graduates. In 1994 over a seven month period ten out of 34 new graduates needed to have their practice restricted. In exit interviews nurses described feeling "intimidated", "out of my depth", "lacking support" and "being scared" (Cook, 1998).

Day (2000), in discussing these issues, acknowledges calls to reintroduce "psychiatric nurse training" as a specialty undergraduate programme. Day refutes this approach on the basis that "any return to single registration programmes would fail to provide an

integrated and holistic approach, by virtue of the narrower focus and specialist emphasis" (p.2). Comprehensive programmes on the other hand are seen to provide educational opportunities in a wide range of areas to help students develop integrated and holistic approaches to care.

One of the critical influences on the supply and demand of psychiatric/mental health nurses relates to the image of mental health nursing and the wider social issues of stigma and discrimination. The practice of mental health professionals is often publicly scrutinised by the media. Continual adverse publicity and increased public questioning of clinical decisions creates tensions between the social control function of psychiatry and the government policies directing care in the least restrictive environment. Will calls for increased accountability by mental health professionals lead to the practice of defensive psychiatry? The lack of popularity as a career pathway for graduates is hardly surprising under these conditions. The hegemony that exists in relation to the valuing of technical/medical skills over interpersonal nursing skills further disadvantages psychiatric/mental health nursing recruitment.

The failure of nurse educators to positively promote mental health nursing as a career option has been identified by Clinton and Hazelton (2000) and Russell (1988) as a reason for the limited numbers of graduates choosing mental health. But a complex interplay of factors is operating here. Before exploring these factors it needs to be said that the culture of nursing education is a major influence in transforming student nurses' perceptions of

> **VIGNETTE**
>
> **(A student speaks)**
>
> *I'm really enjoying my mental health nursing practice. Its much better than I expected, there's a friendly and relaxed atmosphere and I could really enjoy this kind of nursing but I've been told I should consolidate my skills in med/surg. before I go into mental health. What do you think?*

mental health difficulties and nurse educators are the primary facilitators of this process.

Rhode's pilot study (1996) looked at how 22 undergraduate psychiatric nursing students came to look differently at individuals with severe and persistent mental illness after experiencing a seven week clinical rotation. It was hoped that insights generated from the study would increase nurse educators' understanding of perceptual development in

undergraduate psychiatric nursing students by exploring how these changes occurred. Student narratives were analysed using Heideggerian hermeneutics and the interpretation revealed the process of "uncovering" as an important factor in perceptual transformation in students. This process enhanced the development of therapeutic relationships. As the students uncovered similarities between themselves and their patients, therapeutic relationships developed. Rhode suggests that nurse educators can guide students in the development of therapeutic relationships by facilitating the uncovering process.

Service providers also have a role in fostering and nurturing future psychiatric/mental health nurses. A study carried out by Mullen and Murray (2002) surveyed students on a clinical programme aiming to provide a non-threatening relaxed and welcoming atmosphere committed to the process of student learning. Ten students were approached and their feedback shows that being supported and included by staff who are willing to help and share knowledge is highly valued. Responses to the question concerning their thoughts about a career in mental health were revealing. Half the students indicated strong plans or interest in mental health and knew from the second day that mental health nursing practice would be their first choice. Thirty per cent of the sample thought that mental health nursing was an option for the future they would not have considered before the clinical placement, and 20% of the students had a strong preference for other areas of nursing.

What constitutes the mental health content of nursing curriculum in New Zealand and how is this determined? Has what is described as the unique knowledge of psychiatric/mental health nursing been subordinated in favour of psychosocial concepts in the content of nursing curricula? A perusal of course descriptors between 1990 and 2000 at the School of Health Studies, Nelson Marlborough Institute of Technology reveals that all practice and theory connected to the area of mental health is identified as psychosocial/sociocultural. How does this distinction influence the kind of practice that is considered appropriate for a mental illness focus in the nursing curricula? Is for example 200 hours of clinical practice in a women's refuge or an occupational health centre a realistic view of nursing with a focus on psychiatric/mental health? Given the

variety of different settings offering services for people with mental health difficulties, what is considered appropriate mental health nursing practice for undergraduate nurses?

TEACHING AND LEARNING PSYCHIATRIC/MENTAL HEALTH NURSING

Who decides what nurses need to learn? What guidelines are provided? What kind of nurse do service providers want? What is the role of undergraduate education in preparing mental health nurses? What tensions exist between different expectations?

