The therapeutic role of the mental health nurse: implications for the practice of psychological therapies

Jacklin Elisabet Monica Fisher

Southern Cross University
Certificate of Authorship

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other university.

I acknowledge that I have read and understood the Southern Cross University’s (SCU’s) rules, requirements, procedures and policies relating to my higher degree research award and to my thesis.

I certify that I have complied with the rules, requirements, procedures and policies of the Southern Cross University.

Printed Name: Ms Jacklin E. M. Fisher

Signed: ______________________On: ____/___/______
Abstract

This research project identifies therapeutic roles that nurses and consumers believe are most helpful in the nursing care of people with serious and ongoing mental illness, including identifying the knowledge concerning, attitudes towards and usage of evidence-based psychological therapies in mental health nursing practice. A critical realist perspective utilising a mixed-methods’ approach was chosen in this study. Two Delphi studies and an online questionnaire survey were the research methods selected. Three sample groups were identified, comprising consumers of mental health nursing care and expert mental health nurses (MHNs) for the two Delphi studies, and a larger sample (n = 532) of practicing MHNs in Australia for the online questionnaire survey. The findings from the Delphi studies of consumers and expert nurses informed the development of the questionnaire survey for practicing MHNs. The thesis’s literature review incorporates one book chapter, four peer-reviewed and published research papers and three peer-reviewed conference papers by the author in order to provide a critical analysis of how current organisational structures, legislative frameworks, economic resources and gender influence the therapeutic role of the MHN. Four of the publications were co-authored.

Results indicate that there is substantial agreement across all three sample groups on what constitutes therapeutic mental health nursing practice. The Delphi consumer group believed the nurse’s attitude is the most important therapeutic factor. They wanted MHNs to provide care in a way that empowered them, encouraged their achievements and instilled hope. They identified wellness planning, a recovery focused approach to nursing care and cognitive behavioural therapy (CBT) as important therapeutic strategies in maintaining client wellbeing and preventing relapse. The two nurse samples believed empowering therapeutic relationships with clients, a recovery oriented approach, communication and counselling skills and excellent mental and physical assessment skills were the most important therapeutic skills for MHNs. There was enthusiastic support amongst the nurse samples towards incorporating evidence-based psychological therapies in their current nursing practice. Indeed, 94 per cent of respondents had read articles,
journals or books on psychological therapies in the previous twelve months. The nurse
samples identified complex agency and structural relationships as hindering their ability
to practice therapeutically. Amongst these was a conviction that the current educational
preparation for mental health nursing is inadequate and concern was voiced that bio-
medical and custodial practices restricted nurses’ therapeutic ability. The nurses in this
study believed incorporating evidence-based psychological therapies into their current
nursing practice would improve the quality of mental health nursing care for people
experiencing serious and ongoing mental illness. Recommendations, based on the above
findings are made in relation to mental health nursing practice and service delivery,
education and research.
Acknowledgements

I am grateful to many people for their encouragement, support and assistance.

Firstly, I wish to thank my family for the patience, admiration and love they give to me.

I thank my supervisor, Dr Kierrynn Davis, for her astute feedback, friendship and encouragement, and for her gentle and supportive approach and my co-supervisor, Dr Stephen Kermode, for his direct and concise feedback.

Thanks to the nurses who completed the surveys and participated in the interviews and a special thank you to the consumers for their honesty and willingness to be interviewed.

I also wish to acknowledge the journal reviewers and editors whose comments have assisted the writing of the papers included in this PhD, and the staff and fellow students at Southern Cross University who provided practical support, collegial understanding and much-needed humour during our many research days we spent together in sub-tropical Lismore.

Finally, in keeping with many pet-owning PhD candidates, I also wish to acknowledge my beautiful big Molly dog for her nonchalance, shrewd use of silence and delight at going for yet another walk around the block!

It's no coincidence that man's best friend cannot talk. (Anonymous)
I warrant that I have obtained, where necessary, permission from the copyright owners to use any third-party copyright material reproduced in the thesis, or to use any of my own published work in which the copyright is held by another party. The papers included in this thesis have been internationally peer-refereed prior to publication. Evidence to this affect is contained in appendices 1 and 2.


Statement of Contribution of Others

I hereby submit the following work that has been co-authored to be taken into consideration in the marking of this thesis. The nature and extent of the intellectual input by the author of this PhD thesis (Fisher, J.) is indicated below and a written and signed statement to this effect from each of the co-authors is included in Appendix 3.

Refereed Book Chapter


Conception of the study 75%
Design of the study 75%
Collection of the data 100%
Analysis of the data 100%
Interpretation of the data 100%
Conclusions 75%
Writing the paper 75%

Refereed Journal Publications


Conception of the article 50%
Design of the article 25%
Collection of the data not relevant
List of Additional Publications by the Candidate


## Contents

Certificate of Authorship ................................................................................................................................. ii
Abstract ................................................................................................................................................................. iii
Acknowledgements .................................................................................................................................................... v
List of Publications .................................................................................................................................................. vi
Statement of Contribution of Others ..................................................................................................................... vii
  Refereed Book Chapter ....................................................................................................................................... vii
  Refereed Journal Publications ............................................................................................................................. vii
List of Additional Publications by the Candidate ................................................................................................... ix
Contents .................................................................................................................................................................. x
List of Tables .......................................................................................................................................................... xiv
List of Figures .......................................................................................................................................................... xvi
List of Abbreviations ............................................................................................................................................... xvii
Chapter 1: Introduction ........................................................................................................................................... 1
  1.1 Introduction to the Study .............................................................................................................................. 1
  1.2 Background of the Study ............................................................................................................................... 3
  1.3 Significance of the Study ............................................................................................................................... 4
  1.4 Philosophical and Theoretical Foundations ................................................................................................. 5
  1.5 Key Concepts .................................................................................................................................................. 9
    1.5.1 Evidence-Based Practice ......................................................................................................................... 9
    1.5.2 Psychological Therapies ......................................................................................................................... 9
  1.6 Organisation of the Thesis ............................................................................................................................ 10
    1.6.1. Citations .................................................................................................................................................. 15
  1.7 Conclusion ..................................................................................................................................................... 15
Chapter 2: Literature Review ................................................................................................................................... 16
  2.1 Introduction ..................................................................................................................................................... 16
  2.2 The Current Context of Mental Health Nursing Practice .............................................................................. 21
    2.2.1 Definitions and Conceptions of Mental Illness and Mental Health ......................................................... 21
    2.2.2 Diagnosis and Classification of Mental Illness .......................................................................................... 22
    2.2.3 Dominant Epistemological Viewpoints and Their Implications for Mental Health Nursing ..................... 28
      2.2.3.1 Bio-Medical Viewpoints .................................................................................................................. 28
      2.2.3.2 Psychological Viewpoints ................................................................................................................. 31
      2.2.3.3 Socio-Cultural Viewpoints ............................................................................................................. 34
    2.2.4 Application of Theoretical Viewpoints to Mental Health Nursing ......................................................... 36
  2.3 Consumer/client experience of mental health nursing .................................................................................... 37
  2.4 Manuscript 1: Fear and Learning .................................................................................................................. 39
  2.5 Manuscript 2: Mental Health Nurses: De Facto Police .................................................................................. 56
2.6 Current and Potential Therapeutic Roles of Mental Health Nurses in Australia .... 63
   2.6.1 Manuscript 3: The Nurse Practitioner: What Role for Mental Health Nurses? 64
      2.6.1.1 Abstract........................................................................................................ 64
   2.6.2 Manuscript 4: Mental Health Nurse Practitioners: Improving Access to Quality
      Mental Health Care ........................................................................................................ 65
   2.6.3 Manuscript 5: Mental Health Nurse Practitioners and Physicians: Partnerships
      in Health Care ................................................................................................................ 74
      2.6.3.1 Abstract........................................................................................................ 74
      2.6.3.2 Introduction ...................................................................................................... 75
      2.6.3.3 Defining Nurse Practitioners and Mental Health Nurse Practitioners .... 76
      2.6.3.4 Partnerships between Mental Health Nurse Practitioners and Physicians 77
      2.6.3.5 Why Nurse Practitioners Need Support from Physicians.......................... 80
      2.6.3.6 Other Challenges Facing Nurse Practitioners ................................ .......... 82
      2.6.3.7 Conclusion ...................................................................................................... 83
      2.6.3.8 References ...................................................................................................... 84
   2.6.4 Manuscript 6: Mental Health Nurse Practitioners and Physicians .................... 88
      2.6.4.1 Abstract........................................................................................................ 88
   2.6.5 Manuscript 7: The Mental Health Nurse Practitioner in the Emergency
      Department ..................................................................................................................... 89
   2.7 Psychological Therapies ............................................................................................. 98
   2.7.1 Manuscript 8: Implications of Evidence-Based Practice for Mental Health
      Nursing ........................................................................................................................... 100
   2.8 Conclusion ................................................................................................................. 108

Chapter 3: Methodology ...................................................................................................... 111
   3.1 Introduction ................................................................................................................. 111
   3.2 Section 1: Framing the Research: Critical Realism, Ontological, Epistemological
      and Methodological Assumptions .................................................................................. 112
      3.2.1 Critical Realism and the Critical Social Theories of Foucault, Althusser and
         Fraser ............................................................................................................................ 117
   3.3 Section 2: Research Design and Ethical Considerations ........................................ 124
      3.3.1 Ethical Considerations ....................................................................................... 126
   3.4 Phase One of the Study: The Delphi Surveys .......................................................... 127
      3.4.1 Method and Data Analysis of the Delphi Surveys ........................................... 131
      3.4.2 Delphi Survey Consumer Panel ......................................................................... 131
      3.4.3 Delphi Survey Mental Health Nurse Panel ....................................................... 135
   3.5 Phase Two of the Study: The Questionnaire ........................................................... 136
      3.5.1 Sample ................................................................................................................. 138
      3.5.2 Development of the Questionnaire ................................................................... 139
      3.5.3 Validity and Reliability of the Questionnaire ................................................... 140
      3.5.4 Data Gathering and Analysis of Questionnaire ................................................ 143
   3.6 Conclusion ................................................................................................................. 144

Chapter 4: Results................................................................................................................. 146
   4.1 Introduction ................................................................................................................. 146
   4.2 Results from the Delphi Survey: Consumer Panel .................................................. 146
      4.2.1 Response Rate ..................................................................................................... 146
      4.2.2 Panel Characteristics ......................................................................................... 147
4.2.4 Delphi Round Two: Consumer Panel ............................................................... 159
4.2.5 Delphi Round Three: Consumer Panel ............................................................. 162
4.3 Results from the Delphi Survey: Nurse Panel ......................................................... 164
4.3.1 Response Rate ..................................................................................................... 164
4.3.2 Panel Characteristics .......................................................................................... 164
4.3.4 Round Two: Summary of All Responses.......................................................... 177
4.3.5 Delphi Round Three: Nurse Panel..................................................................... 180
4.4 Results from the Questionnaire Survey of Practicing Mental Health Nurses ....... 184
4.4.1 Demographic Characteristics............................................................................. 184
4.4.2 Therapeutic Roles/Modalities Suitable for Inpatient and Community Mental
Health Nursing Practice............................................................................................... 188
  4.4.2.1 Non-Pharmacological Approaches ................................ ........................  191
  4.4.2.2 Psychological Therapies ............................................................................. 193
4.4.3 What Factors Influence Mental Health Nursing Practice in Relation to the Use
of Psychological Therapies? ....................................................................................... 197
4.5 Open-Ended Comments on the Survey ............................................................... 211
4.6 Conclusion ................................................................................................................. 218
Chapter 5: Discussion .......................................................................................................... 220
  5.1 Introduction .............................................................................................................. 220
  5.2 Group Characteristics ............................................................................................ 222
  5.3 What Consumers Think Will Improve the Quality of Their Care.......................... 225
    5.3.1 Nurses’ Attitude.............................................................................................. 225
    5.3.2 Medication and Side Effects ........................................................................... 228
    5.3.3 Supporting Me and My Family/Friends ............................................................ 231
    5.3.4 Empowerment................................................................................................ 233
    5.3.5 Most Helpful Strategies Employed by Mental Health Nurses ....................... 234
    5.3.6 Most Helpful Therapies.................................................................................... 237
  5.4 Therapeutic Nursing Roles/Modalities Suitable for Inpatient and Community Mental
Health Nursing Practice............................................................................................... 238
    5.4.1 Therapeutic Nursing Roles/Modalities Suitable for Inpatient and Community Mental
Health Nursing Practice: Delphi Nurse Panel......................................................... 238
      5.4.1.1 Therapeutic Relationship ........................................................................ 238
      5.4.1.2 Communication Skills .......................................................................... 240
      5.4.1.3 Being There for the Client .................................................................... 243
      5.4.1.4 Medical and Mental Status Assessment Skills ......................................... 245
    5.4.1.5 Helpful Therapies for Mental Health Nursing Practice.............................. 248
    5.4.2 Therapeutic Nursing Roles/Modalities Suitable for Inpatient and Community Mental
Health Nursing Practice: Questionnaire Survey of Practicing Mental Health Nurses ............................................................... 249
  5.5 Factors Influencing Mental Health Nursing Practice in Relation to the Use of
Psychological Therapeutic Modalities ........................................................................... 255
    5.5.1 Morale and Structural Issues ......................................................................... 256
    5.5.2 Nurses’ Role Getting Narrower ...................................................................... 260
  5.6 Limitations, Rigor, and Strengths of the Study ..................................................... 266
    5.6.1 Ethical constraints .......................................................................................... 270
  5.7 Conclusion ................................................................................................................. 270
List of Tables

Table 4.1: Panel Characteristics ................................................................................................................................. 148
Table 4.2: Code Tree: Most Helpful Knowledge, Skills and Attitudes ................................................................. 150
Table 4.3: Example Quotes for Theme One: Most Helpful Knowledge, Skills and Attitudes ........................................ 151
Table 4.4: Helpful Strategies Used by Mental Health Nurses ...................................................................................... 155
Table 4.5: Example Quotes for Theme Two: Helpful Strategies Used by Mental Health Nurses ......................................................... 156
Table 4.6: Helpful Therapies ........................................................................................................................................ 158
Table 4.7: Example Quotes for Theme Three: Helpful Therapies .............................................................................. 158
Table 4.8: Theme One: Most Helpful Knowledge, Skills and Attitudes ................................................................. 160
Table 4.9: Theme Two: Helpful Strategies Used by Mental Health Nurses ............................................................... 161
Table 4.10: Theme Three: Helpful Therapies ........................................................................................................... 162
Table 4.11: Most Helpful Knowledge, Skills and Attitudes ...................................................................................... 163
Table 4.12: Helpful Strategies ....................................................................................................................................... 164
Table 4.13: Helpful Therapies ................................................................................................................................. 165
Table 4.14: Demographics of the Nurse Panel ........................................................................................................... 167
Table 4.15: Code Tree: Most Helpful Knowledge, Skills and Attitudes ................................................................. 168
Table 4.16: Example Quotes for Theme One: Most Helpful Knowledge, Skills and Attitudes ...................................... 171
Table 4.17: Code Tree: Current Problems Preventing Nurses Fulfilling Their Therapeutic Role ...................................... 172
Table 4.18: Example Quotes for Theme Three: Current Problems Preventing Nurses Fulfilling Their Therapeutic Role ......................................................... 174
Table 4.19: Helpful Strategies ....................................................................................................................................... 175
Table 4.20: Theme Three: Helpful Strategies ........................................................................................................... 176
Table 4.21: Most Helpful Knowledge, Skills and Attitudes ...................................................................................... 178
Table 4.22: Current Problems Preventing Nurses Fulfilling Their Therapeutic Role .................................................... 179
Table 4.23: Helpful Strategies ....................................................................................................................................... 180
Table 4.24: Most Helpful Knowledge, Skills and Attitudes ...................................................................................... 181
Table 4.25: Importance Rating of New Ideas Regarding Most Helpful Knowledge, Skills And Attitudes ......................................................... 182
List of Figures

Figure 3.1: Design of the Study ................................................................. 125
Figure 3.2: Delphi Design of the Study .................................................... 125
Figure 4.1: Age ...................................................................................... 186
Figure 4.2: Experience ......................................................................... 187
Figure 4.3: Qualifications ...................................................................... 187
Figure 4.4: Place of Current Employment .............................................. 188
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACMHN</td>
<td>Australian College of Mental Health Nurses</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>ARAFMI</td>
<td>Association of Relatives and Friends of the Mentally Ill</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
</tr>
<tr>
<td>CNC</td>
<td>Clinical nurse consultant</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical nurse specialist</td>
</tr>
<tr>
<td>DEST</td>
<td>Department of Education, Science and Training</td>
</tr>
<tr>
<td>DHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DSM-IV-TR</td>
<td>American Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</td>
</tr>
<tr>
<td>EBM</td>
<td>Evidence-based medicine</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence-based practice</td>
</tr>
<tr>
<td>ECT</td>
<td>Electro-convulsant therapy</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scales</td>
</tr>
<tr>
<td>ICD-10</td>
<td>WHO International Classification of Diseases, Tenth Edition</td>
</tr>
<tr>
<td>MH</td>
<td>Mental health</td>
</tr>
<tr>
<td>MHN</td>
<td>Mental health nurse</td>
</tr>
<tr>
<td>MHNP</td>
<td>Mental health nurse practitioner</td>
</tr>
<tr>
<td>MNHNIP</td>
<td>Mental health nurse incentive program</td>
</tr>
<tr>
<td>MH-OAT</td>
<td>Mental Health Outcome and Assessment Tool</td>
</tr>
<tr>
<td>MHU</td>
<td>Mental health unit</td>
</tr>
<tr>
<td>NANDA</td>
<td>North American Nursing Diagnosis Association</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>NPA</td>
<td>Nurse Practitioners’ Act</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NSWCAG</td>
<td>New South Wales Consumer Advisory Group</td>
</tr>
<tr>
<td>PNIP</td>
<td>Practice nurse incentive program</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>RACGPs</td>
<td>Royal Australian College of GPs</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised control trial</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SCU</td>
<td>Southern Cross University</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

1.1 Introduction to the Study

Current mental health services in Australia have been criticised in terms of both the quality of care provided and for inadequate access to services (Senate Select Committee on Mental Health, 2006; SANE Australia, 2002). Research evidence has established that psychological treatment is essential for effective mental health care and that Mental Health Nurses (MHNs) should employ evidence-based practices (EBPs) in order to improve health outcomes (Buckley, Pettit & Adams, 2007; Jeffery, Ley, McLaren & Siegfried, 2000; Lewis, Tarrier & Drake, 2005; McIntosh, Conlon, Lawrie & Stanfield, 2006; Turkington, Kingdon & Turner, 2002, 2003; Pharoah, Mari & Streiner, 2003). MHNs are well positioned to practice psychological therapy and teach these therapeutic and preventive practices to their patients. Currently, the mental health nursing practice is dominated by bio-medical treatments such as the administration of medication and custodial care of the acutely ill. Other roles such as health promotion, illness prevention and patient education and rehabilitation are given less priority (Clinton & Hazelton, 2000; Select Committee on Mental Health, 2002). Nurses make up 77 per cent of the total clinical workforce in mental health care in Australia. Therefore, they are critical for improving the quality of care received by people with major mental illness (AIHW, 2002; Fisher, 2005).

This research project will determine the current usage of psychological therapies in mental health nursing practice and identify the factors that influence their adoption, from both a consumer perspective and the perspective of MHNs. The research will also determine the beliefs of consumers and MHNs towards incorporating psychological treatment into mental health nursing practice. The findings from the research will promote a range of evidence-based mental health treatments available to MHNs and will have the potential to improve access to quality mental health care for people with serious mental illness. This thesis will examine the extent of usage and appropriateness of
psychological therapeutic modalities such as cognitive behaviour therapy (CBT) for people living with serious mental illness in both inpatient and community mental health settings.

The specific aims of the research are as follows:

1. To identify therapeutic roles/modalities suitable for inpatient and community mental health nursing for people living with serious mental illness.
2. To identify factors that influence mental health nursing practice in relation to the use of evidence-based psychological therapies such as CBT.
3. To ascertain the views of MHNs about adopting these evidence-based psychological therapeutic practices.

The following three research questions arise from these aims:

1. What do consumers think will improve the quality of the care they receive?
2. What therapeutic roles/modalities do nurses think are suitable for inpatient and community mental health nursing practices?
3. What factors influence mental health nursing practice in relation to the use of psychological therapeutic modalities?

Critical social theory formed the basis of the philosophical paradigm of this research. Critical realism, drawing on major theorists such as Bhaskar (1978), McEvoy and Richards (2003, 2006) and Lawson (1995, 1997), was the foundation for framing the research methodology.

This project comprises two methods of data collection undertaken in two phases as follows:

Phase one: Two Delphi surveys (a consumer survey and nurse survey) to determine priority issues relevant to the research questions and assist in questionnaire development for phase two of the study.

Phase two: A survey questionnaire of practicing MHNs in Australia.
1.2 Background of the Study

At least 250,000 Australians (approximately 1.5 per cent) suffer from a major mental illness. Most people are first affected by mental illness in their late teens and early twenties. Twenty per cent of Australians will experience a mental illness at some point in their lives (ABS, 2007). Similar to physical illnesses, mental illnesses are many and diverse. The most common mental illnesses are anxiety disorders, which affect around fourteen per cent of all adult Australians, women more so than men. Up to ten per cent of adults have a depressive disorder, while approximately one per cent of the Australian community suffers from schizophrenia and one per cent, from bipolar disorder. Schizophrenia takes up more hospital beds than any other illness (ABS, 2007; Henderson, Andrews & Hall, 2000; Human Rights and Equal Opportunity Commission (HREOC), 1993; SANE, 2002; Senate Select Committee on Mental Health, 2006).

Currently, approximately six per cent of the health budget is spent on mental health, compared with nineteen per cent in the United States of America (USA), 22 per cent in the United Kingdom (UK) and 23 per cent in the Netherlands (Grace, 2010; Senate Inquiry into Mental Health Services in NSW, 2002). In 2007–2008, mental health-related prescriptions, subsidised by the Pharmaceutical Benefits Scheme, accounted for just over one in ten of all prescription claims (AIHW, 2009). The Burdekin Report found that ten times more dollars per patient are spent on heart disease research, and 50 times more dollars per patient are spent on cancer research, compared to the amounts spent on mental health research (HREOC, 1993). Resources remain a problem today, despite the fact that mental health expenditure rose by 65 per cent from 1993 to 2002. Professor McGorry, Australian of the Year and a prominent psychiatrist, believes the recommendation by the 2006 Senate Committee on Mental Health that nine to twelve per cent of the health budget be spent on mental health will not be realised from the currently (2010) proposed budget:

Mental health services are expected to address 14% of Australia’s health burden with a meagre 6% of our health expenditure, well below comparable developed nations. Yet, rather than address this problem, the Government has widened the

3
gap. This trend must be reversed. With political will, Australia can still meet the 2012 target of 9–12% of the health budget that was recommended by the 2006 Senate Select Committee on Mental Health. (McGorry, as cited in Grace, 2010)

Under these circumstances, it is critical that mental health services are delivered as efficiently and effectively as possible. MHNs must meet the needs of consumers and provide care that reflects national priorities as outlined in the Fourth National Mental Health Plan 2009–2014. The priority areas in this plan include social inclusion and recovery, primary prevention and early intervention, service access, coordination and continuity of care, quality improvement and innovation and accountability (Department of Health and Ageing, 2009).

1.3 Significance of the Study

Problems identified in mental health services for people with major mental illnesses in Australia include a chronic shortage of psychiatrists, especially in the public health sector; inadequate access to mental health services, especially in rural and remote areas; lack of prevention; and inadequate early intervention and rehabilitation programs (Commonwealth Department of Health and Family Services, 1996; HREOC 1993; Mental Health Council of Australia, 2005; SANE, 2002; Senate Select Committee on Mental Health, 2006). These reports have questioned the efficacy of mental health care in Australia.

Nurses comprise 77 per cent of the total clinical workforce in mental health care and 91 per cent of the public psychiatric hospital workforce in Australia, and they are, therefore, well placed to provide solutions to some of these problems (AIHW, 2002; Commonwealth Department of Health Education Science and Training, 2002). Current research on the therapeutic role of MHNs for people living with major mental illness has found it to be dominated by custodial care needs and medication administration (Clinton & Hazelton, 2000; Fisher, 2005; Senate Select Committee on Mental Health, 2006).
The provision of health care that is evidence-based and clinically effective is central to health policy and nursing practice. There is a significant body of research regarding the effectiveness of psychological therapies, particularly CBT, for people with major mental illness. Ongoing efforts to improve mental health services in the UK have identified the need for MHNs to include psychological treatments into their practice. In particular, CBT has been identified as the main focus (Department of Health 2001, 2004, 2006). The provision of psychological treatments by MHNs in Australia is uncommon because the current mental health nursing practice is dominated by bio-medical treatments such as medication supervision and custodial care.

1.4 Philosophical and Theoretical Foundations

Critical social theory provides the philosophical framework for examining the factors that currently influence the therapeutic role of MHNs, determining the influence of dominant hegemonies and exploring challenges to these dominant views. Critical realism will enable exploration of the therapeutic role of MHNs from the perspective of both the consumers and the nurses. Critical realist research recognises that the social world is constructed and influenced by individual life experiences, knowledge and psychology as well as by social structures such as institutions and ideologies. It is emancipatory in that it allows for an understanding of the interaction between agency and structure and as such, can free the individual from bondage to social structures. Critical realism allows the researcher to make judgements on where to focus and employ multiple research methods that best address the needs and purposes of the research. Critical realist approaches are increasingly being used in nursing research because of the need to understand the complexities of both individual agency and social structure in an ever-changing clinical health care environment. A critical realist methodology assists in overcoming the individualist bias, which can deny the complexities and profound external constraints that affect the individual therapeutic practices of nurses (Clarke, Lissel & Davis, 2008; Porter & Ryan, 1996; Wilson & McCormack, 2006).
As critical social theorists, Louis Althusser and Michel Foucault of the French school of philosophy and Nancy Potter and Nancy Fraser as feminist writers on psychiatry guide the broad contours of the thesis. Feminist writers such as Fraser and Potter argue that explanations of women’s unequal status relative to men in society are not freely and rationally provided by women themselves but result from historical, institutional and contextual constraints on women. They argue that economic and social discourses are phallo-centric in that man is the singular and dominant universal subject and non-man therefore becomes his negative; in other words, women are defined in ‘man’s‘ terms. Feminist theory aims to understand the nature of inequality and power relationships and is fundamentally emancipatory. This is particularly relevant in the examination of psychiatric nurse roles because historical gender relationships between the powerful and predominantly male medical profession and the non-powerful predominantly female nursing profession continue to influence the therapeutic roles of both (Potter, 2001). Analysing these patriarchal systems and power relationships is an important dimension in feminist theory and is fundamental in understanding the context of mental health nursing.

Louis Pierre Althusser (1918–1990), a ‘structural Marxist‘ and part of the anti-reductionist movement within the Marxist tradition, has been selected, because research into the role of MHNs has most commonly been conducted through the entry point of the dominant and most powerful force within psychiatry; namely, through the perspective of physicians and the epistemology of the bio-medical model of health care service delivery. The perspective of non-physicians such as nurses and consumers, has been scrutinised less. Althusser suffered from periodic episodes of mental illness, and his own mental illness influenced his philosophical position (Kirshner, 2003). He borrowed from psychoanalysis and Freud’s notion of the unconscious holding that individual self-concept is the consequence of social practices and that society makes the individual in its own image. He argued that social, economic and psychological structures determine the way people act rather than humanist existential notions of man being autonomous and self-determining (Gibson-Graham, 1996). He developed the concept of ‘over determinism’, the likelihood of a social whole that is not structured by the dominance of any social factor or setting, instead considering the complexities of every form of
existence. He was part of a tradition intent in undermining the certainties of Western empiricist epistemology (Gibson-Graham, 1996). Althusser maintained that new science emerges only after a revolutionary reconstruction and epistemological break from past theoretical stances. He explored the relationship between a social structure and its parts, claiming that once an existing structure becomes self-perpetuating, individuals (such as nurses) become the bearers, either consciously or not, of functions that arise from their location within the structures in which they practice (the epistemology of psychiatry). Althusser enabled a vision of a complexly structured social whole made up of intricate interactions, numerous relationships and conflicting priorities. Analysis of these complexities required their examination from different perspectives or ‘entry points‘. Thus, he argued that questions asked from different perspectives will elicit different truths or answers (Gibson-Graham, 1996; Gibson-Graham, Resnik & Wolff, 2001; Mautner, 2000).

Althusser’s contribution to contemporary social theory enables analysis of the therapeutic role of MHNs from the entry points of non-physicians and consumer viewpoints in order to consider how nurses and consumers are captive to current mental health ideology and may need to develop a ‘revolutionary class consciousness‘, as Althusser would argue, to escape the process of conditioning into the dominant ideological structures (Althusser, 1971).

Michel Foucault (1926–1984) was a French professor and leading intellectual at College de France in Paris. He described his work as a historical reflection on how society and the individuals within it have come to believe, think and behave as they do (Mautner, 2000). Foucault explored the relationships between power and social processes such as the maintenance of social inequality, political organisation and social policy. Similarly to Althusser, Foucault challenged Marxist assumptions that the basic structures of oppression were determined by capitalism and class and contended that power and oppression operate universally in social processes. Further, he concentrated on examining the politics of knowledge and the formation and destruction of elite traditions, arguing that knowledge arises from historically instituted practices that are not necessarily value
free, scientific or expert, but are contingent on ungrounded belief systems or assumptions which may, for example, be sexist or racist in nature (Fraser, 1989). Through this process, he undermines the notion of absolute truth, demonstrating that truth can be relative and that even contradictory 'truths' can coexist and produce knowledge. Foucault traced how the concepts and discourses of madness, sexuality and crime and punishment changed through the ages depending upon the different social attitudes and practices of the times. In turn, he showed how rules, regulations and institutions are created to reinforce that dominant discourse. Consequently, when madness was first defined (Foucault shows how in medieval times the mad were considered holy and wandered free in society) a concept of non-madness or normality naturally followed, and those considered to be outside the bounds of normality were incarcerated or subjected to 'treatments' to return them to a socially constructed normal state (Foucault, 1961; Gutting, 1990; Horrocks & Jevtic, 2001). Through this process of definition and discourse, he demonstrated how knowledge becomes synonymous with power and is used to regulate society. He argued that the psychiatric discourse subjected those outside the bounds of normal to the all-powerful, all-knowing psychiatrist: madness was now defined and confined by psychiatry and institutional supports and modes of treatment and containment quickly followed (Gutting, 2003).

Foucault provides a rationale for examining the therapeutic role of the MHN through the lens of shifting power relationships and discourses and justifies an analysis of the more powerless such as consumers and nurses. His ideas on the politics of knowledge and the formation of elite traditions, which may be grounded in sexist, racist or elitist assumptions, provides an avenue to analyse the origin and the impact of the psychiatrist and psychiatric bio-medical model of health care as the dominant ideology controlling both the therapeutic practice of MHNs and the care and control of consumers of mental health services. This analysis will assist in providing an understanding of the difficulties for both nurses and consumers to adopt evidence-based therapies.
1.5 Key Concepts

1.5.1 Evidence-Based Practice

A critical review of the contentious nature of EBP in mental health nursing is provided in Chapter 2 and enables the differences between current mental health nursing practice in Australia and evidence-based mental health nursing practice to be determined. Government, non-government and research reports form the basis for this analysis. An understanding of the major debates around EBP is essential to this research because many clinicians in mental health, including psychologists, psychiatrists and MHNs are critical of the applicability of the concept to mental health practice. At this point a brief exploration of this concept is presented.

Evidence-based nursing and evidence-based psychology have evolved from evidence based medicine (EBM). EBM aims to create a system of clinical decision making and practice where practitioners can readily access an evidence base for their clinical practice rather than reverting to intuitive and possibly ill-informed decisions (Sackett, Straus, Richardson, & Rosenberg, 2000; Sackett, William, Rosenberg, Muir Gray, Haynes, & Richardson, 1996). Sackett and his colleagues believe acquiring and evaluating the research evidence should include reviewing clinical guidelines, alongside systematic reviews and meta analyses of research findings as provided by organisations such as the Cochrane Collaboration (Sackett Straus, Richardson, & Rosenberg 2000).

1.5.2 Psychological Therapies

Psychological therapies are explored in detail in Chapter 2. Psychological therapies employ verbal and nonverbal communication rather than drugs or other physical means in the treatment of mental illness (Harris, Nagy & Vardaxis, 2010). Psychoanalytic, behavioural, person-centred, humanistic and cognitive therapies are outlined in Chapter 2 in order to assist in an understanding of how they impact on the therapeutic role of the MHN. In this research, CBT is emphasised because it has accumulated a strong evidence
base for its effectiveness in mental health nursing (Chan & Leung, 2002; Department of Health, 2004; England, 2007; Poole & Grant, 2005; Turkington et al., 2006).

1.6 Organisation of the Thesis

Chapter 2 comprises the literature review of the thesis, providing background information as well as an analysis of the current context of mental health nursing. An analysis of the hegemony of the bio-medical model and the epistemology of psychiatry and psychiatric illnesses outlines the circumstances and knowledge base in which MHNs apply their practice. Challenges to the reliability and validity of this knowledge base are explored. The impact of legislative and health policy changes and their implications for the therapeutic practice of mental health nursing are also examined. Finally, the evidence-based literature on the appropriateness of psychological therapies in the treatment of mental illness and in mental health nursing practice is also examined.

The literature review includes authored and co-authored work published during the period of candidature. One book chapter based on a previous internationally peer-reviewed journal article, three internationally peer-reviewed conference papers and four articles published in an internationally peer-reviewed journal are included in this chapter to assist in this critical analysis of the current dilemmas facing mental health nursing. Included first is a co-authored chapter in a book published in 2007 titled ‘Fear and Learning‘, which outlines the realities of current mental health nursing as perceived by student nurses undertaking their clinical practicum. The chapter is based on an earlier refereed journal article by the author, which was published in The International Journal of Mental Health Nursing in 2002. This chapter provides insights into the treatment experiences of consumers and the therapeutic milieu of the clinical mental health setting: Fisher, J. & Horsfall, J. (2007). Fear and learning. In S. K. Turrini (Ed.), Consciousness and learning research (pp. 63–77). New York: Nova Science Publishers Inc.

The second paper further outlines the realities of mental health nursing through a document review of recent Australian government and non-government reports.
Conflicting therapeutic roles for MHNs are examined within the context of legislative frameworks, health policy, resource allocation and workforce shortages:


The five papers listed below examine how the newly developed role of the mental health nurse practitioner (MHNP) is changing the mental health workforce. This examination illustrates some of the potential challenges that arise between the medical and nursing professional bodies as a result of changes to traditional models of service delivery and to the composition of the healthcare workforce. These five papers also examine how the legislation for nurse practitioners (NPs) has the potential for both medical practitioners and NPs in partnership to provide care that reflects the priorities of the National Mental Health Plan 1998–2003. Issues of cost effectiveness, power relations, organisational structures and resources are analysed and, in one paper, contrasted with the US experience where NPs have been in practice since the 1960s and over 107,000 NPs are currently practicing. The first three papers listed are refereed conference papers and the two following papers were published in a peer-reviewed international journal and are listed in chronological order from earliest to latest. Two of the five papers are co-authored:


Research evidence examining the efficacy of various psychological treatments, both in the prevention and the treatment of mental illness, is reviewed in the following co-authored paper. In particular, the evidence base for the efficacy of CBT in the treatment and prevention of many of the symptoms of major mental illnesses such as mood disorders, schizophrenia and anxiety disorders is examined. This analysis reveals that MHNs are well positioned to practice psychological therapies and to teach these therapeutic and preventative skills to their patients. This analysis of therapeutic practices suitable for MHNs is guided by the concept of EBP. To facilitate this analysis, an exploration of EBP, as it is applied in mental health nursing, is also the focus of this article, which was published in an internationally peer-reviewed journal:

The research method and methodology of the study are formulated in Chapter 3. This research is framed by critical social science and critical realism, and uses a mixed-methods‘ approach towards data collection. The research has been conducted in two phases. Phase 1 comprised two Delphi studies, one with consumers and one with nurses. The Delphi studies utilised qualitative and quantitative approaches to data collection. In the first Delphi rounds of both studies, semi-structured interviews were conducted in order to identify the perceptions and expectations of both consumers and nurses with regard to the therapeutic role of the MHN. Probing questions were used within specific topics of discussion in order to maintain the focus for the interviews. The interviews were analysed using the computer program Ethnograph 6‘. Subsequent Delphi rounds were analysed quantitatively via short questionnaire surveys in order to prioritise the data. The data from Phase 1 was used in Phase 2 to assist in the construction of an on-line questionnaire. Practising MHNs were invited to complete the questionnaire through
advertisements and the email data base of the Australian College of Mental Health Nurses.

In Chapter 4 the results of the data collection in Phases 1 and 2 are presented and analysed. The results from phase one, the Delphi surveys and phase two, the questionnaire survey are presented separately. The demographic characteristics of each sample surveyed are described and the results are organised under the relevant research question. The results from each round of the Delphi studies are presented separately. The results from round one, the semi-structured interviews, are presented as key themes and the items within each theme are prioritised quantitatively in further Delphi rounds. The three themes identified from the interviews with the Delphi consumer group are: most helpful knowledge, skills and attitudes; most helpful strategies used by MHNs; and most helpful therapies. The three themes identified from the interviews with the Delphi nurse group were: most helpful knowledge, skills and attitudes; current problems preventing nurses from fulfilling their therapeutic role; and most helpful therapies and/or therapeutic models.

The Delphi consumer group identified the nurse‘s attitude as the most important item in the first theme ‘most helpful knowledge, skills and attitudes‘. The most helpful strategies used by MHNs were giving information through education and assisting in developing insight. The most helpful therapies identified are psychological therapies, including CBT. The Delphi nurse group identified the therapeutic relationship as the most helpful item in the first theme ‘most helpful knowledge, skills and attitudes‘. In the second theme, ‘factors that limit therapeutic capability‘, the highest ranking factor is nurse morale, and the most helpful therapy/model identified is a recovery approach.

The results from the questionnaire survey largely support the findings from the Delphi surveys. For example, most helpful knowledge, skills and attitudes identified from the Delphi studies in phase one of the research, are nearly always utilised by the questionnaire survey group in their current mental health nursing practice. Similarly, recovery focused approaches are currently employed by 60 per cent of these nurses.
There was very little philosophical opposition to implementing psychological therapies, with 93 per cent of the questionnaire group agreeing they would like to use psychological therapies in their current mental health nursing practice and 92 per cent agreeing that training in CBT should be made available to all MHNs. Low nurse morale, along with a lack of resources and too much time spent on documentation were identified as barriers limiting their therapeutic ability and their capacity to implement psychological therapies.

Chapter 5 provides a detailed analysis of the results. This analysis draws together the research questions through analytic comparisons between the three sample groups. A critical realist approach is adopted to examine the implications of the findings in terms of the research questions and to determine the implications for mental health nursing. The chapter is organised in the same way as the previous chapter; that is, under the heading of the relevant research question. The influence and interaction between agency and structural factors on the therapeutic role of the MHN is clearly outlined. The Delphi nurse group and the questionnaire nurse group identified a number of intrinsic and extrinsic barriers or factors limiting the nurse’s therapeutic ability. Many of these factors, they believed, were largely beyond the control of the nurse. The discussion in this chapter identifies the potential in terms of both therapeutic roles and scope of practice for MHNs to improve access and provide quality cost-effective care for people experiencing mental health problems.

The final chapter, Chapter 6, reviews the key issues that are identified in the research, outlines the limitations to the study and provides recommendations. Implications for the therapeutic role of the MHN, especially with regard to the use of psychological therapies, are reviewed. One of the overriding themes for the consumers is their powerlessness in decision making about both medical and personal matters. They believed nurses who developed empowering relationships with their patients were the most therapeutic. They identified the nurse’s attitude as a key factor in this. There was general agreement between the three sample groups on what was needed to improve the therapeutic role for the MHN. MHNs were keen to implement psychological therapies, and were making efforts to educate themselves about psychological therapies. However, evidence from this
study shows there are structural or institutional barriers limiting the therapeutic practice of MHNs. These included a perceived over-emphasis on bio-medical and custodial nursing practices. The MHNs in this study were frustrated that this imbalance, combined with agency and structural barriers, is affecting their therapeutic ability. It is noted that when nurses perceive that the quality of their nursing care is affected by matters outside their control, their morale drops, further affecting their therapeutic ability (Day, Minichiello & Madison, 2006). This analysis provides an example of the complex interactions of both agency and structure on the therapeutic role of the nurse. The nurses in this study believed incorporating evidence-based psychological therapies into their current nursing practice were one way to redress these problems and they wanted formal training on how to do this.

1.6.1. Citations

The referencing style chosen for the thesis is the American Psychological Association (APA) 5th edition. Single inverted commas are used for direct quotes on the recommendation of the editors. The Southern Cross University guidelines for the incorporation of publications into theses requires the inclusion of all references cited in publications to be included in the thesis reference list.

1.7 Conclusion

This introductory chapter has overviewed the research project and the structure of the thesis. The following chapter provides a critical review of the literature on issues related to the therapeutic role of the MHN.
Chapter 2: Literature Review

2.1 Introduction

This chapter comprises the literature review of the thesis, providing background information as well as an analysis of the context of the practice of mental health nursing. The specific aims of the literature review are to identify therapeutic roles/modalities appropriate for inpatient and community mental health nursing practice and to identify factors that influence mental health nursing practice, particularly in relation to the use of psychological therapeutic modalities.

The three research questions addressed in the research project are as follows:

1. What do consumers think will improve the quality of their care?
2. What therapeutic roles/modalities do nurses think are suitable for inpatient and community mental health nursing practice?
3. What factors influence mental health nursing practice in relation to the use of psychological therapeutic modalities?

The scope of the literature review therefore covers three key areas:

1. The current context of mental health nursing practice in order to identify factors that influence mental health nursing practice.
2. The treatment experiences of consumers of mental health nursing care in order to identify therapeutic roles suitable for inpatient and community mental health nursing practice.
3. Current and potential therapeutic roles of MHNs in Australia to determine the suitability and usage of psychological therapies.

Definitions and conceptions of mental illness and mental health are examined in order to identify the boundaries of mental health nursing practice and demarcate this from other nursing fields of practice. A review of the literature on diagnosis and diagnostic
classification systems used in psychiatry enables an understanding of the current knowledge base influencing mental health nursing. Challenges to the reliability and validity of current diagnostic and classification systems in psychiatry are assessed to explore the integrity of the knowledge base and ideology that underlies mental health nursing. Theoretical viewpoints on the causation and treatment of mental illness are examined to further explore factors that influence mental health nursing practice. Three main theoretical paradigms, the bio-medical, psychological and socio-cultural paradigms are reviewed and the role of the MHN within each of the paradigms is examined.

The literature investigating the treatment experiences of consumers of mental health nursing care is examined in order to ascertain therapeutic roles suitable for inpatient and community mental health nursing practice and to assess the impact on consumers of reduced resources, bed shortages and fewer skilled specialist staff. A review of recent legislative changes in the MHN’s role, in particular the emergence of the MHNP role, will illustrate the potential for this role to improve accessibility, affordability and appropriateness of mental health services. The appropriateness or otherwise of psychological therapies in the treatment of mental illness and their suitability for incorporating into the therapeutic role of MHNs is also examined.

A number of data bases, including CINAHL, Medline, PsycINFO, PAIS and Expanded Academic ASAP Plus, were accessed to assist in the literature review. These data bases were searched from 1980 to the current date because it was considered that the recent history pertaining to the above topics assists analysis and understanding of the therapeutic role of MHNs today. Additionally, seminal works relevant to the thesis were obtained. For example, a lengthy and sustained critique of modern psychiatry has been ongoing for over 50 years, perhaps most famously articulated by Dr Thomas Szaz in his book ‘The Myth of Mental Illness’ (1974) and continuing since then in his most recent publication ‘The Medicalisation of Every Day Life’ (2007). Similarly, feminist literature maintains an ongoing critique of psychiatry.
The key words used in the search of these data bases included various combinations of those listed below:

- Mental illness/treatment/evaluation
- Psychiatry/anti-psychiatry
- Psychological therapies
- Mental health nursing role/nursing practice
- Nursing
- Nurse practitioner
- Feminism
- Psychology
- Philosophy
- Political economy of health
- Mental health policy in Australia/UK/USA
- Mental health services evaluation
- Health economics
- Sociology
- Consumer
- Occupational health and safety/mental health nursing
- Diagnosis
- DSM-IV

From these searches, experts in the field were identified and their publications were also searched via the data bases. Examples include Professor Richard Bentall’s publications critiquing the current classification processes and treatments used in psychiatry and Professor Phil Barker’s publications on the therapeutic role of the MHN.

In addition, web sites of government and non-government organisations both in Australia and overseas were searched using the same key words. The Sainsbury Centre for Mental Health, King’s College London was a source of extensive research-based information on counselling and psychological therapies for use by MHNs, as well as the consumer experience of service delivery. World Health Organisation (WHO) reports provided a
global perspective and the American and Australian Psychological Associations gave a psychological perspective on mental health nursing and service provision. Similarly, the Australian Institute of Health and Welfare (AIHW) and the Departments of Education, Science and Training (DEST) and Health and Ageing (DHA) publications provided information on the Australian context. The SANE organisation was a source of a number of reports and articles from a consumer viewpoint on the effectiveness or otherwise of current mental health services and treatments. The Australian Bureau of Statistics (ABS) provides statistical information.

Clinical guidelines, systematic reviews and meta analyses of research findings provided by the Cochrane collaborations and Joanna Briggs’ Institute were searched for current evidence-based literature on effective therapeutic practices for MHNs. The Internet search engine ‘Google‘ and ‘Google scholar‘, as well as media programs such as the Australian Broadcasting Commission ‘Health Matters’ were additional sources of information for the literature review.


Five papers examine recent legislative changes to the mental health nursing workforce through the development of the role of the MHNP and highlight some of the challenges that have arisen between the medical and nursing therapeutic roles as a result of these changes to traditional models of service delivery:


Research evidence demonstrating the efficacy of various psychological therapeutic modalities, both in the prevention and treatment of major mental illness, is reviewed to clarify whether MHNs are well positioned to practice psychological therapies. This analysis of suitable therapeutic practices for MHNs is guided by the concept of EBP. The final paper critically examines the appropriateness of psychological therapies and EBP as it applies to mental health nursing:

Before exploring the literature in the publications listed above, the following sections discuss the current context of mental health nursing practice.

2.2 The Current Context of Mental Health Nursing Practice

Major theoretical and conceptual frameworks underlying the therapeutic role of the MHN and the treatment of mental illness are outlined in this section in order to understand the context in which MHNs work. Definitions and conceptions of mental illness and mental health are examined along with current diagnostic and classifications systems. Dominant theoretical approaches to the treatment of mental illness and mental health problems are examined. In keeping with the philosophical and theoretical framework of the thesis, a critical social theory perspective is employed.

2.2.1 Definitions and Conceptions of Mental Illness and Mental Health

Mental illnesses or mental disorders disrupt, to varying degrees, cognitive, affective and behavioural functioning and hence the ability for an individual to function within their community. The Commonwealth Department of Health and Aged Care (2000, p. 3) defines mental illness as:

a diagnosable illness that significantly interferes with an individual’s cognitive, emotional or social abilities. Mental disorders are of different types and degrees of severity and some of the major mental disorders perceived to be public health issues are depression, anxiety, substance use disorders, psychosis and dementia.

Unlike physical illnesses, when a person is diagnosed as suffering from a mental illness they may be forced to receive treatment and become what is known as an `involuntary patient`. The NSW Mental Health Act (2007) provides the legal framework to oversee this process. The Act defines mental illness as:

a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
Delusions,
Hallucinations,
Serious disorder of thought form,
Severe disturbance of mood,
Sustained or repeated irrational behaviour indicating the presence of any of the
above.

(Mental Health Act, 2007, Section 4)

This legal definition of mental illness does not include diagnostic categories such as
schizophrenia, depression or bipolar disorder, instead focusing on the presence of
symptoms; namely, delusions, hallucinations, thought disorders, disturbance of mood and
sustained irrational behaviour. An involuntary patient must be mentally ill or disordered
as defined under the Act, be at risk of serious harm to self or others (including harm to
reputation, finances, self-neglect and neglect of children) and there must be no other less
restrictive options available for care of the person.

Mental health problems or mental distress are other relevant concepts in understanding
the broadness of the role of the MHN. Mental health problems are more common,
relatively short lived and less serious than mental illnesses. They are associated with
feelings of subjective distress, usually in reaction to stressful events and problems in
living. Over time they may develop into mental disorders (Commonwealth Department of
Health and Aged Care, 2000, p. 3).

2.2.2 Diagnosis and Classification of Mental Illness

Medical dictionaries, including Mosby’s Dictionary, define diagnosis as "the
identification of a disease or condition by a scientific evaluation of physical signs,
symptoms, history, laboratory test results and procedures" (Harris et al., 2010, p. 518).
Diagnosis and classification of mental illness is problematic because, unlike physical
illness, objective data such as pathology tests or x-rays are not available to diagnose most
major mental illnesses. Further, people with a mental illness may not believe they are ill
and may not want to receive or cooperate with treatment. The mental health practitioner
is required to make subjective clinical judgments guided by diagnostic classification
systems. A diagnostic category in psychiatry, therefore, is a social construct inferred from
a pattern of signs and symptoms which should be able to predict the course and outcome of a disorder (Barker & Stevenson, 2000, p. 74). The reliability of these diagnostic categories depends on the extent to which clinicians can agree on a diagnosis given a certain set of signs and symptoms and the validity relates to the degree to which they actually measure what they are purported to measure with predictive validity, accurately predicting the outcome of the illness.

The main diagnostic classification systems in psychiatry are the American Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) and the WHO International Classification of Diseases, Tenth Edition (ICD-10). The history of psychiatric diagnosis and classification in Europe commenced with Emile Kraepelin (1856–1926), a German psychiatrist. He recognised patterns of symptoms in mental illness which he organised into syndromes and through this process he distinguished thirteen mental illnesses. His classification system forms the basis of those in use today (American Psychiatric Association, 2000; Bentall, 2003; Elder, Evans & Nizette, 2009). The exponential increase in the number of diagnostic categories of mental illness along with the removal of other categories (homosexuality was considered a mental illness until the 1970s) has raised questions about the validity and reliability of both classification systems. In 1952, the first DSM-1 listed 106 diagnostic categories, the DSM-II listed 182, DSM-III listed 205 and in 2000, DSM-IV-TR listed 390 diagnostic categories (Sarbin 1997, Barker & Stevenson, 2000, pp. 70–71). The ICD is currently in its tenth revision (ICD-10) and has similarly expanded. To provide an outline of the major mental illnesses, a list of the major illness categories listed in the DSM-IV-TR is provided. Within each of these categories are several distinct sub-categories, totalling 390 separate illnesses; for example, the anxiety disorders consist of sub-categories including generalised anxiety disorder, obsessive compulsive disorder, panic disorder and PTSD (these sub-categories have not been listed).

The DSM-IV-TR identifies the following major categories of mental illnesses:

- Adjustment Disorders
- Anxiety Disorders
Bentall (1990, 2003) examined the reliability and validity of the DSM diagnostic classifications of schizophrenia and found continuing disagreement about the symptoms of the disease. He identified poor correlations between symptoms and diagnosis and noted many signs and symptoms of schizophrenia were also associated with other diagnoses. A factor analysis of the symptoms and cluster analysis between individuals did not validate the construct (Bentall, 1990). In particular, he noted the differential diagnosis of schizophrenia was problematic; especially the distinction between schizophrenia and affective disorder, where he found no clear distinction exists between these disorders. He argued it would be more fruitful for scientists and clinicians to focus on treating and researching particular symptoms instead of investigating and treating hypothetical syndromes like schizophrenia. On this point Bentall (2003) has stated that:

Patients do not fall into discrete types of psychiatric disorder … patients experiencing a mixture of schizophrenic and non-schizophrenic symptoms are the norm … there is no clear dividing line between schizophrenia and normal functioning … a schizophrenia diagnosis does not predict outcome or response to treatment. (pp. 32–33)

Similarly, Van Os (2010, p. 309) questions the reliability and validity of a diagnosis of schizophrenia. He points out there is "diagnostically low discriminative power" between diagnostic categories of schizophrenia, bipolar disorder, brief psychotic disorder, schizophreniform disorder, substance-induced psychotic disorder, delusional disorder and
psychotic depression. He concludes, ‘correlates of current diagnostic categories of psychotic illness are not consistently specific in terms of classic validation criteria’ (p. 310).

Further, comparisons of the concordance of diagnostic classification cross-culturally illustrate the problems in reliability and validity of the DSM (Collins, Sorel, Brent & Mathura, 1990; Dubicka, Carlson, Vail & Harrington, 2008; Kleinman, 1991; Kleinman, Eisenberg & Good, 2006; Lopez & Guarnaccia, 2000). Differences in diagnosis occur between UK and US psychiatrists when given the same case study, with UK psychiatrists more likely to diagnose bipolar disorder whilst their US colleagues are more likely to diagnose schizophrenia (Bentall, 2003; Copeland et al., 1975; Craig, 1999; Surawicz & Sandifer, 1970). Even within countries, variance in diagnosis exists between cultures. For example, Pilgrim and Rogers (1993), in their review of the literature, found people with black Caribbean or black African ethnicity in the UK were more likely to be diagnosed with schizophrenia than white patients presenting with the same symptoms and that they were more likely to have their diagnosis changed over time. Neighbors, Jackson, Campbell, and Williams (1989) found that in the USA, African Americans were more likely to be diagnosed with schizophrenia than people exhibiting the same symptoms from white Anglo ethnicity.

Recently, the editors of the prestigious Journal of Mental Health produced a special edition of the journal examining the question of diagnosis in psychiatry. The editorial for this edition of the journal points out that the papers are mostly critical of both the DSM and ICD classification systems (Wykes & Callard, 2010). They express concern that psychiatric diagnosis can ‘medicalise patterns of behavior, compound stigma, pre-determine which interventions are appropriate and narrowly define the frameworks through which mental health problems might be addressed’ (p. 301). For example, the paper by Wakefield (2010, p. 338) argues that using symptom-based criteria creates difficulty in discerning between ‘ordinary trait variation in the human condition and what is part of a disorder’. For Wakefield, the context of a set of symptoms is vital and he points out it is the duration or severity or context which distinguishes between normal
grief and, say, depressive disorder. He argues that diagnosis on the basis of a list of scientific criteria (symptoms) has diminished the importance of context in diagnosis resulting in misdiagnosis and false positive diagnosis. He maintains the high rates of attention deficit hyperactivity disorder, autistic disorder and childhood bipolar disorder are examples of three false positive "epidemics". He expresses concern about the negative consequences of such diagnoses, including the suffering entailed through some treatments as well as the changed sense of "personhood" misdiagnosis in psychiatry can cause.

Feminist critiques of the reliability and validity of the DSM classification system have been unrelenting. Feminists have long argued that sexism is at the centre of psychiatry and that psychiatrists have regarded women as physically and intellectually inferior and, by nature, prone to mental instability (Caplan, 1995; Carmele, Daniels & Anderson, 2001; Lerman, 1996; Pilgrim & Rogers, 1993; Pringle, 1998). Lerman (1996) claims the DSM and ICD classification systems in psychiatry are written by psychiatrists for psychiatrists and are problematic for other health professionals and even more problematic for feminists and ethnic groups. She points out that "almost all psychiatrists in the US, particularly those with organisational power have been male and white … [and argues] … any system devised by this group will clearly reflect primarily white, male values and attitudes" (p. 102). Further, she believes "no claim of objectivity for any diagnostic classification in mental health can be substantiated" (p. 102). In particular, Lerman criticises the diagnostic category of personality disorder, which is most frequently applied to women. She cites research which documents how large numbers of women diagnosed with personality disorders have experienced chronic physical, psychological and sexual abuse during childhood and questions whether a diagnosis of long-term and chronic post-traumatic stress disorder (PTSD) might enable more appropriate treatment regimens for these individuals. Paula Caplan, a clinical and research psychologist and a former consultant to the DSM committee, underlined the political and economic aspects of the DSM classification system, pointing out that for its publisher, the American Psychiatric Association, each revision of the DSM yields millions of dollars in revenue as libraries, lawyers, therapists, insurance companies and
education institutions purchase the revised book and associated products such as casebooks … mini manuals, workshops, interview protocols and computer programs’ (p. xxiii). Further, she pointed out that pharmaceutical companies support the DSM because it enables them to develop new drug therapies which they then market to both consumers and to psychiatrists. She argues that the DSM is big business and because of this there exists a conflict of interest in leaving the classification of mental illness in the hands of psychiatrists (Caplan, 1995).

Despite these concerns, the DSM remains the prominent classification system currently in use in Australia. Government-published morbidity and mortality statistics follow the DSM categories and both private and public health insurers use the DSM diagnostic categories when determining claims. The Second National Mental Health Plan 1998 attempts to incorporate both the DSM diagnostic criteria with the measurement of symptoms, functioning, quality of life, mental health and social functioning when it developed the Mental Health Outcome and Assessment Tool (MH-OAT) and the Health of the Nation Outcome Scales (HoNOS), which are standardised measures used by all medical and allied health workers (Elder et al., 2009).

The North American Nursing Diagnosis Association (NANDA) is the most commonly used nursing diagnosis classification system in Australia. This classification system focuses on the difficulties in living that the symptoms of mental illness produce, whilst also categorising these within DSM diagnostic syndromes. Thus, nursing classification systems incorporate lists of nursing diagnoses under a variety of different DSM diagnoses. For example, a NANDA nursing diagnosis relevant to the DSM-IV-TR diagnostic category for the schizophrenias includes impaired verbal communication, ineffective coping, interrupted family processes, disturbed sensory perception, disturbed thought processes, risk for self-directed violence and risk for other-directed violence (Fortinash & Woret, 2004). These same nursing diagnoses apply for the DSM categories of depression, bipolar disorders and personality disorders. Criticisms of the NANDA diagnostic process in mental health nursing relate to the indiscriminate nature of the classifications and the over-generalising that many of them involve (Powers, 2002). For

Diagnostic classification systems in mental health nursing utilise the DSM, MH-OAT and HoNOS systems in combination with the NANDA nursing diagnoses system. This usage of multiple classification systems can result in a complicated, repetitive, time-consuming and confusing duplication of work for MHNs, which may bear little relationship to their therapeutic role. Questions about the validity and reliability of psychiatric and nursing diagnoses are concerning for MHNs both because of the ethical and legal issues in detaining and treating people against their will and because the treatments and prognosis of these illnesses within the bio-medical model are quite different (Crowe & Barker, 2005).

This discussion and critique of the definitions, conceptions and diagnostic classification systems used in mental health nursing underscore both the complexity and the contested nature of the knowledge base of mental health nursing practice. In the next section theoretical approaches are described in order to illustrate how this contested knowledge influences and guides the therapeutic role of the mental health nurse.

2.2.3 Dominant Epistemological Viewpoints and Their Implications for Mental Health Nursing

Three theoretical approaches, the bio-medical, psychological and socio-cultural approaches to the causation and treatment of mental illnesses and mental health problems are examined in this section. This overview of the key concepts and techniques of the main therapeutic approaches provides a framework to further explore the epistemological context of mental health nursing and the impact this has on the therapeutic role of the MHN.

2.2.3.1 Bio-Medical Viewpoints
Bio-medical theories dominate in both psychiatry and mental health nursing (Barker & Reynolds 2008; Bentall 2003; Holmes 2001). The bio-medical model of health views the body as a matter of individual physiology disconnected from social environments (Petersen & Waddell, 1998). The bio-medical view suggests that mental illness is caused by brain abnormalities that result in patterns of maladaptive behaviour. As with physical illness, mental illness is viewed as a biological illness that will run a characteristic course, have a particular prognosis and respond to physical or somatic treatments, in particular, to pharmacological therapy and electro-convulsant therapy (Holmes, 2001; Nevid, Rathus & Greene, 2000; Sternberg, 2000). The focus on biological processes has its strength in terms of its logical and empirical status and has resulted in a number of developments in the treatment of major mental illness. Predominantly, these consist of new medications that can reduce the seriousness of symptoms but that cannot cure the problem.

Contemporary brain imaging techniques show changes in brain structure and biochemistry in many psychiatric conditions; for example, senile psychosis, cerebral arteriosclerosis, the mood disorders and schizophrenia (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). Genetic influences are implicated, yet do not account entirely for a wide range of mental illnesses including schizophrenia, bipolar disorder, major depression, alcoholism, autism, Alzheimer’s disease, anxiety disorders, dyslexia and antisocial personality disorder (Elder, Evans & Nizette, 2009; Fortinash & Woret, 2004; Konneker et al., 2008).