Decisions about what nurses need to learn are made at a variety of different levels and must consider many different perspectives. Debates about what constitutes an appropriate nursing education are influenced not only by educational concerns, they are strongly affected by economic, social and interest group considerations (Hyman, 1985). The content of nursing curricula not only reflects, but may also shape, social attitudes to health and illness. There are others who question the role nurse educators have in constructing curricula at all and maintain that too much attention is given to the preferences of nurse educators (Clinton & Hazelton, 2000). Constructing a nursing curriculum is therefore a politically sensitive exercise where power is gained, maintained or resisted in negotiation with multiple and competing claims on the ownership of nursing knowledge.

The Nursing Council of New Zealand has responsibility for ensuring that all people can be confident that they will receive safe and competent care from nurses. It establishes policies for the education of nurses and sets and monitors standards for registration (Nursing Council of New Zealand, 2002). Their *Standards for registration of comprehensive nurses*, the *Guidelines for cultural safety in nursing* and guidelines for mental health content within the integrated curriculum are prescribed in the belief that curricula consistency will be ensured and that they have addressed the national strategy for mental health services. The Nursing Council of New Zealand observes that many concepts from mental health nursing are relevant to all aspects of nursing theory and practice. Content related to therapeutic communication, group processes, health promotion and maintenance, serious disorder and culturally safe practice should be integrated across a range of papers. As well as these integrated mental health concepts, "the comprehensive nursing curriculum must include a component specifically dedicated to nursing theory and nursing practice relevant to psychiatric conditions" (Nursing Council of New Zealand, 2002, p.31).

The use of the term psychiatric conditions in a guiding document such as this is notable in the light of contemporary understandings of the role of the psychiatric/mental health nurse. It would be helpful to have Nursing Councils interpretation of this term. On one hand use of the terms "psychiatric nursing" and "psychiatric conditions" raises the visibility and acknowledges the importance of the speciality, but on the other it has the potential to suggest or encourage bio-medical explanations for mental health difficulties. Barker, Reynolds and Stevenson (1997) caution further that medicalisation

> ### *VIGNETTE*
>
> ### *(A mother speaks)*
>
> *She was found by her nurses wandering around her room at night, taking down curtains, rolling herself up in the floor rug and looking for a cigarette she lost some days ago. There seemed to be confusion among the medical staff as to the exact cause of her psychosis. I'm so worried.*

of psychiatric/mental health nursing will be at the expense of further professionalisation. Similarly some of the current conceptualisation of mental health nursing would challenge the idea that framing learning through a psychiatric model is appropriate for the education of nurses let alone with a focus on conditions. Psychiatric conditions per se are not the proper focus of psychiatric/mental health nursing. It is the task of nursing to help people and their families manage the human experiences they encounter as a result of mental health difficulties (Hall, 1996; Hopton, 1997; Horsfall, 1997; Peplau, 1995). Assuming that there exists nursing theory specific to psychiatric conditions, will learning about them produce the kinds of nurses people with mental health difficulties want? Is it the work of nursing to explain people and their experiences by using diagnostic concepts? These issues emerge out of what appears to be a redefining of psychiatric/mental health nursing and the competing claims as to the professional focus of the discipline.

According to Nursing Council of New Zealand (2002, p.31) it is mandatory for comprehensive nursing courses to give appropriate weighting to "psychiatric nursing" in the curriculum and this must be reflected by the amount of clinical experience in psychiatric in-patient and community settings. What is considered appropriate weighting is not specified but left to individual schools to develop. Nursing Council audit processes, New Zealand Quality Assurance approved internal assessment processes and the Nursing Council State examination are the ways by which the

competence of graduates to practice at a beginning level practitioner in mental health services are measured by Nursing Council.

The Ministerial Taskforce on Nursing (1998) stated that "urgency needs to be given by the Nursing Council to auditing the competencies for mental-health nursing developed in 1997" (p.60) and suggests that without this auditing process, the mental health sector has no information as to whether these competencies are working adequately. The Nursing Council prepared a report for the *National mental health workforce development co-ordinating committee on the 1998 audit of the mental health component of comprehensive nursing education*. This report is referenced in *The Strategic Review of Nursing Education* (2000) but despite numerous inquiries, it could not be accessed at the time of writing. Clearly information concerning the clinical component of mental health nursing in undergraduate programmes would be very helpful in getting a picture of what constitutes psychiatric/mental health nursing education, how many hours are devoted to it and how it is integrated throughout a comprehensive curriculum.