Critics of these theories argue that the medical biological model, focusing only on the inner physiological workings of the body, does not give enough emphasis to psychological and environmental aspects. As Pilgrim and Rogers (1993, p. 4) point out, “its dominance should not be confused with its conceptual superiority”. They argue that despite substantial efforts to find a biological cause for mental illness, the majority of such illnesses still cannot be explained by using a purely biological aetiology. For example, research on the causes of schizophrenia has found that biological factors, especially genetics, appear to interact with stressful environmental factors in the development of the disorder (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000).
The earliest and perhaps the best-known critic of biological theories is Thomas Szasz, who in his famous book, *The Myth of Mental Illness*, argued that mental illness was a problem in living and not an illness. He contends that if mental illness was indeed a disease of the brain then it should be treated as a brain disease under the care of a neurologist and not a psychiatrist. He argues that disturbances in thoughts, feelings and behaviours which cause deviations from expected moral, legal and social norms arise from an individual’s attempts to relate with and survive in a conforming society and, therefore, their cause is located within this relationship and not in physiological processes. He clarified this notion stating:

> While I maintain that mental illnesses do not exist, I obviously do not imply or mean that the social and psychological occurrences to which this label is attached do not exist … It is the labels we give them that concern me, and, having labeled them, what we do about them. (Szasz, 1974, p. 21)

Criticisms of biological theories also revolve around issues of subjectivity, conflicting values and attitudes and socio-cultural and gendered hegemony. In America, Dr George Albee (1921–2006), a past president of the American Psychological Association and advisor on mental health to Presidents Carter and Eisenhower, consistently argued that mental illness is mostly caused by social and environmental issues such as poverty, racism and sexism. Albee elaborated this point commenting that:

> The insistence by psychiatry that abnormal behavior can only result from abnormal brain functioning (not yet identified) is nonsense. We already know that abnormal behavior often occurs with normal brain functioning. We also know that so-called mental disorders often occur, or are exacerbated by, the stresses that accompany abject poverty (or other toxic, hopeless social environments). (Brown University, 2000)

Reviews of mental health nursing textbooks such as those by Fortinash and Woret (2004) and Elder et al. (2009), indicate the MHN’s role within the bio-medical framework is to assist with the diagnosis and classification of mental illness by seeking evidence of and reporting on signs and symptoms that might indicate a particular diagnosis. Once a diagnosis is made, the nurse’s role involves the administration of physical treatments such as medication and ECT and in providing for the safety of the patient until these
treatments take effect (Elder et al., 2009; Fortinash & Woret, 2004). A bio-medical approach dictates that physical treatments are paramount; thus, the therapeutic role of the MHN is dominated by the administration of drug therapy and other physical treatments, commonly in response to legally mandated treatment orders (Barker & Reynolds, 2008; Forchuk, 2001; Gournay, 2005; Gournay & Gray, 2003; Handsley & Stocks, 2009).

2.2.3.2 Psychological Viewpoints

Psychological explanations of mental illness stem back to the eighteenth century and focus on maladaptive behaviours that are based on irrational patterns of thinking and perceiving. This view does not exclude a biological aetiology; however, unlike the biomedical view, the treatment is less focused on the biological factors and is focused towards correcting the patterns of thinking and perceiving that cause the problems in living for people with mental illness. For example, Bentall believed psychotic symptoms such as delusions and hallucinations were not meaningless as believed by bio-medical medicine, but were frequently related to the patient’s individual psychological and sociocultural position (Bentall et al., 2009). Four of the major psychological explanations (psychoanalytic, behavioural, person-centred and humanistic and cognitive and cognitive behavioural theories) of mental illness and their treatment focus are briefly outlined in order to examine how they impact on the therapeutic role of the MHN.

2.2.3.2.1 Psychoanalytic Theories

Psychoanalytical theorists interpret behaviour in terms of mostly intrinsic and often unconscious drives and motives (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). According to Freudian psychoanalytic theory, the personality or mind is made up of three components—the id, ego and superego—and these are usually developed within the personality by the age of five years. These three components are often in conflict with each other, giving rise to feelings of anxiety, and as a result, unconscious defence mechanisms are created by the personality in order to deal with this anxiety (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000).
Psychoanalytic theorists believe that there is little separating mental health from mental illness because people are motivated by the irrational drives of the id (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). Mental health is a matter of the balance of energy amongst the psychic structures of id, ego and superego. The ego needs to be strong enough to control the instincts of the id and the condemnation of the superego. In mental illness, this balancing act becomes lopsided and unconscious impulses may ‘leak’ to the conscious in the form of anxiety (often in the form of defence mechanisms), neurosis and psychosis (Nevid et al., 2000, p. 25). Mental health therefore requires socially acceptable outlets for id drives and a superego that is not overly harsh and condemnatory.

2.2.3.2.2 Behavioural Theories

The behavioural perspective focuses on the role of learning in explaining both normal and abnormal behaviour. Behaviourists operate within a positivist paradigm, arguing that the causes of abnormal behaviour must be sought in only empirically observable behaviour. Thus, they do not accept psychoanalytic views of the unconscious motivation of behaviour because this is not observable and measurable. Behaviourists argue that behaviour can be manipulated through positive reinforcement and that maladaptive behaviour is learned and can, therefore, be unlearnt. Operant conditioning, modelling, shaping and positive and negative reinforcement are processes for learning or ‘unlearning’ behaviour (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). From this perspective, mental illness represents the learning of inappropriate maladaptive behaviours. Symptoms associated with mental illness are clusters of learned behaviours that persist because they are somehow rewarding to the individual (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). For example, harsh punishment for early behaviour such as childhood sexual masturbation, might give rise to adult anxieties over autonomy and sexuality or inconsistent and/or harsh discipline might give rise to antisocial personality disorders.
2.2.3.2.3 Person-Centred and Humanistic Theories

These theorists hypothesise that behaviour is due to conscious choices aimed towards achieving personal fulfilment (self-actualisation) that are based on the individual’s perception of a situation (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). Mental illness is thought to arise from the development of a distorted concept of the self and a denial of important ideas and emotions, which leads to frustration, thus setting the stage for abnormal behaviour. In this view, the pathway to mental health (self-actualisation) involves a process of self-discovery and self-awareness, of getting in touch with true feelings, accepting them and acting in ways that genuinely reflect them (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). Carl Rogers (1902–1987) developed client-centred therapy, which focused on the therapist employing unconditional positive regard and sincere empathic understanding, as a means to assist the process of self-actualisation (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000).

2.2.3.2.4 Cognitive Theories and Cognitive Behavioural Therapy

Cognitive theorists focus on how reality is coloured by our expectations, attitudes and values, and how inaccurate or biased processing of information about the world can give rise to mental illness. Cognitive theorists believe it is our interpretations of events in our lives, and not the events themselves, that determine our emotional states. Mental illnesses are viewed as distortions or problems with the input (based on perception), storage, retrieval, manipulation and output of information. For example, people with the symptoms associated with schizophrenia may reflect problems in retrieving and manipulating information, and initial processing of input from their senses (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). Cognitive distortions or errors in thinking can also cause problems. For example, people who are depressed tend to develop an unduly negative view of their personal situation by exaggerating the importance of unfortunate events that they experience (Holmes, 2001; Nevid et al., 2000; Sternberg, 2000). Cognitive theories have a large impact on therapeutic approaches to many mental illnesses. Most notably, the development of CBT, a form of therapy that combines some
of the concepts of behaviour therapy and focuses on modifying self-defeating beliefs and behaviours.

The MHN’s role within a psychological framework differs depending on the theoretical framework. For example, psychodynamic theory has influenced the therapeutic role of the MHN through the belief that the unconscious is a determinant of behaviour and through the importance of early childhood experiences on the mental health of adults. Nurses practicing within this framework focus on accessing unconscious material through the use of therapeutic techniques such as free association, dream analysis and analysis of transference and counter-transference (Corey, 2001). MHNs practicing within a behavioural framework utilise a variety of relaxation training, systematic desensitisation and assertiveness training, with an emphasis on the interplay between the environment and the individual (Corey, 2001).

Mental health nursing within a humanistic framework relies on the development of a personal relationship between the nurse and the client. The role of the nurse is to help the client identify what they want and how they need to grow to achieve it. Thus, the client or consumer leads and decides the direction and focus of the therapy (Corey, 2001), whereas nurses practicing within a cognitive behavioural framework employ directive techniques such as teaching, persuasion and setting homework tasks in order to change a client’s beliefs about themselves (negative thinking). The focus is on demonstrating how dysfunctional beliefs held by the client lead to ‘negative emotional and behavioural results’ (Corey, 2001, p. 327). The emphasis is on practicing new behaviours and thoughts/beliefs to replace old dysfunctional habitual ways of thinking and behaving. CBT has been well researched and has become the therapy of choice for the treatment of depression, anxiety and to teach skills aimed at reducing the severity of delusions and hallucinations (National Institute for Clinical Excellence [NICE]; Cochrane Collaboration; Joanna Briggs‘ Institute).

2.2.3.3 Socio-Cultural Viewpoints
Socio-cultural viewpoints consider mental health to be a dynamic process in which a person’s physical, cognitive, affective, behavioural and social dimensions interact functionally with one another and with the environment (WHO, 2005). Pilgrim and Rogers (1993), in their review of the literature, have shown how those from very low socio-economic groups, those who are socially isolated and those experiencing high levels of stress are more likely to experience all the major mental illnesses, including major psychotic symptoms. Additionally, they cite research that show these factors impact negatively on recovery and relapse rates.

A sense of self-fulfilment, the ability to cope with stress and a sense of belongingness to a community/society are regarded as key components of mental health. The determinants of mental illness within this framework are outlined by the Federal government in the report on the promotion, prevention and early intervention for mental health:

The determinants of mental health status at the population level, comprise a range of psychosocial and environmental factors including income, employment, poverty, education and access to community resources, as well as demographic factors, and most notably gender, age and ethnicity. (Commonwealth Department of Health, 2000, p. 11)

Thus, within a socio-cultural framework, an individual is considered mentally ill when they cannot achieve a sense of purpose and wellbeing for themselves within their socio-cultural environment.

Cultural differences in understandings of mental illness can be profound. In many cultures the behavioural symptoms of mental illness are believed to be caused by evil spirits, punishment from ‘God‘ or are attributed to supernatural gifts. Differing explanations on the causation of mental illness effect how the mentally ill are treated and the therapeutic role of those who treat and care for them. Various cultural practices aimed at removing evil spirits such as ‘smoking‘ ceremonies in some Indigenous Australian communities and religious exorcisms are common practices in many countries (Ranzijn, McConnochie & Nolan, 2009).
Within the socio-cultural paradigm, MHNs advocate on behalf of their patients in order to assist them with the social context of their lives. Finding suitable accommodation for the homeless, organising welfare benefits, assisting in finding employment, education or other forms of meaningful activity and helping to organise legal assistance are all part of the extended role of the MHN (Elder et al., 2009; Fortinash & Woret, 2004). Additionally, given the multicultural nature of the Australian population, alternative definitions and conceptions of mental illness are recognised and sometimes incorporated into the practice of MHNs, especially those working in remote Aboriginal and in migrant communities.

2.2.4 Application of Theoretical Viewpoints to Mental Health Nursing

Mental health nursing centres on the development of a therapeutic relationship with the client/patient and good interpersonal skills, positive attitudes and self-awareness form the basis of this therapeutic relationship (Australian College of Mental Health Nurses Inc., 2010; Elder et al., 2009; Fisher, 2002a, 2002b; Fortinash & Woret, 2004).

The theoretical perspectives provided in this section provide plausible explanations for the cause and treatment of mental illness. Some of these explanations are complimentary and some contradictory. Corey (2001, p. 6) points out that 'in reality, different clients may respond better to one type of intervention than to another' and he acknowledged that the human qualities of a therapist are critical.

Depending on the needs of their client, MHNs commonly adopt an eclectic approach integrating bio-medical, psychological, and socio-cultural frameworks into their mental health nursing practice (Elder et al., 2009; Fortinash & Woret, 2004). Nevertheless, as has been pointed out earlier, there is a substantial body of literature acknowledging and criticising the predominance of the bio-medical paradigm in current mental health nursing practice (For example, Barker & Reynolds, 2008; Forchuk, 2001; Gournay, 2005; Gournay & Gray, 2003; Handsley & Stocks, 2009; Holmes, 2001).
In the previous discussion biomedical, psychological, socio-cultural viewpoints on the
definition, assessment and treatment of mental illness were described, critiqued and the
therapeutic role of the mental health nurse working within these paradigms described.
This discussion included an analysis of how these sometimes contradictory viewpoints
are applied by MHNs. In the following section of the literature review the treatment
experiences of consumers of mental health nursing care are analysed. This analysis
enables an understanding of how structural and agency factors such as bed shortages and
education levels and morale of staff impact on the treatment experiences of consumers of
mental health nursing care.

2.3 Consumer/client experience of mental health nursing

Two peer-reviewed publications by the author, an article and a book chapter are included
in this section of the literature review in order to depict the treatment experiences of
consumers of mental health nursing care. The book chapter offers insights into the
treatment experiences of consumers of mental health nursing care. These insights into the
treatment experiences of consumers are elucidated through the perspective of student
nurses on their mental health nursing clinical practicum. Nursing students, as part of their
studies, undergo mental health clinical placement in a variety of mental health clinical
settings in order to provide an opportunity to learn from MHNs in real settings through
observation of the treatment of consumers and the therapeutic role of MHNs.
Researching the nursing student viewpoint enabled the treatment experiences of
consumers and the therapeutic role of nurses to be analysed through the entry point of
one of the least powerful and least indoctrinated participants within the treatment setting.
According to Althusser, individuals working within a social structure such as a hospital
may unconsciously become the bearer of functions that self-perpetuate the ideologies and
power relationships of that structure. He describes this process in the following quote:

the reproduction of labour power requires not only a reproduction of its skills,
but also, at the same time, a reproduction of its submission to the rules of the
established order, i.e. a reproduction of submission to the ruling ideology for the
workers, and a reproduction of the ability to manipulate the ruling ideology
correctly for the agents of exploitation and repression, so that they, too, will
The perspective of nursing students elicits new insights because they are somewhat external to the clinical setting and, therefore, less indoctrinated into the self-perpetuating ideological forces identified by Althusser. As part of their learning experience, the student nurses were required to describe and reflect on at least three critical incidents that they had observed during their three-week practicum. Critical incidents were defined as a personal experience—snapshot, vignette, brief episode—which epitomises a situation or encounter to you. A critical incident can be small or big, positive or negative‘ (Fisher & Horsfall, 2007, p. 67). Whilst the primary goal of the research was to obtain information on how critical incidents occurring within the clinical setting affected student learning, the treatment experiences of consumers and the therapeutic milieu of the clinical setting can be deduced both from the descriptions of the incidents provided by the students and from the subsequent analysis of the frequency of the events. For example, critical incidents included witnessing psychotic behaviour, verbal abuse, threatened and actual violence, witnessing strong emotions from the patient and the invasion of student professional boundaries. Incidents involving staff most commonly involved the student witnessing what they stated as uncaring and unprofessional behaviour from nursing staff towards the patient in manner, speech and/or attitude. The study found these incidents typically aroused strong, often painful emotional responses such as fear, discomfort and shock in the students. As noted in the study anxieties and fears of students and novice health professionals commonly parallel those of recently diagnosed or newly admitted patients‘ (Fisher & Horsfall, 2007, p. 73).

The book chapter published in 2007 was co-authored with Dr Jan Horsfall in an edited book Consciousness and Learning Research‘. As noted, the chapter is a revision and updating of the previous peer-reviewed article listed below:

The second publication draws on the NSW Mental Health Act 1990 (revised in 1997) and the tensions for MHNs created by conflicting roles of controlling violent behaviour and practicing therapeutically. Whilst the NSW Mental Health Act 1990 has again been revised, the issues raised in this paper, that is the therapeutic tensions between the custodial role, the bio-medical role and caring role of the MHN, remain pertinent to the current role of the MHN both in NSW and nationally. The article provides a literature review of the treatment experiences of consumers through a document review of recent Australian government and non-government reports. Levels of violence in the workplace are increasing and with this there is increasing concern that mental health nursing practice is becoming more custodial with restrictive and defensive approaches adopted rather than therapeutic approaches (Lowe, Wellman & Taylor, 2003). The focus of the paper is to explore the relationship between political, legal and economic structures and the capacity for nursing staff and patients within these social structures to develop a trusting and therapeutic alliance. An analysis of how these structures cause conflicting therapeutic roles for MHNs are explored for their impact on both the treatment of consumers and occupational health and safety of nurses and consumers. For example, mental health policy, lack of resources and bed shortages along with staffing problems and a lack of specialist skills amongst nurses are examined to determine their influence on the ability of MHNs to provide therapeutic care. This discussion demonstrates how the mental health nursing care of patients and their families and carers is directly affected by these factors. The paper concludes that consumers in NSW feel unsafe in hospital, are critical of mental health nursing care and find many mental health settings unhelpful and non-therapeutic (Fisher, 2007):


2.4 Manuscript 1: Fear and Learning

<table>
<thead>
<tr>
<th>Book:</th>
<th>Nova Science Publishers Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manuscript Type:</td>
<td>Book Chapter</td>
</tr>
<tr>
<td>Full Chapter Title:</td>
<td>FEAR AND LEARNING</td>
</tr>
<tr>
<td>Book Title:</td>
<td>CONSCIOUSNESS AND LEARNING RESEARCH</td>
</tr>
<tr>
<td>Author:</td>
<td>Fisher, J. &amp; Horsfall J.</td>
</tr>
</tbody>
</table>
Chapter

FEAR AND LEARNING

Jacklin Fisher
Sessional Lecturer, Faculty of Health Science, Australian Catholic University, Sydney, Australia

Dr. Jan Horsfall
Mental Health Nurse Consultant, Sydney, Australia

This book chapter has been removed because of Copyright restrictions.
2.5 Manuscript 2: Mental Health Nurses: De Facto Police

Journal: International Journal of Mental Health Nursing  
Manuscript Type: Peer Reviewed Original Article  
Full Title: MENTAL HEALTH NURSES: DE FACTO POLICE  
Author: Fisher, J.
FEATURE ARTICLE

Mental health nurses: De facto police

Jacklin E. Fisher
Academic, Australian Catholic University, North Sydney, New South Wales, Australia

This article has been removed due to Copyright restrictions. The published version is available at

2.6 Current and Potential Therapeutic Roles of Mental Health Nurses in Australia

It has been estimated that 22 per cent of medical work can be performed by non-medical practitioners and that 80–90 per cent of medical specialist work can be performed by non-specialist medical practitioners (Light, cited in NSW Department of Health, 1996, p. 100). Further, the WHO (1996) found that in the absence of physicians, the practice of the nurse expands, whereas it becomes restricted when there is an oversupply of physicians. Similarly, if doctors are paid for a procedure or service they are more likely to perform it, whereas if there is no such payment the procedure or service is more likely to become part of nursing practice (WHO, 1996). These facts have led to attempts by governments to significantly restructure medical workforces in Australia. For example, the ‘Better Access to Mental Health Care’ initiative allows Medicare claims to be made in certain instances by allied health professionals who may be a MHN, occupational therapist, social worker or psychologist (Department of Health and Ageing, 2008). The Nurses Amendment (Nurse Practitioners) Act 1998 legislated for nurses in NSW to become independent practitioners able to undertake an expanded nursing role, including the authority to prescribe certain drugs, refer patients to clinical services and specialist doctors and to order some investigative procedures. This expansion of the MHN’s therapeutic role has the potential to improve the accessibility and affordability of mental health care for consumers. However, the successful implementation of these expanded roles for MHNs is dependent upon the development of successful partnerships with medical practitioners and psychiatrists. This, in turn, is dependent on successful negotiation over professional boundaries, resources, accountability, decision making and status (Walker & Adam, 1998).

Five papers by the author that review the literature on current and potential therapeutic roles for MHNs are included in this section. There are three conference papers presented between 2002 and 2004 and two journal articles published in 2003 and 2005, respectively. These papers explore the literature on expanded therapeutic mental health nursing roles and demonstrate how the MHNP has the potential to improve not only
accessibility, but also the affordability, accountability and appropriateness of mental health services. The papers also provide a literature review of the Australian context and contrast it with overseas literature on the therapeutic roles of MHNs in both the USA and the UK where the therapeutic roles of MHNs include running nurse-managed clinics, providing counselling and medication, consulting at in-patient facilities, ordering tests, providing in-service training, and operating private practice clinics. The literature reviewed in these papers demonstrate that the development of an expanded role for MHNs, especially the MHNP role, has the potential to improve working conditions and retention of specialist nurses as well as providing accessible mental health care that better meets the needs of consumers of mental health services.

The conference paper abstract is presented, and then the journal article derived from the conference paper is presented in order to demonstrate dissemination and transparency. One international conference paper is presented in full. This is followed by a co-authored abstract for the second conference paper, which is followed by a co-authored journal article based on the conference paper.

2.6.1 Manuscript 3: The Nurse Practitioner: What Role for Mental Health Nurses?


Manuscript Type: Conference Paper Abstract

Full Title: THE NURSE PRACTITIONER: WHAT ROLE FOR MENTAL HEALTH NURSES? COMING OF AGE: A CELEBRATION OF MENTAL HEALTH NURSING

Author: Fisher, J.

2.6.1.1 Abstract

The Nurses’ Amendment (Nurse Practitioners’) Act 1998 (NPA) was proclaimed on 29 October 1999 to create the position of Nurse Practitioner. Initially, the NPA authorised only 40 NP positions in the public sector of NSW. The legislation required a ‘local agreed need’ from all relevant stakeholders (including general practitioners (GPs) and
Area Health Services) before an NP position could be approved. Mental health was identified as an ‘area of practice‘ suitable for NPs. By April 2000, thirteen positions had been approved; however, it was not until May 2001 that the first NP was appointed in NSW and Australia.

Despite the snail-like pace of the implementation of the NP legislation, the author will argue that the success of the NP movement in Australia is critically important both for the mental health nursing profession and for our clients with mental illnesses.

In this paper, the author will outline the issues surrounding the role of the NP and, in particular, mental health NPs in Australia. An examination of the Australian context will be contrasted with the US experience, where over 6,000 NPs practice. Issues of cost effectiveness, quality of care and partnerships with other health care providers, in particular, medical practitioners, will be examined. It is anticipated that this discussion will identify both causes for ‘celebration‘ and challenges for the role of the mental health NP in Australia.

2.6.2 Manuscript 4: Mental Health Nurse Practitioners: Improving Access to Quality Mental Health Care

**Journal:** International Journal of Mental Health Nursing  
**Manuscript Type:** Journal Article  
**Full Title:** MENTAL HEALTH NURSE PRACTITIONERS: IMPROVING ACCESS TO QUALITY MENTAL HEALTH CARE  
**Short Title:** MENTAL HEALTH NURSE PRACTITIONERS IN AUSTRALIA  
**Author:** Fisher, J.
This article has been removed due to Copyright restrictions. The published version is available at

2.6.3 Manuscript 5: Mental Health Nurse Practitioners and Physicians: Partnerships in Health Care

Conference: World Federation for Mental Health Biennial Congress 2003
Manuscript Type: International Conference Paper
Full Title: MENTAL HEALTH NURSE PRACTITIONERS AND PHYSICIANS: PARTNERSHIPS IN HEALTH
Author: Fisher, J.

2.6.3.1 Abstract

The Nurses’ Amendment (Nurse Practitioners’) Act 1998 was proclaimed on 29 October 1999 in NSW Australia. Initially, only 40 NP positions will be considered for employment in the public sector of NSW. A ‘local agreed need’ is required from all relevant stakeholders (including GPs and Area Health Services) before an NP position is approved. Mental health has been identified as an ‘area of practice’ suitable for NPs. To date (September, 2002), nine NPs have been ‘authorised’ by the Nurses’ Registration Board and four of these have been approved by the Director-General of Health. All other States in Australia are, to various degrees, developing NP legislation similar to that already implemented in NSW. Partnerships and support from physicians is central to the successful development of the role.

In this paper, the author will examine how the recent legislation for NPs has the potential for medical practitioners and NPs in partnership to provide care that reflects the priorities of the National Mental Health Plan 1998–2003; fulfils the ongoing demand for primary prevention counselling and early intervention; and that better meets the needs of consumers of mental health services. Issues of cost effectiveness, power relations, organisational structures and resources will be discussed. An examination of the Australian context will be contrasted with the US experience, where over 107,000 NPs practice. It is anticipated that this discussion will identify both causes for celebration and challenges for the development of partnerships in mental health services.
2.6.3.2 Introduction

Mental Health Nursing is in crisis. Since 1992, under the Mutual Recognition Act, mental health nursing is no longer a separate specialty as, for example, midwifery nursing has remained. This means that all undergraduate nursing students are qualified to practice in mental health settings without specialist training in the field. Claims have been made that Australian universities are failing to adequately prepare undergraduate students for mental health nursing (Australian and New Zealand College of Mental Health Nurses, 1997). Today, in Australia, nearly half of the mental health nursing workforce do not have specialist mental health nursing skills and there is a serious shortage of MHNs both through problems in retaining expert MHNs and in attracting MHNs to the field.

If mental health nursing is in crisis, one could argue the whole sector is in crisis. Nurses are the largest component of the mental health care system, comprising 77 per cent of the mental health workforce in Australia, with nursing staff comprising 91 per cent of the public psychiatric hospital workforce, excluding domestic staff (Australian Institute of Health and Welfare, 2002; Commonwealth Department of Health Education Science and Training, 2002).

Failures in the mental health sector identified in recent reports include:

1. a shortage of psychiatrists for seriously mentally ill people;
2. inadequate access to mental health services for large groups of people;
3. a lack of prevention and early intervention programs, rehabilitation programs, suicide prevention strategies and carer support;
4. and the use of inappropriate and outmoded medications.
   (Commonwealth Department of Health and Family Services, 1996; Select Committee on Mental Health, 2002; SANE Report, 2002).

I wish to argue that the development of the mental health NP role in NSW has a two-fold potential. Firstly, to help resolve the crisis in mental health nursing and secondly, to help resolve the crisis in the sector through providing mental health care that better meets the

2.6.3.3 Defining Nurse Practitioners and Mental Health Nurse Practitioners

In the mental health workforce, the distinctions between the nature of work performed by doctors, nurses and allied health professionals are not great. It has been estimated that non-medical practitioners can perform 22 per cent of medical work and that non-specialist physicians can perform 80–90 per cent of medical specialist work (Light 1980, cited in NSW Department of Health, 1996, p. 100). The World Bank noted that nurses and midwives could deliver most essential clinical and public health services cost-effectively (World Bank 1993, cited in WHO, 2001a).

The NSW Health Department (1992) describes the NP in very general terms. The key aspects are that the NP works autonomously and undertakes an expanded nursing role, which may include the authority to prescribe certain drugs, refer patients to other services and specialist doctors and order some investigative procedures consistent with his or her scope of practice. NPs are expert nurses and they are not intended to be a substitute for medical professionals.

Evidence from NP trials conducted in NSW, Victoria and South Australia had similar findings to those of the most recent trial in the ACT where the Minister for Health stated: "The trial has tested the potential of NPs to improve the accessibility of services for patients and carers, enhance health care delivery and produce quality outcomes. The success of the trial demonstrates that this is the case‘ (ACT Health, 2002, p. iii).

In the USA, State and Federal legislation has encouraged the profession’s growth by giving prescriptive authority to NPs in every state and direct Medicare reimbursement for NP services on the national level. Today, 103,000 NPs are practicing in the USA and this represents a three-fold increase since 1990. Only ten per cent of these are in independent practice; the majority work either in the public or private sectors in collaboration with
physicians. Mental health NPs in the USA most frequently serve low-income urban and rural communities and emphasise prevention and education as well as providing quality acute care services. Studies have found NPs in the USA cost up to 40 per cent less than physicians and are particularly cost-effective in preventive care. However, this cost saving can be partially explained through the less complicated nature of the clients NPs see. NPs refer clients with more complex health problems to physicians (American Association of Nurse Practitioners, 2001; Safriet, 1992; Whitecross, 1999). Interestingly, in the USA it is now the large medical insurers who are advocating for expansion of the NP role, claiming that NPs have demonstrated they can provide cost-effective, quality care when compared to other health care providers (Healthcare Business Digest, 1998).

In the UK, NPs have been found to address health inequalities, coordinate and integrate service delivery, develop community services, whilst also liaising and coordinating acute care and tertiary services provided by hospitals and physicians (Lewis, 1999).

In summary, the evidence from the research into NPs demonstrates mental health NPs have the potential to provide nursing care that better reflects the priorities of the National Mental Health Plan (1998–2003) whilst fulfilling the ongoing demand for primary prevention counselling and early intervention, and providing a service that better meets the needs of consumers of mental health services.

2.6.3.4 Partnerships between Mental Health Nurse Practitioners and Physicians

The US experience provides some valuable insights into what could be achieved through collaborative partnerships between mental health NPs and physicians. The American Medical Association, cited in Kavarik (1998), found that physicians in solo practices who employed one or more NPs tended to have a seventeen per cent higher income from handling more office visits per year. Similarly, a randomised trial comparing NP and GP services found that after one year the NP successfully treated two-thirds of all consultations and reduced the demand on and the workload of the GP, which in turn enabled the practice to increase patient lists by 21 per cent (Spitzer & Sackett, 1974, cited
Another study found the practice of NPs was largely limited to wellness care and the treatment of uncomplicated acute and chronic conditions, which accounted for 50 to 75 per cent of office visits to GPs (Cooper, Laud & Dietrich, 1998).

The development of successful partnerships often involves some confrontation. Walker and Adam (1998, p. 209) state that the partners in collaboration need to ‘negotiate territorial boundaries; consider and come to terms with points of view common in other organisations; negotiate conflicts over issues such as resources and status; deal with different styles of authority, decision-making and accountability; and confront issues of trust and information sharing’. These can create formidable barriers to the formation of successful partnerships between doctors and nurses. Specialist MHNs argue that they have been undertaking an informal NP role, unrecognised, unrewarded, and unprotected by legislation. They wish their expertise to be formally recognised. Conversely, the medical professions see NPs as under-qualified, a potential danger to patients and a potential threat to their authority, employment and income (Appel & Malcolm, 2002; Pearson & Peels, 2002). These dichotomised positions need to be overcome or they will prevent the possibility of mutually beneficial collaboration.

Factors that influence the success of NP and physician partnerships include the doctor’s age, gender, years in practice and type of practice. Ventura and Grandinetti (1999) found 29 per cent of physicians in practice for three–five years report that they currently work with at least one NP, compared with only twelve per cent for physicians who have been in practice for more than 30 years.

To further understand the potential of collaborative arrangements between NPs and physicians, practicing mental health NPs in the USA were contacted through email lists provided by the American Association for NPs. Ninety-five mental health NPs responded from 31 different States in America. These nurses provided general descriptions about their workplace and tasks. The selections of quotes below describe a variety of partnership arrangements and issues:
I work in a private practice with a child psychiatrist and have been in practice with him since 1997. I carry my own caseload if medication is indicated, I have full prescriptive privileges with no limitation on the level of drug I prescribe my agreement with my doc is that he gets all the money and he pays me at various rates for face-to-face services provided I’d probably make a lot more money working in the public sector and even have benefits, but this work pulls me and holds me like magnet it’s hard to leave an established outpatient practice after 5 years. (Rosalikka from Arizona)

We have a 24-bed adult alcohol and opiate detox and dual diagnosis unit and 75 beds for residential adolescents who are there months to years with mostly behavioral problems. I did the admission history and physical exams on all ages, wrote the admission orders and followed the detox patients, and took care of the medical needs of the adults and teens I have full prescriptive authority and my boss was a family practice physician and we worked closely together. (Pam from Connecticut)

I own a private practice I see patients either for medication management or for individual psychotherapy I hire a psychiatrist who’s budgeted for up to five hours a week to provide me with consultation on complex cases and co-sign the sorts of official evaluations and certifications that are still designated by the state as requiring an MD signature. (Thomas)

I have full prescribing rights and the law requires a collaborative relationship with a physician Most NPs practice together with physicians, but a few have free-standing clinics and independent practices I am most comfortable in practice with a physician. (Brenda from Iowa)

I also have a part-time private practice seeing patients for medications and psychotherapy. We prescribe under our own licenses, not under a physician’s license. The law requires us to develop a collaborative agreement with a psychiatrist and register with the Board of Nursing that we have done that. The formation of what the actual agreement entails is between the physician and the nurse My agreements state that I consult with the psychiatrist at my discretion. (Connie from Colorado)

I work as a psych. NP is a student health center at the University We hire a consulting family practice MD a few hours a week to provide PRN consultation Our practice is completely autonomous We do set boundaries on what we can take on If acuities exceed what we can treat here safely we refer to resources in the community. (Carol from Alaska)
We can practice independently, only we have to have a collaborating physician … One of the biggest battles has been acceptance by physicians and administration at the hospital that I work at. Physicians still get additional privileges, as administration still wants to keep us under nursing, although we see as many patients as the physicians and provide the same service. (Ann from Arizona)

2.6.3.5 Why Nurse Practitioners Need Support from Physicians

The relationship between the nursing and medical professions has a long and sometimes ‘rocky’ history. It is beyond the scope of this article to analyse these issues, suffice to say that the factors affecting physicians usually affect the practice of nursing. For example, in the absence of physicians, the practice of the nurse expands, whereas it becomes restricted when there is an oversupply of physicians; if doctors are paid for a procedure or service they are more likely to perform it, whereas if there is no such payment the procedure or service is more likely to become part of nursing practice (WHO, 1996).

It is not surprising, therefore, that physicians have considerable control both over the scope of practice of NPs and the implementation of the role. In order to have an NP position approved in NSW, a ‘local agreed need’ must be established through the formation of a consultative committee formed from all key stakeholders. Key stakeholders include hospitals, professional groups, GPs, unions, consumers and professional organisations such as the local Division of General Practice. This committee determines whether there is a local need for an NP and if so, whether there are alternatives that offer a better solution than the establishment of an NP position. Following agreement to recommend an NP position, a medical practitioner with relevant skills is nominated to support the NP’s practice and the consultative committee develops a framework of protocols and clinical guidelines within which the NP may operate. These guidelines include lists of specific diagnostic imaging and diagnostic pathology tests that can be initiated, medications (S3 and S4) that can be ordered and rules regarding referrals to medical specialists or other allied health professionals. The recommendation then goes to the Director General of Health in NSW for approval (NSW Department of Health, 1996).
The credentialing process with the Nursing and Midwifery Registration Board of the Australian Health Practitioner Regulation Agency (NMRB) requires the applicant to provide evidence of current registration; evidence of 5000 hours advanced practice nursing in a relevant broad area of practice; and evidence of completion of a Master’s degree approved by the NRB leading to authorisation as an NP; or a “package of evidence” (CV and a case study which is peer-reviewed during an interview process) (Nurses Registration Board, 2000).

Quite clearly, partnerships and support from physicians is central to the successful development of the NP role in NSW Australia. The current process gives physicians the power to block the employment of NPs long before the Health Department is made aware that there may be a need for the service.

The steering committee for the NP feasibility study in NSW consisted of three doctors from the Australian Medical Association (AMA) and two from the Royal Australian College of GPs (RACGPs) as well as 20 other members from various nursing, Department of Health and Area Health Services. The AMA were the only group, of the 25 members of the steering committee, who ended up not supporting the development of the NP role. Conversely, the RACGPs was supportive, although it appears that more recently the RACGPs and other physician organisations, including the Rural Doctors Association and the Australian College of Remote and Rural Medicine, have had a change of heart and are moving towards the position taken by the AMA, as quoted in the Sydney Morning Herald (SMH): “NPs are a disaster waiting to happen” and they are “an ad hoc experiment with people’s lives” (NSW Department of Health, 1996, p. iii; Patty, 2000; SMH, 2002). The main stated concerns that the medical professionals have are that NPs will set up practice in direct competition to them and that the educational preparation of the NP is inadequate and may jeopardise patient safety.

Nevertheless, physicians who support the role can develop good working relationships with NPs and this was evidenced in the NSW pilot study where even those GPs who
expressed reservation initially, requested the continuation of NPs in their practices (NSW Department of Health, 1996).

2.6.3.6 Other Challenges Facing Nurse Practitioners

2.6.3.6.1 Professional Indemnity Insurance

A critical issue made even more so in recent times is that of professional indemnity insurance. NPs who work as an employee are not required to carry professional indemnity insurance because the employer has vicarious liability. However, NPs who work privately, including those who contract out their services to GPs or NGOs, may not be covered and will be required to carry this insurance (NSW Department of Health, 1996, p. 95). The costs of this insurance could prohibit NPs. Recently, independent midwives have closed their practices due to difficulties in finding affordable cover. However, insurance premiums should reflect both the level of risk and the size of the pool over which the risk is spread and mental health NPs may not have such high risks as midwives. Certainly, counsellors and psychotherapists in Australia can obtain affordable insurance cover (NSW Department of Health, 1996, p. 96).

2.6.3.6.2 Referrals and Admitting Rights

Currently, Medicare benefits are payable for specialist medical services only if a referral has been made by another medical practitioner. NPs in NSW may not directly refer to a medical practitioner or admit a patient to a public hospital without going through a nominated GP. The inability to refer a patient directly to a psychiatrist or admit a patient to public or private hospitals without going through a GP risks creating discontinuity of care and unnecessary fragmentation of services, and nullifies one potential key role for the mental health NP that might benefit consumers through more streamlined services. Obtaining referral and admitting rights will require a change in the Health Insurance Act 1991 (NSW Department of Health, 1996, p. 88).
The proposed legislation in south Australia allows for limited admitting rights to public hospitals, and NPs in most States in the USA have full referral rights to specialist medical services as well as admitting privileges to designated public and private hospitals (Hughes, 2000).

2.6.3.6.3 Reimbursement from Medicare and the Pharmaceutical Benefits’ Scheme

Access to a Medicare provider number is critical to be able to practice autonomously and provide health care services in Australia. The costs of medications ordered by mental health NPs would be met by the State for public sector NPs, but the clients of private sector NPs, including those in partnerships with GPs, those working for NGOs and those in private practice, would not be eligible for reimbursement under the Pharmaceutical Benefits’ Scheme (NSW Department of Health, 1996, p. 95).

Funding for diagnostic imaging and pathology can be paid for by the state if the NP works in the public sector. However, patients of private sector NPs will not be eligible for reimbursement under Medicare. To date, the government has remained determined to limit the access to Medicare provider numbers to those who have current access; namely doctors, dentists and optometrists.

2.6.3.7 Conclusion

Whilst both the need for and the potential of the mental health NP role is well demonstrated, and the Nurses’ Amendment (NP) Act 1998 is in place, the problems related to the bureaucratic application process combined with organised resistance from physician organisations, lack of reimbursement from Medicare, limitations on referral and admitting rights and professional indemnity insurance provide obstacles both for the employment of mental health NPs and for the fulfilment of the role.

Despite these difficulties, it does appear that NPs are here to stay. Nearly all States in Australia either have or are currently implementing NP legislation. In NSW the Minister
for Health has recently announced plans to advertise 92 positions in 2003 and streamline the excessively bureaucratic processes hindering the development of these positions.

The potential for conflict and overlap between the NP and physicians forms the main focus of concern in much of the medical literature on NPs. The challenge for both professions in developing productive partnerships focused on providing quality cost-effective care for consumers of mental health services is to overcome conflict over territorial boundaries, status and authority and decision making, and develop an environment of trust and mutual respect, information sharing and collaboration. The literature is replete with successful collaborative stories where mental health NPs provide cost-effective quality care for consumers of mental health services whilst at the same time providing effective collaborative partnerships with the medical profession.

Physicians who support the MHNP role in Australia will assist in retaining expert MHN clinicians through better pay, career structure and job satisfaction; help improve access to mental health services and quality, cost-effective mental health care for clients who are not currently serviced adequately; and ease workloads and possibly increase efficiencies in GPs’ practices.

In Australia, GPs, especially those in rural areas, claim excessive workloads accompanied by a shortage of locum doctors and GPs as a serious stressor (Metherell, 2003). NPs can help GPs reduce their workloads whilst maintaining cost efficiencies in their practices.

2.6.3.8 References


86


Sydney Morning Herald. (2002, September 6). Fears hospital super nurse is ‘disaster waiting to happen’.


2.6.4 Manuscript 6: Mental Health Nurse Practitioners and Physicians


Manuscript Type: Abstract

Full Title: MENTAL HEALTH NURSE PRACTITIONERS AND PHYSICIANS

Author: Fisher, J. & Wand, T.

2.6.4.1 Abstract

Whilst both the need for and the potential of the MHNP role is well demonstrated in Australia, only seven MHNPs have been authorised to practice in NSW since the legislation was proclaimed in 1998. Bureaucratic impediments combined with organised resistance from physician organisations have contributed to the very slow implementation of the legislation.

The authors will outline a model of MHNP service delivery in an emergency department (ED) of a large metropolitan hospital in Sydney to demonstrate how the role of an MHNP can exist harmoniously within a heavily medicalised and physician-dominated environment. In this model, overall care in the ED including triage, medical assessment and the process of consultation, referral and disposition is enhanced by MHNP intervention. The service involves the provision of advanced MHN assessment skills, therapeutic techniques, care coordination, referral, follow-up and guideline development. Strengthened links between mental health services, community organisations and mainstream medical services are also achieved through regular contact with the consultation–liaison psychiatry team, the staff of the mental health service and mental health workers and physicians in the community.

The challenge for both the medical and nursing professions in developing this productive partnership was to overcome conflict over territorial boundaries, status, authority, and decision-making and develop an environment of trust, mutual respect, information
sharing and collaboration. The MHNP service is highly valued by nursing and medical staff of the emergency department and is helping to improve access to mental health services and quality care for clients with mental illnesses.

2.6.5 Manuscript 7: The Mental Health Nurse Practitioner in the Emergency Department

<table>
<thead>
<tr>
<th>Journal:</th>
<th>International Journal of Mental Health Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manuscript Type:</td>
<td>Journal Article</td>
</tr>
<tr>
<td>Full Title:</td>
<td>THE MENTAL HEALTH NURSE PRACTITIONER IN THE EMERGENCY DEPARTMENT</td>
</tr>
<tr>
<td>Short Title:</td>
<td>MENTAL HEALTH NURSE PRACTITIONER ROLE</td>
</tr>
<tr>
<td>Author:</td>
<td>Wand, T. &amp; Fisher, J.</td>
</tr>
</tbody>
</table>
This article has been removed due to Copyright restrictions. The published version is available at

2.7 Psychological Therapies

To examine the potential therapeutic role of mental health nursing in terms of clinical practice, it is necessary to review the relevant evidence-based literature. Psychological therapies are increasingly recognised by health care management, practitioners and researchers as important in the treatment of mental illness and are suitable for incorporating into the therapeutic role of MHNs.

There is a significant body of research highlighting the effectiveness of psychological therapies in treating the symptoms of major mental illness (Buckley et al., 2007; Jeffery et al., 2000; Lewis et al., 2005; McIntosh et al., 2006; Pharoah et al., 2003). Many researchers and scholars, in their reviews of the literature, have shown how CBT can help to reduce both the negative symptoms such as social withdrawal and the positive symptoms such as hallucinations that are associated with schizophrenia, and that these effects are long lasting (Dickerson, 2000; Grant, 2004; Haddock et al., 1998; Rector & Beck, 2001; Tarrier, 2005). Similarly, reviews of the literature have shown the effectiveness of CBT for the successful treatment of the symptoms of mood disorders and anxiety disorders, and again these effects are shown to be long lasting (Beck, 2005; Butler, Chapman, Forman & Beck, 2006; Grant, 2004). For example, Munro, Baker and Playle (2005) in their review of the literature of the effectiveness of CBT to clients who were acutely psychotic within acute mental health care settings found a significant reduction in severity of positive symptoms across all studies as measured on various assessment scales. They also noted that CBT was viewed as an acceptable intervention by most patients.

A number of studies have also shown that when nurses incorporate CBT into their practice, similar long-term improvements in health outcomes occur (Chan & Leung, 2002; Department of Health, 2004; England, 2007; Poole & Grant, 2005; Turkington et al., 2006). Turkington Kingdon and Turner (2003) in a randomised controlled trial of 422 people with schizophrenia, found that patients who received up to 6 hour long
sessions of CBT from community psychiatric nurses had significantly (p<0.05) improved symptoms overall, were less depressed and had improved insight compared to the control group. Similarly, Durham et.al. (2003) in their research tested the effectiveness of CBT delivered by clinical nurse specialists compared with treatment as usual and supportive psychotherapy. Two hundred and seventy-four patients diagnosed with schizophrenia were randomly allocated to one of the three groups and were followed up for 3 months. The patients receiving CBT showed significantly greater improvement in overall symptom severity and higher scores of patient satisfaction than those in the other groups (Durham et.al. 2003). Turkington et. al. (2006) in a 1 year follow-up study of 336 of the 422 randomised at base line patients with schizophrenia, found those who had received CBT from nurses compared with those who received usual care had significantly more insight (p=0.021) and significantly fewer negative symptoms (p=0.002). Those who received CBT were also protected from depression, were less likely to relapse, and spent significantly less time in hospital if they did relapse, and re-admission was delayed. They also found on 1 year follow-up that CBT did not improve psychotic symptoms or occupational recovery. They concluded mental health nurses should be trained in using CBT for the treatment of schizophrenia as a supplement to case management (Turkington et. al. 2006).

Mullen (2009) reviewed the literature on psychological interventions in acute care mental health units and found that whilst research evidence supports the use of these interventions, in particular CBT, they were not being used by MHNs. He noted that “for some time, the literature has expressed concern over the lack of routine use of psychosocial interventions within mental health services, including acute inpatient units” (Mullen, 2009, p. 85). Since the research evidence has demonstrated that psychological interventions, in particular CBT, are useful therapeutic interventions in mental health nursing, it is necessary to examine why they are not being incorporated into the therapeutic role of nurses. Mullen (2009) found that despite the evidence base supporting these interventions, an over-reliance on medications and custodial care were two problems contributing to this situation. It is clear from the above discussion that the therapeutic role of the mental health nurse will be improved if nurses adopt psychological
therapies such as CBT in their therapeutic practice. However, there appear to be problems that prevent mental health nurses from adopting these evidence based therapies.

Problems in adopting EBP by MHNs are examined in the following co-authored article published in the *International Journal of Mental Health Nursing*. The analysis within the article helps explain why EBP is problematic when applied to mental health nursing and also provides some clarification on why CBT is sometimes viewed contentiously by mental health nurses. In keeping with the theoretical foundations of this thesis, the article provides a literature review and critical analysis of EBP as it applies to mental health nursing and examines the evidence supporting the use of psychological therapies by MHNs.

### 2.7.1 Manuscript 8: Implications of Evidence-Based Practice for Mental Health Nursing

<table>
<thead>
<tr>
<th><strong>Journal:</strong></th>
<th>International Journal of Mental Health Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manuscript Type:</strong></td>
<td>Journal Article</td>
</tr>
<tr>
<td><strong>Full Title:</strong></td>
<td>IMPLICATIONS OF EVIDENCE-BASED PRACTICE FOR MENTAL HEALTH NURSING</td>
</tr>
<tr>
<td><strong>Short Title:</strong></td>
<td>EVIDENCE-BASED PRACTICE AND MENTAL HEALTH NURSING</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Fisher, J. &amp; Happell, B.</td>
</tr>
</tbody>
</table>
This article has been removed due to Copyright restrictions. The published version is available at
2.8 Conclusion

The discussion in this chapter comprised the literature review of this research project, which examines the current and potential therapeutic roles of the MHN, the current context of mental health nursing practice, the treatment experiences of consumers of mental health nursing care and which determined the suitability and usage of psychological therapies by MHNs.

The scope of the literature review therefore covered three key areas:

1. The current context of mental health nursing practice in order to identify factors that influence mental health nursing practice.
2. The treatment experiences of consumers of mental health nursing care in order to identify therapeutic roles suitable for inpatient and community mental health nursing practice.
3. Current and potential therapeutic roles of MHNs in Australia in order to determine the suitability and usage of psychological therapies.

A review of the literature on diagnosis and diagnostic classification systems used in psychiatry enabled an understanding of the current knowledge base influencing mental health nursing. It is shown in the literature review that the DSM and ICD psychiatric diagnostic systems dominate and guide the therapeutic treatment of patients/consumers, the gathering of hospital and medical statistics, and that they determine Medicare and pharmaceutical rebates and, therefore, the therapeutic role of the MHN. The literature revealed a large body of work that challenged both the reliability and validity of these diagnostic categories, arguing that the bio-medical model they represent is inadequate for the care and treatment of people living with mental illness. Consequently, this raises questions about the integrity of the knowledge base that underlies mental health nursing and is relevant to this research because these diagnostic systems and the bio-medical model reduce the capacity of MHNs to employ other therapeutic perspectives.
Theoretical frameworks for the causation and treatment of mental illness were examined to further explore factors that influence mental health nursing practice. The review of the literature in this area identified three main theoretical paradigms. The role of the MHN was shown to be very different within each of the paradigms. For example, within the bio-medical paradigm, the nurse’s role is shown to be dominated by the administration of drug therapy and other physical treatments, commonly in response to a legally sanctioned treatment order. MHNs operating within a psychological framework utilised a variety of psychological counselling techniques to assist their patients towards recovery. Nurses operating within a socio-cultural paradigm advocate for and assist consumers to function in the social context of their lives. Despite the different focus of the roles within these paradigms, it was noted in the literature that while MHNs integrate various theoretical frameworks adopting eclectic and pragmatic approaches to their therapeutic practice, their current practice is dominated by the bio-medical model.

The literature investigating treatment experiences of consumers of mental health nursing care was examined in order to ascertain therapeutic roles suitable for inpatient and community mental health nursing practice. The impact on consumers of reduced resources, bed shortages and fewer skilled specialist staff showed there was an increasing risk of violence, self-directed or otherwise within mental health care settings. It was clear from this review that consumers frequently feel unsafe and find many mental health settings unhelpful and not therapeutic.

The literature investigating current and potential therapeutic roles of MHNs in Australia helped to determine the usage and suitability of psychological therapies for MHNs. Changes in the MHN’s role, in particular the emergence of the MHNP role, illustrated the potential for this role to improve accessibility, affordability and appropriateness of mental health services. Additionally, the literature review overviewed the forces resisting change in mental health and in the role of mental health nursing. For example, professional boundaries between allied health care workers, nurses and psychiatrists were shown to be highly protected, causing resistance to change and reluctance to form partnerships between professionals. Additionally, the literature clearly demonstrated that
psychological therapies are effective in the treatment of mental illness and that they are suitable for incorporating into the therapeutic role of MHNs. Yet the literature also shows that the adoption of EBP in mental health nursing can be contentious because of the bias within EBP on randomised control trials (RCTs) as being the most trusted form of scientific evidence. MHNs argue that what counts as evidence in MHN practice must incorporate patient values, characteristics and circumstance as well as the expertise and skills of the practitioner; all of which are difficult to quantify via an RCT.

The current project is positioned and justified within this review of the literature in the following ways. Firstly, the literature demonstrates that there are significant challenges to the theoretical context and accepted knowledge base of bio-medical psychiatry and of mental health nursing. Given bio-medical psychiatry significantly justifies and guides the therapeutic practices of MHNs, there is a need to re-examine contemporary mental health nursing practice in light of these criticisms. Secondly, the literature review identified serious criticisms in Australia from consumers, non-government organisations and from government of current mental health services and mental health nursing care. These criticisms justify an examination of the current therapeutic role of the MHN to see if there may be therapeutic alternatives to improve current practices. The importance of including the consumer voice in this project is justified by this consumer criticism. Thirdly, there is substantial evidence justifying the use of psychological therapies by nurses caring for people living with serious mental illnesses. Despite this, there is limited research examining the usage of psychological therapies by MHNs both internationally and particularly in Australia. This project will identify the current attitudes towards and use of psychological therapies by MHNs in Australia with an aim to improve the therapeutic role of the MHN.

In the following chapter the methodology is outlined. A multi-method approach is described, including interviews with a small sample of experts, both consumer and clinical MHNs, a modified Delphi process for analysis of these interviews, followed by a questionnaire survey of practicing MHNs. The research methods are described in detail in the following chapter.
Chapter 3: Methodology

3.1 Introduction

This research project investigates the therapeutic role of the MHN in order to enable identification of therapeutic nursing practices and factors influencing the adoption and usage of psychological treatments by MHNs:

1. What do consumers think will improve the quality of their care?
2. What do nurses think will improve the quality of nursing care for people living with mental illness?
3. What factors influence mental health nursing practice in relation to the use of psychological therapies?

To address these three questions a research approach was required that enables predictions of the future therapeutic role of MHNs from both a consumer and clinical MHN viewpoint. Additionally, the method selected needs to address and make visible the complexity of the therapeutic role of MHNs and the contextual dimensions of these two different viewpoints.

In this chapter the methodology of the research is described. The chapter is divided into four sections: the first provides the methodological framework for the study; the second section describes the research design and ethical considerations; the third outlines the methodological processes for phase one, the Delphi surveys of consumers and expert MHNs; and the fourth section describes the methodological processes for phase two, the questionnaire survey of MHNs.
3.2 Section 1: Framing the Research: Critical Realism, Ontological, Epistemological and Methodological Assumptions

The research is framed within the post-positivist paradigm. In this paradigm ontology is given preference over epistemology and critical realism is given a central place in this ontology. Critical realism has been described as both a philosophy (Yeung, 1997) and a theory (Connelly, 2001). It is “a distinct version of the realist philosophy originally proposed by Roy Bhaskar … and adapted by many other writers” (Yeung, 1997, p. 52). The adaptation has resulted in a variety of forms of realism with different labels. Scheurich (1997) has suggested that critical realism, along with coherent realism and neo-realism, can be grouped together under the label of scientific realism. This is supported by Yeung (1997, p. 52), who has suggested that critical realism represents a “Bhaskarian version of scientific realism in the social sciences”.

Post-positivism, and in particular, critical realism, arose as a reaction to the criticisms, tension and epistemological problems of positivism, which is said to be characterised by a naïve realism (Scheurich, 1997). For example, the positivist view that all genuine enquiry into both the physical and the social sciences should be concerned with the observation, description and explanation of empirical facts, ignores the observation that empirical facts are not always observable because they may be: a) unactivated, or b) they may be activated but not perceived, or c) they may be activated but counteracted by other mechanisms which make them unpredictable (Mautner, 2000). Thus, non-realisation of an ‘empirical fact’ does not necessarily mean it does not exist. Post-positivism is seen by Guba (1990) as a modification of positivism rather than a total break from this tradition. In post-positivism there is a move away from the positivists’ notion that reality is ‘out there’ and that it can be fully grasped (Guba, 1990, p. 20). A more comprehensive reality is revealed by using multiple methods to capture as much information about a phenomenon as is possible. Therefore critical realism can be described as an intermediate philosophical stance between realism and critical theory (Lincoln & Guba, 2000). According to Giddens (1981), realism acknowledges a comprehensible and independently existing nature whilst also conceding that scientific objectivity is not absolute. Sim and
Van Loon (2002) point out that critical theory offers a range of possible scientific methods and perspectives with which to analyse social, political, historical, cultural and gender contexts.

According to Guba (1990), there are three levels that demonstrate the characteristics of post-positivism. Firstly, ontological realism, the recognition that we live in a world that exists independently of us and our thoughts and that, therefore, some facts are beyond our grasp, is a central concept of post-positivism. Denzin and Lincoln (2003, p. 14) have argued that in this tradition ‘reality can never be fully apprehended, only approximated’. Secondly, at an epistemological level, objectivity is seen as a ‘regulatory ideal’ (Guba, 1990, p. 221) with a striving for as high a level of neutrality as possible. Assumptions and presumptions are laid out for all to critique. Thirdly, at a methodological level there is a ‘commitment to critical realism and modified subjectivity, and an emphasis is placed on critical multiplism’ (Guba, 1990, p. 21). Critical multiplism allows for the notion of triangulation or multiple methods in order to limit ‘distorted interpretations’ (Guba, 1990, p. 21). Research is conducted in a more natural environment than in positivist research, and qualitative methods are encouraged, thus creating the space for discovery as well as generalisation.

Thus, critical realist research recognises that studying the human (social) world is different from studying the physical world, but that there exists a physical and social world that may be beyond our knowledge, and is constructed, structured and influenced by both the physical world and individual life experiences, knowledge and psychology. In order to study the human world and the social structures humans inhabit, the scientific method needs to be adapted. The focus of critical realism in this post-positivist framework involves a social scientific method aiming to identify what produces social events and how individuals inhabit and change social structures; ‘the interaction between structures and agents is the focus of critical realist research’ (Scott, 2007, p. 15). For example, in addition to understanding the individual within a specific context, critical realism requires an examination of social structures, and the ‘historical generative mechanisms’ and ‘causal powers’ that have produced them. Causal powers can be
material, cognitive or emotional and they influence individual actions, which, in turn, become a part of generative mechanisms (Pawson, 2006). Critical realist research avoids methodological individualism and enables an examination of the interplay between agency and structure, context and power relations. The relationship between causal powers and generative mechanisms and the individual are described by Carter and New (2006, p. 14): “Structures are described as generative mechanisms, because when their causal powers are realised they work to make something happen. But the effects of structures are mediated by agency: in social life, nothing happens without the activation of the causal powers of people. Crucial among these is the power to decide.”

Researchers who subscribe to a critical realist paradigm draw on research methods that best address the needs and purposes of the research, sometimes using a mixture of both quantitative and qualitative methods or using more than one strategy of inquiry from within the same methodology (McKerchar, 2009). For example, McEvoy and Richards (2003, p. 414) list ethnography, participant observation, structured and unstructured interviews, descriptive statistics, participatory action research and quasi experimental designs as valid critical realist ways of exploring social phenomena. Downward and Mearman (2002, p. 2), in their critique of research methods in economic theory, argue that quantitative methods alone such as mathematical and statistical methods are inadequate in explaining and predicting human behaviour and that examination of the assumptions of these empirical insights should be a central part of any empirical claims. In support of the critical realist approach they draw on Lawson’s (1994, 1997) work, arguing that the central core of critical realist epistemology is an acknowledgement of the complexity of social systems and the need to move beyond simply inductive and deductive reasoning towards broader conceptions of causal relationships and explanations of phenomena. Downward and Mearman (2007) agree that multiple methods, triangulation or mixed-method research (they use the terms interchangeably) can be used as a means to understanding the complexity of social systems, and that relying on only one method, for example, statistical or mathematical modelling, is misguided. They believe that mixed-method research or triangulation can break down barriers between disciplines and therefore help to create empirical insights into complex social systems.
These notions are further expanded by Yeung (1997, p. 51), who has argued that appropriate methodological considerations for researchers choosing to investigate social phenomena in this paradigm include ‘iterative abstraction, qualified grounded theory method and methodological triangulation’. In particular, the ‘realist interview’ is an important social scientific method for both identifying and predicting the social context under study (Connelly, 2001). Whilst some critical realists emphasise qualitative approaches, others argue for largely quantitative methods; however, most agree it is the way the methods are used rather than the methods themselves that is important (McEvoy & Richards, 2003).

The idea of mixed-method research or triangulation has itself been criticised because it assumes that data arising from different research methods can be compared and treated equally in terms of explanatory capacity, even though it may have arisen from quite different contexts and influences. Modell (2009, p. 208), McEvoy and Richards (2006, p. 66) and Bryman (2004) caution about the confusion that may result from ‘paradigm switching’, where research methods developed out of different philosophical assumptions are integrated. Nevertheless, these authors remain convinced that multi-method approaches function to increase researchers’ sensitivity to context-specific variations. McKercher (2009) argues that critical realism and a mixed-method approach allows for and acknowledges the complexities in the relationships under study and enables both validation and compensation for any weaknesses of each research strategy used within a mixed-method approach.

Some scholars differentiate between mixed-method research and triangulation. For example, Andrew and Halcomb (2009) define triangulation as ‘two or more data sources, investigators, methods, or theories in the study of a phenomenon’ (p. xxvii) and a mixed method as ‘where both qualitative and quantitative methods of data collection are used in a single study’ (p.xv). Whereas Bryman (2004) prefers the term ‘triangulation’ to be reserved for those instances where researchers use different methods as a means to cross-check the validity of their findings. The notion of validity checking is in itself criticised for the inherent naïve realism implied in believing the validity of findings from complex
social systems can be definitive rather than simply viewed as one explanation amongst many possible explanations (Poutanen & Kovalainen, 2005). Denzin (1970, 2006), an early and regular writer on triangulation, advocates a broader definition of the term, which is as a description of different research methods aimed to improve the validity of findings of complex social systems. He distinguishes between ‘within-method‘ and ‘between-method‘ triangulation, where the former might involve using two different methods of questioning within a questionnaire survey, for example, Likert scales and true or false questions, and the latter involves different research methods, for example, observations, the Delphi technique and questionnaire surveys.