The Strategic Review of Undergraduate Nursing Education (Nursing Council of New Zealand, 2001 p. 74) has made seven recommendations in relation to the issue of mental health content and practice in undergraduate nursing programmes and comments that:

> The issue of mental health input to the curriculum attracted the largest number of individual responses to this review. There is almost unanimous agreement between all respondents who have provided feedback to the review that the current undergraduate programme does not address mental health issues appropriately ...

One of the main criticisms identified through the review is the lack of national consistency in the way the mental health component of the curriculum is delivered. The report links this to lack of experience or understanding of teaching staff, lack of empathy with the culture of mental health and lack of appropriate practicum experiences. The report supports maintaining a comprehensive preparation for all registered nurses but recommends "that the teaching of the mental health component of the curriculum be transparent" (p.74) for all students with "appropriate mental health learning environments" (p.75). In order to fulfil obligations to practice, the Nursing

Council is asked to "review its approach to curriculum approval and audit" (p.75) to ensure that the curriculum is delivered appropriately. The role and focus of the Nursing Council in the approval and ongoing monitoring of undergraduate programmes has been analysed by Horsburgh (2000) who suggests that the approach taken by the Nursing Council is accountability led, where minimal attention is given to teaching and learning and actual graduate outcomes. An audit in this sense does not contribute to or enhance programme quality. It is of significance to educators that the Nursing Council has been asked to review its approach to curriculum approval and audit. There is awareness at Nursing Council level of the need for information specific to psychiatric/mental health content. The nursing school where I was employed late in 2001 was audited and particular attention was paid to the mental health component (especially the practice placements) of the curriculum.

The *Strategic Review of Undergraduate Nursing Education* recognises that knowledge and supported contact increases positive attitudes towards people with mental health difficulties and recommends that undergraduate students must have access to appropriate mental health learning environments as part of the core of the programme. But what is meant by appropriate mental health learning environments? I believe this is an important question for nurses to address given the range of possible learning environments available and the question of what constitutes the required skills for registered nurses in those environments.

The requirement that the curriculum "demonstrate involvement of consumers, carers and mental health nurses within mental health curriculum development and undergraduate teaching" (p.76). and develop "formalised partnership arrangements" between education and service providers to plan appropriate mental health content including clinical experience for the curriculum highlights the many groups who have a stake in the education of nurses. There are many perspectives to take into consideration.

The *Strategic Review of Undergraduate Nursing Education* clearly articulates the current issues of concern related to mental health nursing content and practice in undergraduate programmes. On one level the recommendations developed out of these concerns seem to recognise and attempt to remedy two decades of marginalisation of

psychiatric/mental health nursing. How do these good intentions fit with the recommendation that the specific mental health competencies be removed from the Nursing Council Handbook? The review notes that the "current process in which the undergraduate curriculum specifies both generic and mental health performance criteria (Nursing Council 2000) is both confusing and unnecessary" although it does recognise that a number of the mental health performance criteria should be generic. It is hard to see how the visibility of psychiatric/mental health nursing will be raised if, as recommended, the *Nursing Council Handbook and Standards* are revised to delete the separate performance criteria for mental health nursing. But at the same time, the relationships between the existence of specific psychiatric/mental health criteria, increased professional recognition and best practice are not clear. However, as an educator I agree with the review on this point. In my experience having to manage two sets of performance criteria is onerous and confusing and, more importantly, it reinforces the mind/body/spirit split which is the antithesis of holistic nursing.

Prebble (2001), in response to the *Strategic Review of Undergraduate Education*, comments that she finds it both disappointing and disturbing in relation to mental health nursing, noting that, "The alternatives that are suggested are confusing, do not provide for a national qualification, and potentially lead to further minimisation of mental health as a branch of nursing" (p.143). She maintains that the report has side-stepped the issues and has been driven "by a basic misunderstanding of what is psychiatric/mental health nursing" adding that "The compilers of the report have not listened to the voices of those who know, but rather accepted the views of the dominant misinformed" (p.144). From these statements one might conclude that although psychiatric/mental nurses took the opportunity to voice concerns they have not felt heard. Given that the recommendations have not been followed-up as yet suggests that they have not been a priority. The latest Nursing Council news update (September 2002) states that the report's recommendations were accepted and consolidated into a number of activities but none of the activities listed relate directly to undergraduate mental health nursing content.

Government policy is a further influence on the education of nurses. Three key mental health services planning reports (Health Funding Authority, 1998; Ministry of Health,

1994; Ministry of Health, 1997) highlight the importance of the mental health workforce. These strategies also determine the type of workforce required by having expectations as to the quantity and quality of service. In 1997 the Ministry of Health and the Ministry of Education Joint Working Party convened a meeting of stakeholder representatives to consider the impact of undergraduate nursing education and post-education support structures on mental health workforce planning and development (National mental health workforce development co-ordinating committee, 1999). Their paper identifies the issues influencing the current shortage of experienced mental health nurses and recommends nurse educators to: ensure undergraduate curricula prepare graduates to meet beginning practitioner mental health nursing competencies and standards; consult with service providers about health service direction, and offer practice-based postgraduate education. It is important that the implementation of these recommendations be assessed in the near future.

Clearly there are issues in relation to the kinds of skills that providers want from the nurses they employ and the kinds of skills that the beginning level practitioner offers. There is a mismatch in expectations where service providers require nurses with skills in interviewing and assessment, psychopharmacology, seclusion, ECT, defended hearings and the Mental Health (compulsory assessment and treatment) Act 1992. Educators on the other hand are concerned with transforming attitudes towards psychiatric/mental health nursing and helping students develop confidence relating to people who have complex problems in relation to their mental health. Clearly collaborative effort is needed to provide students with satisfying psychiatric/mental health experiences.

CONCLUSIONS AND RECOMMENDATIONS
What has been revealed? So what and where to from here?

My explorations undertaken find undergraduate psychiatric/mental health nursing positioned precariously within multiple and competing discourses. The origins to the crisis reveal historical, structural and ideological influences overlapping and merging through time. This over lapping and merging offers us many different ways to view the crisis and no one right way. Like the problems the solutions are multiple and need to be addressed at many levels. Owning the history of psychiatric/mental health nursing is a start. Locating the past can have significance to where we find ourselves now as nurses teaching, learning and practising psychiatric/mental health nursing. Questions raised 130 years ago about the definition of lunacy and the purpose of the asylum are echoed in the contemporary conflict between the social control function of psychiatry and a philosophy of least restrictive environment. Revealing to students the historical process that positions nurses power over the people who use mental health services is an important part of a critical education. Awareness of the history of mental health services helps us gain some understanding of how beliefs about mental health, mental health difficulties and mental health care have developed. An ideology of mental illness has become one of mental health, and it is now recognised that all people have mental health needs. This highlights the need for nurses to be aware of, and acknowledge that there are multiple and competing ideas explaining the causes of, and influencing the responses to, mental health difficulties.

The structure of early mental health services under the control of the Department of Health caused the separate development of mental health services. As a result the majority of psychiatric institutions became isolated professionally, socially and politically from other health services. Past policies of segregation and exclusion, that established patterns of stigma and discrimination, have contributed to a negative image of psychiatric/mental health nursing. This has placed psychiatric nursing on the back foot particularly in relation to education, recruitment and retention. Unlike general nursing psychiatric/mental health nursing has not been idealised or glamorised and has been positioned in the margins of nursing history. This marginalised position can be seen quite clearly at a structural level. The *Carpenter Report* and the Department of

Education (1972) report failed to fully consider the implications of their recommendations on psychiatric/mental health nursing and the services they provide. The suggestion that psychiatric/mental health nursing content could be easily and equitably transferred into an integrated curriculum failed to take into account the sociological contexts influencing the discipline and its position before the glass slipper as Cinderella of the health services. The 1.6 Committee, in particular, seemed to have little understanding of the knowledge and skills of psychiatric/mental health nurses.

Structural influences have substantially changed the practice, the location and even the name of psychiatric nursing. The role of the person who uses mental health services has also changed radically. The views of service users are now sought with regard to mental health policies and education. Given these changes how are student nurses best prepared for such a diverse workforce?