Critical realism and multi-method approaches are becoming increasingly popular in nursing research. Lidscomb (2008) noted a significant rise in the number of articles using the key word ‘mixed method‘ in the British Nursing Index and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) between 1997 and 2006. McEvoy and Richards (2003, 2006) argue that critical realism is important for researching frontline nursing services, in particular, evidence-based interventions, to ensure that they are used effectively in the context of clinical practice and policy analysis. Clarke et al. (2008) argue that critical realist research methods help nursing researchers to understand the complexities of both agency and structural factors in health care and facilitate collaborative cross-disciplinary research aimed at improving interventions and ‘explicate biopsychosocial pathways‘ (p. 178). Wilson and McCormack (2006, p. 45) draw attention to critical realist evaluative research in nursing, particularly showing how emancipatory practice development is linked to effective evaluation that examines the complexities of the ‘ever changing environment of clinical practice‘ and evaluates the outcomes of practice development activities within these complexities. Wand (2010) similarly shows how critical realist research methods can be applied in evaluative research and uses this approach to evaluate the first MHNP outpatient service in NSW Australia. Porter and Ryan (1996, p. 420) demonstrate how a critical realist methodology can overcome the individualist bias in nursing research, which they argue denies causal complexities and the ‘profound external constraints upon the operationalisation of effective nursing care‘.
The research method selected in this study follows a critical realist method with an emphasis on quantitative methods. The research employs Denzin’s 'within-method' and 'between-method' triangulation and utilises the broader definition of the term. The Delphi method selected for phase one of this study comprises 'within-method' triangulation employing qualitative semi-structured interviews and a series of quantitative questionnaire surveys. In contrast, a randomised questionnaire survey, informed by the Delphi surveys, was selected as the method in phase two of the study. As these two methods are different from each other, they fulfil Denzin’s definition of 'between-method' triangulation. Further, a sequential design was selected where the data analysis from one method informed the subsequent method. This is common in triangulation or mixed-method research and can assist with the reliability and validity of both the research instruments and the findings. These research methods are discussed in more detail in Sections 3.4 and 3.5 and issues of validity and reliability are discussed in Chapter 6.

3.2.1 Critical Realism and the Critical Social Theories of Foucault, Althusser and Fraser

The critical realist method allows the researcher to make judgments and selections on where to focus in order to discover the generative mechanisms and causal powers underlying the question under study; in this case, the therapeutic role of the MHN. Yeung (1997) argues for the researcher to select, from multiple viewpoints, a relevant focus for the question under study. He acknowledges in the following quote that not all viewpoints are necessarily equally valid, ‘to a critical realist, all knowledge is fallible, but not equally fallible’ (p. 54). Scott (2007, p. 14) suggests that decisions about philosophical approaches are central to the selection of viewpoints and research methods and strategies within a critical realist method. The following discussion justifies the philosophical framework for the viewpoints examined, which then provide guidance to the selection of method and analysis used in this study. For example, Foucault’s focus on the importance of ‘epistemic structures’ provides one viewpoint to explore, Althusser’s theory of ideology and its influence on social structures provides another and Fraser’s feminist views are important because nursing is a gendered profession operating within gendered
economic social structures. Whilst Foucault, Althusser and Fraser provide guidance for the philosophical focus of the analysis and discussion, a critical realist research method is employed. As can be seen from the previous discussion, critical realism enables the researcher to select a multi-method approach in order to obtain multiple viewpoints about the issue under study.

From the standpoint of critical social theory and critical realism, Foucault’s work adds considerably to an understanding of the way the social operates. Foucault rejected the positivist approach of discovering essential truths about the self and society in favour of discovering cases in which what are presented as truths are in fact products of historical social beliefs and situations. As Bunnin and Tsui-James (2003) argue, Foucault’s writings do not provide an ontological theory of being or how we are, but rather through an epistemological examination of historical discourses and power relationships he shows how we could be different to what we are. Through this process, Joseph (2004) describes Foucault’s studies of madness and illness and his treatise _The Order of Things_ and _The Archeology of Knowledge_, as epistemological accounts influenced by an anti-humanist structuralism which he believes adds considerably to an understanding of the way the social operates through techniques of discipline, control and regulation. In this sense, Foucault can be seen to fit the critical realist paradigm in two aspects. Firstly, the critical realist awareness that the real world is independent of the knowledge we have of it and secondly, that the world itself and the knowledge we have of it are not necessarily one and the same thing (Joseph, 2004). Foucault’s constructivist view of the relativity of truth is well illustrated in the following quote:

> Each society has its regime of truth, its general politics of truth: that is the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements; the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (Foucault, 1980, p. 131)

Foucault can also be read from a post-modern paradigm if his works are viewed as implying that all knowledge (and social events) are intransitive and that, therefore, reality is defined only according to the power of the discourses that describe it. For example,
reality outside of what we understand it to be (knowledge) does not exist. This post-modern notion is antithetical to critical realists, who would describe this as an ‘epistemic fallacy’ where reality is reduced to the knowledge that we have of it (Bhaskar, 1978, p. 22). At the same time, critical realists acknowledge that it is important to show that the transitive domain of human knowledge is full of power relations and that knowledge therefore develops not only from a desire to understand the world, but is also influenced by theoretical, practical and institutional contexts. Joseph (2004, p. 145) resolves this dilemma for critical realism most clearly in the following quote: ‘critical realism argues that the possibility of knowledge and the forms that it takes (as practices and disciplines) reflects the fact that the world has an ordered, intelligible, and relatively enduring structure that is open to scientific investigation’. Critical realism acknowledges that social structures and actions act as ‘historical generative mechanisms’ (Connelly, 2001, p. 118), recognising the role of history in the evolution of social structures.

Foucault’s method of exploring a series of histories or ‘epistemic structures’ designed to show how social structures and ourselves within those structures can be construed differently, fits well with the Bhaskarian construct of ‘historical generative mechanisms’. This notion that human reality will change under the influence of differing ‘generative mechanisms’ is particularly relevant when studying the therapeutic role of the MHN. Foucault’s method allows an analysis of the dominant epistemic structures (for example, the bio-medical model) controlling the therapeutic actions/roles of MHNs and the care and treatment of consumers of mental health services and can explain how ‘epistemic structures’ become generative mechanisms in the critical realist perspective. In addition, his first book written in 1967 ‘Madness and Civilization’, which traces the dominant paradigms and discourses underlying the treatment of mental illness historically, is particularly relevant to the topic under study.

Althusser was selected as a theorist underpinning this research for three reasons. Firstly, his ideas, which are normally classed as structuralist Marxism, are informative for an examination of how ideology influences scientific knowledge. Secondly, his theories provided a foundation for early critical realists such as Bhaskar (Puehretmayer, 2001) and
thirdly, his personal experiences with mental illness. Althusser suffered from depression all his adult life, spending extensive periods in mental institutions where he received some of the most aggressive psychiatric treatment available including electroconvulsive therapy, narco-analysis and psychoanalysis (Roazin, 2003). This contact with psychiatry influenced his theories; in particular, his notions of the unconscious mind were incorporated into his theory of ideology (Lewis, 2005). It is interesting to note how, despite Althusser's critique of ideology, as a consumer he succumbed un 'critically' to the power and ideology of bio-medical psychiatry and psychoanalysis. Althusser's 'treatment' was viewed as detrimental by his colleagues and at one stage they signed an unpublished letter to Le Monde protesting the conduct of his analyst (Roazin, 2003, p. 90).

Althusser's analysis of Marx aimed to expose and separate the unconsciously held ideological concepts influencing his work and through this process reveal Marx's true philosophy. Althusser believed that texts and their authors are products of the ideologies of their times and in order to understand the true philosophy of a text it was necessary to separate and disentangle the influence of the underlying ideology. He believed that these underlying ideologies held by the author of a text could be unveiled through searching for 'symptoms' within the text. These symptoms were demonstrated via contradictions within the text (the theory of Dialectical Materialism). His analysis of Marx demonstrated how ideology was inherent in Marx's work, but because Marx had not made his ideological assumptions explicit, Althusser believed Marx was consciously unaware of their influence. Althusser argued that the job of science is to weed out ideological distractions in order to get closer to scientific truths (Lewis, 2005). He argued that philosophy is a type of ideological production (linked to the Marxist 'mode of production') and, therefore, tends to sustain existing socio-economic relations. Althusser used the term 'epistemological break' to describe a period when ideological concepts are replaced by scientific ones (Mautner, 2000). He claimed that an example of such a transformation occurring is Marx's founding of historical materialism, which enabled theorists to comprehend the ways we materially produce our 'selves', our environments, our knowledge and our histories (Lewis, 2005). Thus, Althusser's method works to
provide a scientific method (dialectical materialism) to distinguish between ideological concepts and scientific ones and through this enable a science to transform existing ideas into scientific knowledge. Thus, he argues that Marx's method of 'historical materialism' shows us that human beings and the structures within which they operate are 'ideological state apparatuses', historically generated and serving to reproduce existing social relations; in other words, they are generative mechanisms in the sense that they produce and maintain social events, social structures and social roles.

Althusser's theory of ideology, the role of ideology on social structures (ideological state apparatuses) and his method of dialectical materialism assist social theorists to distinguish what is real from what is thought or imagined to be real. Through this process, philosophers are able to clarify where and how the concepts scientists employ are ideological, thus enabling a shift from an idealist ideology to one that is materialist and more scientific and, therefore, more able to achieve its goals. This is relevant to an analysis of the current and future therapeutic role of the MHN in order to help make explicit the influence of ideology on the nurse's role and to examine how ideology is restricting nurses from adapting their therapeutic practice, for example, by adopting evidence-based psychological therapies such as CBT and achieving professional emancipation from the restrictions of the bio-medical paradigm in psychiatry.

Feminist theory is concerned with understanding the role of gender and gender inequality in society, in particular, the causes of gender inequality and how to promote the emancipation of women. As such, feminist theory involves a structural critique of society in terms of gender. Initially, feminist theorists focused on understanding political inequalities and on achieving the right for women to vote. When this was achieved, feminism broadened its examination of gender inequality to the social, cultural, economic and political spheres. Fraser (1989, 2009) sits within this 'second wave' of feminism and identifies herself as a socialist feminist working within a critical theorist paradigm. As with Marxist theorists such as Althusser, socialist feminists make central the influence of economic structures in society; however, their focus is on the examination of the role of economic structures in perpetuating gender inequality and preventing gender justice.
Fraser points out that it is frequently argued that _second wave feminism has wrought an epochal cultural revolution, but vast change in mentalities has not (yet) translated into structural institutional change_ (Fraser, 2009, p. 2). By this, she acknowledges that feminist ideals of gender equality are largely accepted in mainstream society, however significant gender inequalities remain because the structures and institutions of society are resisting this cultural change. Fraser puts forth the argument that this resistance is largely a result of neo-liberalist capitalism, which promotes deregulation, privatisation, competition and personal responsibility, thereby reducing the political power of governments to control capital and _steer_ national economies (Fraser, 2009, p. 6). Fraser is concerned that aspects of feminist ideals were incorporated to promote neo-liberalist ideology but the important emancipatory and social egalitarianism ideals of feminism were not. Thus, institutions and economic structures within this neo-liberalist thrust are focused on the exploitation and subordination of workers. She argues that the cultural change in attitude has allowed women to _pour into labour markets_, but under a deregulated market the effect of this has been to _depress wage levels, decrease job security, …and increase the number of hours worked per household_ (Fraser, 2009, p. 7). Fraser’s analysis highlights the power of economic ideologies over social structures and institutions to both resist change and dictate the quality of gender relationships. Her analysis is relevant to this project because MHNs are operating within bureaucratic health care institutions and systems that, in turn, are controlled by economic ideologies such as neo-liberalist economics. Potter (2001, p. 69), also a second-wave feminist, in her examination of psychiatric and psychological institutions, points out that _science as we know it is deeply implicated in structures of oppression and violence done to humans and our environment_. Potter argues that clinicians and researchers in psychiatry and psychology have progressed more slowly than other disciplines and practices in efforts to eradicate _epistemological assumptions, ontological commitments and conceptual errors that are devaluing of and debilitating to women_ (p. 61). Potter (2002) believes that the majority of psychology and psychiatric literature still takes an androcentric view as the norm for humans.
Feminist theorists debate the view that Bhaskar’s critical realism is turning the clock back towards a positivist view of social science. Poutanen and Kovalainen (2005) summarise the critiques of critical realism by four feminists: Drucilla Barker, Sandra Harding, Julie Nelson and Fabienne Peter. Firstly, critical realism wrongly privileges reason, abstraction and precision over emotion; secondly, it emphasises the commonality of human nature such as shared interests, needs and motives rather than the feminist position that there is no self-evident commonality to human nature; and thirdly they argue, the critical realist notion that reality can be represented in culture-free ways or that science can accurately represent this reality is scientific naivety (Poutanen and Kovalainen, 2005). These criticisms have been countered by others who support critical realism within a feminist framework. Lawson (1999) claims the methodological framework of critical realism provides a \textit{methodological means} to analyse the explanatory and emancipatory projects of feminist theorists. Lovell (2007), whilst acknowledging there has been limited engagement between feminist theory and critical realism, believes Fraser’s analysis sits well within a critical realist perspective. Similarly, Margaret Archer, one of the most influential critical realist theorists, argues that as a method, critical realism allows feminist researchers to produce empirically grounded knowledge and as such contribute to emancipatory practice (Archer et al., 1998).

Notwithstanding this debate, a feminist analysis is relevant to an examination of the therapeutic role of the MHN because nurses are employed in a gendered workplace that utilises a predominantly reductionist and positivist medical model of service delivery. Additionally, as noted by Fraser, economic structures and institutions have a powerful role in the formation of attitudes and the implementation of change. For example, psychiatrists (mostly male) operating from a positivist bio-medical framework and working through a complex interplay of institutional forces, influence the therapeutic role of nurses (predominantly female) who are situated in a subordinate position within these institutions. The following quote by Potter (2002, p. 69) encapsulates why a feminist perspective is particularly relevant to this study:

\begin{quote}
a feminist-informed psychology and psychiatry that are willing to reexamine basic ontological commitments can be liberating both to the practitioner and patient. For example, clinicians and researchers may entertain some skepticism
\end{quote}
about the medical model in light of claims that the underlying metaphysics is reductionist in ways that are particularly harmful to women.

The therapeutic role of the MHN is acted out within cultural environments shaped by complex epistemological and ontological social scientific paradigms and institutional structures. Critical realism provides a method of scientific enquiry to meet the research objectives of this study because the critical realist approach reduces unnecessary polarisations within scientific enquiry and allows the researcher to select from differing theoretical perspectives those aspects of particular relevance.

3.3 Section 2: Research Design and Ethical Considerations

In keeping with post-positivism and critical realism and in order to increase the validity of the findings, a mixed-method approach as defined by Denzin (2006), using both quantitative and qualitative methods of data collection, is utilised in this research. The use of this approach, as discussed in the previous section, is chosen to ensure a richer data base, enable quantification of data and give rise to a more complete picture of the current and future therapeutic role of the MHN. In addition, using multiple methods can increase the validity and reliability of the findings.

Two research methods were selected to address the three research questions. The first method (phase one) comprised two Delphi surveys—one for consumers and the other for clinical MHNs. The Delphi design for this project was selected from examples of Delphi technique available from the literature. The Delphi surveys comprised individual semi-structured interviews that were transcribed and analysed to identify key themes. These key themes were then returned to participants for comment and prioritisation utilising the Delphi survey process. The second method (phase two) comprised a questionnaire survey of clinical MHNs. Information obtained from the Delphi survey and the literature review contributed to the development of the questionnaire. Figure 3.1 illustrates the design of the study. Figure 3.2 illustrates the Delphi design used in this study.
Figure 3.1: Design of the Study.

Research questions
1. What do consumers think will improve the quality of their care?
2. What do nurses think will improve the quality of nursing care for people living with mental illness?
3. What factors influence mental health nursing practice in relation to the use of psychological therapies?

Phase one
a. Delphi study - consumer group
b. Delphi study - mental health nurse group

Phase two
Online questionnaire survey of practicing mental health nurses

Figure 3.1: Design of the Study.

Figure 3.2: Delphi Design of the Study
3.3.1 Ethical Considerations

Ethical approval to conduct the study was granted by the Southern Cross University Human Research Ethics Committee. As the research was conducted in two phases, with the questionnaire developed from the findings in phase one, two ethical approvals were granted. Both of these can be viewed in Appendix 4.

Participating in the study was voluntary and there was no obligation to participate. Participants were able to withdraw from the study at any time without providing a reason or having any negative consequence. Participants were clearly and adequately informed about the purpose of the study and its likely benefits. Participants’ welfare and rights took precedence and in terms of the consumers’ panel, capacity to consent was an ongoing negotiation between the participant and the researcher. Confidentiality was maintained through coding of participants and removal of identifiers at an early stage in data analysis.

The consent process involved two steps. Firstly, potential participants in phase 1 of the study were sent a participant information statement and consent form to sign. These can be viewed in Appendices 6a and 6b. In phase 2 the questionnaire was accompanied by a participant information statement and completion of the questionnaire by MHNs was taken as consent to participate. The participant information statement outlined the purposes of the study, the methods of the research, a timeline, the name and qualifications of the researchers and the name of contact people for further information. The information statement also included a statement about any possible risks and/or discomforts that might arise for the participant and the subsequent actions and responsibilities of the researchers. The steps required to become involved were clearly articulated along with a statement noting that withdrawal from the study could occur at any time without any negative consequence for the participant.

Due to the ongoing and fluctuating nature of mental illness, consent to participate for the consumer panel meant special measures were undertaken to ensure the research was
conducted in an ethical manner (Saks, Jeste, Granholm, & Schneiderman 2002). The consumer Delphi study in phase one of the study included an assessment of current mental wellbeing. Each consumer participant was asked to complete a ten-item self-report questionnaire known as the ‘Kessler-10 plus‘ (K-10+), which is used by the NSW Health Department to ascertain levels of psychological distress. A copy of the K-10+ is included in Appendix 5. If the results of the K-10+ indicated a moderate to high level of psychological distress, capacity to participate was determined collaboratively by the researcher, a qualified and experienced MHN and the consumer. If necessary, the researcher was able to provide the participant with the name and contact details of a counsellor for follow-up support.

Information about the participants is kept in secure storage both whilst the project was being conducted, as well as after the project was completed. The information is stored in both paper copy, tape recordings, computer file and on CD disk. The data are only accessible to the research team. The storage locations are on secured computers in the offices of the research team. Hard copy data are stored in a locked cupboard in the office of Dr Kierrynn Davis, SCU, and in a locked filing cabinet in the home of Ms Jacklin Fisher. Identifiers were used only to ascertain the randomisation of the questionnaire sample and were removed as soon as practicable after the data was coded by computer. As recommended by the National Health and Medical Research Council (NHMRC), the data will be destroyed after a 5-year period unless participants consent to it being used in future research (NHMRC, 2007).

3.4 Phase One of the Study: The Delphi Surveys

The Delphi technique was developed in the 1950s by Olaf Helmer, a mathematician who worked for the Rand Corporation in the USA. He first developed the Delphi technique in order to predict the impact of technology on warfare. The Delphi technique is based on the principle that consensus of opinion from a panel of experts can accurately make predictions about the future, assist in decision making, policy formation and understanding complex human situations (McLeod & Childs, 2007). The traditional
Delphi technique is a highly structured procedure involving a panel of experts who are kept anonymous from each other and a facilitator/researcher who structures the information flow and provides regular feedback to the participants. Typically this involves a series of sequential questionnaires that are sent to each participant for comment, prioritising, and adding or deleting information. The individual feedback from each expert is then returned to the facilitator, who processes it by including new information and filtering out irrelevant content. The revised information is sent back to each participant as a new questionnaire for further comment, prioritising, and adding or deleting of information. This structured feedback continues until consensus between the experts occurs, usually after three feedback rounds (Crisp, Pelletier, Duffield, Adams & Nagy, 1997; Crisp, Pelletier, Duffield, Nagy & Adams, 1999; Duffield, 1993; Powell, 2003).

Whilst it is clear that the expert panel is a key component in determining the quality of the Delphi survey, there is a wide variation on the recommendations for the preferred size and composition of the expert panel. Powell (2003) notes that expert panel size can vary between ten and 1685 and suggests the size of the panel might depend upon the scope of the problem and the resources available, whereas Duffield (1993) suggests that when a panel is homogenous, then a smaller group of members is adequate. How the panel is selected and how an ‘expert’ is determined is similarly flexible within the Delphi process. For example, as Powell (2003) and Crisp et al. (1997) note, there is no requirement that the panel be representative for statistical purposes or that it is randomly selected.

Turoff and Linstone (2002), Crisp et al. (1997, 1999), Duffield (1993), Powell (2003) and others have identified a number of benefits and problems with the method. For example, they point out that if done well, the technique is valued for its ability to structure and organise group communication. Turoff and Linstone (2002) believe that the Delphi method is superior for forecasting because it combines expert opinion whilst maintaining the anonymity of experts from each other, allowing them to more freely express opinions, openly critique others and admit to errors by revising their opinions. Additionally, validity and reliability are enhanced through the regular feedback of results, structuring
of the information flow and through achieving consensus of opinion. The criticisms identified in the literature include the risks that consensus may be forced, and may result in an over-simplification of complex issues. Additionally, the consensus of experts is not always accurate—uncertainty and divergent views, along with the unconventional thinking of amateurs are also important in making predictions about the future and understanding complex issues (Crisp et al., 1997; McLeod & Childs, 2007; Powell, 2003; Skulmoski, Hartman & Krahn, 2007; Turoff & Linstone, 2002). Research into the application of the Delphi technique shows that the technique can be modified to try to meet these criticisms. For example, Turoff and Linstone (2002) show that the technique can also be used to ‘expose uncertainty and divergent views’ (p. 564) and they stress that Delphi can also be used to explore differences in expert opinion.

**Rationale Delphi**

This research, therefore, has selected a Delphi technique, as suggested by Turoff and Linstone (2002), in order to fully explore both divergent and consensus views. Reasons for selecting the Delphi technique in the context of this research are:

1. Structuring of information flow enables the researcher to control the interactions amongst the participants, avoiding problems with group dynamics and facilitating refinement of responses.
2. Regular feedback to participants enables them to comment on their own responses and also the responses of others, further refining the data and also ensuring the analysis was valid and reliable.
3. Anonymity of the participants is particularly important for the consumer group.
4. The method is time- and resource-efficient both for the researcher and for the participants.
5. Whilst it is considered important to try to achieve consensus of opinion from the experts, divergent views are also recognised as potentially relevant in understanding the therapeutic role of MHNs.

Turoff and Linstone (2002) and others point out the first round of the Delphi survey should be relatively unstructured, so that participants can identify the issues to be
addressed about the topic under investigation and are able to elaborate on the topic and present their opinions without censure. This typically involves an unstructured questionnaire survey or a semi-structured interview, seeking open-ended responses on the topic under investigation (Beaumont, 2003; Boath, Mucklow & Black, 1997). Interviewing is one of the most widely used methods for conducting research in the humanities and fits well within a critical realist framework. Connelly (2001, p. 116) states that "the realist interview … is the primary source for both identifying and predicting the generative mechanisms at work in the specific context being studied‘. Varying amounts of structure are used during the interview process. Highly structured interviews are most frequently used in positivist research where eliciting ‘facts’ from the interviewee is the aim. The structured interview is controlled by the interviewer and consists of a series of pre-determined questions asked uniformly of each interviewee. In contrast, unstructured interviews usually consist of few, if any pre-determined questions and allow the interviewee to have control over the content of the interview (Beanland, Schneider, LoBiondo-Wood & Haber, 1999). A semi-structured interview format lies between these and consists of a series of pre-determined themes to be explored during the interview (Beanland et al., 1999). Typically, these themes are explored through communication skills that encourage in-depth discussion. For example, the use of open-ended questioning, probing questions, clarification and reflection are common communication skills utilised in semi-structured interviews (Thomas, 1990).

The semi-structured interview format was selected as the first phase of data gathering for the Delphi surveys because it allows for initial predictions and ideas about the therapeutic role of the MHN to be outlined whilst at the same time allowing for flexibility for new questions and ideas to be raised during the interview. Additionally, semi-structured interviews enable the interviewer to tailor questions to the varying contexts and people being interviewed (Lindlof & Taylor, 2002, p. 195). Individual interviews were also considered favourable to establishing rapport and trust with the participants. This was considered critical in order to enable a free exchange of information to occur for the consumer participants, who may have had problematic experiences with mental health services and nurses. Finally, in order to meet the ethical criteria that the consumer
participants were fully able to give informed consent to the study and were not experiencing mental health problems or psychological distress, it was necessary that the researcher meet the consumer to administer the K-10+ psychological scale prior to interview (see Section 3.4.1 for detailed explanation of the K-10+ scale). To maintain internal consistency, the same method for initial data gathering for the Delphi survey was used with expert MHNs.

### 3.4.1 Method and Data Analysis of the Delphi Surveys

Two Delphi surveys were conducted, one to elicit the views of consumers about the therapeutic role of the MHN and one to elicit the views of MHNs on the same topic. Confidential interviews with small panels of expert consumers and expert MHNs were selected as the means to obtain initial data for round one of each of the Delphi surveys. This was followed by sequential questionnaire survey rounds, repeated until consensus and/or divergences between the panel members were clearly identified.

### 3.4.2 Delphi Survey Consumer Panel

Consumer experts were selected through convenience sampling, a non-probability sampling method that selects “the most convenient subjects at hand” (Borbasi et al., 2008, p. 127). A convenience sampling technique was used in order to obtain a sample of consumers who were prepared to both volunteer for the research, and had the capacity to provide consent and who met the eligibility criteria. This is consistent with the Delphi method, where there is no requirement for randomisation of the sample (Powell, 2003; Crisp et al., 1997). Telephone contact was made with consumer and carer organisations including the Clubhouse Pioneer in Sydney, the Association of Relatives and Friends of the Mentally Ill (ARAFMI) and the NSW Consumer Advisory Group (NSWCAG), who agreed to distribute the information sheet about the research and the letter of invitation to participate via their newsletters and email contacts (see Appendix 7).
The information sheet briefly explained the research process and invited potential participants to contact the researcher in person or by phone or email. The eligibility criteria for the consumer panel included the following:

1. Eighteen years or older and a resident of NSW.
2. A diagnosis of a major mental illness for at least 2 years but not currently an inpatient.
3. Recipient of care from MHNs.
4. A K-10+ score that indicates little or no psychological distress on the day of interview and signing of consent to participate.

All consumer respondents who met the above criteria were considered as ‘experts’ on the basis of their experiences with mental health services and MHNs. This notion of consumer ‘expert’ is well supported in the literature (Bennett, 2009; Griffiths, Jorm & Christensen, 2004; McLaughlin, 2009; Morrison, 2006). Ten consumer participant experts who met the eligibility criteria and wanted to participate in the study were selected for the panel and were individually interviewed after signing consent forms (see Appendix 6a) and completing the ‘Kessler-10+ plus’ form. According to the Kessler-10+ plus interpretation guidelines, a score of between ten and nineteen indicates the individual is not currently experiencing significant feelings of distress; scores between 20 and 24 indicate there may be mild symptoms of depression and/or anxiety which may be causing mild distress in everyday life; scores between 25 and 29 indicate there may be moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder; and scores between 30 and 50 indicate it is likely that the individual is experiencing severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder (Kessler et al., 2002). If the consumer participant scored above 25, the researcher discussed with the participant how they were feeling and whether they wanted to continue or would prefer to postpone or discontinue the interview. There were two participants who scored within this range and this led to a discussion with the researcher about their high scores and their own assessment of their current mental wellbeing. Both participants assured the researcher that they wanted to participate in the
study, were able to give informed consent to participate and wished to continue with the interview.

As already discussed, an in-depth semi-structured interview was the chosen method for round one of the Delphi survey. In order to encourage participation and provide a non-threatening environment where the participants felt comfortable to express their opinions on MHNs, it was decided to avoid a traditional bio-medical format of questioning that consumers may have experienced in their contact with mental health services. Specific questions about demographic data such as diagnosis, age and numbers and types of hospitalisation therefore were avoided unless the participant volunteered this information.

Prior to conducting the interviews, the following interview schedule was devised. Firstly, the purpose of the research was explained and questions from the participants clarified. Secondly, participants were asked when they had most recently seen a MHN and to briefly describe the circumstances. This question then led to the following questions which were explored in detail:

1. What do you find are the most helpful things mental health nurses do/have done for you?
2. What therapies (if any) have you found useful in your treatment?
3. In your experience are psychological therapies used by mental health nurses?
4. In what ways do you think the therapeutic role of the mental health nurse can be improved?

The interviews were of approximately one half to one hour in duration and were conducted at a place of choosing by the participant. This meant that some interviews were conducted at an activity centre attended by the consumers, others were conducted in local cafes and one was conducted at the interviewer's work place.

The interviews were recorded and later transcribed using 'Pacific Solutions' online transcription service. Key points and themes were identified and coded through analysis with the qualitative data analysis software 'Ethnograph 6.0'. This software enabled data
from the interviews to be coded and for these coded segments to be linked to each other and grouped into parent codes. Additionally, frequency tables were compiled to determine the frequency of the different code words. Common and conflicting views and key points were identified from this process, and these were compiled into the Delphi round two questionnaire survey by the researcher. The questionnaire was piloted by a consumer of mental health services who was not part of the study and minor adjustments to improve clarity were made to the format. The modified questionnaire was then sent confidentially by email or post to each participant as round two of the Delphi study (see Appendix 8a). The participants were asked to rate each key point as high, medium or low importance and add any comments. Participants were advised that completing the questionnaire would take approximately fifteen–twenty minutes, depending on the length of their comments and additions.

Data from the responses to the round two Delphi survey were analysed quantitatively with each response allocated a raw score. For example, key points rated as high importance were scored as 3, key points rated as medium importance were scored as 2 and key points rated low importance were scored as 1. The scores for each key point were then totalled and the key points were prioritised according to their total score. New ideas and comments were noted. The results from this analysis were incorporated into another questionnaire to participants as Delphi round three for further ranking (see Appendix 8b). Feedback from participants who responded to the round three questionnaire survey were again compiled and analysed in the same way as in round two above. That is, the scores for each key point were totalled and prioritised according to their total score. After the conclusion of the round three analyses, it was determined that no more Delphi rounds would be conducted, as consensus had been ascertained and the response rate from the consumer participants had reduced to 50 per cent. In the final analysis, the three highest key points within each theme were included in the final results.
3.4.3 Delphi Survey Mental Health Nurse Panel

As with the consumer panel, individual semi-structured interviews with expert MHNs comprised the first round of the Delphi survey. The MHN panel consisted of expert MHNs who were considered to have extensive knowledge, experience, opinions and ideas on the therapeutic role of MHNs.

Similar to the consumer group, the sampling process was through convenience and purposive sampling. An invitation to participate and an explanatory letter outlining the purposes of the research were distributed by email to colleagues of the researcher, who forwarded them on to their networks (see Appendix 7). This resulted in one individual contacting the researcher and wishing to participate in the study. As a result of this poor response rate, expert MHNs were contacted directly by the researcher and invited to participate. This process resulted in a further seven participants, who were selected based on a set of defined criteria to ascertain their experience and expertise in mental health nursing. An information sheet was provided and participants were given the opportunity to ask questions and have the questions answered, Consent to participate forms were signed prior to interview (see Appendix 6b). The minimum eligibility criteria included the following:

1. Eighteen years or older and a resident of NSW.
2. Currently working in mental health nursing either in the community or inpatient services.
3. At least five years clinical experience in mental health nursing.

The interviews were conducted in the workplace of the participant and typically lasted one hour. The following themes and questions were explored to elicit responses and promote discussion:

1. Demographic information, including years of experience and current place of work (community, inpatient, specialty area).
2. What factors influence mental health nursing practice in relation to the use of psychological therapies?
3. What factors influence the therapeutic role of the nurse?
4. What is the knowledge/understanding of MHNs concerning psychological therapies?

The interviews were recorded, transcribed and analysed using the same process employed for the consumer group. Three rounds of the Delphi process were conducted to ascertain areas of consensus and divergence within the expert MHN panel. The MHN group Delphi surveys can be viewed in Appendices 8c and 8d.

3.5 Phase Two of the Study: The Questionnaire

In phase two, a descriptive explorative questionnaire survey of practicing MHNs was selected to examine the therapeutic role of MHNs (Beanland et al., 1999; Borbasi et al., 2008). The questionnaire survey was conducted to provide quantitative data on the therapeutic role of the MHN and assist with the validity, generalisability and rigor of the study through cross-validating the findings from the Delphi surveys. The questionnaire survey identifies the factors that influence mental health nursing practice, determines the current usage of psychological therapies and ascertains attitudes towards and beliefs about psychological therapies by MHNs. Demographic factors are also determined through the questionnaire survey. An Internet or online method of conducting the survey was selected because this method is usually cheaper, easier and faster to process and conduct than mail-based methods of distribution or telephone surveys (see, for example, Evans & Mathur, 2005; Fricker & Schonlau, 2002; Greenlaw & Brown-Welty, 2009; Porter & Whitcomb, 2005, 2007; Tse-Hua Shih & Fan, 2008).

The literature on Internet surveys identifies low response rates when compared to postal or telephone surveys as problematic. Email recipients of surveys have many opportunities to avoid responding to the survey. For example, they must first open the initial contact email, then click on the hyperlink to the survey web page, respond to the survey
questions and finally, submit the survey. At any point in this process it is very easy for the recipient to simply hit the delete button and cease participation. Similarly, postal and telephone survey recipients can decide to discontinue; however, response rates to these types of surveys are significantly higher (Tse-Hua Shih & Fan, 2008). Privacy and security issues about how the data will be used, how secure it is from interception by non-authorised people, and whether respondents’ contact information will be sold or distributed are also of concern to potential recipients and may affect response rates. In addition, technological variations in the configuration of the user’s computer can create obstacles in accessing and responding to the survey (Evans & Mathur, 2005; Fricker & Schonlau, 2002; Greenlaw & Brown-Welty, 2009; Porter & Whitcomb, 2005, 2007; Tse-Hua Shih & Fan, 2008). The literature clearly identifies the biggest cause for the low response rate to online surveys as the fear of junk or spam emails that are increasingly cluttering email inboxes and can cause virus infection to home computers (Evans & Mathur, 2005; Project Honey Pot, 2009).

Clearly, Internet surveys need to be conducted in a manner that mitigates these problems. Evans and Mathur (2005) suggest sampling problems and junk emails can be reduced when the sample is contacted via an organisational data base with valid e-mail addresses. Additionally, they believe technological variations can be minimised through ensuring pre-testing with multiple browsers to be sure of their applicability, and that privacy and security issues can be overcome by having respondents visit secure web sites rather than emailing surveys as attachments. Tse-Hua Shih and Fan (2008) found that follow-up reminders were not very effective for increasing response rates for Internet surveys. As with postal surveys, the literature supports the importance of short, relevant questions focusing on areas of interest to the target group as effective in improving response rates (Evans & Mathur, 2005; Fricker & Schonlau, 2002; Greenlaw & Brown-Welty, 2009; Porter & Whitcomb, 2005, 2007; Tse-Hua Shih & Fan). Additionally, Porter and Whitcomb (2005), in their investigation of the effect of email subject lines on response rates, found that blank subject lines elicited marginally more responses than subject lines identifying a survey sponsor or ones requesting help.
To maximise the response rate, secure and track the sample, and reduce the possibility of the survey being mistaken for junk mail or ‘spam’, the survey was distributed by The Australian College of Mental Health Nurses (ACMHN) to their membership data base in the first instance. Security, privacy and technical concerns were reduced by using a reputed and long-established web-based software platform to design and conduct the survey. SurveyMonkey Pro was selected as suitable for this purpose because of its reputation for technological compatibility with most computer systems, high security, template design features, ease of use and its free availability for the researcher via Southern Cross University.

3.5.1 Sample

MHNs are a disparate group both geographically and in the type of work they perform. As a consequence, there is no single and complete list of names and addresses of MHNs that is available to this study. Both the Australian Nurses‘ Federation and the Nurses‘ and Midwives‘ Registration Boards in each State rarely allow access to their data bases for the purposes of distributing surveys. As it was not possible to obtain a list of MHNs from which to determine a random sample, a convenience sampling technique of readily accessible MHNs was selected.

The target population for the questionnaire survey was defined as all practicing MHNs in Australia. The survey was distributed to MHNs through the Australian College of Mental Health Nurses (ACMHN) email list, colleagues of the researchers and through a recruitment campaign advertising the study. According to the most recent data available from the Australian Institute of Health and Welfare (2007), the population of MHNs currently employed in Australia is estimated at 11,290. The membership of the ACMHN is currently 2,367, representing 21 per cent of the target population (Taylor, membership officer ACMHN, personal communication, February 152010). However, since members of the ACMHN may not be representative of the population, an online ‘snowball‘ sampling technique was used to increase the sample size. That is, colleagues of the researchers received an email invitation to participate with a URL link to the survey. A
request that they forward the email with the URL survey link to other MHNs who might be interested in participation was included. Similarly, respondents from the ACMHN list were requested to forward the email invitation to potential recipients. In order to minimise multiple responses from the same person, a request was included that the person only respond to the survey once and the computer IP address of each respondent was recorded for later tracking if needed. A comparison of the demographic composition of the sample compared with the target population is provided in the results chapter in Section 4.4.1.

The sample size for the questionnaire survey was set at 128: assuming a response rate of 20 per cent, it was planned to survey 640 participants to achieve this sample size. The sample size was determined using the application ‘PS—Power and Sample Size’ and was determined using a hypothetical $t$-test design based on the assumption that mean five-point scale scores may be obtained for a number of factors or themes, and that these will be used to compare two sub-groups within the sample (Dupont & Plummer, 1997). A significance level of 0.05, a Power of 0.8 and a moderate effect size of 0.5 were chosen for this purpose. These parameters resulted in two groups of 64 for a total sample size of 128.

3.5.2 Development of the Questionnaire

The questionnaire was divided into five main sections: current therapeutic strategies used by MHNs; limitations to the therapeutic role of the MHN; use of psychological therapies and barriers to their implementation by nurses; attitudes of nurses towards CBT; and demographic details of the respondents. The results from the literature review and from the Delphi studies in phase one of the research determined the scope and guided the development of the questionnaire. For example, question three assessed the level of agreement of the respondents to the findings from both the consumer and nurse Delphi groups regarding what they viewed to be the most helpful strategies for MHNs to adopt. Similarly, question four assessed the level of agreement of the respondents to the issues identified by the nurse Delphi group as limiting the nurse's therapeutic ability. The
psychological therapies and techniques listed in question nine were identified by the nurse and consumer Delphi group as being the most helpful.

Published questionnaire surveys on the topic also assisted in the development of the questionnaire. The peer-reviewed literature on the topic was examined in order to obtain already published, validated and peer-reviewed survey questions. A survey of CBT and psychological therapies usage by GPs in United Kingdom by Toner, Snape, Acton and Blenkiron (2009) provided questions about both non-pharmacological approaches suitable for MHNs and barriers to their implementation. Permission to use some of these questions was sought and granted from the research team and they comprised questions five and eleven of the survey (P. Blenkiron, personal communication, 27 January 2010). Similarly, survey question twelve, exploring attitudes towards CBT, is adapted from a survey of usage of CBT by Scottish psychiatrists (Le Fevre, 2001). In order to facilitate comparison of the survey sample with the population under study, the questions seeking demographic information on age and qualifications replicated those used by the Australian Institute of Health and Welfare (2007). A copy of the questionnaire in its final form, complete with instructions for responding, is contained in Appendix 10.

3.5.3 Validity and Reliability of the Questionnaire

The scientific rigor of a questionnaire survey depends on its reliability and validity. Reliability refers to the ability to replicate and repeat findings from scientific research. Joppe (2000, p. 1), as cited in Golafshani (2003, p. 598), defines reliability as:

The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable.

Beanland et al. (1999) identify three types of reliability in quantitative research; the degree to which a measurement given repeatedly remains the same, the stability of a measurement over time and the similarity of measurements within a certain time period. Validity refers to whether the questionnaire accurately measures what it is supposed to
measure and reliability refers to the extent to which the questionnaire yields the same results on repeated measures (Beanland et al., 1999; Borbasi et al., 2008).

A major problem affecting reliability and validity of questionnaire surveys is the size and representativeness of the sample. A risk with all surveys and, in particular, online surveys, is a low response rate (Fricker & Schonlau, 2002; Porter & Whitcomb, 2007; Tse-Hua Shih & Fan, 2008). Other potential problems of online surveys include issues about sample selection, sample representativeness and data security. For example, because of the ease in forwarding emails it is difficult to ensure that only the intended recipients respond to the survey. These problems were mitigated through the distribution of the survey to the data base of the Australian College of Mental Health Nurses and a request that they forwarded the survey to their colleagues. Whilst this sampling method was not randomised and therefore could make the sample less representative, it did facilitate a large response rate, and subsequent analysis showed the sample was representative of the target population.

Stability and reliability in questionnaire surveys can be accomplished by the test–retest method. For example, giving the same test at different times to the same people should result in the same or similar results if the questionnaire is reliable. However, in social research this can be problematic. Joppe (2000), as cited in Golafshani (2003), points out that the test–retest method may sensitise the respondents to the subject matter and thereby change the responses. Additionally, she argues that the retest method assumes that social reality is unchanging. She adopts a constructivist view that „reality‘ is a human construct and is contingent upon human practices. As such, she points out that responses to surveys may change due to a variety of reasons and provides examples such as a characteristic of the respondent may change or extraneous influences may impact on the views of the respondent, thus leading to different responses in the retest. This is consistent with a critical realist view which recognises that in order to study the social world, the scientific method needs to adapt in order to understand how individuals inhabit and change social structures (Scott, 2007).
To overcome these problems and assist with ensuring reliability and validity, the questionnaire was informed by the earlier Delphi surveys of consumers and expert nurses, which employed both quantitative and qualitative methods for data collection. As noted in the discussion in Section 3.2, multi-method approaches can assist with both the validity and reliability of the research instruments (Borbasi et al., 2008; Bryman, 2004; Modell, 2009; McEvoy & Richards, 2006; McKercher, 2009). To assist further with the reliability and validity of the questionnaire, several of the survey questions incorporated into the questionnaire came from previously published and refereed surveys assessing the use of and the attitudes towards psychological therapies and CBT by health professionals (Eckers, Lovell & Playle, 2006; Le Fevre, 2001; Mason, 2007; McLeod, Deane & Hogbin, 2002; Toner et al., 2009).

When the questionnaire was constructed, careful consideration was given to the advantages and disadvantages of the various ways that questions could be structured. Likert rating scales were most frequently employed because they offer an efficient method for capturing a wide range of variance in self-reported attitudes, views and behaviours (Babbie, 2005). Likert rating scales were developed by Rensis Likert in 1932 and have been extensively used in social research. They require the respondent to make a decision on their level of agreement to a statement using a rating scale such as strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. Numerical values are assigned to each response and the total score is obtained by adding the values for each response. However, it is acknowledged that Likert scales can be subject to distortion. For example, respondents may avoid using extreme response categories (central tendency bias), agree with statements as presented (acquiescence bias) or try to portray themselves in a more favourable light (social desirability bias) (Babbie, 2005). In order to mitigate these problems, the advice of Babbie (2005) was incorporated into the structure of the questionnaire and the questions were arranged so that the agreement scales and disagreement scales were varied as much as possible within the survey.

A pilot version of the questionnaire was undertaken to help ensure construct and content validity of the survey and to guarantee clarity in order to minimise ambiguity and
possible misinterpretation by respondents. The pilot also provided an opportunity for nursing leadership and nurse clinicians to suggest whether the questions in the survey adequately covered the issues surrounding the therapeutic role of mental health nursing. As such, it was important in relation to content validity, which according to Borbasi et al. (2008, p. 132) “is assessed by logical evaluation and judgment of whether the instrument adequately reflects the content of the concept”. By this they mean the concept that is being measured. The pilot was distributed to three nurse clinicians and four academics in mental health nursing who were asked to complete the survey and critique the questionnaire (see Appendix 9 for pilot survey feedback questions). Five questionnaires were returned in the pilot survey. Revision of the questionnaire was based upon the feedback from the pilot study. Some items were added, some deleted and others modified.

It is acknowledged that in spite of these efforts to ensure the reliability and validity of the survey, it is possible that some questions were misinterpreted and that, therefore, the responses themselves may or may not reflect the judgments of the respondents on the stated propositions. Secondly, the motivation of respondents may influence both positively or negatively their responses to the questions. Finally, there is the possibility of bias in that those who responded to the questionnaire may not be representative of the population in ways that are outside the control of the researcher and, therefore, the responses to the questions may or may not adequately represent the opinions of the population under study (Beanland et al., 1999). However, as discussed above, these possibilities were controlled for by following the processes outlined by Beanland et al. (1999). As far as can be determined, the sample of 528 represents approximately five per cent of MHNs in Australia (AIHW, 2007). This constitutes an adequately representative though non-random sample (Dupont & Plummer, 1997).

3.5.4 Data Gathering and Analysis of Questionnaire

Data were analysed using the Statistical Package for the Social Sciences (SPSS) computer package, version 14.0 for Windows. Descriptive statistics including means,
medians, standard deviations, frequency distributions, percentages and cross-tabulations were generated for all variables. Categorical data were analysed by a chi-square non-parametric procedure (Field, 2009). Rating scales were assigned numerical scores such that options between positive and negative were considered to be along a continuum (Field, 2009). To compare the mean scores of continuous variables, independent sample t-tests were undertaken. The Mann–Whitney U test was used to test for difference between two independent groups on a continuous measure (Field, 2009). Tests for statistical significance were performed with a significance level of $P = .05$. Correlations were determined using the Pearson correlation (two-tailed) test with a significance level of $r = .7$ (Field, 2009). Inferential statistics were used to compare responses across subgroups within the data set. This was done to determine whether any demographic variables might be influencing participant responses. The quantitative data were collected on an interval level scale which allowed parametric tests to compare means. Where means were compared across only two groups an independent samples t-Test was employed. Where means were compared across three or more groups a One-way Analysis of Variance was used. In this way, using two-tailed tests of significance, any cohort differences could be identified and interrogated (Beanland, Schneider, LoBiondo-Wood, Haber 1999).

3.6 Conclusion

The methodological framework including ontological, epistemological and methodology assumptions was outlined in this chapter. Critical social theory will provide the philosophical framework and critical realism the methodology. The critical social theories of Foucault, Althusser and Fraser will guide the broad contours of the research.

The research design and ethical considerations were discussed and the methodological processes described. A mixed-method approach with an emphasis on quantitative methods was selected. Phase one of the study will comprise two Delphi surveys of consumer and clinical nurse experts. Phase two of the study will comprise a questionnaire survey of practicing MHNs, incorporating data from phase one of the study. Due to the
potential vulnerability of consumers and the chronicity and fluctuating nature of mental illness, ethical considerations were paramount. These considerations included an assessment of current wellbeing using the K-10+ plus self-assessment questionnaire before consent to participate was obtained, and the offer of counselling with a clinical psychologist should the need arise.

In the following chapter the results arising from the Delphi surveys of consumers and expert MHNs and the online questionnaire survey of practicing MHNs in NSW are delineated.
Chapter 4: Results

4.1 Introduction

This chapter begins with the results arising from the Delphi surveys with the consumer and nurse panels, and then presents the results of the questionnaire survey of practicing MHNs. The results are discussed in the context of the three research questions. Namely:

1. What do consumers think will improve the quality of their care?
2. What therapeutic roles/modalities do nurses think are suitable for inpatient and community mental health nursing practice?
3. What factors influence mental health nursing practice in relation to the use of psychological therapeutic modalities?

For the sake of clarity, the results from the Delphi studies and the questionnaire will be presented separately. Each of the Delphi studies comprised three rounds. The Delphi round one incorporated a semi-structured interview and Delphi rounds two and three consisted of questionnaire surveys to the panel members. The surveys can be viewed in Appendices 8a-8d. The results of the Delphi survey, along with previous studies in the literature informed the development of the questionnaire.

The results of the Delphi study with the consumer panel address research questions 1 and 2. The results of the Delphi study with the nurse panel and the questionnaire survey of practicing MHNs address research questions 2 and 3.

4.2 Results from the Delphi Survey: Consumer Panel

4.2.1 Response Rate

Ten consumer experts (four females and six males) formed the consumer panel. There was a 100 per cent response rate to the Delphi round one survey. Six members of the
consumer panel responded (60 per cent response rate) to the round two Delphi survey, and five members (50 per cent) responded to the Delphi round three. Two of the surveys returned in the Delphi round two and three surveys from Delphi round three had some missing data; otherwise, all the items were rated by all panellists who responded to each round.

4.2.2 Panel Characteristics

The most recent contact with MHNs for members of the consumer panel ranged from 1 week to 30 years ago. However, even those members of the panel who had not seen a nurse for many years had received treatment from MHNs for extended periods of time and they were in contact with other consumers who were more currently receiving nursing care. During the interview it became clear that these panel members had retained strong memories of their nursing care and were able to recall vividly those nurses that they assessed to be especially helpful or unhelpful when they were ill. Additionally, members of the consumer panel were more likely to have had contact with MHNs during times of crisis in their lives when they required hospital admission or community-based emergency mental health care. Otherwise, most members of the consumer panel receive ongoing mental health care and support from monthly or fortnightly appointments with case workers, who they stated were not nurses. These health workers were identified as social workers, GPs, drug and alcohol counsellors and psychologists. It is possible that the consumers did not realise some of these workers were in fact community MHNs because they were not in nurses‘ uniform and did not identify themselves as nurses.

The composition of the consumer panel outlining gender, most recent and type of contact with MHNs, an indication of the type of mental illness and K-10+ score at the time of interview is provided in Table 4.1 below. As discussed in the methodology section, in order to provide a non-threatening environment, specific questions following a biomedical format, for example, about medical information such as diagnosis, were not asked; hence the information listed in the table is non-specific and was volunteered by the participants.
### Table 4.1: Panel Characteristics

<table>
<thead>
<tr>
<th>Sex</th>
<th>Most recent nurse contact and current health worker contact</th>
<th>Type of contact with mental health nurses</th>
<th>Year first diagnosed</th>
<th>K-10+ score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>One week ago</td>
<td>Over 7 years–mostly community nurses</td>
<td>2002 psychosis</td>
<td>13</td>
</tr>
<tr>
<td>Male</td>
<td>8 years ago</td>
<td>During many hospital admissions</td>
<td>1989 psychosis</td>
<td>26</td>
</tr>
<tr>
<td>Male</td>
<td>30 years ago Drug &amp; alcohol counsellor</td>
<td>During many hospital admissions</td>
<td>Early 1970s psychosis</td>
<td>19</td>
</tr>
<tr>
<td>Male</td>
<td>July 2006</td>
<td>During hospital admission</td>
<td>Jan 2006 psychosis</td>
<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>1 year ago Sees psychologist</td>
<td>During crisis at hospital emergency</td>
<td>1999 psychosis</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>12 years ago Community nurse when diagnosed</td>
<td></td>
<td>1997 anxiety</td>
<td>31</td>
</tr>
<tr>
<td>Male</td>
<td>1 year ago Sees social worker</td>
<td>During many hospital stays – 5 since 1997</td>
<td>1975 psychosis</td>
<td>12</td>
</tr>
<tr>
<td>Male</td>
<td>2 years ago Sees GP regularly</td>
<td>Mostly during crisis at hospital emergency</td>
<td>2004 anorexia</td>
<td>22</td>
</tr>
<tr>
<td>Female</td>
<td>10 years ago Sees GP and psychologist</td>
<td>During hospital admission and community crisis team</td>
<td>1999 psychosis</td>
<td>11</td>
</tr>
<tr>
<td>Male</td>
<td>4 years ago Sees psychologist</td>
<td>During many hospital admissions</td>
<td>1993 psychosis</td>
<td>22</td>
</tr>
</tbody>
</table>

4.2.3 Delphi Round One: Consumer Panel–Interviews

The following four questions formed the starting point for the semi-structured interviews with the consumer panel as Delphi round one:

1. What do you find are the most helpful things that mental health nurses do/have done for you?
2. What therapies (if any) have you found useful in your treatment?
3. In your experience, are psychological therapies used by mental health nurses?
4. In what ways do you think the therapeutic role of the mental health nurse can be improved?
Structuring the information flow through identifying, prioritising and coding major themes and key points is an important aspect of Delphi studies (Turoff & Linstone, 2002). For this purpose, a computer-assisted qualitative analysis using ‘Ethnograph 6.0’ was conducted and quotes relevant to the research questions were recorded. Ninety-four code words were derived from the interviews and were sorted into parent code groups. Codes grouped within these parent codes were re-checked with the interview transcripts to ensure that they reflected the meaning of the parent code and minor adjustments were made. For example, ‘giving information’ was moved into the parent code ‘knowledgeable’, because the relevant content of the interviews under this code was related to giving information based on nurses’ knowledge of disease and symptoms. ‘Gender issues’ was moved to the parent code ‘safety’, because the relevant content was about gender and feelings of safety. Coded data that appeared only once in an interview and did not appear in other interviews were removed from further Delphi rounds by the facilitator, who structured the information flow by filtering out irrelevant content (Turoff & Linstone, 2002). In addition, coded data deemed irrelevant to the therapeutic role of the mental health nurse were noted as such and not included in the Delphi round two survey.

The analysis of round one resulted in a list of 37 items, which were sorted into the following three themes:

- Most helpful knowledge, skills and attitudes (sixteen key points).
- Helpful strategies used by MHNs (fourteen strategies).
- Helpful therapies (seven therapies).

Whilst the above themes are presented as discrete, it is important to acknowledge that there is some overlap within the different subject areas. Table 4.2 outlines the code tree for the first theme ‘most helpful knowledge, skills and attitudes’. The name of the parent code, the code words subsumed into each parent code and the number of consumers who mentioned the code tree are listed. The number of consumers who mentioned each parent code and subsumed code words (code score) may be higher than the sample size because
each parent code incorporates several coded items. These parent codes were summarised into a question format for section one of the Delphi round two survey (see Appendix 8a).

Table 4.2: Code Tree: Most Helpful Knowledge, Skills and Attitudes

<table>
<thead>
<tr>
<th>Parent code</th>
<th>Codes subsumed into parent code</th>
<th>Code score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement</td>
<td>Employment; Goals</td>
<td>8</td>
</tr>
<tr>
<td>Availability</td>
<td>Follow-up</td>
<td>8</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Empathised; Interpersonal skills; Listening; Talk</td>
<td>22</td>
</tr>
<tr>
<td>Correct diagnosis</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Stick up for self; Help yourself</td>
<td>5</td>
</tr>
<tr>
<td>Encouraging</td>
<td>Keep going; Motivating</td>
<td>9</td>
</tr>
<tr>
<td>Instilling hope</td>
<td>Hopelessness</td>
<td>4</td>
</tr>
<tr>
<td>Maintaining independence</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>Explaining; Symptom clarification</td>
<td>10</td>
</tr>
<tr>
<td>Medication</td>
<td>Side effects</td>
<td>17</td>
</tr>
<tr>
<td>Nurse’s attitude</td>
<td>Calm; Caring; Concern; Detachment; Firm; Friendly;</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Gentle; Kind; Power; Respect; Shows interest; Trust;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treated as an equal</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>Fear; Fear incarceration; Gender issues</td>
<td>11</td>
</tr>
<tr>
<td>Reducing stigma</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Supports me</td>
<td>Family; Friends; Valued</td>
<td>13</td>
</tr>
<tr>
<td>Taking time with me</td>
<td>Taken seriously</td>
<td>9</td>
</tr>
<tr>
<td>Teamwork with other health</td>
<td>Crisis team; Expand nurse’s role; Referrals; Shared</td>
<td>11</td>
</tr>
<tr>
<td>workers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following quotes illustrate the coding process and provide examples of each parent code in the theme ‘most helpful knowledge, skills and attitudes’. The quotes are selected as typical examples of the type of comments that were coded into each key point. Whilst they are representative of the comments from the panel members, they do not necessarily come from all members of the consumer panel.
Table 4.3: Example Quotes for Theme One: Most Helpful Knowledge, Skills and Attitudes

<table>
<thead>
<tr>
<th>Key point</th>
<th>Data</th>
</tr>
</thead>
</table>
| 1: Achievement             | If they can find some value in work, I reckon. Because I reckon work is good. I like to work. (Participant 2).  
If you do something or manage to achieve something, it gives you a positive. Even if it’s making a bracelet, you can see that you’ve actually done something. Or painting a picture. It gives you some sense of satisfaction. (Participant 1). |
| 2: Availability            | Having that 24/7 availability was, especially when you’re very sick is, yes, at the crucial crisis moment is the best thing. (Participant 9).  
Doing routine calls to make sure and check up. Even if I was okay, just on a regular basis. So once every three days, then once a week, then once every two weeks, then once a month or whatever. But just to be regular and diligent with the telephone calls. That makes you realise that you’re not alone. (Participant 1). |
| 3: Communication skills    | What they tend to say to you is, look if you don’t calm down, I’m going to have to—don’t fuckin’ say that to anyone—I’m gonna have to. You know what I mean? They’ve got to piss that line off and they’ve got to say look,..., you haven’t eaten, your mind’s a little bit—you’re not sure about yourself. What we’re going to do for you—they need to come down with their tone. (Participant 8).  
The best form that they did was listen to all my word salad. Even though it was garbage that was coming out of my mouth, it was like, okay, come for a drive and pour it all out and then settle down and take you back home. (Participant 10). |
| 4: Important to get correct diagnosis | Well in a sense that as I said I didn’t have a diagnosis, and when I was given an indication of what was wrong with me, it never felt very clear and I didn’t feel safe and I felt concerned about what was wrong with me, what was going to happen to me, whether I’d have it forever, whether I’d die; all sorts of things. (Participant 6).  
I want to be told what the illness is, not just—I want a documentation to say ... |
this is the kind of things, like for example, you have a document. It says ideas of reference and then it will say a list of what ideas of reference means...
(Participant 10).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4: Empowerment</td>
<td>You really have to want to help yourself. (Participant 1).</td>
</tr>
<tr>
<td></td>
<td>I’ve been in the system that long now that I sort of try to stick up for myself, but I don’t want to get too overboard in case—well, I don’t know. You’ve got to—you know, it’s not an easy game, is it, really? (Participant 2).</td>
</tr>
<tr>
<td>6: Encouraging</td>
<td>She would always encourage me to do courses, whatever was available. I didn’t do them. But when I did eventually do one that changed my whole way of thinking, to see that somebody who had a mental illness could be successful. (Participant 4).</td>
</tr>
<tr>
<td></td>
<td>And I think if you’re afraid of—I mean I kind of have a phobia but I don’t have it now—so if you had somebody there to help overcome those sorts of things, just sort of get you out, that would be very valuable. (Participant 6).</td>
</tr>
<tr>
<td>7: Instilling hope and reducing hopelessness</td>
<td>The nurses need to reaffirm that people do recover and that you’re ill and things can get better. (Participant 4).</td>
</tr>
<tr>
<td></td>
<td>I needed to know that I was going to move forward. I wasn’t going to be just like the psychiatrist said, which was you’re going to be on medication, you’re going to be sick and that’s it, your life’s over. So I needed that positive affirmation to feed my resilience. (Participant 9).</td>
</tr>
<tr>
<td>8: Helping me maintain independence</td>
<td>Here it’s good because we cook for ourselves and we keep the place running. (Participant 2).</td>
</tr>
<tr>
<td></td>
<td>[promote] a greater sense of their dignity and their independence. (Participant 5).</td>
</tr>
<tr>
<td>9: Knowledgeable</td>
<td>Even if you’ve got a mixture of mental illnesses to explain, this is for this and this is for this. Or this is a website you can look up, say Beyond Blue or whatever, to inform you about the medication you’re taking. Because I find all they do is sit there and listen and go mm ahh, and that’s it. (Participant 6).</td>
</tr>
<tr>
<td></td>
<td>To clarify what the symptoms are because it can lead to suicide. If you don’t get help, people can hurt themselves. It eats you from the inside out. Your whole world has changed and you don’t see things normally or rationally. You’re irrational and it makes it very confronting. You’re just absorbed by</td>
</tr>
<tr>
<td>Column 1</td>
<td>Column 2</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>what your delusions are, especially if you’re seeing people that aren’t there and things like that. I was. It makes it difficult to distinguish between what is reality and what isn’t.</strong> (Participant 4).</td>
<td><strong>10: Knowledge of and responding promptly to medication issues including problems with side effects</strong> They would usually give you medication. And I found that medication was what they would rely upon. They would rely upon giving you a pill to solve your problem. Or they’d tell you to go and have a glass of water and sit down, and just watch television or do something else. So medication was their advice most of the time, or they’d give you your medication early. (Participant 4). The medication for mental illness can give side effects, and when that happens, you do lose a lot of faith in the system. That’s not the nurses’ fault, it’s just the fact that different medications work differently and I think when you have to endure those side effects, you sort of you wonder what’s going on, what kind of treatment this is. (Participant 3).</td>
</tr>
<tr>
<td><strong>11: Nurse attitude</strong> What they do isn’t really important so much, as the fact that from time to time I’ve seen little aspects where they tell me that they do actually care to some degree and that tends to mean a great deal to me, you know. (Participant 1). Just to be friendly and kind, you know… (Participant 2). There was a time there when I was talking to this nurse. He had his back up against the wall and I was talking to him. I was here and you were there and the next minute he kicked me in the shin … Yeah very hard. Now I thought no I can’t have a go at him. As soon as I have a go they’re going to put me away, I’ve got no say in this. So I bit the dust. I took it. (Participant 7). I was willing to cooperate because my health was in jeopardy but not only that, if you didn’t abide by them or do what they say they’d make it hard for you. This was the realisation after a few days, three, four, five days or something. (Participant 7).</td>
<td><strong>12: Safety</strong> But one of the nursing staff reiterated that I was safe. I remember now. That the doors were locked, just basic things to let me know that I was safe. The doors are locked at night time, nobody can come in or out, there’s nursing staff in the office if you need any help. And just you’re safe, there’s nothing to threaten or harm you here, and if anything does happen we’ll call the</td>
</tr>
</tbody>
</table>
But with some of us, it’s a bit scary being in hospital too. Do people realise that? It’s actually a bit scary. Because you’re in an environment that’s saying you’re weak, you’re vulnerable and you need help. (Participant 8).

There have been times when I felt such stigma. When I left … I mean I lost all my friends because of it, because people are frightened of you when you're mentally ill and if you behave in an odd way or you don’t want to wash or you don’t want to get up; all the sort of basic things. People don't know how to respond. They stay away. (Participant 6).

I think that nurses, when you are in a hospital, should spend more time with the patients. (Participant 1).

Yet it's like you're in and out in 10 minutes with these guys. These guys doctors. You know what I mean? In and out. It's like fuck. Did you just hear what I said? I have anorexia, and if I don’t eat, I’m going to fuckin’ die. (Participant 8).

It’s better, been better, and people I know go to dieticians now and they get referrals so it’s been improved. (Participant 9).

When I was a teenager, I needed the medicine to confine it and to be able to have a manageable way of living, but now it’s really progressive, insightful and that’s due to my GP, shared care. My GP’s really good...Yes and the free psychologist, it's brilliant. (Participant 9).

---

<table>
<thead>
<tr>
<th><strong>13:</strong> Reduce stigma in the community</th>
<th><strong>14:</strong> Supporting me and my family/friends</th>
<th><strong>15:</strong> Taking time with me</th>
<th><strong>16:</strong> Teamwork between nurses and other health workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>There have been times when I felt such stigma. When I left … I mean I lost all my friends because of it, because people are frightened of you when you're mentally ill and if you behave in an odd way or you don’t want to wash or you don’t want to get up; all the sort of basic things. People don't know how to respond. They stay away. (Participant 6).</td>
<td>I felt that aside from doing his job he also was just happy to sort of chat and just support me and yeah. (Participant 3).</td>
<td>I think that nurses, when you are in a hospital, should spend more time with the patients. (Participant 1).</td>
<td>It’s better, been better, and people I know go to dieticians now and they get referrals so it’s been improved. (Participant 9).</td>
</tr>
</tbody>
</table>

The second theme identified from the Delphi first round interviews with the consumers, ‘helpful strategies used by mental health nurses’, contains fourteen coded strategies that were viewed as either helpful or unhelpful. Table 4.4 lists these strategies along with the
number of consumers who mentioned each strategy. An example quote for each strategy is provided in Table 4.5 in order to illustrate the coding process, the context of the statement and to clarify what the consumer meant when they described a strategy. The quotes are selected as examples due to their explanatory power and, as a result, not all panel members are represented.

Table 4.4: Helpful Strategies Used by Mental Health Nurses

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Code score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive affirmations</td>
<td>1</td>
</tr>
<tr>
<td>Early intervention</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td>1</td>
</tr>
<tr>
<td>Developing insight into illness</td>
<td>3</td>
</tr>
<tr>
<td>Lifestyle (diet, exercise)</td>
<td>2</td>
</tr>
<tr>
<td>Reality orientation</td>
<td>2</td>
</tr>
<tr>
<td>Giving reassurance</td>
<td>1</td>
</tr>
<tr>
<td>Relaxation training</td>
<td>2</td>
</tr>
<tr>
<td>Seclusion room</td>
<td>1</td>
</tr>
<tr>
<td>Sharing activities with nurses</td>
<td>3</td>
</tr>
<tr>
<td>Teaching thought-control techniques</td>
<td>1</td>
</tr>
<tr>
<td>Giving time out</td>
<td>1</td>
</tr>
<tr>
<td>Wellness plan</td>
<td>1</td>
</tr>
<tr>
<td>Holistic care</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 4.5: Example Quotes for Theme Two: Helpful Strategies Used by Mental Health Nurses

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive affirmations</td>
<td>So I’ve written little affirmations, which helps me. When I’m down I just open up that. (Participant 4).</td>
</tr>
<tr>
<td>Early intervention</td>
<td>I believe, in myself, from my experience that if you can transform, change those issues early on and intervene early on, it’s very, very vital to that person’s life, difference in life, quality of life, and assists them to pursue eventually their goals and to live pretty much an ordinary existence. (Participant 9).</td>
</tr>
<tr>
<td>Education</td>
<td>…need some knowledge, some education about what the illness was. Some explanation for all these signs and symptoms that you were experiencing. (Participant 4).</td>
</tr>
<tr>
<td>Developing insight into illness</td>
<td>It still was up to me to decide to quit marijuana and also accept the illness. Despite her best efforts I still had to do that and it took a long time from first being diagnosed in 2001 to 2006 after just rock bottom and psychotic and just terrible, terrible part of my life. (Participant 3).</td>
</tr>
<tr>
<td>Lifestyle (diet, exercise)</td>
<td>Well, I see hospitals as—not just standard hospital, I mean psychiatric hospitals—as places where they try and probably get you away from bad influences, they try and put you on the right path, they try and get you to live a healthier life. They haven’t always succeeded with me, you know, quite often I’ve got into hospital and come out sicker than when I went in. (Participant 1).</td>
</tr>
<tr>
<td>Reality orientation</td>
<td>There was a couple [of nurses] that seemed to cut through the psychosis kind of and they would say things that were very relevant to me right at that time so they’d be able to give me a bit of clarity or insight to the situation that I was in …So yes, they just used to put things more, less chaotically for me and more in perspective and more, with more clarity. (Participant 9).</td>
</tr>
<tr>
<td>Giving reassurance</td>
<td>she provided… some reassurance, absolutely. (Participant 6).</td>
</tr>
<tr>
<td>Relaxation training</td>
<td>Or I do relaxation. I’ve got a tape where you tense your muscles and release, and let go and concentrate on your breathing. So I do that as well. (Participant 4).</td>
</tr>
<tr>
<td>Seclusion</td>
<td>I was thinking these crazy things, you know, all this was happening. So they rang that bell and then they—they charged down like the charging light brigade, all these nurses. Next thing I knew they got the doctor, they take you into a special room, they lay you on your back and they give you an intravenous in your back part of your hand. I remember this happening several times.</td>
</tr>
</tbody>
</table>

156
times for several different reasons. I looked at the nurses and it was like being executed and you’re a criminal with no mercy. You looked at them and you felt as though they had no mercy on you or for you. They looked at you in a way, and it’s terrible you know. It’s awful. I know I caused the dilemma but I’m sick, I was having a breakdown in the hospital. (Participant 7).

**Sharing activities with nurses**

They [nurses] got me involved in painting and drawing and stuff. Then when I went to… she was very interested in painting and stuff so we used to get together and paint a lot and draw a lot and stuff. (Participant 1).

**Teaching thought-control techniques**

There was one nurse that said I should sort of compartmentalise painful thinking and used the analogy of maybe pushing the delete button on the computer, delete that information, discard the negatives that are causing problems, I guess, so that was interesting. (Participant 10).

**Giving time out**

Yes, it was good to have that break from everything, including family and everything and to reassess and get back on track. (Participant 9).

**Wellness plan**

I found… doing the Wellness Being plan really helpful. It showed me what my triggers are, what to do. To contact the crisis team, have a chat, see my doctor, tell my parents what’s going on. Also to breathe, to list five things I can think, feel, hear, see, and write them down. I find that helps me to take a grip of what is reality and what isn’t. (Participant 4).

**Holistic care**

R… has multi-talented staff in every range of teacher and psychiatrist and social worker and everything. It was a very good, holistic way to recover. (Participant 9).

The third theme identified by the consumers in the Delphi first round, ‘helpful therapies’, contained seven therapies and/or programs that members of the consumer panel stated they had received as part of their treatment. These therapies were not necessarily delivered by MHNs. Table 4.6 lists each therapy along with the code score reflecting the numbers of the consumer panel who mentioned the therapy. Table 4.7 presents example participant quotes for this theme.
Table 4.6: Helpful Therapies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Code score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twelve-step program (alcoholics anonymous)</td>
<td>1</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>4</td>
</tr>
<tr>
<td>Clubhouse program</td>
<td>2</td>
</tr>
<tr>
<td>Group therapy</td>
<td>1</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td>2</td>
</tr>
<tr>
<td>Peer-support groups</td>
<td>1</td>
</tr>
<tr>
<td>Alternative therapies</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.7: Example Quotes for Theme Three: Helpful Therapies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twelve-step program (alcoholic anonymous)</td>
<td>That’s why I go to the program and I have that twelve-step sort of program that helps, yes. (Participant 10).</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>Sometimes you have to change the way you’re thinking, and doing something different does put you in a better frame of mind. (Participant 4).</td>
</tr>
<tr>
<td>Clubhouse program</td>
<td>Seroquel (Epalin) and Modecate. I’m on quite a bit but in the last five years I’ve never been happier. I’ve got a life, you know, especially coming to this place (Clubhouse). It gives you something to do. (Participant 7).</td>
</tr>
<tr>
<td>Group therapy</td>
<td>She’s pretty good, but she can sort of say, well, there’s these groups to go to. She can offer places to go to, but it’s up to you whether you want to do it or not. (Participant 2).</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td>I had problems when I was young with abuse so that, bringing that into the open and clearing it, now I mean it’s 30 years later, but clearing it up now when I have the maturity to deal with it is really good. It’s sort of understood that sort of, that stuff, why all of that stuff happened when I was a teenager but I didn’t know then. (Participant 9).</td>
</tr>
<tr>
<td>Peer-support groups</td>
<td>Very, very frustrating because of, it didn’t involve mum in the situation. Mum had no help, no assistance, no clue, no resources, no anything to help her go through the problems. I think there were some things she could have taken on like there are some groups, like self-help groups,</td>
</tr>
</tbody>
</table>
The key points and themes identified from round one were formulated into a questionnaire survey for verification and ranking of the key points, strategies and therapies within the three themes as the Delphi round two. A copy of the Delphi round two survey for the consumer panel can be found in Appendix 8a.

**4.2.4 Delphi Round Two: Consumer Panel**

There was a 60 per cent (n = 6) response rate to the round two Delphi survey. Some of the surveys returned had missing data, otherwise all the items were rated by all panellists. No divergent opinions arose between the panellists from the Delphi round two survey. As discussed in the methodology section, the priority ratings were determined by allocating a score to each item and then adding the scores. For example, items rated as high importance or helpfulness received a score of 3, items rated as medium a score of 2 and items rated as low a score of 1. Items rated as ‘don’t know‘ received a 0 score. Where a question was not answered in a survey, the total score was averaged to n = 6 in order to compensate for that non-response. New ideas and comments were treated as qualitative data and, where appropriate, are discussed under the relevant research question.

All the key points for the first theme ‘most helpful knowledge, skills and attitudes‘ received high ratings of importance from the consumer panel, with empowerment receiving the highest priority weighting. Key points nominated as of highest importance (not highest priority rating) were grouped together for ranking in Delphi round three. Four key points; encouraging, instilling hope and reducing hopelessness, helping me maintain independence and achievement were incorporated into the key point ‘empowerment‘, because the literature regards them as necessary elements for achieving a level of empowerment (Cook et al., 2009; Corrigan, 2002; Rogers, Chamberlain,
Ellison & Crean, 1997). The other three that were nominated as highest importance—nurses’ attitude, supporting me and my family, knowledge of and responding promptly to medication issues including problems with side effects—were considered separately and were included in round three. Table 4.8 illustrates the responses to the Delphi round two survey for the first theme ‘most helpful knowledge, skills and attitudes’.

Table 4.8: Theme One: Most Helpful Knowledge, Skills and Attitudes

<table>
<thead>
<tr>
<th>Key point</th>
<th>High importance</th>
<th>Medium importance</th>
<th>Low importance</th>
<th>Priority wt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse’s attitude</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Communication skills</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Medications and side effects</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Supporting me and my family</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Taking time with me</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Encouraging</td>
<td>12</td>
<td>2</td>
<td></td>
<td>16.8*</td>
</tr>
<tr>
<td>Availability</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Safety</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Teamwork</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Empowerment</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Hope</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Maintain independence</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Achievement</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Reduce stigma</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
</tbody>
</table>

* One respondent missed this question. The score was adjusted to equate to n = 6

Responses to the strategies listed in the second theme, ‘helpful strategies used by mental health nurses’ similarly tended to be rated as highly important. ‘Seclusion room’ had the lowest priority rating and also the lowest response rate with two respondents not rating this item. Two strategies, ‘giving time out’ and ‘teaching thought-control’ also had lower priority ranking. ‘Early intervention’, ‘education’, ‘developing insight into my illness’, ‘giving reassurance’, and ‘lifestyle’ (diet, exercise) received the highest priority ratings with five out of the six respondents rating each item as highly helpful. For the purposes
of the Delphi round three survey these five strategies were grouped together and respondents were asked to prioritise within this group.

The following strategies, "holistic care", "positive affirmations", "wellness plan", "relaxation training", and "sharing activities with nurses" were the next highest scoring items with four of the six respondents rating these strategies as highly helpful. For the purposes of the round three Delphi survey these five strategies were grouped together for prioritising within this group. The remaining strategies were not included in the round three survey because of their lower priority ratings. Table 4.9 illustrates the responses of the consumer panel to the second theme "helpful strategies used by mental health nurses" in Section 2 of the Delphi round two survey.

**Table 4.9: Theme Two: Helpful Strategies Used by Mental Health Nurses**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>High helpfulness</th>
<th>Medium</th>
<th>Low helpfulness</th>
<th>Don’t know</th>
<th>Priority wt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive affirmations</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Early intervention</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Insight</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Lifestyle</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Holistic care</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Reality orientation</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Reassurance</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Relaxation training</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Seclusion room</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>10.5*</td>
<td></td>
</tr>
<tr>
<td>Sharing activities with nurses</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>14**</td>
<td></td>
</tr>
<tr>
<td>Teaching thought-control</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Time out</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Wellness plan</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>

* 2 non-responders  ** 1 non-responder

Responses to the therapies listed in the theme "helpful therapies" are illustrated in Table 4.10 below. "Psychological therapies" received the greatest priority weighting with five
respondents scoring this item as highly helpful. 'Support groups’, 'group therapies’ and 'cognitive behavioural therapy’ were also rated highly. These four therapies were included in the round three survey, and because CBT is a psychological therapy these two items were merged for the round three Delphi survey of consumers. The round three Delphi survey is included in Appendix 8b.

**Table 4.10: Theme Three: Helpful Therapies**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>High helpfulness</th>
<th>Medium helpfulness</th>
<th>Low helpfulness</th>
<th>Don’t know</th>
<th>Priority wt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twelve-step program</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Alternative therapies</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>CBT</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>15.6*</td>
</tr>
<tr>
<td>Clubhouse program</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>13.2*</td>
</tr>
<tr>
<td>Group therapy</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Support groups</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>

*One non-responder

**4.2.5 Delphi Round Three: Consumer Panel**

There was a 50 per cent (n = 5) response rate to the round three Delphi survey. To calculate the rankings in the Delphi round three survey, those items ranked lowest received a score of one, those ranked second lowest a score of two, those scored third lowest a score of three, and so on. If a respondent did not rank all the items, their responses to the items they did rank were removed from the data and it was considered a non-response. For example, when ranking the four key points in the theme ‘most helpful knowledge, skills and attitudes’, one respondent ranked only one of the key points and gave that key point a ranking of third. In this case the response was not considered a valid ranking of the four key points and the response was removed from the data. As with the round two Delphi survey, new ideas and comments were treated as qualitative data and, where appropriate, are discussed under the relevant research question.
In the first theme, "most helpful knowledge, skills, and attitudes", the nurse’s attitude was scored as the highest ranking key point with very little divergence between the ranks. Table 4.11 illustrates the ranking of these items.

<table>
<thead>
<tr>
<th>Key point</th>
<th>Highest ranking</th>
<th>Second highest</th>
<th>Third highest</th>
<th>Fourth highest</th>
<th>Ranking score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse’s attitude</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>14*</td>
</tr>
<tr>
<td>Medications and side effects</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>11*</td>
</tr>
<tr>
<td>Support me and my family</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>11*</td>
</tr>
<tr>
<td>Empowerment</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>8*</td>
</tr>
</tbody>
</table>

*One non-responder

In the second theme, "helpful strategies used by mental health nurses", the highest ranking strategies in group one were "education" and "developing insight into my illness". The highest ranked strategy in the group two strategies was "wellness plan", where three of the four valid responses gave this item the highest priority. Table 4.12 illustrates the ranking results for the analysis of this theme. The highest ranking strategies in groups one and two were considered to be the most helpful strategies identified by the consumer Delphi study. The two highest strategies in group one were evenly rated and were therefore both included in the final results.

<table>
<thead>
<tr>
<th>Group 1 therapies</th>
<th>Ranking score</th>
<th>Group 2 therapies</th>
<th>Ranking score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>14*</td>
<td>Wellness plan</td>
<td>17*</td>
</tr>
<tr>
<td>Insight</td>
<td>14*</td>
<td>Relaxation</td>
<td>12*</td>
</tr>
<tr>
<td>Giving reassurance</td>
<td>11*</td>
<td>Sharing activities with nurses</td>
<td>11*</td>
</tr>
<tr>
<td>Early intervention</td>
<td>10*</td>
<td>Positive affirmations</td>
<td>10*</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>7*</td>
<td>Holistic care</td>
<td>12**</td>
</tr>
</tbody>
</table>

*One non-responder **Two non-responders—score averaged to n = 4
The results of the analysis of the third theme 'helpful therapies' are illustrated in Table 4.13 below. As with the analysis of the other themes, there was one respondent who did not prioritise the therapies and as a result the responses were considered as non-responses. Additionally, one respondent labelled one of the therapies as 'not applicable' and as a result this was also considered a non-response and the score averaged to the same number of valid responses (n = 4) as the other items. All three therapies were included in the final results of the Delphi study consumer group.

<table>
<thead>
<tr>
<th>Therapies</th>
<th>Ranking score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological therapies including CBT</td>
<td>10*</td>
</tr>
<tr>
<td>Group therapy</td>
<td>6.6**</td>
</tr>
<tr>
<td>Support groups</td>
<td>8*</td>
</tr>
</tbody>
</table>

*One non-responder **Two non-responders—score averaged to n = 4

4.3 Results from the Delphi Survey: Nurse Panel

4.3.1 Response Rate

Eight clinical MHN experts (five female and three males) comprised the nurse panel. There was a one hundred per cent response rate to the Delphi round one; however, this dropped to 62.5 per cent (n = 5) in round 2 and increased to 87.5 per cent (n = 7) in round three. One of the surveys in round three did not rank the items as requested. In order not to bias the results, this survey was not included in the analysis, reducing the response rate to n = 6 (75 per cent). In addition, one of the surveys returned in round two had some missing data; otherwise, all the items were rated by all panellists who responded to each round.

4.3.2 Panel Characteristics

All panellists were currently working in mental health nursing in a variety of different workplaces and positions. They all had over 10 years' experience in mental health
nursing. Table 4.14 summarises the experience, qualifications, place of work, sex and current position of the participants who made up the MHN panel.

Table 4.14: Demographics of the Nurse Panel

<table>
<thead>
<tr>
<th>Sex</th>
<th>Experience in mental health nursing</th>
<th>Most recent place of work</th>
<th>Current position</th>
<th>Highest qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>19 years</td>
<td>Emergency department</td>
<td>Mental Health Nurse Practitioner</td>
<td>Master’s degree</td>
</tr>
<tr>
<td>Male</td>
<td>10 years</td>
<td>Adult mental health inpatient unit</td>
<td>Clinical Nurse Consultant</td>
<td>unknown</td>
</tr>
<tr>
<td>Female</td>
<td>20 years</td>
<td>Drug and alcohol mental health</td>
<td>Clinical Nurse Specialist</td>
<td>Master’s degree</td>
</tr>
<tr>
<td>Male</td>
<td>Over 10 years</td>
<td>Crisis team</td>
<td>Community Mental Health Nurse</td>
<td>unknown</td>
</tr>
<tr>
<td>Female</td>
<td>15 years</td>
<td>Community and inpatient services</td>
<td>Registered Nurse</td>
<td>Master’s degree</td>
</tr>
<tr>
<td>Female</td>
<td>Over 10 years</td>
<td>University, community and inpatient services</td>
<td>Lecturer/Clinical Consultant</td>
<td>PhD</td>
</tr>
<tr>
<td>Female</td>
<td>Over 10 years</td>
<td>Community mental health</td>
<td>Registered Nurse</td>
<td>PhD</td>
</tr>
<tr>
<td>Female</td>
<td>30 years</td>
<td>Inpatient services</td>
<td>Clinical Professor</td>
<td>PhD</td>
</tr>
</tbody>
</table>

4.3.3 Delphi Round One: Nurse Panel–Interviews

The following questions formed the foundation of the semi-structured interviews with the nurse panel:

1. What factors influence mental health nursing practice in relation to the use of psychological therapies?
2. What factors influence the therapeutic role of the nurse?
3. What is the knowledge/understanding of MHNs concerning psychological therapies?

As with the consumer panel analysis, a computer-assisted content analysis was used to identify major themes, key points and quotes from round one of the Delphi survey. One hundred and thirty-one code words were derived from the initial analysis of the interviews and these were further sorted, merged and finally grouped into eighteen parent
code groups to be included in the round two Delphi survey. These eighteen parent codes were further sorted into the following three themes containing 40 items in total:

1. Most helpful knowledge, skills and attitudes, which comprised fifteen key points;
2. Current problems preventing nurses from fulfilling their therapeutic role, which comprised sixteen problems;
3. Helpful strategies, comprising nine therapies/techniques.

These three themes and their key points, problems and therapies became part of the Delphi round two survey. The table below outlines the code tree for the first theme ‘most helpful knowledge, skills and attitudes‘.
<table>
<thead>
<tr>
<th>Parent code</th>
<th>Code words in parent code</th>
<th>Code score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisting with activities of daily living</td>
<td>Not just manage illness; Relapse prevention; Social rehabilitation</td>
<td>6</td>
</tr>
<tr>
<td>Assessment skills</td>
<td>Mental status assessment; Assess for physical illness</td>
<td>7</td>
</tr>
<tr>
<td>Being there for the client</td>
<td>Home visit; Regular contact; Reliability; Sitting with patient</td>
<td>7</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Clarification; Conversation; Empathy; Explore alternatives; Grounding; Listening; Empowerment; Rapport.</td>
<td>20</td>
</tr>
<tr>
<td>Ensuring continuity of care</td>
<td>Care coordinator; Multidisciplinary approach; Coordinate care; General Practitioner; Psychologist</td>
<td>7</td>
</tr>
<tr>
<td>Crisis care</td>
<td>Crisis counselling</td>
<td>3</td>
</tr>
<tr>
<td>Custodial aspects</td>
<td>Custodial; Control; Community treatment order; Enforcers of the law; Surveillance; Observation skills; Tribunal</td>
<td>8</td>
</tr>
<tr>
<td>Health promotion</td>
<td>Minimising aggression; Aggression; Risk assessment</td>
<td>2</td>
</tr>
<tr>
<td>Maintain safety</td>
<td>Medication prescribing; p.r.n.; Side-effects medication</td>
<td>5</td>
</tr>
<tr>
<td>Medication</td>
<td>Nurse attitude; Confidence; Creative; Nurse self-esteem; Nurse motivation; Nurse passion; Optimism</td>
<td>17</td>
</tr>
<tr>
<td>Nurse attributes</td>
<td>Provide information</td>
<td>2</td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td>Collaborative; Hope; Normalisation; Not therapist; Patient focused; Problem solving; Provide information; Strength based; Holistic</td>
<td>12</td>
</tr>
<tr>
<td>Knowledge of the system</td>
<td>Politically active</td>
<td>3</td>
</tr>
<tr>
<td>Reframe experiences</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

The following quotes in Table 4.16 are selected from the interviews with expert MHNs as exemplars to illustrate each of the key points listed under the first theme ‘most helpful knowledge, skills, and attitudes‘.
Table 4.16: Example Quotes for Theme One: Most Helpful Knowledge, Skills and Attitudes

<table>
<thead>
<tr>
<th>Key point</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Assisting with activities of daily living</td>
<td>That day-to-day practical, how are you going to get to the store, how are you going to get your shopping done, how are we going to get this done for you, how are you going to manage that, how are you coping this way? (Participant 8).</td>
</tr>
<tr>
<td>2: Assessment skills</td>
<td>Actually being very conscious about observing changes in the mental state and acting on what you observe. And it’s really hard, I know how hard it is when, say, you’re in a public hospital in an admission ward and you’re watching usually what is at least six patients that might be on 15-minute or 30-minute obs, because they’re either at risk of self-harm or absconding or whatever. (Participant 5).</td>
</tr>
<tr>
<td>3: Being there for the client</td>
<td>I think that sitting down with someone just being with them is therapeutic and maybe even just engaging them in a conversation about something other than their mental health problem, I think that’s a therapeutic thing to do in an acute setting and maybe some nurses don’t recognise that they are actually being therapeutic by engaging people in conversation is like that or just sitting with people can be—and being present with them can be therapeutic. (Participant 1).</td>
</tr>
<tr>
<td>4: Communication skills</td>
<td>I suppose a reflective listener. Just so you’re able to understand what your patient is actually saying not just your experience of the patient but what are they trying to say to you and being able to reflect that back. (Participant 3).</td>
</tr>
<tr>
<td>5: Ensuring continuity of care</td>
<td>Some continuity of care I think it’s really undermined at the moment with increase in casualisation and people not being able to cope with the system so retreating into part-time work so you know you get much less continuity of care. (Participant 4).</td>
</tr>
</tbody>
</table>

I had this woman, 62-year-old woman, who went out with a psych registrar, she has had a long history of psychosis, she lost both her children because she was unwell very early on in her parenthood. She now is delusional about the itching she feels in her skin which is due to diabetes, but she believes that there are bugs in her blood. She is abandoned to the private system, there’s nobody she—although she had an admission a year ago and was discharged with a plan to be on an
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>169</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>antipsychotic Depo, nobody paid attention to her. She didn’t get it from anybody. When I rang the GP, she didn’t know what these drugs were and wasn’t doing anything about it. (Participant 4).</td>
</tr>
<tr>
<td><strong>6: Crisis care</strong></td>
<td>[you’re expected to step in again when there’s a crisis]. Yeah with people we don’t know, disengaged, totally fragmented, atomised kind of service. (Participant 4).</td>
</tr>
<tr>
<td><strong>7: Custodial aspects</strong></td>
<td>You get somebody put on a CTO and don’t want to take the medication because they have too many side effects. They’re not getting very much else in the way of care. But if they say they’re not going to take their medication, if they’re non-compliant, if they don’t want to have to come in here and pick it up or if they can’t afford to pay for it, they don’t believe it works. They get put on the CTO and they’re forced to come and have Depo injections for something that doesn’t work. It’s a grossly dehumanising process and we’re supposedly the police. (Participant 4).</td>
</tr>
<tr>
<td><strong>8: Health promotion</strong></td>
<td>Health promotion, I think, is a therapeutic component of our role. (Participant 1).</td>
</tr>
<tr>
<td><strong>9: Maintain safety</strong></td>
<td>I guess the other thing that nurses do in inpatient units is to keep the whole environment safe and therapeutic. Not just the individual relationship. (Participant 8).</td>
</tr>
<tr>
<td><strong>10: Medication</strong></td>
<td>And the other thing that we’ve got to be careful of is that we medicate them correctly, because I’ve seen things go wrong with medication that have been atrocious, and that’s very frightening too … if people do not have the intelligence and the competency to safely administer medication and observe patients well enough to make sure they don’t come to harm, you can forget about everything else. (Participant 5).</td>
</tr>
<tr>
<td><strong>11: Nurse attributes</strong></td>
<td>Well if you don’t have a genuine regard for the wellbeing of the person experiencing some form of emotional pain, or whatever way you want to look at it, I don’t think you can ever fake that. That quality can’t be—I think it’s a quite interesting thing, you can look at all the competencies and all the ethics and all the codes of conduct in the world, but if a person doesn’t have that quality they’ll do the job but they’ll do it on a level that’s kind of custodial. But unless you have the capacity to really empathise with the patient then you just fake it, but they know if you’re faking it. Pretty quickly. Because I always think patients are better at assessing us than we ever are at assessing them. (Participant 5).</td>
</tr>
<tr>
<td><strong>12: Provide information</strong></td>
<td>Providing information, which I think reassures people, it informs them in order for them to make decisions about their own health care.</td>
</tr>
</tbody>
</table>
The second theme ‘current problems preventing nurses from fulfilling their therapeutic role‘ contained sixteen problems identified from the analysis of the round one Delphi interviews with the expert nurse panel. For the purposes of the Delphi round two survey these were further grouped into the following five sub-themes:

- Bio-medicalisation
- Nurse’s role getting narrower
- Morale
- Workforce issues, and
- Structural issues.

Table 4.17 illustrates the content of these themes and sub-themes along with the code score for each item. Table 4.18 provides example quotes taken from the interviews with the nurse panel. As with the previous quotes, these are selected on the basis of their ability to illustrate the sub-theme.
Table 4.17: Code Tree: Current Problems Preventing Nurses Fulfilling Their Therapeutic Role

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Code phrases in parent code</th>
<th>Code score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio-medicalisation</td>
<td>Bio-medical treatment only; Too much focus on medical diagnosis</td>
<td>7</td>
</tr>
<tr>
<td>Nurse’s role getting narrower</td>
<td>Nurses do not do counselling; Nurses don’t talk with patients; Outsourcing of therapeutic role</td>
<td>9</td>
</tr>
<tr>
<td>Morale</td>
<td>No job satisfaction; Hostility from peers including allied health colleagues; Poor nursing leadership; Nurses lack confidence</td>
<td>8</td>
</tr>
<tr>
<td>Workforce issues</td>
<td>Nurses inexperience; Ageing workforce; Nurse shortage</td>
<td>5</td>
</tr>
<tr>
<td>Structural issues</td>
<td>Centralisation and mainstreaming of services; Poor funding/lack of resources; Short hospital stays; Too much documentation</td>
<td>9</td>
</tr>
</tbody>
</table>
Table 4.18: Example Quotes for Theme Three: Current Problems Preventing Nurses Fulfilling Their Therapeutic Role

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio-medicalisation</td>
<td>The DSM, it’s a political document. It’s made by the American Psychiatric Association so that it can get third-party payment. If you don’t have a DSM number, you don’t get insurance money. Nobody seems to realise it, they think it’s some scientific document. It’s considered the weakest form in evidence basis, just consensus view. And self-serving interest consensus, I might add. (Participant 8). It’s based on medical models based on the germ theory. So if we find the germ or the clause and we resist it and fight it and cut it out or suppress it, then we’ll bring about some sort of cure. Once you get into that disease mode, people are [not] responsible—they’re not responsible for getting sick, they’re not responsible for the cure. We’ll prescribe and we’ll tell you what to do and you’ll get better. That’s what I mean, as compared to a different model that says, okay you’ve got these difficulties in your life. How are we going to manage it? (Participant 7).</td>
</tr>
</tbody>
</table>
| Nurse’s role getting narrower      | You hear a lot of very different things from different people about whether there is a therapeutic role at all. Our previous NUM, who was a great nurse and very involved in the acute care plan and very helpful et cetera, but he absolutely denied there was any counselling role at all, that he was not qualified to do so. (Participant 4).  
Our consumer rep here … who has ongoing issues in his personal life, has the occasional admission et cetera tells me that he had a three-month admission a year or two ago to … Hospital and no-one talked to him. No-one talked to him on a personal level. He was instructed to take his pills, to go to bed, to come to meals. (Participant 4). |
| Morale                             | I think the thing that’s lacking in the clinical and perhaps in the academy is really good leadership. Really good leadership. I don’t just mean management, I mean leaders with vision and commitment and can see a way forward. (Participant 8).  
So you know, people are getting very little attention there, the case management team is 40 per cent below par and people are leaving more and more as they find out. It’s not a job that you want to be—you don’t get much |
| **Workforce issues** | More staff. And more experienced staff, because it just doesn’t work very well when you don’t have experienced staff. It actually is harder work because you wonder what they’re going to do sometimes. Upset the patients, do things that are based on inexperience and poor decision making, that actually increase your responsibility and upset patients unnecessarily sometimes. (Participant 5). Short of staff because the staff turnover is so high. Sometimes what happens is that the shortage of staff and some of the kids’ settings that I’ve been to is so high that the patient load is too high for how many nurses there are and so what ends up happening is that the mental health patients are coming to emergency. (Participant 3). |
| **Structural issues** | My superior’s, superior’s, superior confronted us and me in particular about if we don’t do this data entry then our work is not counted. Which is as much as to say, you don’t count. That’s what they say to you, you don’t count. If you don’t do the data entry, if you don’t neglect the patient care in favour of data entry it doesn’t count. (Participant 4). I mean some people were able to spend more time trying to do something a little bit more therapeutic, but by and large most of the work that’s done—and I mean with the electronic medical record, people try to persuade you that it’s a fantastic method of keeping tabs on who is in the system, occasions of service, *et cetera, et cetera*, but it takes up a lot of time and it’s very, very frustrating for all concerned. I think most people just feel hugely pissed off with that because it does take up time and doesn’t really give a true reflection on the sort of work that people are doing. It just shows that you’re doing something. (Participant 7). And, you know, the paperwork: since I’ve been working as a clinician, in about four years we’ve had about three changes of documents. You know, they’ve gone from being too huge, too convoluted, to something that was a little bit more manageable, to going back to something that’s a midway point between something manageable and something a little bit convoluted. (Participant 7). In the inpatient facilities—for a start, most people are not there for a very |
long time. Their stay tends to be very short compared with how stays used to be. People who stay there for any length of time are usually people who are quite unwell, people who might come up as being treatment resistant, who need to have their medication monitored and changed and so on. But apart from those people, most clients go in there in an acute phase; they’re dealt with very, very quickly… That makes it very difficult then, I think, for nurses to actually engage on anything other than very much a custodial level. (Participant 7).

The third theme, ‘helpful strategies’, contained nine therapeutic models and/or strategies identified by the expert nurse panel as being helpful in mental health nursing. The defining line between some of the strategies and ‘counselling’ is not always clear, however members of the nurse panel identified ‘counselling’ as a helpful strategy separating it from the other categories. For this reason it is included as a separate category. Table 4.19 outlines these strategies and/or therapeutic models and the code score for each. Table 4.20 provides quotes which exemplify and provide a context to the discussions about helpful strategies in the round one Delphi interviews with nurses.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Code score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioural therapy (CBT)</td>
<td>7</td>
</tr>
<tr>
<td>Counselling</td>
<td>4</td>
</tr>
<tr>
<td>Dialectical behavioural therapy (DBT)</td>
<td>4</td>
</tr>
<tr>
<td>Group therapy</td>
<td>3</td>
</tr>
<tr>
<td>Assisting catharsis</td>
<td>1</td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>1</td>
</tr>
<tr>
<td>Recovery model</td>
<td>1</td>
</tr>
<tr>
<td>Solution-focused therapy</td>
<td>1</td>
</tr>
<tr>
<td>Tidal model</td>
<td>1</td>
</tr>
<tr>
<td>Strategy</td>
<td>Data</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cognitive behavioural therapy (CBT)</td>
<td>I don’t know—in fact in my area I don’t know anyone trained in CBT. So I—the odd nurse understands it but she might not have had any training in it. So she’ll understand it, she’ll maybe do a little bit of relapse prevention work but I don’t see it actively being used yeah. (Participant 1). This discussion from, I think, London University about the appropriateness of CBT for psychosis, claiming that it can be as effective. Unfortunately, what you need then is expert practitioners of CBT whereas you don’t have to be an expert practitioner much at all to dole out pills. (Participant 4). However, the older ones I have seen many of them, especially one at the moment that I have met with, she is a therapist for drugs and alcohol and she does use CBT very effectively. So—but then she has been working in drugs and alcohol for quite some time and she has done a special course, the counselling course as well and therein lies the dilemma. (Participant 6).</td>
</tr>
<tr>
<td>Counselling</td>
<td>It’s basic counselling anyway, just simple Rogerian unconditional positive regard for people. (Participant 4). The counselling skills will vary between nurses. I think there’s some cultural issues that come into play with mental health nursing as well. I see a lot of nurses who were trained in the old system who can be very skilled and very good at what they do but I also see a nursing—some nurses from that system who are not so healthy and look at these patients as never getting well so why would you bother doing that kind of stuff. So the newer nurses who are coming in to the system if they don’t have someone to model on who is healthy in doing the work they tend to model on the nurses who are unhealthy who sit around doing nothing. That’s just an observation. (Participant 3).</td>
</tr>
<tr>
<td>Dialectical behavioural therapy (DBT)</td>
<td>You know dialectical behaviour therapy has become quite a focal point in acute mental health settings these days but it tends to be the social work for psychology staff that are undertaking those kinds of roles whereas the mental health nurses don’t seem to be involved so much in taking those groups and doing that form of therapy. (Participant 1). A couple of team members wanted to go off and do their DBT training but the logistics were such it would have meant that the person but have had to go up</td>
</tr>
</tbody>
</table>
to B… two or three times a week, so that’s created staffing problems on team. Then the level of input that’s required following their training and the subsequent supervision required when they actually start seeing people, meant that it wasn’t a viable proposition. (Participant 7).

| Group therapy | Most of us haven’t been given the experience to really develop those skills, to develop them fully. And if I hadn’t worked in the private health system I wouldn’t have learned more than the basics about those skills. But because I did groups in the private system, and I worked with teams of psychologists, I learned, learned a lot. So that was really useful. (Participant 5). I’ve been asked to come in and run groups in the mental health setting and I believe the nurses should be doing that which I’m happy to train them up in doing that. But I don’t feel that people outside should be coming in. It should be the nurses who are actually working with the patients day in day out doing the groups. So I don’t see the group work happening in the area I you know—in the area health system I work in. (Participant 3). |
| Assisting catharsis | Hearing people’s stories, allowing people an opportunity for a catharsis, which is therapeutic too. (Participant 1). |
| Psychodynamic therapy | An understanding of psychodynamic models is important as well … still understanding them because they’re important when you’re understanding transference and counter-transference. (Participant 3). |
| Recovery model | But the therapeutic role, as I see it, is to help people who are experiencing any sort of mental health issue to manage their lives. Not just to manage an illness. I think nurses have always been well positioned to say, we’re not just managing an illness here, you have a life. That’s now that recovery model. All of a sudden people start to see this as something new. Well, to me, it’s always been what nurses do. Because, as you know, the recovery idea is to help people get the life they want, not just manage an illness. That’s how I see our role. (Participant 8). |
| Solution-focused therapy | Solution-focused therapy is helpful. (Participant 1). |
| Tidal model | Tidal model and to do that they realised that their time at the computer was pretty separate from their engagement with clients. So what they introduced was a system where you have all the notes are done in conjunction with the relevant client and clients both discuss what goes in the notes and they get to write their own notes. They have a classy little pen so they can write longhand and the pen translates it into text which can be uploaded to the computer and becomes part of the record. (Participant 4). |
The three themes identified from round one were formulated into a questionnaire survey for verification and ranking. A copy of the Delphi round two survey for the nurse panel can be found in Appendix 8c.

4.3.4 Round Two: Summary of All Responses

There was a 62.5 per cent (n = 5) response rate in the round two Delphi survey for the nurse panel. One of the surveys returned did not respond to Section 3 of the survey, the priority rating of ‘helpful therapies’; one other survey had some missing data. The method of analysis and scoring of the data from the round two survey was the same as for the consumer panel.

Eight of the fifteen key points for the first theme ‘most helpful knowledge, skills and attitudes’ received high ratings of importance in the Delphi round two survey, although there was divergence of opinion in two of the highly ranked items where one respondent rated two of the items of low importance. These eight items were selected for further ranking in the Delphi round three survey. Table 4.21 illustrates the responses to the Delphi round two survey for the first theme of ‘most helpful knowledge, skills and attitudes’.
<table>
<thead>
<tr>
<th>Key point</th>
<th>High importance</th>
<th>Medium importance</th>
<th>Low importance</th>
<th>Priority weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of daily living</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Assessment skills</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Being there for client</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Communication skills</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Ensuring continuity of care</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Crisis care</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Custodial aspects</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Health promotion</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Maintain safety</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Medication</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Nurse attributes</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Provide information</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Knowledge of system in which they work</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Reframe experiences</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
</tbody>
</table>

There was little divergence in the responses to the items in the second theme 'current problems preventing nurses fulfilling their therapeutic role'. The problems that received the highest importance rating were bio-medicalisation, item two, 'too much focus on medical diagnosis', 'nurse's role getting narrower', item 1, 'nurses do not do counselling', morale items two and three, 'hostility from peers' and 'poor leadership'. 'Structural problems' such as 'centralisation and mainstreaming', 'short hospital stays' and 'too much documentation' were rated of low importance as problems preventing nurses from fulfilling their therapeutic role. Table 4.22 shows the spread of responses to theme two.
### Table 4.22: Current Problems Preventing Nurses Fulfilling Their Therapeutic Role

<table>
<thead>
<tr>
<th>Problem</th>
<th>High importance</th>
<th>Medium</th>
<th>Low</th>
<th>Priority weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bio-medicalisation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Bio-medical treatment only</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>2. Medical diagnosis emphasis</td>
<td>12</td>
<td>2</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td><strong>Nurse’s role narrower</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. No counselling</td>
<td>12</td>
<td>2</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>2. No talk with patients</td>
<td>9</td>
<td>2</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>3. Outsourcing of therapeutic role</td>
<td>6</td>
<td>2</td>
<td></td>
<td>10 *</td>
</tr>
<tr>
<td><strong>Morale</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. No job satisfaction</td>
<td>9</td>
<td>4</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>2. Hostility from peers</td>
<td>12</td>
<td>1</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>3. Poor leadership</td>
<td>12</td>
<td>1</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>4. Lacking confidence</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td><strong>Workforce issues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Lacking experience</td>
<td>9</td>
<td>1</td>
<td></td>
<td>12.5*</td>
</tr>
<tr>
<td>2. Ageing workforce</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>3. Nurse shortage</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td><strong>Structural issues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Centralisation and mainstreaming</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>2. Low funding/resources</td>
<td>3</td>
<td>6</td>
<td></td>
<td>11.25*</td>
</tr>
<tr>
<td>3. Short hospital stays</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>8.75*</td>
</tr>
<tr>
<td>4. Too much documentation</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

*One respondent omitted this question. The score was adjusted to equate n = 5

In the round three Delphi survey the five categories; bio-medicalisation, nurses‘ role getting narrower, morale, workforce issues and structural issues were listed for prioritising and comment and the theme name was modified to ‘factors that limit therapeutic capability’.

Responses to the strategies and/or therapeutic models listed in the third theme, ‘helpful strategies’, are illustrated in Table 4.23 below. The response rate for this section was reduced to four because one member of the nurse panel did not provide responses to the section. In addition, there were three questions in this section with missing data. The
strategies and/or therapeutic models rated as highly helpful are ‘group work’, ‘recovery model’ and ‘solution-focused therapy’. There was some divergence in the rating of the remaining strategies and/or therapeutic models. This divergence also included ‘cognitive behavioural therapy’, where two of the five respondents rated this as low and the others as high in helpfulness. ‘Psychodynamic therapy’ received the lowest priority rating and was omitted from the round three Delphi survey.

Table 4.23: Helpful Strategies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>High helpfulness</th>
<th>Medium helpfulness</th>
<th>Low helpfulness</th>
<th>Priority rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group work</td>
<td>9</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Recovery model</td>
<td>9</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Solution-focused therapy</td>
<td>9</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Assisting catharsis</td>
<td>6</td>
<td>1</td>
<td>9.3*</td>
<td></td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td>6</td>
<td>1</td>
<td>9.3*</td>
<td></td>
</tr>
<tr>
<td>Dialectical behaviour therapy</td>
<td>6</td>
<td>1</td>
<td>9.3*</td>
<td></td>
</tr>
<tr>
<td>Tidal model</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

*1 non-responder. Score adjusted to equate n = 4

There were two new ideas on the therapeutic role of the MHN suggested by one of the respondents for inclusion into the next Delphi round. These were: 1) assist consumer in self-management, and 2) advocate to get consumers ‘off’ involuntary treatment. These two items were included for ranking in terms of high, medium and low importance in the Delphi round three survey.

4.3.5 Delphi Round Three: Nurse Panel

There were six useable responses to the Delphi round three survey. The rankings were analysed using the same method that was used for the consumer panel Delphi round three analysis. The highest ranked item in group one was the ‘therapeutic relationship’ with a ranking score of 22. The highest ranked item in group two was ‘nurse attributes’ with a
ranking score of 22. The lowest ranked in group one and two, respectively, were ‘assessment skills’ and ‘medication’. Two of the respondents noted in the comments section that they found it hard to rank these items because they were all important. The round three survey can be viewed in Appendix 8d.

The two new ideas from round two, ‘assist consumer in self-management’, and ‘advocate to get the consumer off involuntary treatment’ were rated as high, medium or low importance as per the round two Delphi survey. Their pro-rata scores were 15 and 11.6, respectively. Thus, new idea #1, ‘assisting the consumer in self-management’, received a score higher than the highest score for this theme in the round two analysis. Whereas new idea #2, ‘advocate to get the consumer off involuntary treatment’, was amongst the lowest scoring key points in Delphi round two. Both these items were not prioritised in the round three survey. Table 4.24 illustrates the ranking scores for each item in the two groups and Table 4.25 the priority ranking for the two new ideas.

### Table 4.24: Most Helpful Knowledge, Skills and Attitudes

<table>
<thead>
<tr>
<th>Group 1 key points</th>
<th>Highest ranking</th>
<th>Second highest</th>
<th>Third highest</th>
<th>Fourth</th>
<th>Ranking score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic relationship</td>
<td>12</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Communication skills</td>
<td>0</td>
<td>12</td>
<td>6</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Being there for the client</td>
<td>8</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Assessment skills</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2 key points</th>
<th>Highest ranking</th>
<th>Second highest</th>
<th>Third highest</th>
<th>Fourth</th>
<th>Ranking score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse attributes</td>
<td>20</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Provide information</td>
<td>0</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Maintain safety</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Medication</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>
Table 4.25: Importance Rating of New Ideas Regarding Most Helpful Knowledge, Skills And Attitudes

<table>
<thead>
<tr>
<th>New ideas</th>
<th>High importance</th>
<th>Medium importance</th>
<th>Low importance</th>
<th>Priority weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist consumer in self-management</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>15*</td>
</tr>
<tr>
<td>Advocate to get consumer off involuntary treatment</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>11.6*</td>
</tr>
</tbody>
</table>

The priority weight was adjusted to equate with n = 5 as per round two response rate.

In the second theme, factors that limit ‘therapeutic capability’, the highest ranking factor overall, was ‘morale’. There was some divergence of opinion for two items, ‘structural issues’ and ‘bio-medicalisation’, which both received the highest rankings but lower total ranking scores. This was especially marked for the item ‘bio-medicalisation’ with two respondents ranking this highest and three ranking it lowest. Table 4.26 illustrates the ranking results for the analysis of this theme.

Table 4.26: Factors That Limit Therapeutic Capability

<table>
<thead>
<tr>
<th>Item</th>
<th>Highest ranking</th>
<th>Second highest</th>
<th>Third highest</th>
<th>Fourth highest</th>
<th>Fifth highest</th>
<th>Ranking Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morale</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Nurse’s role narrower</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Structural issues</td>
<td>10</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Workforce issues</td>
<td>0</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Bio-medicalisation</td>
<td>10</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>16</td>
</tr>
</tbody>
</table>

The results of the analysis of the third theme, ‘helpful strategies’, are illustrated in Table 4.27. The ‘recovery model’ received the highest ranking in group one followed by ‘solution-focused therapy’. There was a strong convergence of opinion in group two, with ‘counselling’ receiving the highest ranking unanimously and ‘cognitive behavioural therapy’ the second highest ranking, although one respondent placed this therapy in the lowest rank. Comments on this section included that it was hard to prioritise since nurses tended to be eclectic in their use of therapies. Additionally, there was some questioning...
as to whether ‘catharsis’ was a therapy in itself and not the result of therapeutic intervention.

Table 4.27: Helpful Strategies

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Highest ranking</th>
<th>Second highest</th>
<th>Third highest</th>
<th>Fourth highest</th>
<th>Ranking Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery model</td>
<td>12</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Solution-focused therapy</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Group work</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Tidal model</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2</th>
<th>Highest ranking</th>
<th>Second highest</th>
<th>Third Highest</th>
<th>Fourth Highest</th>
<th>Ranking Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>24*</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>15.6*</td>
</tr>
<tr>
<td>Dialectical behaviour therapy</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>10.8*</td>
</tr>
<tr>
<td>Assisting catharsis</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>9.6*</td>
</tr>
</tbody>
</table>

*One non responder—score averaged to n = 6

New ideas on the therapeutic role of the MHN included those listed below and these will be incorporated in the discussion under the relevant research question.

1. nurses need to be more engaged with the consumer movement;
2. what patients need from nurses is to ‘care’;
3. nurses need to have compassion and competency;
4. therapeutic approaches need to be tailored to individual needs;
5. inner qualities and core beliefs of the nurse have the most significant impact on the relationship—external problems always exist;
6. a supportive therapeutic role needs a supportive work culture;
7. need self-awareness and to foster hope.
4.4 Results from the Questionnaire Survey of Practicing Mental Health Nurses

The results for this section are reported under the headings of the two research questions relevant to the opinions of MHNs rather than consumers. These are:

1. What therapeutic roles/modalities do nurses think are suitable for inpatient and community mental health nursing practice?
2. What factors influence mental health nursing practice in relation to the use of psychological therapeutic modalities?

However, firstly the demographic characteristics of the sample are reported.

4.4.1 Demographic Characteristics

Five hundred and twenty-eight nurses responded to the online survey representing approximately five per cent of MHNs in Australia (AIHW, 2007). This constitutes an adequately representative though non-random sample (Dupont & Plummer, 1997). The population sample was compared to nursing and midwifery labour force data and is closely matched to the known population in terms of geographic location, age and sex, although the age group 25–34 years is under-represented at 7.7 per cent of the sample compared to fourteen per cent of the population (AIHW, 2007). However, there are differences between the sample and the target population in terms of qualifications, with more nurses in the sample holding mental health nursing qualifications. Table 4.28 illustrates this comparison in terms of percentages rather than whole numbers because not all respondents responded to every question. For example, 33 respondents did not provide information on their sex, 35 did not provide information on their age and 34 did not provide information as to which State or Territory they were working in.
Table 4.28: Comparison of Research Sample and the Known Population

<table>
<thead>
<tr>
<th></th>
<th>Study sample (n = 528)</th>
<th>Population (n = 11,290)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 25 years</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>25–34 years</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>35–44 years</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>45–54 years</td>
<td>43%</td>
<td>39%</td>
</tr>
<tr>
<td>55+ years</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Female</td>
<td>71%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>State</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td>VIC</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>QLD</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>SA</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>WA</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>TAS</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>ACT</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>NT</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Post-registration course in mental health</strong></td>
<td>49%</td>
<td>23%*</td>
</tr>
</tbody>
</table>

*Mental Health Workforce Advisory Committee (2008)

The participants were currently practicing MHNs working in the public or private sector in community, GP or inpatient services. All but 31 of the respondents indicated that they worked with clients with severe mental illness, as defined by the NSW Mental Health Act, 2007, Section 4, on a daily basis. The majority of those who did not have an active caseload indicated that they were either in MHN education or MHN management. On average, the respondents were highly experienced and educated MHNs. Seventy-five per cent had been working in mental health nursing for over ten years. Less than half a per cent had less than one year’s experience in mental health nursing. Most participants were registered nurses, with 245 (49.4 per cent) holding a post-graduate degree in mental health nursing. In addition, 74 per cent of respondents had received formal training in applying psychological therapies/techniques in their practice, and 94 per cent have read
articles, journals or books on psychological therapies in the previous twelve months. Eighty-eight per cent of respondents either strongly agreed or agreed that they found their mental health nursing work satisfying.

Respondents were asked to nominate their place of current employment and could choose as many from a list of seven that applied to their circumstance. Thirty-eight per cent were employed in community health, 23.6 per cent in a public hospital mental health unit, 8.9 per cent in a psychiatric hospital, 8.2 per cent were employed in a private hospital, 9.5 per cent were employed by a GP and 7.6 per cent of respondents had their own private practice. The following figures provide further information on the demographic characteristics of the respondents.

Figure 4.1: Age
Figure 4.2: Experience

Figure 4.3: Qualifications
Nearly 25 per cent of the respondents were currently employed in workplaces not listed in the answer options. These respondents selected the ‘other’ category and were able to specify or explain further about their current employment. Of those who were employed in categories not listed in the question, nineteen worked in forensic mental health, fifteen in the education sector, eight were employed in Divisions of General Practice, five were working in non-government organisations, three in Aboriginal and Torres Strait mental health and one was employed by the military.

4.4.2 Therapeutic Roles/Modalities Suitable for Inpatient and Community Mental Health Nursing Practice

Questions three, five, nine, ten and twelve addressed therapeutic strategies, non-pharmacological approaches and psychological therapies and techniques currently employed by MHNs.
Many of the strategies listed in question three arose from the Delphi studies with consumers and expert MHNs. The majority of respondents either agreed or strongly agreed that MHNs nearly always employ the strategies outlined in the question. Responses were considered to be on a continuum between one and five with those who rated ‘strongly agree’ receiving a score of ‘1’ and those who rated strongly disagree receiving a score of ‘5’. Respondents who rated neither disagree or agree were considered neutral and received a score of ‘3’.

The strategies with the strongest level of agreement were ‘maintaining safety through aggression minimisation’, ‘providing reassurance’ and ‘mental status assessments and physical assessments’. The strategies attracting the most disagreement were ‘sharing activities’, where 29.3 per cent of respondents disagreed or strongly disagreed and ‘encouraging healthy lifestyle choices’, where sixteen per cent of respondents disagreed or strongly disagreed that MHNs nearly always employ these strategies. Table 4.29 lists the strategies, the rating mean of respondents to this question, the percentage of respondents who agreed/strongly agreed or disagreed/strongly disagreed and the number of respondents to each answer option.
Table 4.29: Strategies Employed by Mental Health Nurses

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Rating mean</th>
<th>Std. Dev.</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing activities. For example, going shopping, sharing cups of tea, playing</td>
<td>2.78</td>
<td>1.07</td>
<td>45</td>
<td>29.3</td>
<td>522</td>
</tr>
<tr>
<td>cards, pool, guitar or painting together</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouraging attendance at peer-support groups</td>
<td>2.41</td>
<td>.93</td>
<td>60.1</td>
<td>14.6</td>
<td>526</td>
</tr>
<tr>
<td>Encouraging healthy lifestyle choices. For example, healthy diet, exercise and</td>
<td>2.35</td>
<td>2.35</td>
<td>62.9</td>
<td>16.2</td>
<td>526</td>
</tr>
<tr>
<td>quitting smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing on developing insight</td>
<td>2.29</td>
<td>.97</td>
<td>65.7</td>
<td>13.8</td>
<td>522</td>
</tr>
<tr>
<td>Supporting families and friends of the patient/client</td>
<td>2.18</td>
<td>1.00</td>
<td>72.2</td>
<td>14.4</td>
<td>525</td>
</tr>
<tr>
<td>Maintaining regular contact either through home visits or sitting with patients</td>
<td>2.17</td>
<td>.95</td>
<td>69.8</td>
<td>10.9</td>
<td>523</td>
</tr>
<tr>
<td>/clients—‘being there’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervening early when they are becoming ill</td>
<td>2.13</td>
<td>1.06</td>
<td>72.8</td>
<td>13.4</td>
<td>523</td>
</tr>
<tr>
<td>Encouraging self-management</td>
<td>2.07</td>
<td>.97</td>
<td>73.9</td>
<td>10.4</td>
<td>526</td>
</tr>
<tr>
<td>Demonstrating an attitude of calm, caring, friendliness and respectfulness</td>
<td>2.02</td>
<td>.89</td>
<td>81</td>
<td>10.4</td>
<td>527</td>
</tr>
<tr>
<td>Responding promptly to medication issues including problems with side effects</td>
<td>1.98</td>
<td>.87</td>
<td>82.2</td>
<td>8.1</td>
<td>523</td>
</tr>
<tr>
<td>Providing reassurance</td>
<td>1.88</td>
<td>.80</td>
<td>85.2</td>
<td>5.0</td>
<td>525</td>
</tr>
<tr>
<td>Mental status assessments and physical illness assessment</td>
<td>1.88</td>
<td>.87</td>
<td>85.8</td>
<td>7.7</td>
<td>520</td>
</tr>
<tr>
<td>Maintaining safety through aggression minimisation and risk assessment</td>
<td>1.79</td>
<td>.83</td>
<td>87.2</td>
<td>5.4</td>
<td>526</td>
</tr>
</tbody>
</table>

There were no significant differences found between respondents in terms of age, gender, years of experience, education level or geographic location and strategies employed. However, place of employment showed some significant differences in terms of the strength of agreement to some of the strategies. For example, an independent samples $t$-
test with a 2-tailed test of significance and a significance level of $P = .05$ revealed MHNs working with GPs and those in private practice were significantly more likely to agree strongly with the strategies 'supporting families' and 'encouraging healthy lifestyles'. Private-practice MHNs also agreed more strongly with 'developing insight'. MHNs working in the community were more likely to agree with the strategies 'maintain regular contact', and 'encourage self-management'. The following table illustrates these areas of significance in relation to place of current employment and mean strength of agreement with the strategies.

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Place of employment</th>
<th>Means</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain regular contact</td>
<td>Community health</td>
<td>2.01</td>
<td>.003</td>
</tr>
<tr>
<td></td>
<td>Not community health</td>
<td>2.96</td>
<td>.002</td>
</tr>
<tr>
<td>Encourage self-management</td>
<td>Community health</td>
<td>1.98</td>
<td>.119</td>
</tr>
<tr>
<td></td>
<td>Not community health</td>
<td>2.12</td>
<td>.103</td>
</tr>
<tr>
<td>Family support</td>
<td>GP practice</td>
<td>1.73</td>
<td>.044</td>
</tr>
<tr>
<td></td>
<td>Not GP practice</td>
<td>2.01</td>
<td>.031</td>
</tr>
<tr>
<td>Encourage healthy lifestyle</td>
<td>GP Practice</td>
<td>2.00</td>
<td>.018</td>
</tr>
<tr>
<td></td>
<td>Not GP practice</td>
<td>2.39</td>
<td>.022</td>
</tr>
<tr>
<td>Develop insight</td>
<td>Private practice</td>
<td>2.00</td>
<td>.060</td>
</tr>
<tr>
<td></td>
<td>Not private practice</td>
<td>2.31</td>
<td>.042</td>
</tr>
<tr>
<td>Encourage healthy lifestyle</td>
<td>Private practice</td>
<td>1.97</td>
<td>.022</td>
</tr>
<tr>
<td></td>
<td>Not private practice</td>
<td>2.38</td>
<td>.019</td>
</tr>
<tr>
<td>Encourage self-management</td>
<td>Private practice</td>
<td>1.72</td>
<td>.024</td>
</tr>
<tr>
<td></td>
<td>Not private practice</td>
<td>2.10</td>
<td>.018</td>
</tr>
</tbody>
</table>

4.4.2.1 Non-Pharmacological Approaches

The approaches listed in question five, 'Which of the following non-pharmacological approaches do you use in your current mental health nursing practice?' were in most
cases uniformly employed by the respondents. The most popular non-pharmacological approaches were "practical problem-solving techniques", "challenging negative thoughts" and "deciding management plan in collaboration with the patient". The least popular approaches were "no intervention—observe only" and "offering relevant Internet-based self-help information". Table 4.31 below lists the non-pharmacological approaches employed and the percentages of respondents who use the approach in their current practice.

Table 4.31: Non-Pharmacological Approaches Employed by MHNs

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Percentage</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical problem-solving techniques</td>
<td>92</td>
<td>479</td>
</tr>
<tr>
<td>Challenging negative thoughts in my patients/clients (e.g. &quot;I’m a failure&quot; and &quot;it’s hopeless&quot;)</td>
<td>90</td>
<td>469</td>
</tr>
<tr>
<td>Deciding management plan in collaboration with patient/client</td>
<td>90</td>
<td>467</td>
</tr>
<tr>
<td>Providing written information about the relevant mental illness</td>
<td>84</td>
<td>439</td>
</tr>
<tr>
<td>Teaching relaxation techniques with my patients/clients</td>
<td>78</td>
<td>408</td>
</tr>
<tr>
<td>Assisting my patients/clients to develop positive affirmations about themselves</td>
<td>73</td>
<td>379</td>
</tr>
<tr>
<td>Developing a ‘wellness plan’ with my clients/patients</td>
<td>65</td>
<td>341</td>
</tr>
<tr>
<td>Getting a patient/client to keep a diary of mood, thoughts and activities</td>
<td>63</td>
<td>330</td>
</tr>
<tr>
<td>Activity scheduling—scheduling of pleasurable activities as ‘homework’</td>
<td>61</td>
<td>317</td>
</tr>
<tr>
<td>Offering relevant Internet-based self-help information (MoodGYM and Reachout.com)</td>
<td>47</td>
<td>244</td>
</tr>
<tr>
<td>No intervention—observe only</td>
<td>20*</td>
<td>104</td>
</tr>
<tr>
<td>None of the above</td>
<td>3</td>
<td>14</td>
</tr>
</tbody>
</table>

*These respondents were significantly (independent samples t-test for equality of means, 2-tailed P = .05, .026 yes, .048 no) less likely to agree that their mental health nursing work was satisfying
4.4.2.2 Psychological Therapies

Ninety-three per cent of the respondents agreed they would like to use psychological therapies in their routine mental health nursing practice. Psychological therapies used by MHNs are listed below. The therapies/techniques that received the highest response rates were ‘a mixture of the above to suit the circumstances at the time’, ‘CBT’ and ‘counselling’. ‘Psychoanalytic therapy’ was used least by the respondents with only 13.4 per cent of respondents nominating this therapy. ‘Dialectical behaviour therapy’ and ‘group therapy’ were used by the respondents 25.7 per cent and 26.5 per cent, respectively. Table 4.32 illustrates the response per cent and the respondent number for each therapy specified in the question.