A link between the integrated curriculum and the subordination of psychiatric/mental health nursing content in nursing curriculum is frequently made. The research consistently shows that when students are given knowledge and positive learning opportunities their attitudes towards psychiatric/mental health nursing are transformed. Despite the growing evidence of the need for changes to be made, nursing in New Zealand appears to have made no progress in addressing these concerns.

Have the calls made in 1996 by the Ministry of Health national working party on mental health workforce development to increase the mental health content in undergraduate nursing curricula been responded to? Have calls for national consistency in the way the mental health component of the curriculum is delivered been responded to? What evidence is there that the mental health component of the undergraduate curriculum is transparent and supported by appropriate learning environments? What constitutes an appropriate learning environment given that educators are dealing with the multiple complexities of a diverse workforce? Has the Nursing Council reviewed its approach to curriculum approval and audit? Clearly there are many questions here that need to be addressed before the current crisis in recruitment can be fully understood and steps taken to address it. In the absence of this information there is little for the profession to respond to or focus on.

It is urgent that an accurate picture of psychiatric/mental health content in undergraduate programmes in terms of hours and supported practice be gained. The Nursing Council of New Zealand needs to conduct an audit of nursing programmes to find out how psychiatric/mental health content is managed. In doing so it is important that psychosocial nursing concepts and psychiatric/mental health nursing concepts are differentiated and clarified. These two distinct areas of knowledge need to be transparent in the nursing curriculum, as students have identified that they confuse psychosocial aspects of care with psychiatric/mental health nursing skills.

Any audit of curriculum content would be incomplete without a similar review of clinical placements. The Nursing Council needs to look seriously at the lack of placement opportunity for students within mental health settings and work with schools to develop strategies around this. Some agreement and flexibility on what constitutes an appropriate psychiatric/mental health learning environment would be useful. The literature suggests that the clinical placement is absolutely critical in transforming student nurses' attitudes towards psychiatric/mental health nursing. The role of registered nurses in this cannot be overstated. Educators have a role in supporting buddy nurses by acknowledging and honouring the role and providing workshops and seminars where knowledge and information can be shared and exchanged. Educational institutions might consider some rewards for outstanding and committed buddy nurses by way of reduced study fees or access to information technology. The practice of joint appointments as suggested by Ministry of Health (1996) would encourage movement between practice and education and develop partnerships with service providers. The processes that allow this to occur need to be streamlined and expedient.

It is critical that the crisis is addressed and this needs to occur at multiple levels. Nurses in education and practice, the Nursing Council, the Ministry of Health and the Mental Health Commission all have a role in working with the history, the structures and the ideas that inform mental heath services to bring about change. Nurses have so much to offer yet their contributions to mental health services are at risk of disappearing unless action is taken.

REFERENCES

Ames, N. M. (1970). What a psychiatric nurse says. *The New Zealand Nursing Journal*(June), 23.

Barker, P. J., Reynolds, W., & Stevenson, C. (1997). The human science basis of psychiatric nursing: theory and practice. *Journal of Advanced Nursing, 25*, 660-667.

Bazley, M. (1972). Report affects all nurses. *The New Zealand Nursing Journal, May*, 4-5.

Bazley, M. (1973). Psychiatric nursing in New Zealand. *International Journal of Nursing Studies, 10*, 103.

Breggin, P. (1993). *Toxic psychiatry*. London: HarperCollins.

Brunton, W. A. (1967). Hospital or prison? Some attitudes at the Nelson Asylum. *Comment: A New Zealand Quarterly Review, 31*, 19-23.

Brunton, W. A. (1986). Deinstitutionalisation: A Romance for all Seasons. In H. Haines & M. Abbott (Eds.), *The Future of Mental Health Services in New Zealand: Deinstitutionalisation.* (Vol. two of the edited proceedings of the Mental Health Foundation of New Zealand's 1985 conference, pp. 44-63). Wellington: Mental Health Foundation.

Busfield, J. (1996). *Men, women and madness.* (1st ed.). London: Macmillan Press Ltd.

Carpenter, H. (1971). *An improved system of nursing education for New Zealand.* Wellington: Department of Health.

Carpenter, M. (1980). Asylum nursing before 1914: A chapter in the history of labour. In C. Davies (Ed.), *Rewriting Nursing History* (pp. 123-146). London: Croom Helm.

Chan, S., & Cheng, B. (2001). Creating positive attitudes: the effects of knowledge and clinical experience of psychiatry in students nurse education. *Nurse Education Today, 21*(6), 434-43.

Cherrington, A. (1984). Transfer of nursing education. *Kai Tiaki The New Zealand Nursing Journal, 77*(11), 10-11.

Christenson, J. C. (1976). After three years. *The New Zealand Nursing Journal* (March), 23-24.

Church, O. M. (1987). The development of nursing at the Bellevue and Yale hospitals'. In C. Maggs (Ed.), *Nursing history: the state of the art?* London: Croom Helm.

Clinton, M., & Hazelton, M. (2000). Scoping mental health nursing education. *Australian and New Zealand Journal of Mental Health Nursing, 9*(1), 2-10.

Cook, N. (1998). Quality improvements for psychiatric mental health services. *Whitireia Nursing Journal, 5*, 25-31.

Cooper, D. (1980). *The language of madness*. Harmondsworth: Pelican.

Coppock, V., & Hopton, J. (2000). *Critical perspectives on mental health*. (1st ed.). London: Routledge.

Crowe, M. (1997). An analysis of the sociopolitical context of mental health nursing practice. *Australian and New Zealand Journal of Mental Health Nursing, 6*(2), 59-65.

Crowe, M. (2000). Constructing normality: a discourse analysis of the DSM-IV. *Journal of Psychiatric & Mental Health Nursing, 7*(1), 69-77.

Cutliffe, J. R., & Goward, P. (2000). Mental health nurses and qualitative research methods: a mutual attraction? *Journal of Advanced Nursing, 31*(3), 590-598.

Day, R. (2000). Ensuring a quality mental health workforce. *Kai Tiaki Nursing New Zealand, September*, 2.

Department of Education. (1972). *Nursing Education in New Zealand*. Wellington: Department of Education.

Department of Health. (1971). *The Public Health: Report of the Department of Health for Year Ended 31 March 1971*. Wellington: Government Printer.

Department of Health. (1972). *Royal Commission to enquire into and report on hospital and related services. Stage 11, Psychiatric Services, Volume 11*. Wellington: Department of Health.

Department of Health. (1982). *Health Manpower Resources 1980 Data*. (13). Wellington: Department of Health.

Department of Health. (1988). Nursing Education in Transition. *The transfer of nursing education to the general system of education. 1973-1988: The Department of Health's perspective*. Wellington: Department of Health.

Division of Mental Hygiene. (1948). History of the division. Wellington: Division of Mental Hygiene.

Division of Nursing. (1985). *The Nursing Workforce in New Zealand 1984*. Wellington: Department of Health.

Farrell, G., & Carr, J. (1996). Who cares for the mentally ill? Theory and practice hours with a mental illness focus in nursing curricula in Australian universities. *Australian and New Zealand Journal of Mental Health Nursing, 5*(2), 77-83.

Feringa, H. (1970). The therapeutic community. *The New Zealand Nursing Journal*(May), 9-11.

Flaskeraud, J. H., & Wuerker, A. K. (1999). Mental health nursing the 21st century. *Issues in Mental Health Nursing, 20* (1).

Foucault, M. (1967). *Madness and civilisation: A history of insanity in the age of reason*. London: Tavistock.

Goffman, E. (1961). *Asylums*. Harmondsworth: Penguin.

Gournay, K. (1996). Schizophrenia: a review of the contemporary literature and implications for mental health nursing theory, practice and education. *Journal of Psychiatric and Mental Health Nursing, 3*, 7-12.

Gournay, K., & Ritter, S. (1997). What future for research in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 4*, 441-446.

Gray, T. G. (1925). Letter to Inspector General Mental Hospitals Department, Wellington, 4th June : Ngawhatu hospital records, file no. 1/2/9.

Hall, B. A. (1996). The Psychiatric model: A critical analysis of its undermining effects on nursing in chronic mental illness. *Advances in Nursing Science, 18*(3), 16-26.

Happell, B. (1996). Tertiary psychiatric nursing graduates: something different or more of the same? *Australian and New Zealand Journal of Mental Health Nursing, 5*(3), 112-119.

Health Funding Authority. (1998). *National Mental Health Funding Plan 1998-2002*. Christchurch: Mental Health Funding Authority.