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Response percentage</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A mixture of the above to suit the circumstance at the time</td>
<td>69</td>
<td>353</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>69</td>
<td>349</td>
</tr>
<tr>
<td>Counselling</td>
<td>66</td>
<td>334</td>
</tr>
<tr>
<td>Solution-focused therapy</td>
<td>55</td>
<td>280</td>
</tr>
<tr>
<td>Recovery model</td>
<td>52</td>
<td>265</td>
</tr>
<tr>
<td>Group therapy</td>
<td>27</td>
<td>135</td>
</tr>
<tr>
<td>Dialectical behaviour therapy</td>
<td>26</td>
<td>131</td>
</tr>
<tr>
<td>Psychoanalytic therapy</td>
<td>13</td>
<td>68</td>
</tr>
<tr>
<td>None of the above</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td>114</td>
</tr>
</tbody>
</table>

One hundred and fourteen respondents also nominated the ‘other’ category and used this to further outline their selection of therapies from the list in the question or to outline a therapy not on the list. Therapies outlined that were not on the list included a very wide
variety of therapies. Those specified more than once by the respondents are listed in Table 4.33 below.

**Table 4.33: Other Therapies Specified by Respondents**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative therapy</td>
<td>18</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>16</td>
</tr>
<tr>
<td>Acceptance and commitment therapy</td>
<td>16</td>
</tr>
<tr>
<td>Motivational interviewing</td>
<td>16</td>
</tr>
<tr>
<td>Family therapy</td>
<td>5</td>
</tr>
<tr>
<td>Transactional analysis</td>
<td>4</td>
</tr>
<tr>
<td>Gestalt therapy</td>
<td>4</td>
</tr>
<tr>
<td>Cognitive analytical therapy</td>
<td>3</td>
</tr>
<tr>
<td>Relaxation therapy</td>
<td>3</td>
</tr>
</tbody>
</table>

Question twelve, “Do you agree with the following statements about CBT?“, comprised ten value statements adapted from studies by Le Fevre (2001) and Wilson and White (2007). Responses were considered to be on a continuum between one and five with those who rated ‘strongly agree’ receiving a score of ‘1’ and those who rated strongly disagree receiving a score of ‘5’. Respondents who rated neither disagree or agree were considered neutral and received a score of ‘3’. As can be seen from the table below, the majority of respondents demonstrated a positive attitude towards CBT by either agreeing or strongly agreeing with those statements supporting CBT or disagreeing or strongly disagreeing with those statements not supportive of CBT. The two items most strongly agreed with by the respondents were the statements that training in CBT should be made available for MHNs and that MHNs should be able to advise their clients about CBT. The statements that received the strongest disagreement were the statements that ‘CBT is not a good use of time for MHNs’, and ‘I don’t know what CBT is’. Table 4.34 below illustrates the mean rating, the percentage of respondents who either agreed/strongly agreed or disagreed/strongly disagreed and the number of respondents who responded to each option.
Table 4.34: Attitudes to CBT

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Rating mean</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t know what CBT is</td>
<td>4.62</td>
<td>1.8</td>
<td>94.2</td>
<td>477</td>
</tr>
<tr>
<td>CBT is not good use of time for Mental Health Nurses (MHNs)</td>
<td>4.08</td>
<td>5.6</td>
<td>82.3</td>
<td>504</td>
</tr>
<tr>
<td>CBT should only be used in minor problems and not in the treatment of more serious mental illness</td>
<td>3.79</td>
<td>9.0</td>
<td>69.6</td>
<td>507</td>
</tr>
<tr>
<td>CBT should only be carried out by individuals with an approved qualification</td>
<td>2.73</td>
<td>45.9</td>
<td>28.1</td>
<td>506</td>
</tr>
<tr>
<td>More resources should be available to provide prompt CBT for my patients/patients</td>
<td>1.99</td>
<td>79.3</td>
<td>4.5</td>
<td>507</td>
</tr>
<tr>
<td>CBT should be recommended/tried as well as giving people medications such as anti-psychotics and anti-depressants</td>
<td>1.83</td>
<td>85.7</td>
<td>3.0</td>
<td>504</td>
</tr>
<tr>
<td>Training in CBT should be made available to all trainee MHNs</td>
<td>1.79</td>
<td>85.2</td>
<td>7.1</td>
<td>506</td>
</tr>
<tr>
<td>CBT is a valuable treatment option for people with mental illness</td>
<td>1.75</td>
<td>81.7</td>
<td>1.6</td>
<td>508</td>
</tr>
<tr>
<td>Training in CBT should be made available to all MHNs</td>
<td>1.61</td>
<td>91.6</td>
<td>3.4</td>
<td>507</td>
</tr>
<tr>
<td>MHNs should be able to advise their clients/patients about CBT</td>
<td>1.61</td>
<td>93.8</td>
<td>1.6</td>
<td>504</td>
</tr>
</tbody>
</table>

There were no significant differences found between respondents in terms of age, gender, years of experience or geographic location. However, an independent samples t-test for significance revealed those respondents who had done formal training in CBT and the place of employment of respondents showed some significant differences in terms of the strength of agreement/disagreement to some of the value statements. For example, at a 2-tailed test of significance and a significance level of P = .05, MHNs working in GP practices and those in private practice were significantly less likely to strongly agree that more resources should be available to provide CBT for their clients. Whereas, MHNs
working in mental health units in public hospitals were significantly more likely to strongly agree that more resources were necessary. MHNs employed in GP practices were more likely to strongly disagree that CBT is not a good use of time for MHNs. Private-practice MHNs were less likely to strongly agree that CBT should be recommended as well as medications.

The independent samples *t*-test also revealed those MHNs who had received formal training in psychological therapies were significantly more likely to strongly agree that training in CBT should be made available to both trainee and qualified MHNs and that MHNs should be able to advise their clients about CBT. They were also less likely to agree that CBT should only be carried out by individuals with an approved qualification and more likely to strongly disagree that CBT is not a good use of time for MHNs or that they do not know what CBT is. Table 4.35 and 4.36 illustrate these results.

Table 4.35: Significant Differences–Cognitive Behavioural Therapy

<table>
<thead>
<tr>
<th>Statement</th>
<th>Private practice</th>
<th>Not private practice</th>
<th>Public Hospital MHU</th>
<th>Not public Hospital MHU</th>
<th>GP practice</th>
<th>Not GP practice</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More resources should be available to provide prompt CBT for patients/clients</td>
<td>2.39</td>
<td>1.96</td>
<td>1.78</td>
<td>2.05</td>
<td>4.34</td>
<td>4.06</td>
<td>.002</td>
</tr>
<tr>
<td>CBT is not a good use of time for mental health nurses (MHNs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.047</td>
</tr>
<tr>
<td>CBT should be recommended/tried as well as giving people medications</td>
<td>2.33</td>
<td>1.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.007</td>
</tr>
</tbody>
</table>
Table 4.36: Significant Differences—Formal Training in Psychological Therapies

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT is not good use of time for mental health nurses (MHNs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.17</td>
<td>.000</td>
</tr>
<tr>
<td>No</td>
<td>3.84</td>
<td>.000</td>
</tr>
<tr>
<td>Training in CBT should be made available to all trainee MHNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.73</td>
<td>.005</td>
</tr>
<tr>
<td>No</td>
<td>1.99</td>
<td>.007</td>
</tr>
<tr>
<td>Training in CBT should be made available to all MHNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.56</td>
<td>.010</td>
</tr>
<tr>
<td>No</td>
<td>1.77</td>
<td>.014</td>
</tr>
<tr>
<td>MHNs should be able to advise their clients/patients about CBT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.56</td>
<td>.011</td>
</tr>
<tr>
<td>No</td>
<td>1.74</td>
<td>.014</td>
</tr>
<tr>
<td>I don’t know what CBT is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.66</td>
<td>.040</td>
</tr>
<tr>
<td>No</td>
<td>4.51</td>
<td>.050</td>
</tr>
</tbody>
</table>

Respondents who strongly agreed that student nurses should receive CBT training were highly likely to also strongly agree that MHNs should receive CBT training (Pearson correlation = .749). Similarly, respondents who strongly agreed with the statement that MHNs should be able to advise their clients about CBT were also likely to strongly agree that CBT training should be made available to all MHNs (Pearson correlation = .726). There were no further statistical correlations detected.

4.4.3 What Factors Influence Mental Health Nursing Practice in Relation to the Use of Psychological Therapies?

Questions four and eleven addressed factors influencing mental health nursing practice and their use of psychological therapies. Question four determined factors limiting the therapeutic ability of MHNs and question eleven identified barriers to MHNs implementing psychological therapies.

Responses to question four, “Do you agree that the following factors limit the ability of mental health nurses to be therapeutic?”, are illustrated in Table 4.37 below. The majority of the respondents either agreed or strongly agreed that the factors identified in the question limited the therapeutic practice of MHNs. Responses were considered to be on a
continuum between one and five with those who rated ‘strongly agree’ receiving a score of ‘1’ and those who rated strongly disagree receiving a score of ‘5’. Respondents who rated neither disagree or agree were considered neutral and received a score of ‘3’. The factors receiving the strongest level of agreement were ‘too many forms to fill out’ and ‘funding shortages’. The factor with the weakest level of agreement was ‘the integration of community health into the hospital system’, with 32.2 per cent of the respondents providing a neutral response, 35.3 per cent disagreeing with the statement and 32.4 per cent agreeing with the statement. Table 4.37 lists the factors, the rating mean, the percentage either agreeing/strongly agreeing or disagreeing/strongly disagreeing and the number of respondents to each factor.

Table 4.37: Factors Limiting the Therapeutic Practice of MHNs

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Rating mean</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The integration of community health into the hospital system</td>
<td>2.98</td>
<td>32.4</td>
<td>35.3</td>
<td>521</td>
</tr>
<tr>
<td>Nurses don’t do counselling because they are told they don’t have the skills</td>
<td>2.82</td>
<td>43.6</td>
<td>36</td>
<td>523</td>
</tr>
<tr>
<td>Nurses spend too much time doing observations</td>
<td>2.81</td>
<td>38.6</td>
<td>60.1</td>
<td>525</td>
</tr>
<tr>
<td>Nurses don’t do counselling because they don’t think they have the skills</td>
<td>2.79</td>
<td>48.1</td>
<td>34.9</td>
<td>524</td>
</tr>
<tr>
<td>Ageing workforce</td>
<td>2.59</td>
<td>50.6</td>
<td>29.3</td>
<td>522</td>
</tr>
<tr>
<td>Nurse’s role is getting narrower</td>
<td>2.53</td>
<td>54.7</td>
<td>26.3</td>
<td>524</td>
</tr>
<tr>
<td>An over-emphasis on medical assessment, diagnosis, and bio-medical treatments such as medication and electroconvulsant therapy (ECT)</td>
<td>2.42</td>
<td>54.1</td>
<td>21.2</td>
<td>523</td>
</tr>
<tr>
<td>High patient-to-staff ratios</td>
<td>2.07</td>
<td>70.0</td>
<td>12.6</td>
<td>524</td>
</tr>
<tr>
<td>Low morale of nurses</td>
<td>1.97</td>
<td>79.5</td>
<td>10.0</td>
<td>526</td>
</tr>
</tbody>
</table>
Funding shortages | 1.91 | 76.7 | 11.5 | 523
Too many forms to fill out | 1.87 | 77.7 | 9.5 | 525

There were no significant differences found between respondents in terms of gender, level of education, age, geographic location or years of experience. However, a one-way ANOVA revealed there were significant differences in terms of strength of agreement or disagreement depending on place of employment and whether they had received formal training in psychological therapies. For example, using a 2-tailed test of significance and a significance level of $p = .05$, private hospital MHNs were significantly less likely to agree that nurses spend too much time doing observations, that nurses do not have counselling skills or that funding shortages are limiting factors. However, using the same level of significance, MHNs employed in MHUs in public hospitals and in public psychiatric hospitals were more likely to agree that nurses spend too much time doing observations. Nurses employed in community health were significantly more likely to agree that they had too many forms to fill in and that this factor limited their therapeutic practice. Whereas MHNs who had received formal training in psychological therapies were less likely to agree that high staff–patient ratios limited their ability to be therapeutic but they were more likely to agree that an over-emphasis on medical assessment, diagnosis and bio-medical treatments limited their therapeutic ability. Table 4.38 and Table 4.39 below illustrate these and other areas of significant difference in levels of agreement between these nurses.
Table 4.38: Significant Differences: Factors Limiting the Therapeutic Practice of MHNs

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Mean</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses spend too much time doing observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospital</td>
<td>3.15</td>
<td>.039</td>
</tr>
<tr>
<td>Not private hospital</td>
<td>2.78</td>
<td>.051</td>
</tr>
<tr>
<td>Public psych hospital</td>
<td>2.45</td>
<td>.024</td>
</tr>
<tr>
<td>Not public psych hospital</td>
<td>2.84</td>
<td>.022</td>
</tr>
<tr>
<td>Public hospital MHU</td>
<td>2.62</td>
<td>.030</td>
</tr>
<tr>
<td>Not public hospital MHU</td>
<td>2.86</td>
<td>.035</td>
</tr>
<tr>
<td>Nurses don’t do counselling because they don’t think they have the skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospital</td>
<td>3.33</td>
<td>.006</td>
</tr>
<tr>
<td>Not private hospital</td>
<td>2.75</td>
<td>.011</td>
</tr>
<tr>
<td>GP practice</td>
<td>3.18</td>
<td>.034</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>2.76</td>
<td>.066</td>
</tr>
<tr>
<td>Funding shortages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Hospital</td>
<td>2.31</td>
<td>.013</td>
</tr>
<tr>
<td>Not private hospital</td>
<td>1.87</td>
<td>.052</td>
</tr>
<tr>
<td>Nurse’s role is getting narrower</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public psych hospital</td>
<td>2.17</td>
<td>.045</td>
</tr>
<tr>
<td>Not public psych hospital</td>
<td>2.56</td>
<td>.039</td>
</tr>
<tr>
<td>GP practice</td>
<td>3.24</td>
<td>.000</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>2.46</td>
<td>.000</td>
</tr>
<tr>
<td>High patient-to-staff ratios</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public psych hospital</td>
<td>2.45</td>
<td>.013</td>
</tr>
<tr>
<td>Not public psych hospital</td>
<td>2.04</td>
<td>.030</td>
</tr>
<tr>
<td>Too many forms to fill out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health</td>
<td>1.75</td>
<td>.047</td>
</tr>
<tr>
<td>Not community health</td>
<td>1.94</td>
<td>.046</td>
</tr>
</tbody>
</table>

(One way ANOVA computed for each item, only results significant at p<0.05 reported)
Table 4.39: Significant Differences: Received Formal Training in Psychological Therapies

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Mean</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High patient-to-staff ratios</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2.11</td>
<td>.042</td>
</tr>
<tr>
<td>No</td>
<td>1.89</td>
<td>.038</td>
</tr>
<tr>
<td>Ageing workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2.65</td>
<td>.035</td>
</tr>
<tr>
<td>No</td>
<td>2.38</td>
<td>.030</td>
</tr>
<tr>
<td>An over-emphasis on medical assessment, diagnosis,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and bio-medical treatments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2.33</td>
<td>.003</td>
</tr>
<tr>
<td>No</td>
<td>2.68</td>
<td>.004</td>
</tr>
</tbody>
</table>

(t-Test computed for each item, only results significant at p≤0.05 reported)

This question also provided an opportunity for respondents to make open ended comments and 202 respondents did so. These comments were analysed and coded using Ethnograph 6.0 and mostly reflected and enlarged upon the responses already provided. Where this was the case the comments were coded under the relevant answer option in question 4. In addition, 26 comments were coded as 'education poor', a separate item not listed as an answer option. These comments were critical of both the undergraduate and post graduate education offered to MHNs and this was nominated as a limiting factor on the ability of MHNs to be therapeutic. The Table below provides both the code frequency and examples of the comments provided in response to question 4.
Table 4.40: Exemplar Comments Regarding Question Four: ‘Factors Limiting the Ability of Mental Health Nurses to Be Therapeutic’

<table>
<thead>
<tr>
<th>Limiting factor</th>
<th>Data examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses don’t do counselling because either they don’t have the skills or are told they don’t (n = 28)</td>
<td>University-trained nurses are not taught any therapy in depth; I believe this is the reason why nurses do not do counselling/therapy with patients. There are limited staff development opportunities to consolidate their skills. (Response number 9). I love counselling my patients. The hardest part is actually having the appropriate space to counsel in. I have to make do with kitchens, on the oval playing footy, medication time, whilst walking to the shops. That’s often the best I can do. I envy other professions who are allocated space to work and to see clients. I believe that the use of self and the establishment of therapeutic relationships are the core role of mental health nurses. (Response number 54).</td>
</tr>
<tr>
<td>Low morale of nurses (n = 26)</td>
<td>My experience over 25 years of MH nursing has been one of feeling de-valued by other professional groups. (Response number 116). When/if they are asked, any suggestions or recommendations made by ‘at the coal-face’ nurses, there is either little notice taken or no notice taken by those in the respective authority. Therefore my conclusion it that it is a pointless exercise to become involved with such activities. (Response number 153).</td>
</tr>
<tr>
<td>Too many forms to fill out (n = 26)</td>
<td>There is far too much paperwork and we are losing our usefulness as we are not able to respond. For every new client that is referred, it takes eight hours of paperwork if one is to do the required assessment including NOCC assessments and care plans. (Response number 41). Poor management models, which emphasise form-filling as defensive practice to protect management from litigation and shift ‘blame’ away from the Health Service. (Response number 55).</td>
</tr>
<tr>
<td>Nurse’s role is getting narrower (n = 21)</td>
<td>I would suggest that the nursing role is often seen by both nurses and other staff of a custodial nature and this can impact on our own perceived abilities or lack of them that in turn influences whether we think we can be therapeutic. (Response number 23). The scope of practice for an MHN in private practice is broadly decided by the nurse themselves. I believe the role of the nurse is actually expanding not</td>
</tr>
<tr>
<td>Issue</td>
<td>Response</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>High patient-to-staff ratios (n = 12)</td>
<td>Staff numbers reduced because of three per cent budget cuts. Nurse–patient ratio min 6:1 as high as 7:1 at xmas. Work environment not therapeutic because of this for either staff or clients. Also physical environment is a factor, i.e. dull. (Response number 19). We need more nurses. We need to spend more time on the floor with our clients. We need to do something about the excessive ‘doubling up’ of paperwork. We need to advocate more for client participation in treatment plans and ongoing maintenance to ensure good quality of life for our clients. (Response number 76).</td>
</tr>
<tr>
<td>Funding shortages (n = 10)</td>
<td>No funding for ongoing professional development and a culture that does not ask for further development. (Response number 46). It seems obvious to me that the long-term goal of the mental health framework is to make the system untenable via increasing workloads, low pay, ridiculous expectations, higher and higher levels of responsibility without appropriate remuneration. This can only result in gradual movement towards privatisation away from Govt. responsibility and placed back to GP surgeries with mental health staffing. (Response number 202).</td>
</tr>
<tr>
<td>Lacking experience (n = 9)</td>
<td>There are insufficient experienced nurses to mentor inexperienced staff to help them build up the necessary skills to fully assess the risk factors for the patient. Wards are often overloaded with these inexperienced staff members. (Response number 67). The workforce has a small number of senior clinicians. Less experienced clinicians (with a maximum of five years of experience) are predominant in number. The learning may be different—definitely a huge gap between theory and practice. (Response number 92).</td>
</tr>
<tr>
<td>Poor management (n = 5)</td>
<td>Lack of leadership by senior nursing staff due to an overemphasis on financial and service-focused priorities such as rostering and pay duties being devolved to nurse managers. (Response number 115). High workloads, limited support from management, staff bullying and harassment, inappropriate admissions, under-medication, nil security (serious staff assault). (Response number 210).</td>
</tr>
<tr>
<td>Over-emphasis on medical assessment, diagnosis and bio-medical treatments (n = 4)</td>
<td>Medicalisation and bureaucratisation of mental health whilst useful (in its place) shifted the emphasis from doing to being seen to be done particularly from the nursing perspective. Mental health nursing is both an art and a science that is too often relegated to a support role for the system rather than the primary means of care delivery. (Response number 6). As a nurse who has worked in both public and private sector I have seen the push by psychiatrists with the medical model and undermining nurses skills to ensure that their patients’ (clients) requests are met. This is not always in the patient’s bests interests. (Response number 167).</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Ageing workforce (n = 3)</td>
<td>Age is impacted by old attitudes in my perception. Too many nurses have spent the last fifteen years sitting on their backside instead of engaging in the development of the therapeutic relationship by <em>‘being’ with the consumer.</em> (Response number 134). Older worker’s frustration levels increasing and the newer entrants are not being given the opportunity and mentoring required to allow development. (Response number 157).</td>
</tr>
<tr>
<td>New item Education poor (n = 26)</td>
<td>Lack of appropriate therapy skills (training and supervision) and subsequent confidence to feel they can treat patients independently of a GP or psychiatrist. (Response number 27). The mental health nursing workforce is a very deskilled one mainly due to the paucity of mental health content in the comprehensive undergraduate programs. Broadly speaking, there is little interest in gaining more knowledge post-registration. In general, new graduates don’t know what they don’t know and there are very few skilled role models. (Response number 73). The medicalisation of nursing education. (Response number 50).</td>
</tr>
</tbody>
</table>

Factors influencing the use of psychological therapies by MHNs were identified in question eleven, _‘Do you agree that the following are barriers to implementing psychological therapies in your practice?’ _Limiting bureaucratic practices in organisation of client care’ was the answer option most strongly agreed with, whereas _‘I don’t believe psychological therapies will work’_ was the answer option most strongly disagreed with. Table 4.41 below lists the barriers to implementing psychological
therapies, the response rates, percentages for agree/strongly agree and disagree/strongly disagree and the rating mean for each answer option.

Table 4.41: Barriers to Implementing Psychological Therapies

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Rating mean</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t believe psychological therapies will work</td>
<td>4.5</td>
<td>7.3</td>
<td>92.3</td>
<td>508</td>
</tr>
<tr>
<td>Not appropriate for my clients/patients</td>
<td>4.2</td>
<td>4.2</td>
<td>81.5</td>
<td>503</td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are adequately treated</td>
<td>4.01</td>
<td>8.9</td>
<td>75.6</td>
<td>508</td>
</tr>
<tr>
<td>Clients/patients do not like the approach</td>
<td>3.9</td>
<td>5.3</td>
<td>69.7</td>
<td>508</td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are experiencing</td>
<td>3.81</td>
<td>11.1</td>
<td>65.9</td>
<td>505</td>
</tr>
<tr>
<td>symptoms that are too severe for psychological therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family members or friends do not agree with the approach</td>
<td>3.76</td>
<td>6.6</td>
<td>62.1</td>
<td>504</td>
</tr>
<tr>
<td>Clients/patients do not comply with the approach</td>
<td>3.69</td>
<td>9.3</td>
<td>59.1</td>
<td>506</td>
</tr>
<tr>
<td>Clients/patients do not understand the approach</td>
<td>3.57</td>
<td>15.0</td>
<td>55.0</td>
<td>507</td>
</tr>
<tr>
<td>My lack of training in the area</td>
<td>3.13</td>
<td>35.7</td>
<td>44.2</td>
<td>509</td>
</tr>
<tr>
<td>Other staff won’t support me in applying psychological therapies</td>
<td>3.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff turnover excessive</td>
<td>2.93</td>
<td>35.4</td>
<td>35.2</td>
<td>503</td>
</tr>
<tr>
<td>Colleagues not interested in applying psychological therapies</td>
<td>2.68</td>
<td>48.5</td>
<td>27.5</td>
<td>505</td>
</tr>
<tr>
<td>Too few staff to carry out psychological therapies</td>
<td>2.3</td>
<td>63.4</td>
<td>20.2</td>
<td>505</td>
</tr>
<tr>
<td>Insufficient resources to help clients/patients</td>
<td>2.3</td>
<td>55.5</td>
<td>18.5</td>
<td>507</td>
</tr>
<tr>
<td>Lack of time within workload</td>
<td>2.21</td>
<td>68.7</td>
<td>20.5</td>
<td>508</td>
</tr>
<tr>
<td>Limiting bureaucratic practices in organisation of client care</td>
<td>2.05</td>
<td>55.5</td>
<td>18.4</td>
<td>503</td>
</tr>
</tbody>
</table>

An independent samples $t$-test revealed there were no significant differences between the respondents in terms of gender or geographic location. However, there were significant differences in terms of levels of agreement or disagreement with current place of employment, whether they had received formal training in psychological therapies, age and years of experience. For example, MHNs working in the public sector were
significantly likely to agree more strongly that lack of time, too few staff, low resources, bureaucracy, lack of support, no training and colleagues not being interested were barriers to implementing psychological therapies than respondents working in the private sector whether in GP offices, private practice or private hospitals. Table 4.42 below illustrates these levels of significance for MHNs employed in public mental health units and public psychiatric hospitals. Table 4.43 compares significant levels of difference between nurses employed in the public and private sector. Nurses employed in the public sector included those working in public hospital mental health units, public psychiatric hospitals and community mental health. Nurses employed in the private sector included those employed in a private hospital, working in a GP office or in private practice.
Table 4.42: Public Hospital Nurses Difference in Levels of Agreement to Nurses Working in the Private Sector: Barriers to Implementing Psychological Therapies

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Public hospital MHU</th>
<th>Not public hospital MHU</th>
<th>Public psych hospital</th>
<th>Not public psych hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time within workload</td>
<td>112</td>
<td>396</td>
<td>42</td>
<td>463</td>
</tr>
<tr>
<td>Mean</td>
<td>1.86</td>
<td>2.32</td>
<td>1.79</td>
<td>2.07</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td>.102</td>
<td>.044</td>
</tr>
<tr>
<td>Too few staff to carry out psychological therapies</td>
<td>112</td>
<td>393</td>
<td>42</td>
<td>463</td>
</tr>
<tr>
<td>Mean</td>
<td>1.96</td>
<td>2.40</td>
<td>1.79</td>
<td>2.07</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.001</td>
<td>.000</td>
<td>.102</td>
<td>.044</td>
</tr>
<tr>
<td>Insufficient resources to help clients/patients</td>
<td>112</td>
<td>395</td>
<td>42</td>
<td>463</td>
</tr>
<tr>
<td>Mean</td>
<td>1.96</td>
<td>2.39</td>
<td>2.36</td>
<td>2.71</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.000</td>
<td>.059</td>
<td>.030</td>
</tr>
<tr>
<td>Limiting bureaucratic practices in organisation of client care</td>
<td>Public hospital MHU</td>
<td>112</td>
<td>391</td>
<td>42</td>
</tr>
<tr>
<td>Mean</td>
<td>1.81</td>
<td>2.12</td>
<td>1.79</td>
<td>2.07</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.009</td>
<td>.005</td>
<td>.102</td>
<td>.044</td>
</tr>
<tr>
<td>Colleagues not interested in applying psychological therapies</td>
<td>Not public hospital MHU</td>
<td>394</td>
<td>463</td>
<td>42</td>
</tr>
<tr>
<td>Mean</td>
<td>2.44</td>
<td>2.75</td>
<td>2.36</td>
<td>2.71</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.014</td>
<td>.013</td>
<td>.059</td>
<td>.030</td>
</tr>
<tr>
<td>Other staff won’t support me in applying psychological therapies</td>
<td>Public hospital MHU</td>
<td>111</td>
<td>394</td>
<td>463</td>
</tr>
<tr>
<td>Mean</td>
<td>2.70</td>
<td>2.75</td>
<td>2.36</td>
<td>2.71</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.013</td>
<td>.059</td>
<td>.030</td>
</tr>
<tr>
<td>My lack of training in the area</td>
<td>Public hospital MHU</td>
<td>112</td>
<td>397</td>
<td>465</td>
</tr>
<tr>
<td>Mean</td>
<td>2.91</td>
<td>3.19</td>
<td>3.12</td>
<td>.002</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.032</td>
<td>.037</td>
<td>.037</td>
<td>.037</td>
</tr>
<tr>
<td>Staff turnover excessive</td>
<td>Public hospital MHU</td>
<td>109</td>
<td>394</td>
<td>463</td>
</tr>
<tr>
<td>Mean</td>
<td>2.70</td>
<td>3.00</td>
<td>2.71</td>
<td>3.00</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.015</td>
<td>.013</td>
<td>.013</td>
<td>.013</td>
</tr>
</tbody>
</table>

(One way ANOVA computed for each item, only results significant at p<0.05 reported)
Table 4.43: Private Sector Nurses Difference in Level of Disagreement with Public Hospital Nurses: Barriers to Implementing Psychological Therapies

<table>
<thead>
<tr>
<th>Answer options</th>
<th>N</th>
<th>Mean</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not appropriate for my clients/patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospital</td>
<td>39</td>
<td>4.51</td>
<td>.020</td>
</tr>
<tr>
<td>Not private hospital</td>
<td>464</td>
<td>4.17</td>
<td>.003</td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>4.09</td>
<td>.049</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>460</td>
<td>3.79</td>
<td>.033</td>
</tr>
<tr>
<td>Other staff won’t support me in applying psychological therapies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>3.67</td>
<td>.000</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>462</td>
<td>3.03</td>
<td>.001</td>
</tr>
<tr>
<td>Staff turnover excessive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>3.49</td>
<td>.001</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>458</td>
<td>2.88</td>
<td>.003</td>
</tr>
<tr>
<td>I don’t believe psychological therapies will work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>4.48</td>
<td>.000</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>463</td>
<td>4.47</td>
<td>.000</td>
</tr>
<tr>
<td>Private practice</td>
<td>35</td>
<td>4.74</td>
<td>.033</td>
</tr>
<tr>
<td>Not private practice</td>
<td>473</td>
<td>4.49</td>
<td>.007</td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are experiencing symptoms that are too severe for psychological therapies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>4.09</td>
<td>.049</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>460</td>
<td>3.79</td>
<td>.033</td>
</tr>
<tr>
<td>Clients/patients do not like the approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>4.24</td>
<td>.005</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>463</td>
<td>3.87</td>
<td>.003</td>
</tr>
<tr>
<td>Private practice</td>
<td>36</td>
<td>4.31</td>
<td>.003</td>
</tr>
<tr>
<td>Not Private practice</td>
<td>472</td>
<td>3.87</td>
<td>.003</td>
</tr>
<tr>
<td>Clients/patients do not understand the approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>3.96</td>
<td>.006</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>462</td>
<td>3.53</td>
<td>.008</td>
</tr>
<tr>
<td>Family members or friends do not agree with the approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP practice</td>
<td>45</td>
<td>4.09</td>
<td>.008</td>
</tr>
<tr>
<td>Not GP practice</td>
<td>459</td>
<td>3.73</td>
<td>.012</td>
</tr>
<tr>
<td>Clients/patients do not comply with the approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private practice</td>
<td>36</td>
<td>4.11</td>
<td>.004</td>
</tr>
<tr>
<td>Not private practice</td>
<td>470</td>
<td>3.66</td>
<td>.004</td>
</tr>
</tbody>
</table>

(One way ANOVA computed for each item, only results significant at p<0.05 reported)

An independent t-test at a significance level of P = .01 revealed MHNs who had received formal training in psychological therapies were less likely to agree that too few staff, low resources, lack of training and high staff turnover were barriers to practicing psychological therapies. Further, at a P = .01 level of significance they were more likely
to strongly disagree that psychological therapies would not work, are not appropriate for their clients, that symptoms of mental illness are too severe for psychological therapies, that medications alone are adequate, that patients do not like psychological therapies, that patients do not comply with or understand psychological therapies or that families do not agree with a psychological approach. Table 4.44 below illustrates these findings.
Table 4.44: Nurses Who Have Received Formal Training in Psychological Therapies
Levels of Significant Difference: Barriers to Implementing Psychological Therapies

<table>
<thead>
<tr>
<th>Answer options</th>
<th>Formal training</th>
<th>N</th>
<th>Mean</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time within workload</td>
<td>Yes</td>
<td>376</td>
<td>2.29</td>
<td>.019</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>132</td>
<td>2.00</td>
<td>.011</td>
</tr>
<tr>
<td>Too few staff to carry out psychological therapies</td>
<td>Yes</td>
<td>374</td>
<td>2.41</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>131</td>
<td>1.99</td>
<td>.000</td>
</tr>
<tr>
<td>Insufficient resources to help clients/patients</td>
<td>Yes</td>
<td>375</td>
<td>2.39</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>132</td>
<td>2.02</td>
<td>.000</td>
</tr>
<tr>
<td>Other staff won’t support me in applying psychological therapies</td>
<td>Yes</td>
<td>375</td>
<td>3.14</td>
<td>.052</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>132</td>
<td>2.92</td>
<td>.046</td>
</tr>
<tr>
<td>My lack of training in the area</td>
<td>Yes</td>
<td>376</td>
<td>3.39</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>133</td>
<td>2.39</td>
<td>.000</td>
</tr>
<tr>
<td>Staff turnover excessive</td>
<td>Yes</td>
<td>372</td>
<td>3.03</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>131</td>
<td>2.67</td>
<td>.002</td>
</tr>
<tr>
<td>I don’t believe psychological therapies will work</td>
<td>Yes</td>
<td>376</td>
<td>4.59</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>132</td>
<td>4.25</td>
<td>.000</td>
</tr>
<tr>
<td>Not appropriate for my clients/patients</td>
<td>Yes</td>
<td>372</td>
<td>4.28</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>131</td>
<td>3.96</td>
<td>.001</td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are experiencing</td>
<td>Yes</td>
<td>372</td>
<td>3.91</td>
<td>.000</td>
</tr>
<tr>
<td>symptoms that are too severe for psychological therapies</td>
<td>No</td>
<td>133</td>
<td>3.55</td>
<td>.000</td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are adequately</td>
<td>Yes</td>
<td>375</td>
<td>4.07</td>
<td>.017</td>
</tr>
<tr>
<td>treated with medication</td>
<td>No</td>
<td>133</td>
<td>3.83</td>
<td>.015</td>
</tr>
<tr>
<td>Clients/patients do not like the approach</td>
<td>Yes</td>
<td>375</td>
<td>4.02</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>133</td>
<td>3.57</td>
<td>.000</td>
</tr>
<tr>
<td>Clients/patients do not comply with the approach</td>
<td>Yes</td>
<td>374</td>
<td>3.80</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>132</td>
<td>3.39</td>
<td>.000</td>
</tr>
<tr>
<td>Clients/patients do not understand the approach</td>
<td>Yes</td>
<td>374</td>
<td>3.69</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>133</td>
<td>3.23</td>
<td>.000</td>
</tr>
<tr>
<td>Family members or friends do not agree with the approach</td>
<td>Yes</td>
<td>373</td>
<td>3.85</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>131</td>
<td>3.50</td>
<td>.000</td>
</tr>
</tbody>
</table>

(t-Test computed for each item, only results significant at p<0.05 reported)
Respondents who strongly agreed that lack of time within workload was a barrier to practicing psychological therapies were highly likely to also strongly agree that too few staff was a barrier (Pearson correlation = .722). Similarly, those respondents who nominated patients not liking psychological therapies as a barrier were also likely to nominate that patients do not comply (Pearson correlation = .791). Respondents who nominated that patients do not understand psychological therapies were likely to also nominate the barrier that patients do not comply (Pearson correlation = .712) and families would not agree (Pearson correlation = .739).

4.5 Open-Ended Comments on the Survey

At the end of the survey an opportunity was provided for open-ended comments. One hundred and 93 respondents provided comments. As in question four, comments tended to reflect a focus on areas the respondent felt were priority areas within the survey and that they wanted to explain further. The comments were analysed and coded using Ethnograph 6.0. The items most frequently commented upon included 47 comments on question four, “factors that limit the ability of mental health nurses to be therapeutic”, 36 comments discussing psychological therapies/techniques used in the management of people with mental illness (questions six–ten) and 26 specifically about CBT—question twelve in the survey. There were also comments on other factors not surveyed, such as the importance of the therapeutic environment, education of nurses and consumer involvement. These are listed as “new ideas” at the end of Table 4.45 below. Table 4.45 provides a list of both the code, the code frequency for each comment and examples of the comments provided.
<table>
<thead>
<tr>
<th>Code</th>
<th>Data examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors limiting the ability of MH nurses to be therapeutic (n = 47)</td>
<td>Clinical abilities are being lost in this new world order of outcomes. A HONOS is not a tool to decide if an inpatient stay has had a beneficial outcome. The defensive documentation has taken over. I used to be able to see six+ patients a shift for full assessment and documentation. This is now down to two. That leaves four patients waiting for the next shift as no extra staff have been provided. (Response number 4). Many nurses don’t appear to want the responsibility of providing individual or group therapy for the consumers, which is a tragedy, as it is then left to psychiatrists (although few use a formal therapeutic approach and psychologists to provide it). (Response number 52). We also need more time to do this. With the invention of computers, wonder machines that they are, too much bullshit paperwork has been created simply because it can be done, and we community workers have become slaves behind the machine, not freed up to assist our clients with much more effective counselling and hands-on alliance work. (Response number 77). I see talented nursing expertise under-utilised and I see the downgrading of nursing skills. I witness and have reported to me some of the effect on MH clients of this poor use of nursing skills—also the poor attitude of some nurses to MH clients in treatment facilities. There are shortages of allied health staff so MH clients go begging for more than medication when counselling is not available—nursing staff often left in the role of the custodial caregiver because of either their lack of professional development opportunities or frank discouragement from offering additional support beyond what is seen as ‘nursing’. (Response number 96). I believe the main reason a therapeutic approach is not entrenched into our practice is one of poor leadership, direction and vision, coupled with a depressed workforce rapidly approaching burn-out status. (Response number 192).</td>
</tr>
<tr>
<td>Psychological therapies/techniques used</td>
<td>I believe antidepressants are appropriate in some instances but that psychological therapies are the long-term treatment option for my clients.</td>
</tr>
</tbody>
</table>
CBT and other psychological approaches are just formalising (putting a framework around) of the skills that mental health nurses have been using for many years. We have allowed other professions to use the academic process to claim ownership of processes that we already have very good skills in and use as an integrated part of our practice. We as a group have allowed others to make nurses feel inadequate and disempowered. (Most nurses were just too busy getting on with the job and not interested in academic qualifications.) Combined with a process of devaluing nurses by the institutions we work for (nurses carry the biggest workload often with the most complex clients and get it done), as reflected in our low base wages and the process of making role no nursing rather than open to anyone with the skills and a relevant qualification. (Response number 123).

MHNs are just as capable as psychologists, psychiatrists and GPs in delivering psychological therapies to their clients. (Response number 133).

The type of therapy that would be beneficial for a client is very dependent on their presentation and their needs and where they are in their recovery process. In my opinion there is no one therapy that has proven to provide consistent positive health outcomes. It therefore is essential that mental health nurses have a repertoire of therapy skills to utilise to assist clients in recovery. It is not useful to limit our skill base and I believe that this is the foundation of mental health nursing; i.e. a broad base of skills to enhance the therapeutic relationship. (Response number 136).

I don't think CBT is the only form of psychological treatment that is useful for people with a psychiatric illness. A lot of research has been done on the benefits of just developing a trusting and communicative relationship with the client without having to follow a model of therapy. (Response number 87).

CBT is one approach that really can benefit most mental health patients, not always in controlling symptoms, but often in developing coping mechanisms and strategies to more effectively deal with them. A knowledge of the concepts and language of CBT can assist mental health nurses to support clients, even though the nurse is not delivering a complete CBT program.
Nurses can also explain the benefits of CBT to clients and encourage continuation of therapy, particularly in early stages, when the client may be experiencing a lack of confidence in the process. (Response number 104).

My nurse training at Uni (in the UK) was in conjunction with the psychology students so there was a strong emphasis on CBT as a trainee and that psychological therapy was the main role of an MHN in terms of holistic care in adjunct to medicine. (Response number 119).

We need to be cautious about placing an over-emphasis on CBT; although it has its uses, CBT is not a good fit for all people all the time. A client-centred approach to therapy is what’s required, not a therapy-centred approach to the client. (Response number 120).

<table>
<thead>
<tr>
<th>Barriers to implementing psychological therapies (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe there should be more focus on these therapies during post-graduate training programs for mental health nurses. I also feel that mental health facilities should provide ongoing training to their clinicians in all these areas thus providing additional treatment regimens for their clients. (Response number 72).</td>
</tr>
<tr>
<td>It is time therapeutic skilling became part of the basic training for nurses. The staff that spend most time with clients in an in-patient setting. (Response number 78).</td>
</tr>
<tr>
<td>The point of one of the questions, about colleagues not willing to participate in psych-based intervention is more than true. I feel many do not want to do any therapeutic work with patients due to their bad attitudes—even though they are meant to be trained professionals. (Response number 138).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies employed by MH nurses (n = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy can be offered but is only part of a MHN’s role, other parts consist of monitoring mental state, liaising with families and carers, engaging in social programs, health education, monitoring physical state, administering medication, assisting with housing etc. I don’t want to see the MHN role ever turn into a psychologist role, I like to remain as I currently am—a one-stop shop and able to help in many ways! (Response number 28).</td>
</tr>
<tr>
<td>I think the greatest asset that makes the most difference is the person of self. What the nurse brings into the relationship. A self that is honest, caring and encouraging, real and genuine can do more than any particular therapeutic</td>
</tr>
<tr>
<td>Approach given. (Response number 151).</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Good nurses help the patient to do things for themselves, whenever possible, not do the tasks for the patient. (Response number 161).</td>
</tr>
<tr>
<td><strong>MHN work satisfying</strong> (n = 11)</td>
</tr>
<tr>
<td>Following my change of employment to GP surgery I am being actively encouraged to run groups and the main part of my day is spent counselling. I am happy in my work for the first time in many years. (Response number 73).</td>
</tr>
<tr>
<td>The way of the future is mental health nurses placed in GP practices in primary health care providing effective therapeutic interventions. I personally have gained a lot more professional satisfaction since practicing in this model. (Response number 76).</td>
</tr>
<tr>
<td>I do enjoy my work, but the system is very depressing. I go to work and do the best I can. (Response number 155).</td>
</tr>
<tr>
<td><strong>Current place of employment</strong> (n = 9)</td>
</tr>
<tr>
<td>I work as a GP Mental Health Nurse through the Mental Health Nurse Initiative Program and find this challenging and rewarding, and I feel this area of MHN should be more widely encouraged as I feel there is significant benefit to the client, the family and the community. (Response number 123).</td>
</tr>
<tr>
<td>I work 2/7 in a private practice model, I would see between four to eight clients a day and I am utilising a variety of psychological therapies with all my clients. (Response number 133).</td>
</tr>
<tr>
<td><strong>Formal training</strong> (n = 9)</td>
</tr>
<tr>
<td>I have been disappointed by my own lack of training in psychological therapies. My under- and post-grad degrees were medically orientated. And at my workplace, psychologists have promoted themselves as the sole experts at CBT—and systems have made it difficult for nurses to practice. This is also present outside of public mental health. Nurses are ‘left out’. (Response number 56).</td>
</tr>
<tr>
<td>I would like further training and support in CBT. I feel it is a valuable tool that empowers MHNs to do really productive work with their clients. Many clients appreciate the benefits of this work. (Response number 140).</td>
</tr>
<tr>
<td>Staff need to be allowed the time to learn a variety of strategies unfortunately, unless they pursue them in their own time (many of which I did—attending uni summer courses etc.) there is a lack of knowledge in many ward-based</td>
</tr>
</tbody>
</table>
staff, and the more experienced clinicians are not on the wards to role model or teach, they have been driven into other areas because the politics, and patient acuity. (Response number 180).

<table>
<thead>
<tr>
<th>Experienced MHNs (n = 5)</th>
<th>I find that staff who are assertive and willing to lean make good team work on the ward. It's not so much about how experienced they are. (Response number 100). Qualifications great but ground roots experience cannot be taught, it must be experienced. (Response number 144). There has been an obvious decline in the uptake of mental health nursing since the hospital-based training model was phased out. Our clients now experience more discrimination and are often working with much less knowledgeable staff. (Response number 145).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Qualifications (n = 4)</th>
<th>It is my observation that Div1 &amp; Div2 nurses are been employed in the private psychiatric hospitals without psych experience as an economic measure. I believe these people should undertake studies in mental health to show their commitment to this specialty, and these studies should be compulsory and supported financially and emotionally by the employer. Private mental health is an expensive but necessary alternative to the public system, and a proportion of this cost should be allocated towards education of the staff so the client receives the best care in a timely and meaningful way. (Response number 110).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Non-pharmacological approaches (n = 2)</th>
<th>I have been active in attempting to improve the therapeutic program in this very restrictive mental health setting and have found that a number of my colleagues are reluctant to improve on their therapeutic skills. They are not encouraged and often see these as the domain of the other allied health professionals in the multi-disciplinary team. I have introduced the use of the Internet and other group skills to the unit and have been teaching by example other younger staff that have never had the opportunity to do this for themselves. (Response number 3).</th>
</tr>
</thead>
</table>

| New ideas | Education of MH nurses (n = 10) | As one from the ‘fossil’ era of hospital-based training, I have witnessed the demise of MH nursing standards. Too much emphasis, now, is based on academic achievements and knowledge and nowhere near enough of practical, hands on, functional skills’ development. (Response number 65). |
Bring back direct entry hospital-based psych nurse training, universities have failed us in so many ways. I, as a senior clinician and manager, could go on for hours. (Response number 102).

I think that mental health nurses are not being prepared well enough regarding therapeutic intervention and would benefit from more hands on experience under close supervision of more experienced nurses. (Response number 108).

| Therapeutic environment (n = 7) | I have been very disappointed with Qld Health’s poor settings for people with mental health issues. They place older persons amongst young, potentially violent/aggressive patients, placing them at risk, as well as terrifying them! There should be a standalone unit for better care of older services patients. It is appalling, to say the least. There is nowhere for those patients who don’t smoke to get fresh air, in particular if they are detained and have no outside leave arrangements. There are few places for patients to have some quiet time if they need it. No activities are dedicated OT or support areas for any group programs to be able to be carried out. (Response number 5). |
| Consumer involvement (n = 2) | NSW public hospitals are woefully inadequate in meeting the needs of people with a mental illness. They are noisy and lacking in space to allow many therapeutic activities to be undertaken and mostly operate with a revolving door band-aid approach. (Response number 186). |

A Story of Positive Experience: I found the creativity of the people who organised the opening introduction to The C… Mental Health Unit in 1998–9 was very positive. The process was to invite stable clients of Mental Health Services to attend six weeks of Therapeutic Alliance and Workshops with the Nurses, Doctors and Allied Health who would be working in the district. There were great opportunities for clients to talk of their likes and dislikes of previous treatment. (Response number 98).

Although I feel there is a place for psychological therapies I also value working alongside a consumer to learn about their strengths and weaknesses. (Response number 157).
4.6 Conclusion

This chapter comprises an outline of the results for the research project within the context of the three research questions. Results from the two Delphi surveys and the questionnaire survey of practicing MHNs were delineated. Group characteristics of the two Delphi samples and the practicing MHN questionnaire sample were described.

Results from the findings from the consumer Delphi survey addressed research questions one and two. From this analysis a number of factors were identified by the consumer panel and these factors were grouped under the following three themes, namely:

- Most helpful knowledge, skills and attitudes;
- Helpful strategies used by MHNs; and
- Helpful therapies.

Results from the findings of the nurse Delphi survey addressed research questions two and three. Similarly, several factors were identified by the nurse panel, and these were grouped into the following three themes, namely:

- Most helpful knowledge, skills and attitudes;
- Current problems preventing nurses from fulfilling their therapeutic role; and
- Helpful therapies.

Results from the questionnaire survey of practicing MHNs also addressed research questions two and three. Nursing strategies employed by MHNs including non-pharmacological approaches were determined and tests of significance and correlation were conducted to assess for significant differences and correlations between respondents. Additionally, attitudes towards and usage of psychological therapies were identified along with identification of factors limiting the therapeutic practice of MHNs. A number of barriers to implementing psychological therapies and structural limitations on therapeutic ability were identified. In particular, statistically significant differences were found between nurses employed in the public sector with those employed in the
private sector regarding these barriers and limitations to therapeutic practice. A discussion of these results follows in the next chapter.
Chapter 5: Discussion

5.1 Introduction

This chapter presents the discussion of the results. The discussion follows the three research questions for the study that are listed below. The discussion of the Delphi study with the consumer panel addresses research question one. The discussion of the Delphi study with the nurse panel and the questionnaire survey of practicing MHNs addresses research questions two, and three:

1. What do consumers think will improve the quality of their care?
2. What therapeutic roles/modalities do nurses think are suitable for inpatient and community mental health nursing practice?
3. What factors influence mental health nursing practice in relation to the use of psychological therapeutic modalities?

The characteristics of the three sample groups is presented and discussed in terms of their representativeness to the population. Priorities identified by the both the Delphi consumer and Delphi nurse samples for improving the quality of nursing care are identified and discussed within the theoretical framework of the thesis and the relevant current literature. Following this exploration, the results from both the nurse Delphi and questionnaire samples relevant to research questions two and three are discussed with reference to the theoretical framework of the thesis and the current literature. A comprehensive conclusion both summarising and linking the critical elements of the discussion concludes the chapter.

A critical realist approach is adopted in the discussion in order to present a social construction of how consumers and nurses perceive, experience and understand the quality of care delivered by MHNs. Critical realism allows the researcher to select where to focus from multiple viewpoints (Yeung, 1997). The subjective experience and interpretation of the therapeutic role of the MHN by both consumers and nurses provides
valuable insights. The consumer viewpoint provides a lens as an 'agent' receiving care and the nurse viewpoint as 'giver' of that care. Reference has already been made to Foucault, Althusser and feminism to help guide the broad contours of the study into the current therapeutic practices of MHNs. In particular, these theorists provide a framework to examine how 'epistemic structures', as understood by Foucault, unconsciously held ideological concepts and the 'ideological state apparatus' identified by Althusser and patriarchal relationships in psychiatry, as identified by Potter, Fraser and others, might be used to justify, influence and sustain the current therapeutic practices of MHNs. As Habibis (2009, p. 300) points out, 'illness experiences are situated within the institutional framework of health care systems and are profoundly shaped by this'.

The Delphi studies and the questionnaire survey of practicing MHNs, therefore provides insight into how consumers and nurses perceive the effectiveness of the current ideological focus in mental health nursing, how power relations between patients and nurses effect care and recovery, how symptoms may be perceived differently by both groups and how all this impacts upon and controls the quality of nursing care as perceived by both groups. Consumers and mental health nurses agree psychological therapies are appropriate and effective therapeutic strategies for mental health nurses, with over 90 per cent of nurses indicating they want to employ psychological therapies in their practice. Mental health nurses believe structural and to a lesser degree individual barriers are preventing them from employing psychological therapies. These barriers include the domination of the biomedical model, low staff morale, high patient-staff ratios, outsourcing of nursing roles such as counselling and inadequate educational preparation of nurses in evidence based psychological therapies. CBT and solution-focused therapy are highly regarded psychological therapies by mental health nurses. Consumers point out the attitude of the nurse is a key factor in therapeutic helpfulness identifying nurses who are respectful and provide care in a way that empowers them as most therapeutic. These are key findings contributing to the body of knowledge on the therapeutic role of the mental health nurse.
5. 2 Group Characteristics

It is a requirement of the Delphi technique that panel members are experts in their field and, as such, can make predictions about the future and assist in policy formation and in understanding complex human situations (McLeod & Childs, 2007). The composition of the expert panel, therefore, is a key component in determining the quality of the Delphi survey. There is no requirement that the panel be representative for statistical purposes or that it is randomly selected (Crisp et al., 1997; Powell, 2003). Similarly, there is flexibility in determining who the ‘experts’ are. In this Delphi survey, members of the consumer panel were considered experts on the basis of their experiences as consumers with mental health services.

All the consumers lived with a serious mental illness that required ongoing treatment from mental health services. Eight of the participants were diagnosed with a psychotic illness, one with severe anxiety and the remaining participant was diagnosed with anorexia nervosa. They had received treatment from MHNs for extended periods and had strong memories and opinions about the nursing care they had received. Due to the ethical requirements for informed consent to participate in the study and for the participants not to be experiencing psychological distress, all the consumer participants were mentally stable and living independently in the community. This might explain why only one of the participants was currently seeing a MHN with the remainder being supported in the community by GPs or allied health workers such as psychologists. This meant that their discussions about the therapeutic role of MHNs were mostly retrospective accounts reliant upon the memories of their experiences.

Members of the nurse panel were considered expert if they had at least five years of current experience in clinical mental health nursing, held post-graduate qualifications in MH nursing and were in senior or leadership positions in MH nursing. All participants in the Delphi survey nurse panel had more than ten years’ experience in clinical mental health nursing with the majority holding Master’s degrees or PhDs in topics related to mental health nursing as their highest qualification. Seven of the eight participants were
working in the related clinical areas as clinical nurse specialists (CNSs), clinical nurse consultants (CNCs), NPs, clinical professors or RNs. Their current place of employment included emergency departments, adult mental health inpatient units, drug and alcohol units, crisis teams and community mental health positions. One of the participants was in academia as a MHN senior lecturer. There were five women and three men making up the nurse panel. These characteristics indicate the nurse panel fulfilled the criteria for ‘expert mental health nurse‘ with up-to-date clinical knowledge of the therapeutic role of the MHN and knowledge of the barriers to MH nurses fulfilling their potential therapeutic roles.

Sample size and representativeness to the target population are important criteria in determining the quality and relevance of the results in the questionnaire survey. The target population was all practicing MHNs in Australia. The sample size is large, with 528 respondents to the survey. All but 31 of the 528 respondents are employed in clinical mental health nursing and work with the seriously mentally ill, as defined by the Mental Health Act NSW, 2007. Those few not employed in direct clinical services were employed in associated fields as nurse educators or in management.

The demographic characteristics of the sample are similar to the target population. The population is closely matched to the known Australian MHN workforce in terms of geographic location, age, sex and place of employment. The majority of the respondents (72.8 per cent) came from NSW, Victoria or Queensland. As with the overall nursing workforce, the mental health nursing workforce is ageing, with 68.7 per cent of the sample over the age of 45 years and a quarter over the age of 55 years. Similar to the target population, most of the sample are female (70.9 per cent) and are employed in the public health sector. The majority are working either in community health or in public hospital inpatient units. It was not possible to determine if the sample differed from the target population in terms of numbers employed in community nursing (32.5 per cent) as opposed to inpatient services, as there is no data on community nurse employment figures (Mental Health Workforce Advisory Committee, 2008, p. 2). Interestingly, newer positions, such as those created under the Medicare Professional Incentive Programs, are
starting to make an impact on the place of employment for this sample, with nearly ten per cent of the respondents employed in general practice working alongside GPs whilst 7.6 per cent nominated that they had their own private practice. Nearly four per cent of respondents are working in forensic mental health. Nearly all the respondents (88 per cent) found their work satisfying.

The sample differed from the target population in terms of qualifications, with the sample being more highly qualified than the target population. Nearly half the sample held a post-graduate degree in mental health nursing, whereas only 22.8 per cent of the target population have post-registration qualifications in mental health nursing (Mental Health Workforce Advisory Committee, 2008). The respondents were also highly experienced MHNs with over three-quarters of them working in mental health nursing for over ten years.

From this analysis, the respondents to the survey may be much more qualified and experienced than the current mental health nursing workforce overall. This skew in the sample may have resulted from the sampling process selected, where the membership data base of the College of Mental Health Nurses in Australia was the initial distribution mechanism. The membership of the College amounts to 21 per cent of the target population. It could be argued that MHNs who are motivated to join their College and pay their annual membership dues are more professionally involved and thus more likely to undertake further education than those who are not members. This has the potential to bias some of the results when one considers that over three-quarters of the mental health nursing workforce do not hold qualifications in mental health nursing. Conversely, it also means that the information received from the questionnaire survey is informed by highly experienced and qualified MHNs. This issue will be discussed further in the limitations to the study in Section 6.3.
5.3 What Consumers Think Will Improve the Quality of Their Care

The consumer viewpoint provides a lens to explore the impact on the MHN as an ‘agent’ of care. Particularly, the role of ‘epistemic structures’, as understood by Foucault, and of unconsciously held ideological concepts and the ‘ideological state apparatus’ identified by Althusser are considered, providing insight into how these concepts might be maintaining the therapeutic practices of MHNs. The following comprises a discussion of the findings from the Delphi study of consumers on what they have experienced as the most helpful knowledge, skills, attitudes, strategies and therapies used by MHNs.

5.3.1 Nurses’ Attitude

The attitude of the nurse was overwhelmingly the most important factor for the consumers in terms of helpful things MHNs do/have done for them. There were positive and negative comments about the nurses‘ attitude. Nearly all the panel members remembered nurses whose attitudes were identified as being particularly helpful. This included an attitude of calmness, caring and concern, being friendly, gentle and kind, showing interest and being trustworthy. This finding reflects a person-centred and humanistic theoretical perspective, where the relationship between the nurse and the client is central and the MHN’s attitude is more important than any specific techniques or therapy. For example, Rogerian client-centred therapy emphasises an attitude of unconditional positive regard and the development of empathic understanding as key attitudinal attributes of therapy (Corey, 2001; Sternberg, 2000).

Nursing is predominantly a caring profession and, as such, the humanistic qualities identified by consumers as being the most helpful factor could be assumed as necessary prerequisites for a career in nursing (Kellerher, 2009). The fact they were identified by consumers as stand-out therapeutic qualities in MHNs implies there may be structural, personal and/or ideological mechanisms limiting MHNs from demonstrating these attitudinal qualities.
In their study of the learning experiences of student nurses in clinical mental health settings, Fisher and Horsfall (2007) identified numerous negative environmental stressors in the clinical setting. These included stressful incidents of verbal abuse, threatened and actual violence and bizarre psychotic behaviour from patients as well as negative incidents involving treatments such as medications, ECT and group therapy. They noted that nursing students identified more incidents that identified uncaring/unprofessional behaviour towards patients by staff than incidents complimenting staff competence and commented that “it should be of serious concern to clinical staff, to consumers of mental health services, and to educators, that students so frequently identified problematic attitudes towards patients by staff” (p. 11). The findings from the final report from the Health Issues Centre (2007) confirms that consumers believe that the attitudes of staff remain problematic and they identified positive attitudes of staff to be fundamental in the recovery journey.

Lawrence (2002) claimed that mental health services were adopting a “risk-avoidance” agenda because of insufficient funding and services were focused on public safety rather than on meeting the needs of people with mental illness. Fisher (2007), in her paper examining the impact of violence on the therapeutic role of the nurse in Australia, pointed out that whilst it is still a very small cohort of clients that demonstrate problematic behaviour, increased morbidity, an under-resourced health system, a lack of experienced nursing staff and shortage of specialised units for these clients means that the conflicting roles for nurses to control behaviour and provide care and therapy become problematic. Whilst these structural issues remain, she believes managerial imperatives and the MHN’s role becomes dominated by risk management and the need to control the behaviour of this small group. Lawrence (2002) and Fisher (2007) point out that this environment negatively impacts on the ability of the nurse to be therapeutic. Fisher and Horsfall (2007) hypothesised that environmental stressors such as those described above may result in more frequent situations where MHNs adopt a controlling attitude based on a perceived need to “limit set” and manage problematic behaviour in patients. Fisher (2007) concludes that “the vast majority of patients and their families who are seeking help for their mental illness and emotional distress rightfully expect the hospital and
nursing staff to provide a therapeutic environment that is respectful of their needs, is peaceful and safe, and is conducive to providing therapeutic nursing care (p. 234).

The consumer group acknowledged that, at times, nurses needed to remain detached and firm but they believed nurses should develop rapport, provide more explanations and treat them ‘normally’ and ‘as equals’. Unhelpful attitudes were identified when nurses and other personnel used their power over them without adequate explanation and in an aggressive manner. Some consumers described what they believed to be unprovoked physical violence from nurses. However, the majority of consumers simply acknowledged that nurses (and doctors) had considerable power over them, which they realised could be used against them, and this contributed to them feeling fearful of staff. They knew they were vulnerable to the authority of nurses and found this feeling of fearfulness and lack of trust to be particularly unhelpful.