Henderson, A. J. (1990). Nurse education in Australia-comprehensive nursing challenged. *Australian Journal of Mental Health Nursing, 1*(1), 7-12.

Holland, E. (1975). Change-Rehabilitation in Psychiatric Nursing. *The New Zealand Nursing Journal, September*, 24-25.

Hopton, J. (1997). Towards a critical theory of mental health nursing. *Journal of Advanced Nursing, 25*, 492-500.

Horsburgh, M. (2000). Quality in undergraduate nursing programmes: The role of Nursing Council. *Nursing Praxis in New Zealand, 16*(2), 25-37.

Horsfall, J. (1997). Psychiatric Nursing: Epistemological Contradictions. *Advances in Nursing Science, 20*(1), 56-65.

Hughes, P. T. (1909). Mental Nursing. In *The Science and art of nursing* (Vol. IV, pp. 36-38): Waverly Book Co. Ltd.

Hunter Williams, W. (1987). *Out of Mind Out of Sight*. Porirua: Porirua Hospital.

Hyman, P. (1985). Some controversies in the education of nurses in New Zealand, Great Britain and the United States, with reference to the impact of economic and social factors. *Studies in Higher Education, 10*(2), 205-222.

Jones, K. (1993). *Asylums and after. A revised history of the mental health services: from the early 18th century to the 1900s*. London: The Athlone Press.

Keene, L. (1986). Staying out of psych? *The New Zealand Nursing Journal*(July), 17.

Laing, R. D. (1982). *The voice of experience*. New York: Pantheon.

Lowery, B. J. (1992). Psychiatric nursing in the 1990s & beyond. *Journal of Psychosocial Nursing, 30*(1), 7-13.

Mackie, J. O. (1972). Psychiatric integration: the historical background. *New Zealand Hospital, 24*(3), 12-18.

Maloquin, M. (1970). Letter to Assistant Secretary : Ngawhatu hospital records. Early hospital history file 1/2/9.

Marshall, M. (1948). Nursing the sick mind. *The New Zealand Nursing Journal, October*(15), 215-218.

McBride, A. B. (1999). Breakthroughs in nursing education: Looking back, looking forward. *Nursing Outlook, 47*(3), 114-9.

Mental Health Commission. (1997). *Discrimination against people with experiences of mental illness. A discussion paper* . Wellington: Mental Health Commission.

Mental Health Commission. (1998). *A travel guide*. Wellington: Mental Health Commission.

Miller, G. (2001). Between the lines - Maximising nursing students exposure to mental health concepts in a comprehensive curriculum. *The Australian Electronic Journal of Nursing Education, 7*(2), 1-6.

Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing*. Wellington: Ministry of Health.

Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services* . Wellington: Ministry of Health.

Ministry of Health. (1996). *Towards Better Mental Health Services: The Report of the National Working Party on Mental Health Workforce Development.* Wellington: Ministry of Health.

Ministry of Health. (1997). *Moving Forward: The national mental health plan for more and better services.* Wellington: Ministry of Health.

Morall, P., & Hazelton, M. (2000). Architecture signifying social control: The restoration of asylumdom in mental health care? *Australian and New Zealand Journal of Mental Health Nursing, 9*(2), 89-96.

Mullen, A., & Murray, L. (2002). Clinical placements in mental health: Are clinicians doing enough for undergraduate nursing students? *International Journal of Mental Health Nursing, 11*(1), 61-68.

National Alliance for the Mentally Ill. (1996). Open your mind. Washington DC: NAMI.

National Mental Health Workforce Development Co-ordinating Committee. (1999). *Developing the Mental Health Workforce.* Wellington: National Mental Health Workforce Development Co-ordinating Committee.

New Zealand Nurses Association. (1984). History of basic nursing education in New Zealand. *The New Zealand Nursing Journal*(November), 13.

New Zealand Public Service Association. (1974). *Report on Nursing Education.* Wellington: New Zealand Public Service Association.

Nieradzik, K., & Cochrane, R. (1985). Public attitudes towards mental illness - the effect of behaviour, roles and psychiatric labels. *International Journal of Social Psychiatry, 31*(1), 23-33.

Nolan, P. (1993). *A History of mental health nursing.* London: Chapman & Hall.

Nursing Council of New Zealand. (2001). *KPMG report on the strategic review of undergraduate nursing education.* Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. (2002). Nursing Schools/Departments Handbook for Pre-registration Nursing Programmes.

Papps, E. (1997). *Knowledge, power and nursing education in New Zealand: A critical analysis of the construction of the nursing identity.* Unpublished Doctor of Philosophy, University of Otago, Dunedin.

Peplau, H. (1995). Another look at schizophrenia from a nursing standpoint. In C. Anderson (Ed.), *Psychiatric Nursing 1946-1994: A Report of the State of the Art.* St Louis: Mosby-Year book Inc.

Peplau, H. E. (1952). *Interpersonal relations in nursing*. (1988 ed.) London: MacMillan Education Ltd.

Perkins, R. E., & Repper, J. M. (2001). Exclusive language? In T. Mason, C. Carlisle, C. Watkins, & E Whitehead (Eds.), *Stigma and social exclusion in healthcare* (pp. 147-157). London: Routledge.

Perry, J., & Moss, C. (1989). Generating alternatives in nursing. Turning curriculum into a living process. *Australian Journal of Advanced Nursing, 6*(2), 35-40.

Pilgrim, D., & Rogers, A. (1999). *A sociology of mental health and illness*. (2nd ed.). Buckingham: Open University Press.

Prebble, K. (2001). On the brink of change? Implications of the review of undergraduate education in New Zealand for mental health nursing. *Australian and New Zealand Journal of Mental Health Nursing, 10* (3), 136-144.

Prebble, K., & McDonald, B. (1997). Adaption to the mental health setting: The lived experience of comprehensive nurse graduates. *Australian and New Zealand Journal of Mental Health Nursing, 6*(1), 30-35.

Rhode, D. (1996). Uncovering a world of mental illness: An analysis in perceptual transformation in undergraduate nursing students. *Archives of Psychiatric Nursing, X*(6), 347-354.

Rushworth, L., & Happell, B. (2000). 'Psychiatric nursing was great, but I want to be a "real" nurse' : Is psychiatric nursing a realistic choice for nursing students? *Australian and New Zealand Journal of Mental Health Nursing, 9*(3), 128-137.

Russell, R. L. (1988). Nursing education: a time for change 1960-1989. *The Australian Journal of Advanced Nursing, 5*(4), 36-44.

Sanggaran, R. (1993). Mental Projections. *Nursing New Zealand* (May), 12-13.

Scull, A. (1979). *Museums of madness: Social organisation of madness*. London: Allen Lane.

Shaughnessy, P. (2002). Not in my back yard. In Mason, Carlisle, Watkins, & Whitehead (Eds.), *Stigma and social exclusion in health care* (pp. 182-189). London: Routledge.

Shorter, E. (1997). *A history of psychiatry from the era of the asylum to the age of prozac*. London: John Wiley.

Sines, D. (1994). The arrogance of power: a reflection on contemporary mental health nursing practice. *Journal of Advanced Nursing, 20*, 894-903.

Szasz, T. (1994). *Cruel compassion*. Chichester: John Wiley.

Szasz, T. S. (1971). *The manufacture of madness*. London: Routledge and Kegan Paul.

Trnobranski, P. H. (1993). Biological sciences and the nursing curriculum: a challenge for educationalists. *Journal of Advanced Nursing, 18*, 493-99.

Truman, K. M. (1984). *The Development of Mental Health Services in the Wellington Region 1945-1978*. Unpublished Master of Arts (Sociology), Victoria University, Wellington.

Trygstad, L. N. (1994). The need to know: Biological learning needs identified by practicing psychiatric nurses. *Journal of Psychosocial Nursing, 32* (2), 13-18.

Van Lier, M. (1976). The care of the psychiatric patient today. *The New Zealand Nursing Journal*(November), 23-26.

Wilson, H., & Kneisl, C. (1992). *Psychiatric nursing*. Redwood City, California.: Addison-Wesley.

Wynaden, D., Orb, A., McGowan, S., & Downie, J. (2000). Are universities preparing nurses to meet the challenges posed by the Australian mental health care system? *Australian and New Zealand Journal of Mental Health Nursing, 9* (3), 138-146.

Zilboorg, G. (1941). *A history of medical psychology*. New York, NY: Norton.