The exercise of power in psychiatry has been explored by many writers including Foucault, Althusser and Feminist writers such as Potter, Fraser and others. Foucault, in his lectures at the College de France, 1973–1974, included a lecture titled Psychiatric Power and much of his writings in his books ‘Madness and Civilization’ ‘The Birth of the Clinic‘ and ‘The Archeology of Knowledge‘ explore the relationship between power and knowledge. He coined the phrase ‘power-knowledge’ to explain this relationship. For Foucault, power-knowledge comprises a series of authoritative claims or regimes of truth about the world (Foucault, 1980). Fox (1998) explains that biomedicine is one of these power-knowledge discourses, where individuals experiencing deviations from a healthy ‘normal physiology’ are to be treated by experts in biomedicine, thus giving the medical professions, including nurses, authority over the patient as well as the power to exclude other explanations and, when deemed necessary, to force treatment on the mentally ill through invoking the powers of the NSW Mental Health Act (2007) or other mental health Acts in relevant states. Johansen, Skarsater and Danielson (2006) determined that inpatient units are dominated by power issues. They assert that staff have power over patients, but that patients have coercive power over staff. They further assert that management has power over nursing staff and that medical staff have power over
management. Within this power hierarchy, consumers and nurses are in the least powerful and most vulnerable positions. Structural oppression such as this has been acknowledged as a cause of reduced self-esteem and conversely emotional dependence upon the most powerful (Attridge, 1996; Lee & Saeed, 2001).

Barker (2000) describes how nurses have power to determine the milieu or _life space_ of the patient both in the community and in the hospital. He outlines the use of seclusion rooms and _pro re nata_ (p.r.n. or _as needed_) medication as overt examples of this power. Potter (1999) argues that nurses, in their role as brokers for both the institution and the psychiatrist, legitimise dominant ideologies by cooperating with diagnostic labelling and treatment practices that can result in oppressive outcomes for patients. The vulnerability to this power and authority felt by the consumers in this study reflects their situation within this power-knowledge hierarchy. They were fully aware that their freedom was subjugated to the power of the MHN. This often unspoken reality is exemplified in the following quote from one of the consumers:

I’ve been in the system that long now that I sort of try to stick up for myself, but I don’t want to get too overboard in case—well, I don’t know. You’ve got to—you know, it’s not an easy game, is it, really?

Althusser, in his notion of the role of the ideological state apparatus, similarly explored power relations, which he sees as instruments in the class struggle. Feminist writers such as Potter (1999, 2001), Fraser (1989, 2009) and Pringle (1998) have also examined power relations in psychiatry, especially in terms of patriarchal power. The impact of these aspects on the therapeutic role of the MHN will be explored later.

5.3.2 Medication and Side Effects

All the consumers had experienced problems with medications and side effects and raised these as the second most important factor determining the quality of their care. They described in detail the severe and distressing side effects they had experienced from neuroleptic drugs including acute dystonic reactions, akathisia, sedation, anticholinergic side effects and weight gain. In particular, they remembered with aversion having to
experiment with taking several different medications and enduring serious side effects until the right medication for them was found.

The overriding theme for many of the consumers was one of powerlessness in decision making over medications and a frustration that they believed their complaints of serious side effects were not taken seriously by nurses. They pointed out how difficult it was to maintain belief in a treatment and those treating them when the medications seemed to have little positive effect and were causing very significant side effects. This reflects one of the key problems with the legitimacy of bio-medical psychiatry. Whilst it is generally acknowledged that the discovery of the therapeutic effects of neuroleptic drugs was significant in the treatment of severe mental illness, it is not possible to predict how each patient will respond to these drugs or even whether each patient will respond (Bentall, 2003).

Typically, these major problems with side effects happened when they were newly diagnosed and resulted in an early crisis in confidence with their medical treatment and the treating team. This loss of faith in their medical treatment reflects a major criticism from both within medicine and nursing and from sociology and psychology that the biomedical model in psychiatry overestimates the role of biology and underestimates the importance of social and psychological factors in determining and treating severe mental illness (Bentall, 2003; Germov, 2009; Gray, Rofail, Allen & Newey, 2005; Lawrence, 2002). Clearly, it becomes increasingly difficult for patients to adopt what Tallcot Parsons described as the social expectations of the sick role, such as believing the health professional knows best and complying with recommended treatment, when their experience with this treatment is that it does not work and makes them feel worse (Germov, 2009).

The ‘Catch 22’ for the consumer is that if they do not comply voluntarily then they know there is a risk that doctors and nurses will obtain the authority to force them to comply under the powers of all the Australian State and Territory Mental Health Acts, even though these Acts also emphasise the rights of consumers and carers in the decision-
making aspects of care. For example, Section 21 of the NSW Mental Health Act (2007) allows a person to be involuntarily detained in hospital on the certificate of a doctor, but also says that patients and nominated carers should, where possible, be consulted. The consumers described feelings of anger, powerlessness and fatalism when given medications against their will. Lawrence (2002) points out that patient involvement in decisions around medications results in an increase in compliance with taking the medications. Similarly, Marland and Sharkey (1999), in their review of the literature, draw attention to the increasing body of knowledge demonstrating that there is an increase in compliance rates when nursing approaches the administration of medication from the viewpoint of seeking to empower the patient.

The consumers felt that there was a need for nurses to communicate more with patients about taking medication and to provide a lot of reassurance. They stated that they appreciated when they were given information about medications, side effects and dietary advice from nurses and believed that this information helped them to be compliant in taking medication. Additionally, they commented that it was helpful for nurses to encourage them to stay with the medication and to reassure them that it was effective and would help them to get better.

They expressed frustration that many nurses seemed to regard medication treatment as the solution to their problems and were not prepared to listen or talk things through with them. One complained of being overdosed with sedatives whilst in hospital to the point that she believed she had become addicted. The consumers understood why the nurses tended to hand out medications freely in some circumstances, noting that for some psychotic patients the safety of the nurse might be at risk and that it was necessary to keep them calmed down. The consumers also acknowledged that when they were very ill they frequently did not believe that they needed medication and that this made it difficult for the nurses. One person commented that when they were very ill they believed the medication was poison and that it was melting their insides but that when they were well they knew taking medication was important in maintaining their good health. They all
acknowledged the importance of receiving the right medication with the correct dosage and that this was crucial for their recovery and ongoing psychological wellbeing.

5.3.3 Supporting Me and My Family/Friends

The consumers expressed feelings of sadness and regret at having lost friends as a result of their illness. They would have liked nurses to have assisted them in maintaining contact with friends and to help them reduce their social isolation as a result of their loss of friendships. Four of the consumers mentioned the support they received from friendly nurses whilst they were ill. They remembered those nurses as assisting them on their road to recovery.

The Commonwealth Department of Health and Ageing, in its survey of the mental health and wellbeing of people living with psychotic illness, found that 84 per cent were single, separated, divorced or widowed and 45 per cent were living in hostels or supported accommodation or were homeless, 39 per cent did not have a close friend and 45 per cent wished they had good friends (Jablensky et al., 1999). Elisha and Hocking (2005), in their review of the literature, demonstrate that maintaining friendships and social relationships are important for recovery, stress reduction, reducing the frequency and severity of symptoms and enhancing feelings of wellbeing for people living with severe mental illness. Conversely, they cite literature that show social isolation increases the risk of suicide and makes it significantly harder for people with mental illness to cope with their illness. They believed the social needs of people with mental illness were not being addressed adequately by mental health workers in Australia. Elisha, Castle and Hocking (2006) found that existing psychosocial rehabilitation programs were under-utilised by people with mental illness and linked this to under-referral to these services by mental health workers. They found that active referral by a medical professional correlated strongly with attendance (p. 282). Similarly, Gilbert, Miller, Berk, Ho and Castle (2003) note the importance of clinicians prioritising the psychosocial needs of people living with mental illness and believe this should be a part of routine clinical practice.
The consumers also felt their family members were unsupported and isolated and should have received more help, information and advice on support groups from nurses. These concerns reflect research on the needs of carers of people with major mental illness (Cassidy, Hill & O’Callaghan, 2001; Chambers, Ryan & Connor, 2001; Gibbs, Dawson & Mullen, 2006; Goodwin & Happell, 2006; Lammers & Happell, 2004; Shepherd et al., 2008; Wancata et al., 2006). For example, Lammers and Happell (2004), in their study into the impact of health reforms in Victoria, Australia, found that whilst consumers felt they had more say about service delivery, carers remained frustrated at the treatment they received from service providers, noting in particular the lack of information they received, difficulties in accessing services for themselves, lack of involvement in care planning and the lack of support they received for the care they were providing.

Powerlessness over decisions made by staff about whether to inform family members about their admission to hospital was also mentioned in the study. One consumer remembered how, as a young person, her family was not told of her admission to hospital. On reflection she would have liked them to know because at the time they were the only support she had. She believed that if her family had known where she was, she would have recovered quicker and would not have needed to endure a lengthy stay in hospital. The consumers were also concerned that this alienation of family carers continued after they were discharged from hospital, describing how community nursing staff would exclude family members when visiting the family home by insisting that they leave the room whilst they were talking with the client, despite the fact that the client wanted the family member included. This concern was also voiced by the carers in both the Lammers and Happell (2004) and Goodwin and Happell (2006) studies, where carers stated they felt powerless in overcoming the barriers created by privacy and confidentiality policies in mental health services. They wanted more information and involvement in care planning. The authors noted that part of the problem for MHNs trying to provide this support for carers was the sometimes conflicting needs of consumers and carers at times of crisis. These authors believed it was important for policy makers to acknowledge that the interests of consumers and carers are not always synonymous.
Perhaps because of these ongoing disputes, some State and Territory Mental Health Acts have been changed to legally empower nominated carers. For example, in the NSW Mental Health Act, 2007, it is a statutory requirement to identify and notify carers in every involuntary admission and to include them in decision making (Department of Health NSW, 2007).

5.3.4 Empowerment

The consumers identified the need to achieve, be encouraged, have hope and maintain independence as important elements in their recovery. During even the most severe episodes of their illness the consumers believed it was very important that nurses provide nursing care in a way that empowered them. The consumers discussed how achieving even small things such as making small craft objects such as a bracelet or painting or being allowed unsupervised leave from hospital, helped them to feel better and gave them a sense of achievement. Rogers et al. (1997), in their consumer-constructed scale to measure empowerment, found a sense of achievement was coupled with increased self-esteem. Self-esteem was regarded as an important component in empowerment. Linked with self-esteem, the consumers identified the need for independence and the ability to stick up for themselves and assert their rights as important in empowering themselves, although they acknowledged that this needed to be done diplomatically and was not easy. This agrees with the finding of the study by Rogers et al. (1997), where self-esteem and self-efficacy were found to be the strongest and most consistent components of empowerment.

The consumers also identified encouragement by nurses as an important part of their recovery. They remembered those nurses who encouraged them to challenge themselves beyond the stigma and stereotype of mental illness. It was important for nurses to reassure them that they would get better and that they could take up different activities such as further study, short courses or writing poetry. The consumers noted that sometimes they needed the nurse to do more than verbally encourage, but to actually
assist them to get out and to take the first steps. Corrigan (2002, p. 223) describes stigma as "the societal embodiment of disempowerment". He notes that societal stigma can become internalised by people living with severe mental illness and is experienced as shame and lowered self-esteem with the consequence of self-doubt in the ability to live independently, work or form relationships. Similarly, Rogers et al. (1997) found one of the attributes of empowerment was increasing one's positive self-image and overcoming stigma.

Instilling hope is also viewed as an important factor by consumers in their recovery. Several consumers mentioned how important it was for nurses to instil hope for the future, to reaffirm that they would get better, to assist the client to view themselves as more than someone with a mental illness and to help them to draw on their strengths. They described experiencing feelings of hopelessness, where they felt like giving up, because they believed nothing could be done to improve their lives. The literature on empowerment identifies hopefulness as an important component in empowering people with mental illness. The ability to foster hope and empowerment by nurses and other health care workers is regarded as fundamental to consumers regaining and maintaining wellness (Barbic, Krupa & Armstrong, 2009; Cook et al., 2009; Corrigan, 2002; McCann, 2002; Schout, de Jong & Zeelen, 2009; Shepherd et al., 2008; Strack, Deal & Schulenberg, 2007). Empowerment is discussed and further theorised in Section 5.4.1.

5.3.5 Most Helpful Strategies Employed by Mental Health Nurses

Giving information through education, assisting in developing insight into their illness and its signs and symptoms and employing wellness plans were regarded as the most helpful strategies by the consumer group.

A number of consumers indicated that they found it very helpful to be given pamphlets and other information about their specific illness including being directed to relevant websites. They found this particularly helpful when they were experiencing psychotic symptoms as it helped them to understand that their hallucinations, delusions and
disordered thoughts were regarded as symptoms of an illness and it was reassuring for them to know that they were not the only person who had experienced these strange things—most importantly, that this had happened to others before them. Having this information, they believed, enabled them to name what was happening, understand why it was happening and thereby begin to become more in control and empowered.

The need for knowledge about their illnesses is well supported in the literature (Bee et al., 2006; Fernandez, Evans, Griffiths & Mostacchi, 2006; Happell, Manias & Roper, 2004; Shepherd, Boardman & Slade, 2008; Sterling et al., 2009; Taylor et al., 2009). The Health Issues Centre (2007), in its final report on education needs of mental health consumers, reinforced the importance of education in all stages of the consumer recovery journey. The report noted that during the initial stages of the recovery journey there was a fundamental need for nurses to provide information to consumers that assists them to regain their self-confidence, which was shattered by mental illness. Similarly, Lawrence (2002, p. 17) identifies the need for the patient to be given ‘clear information on the disorder, its likely course and the treatment options’ so that the patient is more able to negotiate their own treatment, has more control and their preferences can be accommodated. The consumers wanted education to include information about alternative treatment options, how to obtain help after discharge and education about their rights as service users. Research indicates such information needs to be given via multiple media such as computer programs, DVDs and web sites, and not simply through written materials such as pamphlets and information sheets. Web-based information and online counselling services have been found to be therapeutically useful not only as a source of information, but also for online counselling and for promoting behaviour change for healthy lifestyles (Australian National University, n.d.; Barry & Jenkins, 2007; Beyondblue, n.d.; Burns, Ellis, Mackenzie & Stephens-Reicher, 2009; Griffiths & Christensen, 2002; Reachout Australia, n.d.; WHO, 2005).

The consumers believed that becoming more knowledgeable about their diagnosis and treatment enabled them to develop insight and understanding that they felt was very helpful in their recovery. They acknowledged that without insight they had great
difficulty accepting their circumstances and the treatment they were receiving. They blamed the nursing staff for their predicament and as one consumer commented, ‘I actually don’t think there was a nurse who was ever terrible, I really don’t, but for what it’s worth believe me I did think that when I was unwell’. The consumers felt it was important for nursing staff to supportively assist them to remember and reflect on what had occurred when they were very ill so that they could better reconcile the traumatic events with efforts to assist their recovery. This cognitive restructuring is highlighted in the literature as important during and after highly emotional traumatic events such as acute psychosis. Drury, Birchwood and Cochrane (2000) and Jackson et al. (2008) found patients recovered quicker, were less likely to relapse and developed better insight and understanding of their illness after receiving cognitive therapy during an admission for acute psychosis. This literature will be discussed in more detail in the following section.

Wellness planning was also regarded as an important strategy for developing insight and maintaining recovery from mental illness. Wellness planning enabled the consumers to identify their triggers and identify helpful strategies to prevent relapse. One consumer noted that attending a wellness planning education course increased her knowledge of mental illness, enabled her to confide in her parents about how she was feeling and provided practical techniques to stay well and in touch with reality. This is in concordance with research findings (Cook et al., 2009; Fisher & Hapell, 2009; Sterling et al., 2010; Swarbrick, 2006). For example, the Wellness Recovery Action Plan (WRAP) program developed by Mary Ellen Copeland in 1989 is one of the most widely used wellness plans and training programs. The key principles include that the training program is peer-led, is focused on recovery and self-management and is strengths-based (Cook et al., 2009). Evaluation of this and other similar programs have demonstrated significant positive results including increases in self-reported knowledge of early warning signs of psychosis, skills for coping with prodromal symptoms, use of wellness strategies in their daily routines, ability to create crisis plans and improvements in self-advocacy skills such as confidence in seeking information from mental health services (Salyers & Tsembris, 2007; Shepherd et al., 2008a, 2008b; Sterling et al., 2010; Till, 2007). For example, an evaluation of an eight-week WRAP course with a sample of 108
participants demonstrated that after successful completion of the program participants showed significantly lower global symptom severity outcomes as well as lower scores on psychoticism, somatisation and phobic anxiety. They also showed significant improvement in recovery subscales of personal confidence, willingness to ask for help, goal orientation, reliance on others and freedom from symptom domination. There were also significant improvements in the participants’ feelings of hopefulness and self-perceived physical health (Cook et al., 2009).

5.3.6 Most Helpful Therapies

The most helpful therapies identified by the consumer group were CBT, other psychological therapies and group therapy, particularly support groups. None of the consumers had received psychological therapies from MHNs.

Those consumers who had received CBT found that analysing their thoughts, feelings and behaviours with a therapist enabled them to get back in touch with their feelings and thoughts after acute psychosis. For example, one person stated, “it's teaching you how to think and feel again. You become dead. I was like a zombie. I didn’t think or feel”. Another found it useful to learn the skills to be able to disassociate from strange thoughts and not to allow them to dominate their thinking. Others identified individual psychotherapy as helpful with day-to-day problem solving of interpersonal relationships, particularly exploring and sometimes role playing with their therapist different options for dealing with them. Psychotherapy was also helpful to enable an understanding of how past experiences may have contributed to their mental health problems. For example, one consumer said how valuable it had been to be able to discuss with her therapist the abuse she had experienced as a teenager 30 years previously. With her understanding as a mature woman and the assistance of her therapist, she found it very helpful to be able to “bring it into the open and clear it”.

Despite the fact that none of the consumers had received psychotherapy from nurses, there is a significant body of research highlighting the effectiveness of psychological
therapies, particularly CBT, in treating the symptoms of major mental illness (Buckley et al., 2007; Jeffery et al., 2000; Lewis et al., 2005; McIntosh et al., 2006; Pharoah et al., 2003). Many researchers and scholars, in their reviews of the literature, have shown how psychological therapies such as CBT can help to reduce both the negative symptoms such as social withdrawal, and the positive symptoms such as hallucinations, that are associated with schizophrenia and that these effects are long lasting (Dickerson, 2000; Grant, Mulhern, Mills, & Short, 2004; Haddock et al., 1998; Rector & Beck, 2001; Tarrier, 2005). Similarly, reviews of the literature have shown the effectiveness of CBT for the successful treatment of the symptoms of mood disorders and anxiety disorders and again these effects are shown to be long lasting (Beck, 2005; Butler et al., 2006; Grant et al., 2004). A number of studies have also shown that when nurses incorporate CBT into their practice, similar long-term improvements in health outcomes occur (Chan & Leung, 2002; Department of Health, 2004; England, 2007; Poole & Grant, 2005; Turkington et al., 2006).

5.4 Therapeutic Nursing Roles/Modalities Suitable for Inpatient and Community Mental Health Nursing Practice

The nurse viewpoint provides a different lens with which to explore the roles of the MHN as an ‘agent’ of care. The following comprises a discussion of the findings from the Delphi study of expert nurses and the questionnaire survey of practicing MHNs on what they believe are the most helpful therapeutic roles for MHNs. The findings from the Delphi nurse group and the questionnaire survey group will be discussed separately.

5.4.1 Therapeutic Nursing Roles/Modalities Suitable for Inpatient and Community Mental Health Nursing Practice: Delphi Nurse Panel

5.4.1.1 Therapeutic Relationship

The therapeutic relationship was identified by the Delphi nurse group as the most critical factor in providing quality mental health nursing care. The nurse group believed the therapeutic relationship must be empowering for consumers at all times. They identified
the key elements of an empowering therapeutic relationship as being patient-focused, collaborative, strength-based, holistic, hopeful and optimistic. They thought nurses should avoid dictating what they believed was in the best interest of the consumers. The nurse group believed if the relationship nurses had with their clients was based on empowerment principles and incorporated the elements identified above then it would serve to guide all other nursing activities. This finding accords very strongly with the findings from the consumer group, who identified nursing care provided in a way that empowered clients as an important factor in their recovery.

Ryles (1999) undertook a concept analysis of empowerment in relation to mental health nursing. He noted that there was considerable ambiguity with the concept, which he regards is caused by a tendency for the health literature on empowerment to ignore the theories of power that underlie the concept. He noted overall empowerment was regarded as a positive concept, suggesting an increasing ability to gain access to social, political and economic resources to improve one's lot in life. However, he notes that the nursing literature tends to focus on enhancing individual attributes such as emphasising self-awareness and personal growth of patients as a means to empowerment and negate the importance of the political and social aspects of empowerment. For example, he cites Foucault and Friere, where empowerment is regarded as the ability of people and communities to gain control of their lives by recognising the ideological and epistemological forces that conspire to maintain the status quo. Thus, Ryles (1999) argues that true empowerment necessarily involves political consciousness raising and collective action towards a common cause. He believes fostering individual responsibility and accountability alone may serve to further oppress rather than empower clients. Similarly, critical social theorists such as Althusser and feminist writers such as Potter and Fraser would emphasise the need to challenge prevailing hegemonies and social structures as necessary prerequisites to foster empowerment (Fraser, 2009; Lewis, 2005; Mautner, 2000; Potter, 2002). In support of this view, McAllister and Moyle (2008, p. 24) argue that patient-centred and recovery models of care in mental health nursing are ‘reactive rather than strategic’ and do little to empower consumers.
Given the fact that most of the health and nursing literature focuses on empowering the individual through encouraging individual characteristics (Ryles, 1999), it is not surprising that the nurses in this study tended to view empowerment in individualistic rather than communal or political terms. However, as Falk-Rafael (2005, p. 212) points out:

Nurses who practice at the intersection of public policy and personal lives, are therefore, ideally situated and morally obligated to include political advocacy and efforts to influence health policy in their practice. The health of the public and the future of the profession may depend on it.

5.4.1.2 Communication Skills

Communication skills were identified by the nurse group as important both as a therapeutic tool but also as a means of empowering the consumer. Therapeutic communication skills identified included the ability to listen reflectively, develop rapport, clarify, show empathy and explore alternatives. There was disagreement amongst the nurse group about whether counselling skills were an appropriate therapeutic skill for MHNs. Some believed that counselling was not appropriate for MHNs because consumers who were experiencing psychosis would not benefit from counselling and they did not feel nurses were qualified to deliver counselling. Others believed nurses should have skills in basic counselling. It appeared there were differences in opinion on what constitutes communication skills and counselling skills and basic counselling skills.

Elder et al. (2009), in their mental health nursing textbook, identify communication skills as the ability to actively and reflectively listen, ask open-ended questions, paraphrase, summarise and respond to both verbal and non-verbal messages. They do not discuss counselling. Conversely, Berman et al. (2010) in Kozier and Erb’s Fundamentals of Nursing textbook describe specific counselling skills necessary for nurses, such as crisis, grief, sexual dysfunction, health promotion and spiritual counselling. Harris et al. (2010) describe therapeutic communication as a process in which the health professional consciously influences a client or helps the client to better understanding through verbal or non-verbal communication (p. 1706) and counselling as a therapeutic technique that
helps the patients recognise and manage stress and that facilitates interpersonal relationships (p. 444). They appear to imply that communication is an umbrella term of which counselling is a specific communication technique—but they have not clearly differentiated the two terms.

Horsfall, Stuhmiller and Champ (2000) identify active listening, clarifying, paraphrasing, checking perceptions, reflecting conversation content, reflecting feelings, using silence, pinpointing, confronting, providing interpersonal feedback, linking events and feelings and summarising, as therapeutic communication strategies that are fundamental communication strategies for MHNs. They employ the terms ‘communication strategies’ and ‘beginning counselling skills’ interchangeably when they point out that most mental health nursing texts outline these beginning counselling skills (p. 26).

Stein-Parbury (1997, p. 201) believes counselling is engaged in because a person actively seeks…to deal with an aspect of living that has become troublesome. She points out that counselling tends to be conducted by professionals who have received formal training in counselling techniques. This implies that counselling requires a relationship where there is a request made by an individual for assistance from a health professional. Stein-Parbury (1997) points out, however, that the nursing literature uses both these terms interchangeably when referring to the therapeutic patient–nurse relationship in the nursing context. Sutherland (1995, p. 106) in the MacMillan Dictionary of Psychology defines counselling as the discussion of a person’s problems and the provision of advice by a comparative stranger, whether professionally trained or not. Egan (2002, p. 7) identifies two principal counselling goals; help clients manage their problems in living more effectively and develop unused resources and missed opportunities more fully and help clients become better at helping themselves in their everyday lives. His book discusses in detail therapeutic communication skills and a three-stage skilled-helper model. He prefers to use the terms skilled helper and helping rather than counsellor and counselling. Corey (2001), in his counselling textbook, does not describe specific communication skills as identified by Egan (2002), Horsfall et al. (2000) and Elders et al. (2009). Instead, he outlines in detail a number of therapeutic perspectives such as
psychoanalytic therapy, CBT, and family systems' therapy and then describes various
counselling models that evolve from these therapies. He points out the personality of the
counsellor is the critical factor for effectiveness in any counselling process. His book
concludes with a chapter on how it can be useful for counsellors to integrate different
therapeutic perspectives into their practice.

From this analysis it is clear that the word 'counselling' conjures up different meanings
within both the nursing and psychological literature. These definitions can range from
simple advice giving, to employing therapeutic communication skills within a helping
relationship, to more intensive strategies aimed at assisting an individual to deal with
interpersonal relationships, to become more personally fulfilled and to problem solve
inter- and intra-psychic dilemmas. They have in common, however, the idea that
counselling is about helping a client to cope with the day-to-day interpersonal issues in
their lives that they are having difficulty with. In addition, the nursing literature lacks
agreement on whether 'counselling skills' are required by nurses without clearly
differentiating how counselling skills are different to therapeutic communication skills.

MHNs will need to clarify, therefore, exactly what they mean when they say that MHNs
are not qualified to provide counselling to their clients and that people with acute mental
illness are too ill to be helped by receiving counselling. Certainly the consumer group in
the Delphi study made it clear that they found it very helpful when nurses sat down and
talked with them about their feelings and what was going on in their lives. They
remembered those nurses who showed empathy and took the time to really listen to them
even when they were acutely psychotic. They pointed out that talking helped to dissipate
their delusions and hallucinations and reduce their anxiety. As one of the consumer group
succinctly put it:

The best form that they did was listen to all my word salad. Even though it was
garbage that was coming out of my mouth.
5.4.1.3 Being There for the Client

‗Being there for the client‘ was regarded as important by the nurse group. This key point included simply spending time with and being able to sit with someone who was acutely ill. It also meant recognising the importance of maintaining regular contact with clients, monitoring their mental health and being available when needed. The nurse group pointed out that they believed it was therapeutic for clients to know that you were there if they needed you whether via a phone call or home visit. Reliability was also a feature of being there for the client. It was considered important for nurses to follow through with any commitments undertaken with clients. Glass (2003, p. 53) identifies that ‗being there‘ requires the nurse to embed themselves ‗deeply within interpersonal interactions‘ with the patient.

Whilst these concepts are broad and lack specificity, they nevertheless portray the importance of maintaining contact with people with serious mental illness so that they continue to engage with services. Schout et al. (2009), in their qualitative study observing 500 client contacts, identified care providers who establish trust and maintain contact with seriously mentally ill clients. They identify compassion, loyalty, involvement and tenacity as some of the personal characteristics required in MHNs. In their review of the literature they identified a lack of responsiveness of nursing staff and inflexible rules (such as demanding sobriety from clients) meant that many seriously ill consumers had difficulty gaining access to support when it was needed. In turn, this added to their sense of social exclusion and ultimately to avoidance behaviour. When MHNs and services are not ‗there‘ for the client on their own terms, significant numbers withdraw from seeking help and avoid mainstream mental health care. Schout et al. (2009, p. 325) call this ‗care avoidance‘. They argue that rather than viewing care avoidance as caused by the abilities of the clients, the problem is sited with the competencies of the professionals and the inflexibility of the services.

Conversely, there is a developing body of literature supporting the rights of consumers to refuse care. The user/survivor/ex-patient movement exemplifies this viewpoint. Many
consumers do not want help and believe their human rights are denied when their decision not to engage with mainstream mental health services is not respected (Barker & Stevenson, 2000; Graham, 2006; Leung, 2002; Nelson, Ochocka, Janzen & Rainor, 2006; Strack et al., 2007; Watchirs, 2005). Respecting the rights of people to refuse nursing care whilst also fulfilling obligations to provide such care and adhere to institutional policies can put the MHN in a difficult ethical position. Graham (2006) explores this ethical dilemma from the perspective of an examination of competing needs. She points out that despite the rhetoric regarding client-centred services, services tend to assess needs in normative and utilitarian terms such as risk avoidance rather than being based on the needs of the individual client. In these circumstances she questions whose needs are being met, societys’ needs for social control and risk aversion or the expressed wishes and choices of clients. As Fisher (2007) and Graham (2006) argue, it is the frontline workers such as MHNs or the police who often must balance these conflicting demands and ethical dilemmas as best they can. Fisher (2007) points out that this becomes especially difficult in an under-resourced, understaffed and overburdened mental health service.

The consumers in this study agreed with the importance of nurses being available both at times of crisis and on a regular basis. They were critical when nursing staff were not available or did not follow up. They believed that knowing help was available was in itself therapeutic. They stated that it was important for them to know that there was someone they could call that they knew would answer the phone at any time during the day or night. The contact with the nurse was seen as a way of bridging the gap between being at the hospital and being at home alone. The consistency and reliability of this 24-hour contact was much appreciated, particularly at times of crisis or confusion, although one consumer noted that they did not like being ‘badgered’ by nurses and another was critical of the lack of availability of nursing staff when they were in hospital. Thus, the views of the consumers were supported by the nurse panel.
5.4.1.4 Medical and Mental Status Assessment Skills

The importance of bio-medical and mental status assessment skills were identified by the nurse group as a major part of the therapeutic role of the MHN. Ongoing mental status and medical assessment skills were viewed as critically important both in determining diagnosis and appropriate nursing care. Due to the tendency for MHNs to focus on psychopathologies and the increasing frequency of clients with complex health issues, medical assessment skills were regarded as equally important to mental status assessment skills.

Clients with a dual diagnosis, those who were ageing and those experiencing medication side effects were identified by the nurse group as being in particular need of medical assessment so that they could be appropriately referred for timely medical treatment. The nurse group recognised that clients with serious mental illness often had unhealthy lifestyles, difficulty maintaining their physical health, rarely accessed common preventive measures such as regular dental care, pap smears, mammograms, flu inoculations and had problems following medical regimes for treatment of chronic illnesses such as cardiovascular disease and diabetes.

It has been known for over 60 years that serious mental illness is frequently associated with serious physical illness. Barr et al. (2001) pointed out that these clients were more likely to die from untreated medical conditions than from mental illness. Similarly, Brown, Inskip and Barraclough (2000) found that standard mortality rates for diseases of the circulatory, digestive, endocrine and respiratory systems were significantly higher than those in the general population. They concluded that many of these deaths are potentially preventable through health promotion, better medical treatment and better compliance with medical treatment. Saha, Chant and McGrath (2007, p. 1130), in their review of the literature on mortality in schizophrenia, found the differential mortality and morbidity gap between the general population and people with schizophrenia had worsened ‘in recent decades’ and they expressed concern that this situation may continue to worsen with the increased usage of second-generation anti-psychotics, as they are
more likely to cause weight gain and metabolic syndrome. Brown, Kim, Mitchell and Inskip (2010) mirror this concern, finding that people with schizophrenia have a two-three times higher mortality risk than the general population and that most of these extra deaths are from natural causes. Their 25-year mortality study also found an increase in cardiovascular mortality rates relative to the general population.

Phelan, Stradins and Morrison (2001, p. 44) observed that mental health practitioners including psychiatrists are not good at monitoring the physical health of their clients and are ‘poor’ at conducting physical assessments. These authors and others point out that this is despite the fact that most patients with severe mental illness are reluctant to access mainstream services but are in regular contact with mental health services (Brown et al., 2000; Brown et al., 2010; Phelan et al., 2001; Saha et al., 2007). McDevitt (2004) points out that MHNs are especially well placed to identify, refer and monitor the treatment of medical conditions for people living with serious mental illness because they provide continuing care for this group of people. She argues that if MHNs routinely utilised evidence-based assessment skills for the common medical comorbidities, such as hypertension and diabetes, they could contribute to significant reductions in the morbidity and mortality statistics of people living with serious mental illness. In Australia, the mental health liaison nurse partially fulfils this function, although this role is mostly focused on providing mental health assessment and care for general hospital patients suspected of having comorbid mental health problems rather than providing medical care for people with serious mental illness (Happell & Platania-Phung, 2005; Sharrock, Grigg, Happell, Keeble-Devlin & Jennings, 2006). Similarly, models of shared care between community MHNs and GPs also tend to focus primarily on the nurse providing supportive mental health care within the general practice context (McCann & Baker, 2003). However, this model, which emphasises collaboration between community mental health and general practice, has the potential to improve the management of medical problems in people with serious mental illness living in the community. As Happell and Platania-Phung (2005) point out, the provision of holistic nursing care is a central philosophy to the nursing profession and meeting the medical health needs of people with serious mental illness is therefore crucial to providing quality mental health nursing care.
The following lengthy quote from one of the participants illustrates the contemporary difficulties in treating medical illness for people with serious mental health illness, despite the best intentions of at least one MHN. This quote also illustrates the impact on group dynamics and staff morale when resources are low and nurses perceive they cannot provide quality nursing care:

I had this 62 year old woman… she has had a long history of psychosis… She is delusional about the itching she feels in her skin which is due to diabetes, but she believes that there are bugs in her blood…she had an admission a year ago and was discharged with a plan to be on an antipsychotic Depo, nobody paid attention to her. When I rang the GP, she… wasn’t doing anything about it. She did know her… blood sugar level was eighteen or nineteen chronically. So a terribly ill woman and the community nurses were unable to engage with her because of her mental illness. She wouldn’t be there, so they weren’t going to try and give her any insulin… Nobody was looking after her.

So I commenced to pay a bit of attention... I tried to get something happening with the GP and with the clinic nurse who she comes in to see twice a week… it was found that the doctor would give her a Depo that was compatible. The one the hospital prescribed wasn’t compatible with her diabetes… The clinic nurses started to give her just two days a week when it should be seven… and has possibly engaged her son or alienated husband to maybe give her injections more regularly than that. So maybe she can regain some health and not go blind.

But some staff… were on my back not to waste my time to try and look after this woman because it took more time than normally is allowed... and that some of the other work was going to fall on them... So you had that kind of intensely—when resources are really short, people start getting pretty stroppy with one another. It’s destructive, it’s destructive with care.

The nurse group also acknowledged the need for excellent observation skills, speed and accuracy when doing ongoing mental status assessments. They noted the particular difficulty in completing accurate ongoing assessments on inpatient clients who may be at risk of self-harm or absconding. There was acknowledgement that nursing tasks can be too taken up with mechanical assessment focused on filling in forms and assessing risk such as in 15- or 30-minute observations. It was recognised that frequent ongoing assessment of this type could be viewed as a custodial tool that can be tiresome for both clients and nurses and risks alienating and disempowering clients—an observation that was reflected in the literature (Elder et al., 2009; Horsfall et al., 2000; O’Brien & Cole, 2005). The nurse Delphi group believed it was important, therefore, that mental status
assessment and observation must be recognised as a therapeutic interaction in and of itself and be conducted collaboratively by engaging with the client as much as possible.

5.4.1.5 Helpful Therapies for Mental Health Nursing Practice

The nurse Delphi group identified a number of therapies and models that they believed were especially useful for MHNs. At the same time they acknowledged that they found it difficult to prioritise these because they believed that MHNs tended to be eclectic in their use of therapies, and secondly, it depended on the individual client situation and the skills and training of the nurse. However, there was general agreement that using a recovery oriented approach and applying counselling skills were the most helpful therapeutic activities for MHNs.

The unanimous prioritising of counselling as an important therapeutic tool is an interesting finding considering the disagreement amongst the nurse group as to whether providing counselling was part of the MHN’s role. There were a number of different counselling therapies identified by the nurse group including solution-focused therapy, CBT, group therapy and dialectical behaviour therapy. In the context of identifying helpful therapies, the nurse group believed counselling was important. Definitional problems and the role of the MHN regarding counselling and communication skills were discussed previously and will not be repeated here.

The need for a recovery focused approach is shared by both the nurse and consumer Delphi group. As can be seen in the discussion in Section 4.4.2, the consumer group identified supporting family and friends, empowerment, instilling hope, encouragement and the need for knowledge about their illness as the most helpful therapeutic activities that MHNs can implement and they identified wellness planning as an important strategy in their recovery. The MHN’s role within a recovery oriented approach is well documented in the literature (Australian College of Mental Health Nurses, 2010; Elder et al., 2009; Mental Health Coordinating Council, 2008; Office of Mental Health: Department of Health, Government of Western Australia, 2004; Queensland Health,
Recovery focused services are consumer oriented and focused on facilitating the empowerment of the client and the community by sharing knowledge and information and by focusing on consumer strengths rather than deficits. A number of important elements of a recovery oriented approach to nursing care have been identified. They include, assisting the client to develop positive coping strategies to deal with the difficulties associated with mental illness; nurturing self-determination, self-management and empowerment; helping a client to find meaning, purpose and direction; nurturing supportive relationships with family, friends and community so that the person feels socially included rather than isolated; and recognising the importance of nurturing hope. These authors identify the necessity of mental health nursing practice to promote rather than hinder these elements. They believe helping people to build satisfying and fulfilling lives is the most important aspect of a recovery approach to mental health nursing.

5.4.2 Therapeutic Nursing Roles/Modalities Suitable for Inpatient and Community Mental Health Nursing Practice: Questionnaire Survey of Practicing Mental Health Nurses

There was uniform agreement amongst the questionnaire MHN group that all the strategies outlined in question three were nearly always employed by MHNs when caring for people with serious mental illness. Correspondingly, nearly all the non-pharmacological approaches outlined in question five were utilised in current mental health nursing practice. These strategies and non-pharmacological approaches included all the items identified by the consumer group as being most helpful. For example, providing reassurance, responding promptly to medication issues including problems with side effects, demonstrating an attitude of calm, caring, friendliness and respectfulness, encouraging self-management, supporting families and friends and focusing on developing insight were identified by the consumer group as a high priority and nearly all the respondents strongly agreed that these were strategies that were nearly always employed by MHNs. Similarly, several of the most popular non-pharmacological
approaches employed by practicing MHNs such as practical problem-solving techniques, challenging negative thought processes in their clients, collaborative care planning, providing written information about relevant mental illnesses to their clients, teaching relaxation techniques and assisting their clients develop positive affirmations were identified by both the nurse and consumer Delphi group as high priorities in the therapeutic role of the MHN. Only a quarter of the nurses said that at times they chose not to intervene but observe only. Those who stated they selected a non-interventionist observe-only approach are significantly less likely to find their mental health nursing work satisfying.

Whilst nearly all nurses agree they provided relevant written information to their clients, fewer (46.7 per cent) referred their clients to Internet-based resources such as self-help therapies and health information. There is considerable research supporting the therapeutic value of Internet-based information, therapies and online counselling. In particular, Internet-based CBT therapies have been found effective for the treatment of anxiety and depression, both of which can be a part of the aetiology of people with serious mental illness (Calear & Christensen, 2010; Hickie et al., 2010; Spek et al., 2007). Research shows the effectiveness of Internet-based therapies for the promotion of behaviour change for healthy lifestyles such as promoting exercise, smoking cessation and healthy eating (Wantland, Portillo, Holzemer, Slaughter & McGhee, 2004) and as a general information resource for people living with chronic illness (Ybarra & Eaton, 2005).

Items identified by the nurse Delphi group as highly important were nearly always employed by MHNs. For example, mental status and physical assessments, maintaining regular contact by being there for the client and encouraging self-management were all items the practicing nurses agreed were nearly always employed by MHNs. The item receiving the strongest level of agreement, ‘maintaining safety through aggression minimisation and risk assessment‘, was not identified as one of the highest priorities by either the consumer or nurse Delphi group. The emphasis on maintaining safety may reflect the current emphasis on risk-management policies and practices in mental health
service delivery (Fisher, 2007). Both the nurse Delphi group and the literature on this topic observe overemphasising risk assessment in itself risks alienating and disempowering clients and as a consequence should be performed collaboratively and therapeutically rather than in a custodial manner (Elder et al., 2009; Horsfall et al., 2000; O’Brien & Cole, 2005).

Place of employment had a significant impact on some of the therapeutic practices of MHNs. Those nurses who were community based in private practice or employed by GPs agreed more strongly with the strategies emphasising support for families and friends, encouraging healthy lifestyles and developing insight. Similarly, those employed as community nurses agreed more strongly that maintaining regular contact through home visits or being with clients and encouraging self-management were nearly always employed by MHNs. This finding may reflect the difference in employment focus between nurses working in the community and those working in inpatient settings. However, both the literature and the consumer Delphi group highlight it is important that family and friends are supported throughout the illness trajectory (Cassidy et al., 2001; Chambers et al., 2001; Gibbs et al., 2006; Goodwin & Happell, 2006; Lammers & Happell, 2004; Shepherd et al., 2008; Wancata et al., 2006). Similarly, as noted in the discussion on the general health status of people with serious mental illness, prevention of serious physical illness such as cardiovascular disease and diabetes will help reduce mortality rates, which for people with schizophrenia, are two–three times higher than for the general population (Brown et al., 2000; Brown et al., 2010; Saha et al., 2007). Nurses in inpatient settings are well placed to inform their clients about healthy lifestyles, healthy diet and other health-promoting behaviour (McDevitt, 2004).

Recovery and psychological-focused non-pharmacological approaches such as wellness planning, activity scheduling and keeping mood diaries were employed by 60–65 per cent of the practicing nurses in this study. This is despite the fact that 93.1 per cent of MHNs said they would like to use psychological therapies, 74 per cent had received formal training in applying psychological therapies into their practice and 94 per cent had read articles, journals or books on psychological therapies within the previous twelve months.
The reasons for this lower uptake of psychological non-pharmacological approaches, given the stated enthusiasm for their use, becomes clear in the discussion in Section 5.5, when factors influencing the practice of psychological therapies by MHNs are examined.

The most popular psychological therapy used by MHNs was CBT, with 68.6 per cent of nurses using CBT as part of their management of people with serious mental illness. Even though only 69 per cent of nurses were actively employing CBT, over 80 per cent of the nurses in this survey agree CBT is a valuable treatment option for people with serious mental illness and that CBT should be recommended in conjunction with anti-psychotic and anti-depressant medication. Further, 79.3 per cent believed that more resources should be available so that CBT can be provided to their patients. Place of employment significantly affected these views, with those nurses working in the public sector more strongly agreeing that more resources were needed, and MHNs employed in GP practices more strongly disagreeing that CBT was not a good use of time for MHNs. Less than ten per cent of the nurses in the questionnaire survey believed CBT was not suitable for people with serious mental illness or was not a good use of time for MHNs.

Another popular therapy used by 55 per cent of MHNs is solution-focused therapy. Solution-focused therapy is aimed at empowering clients through adopting a client-centred solution-focused and collaborative approach (MacDonald, 2007). The client identifies the goals for therapy and the therapist assists the client to achieve these goals through collaboratively identifying achievable small steps, encouraging and reinforcing change, adopting a respectful and cooperative attitude and most importantly by working within the client’s frame of reference through avoiding professional interpretation of events and use of jargon (MacDonald, 2007). Hagen and Mitchell (2001, p. 89) point out the assumptions of solution-focused therapy are congruent with mental health nursing values; including collaboration, hope, supporting client strengths and focusing on health rather than pathology. These assumptions are similar to those identified by both the consumer and nurse Delphi groups and the nursing literature as being of high therapeutic value.
A number of studies have supported the efficacy of using this therapy in both acute and community mental health nursing settings (Ferraz & Wellman, 2008; Gralton, Udu & Ranasinghe, 2006; Hagen & Mitchell, 2001; MacDonald, 2007; Stevenson, Jackson & Barker, 2003; McAllister, 2003, 2007, 2010). For example, McAllister (2010) shows how a solution-focused model of mental health nursing can be successfully applied by MHNs and how it fits well with the philosophy of recovery based mental health care and with public health principles in the Australian context. In their review of the literature on the integration of solution-focused brief therapy principles in nursing, Ferraz and Wellman (2008) noted there was an urgent need for more nursing research, however, in the nine papers they reviewed they found the application of this therapy positively impacts on nurses’ ability to work with and communicate with patients. MacDonald (2007, p. 113) reviewed literature on the effectiveness of solution-focused therapy in all therapeutic contexts and cites numerous studies demonstrating its benefits for clients including six randomised controlled trials, fourteen comparison studies showing results as good or better than ‘treatment as usual’, and over 2200 case studies.

The underlying assumptions of solution-focused therapy such as being client-centred solution-focused and collaborative, reflect some of the key elements necessary for a recovery oriented approach to mental health nursing care. The need for recovery focused nursing care was identified by the nurse Delphi group as an important model for MHNs to follow. Similarly, the consumer group identified many of the values embedded in a recovery oriented approach as important in their recovery. From the responses to the questionnaire survey, practicing MHNs agree that a recovery model is an important therapeutic strategy, with 52.1 per cent stating that they employ a recovery model in their management of people with serious mental illness. Less frequently used therapies include group therapy (26.5 per cent), dialectical behaviour therapy (25.7 per cent) and psychoanalytic therapy, with only 13.4 per cent of nurses using psychoanalytic therapy in their management of people with serious mental illness.

From this analysis, the majority of practicing MHNs are applying the therapeutic practices recommended by both the consumer and nurse Delphi groups. The Delphi nurse
group identified the nurse’s attitude, knowledge of and responding promptly to medication issues including problems with side effects, supporting me, my family and friends and empowerment as high therapeutic priority skills, knowledge and attitudes. They identified that being given information about their illness assisted clients in developing insight, which they felt was important in their recovery. They also believed CBT, wellness planning and a recovery focused approach were high therapeutic priority strategies and therapies for MHNs.

The Delphi nurse group prioritised developing and maintaining a therapeutic relationship, excellent communication skills, being there for the client and medical and mental status assessment skills as the most helpful knowledge, skills and attitudes for MHNs. They thought there were a number of appropriate therapies such as solution-focused therapy and CBT that nurses could adopt, however, they believed the highest priority was for nurses to be able to apply counselling skills and a recovery focused approach within their choice of therapy as the most important therapeutic focus for MHNs. It was noted by the nurse Delphi group that MHNs tended to be pragmatic and eclectic in their use of therapies depending on the client, the situation and their skills. This was supported in the findings from the survey, with 69.4 per cent of nurses acknowledging that they employ a mixture of these psychological therapies and models depending upon the circumstances at the time.

Points of difference between the findings from the Delphi studies and the current therapeutic practices of MHNs included the following. Firstly, the nurses in the questionnaire survey tend to give information in written form such as pamphlets rather than referring their clients to relevant web based information and online counselling services which have been found to be therapeutically useful (Australian National University, n.d.; Barry & Jenkins, 2007; Beyondblue, n.d.; Burns et al., 2009; Griffiths & Christensen, 2002; WHO, 2005; Reachout Australia, n.d.). Secondly, the nurses in the questionnaire survey emphasise the strategy of maintaining safety through aggression minimisation and risk management, whereas the nurse Delphi group were concerned that there was currently an overemphasis on this and other custodial aspects to the detriment
of the therapeutic relationship. Thirdly, the findings from the questionnaire survey show that when compared with their community based colleagues, MHNs working in inpatient areas were significantly less likely to employ the strategies of ‘supporting family and friends of the patient’ or ‘encouraging healthy lifestyles’. It was noted in the discussion above that the literature shows that both these therapeutic strategies need to be high priorities for nurses in both inpatient and community settings.

5.5 Factors Influencing Mental Health Nursing Practice in Relation to the Use of Psychological Therapeutic Modalities

The complexity of the influence of both agency and structural factors on the therapeutic role of the MHN is perhaps most clearly outlined in this section. The Delphi nurse group and the questionnaire survey of practicing MHNs identified a number of limiting factors that they believed were largely outside the control of the nurse and yet had profound impacts on the ability of the MHN to offer effective nursing care. Some of these factors were agency oriented, for example, nurse morale, and others were clearly structural in nature. However, as Scott (2007) points out, it is not just the individual or the social structures which are of interest to critical realist research, but the interaction between structures and agents. For example, as Pawson (2004) identified, cognitive, emotional and material factors influence individual actions and these can, in turn, become self-perpetuating in the form of ‘generative mechanisms’ or as Foucault would describe them as ‘epistemic structures’ or Althusser as ‘ideological state apparatuses’. Similarly, as can be seen from the following analysis, the power of economic ideologies is also a factor influencing the therapeutic practice of MHNs. Fraser (2009) demonstrates how economic ideologies control bureaucratic institutions such as health and their policies and practices. As a feminist, she is particularly concerned as to how economic ideologies impact on the quality of gender relationships within these institutions. These factors will be discussed in turn.
5.5.1 Morale and Structural Issues

Two of the three highest rating factors identified by the Delphi nurse group that impacted on the therapeutic role of the MHN, ‘morale’ and structural issues such as lack of resources and too much documentation, also received the strongest level of agreement amongst the practicing MHN group. Both groups believed that these factors limited the therapeutic ability of MHNs, especially their capacity to implement psychological therapies.

The nurse Delphi group identified lack of job satisfaction, hostility from peers including allied health workers, poor nursing leadership, low nurse self-esteem and lack of confidence as contributing to morale problems. Staff morale is described in the literature as the capacity of people to maintain belief in themselves, their colleagues and the organisation in which they work. Low morale in nursing has been shown to affect patient care and outcomes as well as staff absenteeism and turnover (Day et al., 2006; Day, Minichiello & Madison, 2007; Happell, 2008). Day et al. (2006, p. 517), in their literature review on nursing morale, define positive morale as ‘an attitude of confidence in the mind of the individual where they identify with a group, accept group goals and work towards achieving them collectively’. They point out that the literature identifies intrinsic and extrinsic variables affecting nursing staff morale.

Intrinsic variables affecting morale are identified as personal factors including a sense of being valued as a professional, having positive workplace relationships, a perceived ability to provide quality care and opportunities for promotion and skill development (Considine & Buchanan, 1999; Day et al., 2006). The Delphi nurse group identified lateral violence such as hostility from both nursing peers and allied health workers and low confidence and low self-esteem in nurses as intrinsic factors currently negatively affecting MHN morale. Day et al. (2007) cite literature that specifically links the quality of peer and group relationships and the nurse’s feelings of professional self-worth and self-esteem. They point out that these feelings combined with a perceived view that the quality of nursing care is falling will negatively affect morale.
According to Day et al. (2006), extrinsic factors affecting nursing morale are those controlled by the organisation and include staffing levels, workloads, participatory leadership and management style, opportunities for professional development and training and levels of violence and bullying. Many of these extrinsic factors were identified as structural issues limiting the therapeutic ability and ability of nurses to employ psychological therapies in this study. For example, the limiting structural issues identified by both the Delphi and questionnaire survey nurses were insufficient funding and consequent lack of resources, high patient–staff ratios, short hospital patient stays combined with high patient acuity, health policy changes such as centralisation of community services and mainstreaming of services and an overemphasis on documentation and paperwork. Place of employment had a significant impact on some of these factors, with public inpatient nurses more likely to strongly agree that funding shortages and high patient-to-staff ratios were limiting their therapeutic practice.

The nurse Delphi group provides an example of how funding shortages impact on staffing levels which, in turn, means nurses cannot attend workplace training because there is nobody to replace them. They also noted how low staffing levels combined with high acuity levels of seriously mentally ill people and a tendency for short hospital stays means nursing practice is dominated by the need for risk management. They believed this adds additional burdens to workload problems in both community and inpatient settings. In addition, they point out major policy changes such as mainstreaming and centralisation of services, combined with multiple changes and increases in documentation requirements, were further hindering both morale and the therapeutic ability of the nurse.

High levels of documentation was the item that received the highest level of agreement that this was a limiting factor on therapeutic practice in the questionnaire survey group with an agreement rating mean of 1.87 and 78 per cent of MHNs agreeing this was a problem. Community nurses were significantly more affected by this factor than were the other nurses. Whilst complaints about high levels of paperwork may appear to be superficial or could be dismissed as _whinging_, the literature confirms that the impact of
excessive paperwork on the therapeutic ability of MHNs has been a serious concern for MHNs for many years and is viewed as an example of an oppressive management style that is thwarting positive patient care (Barker & Buchanan-Barker, 2008; BBC News, 2007; Robinson, Murrells & Smith, 2005).

The most significant barriers to implementing psychological therapies into mental health nursing practice identified by the MHNs in the questionnaire survey group were also institutional or structural in nature. They included limiting bureaucratic practices in the organisation of client care, lack of time within workload, too few staff, insufficient resources and excessive staff turnover. MHNs employed in the public sector were significantly more likely to agree more strongly that these structural barriers were preventing them from implementing psychological therapies. Conversely, MHNs who had received formal training in psychological therapies were significantly less likely to view these as barriers. High staff turnover in mental health services has been identified in the literature as impacting negatively on service delivery, recruitment of nursing staff, increased stress and poor staff morale (Aaron & Sawitsy, 2006; Happell, 2008; Johnson & Delaney, 2007; BBC News, 2007).

To a lesser degree, items indicating a lack of collegial support were also identified as barriers to implementing psychological therapies. These items included colleagues not interested in applying psychological therapies (49 per cent of respondents agreed) and that other staff will not support me (31 per cent agreed). Again, place of employment was an important intervening factor, with MHNs working in the public sector significantly more likely to strongly agree that these factors were barriers and nurses working in general practice being significantly less likely to agree that other staff will not support them in applying psychological therapies. Corrigan et al. (2001), in their factor analysis of the Barriers to Change scale from which these questions were derived, found that structural barriers were significantly associated with staff burnout and that individuals who were dissatisfied with the levels of support they were receiving from their colleagues reported greater institutional barriers to implementing change. They point out that education on therapeutic strategies such as psychological therapies will not necessarily
change individual practices nor increase their implementation unless organisational barriers including collegial relationships are also addressed.

As noted previously, when nurses perceive the quality of their nursing care is affected by matters outside their control, morale falls. In addition, as Fisher (2007) points out, these structural factors will impact on the therapeutic environment, changing it towards one that becomes dominated by risk management, custodial practices and higher levels of chemical sedation. The ongoing criticism of mental health services and mental health nursing care that these practices engender, and which are outlined in numerous recent government and non-government reports cited by Fisher (2007), in turn negatively affects nursing staff morale. MHNs work in emotionally demanding environments with many conflicting demands on the nurse. In situations such as this, the literature shows that MHNs adopt emotional strategies to distance themselves from these conflicting demands and from their patients (Bray, 2001; Freshwater & Stickley, 2004; Warne & McAndrew, 2008). Crowe (2000) argues that the nurse needs to feel cared for within the clinical environment in order to be therapeutic. If the nurse feels devalued this will be reflected in the nurse–patient relationship.

The Delphi group believed nursing leaders had become detached from the reality of the workplace and were also negatively affecting nurse morale by adopting a hierarchical top-down management style. The literature confirms this. McCabe & Timmins (2006) found that hierarchical nursing management styles can devalue clinical expertise, inhibit nurse confidence and prevent nurses from being assertive about what they believe is important to patient care. An Australian study by O’Brien-Pallis, Duffield & Hayes (2006) examined reasons for nurse resignations and noted a discrepancy between reasons cited by nurses and beliefs of nurse executives. Nurses cited factors in the practice environment as reason for their departure whereas the executives believed changes in societal values and the image of nurses were factors in the difficulty in retaining nursing staff. Buchan (2002) studied hospitals in the UK that had reputations for high staff morale and found they had a practice environment that emphasised participatory management and leadership styles, decentralised organisational structures, professional
autonomy and accountability and offered training and career advancement opportunities. Similarly, Webster, Clair and Collier (2005) found that nurses within acute facilities wanted an environment where collegial relationships were constructive and where learning was valued. Robinson et al. (2005) found positive collegial relationships between staff were a major reason why nurses remained in their workplace. Cleary (2004), in her Australian study, found that MHNs in acute care settings struggled with rapidly changing service philosophies and conflicting and increasing workplace demands that they believed compromised patient care. Similarly, Dickenson and Wright (2008), in their study on burnout in forensic units, found increasing and changing workplace demands combined with inadequate management models led to low staff morale and ultimately staff burnout.

There is a risk that the morale issues are evidence that there is a perception amongst nurses that they are unable to provide the kind of quality nursing care they would like to. This can become self-perpetuating, as low morale can in itself affect the quality of nursing care (Day et al., 2006, 2007; Happell, 2008). Althusser would argue that these perceptions can become internalised and unconsciously held and as a result, rather than nurses trying to create change, they maintain the status quo. As such, nurses as agents become a part of the generative mechanisms maintaining dysfunctional social structures and social roles (Pawson, 2004; Scott, 2007; Carter & New, 2006). This interplay between these agency and structural factors may be consciously and unconsciously influencing the individual actions of MHNs and thus may be contributing to the complexity and difficulty in providing quality nursing care.

5.5.2 Nurses’ Role Getting Narrower

The Delphi group identified the nurse’s role getting narrower as a high priority problem with 55 per cent of the questionnaire nurse group also agreeing that this was a limiting factor preventing them from fulfilling their therapeutic role. The nurse Delphi group believed that outsourcing of traditional mental health nursing tasks such as counselling as a major reason contributing to the MHN’s role getting narrower. Outsourcing is defined
as ‘the phenomenon of transferring services to a third party that had traditionally been carried out in-house’ (Young, 2000, p. 99). The literature on outsourcing in health care service delivery is sparse in the Australian context, but it is noted that outsourcing of healthcare services is commonplace. Stanton, Young and Willis (2003), in their editorial examining public management of health care in Victoria, Australia, describe how economic imperatives, skill shortages and the view that the health care sector is underperforming are driving the push towards outsourcing clinical services. They comment that the new political economy is incorporating competitive strategies into the health sector (p. 115). They list six features of what they call this ‘new public management’. These are relevant to this discussion so they will be listed here. They are (1) privatisation of public utilities; (2) the introduction of market-like mechanisms into the public sector; (3) separating core (policy) from periphery (service delivery) tasks; (4) out-sourcing service delivery, whilst maintaining government control over policy; (5) performance management systems; and (6) labour market flexibility. Buchanan-Barker and Barker (2007) support this view. They believe that the MHN’s role has shifted in recent times from one which required deep interpersonal relating with clients towards one dominated by patient observation and risk management. They point out that in this model patients become patients, nurses become service providers and the main focus is to protect the organisation from litigation. They believe nursing management is complicit in this through adopting an economic rationalist approach by applying business and commercial concepts into health care.

Within the framework identified by Stanton et al. (2003) there are three main factors driving the outsourcing agenda in mental health service delivery in Australia. These are cost cutting, separating core work from peripheral activities and the need for labour market flexibility to improve access to services and overcome skill shortages. Core tasks for MHNs include the care and treatment of the seriously mentally ill (ACMHN, 2010; Evans & Nizette, 2009; Fortinash & Woret, 2004). The Delphi nurse group reported that there was an attitude amongst some nurse managers and MHNs that providing biomedical interventions such as conducting assessments to assist with classification of mental illness, reporting signs and symptoms that might indicate a particular diagnosis,
administration of medication and other physical treatments and providing for the safety of the patient until these treatments take effect are core tasks for MHNs. Providing counselling and psychological therapies are not viewed as part of the core work because they are not seen as priorities for people with serious mental illness. Instead, they were viewed as part of the core domain of psychologists.

This view is not supported by the respondents to the questionnaire survey, with 93 per cent indicating they would like to use psychological therapies in their current practice, 76 per cent indicating that patients with mental illness are not adequately treated by medications alone and 83 per cent disagreeing that CBT is not a good use of time for MHNs. Similarly, the barriers to implementing psychological therapies that are associated with philosophical opposition to psychological therapies (Corigan et al., 2001; Ekers, 2006) were not perceived as barriers by the nurses in the questionnaire survey. For example, 92 per cent disagreed with the statement ‘I don’t believe psychological therapies will work’ and only four per cent agreed with the statement that psychological therapies were not appropriate for their clients. Nurses working in general practice and those who had received formal training in psychological therapies were found to be significantly more supportive of psychological therapies. Other findings from the questionnaire survey indicate nearly all respondents would like to use psychological therapies in their routine mental health nursing practice, have recently read articles about how to do this and many (74 per cent) had undergone formal training in applying psychological therapies to their practice. In addition, nearly all the respondents indicated a very positive attitude to CBT and believed that training in CBT should be made available to all MHNs. Taken together, these findings indicate a very strong philosophical support for using psychological therapies amongst the nurse questionnaire survey group and a recognition that structural or organisational barriers are the major impediment to this happening.

Stanton et al. (2003) argue that through outsourcing clinical and other services traditionally conducted within the organisation, budget savings may occur but there is a need for research into how outsourcing is impacting on employment relations, morale and
the work of nurses. Le and McManamey (2006), in their discussion of the literature on outsourcing in health care in Tasmania, note lower morale of permanent staff and loss of control of quality and processes as disadvantages in outsourcing and warn that it is not clear whether cost saving occurs or whether there is a shifting of costs from one government department to another or to the private sector and ultimately to service users. Le and McManamey (2006), Roberts (2001), Stanton et al. (2003), Hazelwood, Hazelwood and Cook (2005) and Young (2008) caution that outsourcing in health care should be undertaken as a collaborative team approach to avoid self-interest, mistrust and blame shifting within the workforce. Additionally, these scholars argue that outsourcing should be linked to quality control strategies such as regular feedback gathering from clients and promoting effective communication between participating parties.

The Delphi nurse group identified outsourcing of mental health nursing roles as one of the main factors causing a narrowing of the MHN’s therapeutic role. They noted the usefulness of the Medicare support of psychologists and social workers under the ‘Better Outcomes for Mental Health’ initiative, but lamented that given the structural and morale issues identified above this had meant the outsourcing and loss of traditional mental health nursing roles. They noted that MHNs tended to take a back seat role to psychologists and social workers and to refer to external services rather than commence therapy or psychological interventions themselves. As an example, the Delphi nurse group expressed concern that there were now widespread views amongst both mental health nursing management and community and inpatient staff that providing counselling was not part of the role of the MHN and that nurses were not qualified to provide counselling. The survey of practicing MHNs confirmed these concerns, with 48 per cent agreeing that they do not do counselling because they do not think they have the skills and 44 per cent agreeing they do not do counselling because they are told they do not have the skills. In keeping with the finding that place of employment is a significant factor impacting on views about the narrowing of the nurse’s role, those MHNs working in private practice or with GPs were significantly less likely to agree that nurses do not do counselling because they do not have the skills. However, despite these concerns,
counselling is being employed by 65.6 per cent of MHNs in the questionnaire survey group as part of their management of people with serious mental illness.

The questionnaire survey nurse group identified poor preparation and education of MHNs at both the undergraduate and post-graduate level as another explanation for the narrowing of the nurse’s role. Concern has been expressed over the years that the undergraduate comprehensive nursing curriculum does not contain enough mental health nursing content to adequately prepare nurses for this specialty area. Fisher (2005) discusses how The Mutual Recognition Act of 1992 meant that all nurses who completed a three-year nursing degree were qualified to work in both mental health and general nursing settings. As a result, the generalist and mental health nursing curricula was combined into a new comprehensive three-year degree. As a result, the mental health nursing curriculum content was considerably reduced both in terms of academic and clinical hours and in some programs was submerged by the generalist nursing curriculum (Clinton & Hazleton, 2000; Commonwealth Department of Education Science and Training, 2002; Select Committee on Mental Health, 2002). The contribution this may have had to the current knowledge levels of MHNs has come under considerable discussion in the literature, with most agreeing that there are deficiencies in the current educational preparation of MHNs at the undergraduate level (Curtis, 2007; Fisher, 2005; Happell, 2009; McCann et al., 2009; Stuhmiller, 2005; Usher, 2006).

There was a clear demand for more education and training from the questionnaire survey group, with over 85 per cent of the respondents believing that training in CBT should be made available to all MHNs including trainees and that nurses should have the knowledge to be able to advise their patients about CBT. The nurses who had received formal training in psychological therapies were significantly more likely to strongly agree that training in CBT should be available for both MHNs and trainee MHNs and that CBT was a good use of time for MHNs. They were also significantly less likely to agree that CBT should only be carried out by individuals with an approved qualification. Additionally, those nurses who had received formal training in psychological therapies were significantly less likely to agree that high patient-to-staff ratios were limiting their
therapeutic practice. This finding reinforces the potential for educational input, such as providing workplace training to provide skills to assist MHN nurses adapt their therapeutic practice to current service delivery realities.

The Delphi nurse group felt that nurse beliefs about counselling combined with outsourcing were evidence that the therapeutic skills of MHNs were under-utilised and in danger of being dominated by bio-medical and custodial nursing practices. The domination of bio-medical practices such as diagnostic assessment based on the DSM, and bio-medical treatments such as medication and electro-convulsive therapy were viewed as factors limiting the therapeutic practice of MHNs by the questionnaire survey nurses. Fifty-four per cent of nurses agreed that these were limiting factors, with those nurses who had undertaken formal training in psychological therapies significantly more likely to agree strongly about this. There is less agreement amongst the questionnaire survey nurses that too much time is spent doing observations, with 39 per cent agreeing with this statement and 60 per cent disagreeing. Again, those nurses working in the public sector inpatient settings were significantly likely to agree more strongly that this factor was limiting their therapeutic ability. As noted earlier, there is agreement in the literature that excellent observation skills are needed by MHNs, whilst at the same time recognising that frequent fifteen–thirty-minute observations of clients may be a useful risk-management tool but in itself it risks alienating and disempowering clients (Elder et al., 2009; Horsfall et al., 2000; O’Brien & Cole, 2005). As is pointed out in the literature, observations of clients should be undertaken with care and conducted collaboratively and in a therapeutic manner.

Whilst both the Delphi group and the majority of the questionnaire survey group of nurses were concerned about the therapeutic role of the MHN getting narrower, those nurses working within General Practice were significantly more likely to disagree with this. These divergent opinions are clearly illustrated in the following comments made by the questionnaire survey group:

- My current role… has been eroded to a „pill-pushers role‘ and the MH nurses‘ training and abilities are dismissed.
The scope of practice for an MHN in private practice is broadly decided by the nurse themselves. I believe the role of the nurse is actually expanding not narrowing.

This apparent contradiction may be illustrative of the expanding roles for MHNs in primary care, which have been initiated by changing government health policy and legislation since the Nurse Amendment (Nurse Practitioners) Acts have been implemented across Australia commencing with the first such Act in NSW in 1998. The changing therapeutic roles for MHNs were explored in the literature review section of this project, where it was shown how expanded roles for nurses, such as the role of the MHNP, can provide quality, cost-effective mental health care and improve access to mental health care (Fisher 2002a, 2002b, 2003, 2004, 2005, 2006). Additional to the NP legislation are the recent legislative, policy and funding initiatives in mental health care that have increased the role of the nurse in primary care. For example, the MHN incentive program (MHNIP) and the practice nurse incentive program (PNIP) fund GPs to employ credentialed MHNs and practice nurses to assist in the delivery of primary care services in mental health (Australian Government 2010a, 2010b; Australian Practice Nurse Association, 2010b). More recently, in May 2010, the Government announced an increase in Medicare funding for practice nurses and the role has been expanded to include Medicare items related to providing nursing care for patients with chronic and complex needs (Australian Practice Nurse Association, 2010a). These innovations in mental health care may be changing the landscape of the therapeutic role of MHNs, however, they are currently under-utilised. In the questionnaire survey group only 7.6 per cent of the respondents were employed within General Practice and six per cent were qualified as MHNP.

5.6 Limitations, Rigor, and Strengths of the Study

Rigor in quantitative research refers to the reliability and validity of the research. Davies and Dodd (2002) argue that there is a quantitative bias in the concept of rigor and that ‘rigor’ in qualitative and mixed-method research needs to be reconceptualised. Critical realism involves a scientific method aimed at identifying what produces social events and
how individuals inhabit and change social structures. The strength of a critical realist paradigm is that it enables the researcher to draw on a mixture of research methods that best address the needs and purposes of the study. This may include a mixture of qualitative and quantitative research methods. Critical realism is increasingly popular in nursing research because a multi-method approach can overcome an individualist bias and facilitate an understanding of the complexities of both agency and structure in the delivery of frontline nursing services (Clarke et al., 2008; Lidscomb, 2008; Porter & Ryan, 1996).

Determining the rigor of critical realist research involves overcoming the problem of reliability which, like Davies and Dodd (2002), Golafshani (2003) argues is a concept more suited to quantitative research methods than qualitative research methods. Lincoln and Guba (2000) assert that whilst reliability and validity are essential criteria for quantitative research, trustworthiness, credibility, neutrality, dependability and applicability are essential criteria for rigor in qualitative research. Golafshani (2003) argues one way to achieve rigor in social research is to eliminate bias and increase the researcher's truthfulness by using triangulation. He describes triangulation as a technique where researchers pursue convergence from different sources of information. Triangulation or multi-method approaches using several data sources and data analysis methods are viewed as strengthening the rigor of both qualitative and quantitative research (Patton, 2001). Golafshani (2003) argues multiple methods, such as observation, interviews and recordings and surveys lead to more valid, reliable and diverse constructions of social realities. In accordance with this discussion on rigor in social research, the research methods selected in this study combine qualitative interviews with quantitative Delphi surveys and an explorative quantitative questionnaire survey. To further strengthen the reliability and validity of the study, a sequential design was selected where the data analysis from one method informed the subsequent methods.

The Delphi method is based on the principle that consensus of opinion from a panel of experts can assist in understanding complex human situations (McLeod & Childs, 2007). The Delphi method relies upon regular feedback from participants for structuring and
refining the data, thus helping strengthen reliability and validity of the data. In this study two Delphi surveys were conducted and each study involved three rounds of feedback and checking from the participants. Analysis of the interviews in round one of the Delphi surveys was strengthened through the use of a computerised qualitative analysis tool ‘Ethnograph 6.0’ to assist with the mechanical aspect of coding the data from the interviews. In addition, the interviews were recorded and transcribed to ensure the full content and context of the coded statements was preserved for cross-checking.

The findings of this study are limited to some extent by the Delphi method employed in the study. The Delphi method requires a sample of experts but does not require randomisation or representativeness of the sample and as such limits the ability to make broad generalisations from the findings of the Delphi surveys. In addition, in both the Delphi surveys conducted in this research the response rate reduced in rounds two and three and some of the surveys returned had missing data. For example, in the Delphi consumer group there was a 60 per cent response rate in round two and a 50 per cent response rate in round three. In the Delphi nurse group there was a 62.5 per cent response rate in round two and a 75 per cent response rate in round three. This problem further limited the ability to make generalisations from the findings of the Delphi studies.

As discussed in chapter 3, it is well supported in the literature that consumer respondents are ‘experts’ on the basis of their experiences with mental health services (Bennett, 2009; Griffiths, Jorm & Christensen, 2004; McLaughlin, 2009; Morrison, 2006). However, it is possible that the consumer experts in this study were not knowledgeable about psychological therapies and may not know therefore whether they had received CBT or other psychological interventions from nurses. This possibility is mitigated by the method of the first round of the Delphi survey which consisted of a semi-structured interview. When necessary, psychological therapies and CBT were explained and defined to the consumer’s during the interview. The semi structure format also allowed a general discussion and in-depth explanation of psychological therapies and CBT to occur throughout the interview. This enabled the researcher to evaluate the consumer’s level of knowledge as to whether they had received psychological therapies, CBT, or CBT
informed interventions, and if these were perceived as helpful by consumers. Similarly, a limitation to the study lies in the fact that it was assumed the ‘expert’ nurse sample would have an in-depth knowledge of both psychological therapies and CBT. However, this limitation was similarly mitigated by the semi-structured interview format of the Delphi first round which enabled clarification and explanation of these therapies if required.

A further limitation concerning the Delphi consumer sample is the recency of contact with MHN’s. Whilst all were currently receiving mental health care, some had not had recent contact with MHN’s. As a result, the experiences described by the consumers may reflect the experiences of mental health services and interventions not related to nursing. This limitation is mitigated by the fact that all members of the consumer panel had received treatment from MHN’s for extended periods of time, were in contact with other consumers currently receiving nursing care, and spoke about memories of their experience with MHN’s and services.

The questionnaire survey was conducted to provide quantitative data on the research questions and assist with the validity, generalisability and rigor of the study through cross-validating the findings from the Delphi surveys. Content and face validity of the questionnaire were strengthened through consultations with a panel of expert MHNs and academic experts in questionnaire development, who agreed that it accurately measured the subject under investigation. In addition, questions in the survey were derived from multiple sources. The results of both the Delphi surveys of consumers and expert MHNs and peer-reviewed and published research incorporating survey questions on similar topics informed the questionnaire development.

The literature on the rigor of Internet surveys identifies low response rates and issues with sample selection and representation as potentially problematic. To help ensure the sample was representative and large and the data was secure, the survey was distributed through the membership data base of The Australian College of Mental Health Nurses. ‘SurveyMonkey Pro’ was selected as the software platform for the survey because of its reputation for technological compatibility with most computer systems, high security and
ease of use. Although the sample for this online questionnaire survey was not randomly selected, the sample size was large at 528 respondents and representative of the target population in most aspects. The sample proved to be representative in terms of State or Territory of residence, age, gender and type of employment; it was not representative in terms of educational qualifications, with the education level of the questionnaire sample being considerably higher than the target population. This fact limits the confidence in making broad generalisations from the findings from the nurse questionnaire sample. Nevertheless, by virtue of the educational levels of the nurse samples combined with their high levels of experience, they represent ‘leaders’ in the field and as such they may have more informed views of the therapeutic role of the MHN than the typical MHN.

5.6.1 Ethical constraints

In order to meet ethical requirements around informed consent, it was necessary that the consumer sample were not experiencing psychological distress or symptoms of mental illness at the time of the study. This meant that all the consumer participants were in remission, did not indicate psychological distress on the K-10+ test and were living independently in the community. All were receiving support for their mental illness from GPs, allied mental health workers or MHNs. However, some members said they had not experienced direct mental health nursing care for several years. For these participants, their comments reflected mostly their memories of the nursing care they had received, sometimes several years previously. Although these reflections were combined with their current observations of nursing care when visiting friends in hospital and from discussions with other consumers, this further limits the ability to make broad generalisations from the findings arising from the consumer group.

5.7 Conclusion

The discussion of the results of this study was outlined in this chapter. The critical realist methodology enabled the subjective experience of both consumers and nurses to be canvassed. The consumer viewpoint as an ‘agent’ receiving care and the nurse viewpoint
as the ‘giver’ of that care were obtained via the Delphi studies. The multi-method approach and sequential design employing the Delphi studies of expert nurses and consumers to obtain their subjective views and also to inform the development of the online questionnaire survey of practicing MHNs enabled points of similarity and difference to be identified and discussed. It was noted that there were significant areas of agreement between these three sample groups on what constitutes therapeutic mental health nursing practice.

Priorities identified by the consumer sample regarding important therapeutic practices for improving the quality of their care included the importance of the nurse’s attitude, the importance of nurses acknowledging and solving problems with medications and side effects, the need for nurses to provide more support for family and friends and the need for nurses to empower consumers by adopting a recovery approach to nursing care, particularly through encouraging their achievements and instilling hope. The consumer group felt vulnerable to the power and authority of the mental health system and those working within it. Theories about the exercise of power in psychiatry were discussed. For example, Foucault’s theories on the relationship between power and knowledge, Althusser’s theories on the role of ideological state apparatus and agents as purveyors of domination and subjugation and feminist theories on patriarchal power in psychiatry were identified. How these theories applied to, and impacted on the therapeutic role of the MHN was analysed.

The therapeutic relationship was seen by the Delphi nurse group to be of the highest priority along with communication skills, being there for the client and excellent skills in mental status and physical status assessment. The nurse Delphi group agreed with the consumer group that a recovery focused approach was important, identifying the need to help their clients to live fulfilling lives as the most important aspect of a recovery approach. Both nurse samples believed in the therapeutic usefulness of psychological therapies for people living with serious mental illness and agreed that MHNs should be incorporating these into their therapeutic practice. The literature supported these findings, identifying the therapeutic effectiveness of psychological therapies such as CBT and the
importance of developing positive coping strategies, nurturing self-determination, self-management, nurturing supportive relationships with family and community and empowerment as important elements in the recovery oriented approach to mental health nursing practice.

Barriers to therapeutic mental health nursing practice identified by both nurse sample groups included intrinsic factors such as morale, confidence and self-esteem of nurses as well as extrinsic structural factors such as staffing levels, leadership styles, peer relationships, opportunities for education and training and outsourcing of mental health nursing roles such as counselling. These interactions between intrinsic and extrinsic factors were explored within the frameworks provided by Foucault, Althusser and Fraser to determine how they may be affecting the quality of mental health nursing care and how they may be contributing to the MHN’s role in the longer term. For example, an Althusserian framework shows how nurses as agents can unwittingly become part of a generative mechanism maintaining dysfunctional social structures and social roles and a Fraserian framework shows how patriarchal economic ideologies control bureaucratic institutions, policies and practices.

Finally, the limitations, strengths, rigour and ethical constraints of the study was discussed. The following chapter presents the conclusion to the study.
Chapter 6: Conclusion

6.1 Introduction

The therapeutic role of the MHN is of increasing importance to improving both access to and quality care for people with serious and ongoing mental illness. Recent health policy changes in the Australian context mean the role of the MHN is expanding in some contexts. This thesis sought to explain apparently contradictory trends between the current therapeutic role of MHNs, which is dominated by bio-medical practices, and the evidence base supporting the use of psychological therapies by nurses. In seeking an explanation for these seemingly opposing trends in the therapeutic role of the nurse, the research focused on identifying the views and experiences of both consumers and mental nurses. Through this process it became clear that consumers and MHNs believed both bio-medical practices such as medication management and psychological therapies were appropriate and effective therapeutic strategies. They believed the problem was that nurses were not incorporating psychological therapies into their current therapeutic practice because of mostly structural barriers restricting their implementation. This final chapter reiterates the logical progression of the research project through a summary of the thesis, leading to a discussion of the significance of the study, implications from the findings of the study, recommendations, limitations and concluding remarks.

6.1.2 Aims of the Research

The specific aims of the project were as follows:

1. Identify therapeutic roles/modalities suitable for inpatient and community mental health nursing of people living with serious and ongoing mental illness.
2. Identify factors that influence mental health nursing practice in relation to the use of evidence-based psychological therapies such as CBT.
3. Ascertain the views of MHNs about adopting evidence-based psychological therapeutic practices.
Three research questions arise from these aims:

1. What do consumers think will improve the quality of their care?
2. What therapeutic roles/modalities do nurses think are suitable for inpatient and community mental health nursing practice?
3. What factors influence mental health nursing practice in relation to the use of psychological therapeutic modalities?

6.2 Overview of the Thesis

Chapter one provides an introduction to the study. The philosophical and theoretical underpinnings and significance of the study are articulated. The aims, research questions arising from the aims and methods of data collection are outlined.

The research and scholarship presented in Chapter 2, the literature review, provided an analysis of the current context of the practice of mental health nursing and demarcated the boundaries of mental health nursing from psychiatry, allied health and other fields of nursing practice. Definitions and conceptions of mental illness were examined, diagnostic classification systems explained and various theoretical paradigms on the causation and treatment of mental illness were explored. Evidence of a significant challenge to the predominant bio-medical paradigm over the previous 30 years illustrated inconsistencies with the integrity of the knowledge foundation and ideology underlying mental health nursing. In particular, epistemic challenges to the reliability and validity of current diagnostic classification systems and resultant therapeutic practices were outlined.

A review of the literature proceeded with the objective of finding an explanatory framework that might account for why the bio-medical model remains the dominant epistemic model underlying the therapeutic practice of mental health nursing. Two theoretical frameworks, critical social theory and critical realism, provide the explanatory framework. Both critical social theory and critical realism enable an exploration of how
social structures influence individual actions and how individual actions in turn maintain social structures; that is, they explore the interplay between agency and structure.

One book chapter based on a previous internationally peer-reviewed journal article, three internationally peer-reviewed conference papers and four articles published in an internationally peer-reviewed journal co-authored or written by the author contributed to the literature review. Resistance to change in the therapeutic practices of MHNs was shown to come from within the profession as well as from outside the profession. A review of the evidence-based literature on psychological therapies helped explain why there was reluctance amongst many MHNs to adopt evidence-based psychological therapies such as CBT. This paper showed that the ‘evidence’ supporting EBP in mental health nursing came from randomised controlled trials and there was a perceived bias within the profession that this form of evidence did not adequately account for patient values, characteristics and circumstance nor the skills and preferences of the nurse.

A review of the legislative, economic and policy framework guiding the practice of MHNs provided evidence on the changing models of service delivery in mental health and highlighted the challenges to traditional therapeutic practice of nurses these cause. For example, one paper examined the difficulties for nurses to control increasing numbers of patients exhibiting problematic behaviour in under-resourced environments. This paper helped explain why custodial and risk-management practices tended to dominate the therapeutic role of MHNs. Four research papers explored power relationships within the mental health workforce to determine how these impacted on the ability of nurses to change their therapeutic practices. In particular, the power of the medical profession over the practice of nurses is exemplified by the organised resistance from physician organisations to legislative changes designed to expand the role of the nurse. The results of these studies repeatedly pointed to the significance of adequate resourcing and constructive collegial partnerships as critical for the successful implementation of changes in the therapeutic roles of nurses.
The review of the literature also considered the treatment experiences of consumers of mental health nursing care. Two further articles by the author offered insights into the treatment experiences of consumers and showed how consumers feel unsafe in hospital, are critical of the nursing care they receive and find many mental health settings unhelpful and non-therapeutic. These findings demonstrated the need to obtain both the views of nurses and of consumers on how to improve the therapeutic role of the MHN. Thus, an empirical investigation of the opinions of consumers and nurses became the purpose of this research project.

The methodology chapter focused on the construction of an innovative methodology that would provide a means with which to investigate the views of both consumers and nurses.

Critical realism allowed the examination of both the consumer and the nurse viewpoints in order to discover the generative mechanisms and causal powers influencing the therapeutic practice of the MHN. The critical social theories of Foucault and Althusser and the feminist theoretical views of Fraser and Potter guided the broader contours of the study. Insights from Foucault contributed to the analysis of the dominant epistemic structures controlling the therapeutic actions of MHNs and helped explain how they have become generative mechanisms in the critical realist perspective. Althusser’s theory of the influence of ideology on social structures helped to make explicit how nurses may unconsciously become the bearers of functions that self-perpetuate the ideologies and power relationships of that structure. For example, an Althusserian analysis demonstrated how the bio-medical ideology is restricting nurses from achieving professional emancipation. Fraser and Potter showed how gender shapes philosophical paradigms, workplace practices, economic structures and bureaucratic institutions. Their feminist critiques showed how gender inequality and androcentric views about ‘normal’ human behaviour are at the centre of psychiatry and how these views manipulate the therapeutic role of nurses who are situated in subordinate positions within a gendered workplace and economic structure.
Utilising a mixed-methods approach, two Delphi studies and an online questionnaire survey were selected as the methods for the study. Three sample groups were identified, comprising consumers of mental health nursing care (Delphi), expert MHNs (Delphi) and practicing MHNs (online questionnaire). This allowed for findings from the Delphi surveys of consumers and expert nurses to inform the development of the questionnaire survey of practicing MHNs and for comparison in the analysis between the three groups.

The results' chapter presents the findings from the Delphi studies and the questionnaire survey of practitioners. Across all three samples there was substantial agreement on what constitutes therapeutic mental health nursing practice. Most helpful knowledge, skills, attitudes, strategies and therapies were identified by the consumer Delphi group. The nurse Delphi group similarly identified most helpful knowledge skills, attitudes and therapies but also outlined current problems preventing MHNs from fulfilling their therapeutic role. The questionnaire survey of practicing MHNs rated the strength of agreement to these findings from the Delphi survey as well as attitudes towards and institutional barriers to the implementation of psychological therapies and CBT. In the most part, the three sample groups were in agreement on what constitutes therapeutic mental health nursing practice.

The discussion chapter presented an analysis and discussion of the results. The overriding theme for the consumers was one of powerlessness in decision making on clinical and personal matters about their mental health. They knew they were vulnerable to the authority and power of nurses and found this could trigger feelings of fearfulness and a lack of trust that were particularly unhelpful to their recovery. Similarly, both the nurse samples believed that power relationships were challenging and identified developing empowering therapeutic relationships as the most important therapeutic skill for MHNs.

6.3 Findings from the Study

The summary of the findings from the study are organised under the three research questions.
6.3.1 What Do Consumers Think Will Improve the Quality of Their Care?

The consumers identified the attitude of the nurse as the most important factor in the therapeutic role of the nurses. The consumers remembered those nurses who treated them ‘normally’ and ‘as equals’ and who demonstrated calm, caring, gentle, friendly and respectful attitudes as being particularly helpful to their recovery. During even the most severe episodes of their illness, the consumers wanted MHNs to provide care in a way that empowered them. Nurses who employed empowering strategies such as encouraging small achievements, instilling hope, helping to maintain independence and giving information about their illness, medications and side effects so that they became knowledgeable and well informed were regarded as the most therapeutic. Wellness planning, a recovery focused approach to nursing care, and psychological therapies such as CBT were identified by the consumers as important to maintaining wellbeing and preventing relapse.

6.3.2 What Therapeutic Roles/Modalities Do Nurses Think Are Suitable for Inpatient and Community Mental Health Nursing Practice?

An empowering therapeutic relationship, communication skills including counselling skills, being there for the client, excellent medical and mental status assessment skills and a recovery focused approach are identified by both the nurse samples as the most important therapeutic practices for MHNs. There is acknowledgement of the problems caused by trying to differentiate between communication skills and counselling skills but there is general agreement that counselling is an important therapeutic part of the MHN’s role.

There is enthusiasm amongst the nurses for applying psychological therapies to their mental health nursing practice, with over 90 per cent of nurses indicating they wanted to use psychological therapies. There is also a desire on the part of nurses for educational input on applying evidence-based psychological therapies into their practice. CBT and
solution-focused therapy are regarded as the most popular psychological therapies. Amongst those who currently use psychological therapies, a majority employ an eclectic mix of therapies to suit the circumstances at the time.

6.3.3 What Factors Influence Mental Health Nursing Practice in Relation to the Use of Psychological Therapeutic Modalities?

A number of factors are identified that are influencing the ability of MHNs to employ psychological therapies. Current barriers limiting the therapeutic practice of MHNs and their use of psychological therapies are a combination of low nurse morale and institutional or structural barriers such as inadequate funding, high patient–staff ratios, short hospital patient stays, outsourcing of nursing roles and too much time spent meeting documentation and paperwork requirements. There is concern that the MHN's role is being narrowed through the domination of bio-medical and custodial practices combined with outsourcing of nursing roles such as counselling. There is a conviction that the current educational preparation for mental health nursing is inadequate. This conviction is combined with a demand for more education and training in applying evidence-based psychological therapies such as CBT into mental health nursing practice.

6.4 Major Implications of the Study

The experiences of consumers and MHNs in this study suggest that there is considerable agreement between them about what constitutes therapeutic nursing practice and recognition that these therapeutic practices are not always employed by MHNs. Improving the therapeutic practice of MHNs cannot occur without addressing nurse morale and the structural barriers that prevent nurses from adopting evidence-based therapeutic practices including the use of psychological therapies. The findings from the study identify a number of institutional barriers that are contributing to this problem. Primary amongst these is the time required to fulfil increasing documentation requirements.
The evidence in this study shows that practicing MHNs recognise that there is an over-emphasis on bio-medical and custodial nursing practices that are not always therapeutic to consumers. The potential for MHNs to progress their therapeutic practice through adopting evidence-based therapies such as CBT and other psychological therapies was supported in this study. MHNs acknowledge there is conflict and an imbalance between their custodial role and their therapeutic role and are keen to employ psychological therapies such as CBT as a way of redressing this. They believe that it is imperative that all practicing MHNs and undergraduate nursing students should receive training in CBT and should be able to employ CBT or at the very least should be able to advise their clients about CBT.

In addition, the findings from this study highlighted the importance of both communication and counselling skills for MHNs. Both the consumer and nurse samples believed therapeutic communication skills and counselling were central to the therapeutic role of the MHN. MHN managers and academics who believe that nurses are not qualified to provide counselling to their clients need to clarify which communication skills are to be excluded from the nurse’s communication repertoire. The literature does not adequately differentiate between counselling and therapeutic communication skills, and whilst confusion remains about this matter it is restricting the therapeutic potential of MHNs to assist their clients. Additionally, the findings from this study highlight the way a very real lack of mental health service delivery alternatives to the bio-medical model, combined with institutional barriers such as poor staffing, lack of funding, inadequate educational preparation and low morale, restricts therapeutic mental health nursing practice, impacting negatively on care and treatment and the recovery of consumers.

Methodologically, this research demonstrates how a critical realist paradigm avoids individualistic interpretations of the therapeutic role of the MHN and enables an examination of the relationship between agency and structure within the context of the diverse power relationships existing in the mental health sector. The research methods selected—two separate Delphi studies of consumers and expert nurses and a questionnaire survey of practicing MHNs—enabled a mixture of quantitative and
qualitative methods. This helped in maintaining the rigor of the study and also enabled the complexity of the social system surrounding the treatment of consumers and the practice of mental health nursing to be more fully apprehended.

Critical realism also allows the researcher to make judgments and selections on where to focus. In this study, the viewpoints of Foucault, Althusser and feminism guided the broad contours and focus of the study. For example, dominant epistemic structures such as the bio-medical model in psychiatry were analysed to ascertain how these ‘epistemic structures’ influence the therapeutic actions and roles of MHNs and the treatment experiences of consumers.

Althusser’s theory on the role of ideology in social structures (ideological state apparatuses) helped make explicit the influence of ideology on the therapeutic role of the MHN and explained how MHNs may unknowingly perpetuate, maintain and reproduce existing social relations within the mental health sector and in their practice. This analysis enabled an understanding of how ideology may be restricting nurses from adapting their therapeutic practice towards adopting evidence-based psychological therapies.

Feminist theories assisted in an analysis of the influence of patriarchy in perpetuating gender inequality in mental health care and services. Feminist critiques of the DSM and psychiatry are long standing. Feminists have argued that these are patriarchal structures that can become systems of oppression, devaluing the reality of mental illness and emotional distress, particularly for women. As MHNs are predominantly female, work in gendered workplaces and are situated in subordinate positions within the mental health bureaucracy, feminist perspectives are particularly relevant to this study.

6.5 Recommendations

On the basis of these research findings, the following recommendations are made.
6.5.1 Improve the therapeutic role of the mental health nurse and the quality of care for consumers

1. That the NSW Department of Health and University Deans of Nursing expand consumer and carer roles in the education of MHNs in both in-service education and in the tertiary sector.
2. That NSW hospitals expand orientation and induction programs for all new mental health nursing staff to include consumer perspectives and evidence-based psychological therapies.
3. That the NSW Department of Health and the Australian College of Mental Health Nurses form a working party to address the confusion in the role and function of inpatient and community MHNs regarding providing counselling to their clients/patients. Expectations regarding this issue need to be clearly outlined and made known to nurses and nurse managers.
4. That the Commonwealth fund research on mental health services and delivery of care that is inclusive of, or focussed on, consumer and carer perspectives and experience.
5. That the Commonwealth fund research evaluating both the therapeutic impact and the staff morale impact of MHNs applying psychological therapies into their mental health nursing practice.

6.5.2 Reduce the barriers inhibiting the use of psychological therapeutic modalities by mental health nurses

1. That all undergraduate nurses as part of their mental health nursing core curriculum receive education about the application of psychological therapies in mental health nursing practice.
2. That institutions involved in the undergraduate and post-graduate education of MHNs provide ongoing learning needs assessment to determine the learning needs of MHNs in applying evidence-based psychological therapies into their practice.
3. That the curriculum accrediting authority of the Nursing and Midwifery Board of the Australian Health Practitioner Regulation Agency systematically evaluate undergraduate mental health nursing programs to ensure their content reflects both a psychological as well as biomedical approach in the treatment and care of clients with serious mental illnesses.

4. That the NSW Department of Health ensure mental health nursing staff workloads do not prevent attendance at in-service programs in evidence-based psychological therapies.

5. That Professional Nursing bodies and NSW Health support as a priority, MHNs undertaking continuing education courses that are focused on incorporating psychological therapies in nursing practice by making this a requirement for continuing professional development as part of the new national registration processes.

6. That the NSW Department of Health support nurse management to identify and remove structural barriers preventing MHNs fulfilling their therapeutic potential. First amongst these must be to rationalise and make more efficient the nurse time spent filling in forms and other paperwork.

7. That the NSW Department of Health and the College of Mental Health Nurses establish a working party to reorganise and restructure the workloads of MHNs to ensure evidence-based psychological therapies are prioritised along with biomedical practices such as medication administration and custodial practices such as observation.

6.6 Conclusion

This thesis has examined the therapeutic role of the MHN from the viewpoints of both consumers and nurses. This research addresses the gap in the Australian nursing literature regarding the therapeutic role of the MHN, and in particular the use of evidence-based psychological therapies such as CBT. A critical realist methodology utilising a mixed-methods approach was selected for the investigation in order to obtain the viewpoints of consumers, expert nurses and practicing nurses.
The findings from the research indicate that consumers and MHNs share common views about therapeutic practices, whilst at the same time recognising that these therapeutic approaches are not always practiced by nurses. A number of intrinsic and extrinsic factors that conspire to restrict the therapeutic practice of MHNs are identified. Chief amongst these is a combination of factors including low nurse morale and self-esteem, inadequate funding, few opportunities for education and training, outsourcing of mental health nursing roles and increasing paperwork taking time away from direct patient care. Significantly, the MHNs in this study are keen to implement evidence-based psychological therapies such as CBT into their therapeutic nursing practice.
Reference List


Australian Practice Nurse Association (2010a). *Nurses in general practice recognised as key care providers in Federal funding shake up*. Media Release. Retrieved 5 July


Office of Mental Health, Department of Health, Government of Western Australia (2004). *A recovery vision for rehabilitation, psychiatric rehabilitation policy and*


Liaison; a Handbook for Nurses and Health Professionals (pp. 43–64). Edingburgh: Bailliere Tindall.


diagnosis, comparing Switzerland, the United States and the United Kingdom.


costuctive framework for structuring the psychiatric nursing practicum. *Journal
of Nursing Education, 34*, 131–133.

MacMillan Press Ltd.


*Sydney Morning Herald*. (2002). Fears hospital super nurse is „disaster waiting to
happen‘. Friday 6 September.


University Press.

Talbott, J. A. (2008). Public-academic partnerships: the evolution and current status of

Tarrier, N. (2005). Cognitive behaviour therapy for schizophrenia – a review of
development, evidence and implementation. *Psychotherapy and Psychosomatics.
74*(3), 136-144.

nationwide survey of practitioners’ attitudes and experiences. *American Journal
of Occupational Therapy*. 63, 198-207.


John Wiley and Sons License
Terms and Conditions

This is a License Agreement between Jacklin Fisher ("You") and John Wiley and Sons ("John Wiley and Sons") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by John Wiley and Sons, and the payment terms and conditions.

All payments must be made in full to CCC. For payment instructions, please see information listed at the bottom of this form.

<table>
<thead>
<tr>
<th>License Number</th>
<th>2524471503326</th>
</tr>
</thead>
<tbody>
<tr>
<td>License date</td>
<td>Oct 08, 2010</td>
</tr>
<tr>
<td>Licensed content publisher</td>
<td>John Wiley and Sons</td>
</tr>
<tr>
<td>Licensed content publication</td>
<td>International Journal of Mental Health Nursing</td>
</tr>
<tr>
<td>Licensed content title</td>
<td>The mental health nurse practitioner in the emergency department: An Australian experience</td>
</tr>
<tr>
<td>Licensed content author</td>
<td>Timothy Wand, Jacklin Fisher</td>
</tr>
<tr>
<td>Licensed content date</td>
<td>Sep 1, 2006</td>
</tr>
<tr>
<td>Start page</td>
<td>201</td>
</tr>
<tr>
<td>End page</td>
<td>208</td>
</tr>
<tr>
<td>Type of use</td>
<td>Dissertation/Thesis</td>
</tr>
<tr>
<td>Requestor type</td>
<td>Author of this Wiley article</td>
</tr>
<tr>
<td>Format</td>
<td>Print and electronic</td>
</tr>
<tr>
<td>Portion</td>
<td>Full article</td>
</tr>
<tr>
<td>Will you be translating?</td>
<td>No</td>
</tr>
<tr>
<td>Order reference number</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.00 USD</td>
</tr>
</tbody>
</table>

Terms and Conditions

TERMS AND CONDITIONS

This copyrighted material is owned by or exclusively licensed to John Wiley & Sons, Inc. or one if its group companies (each a "Wiley Company") or a society for whom a Wiley Company has exclusive publishing rights in relation to a particular journal (collectively "WILEY"). By clicking “accept” in connection with completing this licensing transaction, you agree that the following terms and conditions apply to this transaction (along with the billing and payment terms and conditions established by the Copyright Clearance Center Inc., "CCC’s Billing and Payment terms
Terms and Conditions

1. The materials you have requested permission to reproduce (the "Materials") are protected by copyright.

2. You are hereby granted a personal, non-exclusive, non-sublicensable, non-transferable, worldwide, limited license to reproduce the Materials for the purpose specified in the licensing process. This license is for a one-time use only with a maximum distribution equal to the number that you identified in the licensing process. Any form of republication granted by this license must be completed within two years of the date of the grant of this license (although copies prepared before may be distributed thereafter). Any electronic posting of the Materials is limited to one year from the date permission is granted and is on the condition that a link is placed to the journal homepage on Wiley’s online journals publication platform at [www.interscience.wiley.com](http://www.interscience.wiley.com). The Materials shall not be used in any other manner or for any other purpose. Permission is granted subject to an appropriate acknowledgement given to the author, title of the material/book/journal and the publisher and on the understanding that nowhere in the text is a previously published source acknowledged for all or part of this Material. Any third party material is expressly excluded from this permission.

3. With respect to the Materials, all rights are reserved. No part of the Materials may be copied, modified, adapted, translated, reproduced, transferred or distributed, in any form or by any means, and no derivative works may be made based on the Materials without the prior permission of the respective copyright owner. You may not alter, remove or suppress in any manner any copyright, trademark or other notices displayed by the Materials. You may not license, rent, sell, loan, lease, pledge, offer as security, transfer or assign the Materials, or any of the rights granted to you hereunder to any other person.

4. The Materials and all of the intellectual property rights therein shall at all times remain the exclusive property of John Wiley & Sons Inc or one of its related companies (WILEY) or their respective licensors, and your interest therein is only that of having possession of and the right to reproduce the Materials pursuant to Section 2 herein during the continuance of this Agreement. You agree that you own no right, title or interest in or to the Materials or any of the intellectual property rights therein. You shall have no rights hereunder other than the license as provided for above in Section 2. No right, license or interest to any trademark, trade name, service mark or other branding ("Marks") of WILEY or its licensors is granted hereunder, and you agree that you shall not assert any such right, license or interest with respect thereto.

5. WILEY DOES NOT MAKE ANY WARRANTY OR REPRESENTATION OF ANY KIND TO YOU OR ANY THIRD PARTY, EXPRESS, IMPLIED OR STATUTORY, WITH RESPECT TO THE MATERIALS OR THE ACCURACY OF ANY INFORMATION CONTAINED IN THE MATERIALS, INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTY OF MERCHANTABILITY, ACCURACY, SATISFACTORY QUALITY, FITNESS FOR A PARTICULAR PURPOSE, USABILITY, INTEGRATION OR NON-INFRINGEMENT AND ALL SUCH WARRANTIES ARE HEREBY EXCLUDED BY WILEY AND WAIVED BY YOU.

6. WILEY shall have the right to terminate this Agreement immediately upon breach of this Agreement by you.

7. You shall indemnify, defend and hold harmless WILEY, its directors, officers, agents and employees, from and against any actual or threatened claims, demands, causes of action or proceedings arising from any breach of this Agreement by you.

8. IN NO EVENT SHALL WILEY BE LIABLE TO YOU OR ANY OTHER PARTY OR ANY OTHER PERSON OR ENTITY FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY OR PUNITIVE DAMAGES, HOWEVER CAUSED, ARISING OUT OF OR IN CONNECTION WITH THE
DOWNLOADING, PROVISIONING, VIEWING OR USE OF THE MATERIALS REGARDLESS OF THE FORM OF ACTION, WHETHER FOR BREACH OF CONTRACT, BREACH OF WARRANTY, TORT, NEGLIGENCE, INFRINGEMENT OR OTHERWISE (INCLUDING, WITHOUT LIMITATION, DAMAGES BASED ON LOSS OF PROFITS, DATA, FILES, USE, BUSINESS OPPORTUNITY OR CLAIMS OF THIRD PARTIES), AND WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THIS LIMITATION SHALL APPLY NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY PROVIDED HEREIN.

9. Should any provision of this Agreement be held by a court of competent jurisdiction to be illegal, invalid, or unenforceable, that provision shall be deemed amended to achieve as nearly as possible the same economic effect as the original provision, and the legality, validity and enforceability of the remaining provisions of this Agreement shall not be affected or impaired thereby.

10. The failure of either party to enforce any term or condition of this Agreement shall not constitute a waiver of either party's right to enforce each and every term and condition of this Agreement. No breach under this agreement shall be deemed waived or excused by either party unless such waiver or consent is in writing signed by the party granting such waiver or consent. The waiver by or consent of a party to a breach of any provision of this Agreement shall not operate or be construed as a waiver of or consent to any other or subsequent breach by such other party.

11. This Agreement may not be assigned (including by operation of law or otherwise) by you without WILEY's prior written consent.

12. These terms and conditions together with CCC’s Billing and Payment terms and conditions (which are incorporated herein) form the entire agreement between you and WILEY concerning this licensing transaction and (in the absence of fraud) supersedes all prior agreements and representations of the parties, oral or written. This Agreement may not be amended except in a writing signed by both parties. This Agreement shall be binding upon and inure to the benefit of the parties' successors, legal representatives, and authorized assigns.

13. In the event of any conflict between your obligations established by these terms and conditions and those established by CCC’s Billing and Payment terms and conditions, these terms and conditions shall prevail.

14. WILEY expressly reserves all rights not specifically granted in the combination of (i) the license details provided by you and accepted in the course of this licensing transaction, (ii) these terms and conditions and (iii) CCC’s Billing and Payment terms and conditions.

15. This Agreement shall be governed by and construed in accordance with the laws of England and you agree to submit to the exclusive jurisdiction of the English courts.

16. Other Terms and Conditions:

BY CLICKING ON THE "I ACCEPT" BUTTON, YOU ACKNOWLEDGE THAT YOU HAVE READ AND FULLY UNDERSTAND EACH OF THE SECTIONS OF AND PROVISIONS SET FORTH IN THIS AGREEMENT AND THAT YOU ARE IN AGREEMENT WITH AND ARE WILLING TO ACCEPT ALL OF YOUR OBLIGATIONS AS SET FORTH IN THIS AGREEMENT.

V1.2

Gratis licenses (referencing $0 in the Total field) are free. Please retain this printable license for your reference. No payment is required.

If you would like to pay for this license now, please remit this license along with your payment made payable to "COPYRIGHT CLEARANCE CENTER" otherwise you will be
invoiced within 48 hours of the license date. Payment should be in the form of a check or money order referencing your account number and this invoice number RLNK10863132. Once you receive your invoice for this order, you may pay your invoice by credit card. Please follow instructions provided at that time.

Make Payment To:
Copyright Clearance Center
Dept 001
P.O. Box 843006
Boston, MA 02284-3006

If you find copyrighted material related to this license will not be used and wish to cancel, please contact us referencing this license number 2524471503326 and noting the reason for cancellation.

Questions? customercare@copyright.com or +1-877-622-5543 (toll free in the US) or +1-978-646-2777.
Appendix 1b. License Agreement, Fisher (2005).

JOHN WILEY AND SONS LICENSE
TERMS AND CONDITIONS

Nov 28, 2010

This is a License Agreement between jacklin fisher ("You") and John Wiley and Sons ("John Wiley and Sons") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by John Wiley and Sons, and the payment terms and conditions.

All payments must be made in full to CCC. For payment instructions, please see information listed at the bottom of this form.

<table>
<thead>
<tr>
<th>License Number</th>
<th>2524471185954</th>
</tr>
</thead>
<tbody>
<tr>
<td>License date</td>
<td>Oct 08, 2010</td>
</tr>
<tr>
<td>Licensed content publisher</td>
<td>John Wiley and Sons</td>
</tr>
<tr>
<td>Licensed content publication</td>
<td>International Journal of Mental Health Nursing</td>
</tr>
<tr>
<td>Licensed content title</td>
<td>Mental health nurse practitioners in Australia: Improving access to quality mental health care</td>
</tr>
<tr>
<td>Licensed content author</td>
<td>Jacklin E. Fisher</td>
</tr>
<tr>
<td>Licensed content date</td>
<td>Dec 1, 2005</td>
</tr>
<tr>
<td>Start page</td>
<td>222</td>
</tr>
<tr>
<td>End page</td>
<td>229</td>
</tr>
<tr>
<td>Type of use</td>
<td>Dissertation/Thesis</td>
</tr>
<tr>
<td>Requestor type</td>
<td>Author of this Wiley article</td>
</tr>
<tr>
<td>Format</td>
<td>Print and electronic</td>
</tr>
<tr>
<td>Portion</td>
<td>Full article</td>
</tr>
<tr>
<td>Will you be translating?</td>
<td>No</td>
</tr>
<tr>
<td>Order reference number</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.00 USD</td>
</tr>
</tbody>
</table>

Terms and Conditions

TERMS AND CONDITIONS

This copyrighted material is owned by or exclusively licensed to John Wiley & Sons, Inc. or one if its group companies (each a "Wiley Company") or a society for whom a Wiley Company has exclusive publishing rights in relation to a particular journal (collectively "WILEY"). By clicking “accept” in connection with completing this licensing transaction, you agree that the following terms and conditions apply to this transaction (along with the billing and payment terms and conditions established by the Copyright Clearance Center Inc., ("CCC’s Billing and Payment terms
and conditions"), at the time that you opened your Rightslink account (these are available at any time at http://myaccount.copyright.com).

Terms and Conditions

1. The materials you have requested permission to reproduce (the "Materials") are protected by copyright.

2. You are hereby granted a personal, non-exclusive, non-sublicensable, non-transferable, worldwide, limited license to reproduce the Materials for the purpose specified in the licensing process. This license is for a one-time use only with a maximum distribution equal to the number that you identified in the licensing process. Any form of republication granted by this licence must be completed within two years of the date of the grant of this licence (although copies prepared before may be distributed thereafter). Any electronic posting of the Materials is limited to one year from the date permission is granted and is on the condition that a link is placed to the journal homepage on Wiley’s online journals publication platform at www.interscience.wiley.com. The Materials shall not be used in any other manner or for any other purpose. Permission is granted subject to an appropriate acknowledgement given to the author, title of the material/book/journal and the publisher and on the understanding that nowhere in the text is a previously published source acknowledged for all or part of this Material. Any third party material is expressly excluded from this permission.

3. With respect to the Materials, all rights are reserved. No part of the Materials may be copied, modified, adapted, translated, reproduced, transferred or distributed, in any form or by any means, and no derivative works may be made based on the Materials without the prior permission of the respective copyright owner. You may not alter, remove or suppress in any manner any copyright, trademark or other notices displayed by the Materials. You may not license, rent, sell, loan, lease, pledge, offer as security, transfer or assign the Materials, or any of the rights granted to you hereunder to any other person.

4. The Materials and all of the intellectual property rights therein shall at all times remain the exclusive property of John Wiley & Sons Inc or one of its related companies (WILEY) or their respective licensors, and your interest therein is only that of having possession of and the right to reproduce the Materials pursuant to Section 2 herein during the continuance of this Agreement. You agree that you own no right, title or interest in or to the Materials or any of the intellectual property rights therein. You shall have no rights hereunder other than the license as provided for above in Section 2. No right, license or interest to any trademark, trade name, service mark or other branding ("Marks") of WILEY or its licensors is granted hereunder, and you agree that you shall not assert any such right, license or interest with respect thereto.

5. WILEY DOES NOT MAKE ANY WARRANTY OR REPRESENTATION OF ANY KIND TO YOU OR ANY THIRD PARTY, EXPRESS, IMPLIED OR STATUTORY, WITH RESPECT TO THE MATERIALS OR THE ACCURACY OF ANY INFORMATION CONTAINED IN THE MATERIALS, INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTY OF MERCHANTABILITY, ACCURACY, SATISFACTORY QUALITY, FITNESS FOR A PARTICULAR PURPOSE, USABILITY, INTEGRATION OR NON-INFRINGEMENT AND ALL SUCH WARRANTIES ARE HEREBY EXCLUDED BY WILEY AND WAIVED BY YOU.

6. WILEY shall have the right to terminate this Agreement immediately upon breach of this Agreement by you.

7. You shall indemnify, defend and hold harmless WILEY, its directors, officers, agents and employees, from and against any actual or threatened claims, demands, causes of action or proceedings arising from any breach of this Agreement by you.

8. IN NO EVENT SHALL WILEY BE LIABLE TO YOU OR ANY OTHER PARTY OR ANY OTHER PERSON OR ENTITY FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY OR PUNITIVE DAMAGES, HOWEVER CAUSED, ARISING OUT OF OR IN CONNECTION WITH THE

336
DOWNLOADING, PROVISIONING, VIEWING OR USE OF THE MATERIALS REGARDLESS OF THE
FORM OF ACTION, WHETHER FOR BREACH OF CONTRACT, BREACH OF WARRANTY, TORT,
NEGligence, INFRINGEMENT OR OTHERWISE (INCLUDING, WITHOUT LIMITATION, DAMAGES
BASED ON LOSS OF PROFITS, DATA, FILES, USE, BUSINESS OPPORTUNITY OR CLAIMS OF
THIRD PARTIES), AND WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY
OF SUCH DAMAGES. THIS LIMITATION SHALL APPLY NOTWITHSTANDING ANY FAILURE OF
ESSENTIAL PURPOSE OF ANY LIMITED REMEDY PROVIDED HEREIN.

9. Should any provision of this Agreement be held by a court of competent jurisdiction to be
illegal, invalid, or unenforceable, that provision shall be deemed amended to achieve as nearly as
possible the same economic effect as the original provision, and the legality, validity and
enforceability of the remaining provisions of this Agreement shall not be affected or impaired
thereby.

10. The failure of either party to enforce any term or condition of this Agreement shall not
constitute a waiver of either party's right to enforce each and every term and condition of this
Agreement. No breach under this agreement shall be deemed waived or excused by either party
unless such waiver or consent is in writing signed by the party granting such waiver or consent.
The waiver by or consent of a party to a breach of any provision of this Agreement shall not
operate or be construed as a waiver of or consent to any other or subsequent breach by such
other party.

11. This Agreement may not be assigned (including by operation of law or otherwise) by you
without WILEY's prior written consent.

12. These terms and conditions together with CCC’s Billing and Payment terms and conditions
(which are incorporated herein) form the entire agreement between you and WILEY concerning
this licensing transaction and (in the absence of fraud) supersedes all prior agreements and
representations of the parties, oral or written. This Agreement may not be amended except in a
writing signed by both parties. This Agreement shall be binding upon and inure to the benefit of
the parties' successors, legal representatives, and authorized assigns.

13. In the event of any conflict between your obligations established by these terms and
conditions and those established by CCC’s Billing and Payment terms and conditions, these terms
and conditions shall prevail.

14. WILEY expressly reserves all rights not specifically granted in the combination of (i) the
license details provided by you and accepted in the course of this licensing transaction, (ii) these
terms and conditions and (iii) CCC’s Billing and Payment terms and conditions.

15. This Agreement shall be governed by and construed in accordance with the laws of England
and you agree to submit to the exclusive jurisdiction of the English courts.

16. Other Terms and Conditions:

BY CLICKING ON THE "I ACCEPT" BUTTON, YOU ACKNOWLEDGE THAT YOU HAVE READ AND
FULLY UNDERSTAND EACH OF THE SECTIONS OF AND PROVISIONS SET FORTH IN THIS
AGREEMENT AND THAT YOU ARE IN AGREEMENT WITH AND ARE WILLING TO ACCEPT ALL OF
YOUR OBLIGATIONS AS SET FORTH IN THIS AGREEMENT.

V1.2

Gratis licenses (referencing $0 in the Total field) are free. Please retain this printable
license for your reference. No payment is required.

If you would like to pay for this license now, please remit this license along with your
payment made payable to "COPYRIGHT CLEARANCE CENTER" otherwise you will be
invoiced within 48 hours of the license date. Payment should be in the form of a check or money order referencing your account number and this invoice number RLNK10863130. Once you receive your invoice for this order, you may pay your invoice by credit card. Please follow instructions provided at that time.

Make Payment To:
Copyright Clearance Center
Dept 001
P.O. Box 843006
Boston, MA 02284-3006

If you find copyrighted material related to this license will not be used and wish to cancel, please contact us referencing this license number 2524471185954 and noting the reason for cancellation.

Questions? customercare@copyright.com or +1-877-622-5543 (toll free in the US) or +1-978-646-2777.
Appendix 1c. License Agreement, Fisher & Happell (2009).

JOHN WILEY AND SONS LICENSE
TERMS AND CONDITIONS

Nov 28, 2010

This is a License Agreement between jacklin fisher ("You") and John Wiley and Sons ("John Wiley and Sons") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by John Wiley and Sons, and the payment terms and conditions.

All payments must be made in full to CCC. For payment instructions, please see information listed at the bottom of this form.

License Number 2524470247712
License date Oct 08, 2010
Licensed content publisher John Wiley and Sons
Licensed content publication International Journal of Mental Health Nursing
Licensed content title Implications of evidence-based practice for mental health nursing
Licensed content author Jacklin E. Fisher, Brenda Happell
Licensed content date Jun 1, 2009
Start page 179
End page 185
Type of use Dissertation/Thesis
Requestor type Author of this Wiley article
Format Print and electronic
Portion Full article
Will you be translating? No
Order reference number
Total 0.00 USD

TERMS AND CONDITIONS

This copyrighted material is owned by or exclusively licensed to John Wiley & Sons, Inc. or one of its group companies (each a "Wiley Company") or a society for whom a Wiley Company has exclusive publishing rights in relation to a particular journal (collectively "WILEY"). By clicking "accept" in connection with completing this licensing transaction, you agree that the following terms and conditions apply to this transaction (along with the billing and payment terms and conditions established by the Copyright Clearance Center Inc., ("CCC’s Billing and Payment terms and conditions"), at the time that you opened your Rightslink account (these are available at any
Terms and Conditions

1. The materials you have requested permission to reproduce (the "Materials") are protected by copyright.

2. You are hereby granted a personal, non-exclusive, non-sublicensable, non-transferable, worldwide, limited license to reproduce the Materials for the purpose specified in the licensing process. This license is for a one-time use only with a maximum distribution equal to the number that you identified in the licensing process. Any form of republication granted by this licence must be completed within two years of the date of the grant of this licence (although copies prepared before may be distributed thereafter). Any electronic posting of the Materials is limited to one year from the date permission is granted and is on the condition that a link is placed to the journal homepage on Wiley’s online journals publication platform at www.interscience.wiley.com. The Materials shall not be used in any other manner or for any other purpose. Permission is granted subject to an appropriate acknowledgement given to the author, title of the material/book/journal and the publisher and on the understanding that nowhere in the text is a previously published source acknowledged for all or part of this Material. Any third party material is expressly excluded from this permission.

3. With respect to the Materials, all rights are reserved. No part of the Materials may be copied, modified, adapted, translated, reproduced, transferred or distributed, in any form or by any means, and no derivative works may be made based on the Materials without the prior permission of the respective copyright owner. You may not alter, remove or suppress in any manner any copyright, trademark or other notices displayed by the Materials. You may not license, rent, sell, loan, lease, pledge, offer as security, transfer or assign the Materials, or any of the rights granted to you hereunder to any other person.

4. The Materials and all of the intellectual property rights therein shall at all times remain the exclusive property of John Wiley & Sons Inc or one of its related companies (WILEY) or their respective licensors, and your interest therein is only that of having possession of and the right to reproduce the Materials pursuant to Section 2 herein during the continuance of this Agreement. You agree that you own no right, title or interest in or to the Materials or any of the intellectual property rights therein. You shall have no rights hereunder other than the license as provided for above in Section 2. No right, license or interest to any trademark, trade name, service mark or other branding ("Marks") of WILEY or its licensors is granted hereunder, and you agree that you shall not assert any such right, license or interest with respect thereto.

5. WILEY DOES NOT MAKE ANY WARRANTY OR REPRESENTATION OF ANY KIND TO YOU OR ANY THIRD PARTY, EXPRESS, IMPLIED OR STATUTORY, WITH RESPECT TO THE MATERIALS OR THE ACCURACY OF ANY INFORMATION CONTAINED IN THE MATERIALS, INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTY OF MERCHANTABILITY, ACCURACY, SATISFACTORY QUALITY, FITNESS FOR A PARTICULAR PURPOSE, USABILITY, INTEGRATION OR NON-INFRINGEMENT AND ALL SUCH WARRANTIES ARE HEREBY EXCLUDED BY WILEY AND WAIVED BY YOU.

6. WILEY shall have the right to terminate this Agreement immediately upon breach of this Agreement by you.

7. You shall indemnify, defend and hold harmless WILEY, its directors, officers, agents and employees, from and against any actual or threatened claims, demands, causes of action or proceedings arising from any breach of this Agreement by you.

8. IN NO EVENT SHALL WILEY BE LIABLE TO YOU OR ANY OTHER PARTY OR ANY OTHER PERSON OR ENTITY FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY OR PUNITIVE DAMAGES, HOWEVER CAUSED, ARISING OUT OF OR IN CONNECTION WITH THE DOWNLOADING, PROVISIONING, VIEWING OR USE OF THE MATERIALS REGARDLESS OF THE
FORM OF ACTION, WHETHER FOR BREACH OF CONTRACT, BREACH OF WARRANTY, TORT, NEGLIGENCE, INFRINGEMENT OR OTHERWISE (INCLUDING, WITHOUT LIMITATION, DAMAGES BASED ON LOSS OF PROFITS, DATA, FILES, USE, BUSINESS OPPORTUNITY OR CLAIMS OF THIRD PARTIES), AND WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THIS LIMITATION SHALL APPLY NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY PROVIDED HEREIN.

9. Should any provision of this Agreement be held by a court of competent jurisdiction to be illegal, invalid, or unenforceable, that provision shall be deemed amended to achieve as nearly as possible the same economic effect as the original provision, and the legality, validity and enforceability of the remaining provisions of this Agreement shall not be affected or impaired thereby.

10. The failure of either party to enforce any term or condition of this Agreement shall not constitute a waiver of either party's right to enforce each and every term and condition of this Agreement. No breach under this agreement shall be deemed waived or excused by either party unless such waiver or consent is in writing signed by the party granting such waiver or consent. The waiver by or consent of a party to a breach of any provision of this Agreement shall not operate or be construed as a waiver of or consent to any other or subsequent breach by such other party.

11. This Agreement may not be assigned (including by operation of law or otherwise) by you without WILEY’s prior written consent.

12. These terms and conditions together with CCC’s Billing and Payment terms and conditions (which are incorporated herein) form the entire agreement between you and WILEY concerning this licensing transaction and (in the absence of fraud) supersedes all prior agreements and representations of the parties, oral or written. This Agreement may not be amended except in a writing signed by both parties. This Agreement shall be binding upon and inure to the benefit of the parties’ successors, legal representatives, and authorized assigns.

13. In the event of any conflict between your obligations established by these terms and conditions and those established by CCC’s Billing and Payment terms and conditions, these terms and conditions shall prevail.

14. WILEY expressly reserves all rights not specifically granted in the combination of (i) the license details provided by you and accepted in the course of this licensing transaction, (ii) these terms and conditions and (iii) CCC’s Billing and Payment terms and conditions.

15. This Agreement shall be governed by and construed in accordance with the laws of England and you agree to submit to the exclusive jurisdiction of the English courts.

16. Other Terms and Conditions:

BY CLICKING ON THE "I ACCEPT" BUTTON, YOU ACKNOWLEDGE THAT YOU HAVE READ AND FULLY UNDERSTAND EACH OF THE SECTIONS OF AND PROVISIONS SET FORTH IN THIS AGREEMENT AND THAT YOU ARE IN AGREEMENT WITH AND ARE WILLING TO ACCEPT ALL OF YOUR OBLIGATIONS AS SET FORTH IN THIS AGREEMENT.

V1.2

Gratis licenses (referencing $0 in the Total field) are free. Please retain this printable license for your reference. No payment is required.

If you would like to pay for this license now, please remit this license along with your payment made payable to "COPYRIGHT CLEARANCE CENTER" otherwise you will be invoiced within 48 hours of the license date. Payment should be in the form of a check.
or money order referencing your account number and this invoice number RLNK10863165.
Once you receive your invoice for this order, you may pay your invoice by credit card. Please follow instructions provided at that time.

Make Payment To:
Copyright Clearance Center
Dept 001
P.O. Box 843006
Boston, MA 02284-3006

If you find copyrighted material related to this license will not be used and wish to cancel, please contact us referencing this license number 2524470247712 and noting the reason for cancellation.

Questions? customercare@copyright.com or +1-877-622-5543 (toll free in the US) or +1-978-646-2777.
Appendix 1d. License Agreement, Fisher (2007).

JOHN WILEY AND SONS LICENSE
TERMS AND CONDITIONS

Nov 28, 2010

This is a License Agreement between jacklin fisher ("You") and John Wiley and Sons ("John Wiley and Sons") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by John Wiley and Sons, and the payment terms and conditions.

All payments must be made in full to CCC. For payment instructions, please see information listed at the bottom of this form.

<table>
<thead>
<tr>
<th>License Number</th>
<th>2524460111795</th>
</tr>
</thead>
<tbody>
<tr>
<td>License date</td>
<td>Oct 08, 2010</td>
</tr>
<tr>
<td>Licensed content publisher</td>
<td>John Wiley and Sons</td>
</tr>
<tr>
<td>Licensed content publication</td>
<td>International Journal of Mental Health Nursing</td>
</tr>
<tr>
<td>Licensed content title</td>
<td>Mental health nurses: De facto police</td>
</tr>
<tr>
<td>Licensed content author</td>
<td>Jacklin E. Fisher</td>
</tr>
<tr>
<td>Licensed content date</td>
<td>Aug 1, 2007</td>
</tr>
<tr>
<td>Start page</td>
<td>230</td>
</tr>
<tr>
<td>End page</td>
<td>235</td>
</tr>
<tr>
<td>Type of use</td>
<td>Dissertation/Thesis</td>
</tr>
<tr>
<td>Requestor type</td>
<td>Author of this Wiley article</td>
</tr>
<tr>
<td>Format</td>
<td>Print and electronic</td>
</tr>
<tr>
<td>Portion</td>
<td>Full article</td>
</tr>
<tr>
<td>Will you be translating?</td>
<td>No</td>
</tr>
<tr>
<td>Order reference number</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.00 USD</td>
</tr>
</tbody>
</table>

TERMS AND CONDITIONS

This copyrighted material is owned by or exclusively licensed to John Wiley & Sons, Inc. or one of its group companies (each a "Wiley Company") or a society for whom a Wiley Company has exclusive publishing rights in relation to a particular journal (collectively "WILEY"). By clicking "accept" in connection with completing this licensing transaction, you agree that the following terms and conditions apply to this transaction (along with the billing and payment terms and conditions established by the Copyright Clearance Center Inc., "CCC’s Billing and Payment terms and conditions"), at the time that you opened your Rightslink account (these are available at any
time at http://myaccount.copyright.com).

Terms and Conditions

1. The materials you have requested permission to reproduce (the "Materials") are protected by copyright.

2. You are hereby granted a personal, non-exclusive, non-sublicensable, non-transferable, worldwide, limited license to reproduce the Materials for the purpose specified in the licensing process. This license is for a one-time use only with a maximum distribution equal to the number that you identified in the licensing process. Any form of republication granted by this licence must be completed within two years of the date of the grant of this licence (although copies prepared before may be distributed thereafter). Any electronic posting of the Materials is limited to one year from the date permission is granted and is on the condition that a link is placed to the journal homepage on Wiley’s online journals publication platform at www.interscience.wiley.com. The Materials shall not be used in any other manner or for any other purpose. Permission is granted subject to an appropriate acknowledgement given to the author, title of the material/book/journal and the publisher and on the understanding that nowhere in the text is a previously published source acknowledged for all or part of this Material. Any third party material is expressly excluded from this permission.

3. With respect to the Materials, all rights are reserved. No part of the Materials may be copied, modified, adapted, translated, reproduced, transferred or distributed, in any form or by any means, and no derivative works may be made based on the Materials without the prior permission of the respective copyright owner. You may not alter, remove or suppress in any manner any copyright, trademark or other notices displayed by the Materials. You may not license, rent, sell, loan, lease, pledge, offer as security, transfer or assign the Materials, or any of the rights granted to you hereunder to any other person.

4. The Materials and all of the intellectual property rights therein shall at all times remain the exclusive property of John Wiley & Sons Inc or one of its related companies (WILEY) or their respective licensors, and your interest therein is only that of having possession of and the right to reproduce the Materials pursuant to Section 2 herein during the continuance of this Agreement. You agree that you own no right, title or interest in or to the Materials or any of the intellectual property rights therein. You shall have no rights hereunder other than the license as provided for above in Section 2. No right, license or interest to any trademark, trade name, service mark or other branding ("Marks") of WILEY or its licensors is granted hereunder, and you agree that you shall not assert any such right, license or interest with respect thereto.

5. WILEY DOES NOT MAKE ANY WARRANTY OR REPRESENTATION OF ANY KIND TO YOU OR ANY THIRD PARTY, EXPRESS, IMPLIED OR STATUTORY, WITH RESPECT TO THE MATERIALS OR THE ACCURACY OF ANY INFORMATION CONTAINED IN THE MATERIALS, INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTY OF MERCHANTABILITY, ACCURACY, SATISFACTORY QUALITY, FITNESS FOR A PARTICULAR PURPOSE, USABILITY, INTEGRATION OR NON-INFRINGEMENT AND ALL SUCH WARRANTIES ARE HEREBY EXCLUDED BY WILEY AND WAIVED BY YOU.

6. WILEY shall have the right to terminate this Agreement immediately upon breach of this Agreement by you.

7. You shall indemnify, defend and hold harmless WILEY, its directors, officers, agents and employees, from and against any actual or threatened claims, demands, causes of action or proceedings arising from any breach of this Agreement by you.

8. IN NO EVENT SHALL WILEY BE LIABLE TO YOU OR ANY OTHER PARTY OR ANY OTHER PERSON OR ENTITY FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY OR PUNITIVE DAMAGES, HOWEVER CAUSED, ARISING OUT OF OR IN CONNECTION WITH THE DOWNLOADING, PROVISIONING, VIEWING OR USE OF THE MATERIALS REGARDLESS OF THE
FORM OF ACTION, WHETHER FOR BREACH OF CONTRACT, BREACH OF WARRANTY, TORT, NEGLIGENCE, INFRINGEMENT OR OTHERWISE (INCLUDING, WITHOUT LIMITATION, DAMAGES BASED ON LOSS OF PROFITS, DATA, FILES, USE, BUSINESS OPPORTUNITY OR CLAIMS OF THIRD PARTIES), AND WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THIS LIMITATION SHALL APPLY NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY PROVIDED HEREIN.

9. Should any provision of this Agreement be held by a court of competent jurisdiction to be illegal, invalid, or unenforceable, that provision shall be deemed amended to achieve as nearly as possible the same economic effect as the original provision, and the legality, validity and enforceability of the remaining provisions of this Agreement shall not be affected or impaired thereby.

10. The failure of either party to enforce any term or condition of this Agreement shall not constitute a waiver of either party's right to enforce each and every term and condition of this Agreement. No breach under this agreement shall be deemed waived or excused by either party unless such waiver or consent is in writing signed by the party granting such waiver or consent. The waiver by or consent of a party to a breach of any provision of this Agreement shall not operate or be construed as a waiver of or consent to any other or subsequent breach by such other party.

11. This Agreement may not be assigned (including by operation of law or otherwise) by you without WILEY’s prior written consent.

12. These terms and conditions together with CCC’s Billing and Payment terms and conditions (which are incorporated herein) form the entire agreement between you and WILEY concerning this licensing transaction and (in the absence of fraud) supersedes all prior agreements and representations of the parties, oral or written. This Agreement may not be amended except in a writing signed by both parties. This Agreement shall be binding upon and inure to the benefit of the parties' successors, legal representatives, and authorized assigns.

13. In the event of any conflict between your obligations established by these terms and conditions and those established by CCC’s Billing and Payment terms and conditions, these terms and conditions shall prevail.

14. WILEY expressly reserves all rights not specifically granted in the combination of (i) the license details provided by you and accepted in the course of this licensing transaction, (ii) these terms and conditions and (iii) CCC’s Billing and Payment terms and conditions.

15. This Agreement shall be governed by and construed in accordance with the laws of England and you agree to submit to the exclusive jurisdiction of the English courts.

16. Other Terms and Conditions:

BY CLICKING ON THE "I ACCEPT" BUTTON, YOU ACKNOWLEDGE THAT YOU HAVE READ AND FULLY UNDERSTAND EACH OF THE SECTIONS OF AND PROVISIONS SET FORTH IN THIS AGREEMENT AND THAT YOU ARE IN AGREEMENT WITH AND ARE WILLING TO ACCEPT ALL OF YOUR OBLIGATIONS AS SET FORTH IN THIS AGREEMENT.

V1.2

Gratis licenses (referencing $0 in the Total field) are free. Please retain this printable license for your reference. No payment is required.

If you would like to pay for this license now, please remit this license along with your payment made payable to "COPYRIGHT CLEARANCE CENTER" otherwise you will be invoiced within 48 hours of the license date. Payment should be in the form of a check
or money order referencing your account number and this invoice number
RLNK10863161.
Once you receive your invoice for this order, you may pay your invoice by credit card. Please follow instructions provided at that time.

Make Payment To:
Copyright Clearance Center
Dept 001
P.O. Box 843006
Boston, MA 02284-3006

If you find copyrighted material related to this license will not be used and wish to cancel, please contact us referencing this license number 2524460111795 and noting the reason for cancellation.

Questions? customercare@copyright.com or +1-877-622-5543 (toll free in the US) or +1-978-646-2777.
Appendix 1e. License Agreement, Fisher & Horsfall (2007).

Nova Science Publishers

Dear Professor Fisher,

Please accept this correspondence as permission to reprint Ch 3 pg 63-77 "Fear and Learning " located in the below mentioned book published by Nova Science Publishers, Inc. There is no charge.

Title of book: Consciousness and Learning Research
Chapter author: Jacklin Fisher
Editor/Author: Susan K. Turrini


Please note: while Nova encourages wide dissemination of information we do not authorize supplying single copies on demand in the current, future or any digital format other than the terms listed herein.

I have attached the Nova Science Credit Line Information for your convenience and inclusion.

Sincerely,

Maya Columbus
Department of Acquisitions
Nova Science Publishers, Inc.
400 Oser Avenue, Suite 1600
Hauppauge, NY 11788
Tel: 631-231-7269
Fax: 631-231-8175
Web: www.novapublishers.com

CONFIDENTIALITY: This email and any attachments is for the sole use of the individuals or entities to which it is addressed. Individuals who have received this information in error or are not authorized to receive it must promptly return or dispose of the information and notify the sender. Further use, review, disclosure, printing, copying, distribution of, or reliance upon the contents of this email and attachments is strictly prohibited.
Appendix 2. Evidence articles by author are refereed.

Co-Authorship of Publication


I, Jacklin Elisabet Monica Fisher, contributed the following to the publication listed above.

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conception of the article</td>
<td>80%</td>
</tr>
<tr>
<td>Design of the article</td>
<td>80%</td>
</tr>
<tr>
<td>Collection of the data</td>
<td>not relevant</td>
</tr>
<tr>
<td>Analysis and interpretation</td>
<td>80%</td>
</tr>
<tr>
<td>Conclusions</td>
<td>80%</td>
</tr>
<tr>
<td>Writing up of the paper</td>
<td>80%</td>
</tr>
</tbody>
</table>

Signature of Candidate

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

Full Name of Co-Author

Signature of Co-Author
Appendix 3b. Co-Authorship Statement

Co-Authorship of Publication


I, Jacklin Elisabet Monica Fisher, contributed the following to the publication listed above.

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conception of the study</td>
<td>100%</td>
</tr>
<tr>
<td>Design of the study</td>
<td>100%</td>
</tr>
<tr>
<td>Collection of the data</td>
<td>100%</td>
</tr>
<tr>
<td>Analysis of the data</td>
<td>100%</td>
</tr>
<tr>
<td>Interpretation of the data</td>
<td>75%</td>
</tr>
<tr>
<td>Conclusions</td>
<td>75%</td>
</tr>
<tr>
<td>Writing up of the paper</td>
<td>50%</td>
</tr>
</tbody>
</table>

Signature of Candidate

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

Full Name of Co-Author: Jan Horsfall, Ph.D.

Signature of Co-Author
Appendix 3c. Co-Authorship Statement

Co-Authorship of Publication


I, Jacklin Elisabet Monica Fisher, contributed the following to the publication listed above.

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conception of the article</td>
<td>50%</td>
</tr>
<tr>
<td>Design of the article</td>
<td>25%</td>
</tr>
<tr>
<td>Collection of the data</td>
<td>not relevant</td>
</tr>
<tr>
<td>Analysis and interpretation</td>
<td>25%</td>
</tr>
<tr>
<td>Conclusions</td>
<td>50%</td>
</tr>
<tr>
<td>Writing up of the paper</td>
<td>50%</td>
</tr>
</tbody>
</table>

Signature of Candidate

I, as a Co-Author, endorse that this level of contribution by the candidate indicated above is appropriate.

Full Name of Co-Author

Signature of Co-Author
Appendix 4. SCU Research Ethics Committee Approval

HUMAN RESEARCH ETHICS COMMITTEE (HREC) NOTIFICATION

To: Dr Kierrynn Davis/Jacklin Fisher
    School of Health and Human Sciences/Nursing
    kierrynn.davis@scu.edu.au, jacklinfisher@optusnet.com.au

From: Secretary, Human Research Ethics Committee
      Division of Research, R. Block

Date: 5 March 2010

Project: A Study of the Therapeutic Role of the Mental Health Nurse

Approval Number

Previous ECN-07-164
NEW approval ECN-10-029

At the meeting of the HREC on the 1 March 2010, your change of protocol was noted by the HREC.

It is noted that a renewal is necessary for this research project. This renewal has also been approved.

The approval is subject to the mandatory standard conditions of approval. Please note these and inform the HREC when the project is completed or if there are any changes of protocol.

**Standard Conditions** in accordance with the National Statement on Ethical Conduct in Human Research (National Statement) (NS):

1. **Monitoring**
   
   **NS 5.5.1 – 5.5.10**
   
   Responsibility for ensuring that research is reliably monitored lies with the institution under which the research is conducted. Mechanisms for monitoring can include:
   
   (a) reports from researchers;
   
   (b) reports from independent agencies (such as a data and safety monitoring board);
   
   (c) review of adverse event reports;
   
   (d) random inspections of research sites, data, or consent documentation; and
   
   (e) interviews with research participants or other forms of feedback from them.

   The following should be noted:

   (a) All ethics approvals are valid for **12 months** unless specified otherwise. If research is continuing after 12 months, then the ethics approval MUST be renewed. Complete the Annual Report/Renewal form and send to the Secretary of the HREC.
(b) NS 5.5.5
Generally, the researcher/s provide a report every 12 months on the progress to date or outcome in the case of completed research specifically including:
• The maintenance and security of the records.
• Compliance with the approved proposal.
• Compliance with any conditions of approval.
• Any changes of protocol to the research.

Note: Compliance to the reporting is mandatory to the approval of this research.

(c) Specifically, that the researchers report immediately and notify the HREC, in writing, for approval of any change in protocol. NS 5.5.3.

(d) That a report is sent to HREC when the project has been completed.

(e) That the researchers report immediately any circumstance that might affect ethical acceptance of the research protocol. NS 5.5.3.

(f) That the researchers report immediately any serious adverse events/effects on participants. NS 5.5.3.

2. Research conducted overseas
NS 4.8.1 – 4.8.21
That, if research is conducted in a country other than Australia, all research protocols for that country are followed ethically and with appropriate cultural sensitivity.

3. Complaints
NS 5.6.1 – 5.6.7
Institutions may receive complaints about researchers or the conduct of research, or about the conduct of a Human Research Ethics Committee (HREC) or other review body.

Complaints may be made by participants, researchers, staff of institutions, or others. All complaints should be handled promptly and sensitively.

Complaints about the ethical conduct of this research should be addressed in writing to the following:

Ethics Complaints Officer
HREC
Southern Cross University
PO Box 157
Lismore, NSW, 2480
Email: ethics.lismore@scu.edu.au

All complaints are investigated fully and according to due process under the National Statement on Ethical Conduct in Human Research and this University. Any complaint you make will be treated in confidence and you will be informed of the outcome.
All participants in research conducted by Southern Cross University should be advised of the above procedure and be given a copy of the contact details for the Complaints Officer. They should also be aware of the ethics approval number issued by the Human Research Ethics Committee.

Sue Kelly
Ethics Administration
Ph: +61 2 6626 9139
ethics.lismore@scu.edu.au

Professor Bill Boyd
Chair, HREC
Ph: (02) 6620 3569
william.boyd@scu.edu.au
Appendix 5.

The Kessler–10 Plus (K-10+)

The Kessler 10 Plus (k-10+) is a short self report questionnaire aimed at assessing how you are feeling and how you rate your own mental health. Completion of the form will assist you and the researcher ensure your participation in the study fulfills ethical requirements regarding your informed consent to the study.

Your completion of the K-10+ is voluntary and will remain confidential. It is appreciated if you can complete the K-10+ and discuss the results with the researcher prior to participation in the study. It should take about 10 minutes of your time.

Instructions

The following ten questions ask about how you have been feeling in the past three days. For each question, mark the circle under the option that best describes the amount of time you felt that way.

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the last three days, about how often did you feel tired out for no good reason?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. In the last three days, about how often did you feel nervous?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. In the last three days, about how often did you feel so nervous that nothing could calm you down?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. In the last three days, about how often did you feel hopeless?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. In the last three days, about how often did you feel restless or fidgety?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. In the last three days, about how often did you feel so restless you could not sit still?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. In the last three days, about how often did you feel depressed?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. In the last three days, about how often did you feel that everything was an effort?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
In the last three days, about how often did you feel so sad that nothing could cheer you up?

In the last three days, about how often did you feel worthless?

Thank you for completing this questionnaire.
Please return it to the researcher who asked you to complete it.

Interpretation of Kessler 10 Core item Scores

Please add up the scores of the 10 core items on the 5 point rating scale

1 = None of the time > 5 = All of the time

<table>
<thead>
<tr>
<th>10-19</th>
<th>The consumer may currently not be experiencing significant feelings of distress.</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>The consumer may be experiencing mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.</td>
</tr>
<tr>
<td>25-29</td>
<td>The consumer may be experiencing moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder.</td>
</tr>
<tr>
<td>30-50</td>
<td>The consumer may be experiencing severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.</td>
</tr>
</tbody>
</table>
Appendix 6a. Consumer group information and consent form.

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
CONSUMER GROUP

A Study of the Therapeutic Role of the Mental Health Nurse in NSW

This information is for you to keep and is provided to you after you responded to an advertisement for the study *The Therapeutic Role of the Mental Health Nurse*. The information below refers to phase 1 of the study, interviews with five to ten consumers and five to ten mental health nurses.

Our names are Dr Kierrynn Davis and Jackie Fisher and we invite you to participate in a research project to identify therapeutic roles and modalities aimed to improve mental health nursing practice. Our interests in this area are as both academics and nurses. Kierrynn from the Department of Nursing and Health Care Practices at Southern Cross University will supervise the study and Jackie who is a mental health nurse and PhD student at Southern Cross University will be conducting the research. You have been selected as a possible participant in this study because you are considered to be an important stakeholder in this area as either a consumer of mental health services or as an experienced mental health nurse clinician.

What does the research involve?

If you decide to participate you will be interviewed by telephone or in person. The interview should take no longer than one hour. You will be asked about your opinion on the therapeutic role of the mental health nurse with particular regard to psychological therapies such as cognitive behaviour therapy (CBT). Psychological therapies employ verbal and nonverbal communication rather than drugs or other physical means in the treatment of mental illness. The questions will include your opinion of therapies used by mental health nurses, the types and the extent to which mental health nurses use psychological therapies, what you think are the benefit or otherwise of psychological therapies, your experiences of these and what you think are the constraints (if any) on nurses in employing psychological therapies. The interviews will be recorded and the information derived will be organized into themes and key points by the research team.
Information derived from the nurse interviews and the consumer interviews will remain separated from each other and will not be linked at any stage.

A modified Delphi technique will be used to achieve consensus between the individuals within each of the separated groups. This technique will involve either a mail out or email to participants of a checklist of key points derived from the interviews for you to prioritise and provide feedback. This feedback will then be further reviewed and sorted by the research team and may again be sent to you for further prioritizing and comment. If necessary this process may be repeated a third time in order to achieve consensus. Your time commitment for this stage of the project should be minimal, we anticipate approximately 10-15 minutes to comment on each feedback checklist. The information gathered from this process will contribute to the development of a questionnaire survey of a large sample of practicing mental health nurses as phase 2 of the project.

The findings from the project (phases 1 & 2) will have the potential to improve the quality of mental health care for people with serious and ongoing mental illness through better understanding of the use of psychological therapies by mental health nurses.

Confidentiality

At all times participants will remain anonymous and any information obtained in connection with this study and which may be identifiable to you will be removed. It is intended that reports on the study will be published in professional journals and presented at professional conferences.

Further information

It is expected there will be no financial costs or other detriment in participating in the study. You can withdraw your participation in the study at any time. Your decision to participate or withdraw your participation will not prejudice any future relations with any of the individuals or supporting organizations connected to this study.

Whilst it is not anticipated that there will be any negative consequences arising from the interviews, I will provide you with the contact details for a counselor familiar with the study who will be available for consultation should you request this service.

Because of the fluctuating nature of some chronic mental illnesses, your ongoing capacity to consent and participate will be determined confidentially and collaboratively between you and the researcher. To assist this process the research team would like you to complete a 10 item self report questionnaire (Kessler – 10) designed to ascertain levels of psychological distress as part of the consent process.

The research is being conducted under the supervision of Dr Kierrynn Davis and Dr Stephen Kermode who are members of the Department of Nursing & Health Care Practices, Southern Cross University. If there are any issues you wish to raise in relation
to your participation in the research please contact Dr Kierrynn Davis, email: kierrynn.davis@scu.edu.au and telephone: 02 66203 673

Name of Student: Jackie Fisher PhD Candidate
Department of Nursing & Health Care Practices,
Southern Cross University.
ph: 0432260168
email: Jackie.Fisher@acu.edu.au
The ethical aspects of this study have been approved by the Southern Cross University
Human Research Ethics Committee (HREC). The Approval Number is (Insert when approved)

If you have any complaints or concerns about the ethical aspects of your participation in
the research at any time during the project please contact:
Sue Kelly
HREC Complaints Officer
SCU Human Research Ethics Committee
Southern Cross University
PO Box 157 Lismore NSW 2480
ph. 02 6626 9139
Fax 02 6626 9145,
email: sue.kelly@scu.edu.a

I hope that you will support this important research project by participating in the study.
Informed consent to participate in a research Project Consumer Group

Title: A Study of the Therapeutic Role of the Mental Health Nurse in NSW

Researcher Jackie Fisher
PhD Student, Department of Nursing & Health Care Practices,
Southern Cross University.
ph: 0432 260 168;
email: Jackie.Fisher@acu.edu.au

☐ I agree to participate in the above research project. I have read and understand the
details contained in the Information Sheet. I have had the opportunity to ask questions
about the study and I am satisfied with the answers received.

☐ I agree to my interview being recorded on audiotape.

OR

☐ I do not agree to my interview being audiotaped and prefer the researcher to take
hand written notes.

☐ I understand that I am free to discontinue participation at any time and I have been
informed that prior to data analysis, any data that has been gathered before withdrawal of
this consent will be destroyed.

☐ I understand that neither my name nor any identifying information will be disclosed
or published, except with my permission.

☐ I understand that the Southern Cross University’s Ethics Committee has approved
this project.

☐ I am aware that I can contact the researcher at any time after the interview. If I have
any further questions about this study I am free to contact (Research Supervisor) on:
email: kierrynn.davis@scu.edu.au, telephone 02 66203 673

☐ The ethical aspects of this study have been approved by the Southern Cross
University Human Research Ethics Committee (HREC). The Approval Number is (Insert
when approved)

If you have any complaints or reservations about any ethical aspect of your participation
in this research, you may contact the HREC through the Ethics Complaints Officer, Ms Sue Kelly, (telephone [02] 6626 9139, fax [02] 6626 9145, email: sue.kelly@scu.edu.au)

Any complaint you make will be treated in confidence.

☐ I understand that I will be given a copy of this form to keep.

*I have read the information above and agree to participate in this study. I am over the age of 18 years.*

_________________________________  _______________________________
Signature of Participant               Signature of Witness

_________________________________  _______________________________
Printed Name                        Printed Name

_________________________________  _______________________________
Date                                         Date

*I certify that the terms of the form have been verbally explained to the participant, that the participant appears to understand the terms prior to signing the consent form and that the Kessler – 10 self report questionnaire indicates the participant is not currently experiencing psychological distress. I have discussed with the participant if she/he felt any distress that they may withdraw consent and if requested a counselor familiar with the project is available for appointment.*

_________________________________
Signature of Investigator

_________________________________  _______________________________
Printed Name                        Date

**Revocation of Consent**

I hereby indicate my desire to withdraw my consent to participate in the aforementioned study. I understand that withdrawing my consent in no way jeopardizes my relationship with any of the organising bodies or individuals.

_________________________________
Signature

_________________________________  _______________________________
Printed Name                        Date
PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
MENTAL HEALTH NURSE GROUP

A Study of the Therapeutic Role of the Mental Health Nurse in NSW

This information is for you to keep and is provided to you after you responded to an advertisement for the study *The Therapeutic Role of the Mental Health Nurse*. The information below refers to phase 1 of the study, interviews with five to ten consumers and five to ten mental health nurses.

Our names are Dr Kierrynn Davis and Jackie Fisher and we invite you to participate in a research project to identify therapeutic roles and modalities aimed to improve mental health nursing practice. Our interests in this area are as both academics and nurses. Kierrynn from the Department of Nursing and Health Care Practices at Southern Cross University will supervise the study and Jackie who is a mental health nurse and PhD student at Southern Cross University will be conducting the research. You have been selected as a possible participant in this study because you are considered to be an important stakeholder in this area as either a consumer of mental health services or as an experienced mental health nurse clinician.

What does the research involve?

If you decide to participate you will be interviewed by telephone or in person. The interview should take no longer than one hour. You will be asked about your opinion on the therapeutic role of the mental health nurse with particular regard to psychological therapies such as cognitive behaviour therapy (CBT). Psychological therapies employ verbal and nonverbal communication rather than drugs or other physical means in the treatment of mental illness. The questions will include your opinion of therapies used by mental health nurses, the types and extent to which mental health nurses use psychological therapies, what you think are the benefit or otherwise of psychological therapies, your experiences of these and what you think are the constraints (if any) on nurses in employing psychological therapies. The interviews will be recorded and the information derived will be organized into themes and key points by the research team. Information derived from the nurse interviews and the consumer interviews will remain separated from each other and will not be linked at any stage.
A modified Delphi technique will be used to achieve consensus between the individuals within each of the separated groups. This technique will involve either a mail out or email to participants of a checklist of key points derived from the interviews for you to prioritise and provide feedback. This feedback will then be further reviewed and sorted by the research team and may again be sent to you for further prioritizing and comment. If necessary this process may be repeated a third time in order to achieve consensus. Your time commitment for this stage of the project should be minimal, we anticipate approximately 10-15 minutes to comment on each feedback checklist. The information gathered from this process will contribute to the development of a questionnaire survey of a large sample of practicing mental health nurses as phase 2 of the project.

The findings from the project (phases 1 & 2) will have the potential to improve the quality of mental health care for people with serious and ongoing mental illness through better understanding of the use of psychological therapies by mental health nurses.

Confidentiality

At all times participants will remain anonymous and any information obtained in connection with this study and which may be identifiable to you will be removed. It is intended that reports on the study will be published in professional journals and presented at professional conferences.

Further information

It is expected there will be no financial costs or other detriment in participating in the study. You can withdraw your participation in the study at any time. Your decision to participate or withdraw your participation will not prejudice any future relations with any of the individuals or supporting organizations connected to this study.

Whilst it is not anticipated that there will be any negative consequences arising from the interviews, I will provide you with the contact details for a counselor familiar with the study who will be available for consultation should you request this service.

The research is being conducted under the supervision of Dr Kierrynn Davis and Dr Stephen Kermode who are members of the Department of Nursing & Health Care Practices, Southern Cross University. If there are any issues you wish to raise in relation to your participation in the research please contact Dr Kierrynn Davis, email: kierrynn.davis@scu.edu.au and telephone: 02 66203 673

Name of Student: Jackie Fisher, PhD Candidate
Department of Nursing & Health Care Practices,
Southern Cross University.
ph: 0432260168;
email: Jackie.Fisher@acu.edu.au
The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee (HREC). The Approval Number is (Insert when approved)

If you have any complaints or concerns concerning the ethical aspects of your participation in the research at any time during the project please contact:
Sue Kelly
HREC Complaints officer
SCU Human Research Ethics Committee
Southern Cross University
PO Box 157 Lismore NSW 2480
ph. 02 6626 9139
Fax 02 6626 9145,
email: sue.kelly@scu.edu.a

I hope that you will support this important research project by participating in the study.
Informed consent to participate in a research Project Mental Health Nurse Group

Title: A Study of the Therapeutic Role of the Mental Health Nurse in NSW

Researcher Jackie Fisher  
PhD Student, Department of Nursing & Health Care Practices,  
Southern Cross University.  
ph: 0432260168;  
email: Jackie.Fisher@acu.edu.au

☐ I agree to participate in the above research project. I have read and understand the details contained in the Information Sheet. I have had the opportunity to ask questions about the study and I am satisfied with the answers received.

☐ I agree to my interview being recorded on audiotape.  
OR

☐ I do not agree to my interview being audio taped and prefer the researcher to take hand written notes.

☐ I understand that I am free to discontinue participation at any time and I have been informed that prior to data analysis, any data that has been gathered before withdrawal of this consent will be destroyed.

☐ I understand that neither my name nor any identifying information will be disclosed or published, except with my permission.

☐ I understand that the Southern Cross University’s Ethics Committee has approved this project.

☐ I am aware that I can contact the researcher at any time after the interview. If I have any further questions about this study I am free to contact (Research Supervisor) on:  
email: kierrynn.davis@scu.edu.au, telephone 02 66203 673

☐ The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee (HREC). The Approval Number is (Insert when approved)

If you have any complaints or reservations about any ethical aspect of your participation
in this research, you may contact the HREC through the Ethics Complaints Officer, Ms Sue Kelly, (telephone [02] 6626 9139, fax [02] 6626 9145, email: sue.kelly@scu.edu.au

Any complaint you make will be treated in confidence.

☐ I understand that I will be given a copy of this form to keep.

I have read the information above and agree to participate in this study. I am over the age of 18 years.

_________________________________
Signature of Participant

_________________________________
Printed Name

_________________________________
Date

_________________________________
Signature of Witness

_________________________________
Printed Name

_________________________________
Date
__Signature of Investigator__

__Printed Name__

__Date__

**Revocation of Consent**

I hereby indicate my desire to withdraw my consent to participate in the aforementioned study. I understand that withdrawing my consent in no way jeopardizes my relationship with any of the organising bodies or individuals.

__Signature__

__Printed Name__

__Date__
Appendix 7. Invitation to participate in the research

THE THERAPEUTIC ROLE OF THE MENTAL HEALTH NURSE

WHAT:
You are invited to participate in a research project to examine how to improve the therapeutic role of the mental health nurse through the use of psychological therapies.

HOW:
1. Review the literature on the usefulness of psychological therapies in mental health nursing.
2. Ask both nurse and consumer stakeholders about how to improve the therapeutic role of the mental health nurse. This will include questions about the usefulness of psychological therapies in mental health nursing.
3. Survey mental health nurses about their skills, knowledge, attitude to and usage of psychological therapies.
4. Make recommendations to improve the therapeutic role of the mental health nurse.

WHY:
Reports over the last decade have questioned the effectiveness of mental health services in Australia. Evidence suggests that mental health nurses because of their knowledge, accessibility and affordability are critical to improving mental health care services. Psychological therapies have been proven to be clinically effective in mental health practice.

WHEN:
We expect the results of this research to be available in 2009 and 2010.

WHO:
The research will be lead by Dr Kierrynn Davis, Southern Cross University and conducted by Ms Jackie Fisher PhD candidate and mental health nurse.

HOW CAN I GET INVOLVED?
It is easy!

If you are a mental health nurse or a consumer of mental health services in NSW (not currently an inpatient) please contact Jackie Fisher on the email address below, or by telephone on 02 97392035 or 0432 260 168.

Contact: Jackie.Fisher@acu.edu.au for more details of the project.
Appendix 8a. Consumer group Delphi round 2 survey.

Dear Participant,

We would like to take this opportunity to thank you for contributing to the above research project and apologise for the delay in the completion of the data analysis of the interviews.

The purpose of this letter is to report back the key findings of the data analyses of the interviews with you and the other 7 expert mental health nurses, and seek your opinion on their importance to the therapeutic role of the mental health nurse.

We would like you to prioritise each key point as either of high, medium or low importance and list any new ideas you have at the end of the questionnaire. This should take between 15 and 20 minutes to do depending on your comments.

Please return this letter by email attachment to Jacklinfisher@optusnet.com.au or to:

Ms. Jackie Fisher, School of Nursing, Australian Catholic University, PO Box 968. North Sydney, NSW 2059.

As always your ideas and comments will remain anonymous.

Section 1 - Most helpful knowledge, skills and attitudes.

Key point #1. Assisting with activities of daily living
Examples of words taken from interviews to describe key point #1 – day to day practical assistance such as getting to the shop; not just managing the illness; social rehabilitation.

Please underline one: - high medium low importance

Comments (if any)

Key point #2. Assessment skills
Examples of words taken from interviews to describe key point #2 – Mental status assessment; assessing for physical illness; ongoing assessment of people.

Please underline one: - high medium low importance
Comments (if any)

Key point #3. Being there for the client
Examples of words taken from interviews to describe key point #3 – the client knowing you are there if they need you; doing home visits; maintaining regular contact; reliability; sitting with the patient/client—just being with them is therapeutic.

Please underline one: - high medium low importance
Comments (if any)

Key point #4. Communication skills
Examples of words taken from interviews to describe key point #4 – clarifying; having a conversation; showing empathy; exploring alternatives; grounding; listening; empowering the client/patient; developing rapport.

Please underline one: - high medium low importance
Comments (if any)

Key point #5. Ensuring continuity of care
Examples of words taken from interviews to describe key point #5 – Care coordinator; ensure multidisciplinary approach to care; liaise with GP’s, psychologist.

Please underline one: - high medium low importance
Comments (if any)

Key point #6. Crisis care
Examples of words taken from interviews to describe key point #6 – crisis intervention; crisis counselling

Please underline one: - high medium low importance
Comments (if any)
Key point #7  Custodial aspects
Examples of words taken from interviews to describe key point #7 – Controlling the client; enforcing community treatment orders (CTO); enforcers of the law; providing surveillance; organising tribunals.

Please underline one: - high medium low importance
Comments (if any)

Key point #8  Health promotion
Examples of words taken from interviews to describe key point #8 – health promotion.

Please underline one: - high medium low importance
Comments (if any)

Key point #9  Maintain safety
Examples of words taken from interviews to describe key point #9 – Minimising aggression; risk assessment.

Please underline one: - high medium low importance
Comments (if any)

Key point #10  Medication
Examples of words taken from interviews to describe key point #10 – administering p.r.n. medications; prescribing medications; monitoring side effects.

Please underline one: - high medium low importance
Comments (if any)

Key point #11  Nurse attributes
Examples of words taken from interviews to describe key point #11 – Confidence with multidisciplinary team; creative; good self esteem; attitude of genuine regard for patient; self motivated; passionate; optimistic; politically active.

Please underline one: - high medium low importance
Comments (if any)
Key point #12  Provide information
Examples of words taken from interviews to describe key point #12 – provide information.
Please underline one: - high     medium     low     importance
Comments (if any)

Key point #13  Therapeutic relationship
Examples of words taken from interviews to describe key point #13 – collaborative; hopeful; normalisation (letting them know this is very human for this to happen); patient focussed; problem solving; strength based; wholistic.
Please underline one: - high     medium     low     importance
Comments (if any)

Key point #14  Knowledge of the system in which they work
Examples of words taken from interviews to describe key point #14 - understand the systems in which they work; understanding the policies and procedures; politically active regarding these systems.
Please underline one: - high     medium     low     importance
Comments (if any)

Key point #15  Reframe experiences
Examples of words taken from interviews to describe key point #15 - establishing an understanding for what brings them into hospital.
Please underline one: - high     medium     low     importance
Comments (if any)
Section 2 – Current problems preventing nurses fulfilling their therapeutic role

(please rate each item within each group either high, medium or low importance in preventing nurses fulfilling their therapeutic role, and add any comments if desired)

Bio-medicalisation (please rate these 2 items)

1. Mental health care based on bio-medical treatment only.
   high medium low importance (in preventing nurses fulfilling their therapeutic role).

2. Too much focus on medical diagnosis.
   high medium low importance

Nurses role getting narrower (please rate these 3 items)

1. Nurses do not do counselling - Descriptor – nurses told (by NUMs and others) they are not therapists because they don't have a counselling degree; common for nurses to tell clients that we don't do any counselling.
   high medium low importance (in preventing nurses fulfilling their therapeutic role).

2. No talk with patients - Descriptor - just doing observation, they don't even talk with the patient any more.
   high medium low importance

3. Outsourcing of therapeutic role - Descriptor - we do a lot of referring people through the Better Outcomes Mental Health Programme.
   high medium low importance

Morale (please rate these 4 items)

1. No job satisfaction – Descriptor - there is a lack of confidence in our work; people (nurses) are really offended. I'm really offended.
2. Hostility from peers - Descriptor - lateral violence between the nurses and the other mental health care staff (social workers, psychologists etc.). Negative attitudes towards mental health patients (and staff) from other staff in general hospital settings.

3. Poor leadership - Descriptor – Nursing leaders lacking vision and commitment.

4. Nurses lacking confidence.

---

**Workforce issues (please rate these 3 items)**

1. Nurses lacking experience, knowledge and skills – Descriptors - usually only one nurse with mental health qualifications per shift; it just doesn’t work very well when you don’t have experienced staff.


Structural issues *(please rate these 4 items)*

1. Centralisation and mainstreaming of services - Descriptor – ideological changes moving away from the community; becoming part of a general hospital.

   *high*     *medium*     *low*     *importance*
   *(in preventing nurses fulfilling their therapeutic role).*

2. Poor funding/resources - Descriptor - it's a system under stress really, lack of funding, lack of nurses, too many patients.

   *high*     *medium*     *low*     *importance*

3. Short hospital stay - Descriptor – most patients have very short stays which makes it very difficult for nurses to engage on anything other than a custodial level.

   *high*     *medium*     *low*     *importance*

4. Too much documentation - Descriptor – too busy filling out forms at the expense of patient care.

   *high*     *medium*     *low*     *importance*
**Section 3 – Helpful therapies;**

*(please rate each item high, medium or low helpfulness to the therapeutic role of mental health nurses and add any comments if desired).*

Catharsis (allowing an opportunity for release of emotional tension)  
*high*  medium  low  helpfulness

Cognitive Behaviour Therapy (CBT)  
*high*  medium  low  helpfulness

Counselling  
*high*  medium  low  helpfulness

Dialectical Behaviour Therapy (DBT)  
*high*  medium  low  helpfulness

Group work  
*high*  medium  low  helpfulness

Psychodynamic therapy  
*high*  medium  low  helpfulness

Recovery model  
*high*  medium  low  helpfulness

Solution focussed therapy  
*high*  medium  low  helpfulness
Section 4 - My new ideas on the therapeutic role of the mental health nurse;
Please use back of page if you need more room to write.
Idea #1.

Idea #2.

Thank you for your help.
Please return this letter by email to Jacklinfisher@optusnet.com.au
or in the self addressed envelope provided.
Appendix 8b. Consumer group Delphi round 3 survey.

The therapeutic role of the mental health nurse

Second questionnaire

Dear Participant,

Many thanks for your feedback from the first questionnaire. From your responses I have been able to refine what you as mental health nurse experts believe to be most important regarding the therapeutic role of the mental health nurse.

The purpose of this letter is to ask you to further prioritise these most important key points. Because the list is now much shorter it should only take between 10 and 15 minutes to do depending on your comments. Please feel free to complete this survey even if you were unable to complete the first survey.

As with the previous survey, please list any new ideas you have at the end of the questionnaire and return this letter by email to Jacklin Fisher at my email address jacklinfisher@optusnet.com.au or by postal mail to Ms. Jackie Fisher, School of Nursing, Australian Catholic University, PO Box 968. North Sydney, NSW 2059.

As always your ideas will remain anonymous.

Section 1 – knowledge, skills and attitudes that are most helpful

Group 1 - The four factors below were identified as the most helpful in the first survey. (Please priority rank the 4 factors in this group in terms of their therapeutic importance)

Assessment skills

First or second or third or fourth priority

Examples of words taken from interviews to describe this factor:
Mental status assessment; assessing for physical illness; ongoing assessment of people.

Being there for the client

First or second or third or fourth priority

Examples of words taken from interviews to describe this factor:
The client knowing you are there if they need you; doing home visits; maintaining regular contact; reliability; sitting with the patient/client- just being with them is therapeutic.

**Communication skills**  
*First or second or third or fourth priority*
Examples of words taken from interviews to describe this factor:
Clarifying; having a conversation; showing empathy; exploring alternatives; grounding; listening; empowering the client/patient; developing rapport.

**Therapeutic relationship**  
*First or second or third or fourth priority*
Examples of words taken from interviews to describe this factor:
Collaborative; hopeful; normalisation (letting them know this is very human for this to happen); patient focussed; problem solving; strength based; holistic.

*Your Comments (if any)*...

**Group 2**
The four factors below were identified as moderately helpful in the first survey.
*(Please priority rank the 4 factors in this group in terms of their importance to enhancing the therapeutic role)*

**Maintain safety**  
*First or second or third or fourth priority*
Examples of words taken from interviews to describe this factor:
Minimising aggression; risk assessment.

**Medication**  
*First or second or third or fourth priority*
Examples of words taken from interviews to describe this factor:
Administering p.r.n. medications; prescribing medications; monitoring side effects.

**Nurse attributes**  
*First or second or third or fourth priority*
Examples of words taken from interviews to describe this factor:
Confidence with multidisciplinary team; creative; good self esteem; attitude of genuine regard for patient; self motivated; passionate; optimistic; politically active.

**Provide information**  
*First or second or third or fourth priority*
Examples of words taken from interviews to describe this factor:
Provide information to the client.

*Your Comments (if any)*...

**Group 3**
New ideas from first survey. Please rate as high, medium or low importance.

1) Assist consumer in self management
   high  medium  low  importance

2) Advocate to get consumer ‘off’ involuntary treatment
   High  medium  or  low  importance
Section 2 – Factors that limit therapeutic capability

The five factors below were identified as the most important problems in the first survey. 
(Please priority rank these 5 factors in terms of their importance in limiting the therapeutic capability of the mental health nurse)

**Bio-medicalisation.**  
First or second or third or fourth or fifth priority  
Examples of words taken from interviews to describe this factor: 
Mental health care based on bio-medical treatment only; Too much focus on medical diagnosis.

**Nurses role getting narrower**  
First or second or third or fourth or fifth priority  
Examples of words taken from interviews to describe this factor: 
Nurses told (by NUMs and others) they are not therapists because they don't have a counseling degree; common for nurses to tell clients that we don't do any counseling; just doing observation, they don't even talk with the patient any more.

**Morale**  
First or second or third or fourth or fifth priority  
Examples of words taken from interviews to describe this factor: 
There is a lack of confidence in our work; people (nurses) are really offended. I'm really offended; nursing leaders lacking vision and commitment.

**Workforce issues**  
First or second or third or fourth or fifth priority  
Examples of words taken from interviews to describe this factor: 
Ageing workforce; high patient staff ratios.

**Structural issues**  
First or second or third or fourth or fifth priority  
Examples of words taken from interviews to describe this factor: 
Ideological changes moving away from the community; becoming part of a general hospital; it's a system under stress really, lack of funding, lack of nurses, too many patients; too busy filling out forms at the expense of patient care.

*Your Comments (if any)*...
Section 3 – Helpfulness of therapies to therapeutic practice

**Group 1** – the four therapies below were identified as most helpful in the first survey.
*(Please priority rank this group in terms of their therapeutic importance)*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Group work</td>
</tr>
<tr>
<td>2nd</td>
<td>Recovery model</td>
</tr>
<tr>
<td>3rd</td>
<td>Solution focussed therapy</td>
</tr>
<tr>
<td>4th</td>
<td>Tidal Model</td>
</tr>
</tbody>
</table>

**Group 2** – the four therapies below were identified as moderately helpful in the first survey.
*(Please priority rank this group in terms of their therapeutic importance)*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Cognitive Behaviour Therapy (CBT)</td>
</tr>
<tr>
<td>2nd</td>
<td>Counselling</td>
</tr>
<tr>
<td>3rd</td>
<td>Dialectical Behaviour Therapy (DBT)</td>
</tr>
<tr>
<td>4th</td>
<td>Catharsis</td>
</tr>
</tbody>
</table>

*Comments:*

Section 4 - My new ideas on the therapeutic role of the mental health nurse

Idea #1.

Idea #2.

Thank you for your help.

Please return this letter by email to Jacklinfisher@optusnet.com.au or post to Ms. Jackie Fisher, School of Nursing, Australian Catholic University, PO Box 968. North Sydney, NSW 2059.
Appendix 8c. MHN group Delphi round 2 survey.

The therapeutic role of the mental health nurse

Dear Participant,

We would like to take this opportunity to thank you for contributing to the above research project. The purpose of this letter is to report back the ideas obtained from the interviews and seek your opinion on their importance to the therapeutic role of the mental health nurse.

We would like you to prioritise each key point as either of high, medium or low importance and list any new ideas you have at the end of the questionnaire. This should take between 15 and 20 minutes to do depending on your comments.

Please return this letter in the self addressed envelope to;

Ms. Jackie Fisher, School of Nursing, Australian Catholic University, PO Box 968. North Sydney, NSW 2059.

As always your ideas will remain anonymous.

Section 1 - Most helpful knowledge, skills and attitudes.

Key point #1. Nurses attitude
Examples of words taken from interviews to describe key point #1 - Calm, caring, concern, firm, friendly, gentle, kind, awareness of power issues, respectful, shows interest, can be trusted...

Please circle one: high medium low importance

Comments (if any)

Key point #2. Communication skills
Examples of words taken from interviews to describe key point #2 – Has empathy, interpersonal skills, listening skills, non verbal communication skills, talking with me...
Please circle one: -  high  medium  low  importance
Comments (if any)

Key point #3. Knowledge of and responding promptly to medication issues including problems with side effects
Please circle one: -  high  medium  low  importance
Comments (if any)

Key point #4. Knowledgeable
Examples of words taken from interviews to describe key point #4 – Giving information, symptom clarification and explanation, taking time to explain...
Please circle one: -  high  medium  low  importance
Comments (if any)

Key point #5. Supporting me and my family
Examples of words taken from interviews to describe key point #5 – Family support important, support from friends important, feeling supported by nurses...
Please circle one: -  high  medium  low  importance
Comments (if any)

Key point #6. Taking time with me
Examples of words taken from interviews to describe key point #6 – Giving me time, spend time with patients, not rushing....
Please circle one: -  high  medium  low  importance
Comments (if any)
Key point #7  Encouraging
Examples of words taken from interviews to describe key point #7 – Encouraging me, keep me going, motivating me...

Please circle one: -  high  medium  low  importance

Comments (if any)

Key point #8  Availability
Examples of words taken from interviews to describe key point #8 – Someone being available 24 hours, being available when you need them, having the same nurse, checking I’m OK ...

Please circle one: -  high  medium  low  importance

Comments (if any)

Key point #9  Safety
Examples of words taken from interviews to describe key point #9 –
Ensure the safety of patients/consumers, recognising and addressing fear in patients/consumers, recognising and addressing fear of incarceration, gender issues relating to safety/harassment of female patients/consumers...

Please circle one: -  high  medium  low  importance

Comments (if any)

Key point #10  Teamwork between nurses and other health workers
Examples of words taken from interviews to describe key point #10 – Crisis team is important, expanding the nurses role, providing referrals to other health professionals, medicare funded ‘focuses psychological strategies’ (shared care)...
Key point #11  Empowerment
Examples of words taken from interviews to describe key point #11 – Need to help yourself as a patient/consumer, stick up for self...
Please circle one: - high medium low importance
Comments (if any)

Key point #12  Instilling hope and reducing hopelessness
Please circle one: - high medium low importance
Comments (if any)

Key point #13  Important to get a correct diagnosis
Please circle one: - high medium low importance
Comments (if any)

Key point #14  Helping me maintain independence
Please circle one: - high medium low importance
Comments (if any)

Key point #15  Achievement
Examples of words taken from interviews to describe key point #16 - Helping me to achievement, goal setting, employment assistance...
Please circle one: - high medium low importance
Comments (if any)
Key point #16  Reduce stigma in the community

Please circle one: high medium low importance

Comments (if any)

Section 2 – Helpful strategies used by mental health nurses;
(please rate each item either high, medium or low in helpfulness and add any comments, or indicate ‘don’t know’ if you would prefer).

Positive affirmations

Early intervention

Education

Developing insight into illness

Lifestyle (diet, exercise etc)

Holistic care

Reality orientation when psychotic

Giving reassurance

Relaxation training
<table>
<thead>
<tr>
<th>Activity</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
<th>Helpfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seclusion room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing activities with nurses</td>
<td>high</td>
<td>medium</td>
<td>low</td>
<td>helplessness</td>
</tr>
<tr>
<td>Thought control techniques</td>
<td>high</td>
<td>medium</td>
<td>low</td>
<td>helplessness</td>
</tr>
<tr>
<td>Giving time out</td>
<td>high</td>
<td>medium</td>
<td>low</td>
<td>helplessness</td>
</tr>
<tr>
<td>Wellness plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 3 – Helpful therapies;
(please rate each item high, medium or low helpfulness and add any comments, or indicate ‘don’t know’ if you would prefer).

12 step program as used by Alcoholics Anonymous  high  medium  low  helpfulness

Alternative therapies  high  medium  low  helpfulness

Cognitive behaviour therapy (CBT)  high  medium  low  helpfulness

Clubhouse program  high  medium  low  helpfulness

Groups  high  medium  low  helpfulness

Psychological therapies  high  medium  low  helpfulness

Support groups  high  medium  low  helpfulness

Section 4 - My new ideas on the therapeutic role of the mental health nurse;
Please use back of page if you need more room to write.

Idea #1.

Idea #2.

Thank you for your help.
Please return this letter in the self addressed envelop provided.
Appendix 8d. MHN group Delphi round 3 survey.

Southern Cross University

The therapeutic role of the mental health nurse

Second questionnaire

Dear Participant,

Many thanks for your feedback from the first questionnaire. From your responses I have been able to refine what you as consumers believe to be most important regarding the therapeutic role of the mental health nurse.

The purpose of this letter is to ask you to further prioritise these most important key points, strategies and therapies. Because the list is now much shorter it should only take between 5 and 15 minutes to do depending on your comments.

Please list any new ideas you have at the end of the questionnaire and return this letter in the enclosed stamped and self addressed envelop to Ms. Jackie Fisher, School of Nursing, Australian Catholic University, PO Box 968. North Sydney, NSW 2059.

As always your ideas will remain anonymous.

Section 1 - Most helpful knowledge, skills and attitudes.
Please prioritise the 4 key points listed below in order of importance

Key point #1. Nurses attitude
Examples of words taken from interviews to describe key point #1 - Calm, caring, concern, firm, friendly, gentle, kind, awareness of power issues, respectful, shows interest, can be trusted...

Priority ranking - please circle one only. First or second or third or fourth
Comments (if any)

Key point #2. Knowledge of and responding promptly to medication issues including problems with side effects
Key point #3. Supporting me and my family
Examples of words taken from interviews to describe key point #3 – Family support important, support from friends important, feeling supported by nurses...

Key point #4. Empowerment
Examples of words taken from interviews to describe key point #4 – Need to help yourself as a patient/consumer; instilling hope and reducing hopelessness; helping me maintain independence; helping me to achieve.

Section 2 – Helpful strategies used by mental health nurses;
Please prioritise within each group in order of importance

Group 1
Please give each item a number. i.e. 1 for most important, 2 for second most important, 3 for third most important etc.

Early intervention
Education
Giving reassurance
Developing insight into illness
Lifestyle (diet, exercise etc)

Group 2
Please give each item a number. i.e. 1 for most important, 2 for second most important, 3 for third most important etc.
Holistic care
Positive affirmations
Relaxation training
Sharing activities with nurses
Wellness plan

Section 3 – Helpful therapies
Please prioritise in order of importance the following 3 therapies

Psychological therapies including CBT
Group therapy
Support groups

Section 4 - My new ideas on the therapeutic role of the mental health nurse;
Please use back of page if you need more room to write.

Idea #1.

Idea #2.

Thank you for your help.
Please return this letter in the self addressed envelop provided.
Appendix 9. Invitation to participate in the pilot study.

The Therapeutic Role of the Mental Health Nurse in NSW

Many thanks for agreeing to pilot this online survey examining current therapeutic practices including use of psychological therapies by mental health nurses.

The findings from the project will have the potential to improve the quality of mental health care for people living with serious and ongoing mental illness through better understanding of the therapeutic practices of mental health nurses.

As you respond to the survey please consider the following questions:-

How long did it take you?

Is the survey’s objective clear?

Do you feel comfortable answering the questions? Which ones made you feel uncomfortable?

Is the wording of the survey clear?

Are the questions relevant to the topic?

Are the answer choices compatible with your experience in the matter?

Do any of the items require you to think too long or hard before responding? Which ones?

Which items produce irritation, embarrassment, or confusion?

Do any of the questions generate response bias? Which ones?

Is the survey too long?

Any other comments?

the therapeutic role of the mental health nurse

1. Welcome!

My name is Jackie Fisher, I am a mental health nurse and I am undertaking a PhD in mental health nursing, at Southern Cross University. My supervisor is Dr. Kierrynn Davis and my thesis title is: "A study of the the therapeutic role of the mental health nurse". My intention is to hear from mental health nurses and consumers what is needed to achieve quality nursing care for people with mental illness.

You are invited to participate in this survey because you are working as a mental health nurse. The survey has received the support of the Australian College of Mental Health Nurses who have agreed to distribute the survey to their email lists. If you know of other nurses working in mental health in Australia who may be interested please FORWARD THE EMAIL WITH THE SURVEY URL so that the voices of lots of nurses can be heard.

Participation in this survey is on a secured website and anonymous. All results reported in the thesis and any subsequent research publications will be presented as grouped (aggregated) data. Please note that by entering the survey site you are consenting to participate in this survey however you can stop participating without any consequence by exiting the survey.

This research has been approved by the Southern Cross University Human Research Ethics Committee (ECN-10-029). Any concerns or queries related to this project should be addressed to:

Ms Sue Kelly
Ethics Complaints Officer and Secretary
HREC
Southern Cross University
PO Box 157
Lismore, NSW, 2480
Telephone (02) 6626-9139 or fax (02) 6626-9145
Email: sue.kelly@scu.edu.au
**the therapeutic role of the mental health nurse**

<table>
<thead>
<tr>
<th>2. Some quick tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>This survey contains a range of questions that require you to select a &quot;button&quot; when indicating your response. It will take approximately 15 minutes to complete. A percentage completed indicator is at the top of each page so that you can know when you are nearly finished.</td>
</tr>
<tr>
<td>There are no &quot;right&quot; or &quot;wrong&quot; responses.</td>
</tr>
<tr>
<td>You can NOT save this survey if it is incomplete and return to it at a later date. An incomplete survey that is &quot;exited&quot; will wipe ALL of your responses to that point requiring you to start again. Questions with a &quot;*&quot; require a response from you before you can move to the next question.</td>
</tr>
<tr>
<td>You can move forward or backward between pages by clicking the &quot;previous&quot; or &quot;next&quot; button at the bottom of each page. The survey is not submitted until you click the &quot;DONE&quot; button on the final page.</td>
</tr>
</tbody>
</table>
the therapeutic role of the mental health nurse

3. Definition of mental illness for the purposes of this survey.

Mental illness is a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterized by the presence in the person of any one or more of the following symptoms:
- Delusions,
- Hallucinations,
- Serious disorder of thought form,
- Severe disturbance of mood,
- Sustained or repeated irrational behaviour indicating the presence of any of the above.
(Mental Health Act. 2007. Section 4)

1. How many clients/patients who have a mental illness (as defined above) do you have in your typical daily caseload?

2. Do you agree that your mental health nursing work is satisfying?

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

Please select one button

*3. Do you agree the following strategies are nearly always employed by mental health nurses when caring for people with a mental illness as defined above?

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrating an attitude of calm, caring, friendliness and respectfulness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responding promptly to medication issues including problems with side effects.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting families and friends of the patient/client.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing on developing insight.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing reassurance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervening early when they are becoming ill.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouraging healthy lifestyle choices. For example, healthy diet, exercise and quit smoking.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing activities. For example going shopping, sharing cups of tea, playing cards, pool, guitar or painting together.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouraging attendance at peer support groups.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining regular contact either through home visits or sitting with patients/clients - 'being there'.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Status Assessments and physical illness assessment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining safety through aggression minimization and risk assessment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouraging self management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The therapeutic role of the mental health nurse

4. Do you agree that the following factors limit the ability of mental health nurses to be therapeutic?

<table>
<thead>
<tr>
<th>Factor</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low morale of nurses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses role is getting narrower.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses spend too much time doing observations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses don't do counseling because they don't think they have the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>skills.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses don't do counseling because they are told they don't have the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>skills.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The integration of community health into the hospital system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding shortages.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too many forms to fill out.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High patient to staff ratios.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ageing workforce.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An over emphasis on medical assessment, diagnosis, and biomedical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatments such as medication and electroconvulsant therapy (ECT).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any comments?

5. Which of the following non-pharmacological approaches do you use in your current mental health nursing practice? (Choose as many that apply).

- Deciding management plan in collaboration with patient/client.
- Challenging negative thoughts in my patients/clients (e.g. 'I'm a failure' and 'It's hopeless').
- Practical problem solving techniques.
- Providing written information about the relevant mental illness.
- Activity scheduling - Scheduling of pleasurable activities as 'homework'.
- Getting a patient/client to keep a diary of mood, thoughts and activities.
- No intervention - observe only.
- Offering relevant internet based self help information (e.g. MoodGym and Reachout.com).
- Developing a 'wellness plan' with my clients/patients.
- Teaching relaxation techniques with my patients/clients.
- Assisting my patients/clients to develop positive affirmations about themselves.
- None of the above.
## 4. Psychological therapies

We are interested in your thoughts about the use of psychological therapies for people living with a mental illness as defined earlier.

### 6. Have you received formal training (such as attending workshops) in applying psychological therapies/techniques in your practice?

- [ ] Yes
- [ ] No

### 7. If your answer to question 1 above was yes please answer the following question.

- [ ] What was the name of the therapy?
- [ ] How long was the training?

### 8. In the previous 12 months have you done any self-directed learning such as reading articles/journals/books on psychological therapies/techniques?

- [ ] Yes
- [ ] No

### 9. Which of the following psychological therapies/techniques do you use as part of your management of people with mental illness? (Choose as many that apply).

- [ ] Cognitive Behaviour Therapy
- [ ] Dialectical Behaviour Therapy
- [ ] Solution focused Therapy
- [ ] Psychoanalytic Therapy
- [ ] Recovery model
- [ ] Group therapy
- [ ] Counselling
- [ ] A mixture of the above to suit the circumstance at the time
- [ ] None of the above

Other (please specify):
the therapeutic role of the mental health nurse

* 10. Would you like to use psychological therapies/techniques in your routine mental health nursing practice?

- Yes
- No

If yes, which therapy would be of most use to your practice

* 11. Do you agree that the following are barriers to implementing psychological therapies in your practice.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree or disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time within workload.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too few staff to carry out psychological therapies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient resources to help clients/patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limiting bureaucratic practices in organization of client care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleagues not interested in applying psychological therapies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other staff won't support me in applying psychological therapies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My lack of training in the area.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff turnover excessive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't believe psychological therapies will work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not appropriate for my clients/patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>experiencing symptoms that are too severe for psychological therapies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients/clients who have/are experiencing mental illness are</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adequately treated with medication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients/patients do not like the approach.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients/patients do not comply with the approach.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients/patients do not understand the approach.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family members or friends do not agree with the approach.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## The Therapeutic Role of the Mental Health Nurse
### 5. The following questions seek your opinion on Cognitive Behaviour Therapy (CBT)

### 12. Do you agree with the following statements about Cognitive Behaviour Therapy (CBT)?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT is a valuable treatment option for people with mental illness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More resources should be available to provide prompt CBT for my patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT should only be carried out by individuals with an approved qualification.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT is not good use of time for Mental Health Nurses (MHN's).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training in CBT should be made available to all trainee MHN's.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training in CBT should be made available to all MHN's.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHN's should be able to advise their clients/patients about CBT.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT should only be used in minor problems and not in the treatment of more serious mental illness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT should be recommended/tried as well as giving people medications such as anti-psychotics and anti-depressants.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't know what CBT is.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
the therapeutic role of the mental health nurse

6. About you!

The following questions will help us to analyse the survey to assess how demographic influences such as years of experience might effect the responses.

13. What is your gender?
   - Female
   - Male

14. What is your age group?
   - Less than 25 years
   - 25-34 years
   - 35-44 years
   - 45-54 years
   - 55+ years

* 15. What nursing qualifications do you hold? (Choose as many that apply).
   - RN
   - Hospital or post-graduate certificate in Mental Health Nursing.
   - Post graduate degree in Mental Health Nursing.
   - Mental Health Nurse Practitioner.

* 16. How long have you been working in mental health?
   - Less than one year.
   - 1-2 years.
   - 2 - 5 years.
   - 5 - 10 years.
   - More than 10 years.
the therapeutic role of the mental health nurse

17. Place of current employment in Mental Health Nursing? (Choose as many that apply).

☐ Private hospital
☐ Public hospital mental health unit
☐ Public psychiatric hospital
☐ Community mental health
☐ GP office
☐ Private practice
☐ Other

Other (please specify)

* 18. Which State or Territory are you currently working in?

☐ Victoria
☐ South Australia
☐ Western Australia
☐ Northern Territory
☐ Australian Capital Territory
☐ Tasmania
☐ Queensland
☐ New South Wales

19. Any comments?